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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Welcome, everybody, to the committee. It's going to be a really interesting day. We're very much looking forward to hearing your presentations.

Pursuant to Standing Order 108(2), we're going to have a briefing on sodium consumption in the Canadian diet. We've had some previous witnesses who have given us some very insightful and rather shocking information. It certainly alters one's thinking on the issue when one hears from the experts.

From the Canadian Society for Nutritional Sciences, we have Dr. Katherine Gray-Donald, who is an Associate Professor in the School of Dietetics and Human Nutrition at McGill University. From Kellogg Canada Inc., we have Christine Lowry, Vice-President. From Nestlé Canada Inc., we have Catherine O'Brien, who is the Director of Corporate Aaffairs; and Karen Young, Director of Scientific and Regulatory Aaffairs. From the Canadian Institutes of Health Research, we have Dr. Peter Liu, Scientific Director of the Institute of Circulatory and Respiratory Health; and Dr. Philip Sherman, Scientific Director of the Institute of Nutrition, Metabolism and Diabetes. Welcome.

We ask that each association make a five-minute presentation, and we'll start with Dr. Katherine Gray-Donald.

Dr. Katherine Gray-Donald (Associate Professor, School of Dietetics and Human Nutrition, McGill University, Canadian Society for Nutritional Sciences): Thank you.

I'm representing the Canadian Society for Nutritional Sciences, which is soon to become the Canadian Nutrition Society. My training is in nutritional epidemiology, and I'm an associate professor at McGill.

Today I'd like to cover two points, from the perspective of a nutritionist and member of the Sodium Working Group. The first is that the health benefits of sodium reduction are very well established, and second, the three prongs to the Sodium Working Group program—education, sodium reduction in the food supply, and research—are all necessary components of a strong sodium reduction strategy.

The evidence that sodium leads to increases in blood pressure, a major cause of cardiovascular disease, is indisputable. Our best sources of data come from two types of studies. One is a dosing study, where different levels of sodium are given to the same person and changes in blood pressure are then monitored. The second type of study is the longer-term clinical trial, in which sodium intake is reduced in one group and not in a control group. Such studies, conducted in both patients with hypertension and in healthy subjects, have shown decreases in blood pressure among those randomized to sodium reduction programs.

However, sodium reduction is by no means the only solution to decreasing blood pressure. Weight loss and sodium reduction appear to be additive in their impact on blood pressure. Overweightness and obesity, present in 53% of Canadian adults, cannot be ignored in our messaging lest Canadians think reducing salt is the magic bullet to improving health. It's an important part of the whole problem.

Reducing sodium will require educating the public, changing the food supply, and research to monitor progress. Educational messages are important to sensitize the population to ways of reducing sodium intake. We could add advice to Canada's Food Guide on reducing sodium intake and inform health professionals and the public through many avenues as well.

Certainly some of this is currently being done. We have sodium content information on the nutrition facts labels on processed foods. However, the target on the label is not the desirable level of salt intake for the day but rather the tolerable upper level of intake. This does not follow the labelling for other nutrients wherein we use the desirable level for health as a target. We can thus mislead the public. For example, if one uses the upper limit of the standard, as is currently done, a cup of mystery cereal has 14% of the tolerable upper level amount, but it has 22% of the healthy target set by the Institute of Medicine.

With the current food supply, it is difficult to help consumers have a desirable intake of sodium without asking people to refrain from eating many of the processed foods they're used to and eating out often. This is not very doable. We need to reduce the sodium content of the commonly eaten foods.

Finally, research to monitor progress is essential, as public health interventions sometimes have unintended consequences. Consumers could start using the salt shaker more if we make certain foods less palatable. The best way to measure progress in sodium reduction is through measuring urinary sodium in a sample of Canadians, as this reflects sodium intake over time. Measuring diet is fraught with the difficulties of measuring salt that is added to foods with a shaker and the changing content of sodium in foods.

In closing, both broad-based education on healthy eating and offering Canadians a wide choice of healthy processed foods is essential to improving their health.

Thank you.

● (1535)

The Chair: Thank you very much.

We'll now go to Christine Lowry, vice-president of Kellogg Canada.

Ms. Christine Lowry (Vice-President, Nutrition and Corporate Affairs, Kellogg Canada Inc.): Thank you, Madam Chair and members of the committee, for this opportunity to appear before you today to discuss this important issue.

By way of background, Kellogg Canada is a wholly owned subsidiary of Kellogg Company. Our head office is in Mississauga, and we have sales offices in Montreal and Calgary. We have two cereal plants: one in London, Ontario, and one in Belleville. Throughout Canada we employ 800 Canadians.

As a leading manufacturer of breakfast cereals in Canada, we know that breakfast cereals contribute significant health benefits to the Canadian diet. Breakfast cereals are a major contributor of B vitamins, iron, and zinc, and in fact, breakfast cereals are the number one source of iron in the Canadian diet for children.

The majority are low in fat, and all Kellogg's breakfast cereals have zero trans fats. Most importantly, many of our cereals are among the largest contributors of fibre in the diet, a nutrient that many Canadian adults and children are deficient in. In addition, there is consistent evidence that people who regularly eat breakfast cereals tend to be slimmer than those who do not.

It is very important to note, in the context of your review of sodium, that breakfast cereals represent 3% of the sodium intake in the Canadian diet, according to Statistics Canada. In fact, as this committee heard at your October 5 meeting, cereals are not among the top 10 foods that contribute sodium to the Canadian diet.

This is not to say that we take this issue lightly. We recognize that sodium is an important issue for Canadians, and we are committed to doing our part to help address it in our products. And we'll be doing our part as an ongoing commitment to our health and wellness.

We were very aggressive in renovating all our food products to ensure that there were zero grams of trans fats per serving. We have already lowered the sugar in a number of our breakfast cereals, and we have lowered sodium levels in a number of our cereal products.

Kellogg Canada is committed to gradually lowering the sodium content of our cereals and to continuing to improve their nutritional profile. For context, I think it's helpful for the committee to understand the range of breakfast cereals we make and their contribution to the sodium intake of Canadians.

Kellogg Canada manufacturers 36 cereal products. About 75% of these products have 230 milligrams of sodium or less per serving. Five of our products have zero milligrams of sodium per serving, 13 have 200 milligrams of sodium or less, and nine have between 200 and 230 milligrams of sodium per serving. However, we do have nine products that have sodium levels of over 230 milligrams per serving. These include Kellogg's All-Bran, which was the subject of some recent media coverage.

At the beginning of 2009, we embarked on a project to gradually reduce the sodium levels in these nine products. I'm pleased to announce to the committee today that we are committed to achieving an initial target of 200 milligrams of sodium per serving for each of these products by early 2011.

All along, our strategy has been to reduce sodium gradually, over time, without compromising taste or quality. Consumers are very sensitive to formulation changes and to drastic changes in the flavour profile of an established brand, especially in the breakfast cereals they know so well. If this is not done properly, consumers may reject the new taste and walk away from the food product. In doing so, they may change to a replacement food that may not have the nutritional benefits of the high-fibre cereal. That's why our plan is to have a phased approach to reduce the sodium.

Although there are many challenges associated with reformulating products to reduce sodium while maintaining consumer acceptance, we remain committed. Progress is being made, and more progress is coming. We're focused on achieving this goal, and we know we will be successful.

Kellogg Canada remains recommitted to continually improving the nutritional contribution of our products for all Canadians. As well, we remain committed to working together with the government, health and professional associations, and members of Parliament from all parties to help Canadians reduce their sodium intake.

● (1540)

To that end, I do appreciate the opportunity to present this information to the committee and I welcome any questions you might have today.

Thank you.

The Chair: Thank you, Ms. Lowry.

We'll now go to Catherine O'Brien from Nestlé Canada Inc.

[*Translation*]

Ms. Catherine O'Brien (Director, Corporate Affairs, Nestlé Canada Inc.): Madam Chair, members of the committee, thank you for inviting me here.

[*English*]

I'm Catherine O'Brien, the Director of Corporate Affairs for Nestlé Canada. I have with me my colleague Dr. Karen Young, who is the director of Regulatory and Scientific Affairs.

At Nestlé Canada we're committed to supporting the health and wellness goals of Canadians by providing high-quality, great-tasting, and nutritious products. Our focus is on offering science-based solutions to Canadian consumers to help make their journey towards a healthy lifestyle easier and more enjoyable.

We share the concerns of the Standing Committee on Health with respect to sodium reduction. We are committed to reducing sodium in our products, educating our consumers about sodium reduction, and partnering with the experts.

As with most nutrition issues, reducing sodium in our diets is a complex effort and there is no one-size-fits-all solution. We must balance the push of science against the pull of the market. Consumers will simply not compromise on taste; therefore, it must be a priority, alongside improved health. We must also ensure that the functional qualities of sodium, such as safety, are also considered.

We're here today to share a glimpse of our commitment to sodium reduction, what we've accomplished, and our future plans.

This is an ongoing process, and while we've made great strides, we know that it is a journey and that we certainly have opportunities for improvement. We've established a policy to reduce sodium in our products worldwide, and in Canada especially we have made significant progress in reducing sodium levels in many of our most popular products. I want to offer a few examples today.

Stouffer's meat lasagna is our number one selling Stouffer's product. The sodium levels have been reduced in most of the Stouffer's products in a phased approach that began in 2005. To date, we've been able to reduce the amount of sodium in Stouffer's meat lasagna by 26%. Not only does the sodium level meet the Health Check criteria, Stouffer's meat lasagna is also preferred on taste versus our competitors' products. We've been able to reduce the sodium and maintain the taste for consumers.

Stouffer's meat loaf is another example. Again, this is a product with very high sales. In a similar fashion, we've been working to reduce the sodium level in meat loaf since 2005 and have reduced the sodium by 22%. Meat loaf is another success story among Canadian consumers, as it also was recently preferred on taste versus that of our competitors. It also carries the Health Check symbol.

Another example from the Nestlé portfolio is Lean Cuisine. Every Lean Cuisine recipe we have has a sodium level of 700 milligrams or less, offering consumers a variety of nutritious offerings made with whole grains, without preservatives, and with two servings of vegetables.

Skillet Sensations is yet another example of a nutritious and convenient choice for families. Many of these Skillet Sensations recipes meet the Health Check criteria, with sodium levels of 720 milligrams per serving or less. We've been working to reduce the sodium levels of the Skillet Sensations recipes, with an average reduction of 25% since 2005.

Nestlé is also a food service provider. Our Nestlé professional business has reduced sodium significantly in many of our own branded products as well as our custom products.

As you can see, product renovation is ongoing, but at the same time, we know it's not the only piece of the solution. Communicating with our consumers is extremely important, and we regularly answer questions, offer advice, receive suggestions, and dialogue with our consumers.

One particularly relevant example is a booklet on sodium that we created and distributed through *Reader's Digest* to over 140,000 homes and through 1,800 pharmacies across the country. The booklet contains information about sodium, its role in our diet, and how to understand levels in foods. We know this is only a start and that further education is essential.

We're also working with the Heart and Stroke Foundation and participate in their Health Check program. The majority of our Stouffer's products carry the Health Check symbol, which means the meals were evaluated by the foundation's registered dietitians and found to be a healthy choice, with the appropriate levels of fat, protein, and sodium. We also support the efforts of the multi-stakeholder working group on sodium reduction, led by Health Canada, of which our industry association, Food and Consumer Products of Canada, is a member.

The reduction of sodium in our diets is definitely a journey, but a journey on which we have made great strides. We will continue to make progress, to look at opportunities to improve all of our products, and to dialogue with consumers. We know that industry, government, health experts, and our fellow food manufacturers all play a role, and we look forward to continuing to collaborate to address this important issue.

● (1545)

[*Translation*]

Thank you for listening.

We are now ready to take your questions.

[*English*]

The Chair: Thank you, Ms. O'Brien.

Do you have copies of that booklet you were referring to?

Ms. Catherine O'Brien: I do, yes.

The Chair: Are they in both languages?

Ms. Catherine O'Brien: Yes. I don't have a copy for each person, but I have samples.

The Chair: If you would be so kind as to make sure that each of the committee members does have a copy of that, I think it would be very helpful.

Ms. Catherine O'Brien: Sure, yes.

The Chair: If you have a couple, I can take one of them up here as well.

Can we now go to Dr. Peter Liu from the Canadian Institutes of Health Research? I understand that Dr. Philip Sherman will be sharing his time, so you have five minutes. Thank you.

Dr. Philip M. Sherman (Scientific Director, Institute of Nutrition, Metabolism and Diabetes, Canadian Institutes of Health Research): I'll take the liberty of going first, since that's how we've made the arrangements.

Thank you for inviting us. I'm a practising pediatric gastroenterologist at the Hospital for Sick Children, University of Toronto. My colleague Dr. Liu is an adult cardiologist at the University Health Network, University of Toronto. We are co-leading, together with multiple institutes of the Canadian Institutes of Health Research, a research agenda to support sodium reduction in Canada, which includes a workshop.

You all have the slides with you, so I'll just go through them.

We are holding a low-sodium workshop to look at this initiative during the third week in January in Toronto, to identify strengths, gaps, and opportunities in research capacity in Canada related to sodium reduction in the thematic areas of health, food science, knowledge to action, and evaluation and monitoring of any policy change in sodium content in foods.

We are identifying a research agenda for sodium reduction to support Health Canada's working group on sodium reduction, and we are identifying opportunities for international and global collaborations in this context, as well as engaging potential research funders to support this research agenda on sodium reduction.

The next slide shows a list of partners we've already engaged, including Health Canada, the Public Health Agency of Canada, Blood Pressure Canada, the Heart and Stroke Foundation of Canada, the Canadian Hypertension Education Program, the Kidney Foundation of Canada, and two national centres of excellence, including the Canadian Stroke Network and the Advanced Food and Materials Network.

As you know, there is a Sodium Working Group that is tasked with developing and implementing a program of lowering sodium content, with a three-pronged approach of education, voluntary reduction in sodium levels, and research. It's in the research aspect that Peter and I are involved.

As you know, and the next slide reinforces what you've already heard, most of the salt in Canadians' diet is actually in processed foods. The next slide shows factors associated with increased salt sensitivity, and these are populations of vulnerability. The next slide shows adverse effects of excess sodium intake, including heart disease, blood pressure, effects on bones, and an increased risk of cancer.

The next slide, which is titled “Excess salt stored in the skin stimulates, via macrophages, neolymphatics”, is to show to all of you that there are new advances in the control of sodium intake. Understanding basic biologic principles will have a major impact on the sodium in one's diet and on its impact on health, including blood pressure and cardiovascular disease. This fundamental advance was actually published in a medical journal in May 2009. So we know lots about sodium, but not everything that needs to be known.

On the next slide, it's important to note that sodium is involved in a variety of conditions, including stomach cancer, and there's strong mechanistic evidence that salt is a probable cause of stomach cancer.

I'm going to turn it over now to my colleague Dr. Liu.

● (1550)

Dr. Peter Liu (Scientific Director, Institute of Circulatory and Respiratory Health, Canadian Institutes of Health Research): I will continue to the next slide, which is on global perspectives. It indicates that the actions we take today come from research knowledge to date. In regard to reducing salt intake in populations, there is strong evidence that salt consumption is linked with several chronic diseases—obviously hypertension and heart disease, as we heard earlier. Any intervention to reduce population-wide salt intake can actually be highly cost-effective, as illustrated in other countries. There's an urgency to implement the sodium reduction strategies here in Canada, and we need to look for opportunities to be innovative in this type of setting.

If we go to the next slide, in terms of international perspectives, I think this group already heard that the U.K. has aggressively pursued sodium reduction by setting targets through their publication and also setting up an agency to reduce sodium in the population. In 2008, the Institute of Medicine from the U.S. convened a committee on strategies to reduce sodium intake involving various partners, including food manufacturers, the government, and public health professionals. Most impressively, over the past 30 years in Finland, a one-third reduction in average salt intake was accompanied by a greater than 10-millimetre fall in terms of blood pressure in the population and a 75% decrease in stroke and heart mortality.

Indeed, the data to date on the next slide suggest that the relationship between sodium intake and blood pressure is a progressive and continuous one without an apparent threshold. The next slide shows the long-term effect of reducing sodium intake on cardiovascular disease, but I think this committee is familiar with some of this data, and that reducing sodium in the various contexts has been consistently able to reduce blood pressure. Indeed, each millimetre of blood pressure reduction translates into a 2% reduction in the death rate. This is very impressive.

In terms of supporting the effort in the sodium reduction policy working group, we also proposed in our workshop to monitor the effectiveness of sodium reduction as it is taking place. And the parameters that will need to be monitored included the effectiveness of public education programs in samples of the population, and in terms of a sodium content reduction in the various food categories over time, and also sampling of the total sodium intake in the population, and also sampling of urinary sodium excretion in samples, as we heard earlier.

With that, I'd like to thank the committee for the opportunity to present our research agenda to support sodium reduction efforts.

The Chair: I want to thank all the presenters for their insightful preliminary comments, and I want to remind you that at five o'clock we're going into a half-hour of business. We have some motions and some things to deal with.

For the next hour, we will go into seven-minute questions and answers.

We'll begin round one with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you very much.

This is maybe for the researchers. Would you consider that reducing sodium in the diets of Canadians is an urgent problem?

Dr. Peter Liu: Certainly the data to date suggest that the ability to reduce sodium would have translated into blood pressure reduction, which would have an impact on stroke and on various cardiovascular outcomes. There are data from other countries to suggest that when we are able to do this, it will be important in terms of health consequences.

I would say that this is a thoughtful type of process in which you can achieve this successfully, and it will translate into health benefits.

Hon. Carolyn Bennett: The Sodium Working Group was formed on October 25, 2007. I think a lot of us felt at the last hearing that there doesn't seem to be a lot to show for this in the last two years for something that seems to be an urgent problem. I think we heard there weren't enough resources, that they don't meet often enough. They seem to be waiting to launch a public awareness campaign even though it's quite clear in the mandate, in the terms of reference, that the recommendations of the Institute of Medicine would be a reasonable target, that we don't need a separate target for Canada.

What I'm asking is this. Given what has happened in Finland and around the world, do you believe that for this committee to have their terms of reference be voluntary reductions of sodium levels in processed foods and foods sold in food service establishments is adequate and broad enough to be able to get the job done?

● (1555)

Dr. Philip M. Sherman: I will try to answer that.

One of the points is that when you do make a change in the salt content of foods, it's very important to measure the outcomes—the anticipated as well as the unanticipated outcomes.

The Institute of Medicine report—I see the book there, if you want to look at it—in 2001 actually identified a bunch of gaps in knowledge that really do need to be identified, whether it's a voluntary or mandated change in salt. For example, if you lower salt content in diet, what's the impact on children and their later life—not just the immediate impact, but many years later—and on pregnant women and other vulnerable populations? If there is a change in salt in the diet, our job is to monitor what happens to make sure there is documented benefit, but also to monitor to make sure there is no adverse outcome. We have been working since the beginning of this year to put together the workshop and evaluate if there is a policy change.

Hon. Carolyn Bennett: Do you think there is any reason for the government to wait to do a public awareness campaign? It has now been two years. If it weren't for *The Globe and Mail* series, there wouldn't be any real awareness out there, not thanks to this government, since it has established the working group.

Dr. Philip M. Sherman: Our plans for monitoring and evaluation of a change had been under way in advance of *The Globe and Mail* articles. But you're absolutely right; it certainly did raise awareness.

Again, I would say that if there is any change in salt in the diet, we need to monitor its outcome and evaluate that it's a positive benefit.

Hon. Carolyn Bennett: Dr. Liu, you are interested in cardiovascular health as well. Do you think the failure to make trans fats reductions compulsory or regulated has been working?

Dr. Peter Liu: I will say that currently there is some enthusiasm in looking at the U.K. model, because they have actually started on this. And indeed, the thought is to start out with a voluntary reduction strategy, but with the possibility of regulation as a potential incentive, as a strategy to move forward as a possible—

Hon. Carolyn Bennett: As a working group, do you feel confined that the terms of reference only allow you to look at voluntary reductions and don't allow you to look at a regulatory framework for this?

Dr. Peter Liu: I think right now it's while the positive dialogue is going on that the opportunity is still there for us to achieve the original goals. I think this is where the evaluation becomes particularly important, because if the effect is not what we were hoping for, then I think it would be important—

Hon. Carolyn Bennett: Has the government given any more money to CIHR in terms of the research, which is the three-pronged approach it would include? Is CIHR expected to do this research with its existing funds, or are there additional funds being given for research on sodium?

Dr. Peter Liu: In fact, what we are doing is taking this research agenda forward in the January meeting and looking at the scope of the research requirement, particularly in terms of monitoring.

You are absolutely right. Your point is very well taken that indeed additional resources may be required, but I think we want to do this in a deliberate manner in terms of knowing what to do.

Hon. Carolyn Bennett: Will the January meeting come up with an invoice that you would give the government for what an appropriate research agenda would cost?

Dr. Peter Liu: Yes. Well, it certainly will define the scope of the research agenda: the type of programs we require to have the information, and also the budget that will be required to accomplish the goals.

Hon. Carolyn Bennett: Would that January meeting also include the cost of what an evidence-based public awareness campaign...? I think most of us believe we do want to change the behaviour of Canadians. Would you be involved in evaluating a public awareness campaign that would really determine whether or not you are changing the behaviour of Canadians?

● (1600)

Dr. Peter Liu: Yes, this is also part of the agenda. It's a three-pronged research strategy. It will look, in terms of sodium, at the changes in the population. It will look at the effectiveness of public engagement strategy. And it will look at the food content, which will be important in terms of working with our food industry partners.

Hon. Carolyn Bennett: In terms of the made-in-Canada reality, is there a reason some of the U.K. approaches, or the Institute of Medicine approach, or the Finnish approach...? What changes would we need here in Canada that we couldn't just adopt? In Finland they don't put salt shakers on the table. Why can't we do that?

Dr. Peter Liu: There are some important geographic as well as cultural and system-based considerations, because we're a very large geographic country with diversity in population composition. Some cultural-specific messaging will be important to benefit all the various populations. So I think some of those considerations will probably be important to make sure we have the maximum benefit.

The Chair: Thank you, Dr. Liu.

We'll now go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you very much, Madam Chair.

I would also like to thank the witnesses for joining us this afternoon.

I am always a little surprised when I hear people say that we're in this situation because consumers want food that tastes salty. That amounts to saying that people want to have high blood pressure and to face a greater risk of cardiovascular disease and stomach cancer. It seems to me that if we weigh the facts, we need to ask people if they really want saltier foods and potentially more serious health problems. Do you honestly think that people will admit to preferring saltier foods?

In my view, high-profile companies like Kellogg and Nestlé should play a greater role and show more leadership in getting information out to consumers. They need to let consumers know that they have reduced or plan to reduce the amount of sodium in their products, because independent rigorous studies show that reducing one's sodium intake immediately and dramatically represents a healthy choice with significant health benefits.

Some advertisements sing the praises of having a flat stomach or of eating certain products to achieve a desired body shape. In my opinion, advertisers should also be encouraging people to cut the sodium in their diets in order to be healthier and live longer.

I want to thank you for being here today and for answering this question.

My next comment is directed more specifically to the Kellogg representatives. According to studies done by the World Action on Salt and Health, it would appear that the All-Bran sold in Canada contains more sodium than the same product sold elsewhere in the world. Given that finding, I think we need to make an even greater effort to put things into perspective. You need to be proactive, demonstrate real leadership and show the world that you are taking effective steps to fight cardiovascular disease and reduce the sodium content in food products.

On that note, I will turn the floor over to you.

[*English*]

The Chair: Who would like to comment?

Ms. Catherine O'Brien: I think the question was addressed to both of us.

The Chair: Ms. O'Brien, do you want to start?

Ms. Catherine O'Brien: I can only speak from Nestlé's perspective. We absolutely believe we have a role to play in sodium reduction and education of consumers. We are here today to tell you about some of the things we've done. Is there more we can do? Absolutely.

We have regular dialogue with consumers through our 1-800 line, our website, and so forth. We're continuing to share information on sodium and the renovation of our products through those vehicles.

You referenced advertising. We have an ad campaign now that's really about educating people about total health. It says things like "what's not in your food is as important as what is in your food". We're trying to get people to look at nutrition in a different way.

From Nestlé's perspective, we believe we are embarking on communications with our consumers to educate them on the importance of sodium reduction. It's a journey, and we're on that journey and always open to suggestions about how to do that better.

● (1605)

The Chair: Go ahead, Ms. Lowry.

Ms. Christine Lowry: Thank you very much for your question and your comments.

Similar to my colleague, at Kellogg's we are very committed to improving the nutritional credentials of our products. As I mentioned in my statement, we've been doing this over time. As I said, we've removed trans fats, we've removed sugar, and we're looking at sodium. We identified that, yes, we do have a few products that are over 230 milligrams per serving, and we're working very hard, very diligently, to reduce this.

On your observation that one product is different in one country compared to another, we observed that and noted that, and we started putting action plans together.

I can tell you that we're very committed to reducing this slowly over time. As my colleagues at the end of the table have mentioned, we want to phase it in to make sure the Canadian consumer will accept the changes over time. We are very much committed to that. Anyone who's worked on sodium reduction in food will tell you that there are many technical challenges, but we have a team of researchers and developers and processors who are working to do this. And we are going to get to that level of 200 by 2011, if not sooner. That's something we're very much committed to.

We're also committed to education. I think it is really important. Everyone has mentioned the three-pronged approach of the Sodium Working Group. It's education, reducing sodium in the food supply, and research. The more we can help the Canadian population to be literate, to understand how to read the nutrition facts panel, to make those decisions so that they're empowered to manage their nutrition needs.... I think that's key. For the past two years, Kellogg's has put GDAs on our front pack. We tell consumers on the front what percentage of the daily value of sodium is in one serving of that product. Not only is it on the side panel, we've put it on the front of the box.

We think it's really important, all of us, to be involved in trying to help educate consumers on how to read that nutrition facts panel and to make informed decisions.

[*Translation*]

Mr. Luc Malo: Speaking of that, Dr. Gray-Donald raised a particular problem. She indicated that the target on the label is not the desirable level of salt intake, but rather the tolerable upper level of sodium intake, tolerable in terms of health. That could present a problem as well.

Doctor Gray-Donald, can you tell me why the target used for sodium intake is not the desirable level of salt intake?

Dr. Katherine Gray-Donald: I do not know the background, but we have observed this phenomenon. It's connected to what is happening in the United States. Nutritionists have opted for a daily recommended intake, because it is important to have a figure associated with every nutrient, among other things, because children do not eat as much as adults. They opted for this approach a long time ago and it will be hard to change it.

[*English*]

The Chair: Thank you, Ms. Gray-Donald.

We'll now go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson.

Before I start my line of questioning, I want to make a comment first of all, Madam Chair, and ask for your guidance.

I was quite shocked to listen to the presentation by the representatives of Nestlé Canada in which products were mentioned. Many different products were mentioned. I think it's quite inappropriate for our committee to be used as a forum for any kind of free advertising. In fact, we should consider striking from the record all references to the specific products mentioned in Catherine O'Brien's presentation.

I'll leave that for you to consider, but I think it's just not appropriate for our committee.

● (1610)

The Chair: Ms. Wasylycia-Leis, I'll speak to that. I'm watching your time, so you won't be robbed of any time. I'll take that under advisement, and I'll get back to you at a later time.

Please continue.

Ms. Judy Wasylycia-Leis: I would like some kind of plan of action. We hear from industry that they're doing certain things. We've heard, again, from the scientific community that the impact of sodium intake is very significant. We've heard in the past about heart disease, high blood pressure, heart attacks, and you listed some other serious conditions. Now you're telling us it could even be a cause of stomach cancer. We know this is costing us dearly not only in terms of human health and well-being but in terms of cost to our health care system—$2 billion a year.

Frankly, I don't understand why we're still talking about the voluntary approach and why we're buying the line that industry is going to just do it, here are some good products, and never mind the whole picture. If this has been around for so long and you knew about it, why is industry only at this hit-and-miss approach to cutting sodium in products? Why are Canadian products often so much higher in sodium than your company's equivalent in other countries?

We had the example of a cereal—I won't give the name, but it's produced by Kellogg—that is much higher in sodium in Canada than the exact same product in the United States. Is that because you can get away with it here because we don't have tougher regulations, and that in the final analysis you won't get close to the 1,200 milligrams per day, unless you're forced to, because this salt sells your products?

Canadians are taking in 3,500 milligrams a day, and most of it is from packaged products, not from home cooking. What is the industry going to do? If you're not going to do it, I want to hear from others about what should be done to make this happen and happen quickly.

The Chair: Who would like to please take that on?

Ms. Judy Wasylycia-Leis: I would like to hear from them both.

The Chair: Okay, Ms. Lowry and Ms. O'Brien, could you start? Then could we have Dr. Liu or Dr. Sherman continue?

Ms. Christine Lowry: Thank you very much.

I understand your concern, and I understand the concerns of the committee in everything we've heard today. I can assure you we're committed to working on all of the nutrients of concern and the new science coming forward on elements in the diet to help Canadians live better lives.

As I mentioned, we've had a number of investments and renovations in our products to continually make them healthier for Canadians and to respond to where public health science is going. We've done this in the past, and we'll continue to do it in the future. We are a company that is very much on a journey of improving the nutrition credentials of our products.

We identified one product in particular, and we identified very early that we needed to work on reducing that sodium level. We have that plan in place. We've reduced sodium in other products in past years, and we kept silent on it. We've made many other increases in the nutrition credentials of our products. We do that routinely; it's just part of our plan. There generally isn't a lot of noise that we make about it, because it's something we're committed to.

Ms. Judy Wasylycia-Leis: Why not do it across the board? How do you explain the higher sodium content in a particular Canadian product when the identical product is lower in other countries?

Ms. Christine Lowry: In that particular product we tried different methods of changing it and now we think we've found a solution that's suitable to the palate of Canadians.

Ms. Judy Wasylycia-Leis: Is our palate different from the Americans' palate?

Ms. Christine Lowry: I think you heard there are geographical differences, cultural differences, and there are some differences in palate. Nonetheless, we don't want to rely on that. We want to be able to bring that palate down, and we're going to do that gradually.

We've started that, and we're committed to it. We've made changes in sodium content in some of our products already, and we have a program in place to invest in bringing that sodium down. I can tell you, with full commitment, that's what the company has done, in the same way as we've done it with trans fat. We've also looked at nutrition innovations that we're adding to brands. We have a lot of people committed to improving the products, and we'll continue to do that.

As I said before, we'll continue to invest in education so when consumers are looking at that side panel they know the absolute amount of sodium in the product and what percentage that is of the current DV. If the DV changes, then again, it's communicating to consumers so they're informed and they make those better choices.

● (1615)

Ms. Judy Wasylycia-Leis: Would you have voluntarily reduced your trans fats if there had been no public exposure of the serious problems and outcry from Parliament? If it had just gone on and you knew all the health stats, would you on your own, without any pressure from government, have done that?

Ms. Christine Lowry: Absolutely, because we are a company that takes a look at the science, that looks at public health globally. We have a worldwide commitment to—

Ms. Judy Wasylycia-Leis: Knowing the health consequences of sodium, could you commit to the Canadian public today that you're prepared to do much more than a hit and miss, reducing the odd product here and there, and having international differences? Could you commit to doing something much more definitive so we don't have to have mandatory regulations?

Ms. Christine Lowry: In my previous comments, I said we did commit to getting to a level of 200 milligrams. We're very eager to see what the Sodium Working Group takes a look at, what their guidelines will be, because we know the sodium consumed right now from the cereal category is only 3%. So we'll take a look at the recommendations when we meet with the Sodium Working Group in a couple of weeks.

The Chair: Thank you, Ms. Lowry.

Thank you, Ms. Wasylycia-Leis.

We'll now go to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I want to thank all the witnesses for being here today.

I find this conversation extremely interesting. It is something I think Canadians need to become much more aware of. I must say, though, I'm very proud of our government and our history of taking the health of Canadians seriously. I know we've moved on trans fats. For years sodium was ignored by previous governments, and we know we need to take action on that. I know we got started with the Sodium Working Group in 2007. I think you met for the first time in 2008, so things are moving along.

Academics, why should sodium be a priority for government action at this time?

Dr. Peter Liu: I can start, and Phil can follow.

In terms of the impact of reducing sodium from a health point of view, it's interesting if you look globally at some of the factors that are producing complications. One, for example, is malnutrition worldwide; that's not a problem in Canada. But the other aspect is high blood pressure. One in four of us in this room has high blood pressure, and as we get older the incidence gets higher. If you can reduce sodium, about one-third of us who have high blood pressure can have normal blood pressure. You may not even need to be treated with medication.

People have done some comparisons. For example, comparing to trans fats, comparing to other types of policy changes, if the sodium reduction impact is fully implemented, it's about three to four times higher than many of the other strategies. So I think this is part of the reason that sodium reduction is a very worthwhile venture to be investing time and effort in.

Dr. Philip M. Sherman: I'm the director of the Institute of Nutrition. Nutrition encompasses lots of healthy foods, and it's clear that sodium is one major player, in that altering sodium content could have an impact on the health of Canadians. I think that's why it's been targeted among a series of potential alternative considerations. It's certainly a priority, but not the only priority, for healthy food and healthy eating for Canadians.

Mr. Colin Carrie: You mention the importance of research, and I am very much in favour of research. What kind of research is still required? It seems there's a lot of research in lowering these levels. What else do we need to know?

You mentioned the importance of following through, making sure you get the desired results after you implement a policy or some recommendations.

● (1620)

Dr. Philip M. Sherman: That's a very important question and one we are asking ourselves as a research community. That is the focus of the workshop in January, so I don't want to prejudge. We're going to have a group of Canadian experts as well as some selected international experts speak on this, because there are gaps in knowledge that it would be helpful to fill out.

If there is an adjustment in salt content in the processed foods Canadians eat, we need to monitor that impact. You heard urinary sodium mentioned as a way to do that. It's not clear that all experts think that's the best monitor; maybe we should use another marker. We need to have that in place so when there is an adjustment in dietary salt we can come back to you all and say what it did or didn't do for the health of Canadians. Here's how it altered total body salt, because as you heard, sometimes you are well-intentioned in trying to adjust the salt intake, yet people take in salt in other ways. So you need to see that the reduction in salt in processed foods is evidenced by a reduction of salt in the body and reduction of blood pressure and coronary artery disease. So we need to have things put in place, which we intend to do, to monitor those impacts.

Dr. Peter Liu: From a food sciences point of view, people are interested in salt substitutes. The challenge is to find which salt substitutes are safe and which ones can be used in food processing. The other aspect that we are promoting, at both the Sodium Working Group and the CIHR, is the so-called knowledge translation. We are trying to reach out to the public. We are looking for the best vehicles to get the public energized in this partnership. We needed to innovate in our messaging and our evaluation techniques. We want to discover which strategy is the most effective so that we can help to form an active partnership between the public and the government.

Mr. Colin Carrie: You have made some good points. I wanted to talk to the industry representatives too. I want to commend you for taking action on sodium.

When I was a little younger, when we had our kids, we looked at the different amounts of sodium in things like baby food, soups, and snacks like potato chips. I have noticed that you are lowering the amounts of sodium in your foods, but there seem to be some questions around the table today. Coming from Oshawa and the auto industry, I know that there have been successes with voluntary agreements in the auto industry. Can Canadians be confident that a strategy of voluntary sodium reduction by the industry would work? Are you confident that it could work?

Ms. Catherine O'Brien: I can only speak from my company's perspective. We have made significant strides already, and we continue to do so. We have heard loud and clear from the medical and scientific community about the impacts of sodium on the health of Canadians. We've also heard from our consumers that they want to see sodium reduced. So we don't need any further incentive. I can guarantee you that in our company a voluntary approach is effective. We've already made progress; we will continue to do so. We are fully committed to methodically reducing sodium across the breadth of our products.

Ms. Christine Lowry: As for our company, a voluntary approach would definitely work. We've seen it work in the past on a number of different issues. We have a worldwide nutrition policy under which we are working hand in hand with governments, public health experts, and science. We will always do what's right for the health of Canadians. We try to stay abreast of new information and understand where science is going. We also try to stay current in our understanding of where consumers are going. We strongly support a collaborative approach in helping to improve the health of Canadians.

The Chair: Thank you, Ms. Lowry.

Ms. Murray.

● (1625)

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thanks for the information that you're providing.

It makes me wonder, if Finland started reducing their salt intake 30 years ago, what happened in Canada? Was there an international understanding of the science and Canadians were asleep at the switch? Perhaps you could tell me why we're so late off the mark on this issue?

The Chair: Who would like to comment?

Ms. Gray-Donald.

Dr. Katherine Gray-Donald: Finland was known as the country with the world's highest risk of cardiovascular disease. If I'm not mistaken, they had a higher salt intake than we did. Britain seems to have higher salt intake than we have. We had a national nutrition survey in 1970; our next one was in 2004. So we had a 24-year gap in our knowledge of what Canadians were eating. People have asked why we are only now looking at it. Well, we surveyed 30,000 Canadians and found that the salt intakes are not at all where they should be.

Ms. Joyce Murray: Okay, thank you. I have a couple of other questions.

We have a major problem with salt over-consumption; we understand that. In the material we have, we see that another country that did a major reduction had targets and had government leadership. I'm hearing some good efforts from two representatives of the corporate world, I'm hearing about some research, but I don't see any national leadership on this. I haven't seen any targets, timelines, or any kind of framework other than, “Hey, everybody, this is a problem. Can you do your best?”

Do you think this is the kind of situation, now that we understand the gravity and we're prepared to do something individually, bottom up...? Do you think it would be more effective if there were strong leadership at Health Canada or at the federal government level with measurables, timelines, and stronger leadership and strategic plan?

The Chair: Dr. Liu, do you want to speak to that?

Dr. Peter Liu: I think the three-pronged approach proposed so far is a good approach in terms of public education, collaboration from the food industry, reducing the sodium content, and the ability to actually monitor effectiveness so that we know the strategy is working. I think this is important in terms of a coordinated strategy, because if the public does not know about the importance of sodium, even though the food content may be reduced, they may simply add it back in.

Ms. Joyce Murray: You don't believe targets and timeframes—

Dr. Peter Liu: Oh no, I do believe in it. Of course I do.

Ms. Joyce Murray: —and milestones would be useful?

Dr. Peter Liu: Yes, of course. And my sense is that, in fact, a target has been set. It's a graduated reduction plan. I think that is what's required for a potentially successful strategy in terms of reducing sodium intake for the population.

Ms. Joyce Murray: Where could we find information about a target—who set it, what is it, and by when?

Dr. Peter Liu: In the minutes of the last committee meeting, I think a target was actually identified: 2,300 milligrams for the year 2016.

The Chair: You only have about 30 seconds left, Ms. Murray.

Ms. Joyce Murray: Okay, I have another question.

I'd like to find out about multicultural communities. The material we have here talks about African Americans being particularly susceptible. Averages mask the real dangers. Are there groups in Canada that should know more urgently and more quickly and should have strong targets?

The Chair: Dr. Liu, please.

● (1630)

Dr. Peter Liu: Yes, we certainly know that there are populations or communities that are particularly susceptible, for example, to cardiovascular morbidity and mortality; for example, our first nations population, the South Asian group, and as mentioned from other studies, the African population as well.

I think these are areas where a particularly tailored strategy is going to be important. And there are some cultural-specific practices, in terms of food intake patterns and also salt involved in cooking and things like that, that will be very important to take into account to make sure we have an effective strategy to reach out to these particularly high-risk populations.

The Chair: Thank you, Dr. Liu.

Now, Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

I think I have a number of very different questions.

First, I hear about the great strides that the two of you from the industry have been making. Are there not some issues that a more regulatory kind of framework would put you on a more equal playing field? Are there challenges with your competitors continuing to up-salt? That would be my first question.

Ms. Christine Lowry: Thank you for your question.

The first thing that comes to my mind is that there are many different members of the food industry, and they all make many different products in different categories. The way food is processed by category and the way salt is used is different in every category. There are probably technical challenges within categories, if you will, and there are different solutions by category in ways of reducing. I know that in my category, different grains have different solutions for how you manufacture them. There's quite a bit of technical expertise required. And when something is for the health of the population, I think the food industry responds in a responsible, collaborative manner. This is the right thing to do.

Mrs. Cathy McLeod: The two Catherines both look like they had something to add here.

Ms. Catherine O'Brien: I was going to add that I think where the collaboration comes in is as part of the multi-stakeholder working group, because our association is a member of that working group. Part of that is a subgroup that is made up of manufacturers, and Karen Young is a member as well. There's collaboration certainly happening at that level within the subgroups to the working group.

Mrs. Cathy McLeod: Thank you. Katherine, did you have anything to add on that issue?

Dr. Katherine Gray-Donald: No.

Mrs. Cathy McLeod: Okay.

My next question is this. We've heard about some very dramatic results on a national level in terms of Finland. If you take that down to an individual level... Let's say you have someone with high blood pressure who is consuming outrageous amounts of sodium and they do nothing else other than lower their sodium intake. Is your data really on the population base of those folks' habits? Do the changes individuals make quickly create changes in their own health status?

Dr. Philip M. Sherman: I guess the first thing to say about those population studies is that those kinds of studies don't prove cause and effect. They are associative studies. So you instituted a lower salt diet in a certain country and you see a reduction in cardiovascular disease. Many other things happen during that same timeframe, so we don't know a priori, without studying it, that it's a cause and effect relationship.

It's hard to take that data and extrapolate it to the specific person you're asking about. That's why I think that if there is going to be a change in Canada, we need much more evidence to show that on an individual basis, if you alter the salt content in the foods you eat, it does have an impact on blood pressure, sodium content, and cardiovascular disease. We don't have that information from the associative studies.

Mrs. Cathy McLeod: I also appreciate that in January you're going to be having this group. Is there any collaboration—because of course, research is expensive, and I know that many people like to... You know, research is their world and their life. Is there collaboration in terms of the international community, with different people taking responsibility for tackling different areas of concern, so that we hit those main parts and perhaps share some of the burden of the research cost?

● (1635)

Dr. Philip M. Sherman: Very much so. Research is definitely an international enterprise, and the one thing about our research is that it's not reinventing the wheel. We try to be at the cutting edge of what's going on, and Canadians can provide a niche expertise. That's what we do in all areas of research, and I think it will be niche expertise in this area of sodium reduction and its impact on the health of Canadians.

The Chair: You just have 30 seconds left, Ms. McLeod.

Mrs. Cathy McLeod: I'll just make a final comment.

I think we just need really simple messages, and I know even people who tend to come to this particular session just listen to the information and then they very quickly are peering at labels. I think we could do a very effective public information campaign quickly, because there are a lot of people who just don't understand the very basics.

I think that's it.

The Chair: Thank you, Ms. McLeod.

We'll now go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you, Madam Chair.

I want to thank all of the witnesses for coming here today.

I've looked at the figures submitted to us earlier by industry officials concerning the reduction in sodium levels. I'm happy to see that they are making an effort to bring these levels down. However, I have a problem with how fast they are acting, and with how drastic their efforts have been on this front.

Mention was made of a voluntary approach for government and industry. I have to admit that I have many reservations about a voluntary approach. We're talking about a public health issue and the government must assume some leadership on this file. It must develop standards. To my way of thinking, the people who market the products may not be in the best position to be involved in a voluntary approach to resolving the problem.

Your expertise is very interesting indeed and you have to express your opinion, but I have my doubts about a voluntary approach. Take cigarette manufacturers, for example. They had statistics in hand on the harmful effects of cigarettes as far back as 1970. Yet, it took a very long time to get them to take any kind of action.

This brings me directly to a question that has been put to you on three occasions, namely why it is that a cereal product sold in Canada contains three times the amount of sodium as the same product sold in Europe. I expect to hear the same argument about taste. I have a problem with that argument. Earlier, you said that we needed to strike a balance between taste and health. I for one believe that health takes precedence over any other consideration and that if the industry sets an example, the public will fall in step without any problem.

As my colleague Mr. Malo said earlier, if people were informed that the extremely salty food sold to them was detrimental to their health, no doubt they would not consciously choose to ruin their health. The industry really needs to step up its efforts to address this problem. I will admit that unfortunately, you have not received much help from the government.

Why is it that cereal products marketed in Canada contain three times the amount of sodium? No doubt you could employ the same production techniques as other countries.

[*English*]

The Chair: Who would like to start with that?

Ms. Catherine O'Brien: I don't make cereal.

The Chair: Okay.

Ms. Lowry, do you make cereal?

Ms. Christine Lowry: Yes, I do.

The Chair: Go ahead.

Ms. Christine Lowry: I proudly make cereal.

When we take a look at the nutritional contribution of breakfast cereals to the Canadian diet, as I mentioned before, there are tremendous benefits. One of the larger benefits is that we do know that consumers who choose breakfast cereals as their breakfast option in the morning do have lower BMIs than other food choices, and that's important when it comes to obesity.

We heard from my colleague next to me that keeping our weight down is also an important factor in blood pressure. So we want to make sure that when we talk about our cereals and the nutritional contribution they make to the Canadian diet overall, we take a look at it holistically.

And yes, we are very committed and very concerned about reducing the sodium intake in our products. I can assure each and every committee member of that. We have a plan in place, it has been in place for a while, and we are making those changes. We're trying to move as quickly as we can. As well, as I mentioned, we do have five products that have no sodium at all. We have selections out there. We do have 13 products that have under 200 milligrams of sodium.

So we have made a conscious effort over the time. We do have one outlier out there that has been identified and we do have a plan in place. If we can move more quickly, if our results come more quickly, if we are successful beyond what we think, then we will certainly be in the marketplace sooner, but we are very committed.

● (1640)

[*Translation*]

Mr. Nicolas Dufour: Frosted Flakes, for example, are one product marketed directly to children. In terms of nutritional value and processing, they cannot be compared with fruit eaten at breakfast.

[*English*]

The Chair: Time is up, Monsieur Dufour.

Would you quickly answer that, Ms. Lowry?

Ms. Christine Lowry: Frosted Flakes is a product that contributes vitamins and minerals and essential nutrients to the child's diet. As I mentioned at the very beginning, it's a major contributor of iron. As well, it's low in fat. It is a product that the child finds pleasant to eat; therefore, they're getting the nutrients that they require. It is a very nutrient-dense food at 120 calories per serving.

The Chair: Thank you, Ms. Lowry.

Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you very much, Madam Chair.

And thanks very much to our panel who are with us this afternoon. Certainly we've heard some interesting comments, and they've generated some interesting questions around the table.

I have a couple of questions, for anybody who wants to venture an answer.

Why do we have so much sodium in our diet? Is it strictly for palatability? Is it a taste? Is that why it's there, or is there another reason we have the sodium in the prepared foods?

What about the substitutes? Dr. Liu referred very briefly to substitutes, but there have been substitutes on the market for years that people have used in place of free table salt. Are they not viable? Can they be used in the food production industry?

In terms of research, a lot of comments have been made this afternoon that we really need to have the research done to document the results of a lower-sodium diet. We need to make sure there aren't adverse results of that. Is there hard research out there that shows sodium causing all of these diseases that we've talked about; for example, the high blood pressure? Is there hard research that you're basing those decisions on when you talk about that?

We'll start with those.

Ms. Catherine O'Brien: We can jump in with some information on salt replacements and the purpose of salt in food and so forth.

I'll let Dr. Karen Young speak to that.

Dr. Karen Young (Director, Scientific and Regulatory Affairs, Nestlé Canada Inc.): Thank you for your question.

Absolutely, it has been demonstrated that there is a taste function. But from a functional perspective, salt actually plays a very important role with respect to safety. It is an antimicrobial; it dehydrates many of the pathogenic microbes that are in food. So from that perspective, it absolutely has many different functions, as well as providing texture and so forth.

We have done a lot of research in terms of our development—for example, on incorporating herbs and spices and so forth—to reduce salt levels. We also do a lot of research into the actual replacements for salt. For example, potassium chloride is one of the products we use to reduce salt. However, we have found that if we start replacing too much of the salt, the food has a metallic flavour that the consumer rejects. But we do continue to do a lot of research in terms of flavour enhancers and other technologies that we can use to reduce salt. We're working very actively in that area.

● (1645)

Dr. Peter Liu: If I could follow up on the research question, the evidence comes from three lines. The first is the association, which is not cause and effect. That is, if you actually monitor the sodium intake in a country and the average blood pressure, you can actually line them up. So there is a direct relationship.

The next level of evidence, which is more convincing, are the studies that were mentioned earlier. You take a population and actually reduce sodium in one group and keep the other group doing the same, and you can actually demonstrate that in fact there is reduction in the blood pressure.

The third aspect is the long-term consequence in terms of countries that have done this. The best example is Finland. But the challenge there is that there were many things done at the same time, so how much did the sodium reduction actually contribute to this?

The positive aspect from that is that in most of the studies that carried this out, the benefit you see in terms of heart disease is actually a lot more than you would expect from just blood pressure reduction alone. The fact that you are actually engaging the whole population in this type of effort has many other dividends that appear to pay off at the same time.

Those are the types of evidence. As we do this in Canada, we have to make sure we're actually reaching the goals we are looking for.

Mrs. Patricia Davidson: Is there any difference between the intake of sodium in prepared foods or cooked foods as opposed to free table salt?

Dr. Peter Liu: Generally 80% of our salt intake is actually from processed food.

Mrs. Patricia Davidson: Is there any difference in the effect on the body?

A witness: No.

The Chair: Thank you very much.

We'll now go to Ms. Neville.

Hon. Anita Neville (Winnipeg South Centre, Lib.): Thank you very much, and thank you all for being here today.

I'm sitting here and listening somewhat in bewilderment. I'm substituting in, as you can see, so I've not been part of the earlier discussion, but what I'm hearing is that the reduction of sodium makes a dramatic difference. I'm hearing that there don't seem to be clear targets, although we just heard a figure of trying to reach 2,300 milligrams in 2016.

I'm making notes as you're speaking. Somebody said “when the results come more quickly”. That was one comment. Engaging the whole population was another.

I'm struck by the discrepancy in the urgency of reducing sodium, the importance of it as a health preventative, and the lack of goals or targets set by government, coupled with the lack of public information that goes out there. And how do you marry it all? I would be interested in hearing your comments.

Dr. Katherine Gray-Donald: Could I start to address this?

The problem is that it's very complex. We know the effects of obesity. We could give you figures of $2 billion in health care costs that are related to obesity. It's hard to change. It's hard to get people moving. There are some foods that have fewer calories. We're trying to get people to eat more fruits and vegetables.

Sodium is one of those things where, if we take it out of the food very dramatically, we may find that everybody just pulls in with their salt shaker and really uses them very strongly. We've got to both sensitize the population and slowly change the food supply.

Hon. Anita Neville: But I don't even see you doing that. You talk about obesity. And we've had ParticipACTION programs, or variations on that, in public schools promoting physical education and that sort of thing. Occasionally you go into a grocery store and you can buy a box of sodium-reduced Triscuits or whatever, but there's not a lot of public education on the importance of reducing sodium. There doesn't seem to be leadership from this council, from government, or from whoever on the importance of reducing sodium. And I understand that the palate is an important aspect of it, but it seems to be that you're going way too slowly, given the potential impact in terms of the health of Canadians.

● (1650)

Dr. Katherine Gray-Donald: I'm not sure of the exact date of it, but we have a meeting in early December and we are trying to put together very clear targets. And with a lot of these things, we'll need to come back to get budgets to do them. A lot of that work needs to be done. We're just finalizing what we can do in terms of activities, but public education is costly.

Hon. Anita Neville: But it could well pay off substantially in terms of health care expenses.

Dr. Katherine Gray-Donald: Absolutely.

Hon. Anita Neville: Thank you.

Does anybody else want to comment?

Dr. Philip M. Sherman: When you're looking to make change, one other part is to make sure it has a health economic benefit. So there is the concept that if you reduce salt and you reduce the burden of illness, that could really help to sustain our health care system by reducing costs. So there is a health economic benefit.

Hon. Anita Neville: I understand that.

My concern is that all of these pieces are not coming together in an aggressive plan or an aggressive outreach. I don't know what it is. You have the data. You referred to it. You spoke about the graphs. You know what's happened in other countries. Why is something not happening faster in Canada? That's my question.

Dr. Peter Liu: As I mentioned earlier, the coordinated approach is very important. For example, in terms of having the food sector as partners in this process, a lot of the work at the present time involves engaging the various sectors. While it's easy for us to say we need to reduce sodium, in fact the type of food product we're dealing with is actually very complex. So we need the different groups of food manufacturers to be coordinated in this fashion; otherwise the population just won't pick up on a high-sodium content alternative if the effort is not coordinated from that point.

The Chair: Thank you, Dr. Liu.

Now we're going to go to Ms. O'Neill-Gordon.

Mrs. Tilly O'Neill-Gordon (Miramichi, CPC): Thank you, Madam Chair, and thank you, witnesses, for being here today.

I feel very lucky today, because I'm just filling in and I'm so happy to be exposed to such a great conversation and a great topic.

I realize we have a lot of work yet to do, but when we talk about there having been 30 years in which nothing was done, I'm so happy to be part of a government that is starting to do something and to see people like you getting ready and the industry realizing how much we need to do.

As a former educator, I realize that a lot of it has to come from education. Do you have any plans or do you see anything going forth that will specifically help to educate our people, maybe through media or some such means? Could you perhaps elaborate a little bit on that?

The Chair: Who would like to make a comment?

Dr. Katherine Gray-Donald: I could.

Certainly, media has come up. We've seen examples of a media campaign in a health region that was very good. We need to engage the experts, because that is something you have to do really well, and yes, we're certainly looking to media.

The other part I need to bring up, maybe more to my committee because we haven't discussed it very much, is actually the health professionals. There is a lot being written now. If you read the *Canadian Medical Association Journal*, there's a lot going out to the doctors, there's a lot going out to the dieticians, but we need to really make sure that's there too, so that when people go to their doctor and say, “Well, how important is this salt stuff?” they get the right answer.

● (1655)

Ms. Christine Lowry: That's a very good point. Consumers reach out to many different sources for information. Having a comprehensive, collaborative stakeholder communication program to really inform the people on what the key messages are; and to get those out and keep them succinct is very important, and then to get them to consumers, where consumers are.

When we say “media”, that's a very broad brush. As I said before—and I can't say it more emphatically—nutrition literacy is so important, not just for sodium but for all the issues of nutrition and health that Canadians are facing. The more we can educate Canadians on nutrition fundamentals, on how to read the side panel, how to make informed choices, the better off we will be. I think nutrition literacy is key for all of us to be working together in a collaborative approach.

Mrs. Tilly O'Neill-Gordon: I think your industry deserves a lot of congratulations and support for the work it's doing. We all have to work together. When you realize how little was done for so long, there is that much more we have to do, but I think we're working in the right direction and I'm happy to be part of that.

The Chair: Does anybody have any further comments on that?

We'll now go to Ms. Wasylycia-Leis, very briefly.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chair.

I don't have quite the patience that Tilly does. If you're not prepared to agree to some sort of regulated standards and mandatory targets, I'd like to see what else you might be prepared to do, because I think Canadian consumers are way ahead of you. They would really like to know what they're eating. They've been listening to this health information for years and expect some action.

I just want to say that I doubt that in fact trans fats would have been acted on without that kind of outcry from Parliament and the public. In fact, the numbers didn't start to change until a couple of years ago, when Parliament threatened mandatory action. For you to say that you're taking action on a voluntary basis, it's just not evident.

In fact, if you had been listening to the health experts over the last 30 years who have been talking about sodium, you would have gradually voluntarily reduced your sodium content a few percentages, a few milligrams, every year in all your products. You wouldn't be talking today about having to suddenly deal with this leaping from 3,500 milligrams on a daily basis to 1,200 and only coming up with 2,300. I think you have to come up with more than that.

I'd like to ask two questions, quickly.

To the CIHR folks, I wonder why you're not taking a more proactive position. I'm almost tempted to ask, as I did in the House today, if there's anyone from the food manufacturing business on your board who might be tempering your remarks.

And I want to ask Christine and Catherine that if they won't agree to mandatory targets, will they at least listen to consumers and agree to mandatory front-of-pack warning labels for high-sodium products? Surely you can't disagree with that since Canadians want to know what they're eating. Will you agree at least that the recommended daily value for sodium specified in the food and drug regulations should be in fact 1,500 and not 2,400, even if you're not prepared to move on targets? Would you agree that serving sizes and nutrition facts—

The Chair: Ms. Wasylycia-Leis? Do you want an answer?

Ms. Judy Wasylycia-Leis: —should be based on the standardized referenced amount specific in schedule M of the food and drugs regulations and not left to your discretion?

The Chair: Does anyone want to comment?

Ms. Judy Wasylycia-Leis: One from CIHR and then quickly from Catherine and Christine.

Dr. Philip M. Sherman: I'm sorry, what was your question?

Ms. Judy Wasylycia-Leis: Why aren't you taking a tougher stance on this? You're the health researchers. You have all the information. Why are you so temperate in terms of education and voluntary approaches and collaboration that goes on for three years?

The Chair: I've given you some time, and you're being rude. Please don't do that.

Can you go ahead, please, Dr. Sherman?

Dr. Philip M. Sherman: So the question was whether we have anybody on our board who is a member of the food industry. The answer is that we have lots of interactions. We have an institute advisory board of 16 members, and it has a pharmaceutical representative but not a food industry representative. I certainly do interact, and members of my advisory board do, because we look to work in partnership and not in a confrontational or adversarial way. We are trying to work together to lower sodium and improve the health of Canadians.

● (1700)

The Chair: Thank you, Dr. Sherman.

I want to say a special thank you to all the panel today. You've come here as our guests, and we very much appreciate your input.

We'll now suspend the meeting for two minutes, and then we'll go into a business meeting.

Mr. Malo.

[*Translation*]

Mr. Luc Malo: Madam Chair, earlier our NDP colleague requested that parts of the testimony given by a witness be stricken from the record. I would just like to give you two reasons why I object to this.

Firstly, when we invite witnesses here, we must be open-minded and accept their full testimony. I wouldn't want us to become censors.

Secondly, the witness appeared to give us some examples. Even when the sodium content is reduced, consumers seem to prefer these products.

We would like to see more companies, more manufacturers reduce the amount of sodium in products that consumers still enjoy in spite of everything. When we realize that 75% of all of the sodium consumed comes from processed products, examples like these should make people want to... In my opinion, Ms. Obrien's comments should not be stricken from the record.

[*English*]

The Chair: Thank you.

[*Proceedings continue in camera.*]

● _____ (Pause) _____ ●

[*Public proceedings resume.*]

● (1705)

The Chair: Okay.

Hon. Carolyn Bennett: I think we should be able to go in camera when we ask to go in camera. The default position is open.

The Chair: That's fine too.

Let's get on with the motion. Can you read your motion into the record, Dr. Bennett?

Oh, I'm sorry, Ms. Davidson.

Mrs. Patricia Davidson: Thank you.

I thought what we were just voting on was to have the motions open, and I think we need to. I think they definitely are. But we always do our future business in camera and I'm still in favour of doing future business in camera.

The Chair: Well, Ms. Davidson, that's what I assumed, so obviously we're dealing with motions right now—

Mrs. Patricia Davidson: Motions should be open.

The Chair: —and we'll do the motions first, and then go in camera for the future business. Thank you.

Can you read this now, Dr. Bennett?

[*Translation*]

Hon. Carolyn Bennett: Yes. I move:

> That the Committee hold H1N1 briefings each week on Wednesday from 3:30 p. m. to 4:30 p.m.; and if deemed necessary by the Committee, extra time be allotted to hear from additional witnesses on H1N1 on the following Wednesday.

[*English*]

The Chair: Is there any discussion?

Dr. Carrie.

Mr. Colin Carrie: Yes, out of curiosity. We already have our H1N1 briefings on Wednesdays from 4:30 to 5:30. We've already discussed that. I thought we all agreed that's what we'd do. Why do we want to change it from 3:30 to 4:30? Is there any rationale behind this?

The Chair: Dr. Bennett.

Hon. Carolyn Bennett: I think that in the week previous where it got moved by votes and those... I think it's more secure to make sure that we will have an hour if it starts at 3:30. I think it can fall off the map if it's at the end of the day, based on votes.

The Chair: Dr. Carrie.

Mr. Colin Carrie: That's what I wanted: based on votes...? I believe the votes are always at 5:30, or the bells start ringing at 5:30, don't they, unless it's for an opposition day or something like that?

The Chair: Unless it's a supply vote.

Mr. Colin Carrie: Unless it's a supply vote. I don't think we're going to have any more supply, so I don't think it's relative at all.

Hon. Carolyn Bennett: On two or three different occasions the bells have rung at 5:15, and all of a sudden it's the end of the questions and it's over, so I think it's really important that over this period we have the protected hour for this.

The Chair: Dr. Carrie.

Mr. Colin Carrie: With due respect to the witnesses, because normally we have witnesses come from across the country for an hour sometimes, if there is a change, why don't we recommend a compromise and start 15 minutes earlier just on those days when there are votes?

I don't think we should shortchange our witnesses. Some of these people have travelled to come in front of a committee, whether it's for 45 minutes or not. On H1N1, usually they're officials and they're pretty flexible. If there is an opportunity where that happens, why don't we just start 15 minutes earlier?

The Chair: I want to comment. I've just been advised that Dr. Butler-Jones cannot make it if it's changed this week, so it will be somebody else who comes.

Dr. Bennett.

Hon. Carolyn Bennett: I think that would be a good idea, except that it's really not possible to be here by 3:15 in terms of scrums or the various responsibilities that we have. The reason the committee starts at 3:30 is that this is when people can get here based on the responsibilities that all of us have.

● (1710)

Mr. Colin Carrie: Madam Chair, if you look at the record, I think you'll find it's extremely rare that we would have had the votes starting a little bit earlier. I believe we have set a precedent; we did in fact start at 3:15 once. Yes, we all have responsibilities, but I think to get over here within 10 or 15 minutes is not unreasonable to show respect to witnesses that we've asked to come here from across the country. I don't think shortchanging them is very respectful of this committee. That's where I stand on it.

The Chair: I know that I'm always here by almost 3:15 right now, so I know that as chair I could be here.

Dr. Bennett.

Hon. Carolyn Bennett: I think the role of the opposition is different in that we often do have to be available to the media right after question period, especially during H1N1. We are having to do that as part of our responsibilities.

I think we would be prepared this week to continue as you've said, if that's the availability of Dr. Butler-Jones, but I think that for our due diligence on this committee, going from twice a week down to one hour a week is not really... I am concerned that we're not hearing from some of the people who want to come and testify on H1N1 and that we need to be better at being available to do our job as committee members.

The Chair: Dr. Carrie.

Mr. Colin Carrie: Madam Chair, respectfully, we shouldn't be running things by the seat of our pants and changing things week by week. We've agreed on a schedule, and for an individual member to say she would like to change it after the committee has agreed on it is totally inappropriate. If she feels obligated to do a scrum as opposed to her duty here at the committee, I think it's very appropriate to get a substitute for the 15 or 20 minutes that she might be in front of the media on those rare occasions—let me repeat, rare occasions—when there is a 5:15 ringing of the bell.

We've done all this work, so why should we be juggling this around again? We're spending more time hammering out a schedule because one or two opposition members want to change it weekly for their own personal convenience.

The Chair: As Ms. Wasylycia-Leis knows, I honestly try to be as flexible as I can. I just did that 15 minutes ago when she needed some time. It has been very frustrating to the clerk, the analyst, and the witnesses. I've had feedback to my office about what's going on in this committee when the program is changed. At the beginning of the year we had a very vigorous schedule that we agreed on. Then we had to change it because of H1N1.

It's also becoming rather frustrating for the witnesses, who are on the ground dealing with H1N1, when we change the game plan. For instance, Dr. Butler-Jones wants to come this week, but if this is changed he will not be available.

So could the committee please take all of this into consideration?

Ms. Neville, you're next.

Hon. Anita Neville: I've decided to pass.

The Chair: Okay.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: I want to make two comments.

One, I wasn't asking for any charity this afternoon. I was simply asking you to respect the clock. Our session was to go to five o'clock. I was next on the list and simply asked to be allowed to continue until five o'clock.

The Chair: But I did give you extra time.

Ms. Judy Wasylycia-Leis: That's fine.

I also want you to know, Madam Chair, that if my style isn't to your liking, that's not for you to judge, and to call me rude in front of any of the visitors... That's for me to deal with. If they or the media watching want to call me rude, that's their right. But this is a committee of hard work and—

The Chair: Complaints have been made to my office about how you treat the witnesses sometimes.

Ms. Judy Wasylycia-Leis: It's not about tea parties, it's about—

The Chair: Ms. Wasylycia-Leis, I want to prevent another message coming to my office yet again about rude treatment of witnesses. We have to be very careful when witnesses come that we give them a chance to answer, and you weren't doing that. So apologies if it appeared to you—

● (1715)

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): The question was asked to Judy to clear up the question, and that's when she came in. So I'm just wondering—

The Chair: Go ahead.

Ms. Judy Wasylycia-Leis: On the schedule, some of the items we're dealing with today are new and part of our committee's responsibility. On the question of estimates, perhaps we should have considered that before and included it, but we didn't, so now it's before us. The question of the committee's role and responsibilities in reviewing appointments has been raised for discussion, and a motion is before you on that front.

These are not discretionary items; these are things our committee has responsibility for.

The Chair: I agree about the estimates. That is something I was going to bring up myself at this meeting. As others did, we kind of forgot they were coming. That is a very legitimate request.

Dr. Carrie.

Mr. Colin Carrie: I absolutely agree with my colleague that the supplementary estimates and the notice of motion she brought forward are two different things we hadn't considered. My comments were geared toward the notice of motion by Dr. Bennett that was before us. I believe it's on stuff that we have addressed, and it's another change.

The Chair: Dr. Bennett.

Hon. Carolyn Bennett: Just to be clear, I was uncomfortable with the shortchanging of the H1N1 in a couple of meetings, and therefore my office called the chair's office. She declined to make the change, so that is why there's a motion.

The Chair: Ms. Murray.

Ms. Joyce Murray: I was listening with interest to the debate. I wasn't happy to hear a scolding of anyone on the Liberal side about changing calendars, actually. I remember several times arguing for maintaining a calendar that we had all agreed on, in the face of forceful arguments to insert hearings on things like salt that were not part of the H1N1 month of October. I think that was out of bounds, that scolding.

I would like to make my observation that Dr. Bennett is responding constructively, I think, to what she perceives has been an unanticipated impediment to having full briefings that I know we all want. We can use those constructively to avert problems with H1N1. As we ask questions, they actually do have a benefit in terms of our government's awareness of what might not work.

I wanted to respond to Dr. Carrie's comments, which I thought were completely inappropriate since it's that side that has done some of the rearranging of the schedule. And I think that on our side we're commonly reminding the committee of decisions made about the food policy study, the healthy food study, and the health human resources study and resisting the insertion of new ideas and new requests.

The Chair: Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Yes, Madam Chair.

We are setting up a schedule because we want some reasonable deadlines. However—and I have always said so—I don't want our schedule to be set in stone, with no possibility of making changes. Sometimes, we need to change our schedules because of the realities of day-to-day life. I wouldn't want to see our schedule become set in stone.

You have always agreed with me that our agenda is a very valuable working tool in that it provides us with a certain timeframe, with rules to apply to the various studies that we carry out. However, it is not something that is inflexible.

[*English*]

The Chair: No, that's very true. Thank you, Monsieur Malo. That's why there's “draft” written across it. The estimates are indeed extremely important.

Is there any more discussion?

Ms. McLeod.

Mrs. Cathy McLeod: The only final thing I would add is this. I think it does relate to officials, and I would expect our officials' schedule is like many of ours. It's chock-a-block full, and probably these officials have booked that time in their calendar for the next significant while. To create undue disruption to their schedules, when indeed they're probably already intending to support us, just doesn't make sense to me. I really think we need to respect our officials' schedules.

● (1720)

The Chair: Could we then agree about this H1N1 briefing? I think the committee would be disappointed if Dr. Butler-Jones could not be at committee, because I have heard from members that they would like to have him there. If we do change it this week, we're not going to be able to have him, so could we—

Hon. Carolyn Bennett: I've already said that, Madam Chair. I've already said that if he can't be changed this week—

The Chair: No, but I have to get the consensus of the committee. I'm going to be asking committee, with your agreement, if it would be okay to leave everything as it is this week and then change it next week.

Ms. McLeod.

Mrs. Cathy McLeod: I would really like to check to see if this will create undue hardships for Dr. Butler-Jones before we make a change. Will it impact the week after?

The Chair: Could we leave this pending, then, so that the clerk can check out his schedule? Dr. Bennett, can we then talk about this motion on Wednesday so we can clarify when they can come?

Hon. Carolyn Bennett: My concern has been that in an hour without any external witnesses and only hearing from officials every week, we may not be hearing... There are many people like chief medical officers of health from some of the territories and provinces who would like to be able to tell us how it's going on the ground. Local medical officers of health want to be able to explain how it's going. I don't think we can be giving proper advice or oversight to the government without hearing in a formal way from the people who are actually doing the work on the ground.

I do believe there may be times when we want to hear from the officials and from external witnesses, which is easier to do if the briefing is in the first hour, and then to hear witnesses—or the other way around; I don't really care. I want us to be able to hear from external witnesses when it's appropriate, and that's why the motion says that with a week's notice we can hear from people who are calling our offices, wanting to be heard, like Dr. Sobel from Nunavut.

The Chair: Basically, I'm hearing something different now. We had agreed that we'd have a briefing on H1N1 at committee from officials, publicly, once a week. We have put our schedule in until December break. What I'm hearing is that you want to bring more witnesses in on H1N1 and have the briefing.

Hon. Carolyn Bennett: The understanding from the very beginning was that, at a minimum, we would get a briefing from the officials. But in order for us to do our due diligence, we would, when appropriate, call in witnesses to let us know how this outbreak is being responded to by the people on the ground or by the scientists or the various groups.

There were obviously a couple of areas we carved out, such as vaccines and a couple of other areas that were very specific. But from the very beginning, we knew this was not just a briefing; it was two-way accountability in terms of the role of this committee in overseeing the response to the pandemic.

The Chair: We'll have Ms. Davidson.

Mrs. Patricia Davidson: Thank you, Madam Chair.

With all due respect to Dr. Bennett, I believe this committee agreed that we would hear from witnesses for the month of October. After that, we would have an update from the officials once a week. I firmly believe that this is what this committee agreed to. If we need to, perhaps we can go back through the records to see what we actually talked about.

The Chair: We will all have time for as much discussion as you want. I just want to make you aware that even though I'm hearing this, some of the public are asking about the HHR study, and they're quite concerned that the committee has not done anything about that. But it's the will of the committee. I have no influence on that whatsoever.

We're putting ourselves in a bit of focus from some of the public who are interested in H1N1 but don't want to lose the HHR study. It's the will of the committee. I'm just telling you what I hear in my office.

Go ahead, Dr. Bennett.

● (1725)

Hon. Carolyn Bennett: There is absolutely no point in looking backwards. The point is to look forward to how we as a committee operate in this emergency crisis of H1N1 and whether we are doing our job. That's how we will be judged. Were there witnesses we should have called? Are there people who have insights that can help guide the committee, such as international witnesses?

I am concerned that we need the flexibility to do our job, which the Parliament of Canada gave us, in terms of oversight of the H1N1 outbreak. We had asked for a special committee. That was denied. It was determined that the health committee would be the place where the oversight would take place. We have an obligation to do our job looking forward. That's what we're saying. We cannot do that if it is just a weekly briefing, and I don't believe we agreed to just a weekly briefing. I believe that in all the language, we left the door open to call other witnesses when necessary. Even if the language was tighter than that, I do not believe the people of Canada would think we were doing our job by having just a briefing—

The Chair: That's good, Dr. Bennett. Thank you.

Hon. Carolyn Bennett: —in a restricted time period.

The Chair: We'll try to wrap this up and take it to a vote.

Ms. McLeod, you're first.

We can vote on it very shortly.

Ms. Judy Wasylycia-Leis: Could we have the vote and still have time to get to the other motion?

The Chair: Well, we don't have time to get to everything today.

Ms. McLeod.

Mrs. Cathy McLeod: To conclude, we have a very specific motion here. Perhaps we need to have further discussion in terms of the varying perceptions of what this will consist of, but this is a very specific motion. I suggest that we move forward with it and then perhaps delay this other conversation.

The Chair: If we want to have witnesses on H1N1, can I throw out this fact? Why don't we just do both in one day? We won't lose the other piece then. What do you think? That would be easy to accommodate. Dr. Bennett is saying that there are witnesses who need to be here. We're saying that we want a briefing.

Can I present that? Time is running out, and I need to have some resolution here. If we could leave everything as it is this week so we can get this rearranged for the following week, would that be acceptable? How are things going?

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: I'd like to move my motion while we still have time.

The Chair: I'm sorry, I have to deal with this motion first.

Ms. Judy Wasylycia-Leis: I think someone has called the question.

The Chair: Is there further debate on Dr. Bennett's motion?

[*Translation*]

Mr. Luc Malo: I simply want to have something clarified, Madam Chair.

[*English*]

The Chair: Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Based on my understanding of this motion, a minimum of one hour would be set aside to discuss the pandemic. However, questions were raised earlier as to whether the experts we would like to hear from will be available. We talked about setting the motion aside until we have some assurance that all of the witnesses we want to hear from are available. If we change the meeting time by one hour and if, for example, the chief officer is unavailable, the motion loses some of its relevance.

[*English*]

The Chair: Can we agree to adjourn and leave it until the next meeting? There doesn't seem to be a consensus. Is that agreed?

Ms. Judy Wasylycia-Leis: Could I ask that the committee be extended for two minutes to deal with my motion?

Hon. Carolyn Bennett: And then there's the estimates. There's no reason to use the gavel at 5:30. This is the will of the committee. The will of the committee is to get this work done.

● (1730)

The Chair: Someone else will have to take the chair, because I have another commitment.

First of all, have we agreed with this motion? We will keep things as they are this week and then look at having the whole day for witnesses and H1N1 on Wednesday. Is that agreed?

Hon. Carolyn Bennett: There's a consensus to finish the estimates before December 7. Is that correct? We don't need a motion for that. It's the will of the committee.

The Chair: I haven't had completion on the H1N1. Can we do that? Then I will go into the estimates.

(Motion agreed to)

The Chair: H1N1 will be done next meeting.

Do we agree that the estimates are something we need to deal with?

Some hon. members: Agreed.

The Chair: When would you like to do the estimates?

Hon. Carolyn Bennett: That's with the minister.

The Chair: It will be with the minister, if she can make it.

Hon. Carolyn Bennett: If there's a time when the minister can come between now and December 7, it's up to the clerk to find the availability. It could even be on the 30th, the same day as the Auditor General.

The Chair: Between now and December 7, we'll try to find a time to do the estimates.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: We have a standing order under which our committee can review appointments to boards and commissions. I'm proposing that we do this in the case of the appointment of Bernard Michel Prigent to the CIHR and that we do it before December 9. I so move.

The Chair: That is so moved.

All agreed?

Dr. Carrie.

Mr. Colin Carrie: Could I ask for a friendly amendment? As we have the schedule quite tight, is it okay if we review that first thing when we come back in January?

Ms. Judy Wasylycia-Leis: December 9 is based on the deadline for our committee to do its work.

The Chair: Would it be okay to do one hour on the estimates and one hour on the appointment issue, so that we can get everything in? Is that agreeable?

Hon. Carolyn Bennett: It would be impossible to do the estimates in an hour, especially with the minister. If the minister can stay for only an hour, the officials could probably stay for the other hour.

The Chair: That's fine. Then we'll have one meeting for the estimates.

Hon. Carolyn Bennett: Just as a suggestion, on the 30th, seeing that the Report of the Auditor General was a bit better than people had anticipated, perhaps we could see the Auditor General and do your appointment on that day.

The Chair: On that day then?

Hon. Carolyn Bennett: On the 30th, we can do the OAG as well as the appointment.

(Motion agreed to)

The Chair: I think we have arrived at a conclusion. Thank you.

This meeting is adjourned.

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