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Chair

Mrs. Joy Smith

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● (0900)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, ladies and gentlemen. It's very nice to see everybody out this morning for this very important topic.

I want to especially welcome our guests this morning. We're very much looking forward to your insight on the topics we're dealing with this morning.

Pursuant to Standing Order 108(2), we are doing a study on sodium consumption in the Canadian diet, and for that study we have, from the Dairy Farmers of Canada, Nathalie Savoie, the assistant director of nutrition, national programs. Welcome.

We will also have, from the Canadian Restaurant and Foodservices Association, Mr. Reaman. He is not here yet, but we're hoping he will arrive a little later.

From Food and Consumer Products of Canada, we have Phyllis Tanaka, vice-president of scientific and regulatory affairs, food policy. That sounds very onerous, Phyllis.

From the Heart and Stroke Foundation of Canada, we have Stephen Samis, the director of health policy. And from the University of Ottawa Heart Institute, we have Dr. Andrew Pipe, chief of the division of prevention and rehabilitation, and professor in the faculty of medicine, University of Ottawa. Welcome.

From the University of Toronto, we have Dr. Mary L'Abbé. Mary is a professor and the chair of the department of nutritional sciences in the faculty of medicine.

Witnesses, I'm going to ask each of you, from each organization, to give a five-minute presentation. Following that, we'll go into our questions and answers, which is a very useful part of the presentations, because committee members do ask the questions they really need to know the answers to.

We'll begin with the Dairy Farmers of Canada, and Nathalie, please.

[*Translation*]

Ms. Nathalie Savoie (Assistant Director, Nutrition, National Programs, Dairy Farmers of Canada): Thank you, Madam Chair.

At the Dairy Farmers of Canada, we recognize the public health importance of reducing Canadian sodium intakes and appreciate the opportunity to address the committee this morning on this important subject.

We are the national organization representing Canadian dairy farmers who produce the basic ingredient that is used in the manufacturing of dairy products. The nutrition and health aspects of dairy products are of great importance to us. This is why we have made it a priority to follow this policy development along with others being led by Health Canada.

[*English*]

Moreover, as an interested organization committed to nutrition research and the promotion of healthy eating and living, we have provided comments to Health Canada on their proposed sodium reduction targets and have shared our research with them. We have collaborated and continue to collaborate with dairy processors, in particular cheese manufacturers, as we all assess the proposed Health Canada sodium reduction targets.

The nutrition department at DFC is staffed by some 20 registered dieticians like me, whose goal is to increase awareness of the nutritional values and health benefits associated with milk products as part of a healthy, balanced diet, and to encourage Canadians to consume the number of servings of milk products recommended by Health Canada.

The findings of the Canadian community health survey published in 2006 indicate that a large proportion of Canadians in all age groups is not meeting the minimum recommended servings of milk products. Therefore, if reducing sodium in cheese affects consumers' acceptance of cheese and leads to a reduction in cheese intake, the result will be a worsening of the problem of under-consumption of milk products, with negative consequences for the overall nutrient intakes of Canadians, especially calcium.

It is important to mention that while sodium is a natural constituent of milk and other dairy products, salt or sodium chloride is also added during the cheese-making process to serve many functional properties, such as enzymatic and microbial control, humidity control, and taste and texture; but it's also an essential ingredient to ensure food safety. After consulting researchers specialized in food science and the microbiology of cheese-making, we came to the conclusion that there is currently a lack of knowledge on whether the proposed targets for cheese are achievable and whether they present food safety issues.

In order to provide those scientific data to address the issue of levels of sodium in cheese, we are funding research that deals with the technical and food safety issues associated with salt reduction. Since May 2008, the dairy industry has been supporting research by the Université Laval on the impact of variation in salt in cheddar cheese on organoleptic properties and microbial growth.

In addition, with the help of newly attained funds from the agri-science clusters initiative, we will also jointly finance with Agriculture and Agri-Food Canada a major two-year study starting this year looking into reducing salt in different types of cheese while maintaining product quality and ensuring food safety.

These two studies represent an investment of $750,000 toward the advancement of science in this area. The first study will be completed in April of next year, while the second one will be completed in early 2012. Once the results of these studies are available, the dairy industry will be in a better position to access the level of sodium reduction that is both achievable and safe for different types of cheese.

We are committed to offering nutritious dairy products that meet the highest standards of quality and safety, as well as the demands of consumers. We strongly believe that these high standards must be maintained in any effort to reduce sodium. To ensure that salt reduction in cheese is accomplished while maintaining product quality and without putting the population at risk of food contamination, we have asked Health Canada to provide the dairy industry the proper time needed to conduct the necessary research before establishing targets for cheese, and timelines for reaching these targets.

We believe that special rules should be established for products like cheese, where salt is required for important aspects like preservation and aging. Otherwise, the process needs to account for target revisions and/or re-adjustments if the set targets prove to be unachievable or unsafe. We will be happy to provide the committee with our feedback to Health Canada on these targets.

For technical and food safety aspects related to reducing salt content in cheese, we have turned to the scientific expertise of Dr. Paul Paquin and Dr. Steve Labrie from Université Laval, who have provided a written scientific opinion based on their longstanding expertise in food science and microbiology related to cheese-making. We provided their document, along with our DFC response, to Health Canada. We would be happy to provide the committee with that document as well.

● (0905)

[*Translation*]

Again, thank you for this opportunity to share with the committee the undertakings that Dairy Farmers of Canada is taking on this important health subject. Thank you.

[*English*]

The Chair: Thank you very much.

We'll now go to Phyllis Tanaka.

Ms. Phyllis Tanaka (Vice-President, Scientific and Regulatory Affairs (Food Policy), Food and Consumer Products of Canada): Thank you.

Food and Consumer Products welcomes this opportunity to meet again on the efforts to reduce sodium consumption in Canada. When we met last October, FCPC indicated its support for the work being done in the multi-stakeholder working group process. We continue to supports its work, and I continue to take an active role as a member of the working group.

The multi-stakeholder working group is the driving force developing a fulsome strategy toward reduced sodium consumption in Canada. FCPC members manufacture the majority of the processed food products found on retail shelves in Canada. They are committed to offering a variety of healthy products. For many years they have been developing new products with reduced sodium, and reformulating processed food products to reduce their sodium levels. They will continue to make advances in doing so.

However, as has been stated before, it is important for the committee to understand that lowering sodium levels in food and beverage products is a complex undertaking and takes time. As you already know, sodium performs a number of functions in food manufacturing, so it can't just be removed without having a suitable alternative. There is no one replacement for sodium to meet the varied functions it plays in a food product. That is why successful product reformulation takes time. A rough estimate for a straightforward change is approximately two years, and that's for one product.

It must always be remembered that consumer acceptance is critical to the success of any new product or reformulated product with lower sodium levels. It takes consumer awareness of why the changes are occurring, and consumer acceptance of the changes in the products.

The working group has established a three-pronged approach to achieve the goal of lowering sodium levels, with these very complexities in mind. The strategy involves education, the voluntary reduction of sodium levels in processed food products and food sold in food service establishments, and research. All of the stakeholders involved in these efforts agree that salt reduction in the food supply and overall reduction in the dietary intake of sodium by Canadians will only succeed if it is done in a staged process.

Industry requires time to successfully model sodium reductions in food products. Consumers need time to acclimatize to a new taste profile. Above all, for any initiative to succeed the targets must be realistic, feasible, and sustainable. This last point is a theme that is recognized globally.

FCPC members have been engaged in the process with the working group since it formed. This engagement is driven through FCPC's own sodium committee, which is made up of the scientific-technical representatives from its member companies. Member companies participated in the working group's public consultation in February 2009, providing information critical to understanding the issues industry faced in addressing the challenges they need to overcome to succeed. Right now they are actively engaged in the dialogue with Health Canada to establish sodium reduction targets that will support the working group's interim goal of bringing the population average sodium intake to 2,300 milligrams per day.

In closing, the challenge of reducing sodium is not unique to Canada; it's a global problem. Many other jurisdictions around the world have been contemplating how to do it. While some have initiated steps earlier than Canada, there isn't any one that is further ahead than we are now. Most have come to the conclusion, like Canada, that it's a process that will take time, must be based on collaboration among the many stakeholders, and must be based on realistic and achievable targets.

● (0910)

I believe the Canadian approach stands out as a model that is strategic and reflects good leadership.

Thank you.

The Chair: Thank you, Ms. Tanaka.

We'll now go to Stephen Samis, from the Heart and Stroke Foundation.

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

On behalf of the Heart and Stroke Foundation of Canada, I would like to thank you for the opportunity to appear here today to share with you the foundation's perspective on the issue of sodium consumption in the Canadian diet.

The Heart and Stroke Foundation is one of Canada's largest volunteer-based health charities. We lead in eliminating heart disease and stroke in Canada and reducing their impact through the advancement of research and its application, the promotion of healthy living, and advocacy.

Here are a few facts about cardiovascular disease and sodium.

Heart disease and strokes are the leading causes of death, hospitalizations, and drug prescriptions in Canada and cost the Canadian economy an estimated $22 billion a year in direct and indirect costs.

About five million adult Canadians have high blood pressure, the number one risk factor for stroke, and a major risk factor for heart disease.

Among Canadians aged 19 to 70, over 80% of men and 60% of women have sodium intakes exceeding the recommended upper limit.

About one in seven deaths from stroke and one in 11 deaths from coronary heart disease could be prevented if Canadians reduced their dietary sodium intake by about 1,800 milligrams per day.

Recent studies estimate that there would be direct cost savings of approximately two billion dollars per year as a result of decreasing average sodium consumption to recommended levels. And dietary sodium reduction could eliminate hypertension for over a million Canadians, with a resulting savings of at least $430 million annually in direct high blood pressure management costs. So the costs are significant.

The Heart and Stroke Foundation is committed to reducing Canadians' sodium intake. We continue to provide Canadians with health information, resources, and recipes to help them lower their sodium intake.

The foundation was one of 14 health organizations to sign on to Blood Pressure Canada's policy statement on sodium reduction, the goal of which is to reduce Canadians' daily sodium consumption to between 1,200 and 2,300 milligrams by 2020.

Our Health Check program continues to work directly with food companies and restaurants to improve the nutritional quality of our country's food supply through stronger nutrient criteria. And since 2007, Health Check has announced changes to its nutrient criteria, which have resulted in 25% to 70% reductions in the sodium levels of products in the program.

Since that time, and by meeting those new Health Check criteria, 14 companies alone have removed 500,000 kilograms of salt from their products. This is the equivalent of about 20 dump trucks of sodium being taken from our food supply. And as we continue to lower sodium levels in our criteria in the Health Check program to meet those 2020 levels, more dump trucks will be filling up with salt.

The foundation is also a member of Health Canada's multi-stakeholder sodium working group. We are looking forward to the working group's report and their recommendations anticipated in June 2010.

What can the federal government do? The Heart and Stroke Foundation would like to take this opportunity to outline a few steps we believe the federal government should take to help address sodium levels in the Canadian food supply.

First, continue to support the work of Health Canada's sodium working group and, more importantly, ensure a timely response to the working group's report and timely implementation of its recommendations.

Second, conduct regular national nutrition surveys to establish an effective and timely monitoring system to track sodium levels in the diets of Canadians and report on progress toward achievement of the 2020 goal.

Third, improve food labelling regulations to make the portion sizes on the mandatory nutrition facts panel consistent across similar products to help Canadians compare products better and make better informed and healthier choices.

Fourth, educate Canadians about the health risks of high sodium intake and on how to reduce their sodium consumption within the context of a healthy diet.

What can the food industry do? In addition to the government's support and leadership, the foundation recommends that Canada's food industry continue to take a leadership role and continue to reduce sodium levels in all foods sold in Canada, support efforts to educate Canadians about the health benefits of consuming foods that are low in sodium, and make nutrition information, including sodium content, available at points of purchase in food-service outlets.

In closing, the Heart and Stroke Foundation appreciates that this committee continues to make sodium reduction a priority. We urge the federal government to quickly respond to and implement the working group's recommendations once they report. And we thank you for the opportunity to provide our perspective today.

● (0915)

The Chair: Thank you.

We'll now hear from Dr. Andrew Pipe.

[*Translation*]

Dr. Andrew Pipe (Chief of the Division of Prevention and Rehabilitation, Professor, Faculty of Medicine, University of Ottawa, University of Ottawa Heart Institute): Good morning, Madam Chair. It is a great pleasure for me to be here this morning.

[*English*]

Good morning.

This is probably one of the more important clinical conversations that I have had this year. I say that because I want to have a conversation with you. I'm not going to be speaking from prepared notes.

Probably one of the most useful things that I can do as a physician is to accelerate the development of an environment in which healthy behaviours become easy behaviours. Probably one of the most important things I can do as a clinician is to look you squarely in the eye and tell you that you can do things with your pens, your signatures, and your legislation that will dramatically enhance the health of our community in ways I cannot even dream of.

In one day, as a consequence of thoughtful deliberation, you can transform the environment such that the health of Canadians becomes significantly improved and enhanced.

For more than 40 years, we've known about the deleterious health consequences of sodium. I would argue, perhaps being a little provocative, that for 40 years we've shrugged our shoulders and wrung our hands and asked what we can do. That's despite the fact that there is evidence from around the world where communities very similar to ours have addressed this problem in ways that are thoughtful, engaging, constructive, and that have shown dramatic changes in terms of enhancing the safety—and I want to underscore the word safety—and quality of our food supply.

Daily in my position at the University of Ottawa Heart Institute, I see people who suffer from cardiovascular disease. The nature of the expression of that disease is changing. We've done a very good job, if I may pat my profession on our backs—and Dr. Bennett can also wallow in the approbation I'm offering ourselves—in reducing the incidence of heart disease since the 1960s. On the other hand, there are still very large numbers of Canadians who have heart disease, and as they get older the incidence of heart failure is going to increase dramatically.

Why is that germane and important to our discussion today? It's very simply that one of my patients can leave my clinic, walk down the stairs or take the elevator in the Heart Institute, have a simple lunchtime snack, which he or she perceives to be healthy, from a fast-food enterprise in the foyer of my institute, and as a consequence of the sandwich and soup be in the emergency department eight hours later. He or she could be admitted for several days as the consequence of the fact that the sodium intake represented by that simple lunch tips that individual into unstable heart failure, requiring days of admission in a hospital setting.

I'm also conscious that when I speak to you about these issues, I'm not only speaking about the health of Canadians, in some respects I'm addressing the viability of our health system.

I'm constantly assailed by the rhetoric that speaks to the need for prevention. Prevention is more than fridge magnets and catchy little posters. It's the development of an environment that makes healthy behaviours easy behaviours—and I know I'm being repetitive.

You can tell by my grey hair that I'm now approaching the twilight of my career. Throughout the course of my career, I have been involved in a number of endeavours designed to enhance the health of Canadians. Each time I have heard that we can't do this, this is going to take time, the public isn't ready, it's going to require thoughtful consideration over the course of several years. Substitute seat-belt legislation, reducing the blood alcohol levels for drinking and driving, the time that it took us to get a handle on tobacco legislation, and you see where I'm coming from.

Sodium intake contributes dramatically to blood pressure, which as you heard from my colleagues at the Heart and Stroke Foundation contributes dramatically to the incidence of stroke and coronary artery disease, and deaths from both of those situations. It also contributes dramatically to what is an emerging, pressing public health problem, which is end-stage kidney disease. Nobody anywhere is talking about how we are possibly going to be able to provide dialysis services to the countless Canadians who in the years ahead, as a consequence of their kidney failure, will require dialysis. They will require that dialysis because their kidneys have been destroyed as a consequence of the degree to which hypertension has supervened in their particular personal health setting.

● (0920)

We know that salt is an issue, and most Canadians agree this is an important public health issue. I wish I could share an article with you that my colleagues and I will be publishing in the *Canadian Journal of Cardiology* a few weeks hence. It is currently under—whatever that word is—embargo. But it shows—

The Chair: Dr. Pipe, you're going to have to wrap up.

Dr. Andrew Pipe: I'm moving very rapidly to a conclusion.

Ninety percent of the public we surveyed know that they should reduce their sodium content; 90% of them recognize processed foods as being an important source of sodium; and 50% of them say that they are already taking steps to reduce their sodium content, which of course is inaccurate, because we know that what people say and what they do are very different. They are unable to make those steps because they don't understand where sodium comes from.

So I would hope that you would—

● (0925)

The Chair: Thank you, Dr. Pipe.

Dr. Andrew Pipe: —move quickly to respond to the report, which will be forwarded to you in the weeks ahead.

Thank you.

The Chair: Dr. L'Abbé.

Dr. Mary L'Abbé (Earle W. McHenry Professor, Chair, Department of Nutritional Sciences, Faculty of Medicine, University of Toronto): Thank you, Madam Chair.

I'm here today as professor and chair of the Department of Nutritional Sciences at the University of Toronto and as vice-chair of the Canadian Sodium Working Group.

The sodium working group is a multi-stakeholder task force that has been mandated to oversee a population health-based approach for the successful reduction of the sodium content of the diets of Canadians. As a nutritional scientist and a member of the sodium working group, I'm concerned about the high levels of sodium in the diet. I thought it might be useful to quantify this for you.

Data from the Canadian community health survey that was conducted in 2004 indicated that on average, Canadians consumed more than 3,400 milligrams of sodium a day. The upper level of sodium is set at 2,300 milligrams. So you can see where we are. Over 90% of men and 66% of women exceed this upper level.

But sodium isn't just a problem with adults. It's also a problem for children: 76% of children aged one to three, and 90% of children aged four to eight, and 97% of adolescent boys exceed their upper intake level for sodium.

More than three-quarters of this sodium comes from manufactured and processed foods, which we eat at home or outside the home. Very little of this sodium is either naturally occurring or added at the table or during cooking.

During my remarks to this committee last fall, I shared two figures with you that gave you an overview of the sodium and the sources in the food supply that provide this sodium to Canadians. There are two important features about sodium in the food supply. Firstly, some foods, like bread, are only moderately high in sodium, but they can provide substantial amounts because we eat so much of them. We eat them every day in relatively large quantities. Other foods—and last year I showed you things like soups, frozen meals, hot dogs, some prepared sandwiches—have very high quantities of sodium. Some of those foods in one serving can provide almost your daily recommended amount, and some can even approach the upper level. For example, that submarine sandwich I showed you approached the upper level in a single serving in a day.

Secondly, I think it's important to know not only these levels of sodium in the food supply but that there's no one food, or one food group, that provides most of the sodium. So reducing sodium will mean changes in virtually every food, and nearly every food product in our food supply, if we are going to have meaningful reductions in our sodium intake. Also, for consumers, taste is paramount, so these changes will have to occur at approximately the same time across all foods so that Canadian consumers can get used to reduced levels of sodium. We expect that such approach will take a number of steps phased in over a number of years.

With these numbers in mind, the sodium working group looked at ways to reduce sodium intake by Canadians. Our report, which we expect should be out shortly, focuses on voluntary reductions in sodium levels in foods; an extensive education program to inform consumers, manufacturers, distributors, food service operators, and policy-makers about the need to reduce sodium; as well as identifying the research that will be needed to support these changes.

We announced our interim first target of a reduction in the population average sodium intake to 2,300 milligrams as the upper level by 2016. This first goal is felt to be aggressive and challenging, but one that we are confident that the Canadian food supply collectively can meet. We are actually encouraged by some of the progress that has already occurred.

Lastly, I want to explain to you what we envision by targeted, voluntary reduction, which you've heard about. We hope and we plan that these targets would be published for virtually the whole food supply for prepackaged and manufactured foods, as well as for foods sold in restaurants, cafeterias, and elsewhere outside the home. Not only will these targets be published, but our terms of reference call for developing a monitoring plan. In other words, we expect that the levels of sodium in Canadian foods should be measured regularly and the results of this progress published regularly as well, so we, and in fact all Canadians, will be able to monitor our progress over time.

● (0930)

Now, it's the start of May, and our report is just about nearing completion. We expect it shall be submitted to the Minister of Health early this summer. We hope we have charted a clear path forward for reducing the sodium intakes of Canadians, and we await the opportunity to share our report with you in the near future.

Thank you very much.

The Chair: Thank you.

We'll now go to Mr. Reaman, from the Restaurant and Foodservices Association.

Mr. Ron Reaman (Vice-President, Federal, Canadian Restaurant and Foodservices Association): Thank you, Madam Chair.

Thank you, members of the committee, for having us here today.

My name is Ron Reaman, and I represent the Canadian Restaurant and Foodservices Association. We represent approximately 33,000 restaurants across Canada. I did have the pleasure of appearing before the committee last fall, so I will keep my remarks very brief and not be too repetitive.

I just wanted to underscore for you today that the Restaurant and Foodservices Association and our membership are fully engaged in the issue of sodium reduction. We are a member of the Health Canada sodium working group, and we have continued to participate and support that group in its efforts to look at developing a national strategy for sodium reduction and ultimately to reduce the overall sodium intake of Canadians. We support the three key prongs of the terms of reference for that committee, which are, as I'm sure you are aware, a research component, a voluntary reduction in the sodium levels in food products, and also a comprehensive public education and awareness campaign.

I want to remind the committee that many food companies are already fully working on reducing and reformulating their products, their menu items for offer. We recognize our role in making that contribution to bringing down the overall sodium levels of Canadians. But we have to recognize some of the operational realities that confront our industry. As some of my colleagues have already mentioned, the really critical piece here is to ensure that we are working on a gradual, achievable strategy that actually reduces the sodium that Canadians are consuming.

One of the challenges that we face in the restaurant setting is if those products are not to the taste acceptance of our customers. At the end of the day, we are a consumer-demand-driven business. We offer for sale what our customers ask of us. It's really critical that we ensure that the palates of Canadians actually evolve to a point where that demand shifts to products that are actually saleable. Consumers have a choice at the end of the day, and they exercise that choice on a daily basis in our operations.

We're doing our part through voluntary reduction of sodium in menu items.

The other key point that I wanted to make to the committee is that with respect to the public education and awareness campaign it's our feeling that this is an absolutely critical piece the government needs to support through dedicated funding that actually achieves the public health outcome that we all share, which is to try to reduce the overall intake of sodium by Canadians.

I'll leave it at that and be open to questions.

Thank you.

The Chair: Thank you.

I'd like to welcome to our committee Ms. Megan Leslie, who is replacing Judy Wasylycia-Leis. Welcome to our committee.

Ms. Megan Leslie (Halifax, NDP): Thank you.

The Chair: We'll now go into the first round, seven minutes Q and A. We'll begin with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you all for coming.

I share Dr. Pipe's frustration. The story that Dr. Pipe told of patients actually not knowing what they're getting and ending up in hospital was the story of my father, who in one summer had three hospitalizations, even with a daughter as a physician. I had no idea that the All-Bran he had every morning was three times as salty in Canada as it is in the United States; I had no idea that the soup he was eating was laced with the stuff. We just threw the book at him, and we kept him out of hospital for three years until he died, by being really strict about this.

This is a daughter who had toxemia in my pregnancy, who drank the soup and then thought, “I don't think I should have eaten this”, and then two hours later was being induced with pre-eclampsia.

This Is so serious. It's the reason I'm a doctor: I ended up with acute glomerulonephritis and on a salt-free diet for three months when I was in grade nine, and I felt that no one else should have to live through that.

Dr. L'Abbé, I actually thought I wanted to be a nutritionist first, because Dean Barbara McLaren brought me shortbread that had no salt in it, and I thought she was an angel of mercy, coming to me with delicious foods that actually had no salt in them.

I just have to say first that, with the frustration you must feel, Dr. L'Abbé, having watched what happened with transfats, how on earth can the sodium working group spend all of this time and not even have mandatory regulations in your terms of reference, so that all you're allowed to come up with is voluntary reduction? It seems quite shocking. I don't see the education program coming.

What are we waiting for? Do they have to wait for your report to do a public education campaign to tell people to reduce their salt or lay off the soy sauce or whatever it is? I don't really see a huge amount of money going into research. This is enough, already. I wonder how on earth we can get at this when what Dr. Pipe is saying is absolutely true. We've heard all this before. I don't know that the Canadian palate is different from the American palate. What are we waiting for?

I would rather have Dr. Pipe ask the people who are saying “yes, but..., but....” Maybe Dr. Pipe could finish his presentation and have a go at the rest of the panellists.

● (0935)

The Chair: Okay. Is it Dr. Pipe who wants to have his...?

Dr. Andrew Pipe: I'm not sure that's my role, Madam Chairman.

Hon. Carolyn Bennett: You wanted a conversation, Doctor. Let's have the conversation.

Dr. Andrew Pipe: Let me be conversational.

What we need to do is learn from the experience of others. When we look at the experience in Finland, we see a country that had among the highest rates of cardiovascular and other sodium-related diseases in the world, and in the course of a few years turned it around. They did that by a combination of education, voluntary leadership from the food industry—and we have some examples in Canada of food industry leaders who have transformed the nature of their products because they wanted to be leaders—and as well with appropriate public health legislation. Any successful public health approach generally is comprehensive, but to rely solely on education and voluntary approaches is in my respectful view to delay the inevitable, and while we delay, which others might politely term "dither", more Canadians will die.

If individuals consumed certain food products and were admitted to hospital because of infections derived from those food products, there would be an incredible uproar, and we would move very quickly to deal with it. This is another food quality and food safety issue, and so we need to be prepared sensitively, thoughtfully, but nonetheless forcefully to address this in the best tradition of intelligently designed public health policy.

Hon. Carolyn Bennett: If you had a chance to ask the industry what they're doing.... Or would you rather just dictate to the researchers here what the recommendations for this group should be in our report?

Dr. Andrew Pipe: I want to say that I admire some of the leadership that has been delivered and developed by some members of the Canadian food industry. One of the questions I would ask is, why is it going to take us so many years to do this when we have Canadian corporations—and you've identified this in your remarks—who manufacture the same product, if you will, that is sold in one country, the United Kingdom, or another country, the United States, with a totally different sodium content? We know from our own research, and frankly from the research that I've been privy to from certain food industry leaders, that it takes a few weeks before your palate adjusts to a lower level of sodium. Rather than saying it's going to take us ages to address this issue because the Canadian palate needs to adjust, it's not impertinent to ask the converse question.

The Canadian palate was used to a much lower level of sodium several years ago. Any familiarity with higher levels of sodium has come about because the sodium content of our foods over the last several years has been rising inexorably. I don't recall hearing food industry or hospitality industry individuals saying we can't put this high sodium product on our menu or on our grocery shelves because Canadian palates will require eons to adjust to this. That didn't happen. That may be seen as being a bit flippant, but I think it's a very logical question.

● (0940)

Hon. Carolyn Bennett: Dr. L'Abbé.

Dr. Mary L'Abbé: I think Dr. Pipe had some very useful comments.

I can say that I actually have invested a lot of time and energy into seeing the work of this sodium working group. You mentioned leadership. What was often lacking is people recognized the problem but nobody stepped up and showed the leadership and then set what you might call a road map to go forward. I feel that's the important role that the sodium working group is tasked to do, to ask where we need to get to and how to get there, and then give some clear directions. It won't be up to us as individuals but collectively to the food suppliers to implement the recommendations.

The Chair: Thank you, Dr. L'Abbé.

Each individual on this panel has very good comments, and we want to make sure that everyone gets a chance.

We'll now go to Monsieur Malo.

[*Translation*]

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

Thank you very much for being with us today to discuss this very important matter.

When I hear people from the restaurant or food products industries —after all, we know that most of the salt consumed by the public essentially comes from those two sectors—when I hear them express satisfaction with voluntary targets, I really ask myself why. Is it because since the working group on dietary sodium reduction was established—since 2007, that is— they have put in place a strategy to make major reductions in salt in the products they provide to the public? Or, on the other hand, as we seem to be hearing, is it because they have to make sure that all the parties involved are working together because that is what the public wants? Or is it also to delay the implementation of a real strategy?

We know, of course, that measures that are voluntary—the word says it all—are not binding. It's "if we like" and "if we feel that way inclined". But the target that the working group set was to reduce salt intake by about 1,000 to 1,200 milligrams by 2016. That is six years. They want to go from 3,400 milligrams to 2,300 milligrams in six years.

Ms. Tanaka told us that it will take time before real changes in the manufacture of their products can be made. So I would like to ask the restaurant and food products people a question. Since 2007—that is three years ago now, quite a long time. Ms. Tanaka, you told us that it takes two years to change your products and your methods. So what has really been done since 2007 to put changes into effect? Will we be seeing a real revolution in reduced salt intake on our shelves and on the menus in our restaurants anytime soon, in weeks, in months?

[*English*]

The Chair: Who would like to take that question?

We'll go to Ms. Tanaka.

Ms. Phyllis Tanaka: I can speak to the food processing side but not to the food service side. I'll leave that to Ron.

The Chair: Ms. Tanaka, we'll have you and then Mr. Reaman.

Ms. Phyllis Tanaka: The food industry is, as I said in my remarks, engaged in the whole process of reducing sodium levels. On an individual corporate basis, each company has its own particular strategies for setting up a sodium reduction strategy.

The example I used, with respect to product reformulation, was to give everybody a bit of a visual idea of how long it will take if you take one product, and it's a straightforward product, and you say that you're going to reduce the sodium levels for just that one product. It's roughly about two years for that one product. That was just to give you a visual of the time it takes to do a product reformulation.

● (0945)

[*Translation*]

Mr. Luc Malo: So will people be doing it one product at a time, meaning that all products might have been changed by 2200?

[*English*]

Ms. Phyllis Tanaka: The members of FCPC, who support the working group, all know what the targets are. The dietary consumption target is for 2016. It is to get the dietary consumption down to 2,300 milligrams.

Through the multi-stakeholder working group there's a process for all the individual food companies to engage in dialogue with Health Canada, and that process is going on right now. It began last fall. That process is to have the individual companies or sectors, as was mentioned by the dairy sector, sit down with Health Canada to look at proposed targets that food categories can work towards to bring the sodium down in a particular food category. That's going on right now. The food companies that work for FCPC have been having one-on-one discussions with Health Canada towards that end. Ultimately, part of the goal of the working group is to get those targets in place. They will be the targets that industry is aiming to get to by 2016 for the food categories.

The Chair: Ms. Tanaka, I guess you're not going to share your time.

Ms. Phyllis Tanaka: No, I'm finished. Sorry.

The Chair: We only have a minute left. Would you mind if Mr. Reaman had a chance?

Thank you.

Mr. Ron Reaman: Thanks. No worries.

From my perspective, in terms of our sector, it's not unlike what Phyllis is talking about. When you are considering the large national chain operations, they function, essentially, as typical food processors might in terms of developing internal strategies for sodium reduction. As I sit around the board table with my directors.... Many of those companies, let me assure you, are already very much engaged in that process. They are genuinely committed to looking at this issue and are already working to reduce sodium. Will we see reductions in menu items on offer? Yes, I believe you will see that. I know you will. You already are.

I think the other key point I'd like to make with respect to my industry is that there are over 85,000 restaurants across this country. Many of them are independent operators. We're working to educate those members so that they are implementing different operational realities in their restaurants as well.

The Chair: Thank you, Mr. Reaman.

We'll now go to Ms. Leslie.

Ms. Megan Leslie: Thank you, Madam Chair.

Thank you all for your presentations. They were very informative.

Just to get it on the record, I'm not a huge fan of the voluntary reductions. I don't see that they're necessarily going to work. The U. S. Institute of Medicine has shown that they have little, if any, effect.

Mr. Samis, I have a question for you about Heart Check. Heart Check is voluntary, right?

Mr. Stephen Samis: Yes, but it's called Health Check.

Ms. Megan Leslie: Oh, sorry. Health Check is voluntary.

You mentioned that it's a successful program, and folks have signed up. Companies have signed up voluntarily, and they're benefiting from getting the label. Is that right?

Mr. Stephen Samis: Yes, it is a voluntary program. We have no authority to demand that companies join the program. Companies join the program. There are set nutrition criteria, broken down into about 80 categories, depending on the type of food, and companies have to meet those criteria to get into the program.

Ms. Megan Leslie: In exchange, they get that little logo that indicates to the consumer—

Mr. Stephen Samis: They get that Health Check logo.

Ms. Megan Leslie: I find that really interesting, and I see that as a counter to this idea that there is no demand out there for products with lower sodium.

Ms. L'Abbé, as a nutrition scientist, would you be able to tell us about the Canadian palate? Isn't it possible to reduce the need of our palate for salt? It could be swift, it could be a slightly moderate length of time, but it is possible to reduce that need.

● (0950)

Dr. Mary L'Abbé: Yes, scientific research has shown that the change in palate or the acclimatization of sodium takes anywhere between three weeks and three months.

Ms. Megan Leslie: Three weeks.

Dr. Mary L'Abbé: To three months. The important thing is all food has to be changed. You have to be exposed to the same level of sodium in all food, because if you have some low, some high, you don't acclimatize.

Ms. Megan Leslie: Right. Of course.

Dr. Pipe, I was wondering if you could take the rest of my time, frankly, to just lay out, get it on the record, what is happening in other jurisdictions. We've heard about Finland here at this committee. How do we do this? It is possible. Remarkable things have been done in other jurisdictions.

Dr. Andrew Pipe: I would defer to some of the expertise that's also resident at this table. The two classic examples would be what has been taking place in Finland, which I alluded to earlier, and also more recently what has taken place in the United Kingdom.

The United Kingdom has adopted an approach that involves product labelling in a very clear way so individuals clearly understand the amount of sodium in a particular food purchase. They do that using a so-called traffic light system so there are red, green, or amber signals on the front of food packages, which very clearly communicate the amount of sodium in those packages.

That has been a very successful undertaking. It built on the experience of Finland, where Finland used a combination of education, voluntary leadership from the food industry—and there are very significant examples of very specific leadership being provided by the food industry, and we see it here in Canada—and regulation.

Frankly, one of the things regulation does is create a level playing field. It makes it much easier and it does not penalize members of the food industry who might be out there exhibiting dramatic leadership in terms of the way in which they're reformulating their particular products.

I think those would be two jurisdictions that could be looked at very carefully and very closely for examples of how one could thoughtfully develop these kinds of initiatives.

I know my colleague from the Heart and Stroke Foundation probably has something that might add to that discussion. Stephen.

Mr. Stephen Samis: One of the things Finland did was require a label on foods that were high in sodium. If you didn't meet a certain threshold you had a warning label put on your product that this food is high in sodium. Government can do a variety of things, both in voluntary education but also in regulation.

I think Andrew's point is a very good one: it does create a level playing field. It rewards those companies that are already making a difference and it takes the laggards, who simply can't be bothered, and pulls them in. We've seen the same thing with trans fats. There are companies that have removed all the trans fats from their products, and companies that haven't removed the trans fats at all or very little. It creates a level playing field, not only for the food industry but also for Canadians.

Ms. Megan Leslie: Thanks.

To sum up—to use your words, Dr. Pipe—would you both agree that intelligently designed health policy requires regulation?

Dr. Andrew Pipe: I would certainly agree that some element of regulation will be required, for the reasons that Mr. Samis just outlined.

Ms. Megan Leslie: Great. I think those are all my questions right now. Thank you.

The Chair: Thank you, Ms. Leslie.

We'll now go to Dr. Carrie.

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

I want to take this opportunity to thank all our witnesses here today for their leadership. I know the sodium working group has been working the last couple of years. It's pretty much unprecedented that we would have a body like this looking at such an important issue for Canadians and Canadians' health, so I'd like to thank every one of you for your different perspectives and your input into this important thing we're moving forward.

We have been hearing a lot about the sodium working group. I think our last meeting on it was in November. Madame L'Abbé, would you be able to update the committee a little bit more specifically on what you've accomplished in these last six months? You said the report is coming up fairly soon. Can you give us a little update?

Dr. Mary L'Abbé: We announced our interim target to really help boost the process, to get it going while we were deliberating.

Secondly, a couple of things have occurred. As I mentioned earlier, we had three subcommittees as part of the working group, each of them tasked with developing strategies for our three-pronged approach. One developed the targets for the food supply, and Health Canada has been, since the fall, discussing draft targets with the food industry. The view was that if those targets were reached, we would then have food intakes by Canadians that met the goals of the working group. So that work has been ongoing, fine-tuning the targets. We heard from the dairy industry and they mentioned some concerns, but that work is ongoing.

Our education group has helped develop an education program that would address the needs of the consumers but also the needs of the industry to reduce sodium.

In the third group, we partnered with the Canadian Institutes of Health Research, but also the National Sciences and Engineering Research Council, agriculture, and the food industry, to come up with the types of research that we would need, because some of the answers aren't out there yet.

All three groups have been working together, and as a group we've also crafted our recommendations. That's the final stage of that report that we hope to have ready for the minister early this summer.

● (0955)

Mr. Colin Carrie: Excellent. I think everybody around the table here is looking forward to that.

In regard to my next question, I've been following this for quite some time, and I've noticed even in my own life that when my kids were younger, baby food, for example, was extremely high in sodium. My wife and I used to make our own baby food. It seems that companies have already taken huge steps to make certain foods much more healthy for the Canadian consumer.

Another thing is potato chips. I'm one of those guys who just loves his snacks and crunchy potato chips. I've noticed that they've decreased the sodium in potato chips voluntarily.

I'm going to pose the question to Mr. Reaman and Ms. Tanaka. Where are some of the areas of greatest difficulty in reducing sodium? What are some of the challenges that we have to get over in bringing these levels down?

Mr. Ron Reaman: There are many, many challenges. There are also lots of opportunities, and as you quite rightly highlighted, there have been many companies, on specific products, that have made some great progress to date.

That said, within the food service environment we have a whole host of issues. Earlier Dr. Pipe raised sodium as an issue of food quality and food safety. I'd have to be in violent agreement with Dr. Pipe that it is an issue of both food quality and food safety. Sodium acts as a flavour enhancer, absolutely, but it also acts as a preservation agent and an anti-microbial agent.

There are many functions with respect to food safety: shelf life, food sitting out on trays, etc. These are all very genuine concerns that my industry is grappling with on a daily basis with our food offerings.

Mr. Colin Carrie: That's part of the average Canadian's lifestyle now, too. We have an ordinary family. I work and my wife works. We use a lot more prepared foods. We actually go out a lot more than generations in the past. We've heard of the Americans doing different things, but at the end of the day, if things don't taste very good, if people don't like those products, we always have that salt shaker on the table and we can just add it to them.

Mr. Ron Reaman: You're absolutely correct, and I guess it's another point where I would like to draw the distinction between the transfat issue and the sodium issue.

Sodium is an essential nutrient; it's in our food and it's never going away. Transfat we all agreed we were trying to rid from our food supply. That's not the case with sodium. So it's a different approach that we have to take.

Mr. Colin Carrie: Okay.

The Chair: You have a few more minutes, Dr. Carrie.

Mr. Colin Carrie: I wonder if Ms. Tanaka would comment on that.

Ms. Phyllis Tanaka: I'd just like to support earlier remarks I made. Sodium is a more complex issue or a more complex nutrient to take control of in the food supply. It has several functions in food, and finding replacements for those functions is not straightforward or simple. Taste is one of them, but it's not the only one. As we all know, taste is paramount in the consumer's world or acceptance of a food product. That's where time is going to be required, not just to change products or to find other solutions, but to adapt the whole population's palate towards a lowered sodium taste profile.

Yes, it may only take three weeks in a controlled study to change the palates of a group of people, but to Dr. L'Abbé's point, we're talking about changing the palate of the whole population, and that's not going to take just three weeks.

● (1000)

Mr. Colin Carrie: I think there are huge challenges there, because as a health committee we've heard of all kinds of health difficulties and challenges that Canadians have. Look at the issue of obesity, for example. Many Canadians are looking for prepared foods that are low in fat, but sometimes these low-fat, low-calorie foods have high sodium. Is there research going on right now on how to balance the taste, the low fat? You don't want to pit one disease against another. We don't want to say high blood pressure is worse than obesity, but is there research going on right now on different additives you can add that will do what you said, Mr. Reaman, for the preservatives and all these other functions that salt does?

Mr. Ron Reaman: Thank you again for raising another excellent point. There is no question that when we look at reformulations of products, we have to consider the holistic approach to that particular product and balancing off sodium versus calories and fat, etc. To Dr. L'Abbé's point earlier, the working group did convene through the CIHR, the Canadian Institutes of Health Research, a research conference to look at some of these very issues. One thing that came out of that conference—I participated in it—was the realization that we really are missing a fair number of chunks in the research. That group was tasked with identifying some of the research goals and objectives so that we can start to fill in those gaps. My understanding is that the research is ongoing, and we will look to see some results on that shortly, I hope.

The Chair: Thank you, Mr. Reaman.

We'll now go into our five minutes of questions and answers. Please keep in mind that it's five minutes per question and answer.

We will begin with Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair.

Thank you to all the witnesses for coming.

Dr. Pipe, I really appreciate your remarks about the safety and quality of the food system. I think Mr. Reaman used food safety in a very different way from how you used food safety.

I do not want to see education, voluntary reductions, and research used to slow down real action. We've known for 40 years that salt is an issue. We knew tobacco was carcinogenic for a hundred years, and we knew sunlight was, before we took real action. We did take action and things got done.

We know salt is an issue and 90% of patients know salt is an issue. They know that processed food is a concern.

Dr. Pipe, is there any other community that you would like to highlight, other than Finland, that has done important work this committee should learn from?

Dr. Andrew Pipe: Thank you for your question.

I probably would draw attention to what's taking place in the United Kingdom. Our colleagues in Australia also are grappling with this issue. I think in the questions that were raised earlier, people were talking about the report of the U.S. Institute of Medicine. The academic community in the United States is looking at this issue very carefully. So there are examples and there are ways in which we can move more expeditiously to begin to apply the solutions on which I think there would be a shared consensus, certainly among the clinical and scientific and public health community.

Ms. Kirsty Duncan: Thank you.

How do you feel about the goal of the 2016 target? We've heard today that it is aggressive and challenging. It's 2,300 milligrams, and that's at the upper limit of the daily recommended dose, not that there is a daily recommended dose for salt.

Dr. Andrew Pipe: Well, as you know, if we were free-grazing *homo sapiens*, we probably would require only between 1,200 and 1,500 milligrams of sodium a day, but the nature of the food environment as it has evolved over the last 50 years has been such that we now have very significant increases in sodium intake. I do think it will require some period of time before we can adjust a population's palates to an appropriate level, but 2,300 milligrams is a very significant first step. While there are purists and idealists who could say our physiology is equipped to deal with much less than that, I think that would be to ignore reality. I think this is remarkably consistent with the kinds of recommendations that the World Health Organization has been proffering. I think it makes life appropriately easier for international food manufacturers. I'm not unsympathetic to their particular needs and their particular concerns, but it allows for more consistency across borders. If the kidneys and the hearts and the circulatory systems of English citizens are important, why aren't they just as important among Canadian customers of those same companies? So I think it is a reasonable first step.

● (1005)

Ms. Kirsty Duncan: Thank you. I appreciate that.

The Institute of Medicine is recommending mandatory national standards for sodium content in foods and a gradual reduction in sodium levels. Do you feel that this is an option for Canada, and why or why not?

Dr. Andrew Pipe: I think it's very definitely an option for Canada, and I think one of the reasons why it's an appropriate step is that there will be laggards within the food industry. I want to come back again to the question of food safety. I think it's a fundamental public health responsibility of governments to ensure the safety of the food supply.

There are times around about midnight when I get a little bit more grumpy about these matters, when I say maybe we should be talking not about sodium content of food but about sodium contamination of food. All of a sudden the vocabulary in the discussion would change. I realize that probably does a disservice to the use of vocabulary, but it makes the point.

Notwithstanding the very significant reasons for there being certain levels of sodium in food—food stabilization, shelf life, etc.—I think overall what should be the overriding objective is to ensure that food ultimately contributes to the health of those who consume it. To the degree to which a high sodium content is deleterious to health, it seems to me a pretty straightforward conclusion that we should be moving to moderate the sodium content of our food.

Ms. Kirsty Duncan: Can you—

The Chair: I'm sorry, Dr. Duncan.

Might I just ask one question of the witnesses? Is that all right with the committee?

Dr. Pipe, what does 2,300 milligrams look like? If we were looking at it this morning, the weight of 2,300 milligrams, what would that look like, say, in a glass like this? How much salt would that actually be, visually?

Dr. Andrew Pipe: I'll probably get the figures slightly awry here, but if we were to reduce the average Canadian's diet down to a sodium intake of 2,300 milligrams of sodium, it would be taking a tablespoon of salt out of their daily diet.

Salt is ubiquitous. It's everywhere in food. Most Canadians are blissfully unaware of where the sodium is to be found in their foodstuff. That's the order of magnitude of reduction we would be talking about.

Is that helpful?

The Chair: Yes, it's a really good answer, because you don't think in a day you actually eat a tablespoon of salt. I mean, you don't realize because it kind of sneaks into all these processed foods.

Thank you so much.

Now we'll go to Ms. Davidson.

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

Dr. Andrew Pipe: Madam Chair, I may have misspoke myself. I meant teaspoon, and I'm told I said tablespoon. Forgive me—teaspoon of salt.

The Chair: Oh, a teaspoon. You are forgiven, Dr. Pipe.

Dr. Andrew Pipe: Thank you. *Mea culpa, mea maxima culpa.* I'm sorry.

The Chair: Good. Thank you.

Ms. Davidson.

Mrs. Patricia Davidson: Thank you.

Thanks very much to our presenters. Most of you we have seen before, and it's great to see you back here again.

I have a question that follows up what the chair was just asking. Could somebody tell me how much of the average Canadian's sodium intake comes from free salt, or salt we add at the table, with the shaker? Does anybody know that?

The Chair: Who would like to answer that?

Ms. Tanaka.

Ms. Phyllis Tanaka: Roughly 77% comes from processed food products and foods in restaurants, about 5% to 6% at the table or in cooking, and the balance in cooking, I believe, and naturally occurring. It's about 12% that comes from other sources; 5% of that is at the table.

● (1010)

Mrs. Patricia Davidson: So very little, then, is added consciously; the rest is in the foods that we're eating, whether they be prepared foods or whether it be naturally occurring. Okay.

That will lead me to my next question, for Mr. Reaman. Right now we don't have any regulations making things mandatory for the restaurant groups to do something different, and to lower them we're probably looking at decreasing voluntarily, from the report that's coming out. Dr. L'Abbé, I'm hearing that it's a voluntary system you will be recommending in your report.

Can you, Mr. Reaman, give me any examples of what your group might be doing now to voluntarily reduce things? I think you've said that they're working towards that already, that there has been some progress made. Could you outline what that progress has been?

And could you also give me your perspective on the difference between mandatory and voluntary as far as the amount of regulation goes, and how it would be seen from your group? Would there be a better opportunity for your group to voluntarily reduce the sodium because of less red tape and all of the things that go with mandatory regulation? If that would be the case, then how do we ensure it would be done if it's not mandatory regulation?

Mr. Ron Reaman: If I understand the question correctly, there are a couple of points I can respond to.

The first point is to recognize that within the food service sector, we represent about 20% of foods consumed in the course of a day, on average, by the average Canadian. So when you're talking about 77% coming from processed foods and food sold in restaurants, etc., we need to recognize that food service comprises about 20% of daily food intake for Canadians.

In terms of a voluntary versus mandatory approach, I can't speak specifically about individual companies, but what I can tell you—and this is from direct contact and discussions that I have with our membership—is that there are many food service companies who are fully engaged in reducing, reformulating, and testing reformulated products with consumers. So that process is absolutely under way.

Everyone in my industry who I work with directly is fully aware of the process that the sodium working group is undertaking and of our commitment to be part of the solution, in terms of reducing and bringing down the sodium levels of Canadians. So I can tell you that there's a genuine commitment to the voluntary reduction strategy, and I think it's the best way to go for us, as a country, as a strategy. I genuinely believe in that as the way to go.

Does that answer your question?

Mrs. Patricia Davidson: Yes, thank you.

Dr. L'Abbé, when you're working with your working group and you're recommending voluntary reductions, are you also looking at timeframes within which those voluntary reductions would have to be met?

Dr. Mary L'Abbé: Yes, absolutely. As I mentioned earlier, the working group was setting targets for the food supply, recognizing that those targets would likely be staged over time, but very much that they would be something that could be monitored and evaluated in terms of progress over time.

Mrs. Patricia Davidson: I have a question for Ms. Savoie.

You stated in your opening remarks that DFC has asked Health Canada to provide the dairy industry the proper time to conduct the necessary research before establishing sodium targets for cheese and timelines for reaching these targets. What is DFC looking at as the proper time? What kind of time do you need?

Ms. Nathalie Savoie: We have one research program that is already ongoing, and it's on cheddar cheese, which is the major cheese consumed in Canada. The results are going to be available early next year.

For the larger range of cheeses we're looking at, we've just committed the money with Agri-Food Canada. As we speak, this week the different projects are being assessed by our expert committee. So the research would start this year, to be finished in 2012.

● (1015)

Mrs. Patricia Davidson: So the research on one type of cheese would not be applicable to any other type?

Ms. Nathalie Savoie: No.

The Chair: Thank you, Ms. Savoie.

We're now going to Monsieur Dufour.

[*Translation*]

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

Thanks to the witnesses for being here today.

Mr. Reaman, I have one question to start off with. A little earlier, you told us that 20% of a Canadian's daily diet comes from restaurants. I would be interested to know the percentage of sodium that they get from that 20%.

[*English*]

Mr. Ron Reaman: That is a good question. I'm afraid I don't have the answer off the top of my head.

I can tell you that we comprise about 20% of daily food intake in this country.

[*Translation*]

Mr. Nicolas Dufour: But you have no idea of the specific percentage of sodium they could consume? It may be 20% of a Canadian's food for a normal day, but it might actually represent around 50% of the sodium intake.

[*English*]

Mr. Ron Reaman: I do not have that answer for you. It's not available to me.

[*Translation*]

Mr. Nicolas Dufour: Fine, thank you very much.

Ms. Tanaka, you were telling us earlier that each company has its own strategy for reducing sodium. I just have a few quick questions for you.

First, in your organization, do you have a mechanism that allows you to oversee what companies are doing internally? Do you have any idea how their strategies are working? Are there companies that actually do not have a sodium reduction strategy? What do you do when a company does not have one? Do you provide assistance to those companies to allow them to develop a viable plan to reduce sodium? Do you have an idea of the amount of money that companies might spend on research to find a substitute that will allow sodium to be reduced?

Finally, could you tell me what you think about what Dr. Pipe told us earlier about a labeling system, perhaps modelled on the one in Finland or Great Britain? Would Canadian companies be prepared for a labeling system like that?

[*English*]

Ms. Phyllis Tanaka: With respect to monitoring our individual member companies, that isn't a role of a trade association. However, through the multi-stakeholder working group the fourth step in our game plan is one of monitoring the progress of the food industry against sodium reduction targets. That's part of the game plan of the working group. But as a trade association it isn't our role to monitor the corporate business of our members.

Secondly, we do provide support to our member companies. We have a sodium committee, as I mentioned in my earlier remarks. Through that sodium committee I keep the members apprised of the working group. It was through our sodium committee that we were involved in the public consultation the working group had to discuss moving forward with a strategy. We have a very important facilitative role in allowing our members to stay tuned into what's going on so they know how to act accordingly. It's through FCPC that we made sure members knew of Health Canada's pending discussions with industry that are going on right now to review targets for the different food categories. That is the role we played.

I don't know bottom-line numbers for how much individual corporations have invested. I do know through informal discussions that product reformulation is not a cheap endeavour. It takes substantive dollars to do that. That point, too, was made in the IOM report that was released recently. It's a big investment, not just on the part of governments but also on the part of industry, to move forward with this initiative.

With respect to the labelling aspect, one of the things that Canada has in place is a very good, sound, nutrition facts panel. I think that from industry's perspective and from my personal perspective, building the communications messaging around what we already have in place as a tool to help Canadians make informed decisions makes the most sense.

● (1020)

The Chair: Thank you very much.

Go ahead, please, Mr. Reaman.

Mr. Ron Reaman: I wonder if I might just follow up on your earlier question.

While I can't provide you with a specific statistic, I think it's important to recognize that the restaurant and food service industry sources its foodstuffs from the same food supply chain that we all use. Whether we are a grocery retailer or an individual Canadian who is going to that grocery store and purchasing foodstuffs, we purchase from the same supply chain.

What I would say to you is that it would be relative to the 20%. Within the food service industry we have two different essential types of operators, the chain restaurant operators and the independents. The chains are going to source as per spec for their products. Independents are going to source foodstuffs just like you and I do to cook at home. It's relative to that 20% is what I would say to you.

I hope that helps.

The Chair: Thank you, Mr. Reaman.

We'll now go to Ms. McLeod.

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

First of all, I have a general comment. We talk about the importance of education. Certainly I don't think anyone has had more education than we've had in our first couple of hearings, but what really stands out in my mind are the comments by Dr. Pipe, who said that healthy behaviours become easy decisions.

I'll make a confession. Right after our initial series of meetings, I started making sure I was checking every label I saw, but I recognize that I've drifted away from that behaviour over the months since we last chatted. In ways, the panel is good information, but it doesn't really stand out in terms of awareness.

More importantly, one thing I'd like to explore is understanding some of the research priorities we have around sodium consumption. As well, and related to my initial comment, there is the whole behavioural change piece and where we're going in terms of research with that also.

I'll open that up for general comment.

Dr. Andrew Pipe: With the chair's permission, I'll leap in.

In my day job, I head the division of prevention and rehabilitation at the University of Ottawa Heart Institute. We are always talking about making the healthy choices the easy choices so that Canadians shouldn't have to think about the kinds of options afforded to them and should be able to have some assurance that the foods they purchase are healthy, safe, etc.

In the work we do clinically with our patient population, we spend an inordinate amount of time pointing out to our patient population the enormous amount of sodium found in a variety of food sources, a fact that is not appreciated by most Canadians.

A certain amount of sodium is absolutely necessary, and we understand that, but the degree to which we can begin to improve and enhance the quality of our food supply by minimizing or moderating sodium intake is going to make it a whole lot easier for Canadians to make healthier choices more easily.

Mr. Stephen Samis: One of the things the federal government can do in terms of facilitating research and facilitating our understanding of these issues is to dramatically improve both Canada's health surveillance system and the kinds of research platforms that we have available to us. I'll give you an example.

We have no idea how many heart attacks occur in Canada every year. We have no idea. We don't have a cardiac arrest registry. We have very poor cardiovascular-related health surveillance data in the country. Between 1970 and 2000, we went 30 years without a national nutrition survey.

We have encouraged the government to help us to bolster the health indicators and the measures that are going to be in the new Canadian cancer cohort, the Tomorrow Project, to ensure that we have really good, robust health measures in that cohort that will make it not just a cancer cohort, but a chronic disease cohort.

One of the ways in which we can do that is through a really thorough nutrition survey as people go through that cohort. That's not happening at the moment, and if doesn't happen, we're missing a golden opportunity to learn more about how diets and environments impact Canadians' health over time. The federal government has a tremendous role to play in ensuring that Canadian scientists have a really good research platform and data platform to work with, and we don't have that right now.

● (1025)

Mrs. Cathy McLeod: We've heard a bit about Finland and the U. K. Do they or the other jurisdictions have mandatory limits on the sodium in those examples? Have other jurisdictions pursued mandatory limits on sodium?

Ms. Phyllis Tanaka: I don't actually remember if Finland's is mandatory. I know the U.K. is voluntary.

I think an important point to know also in looking at those two examples is that Finland took well over 20 years to shift their population average sodium intake. In the last record I remember looking at— and Dr. L'Abbé might be able to confirm it—their average intakes are still higher than ours at our starting point here now.

In the U.K. I think it was in 2004 or 2006 when they started looking at shifting their sodium intake. They started at 3,800 and in 2008 they've just shifted it down to 3,400. They're not anywhere near 2,300 yet. So while yes, those are examples of countries that have taken leadership and action on reducing sodium, they've also through their experience demonstrated the significant challenges in doing it.

The Chair: Thank you very much.

We'll now go to Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thanks, Madam Chair.

I note that the Institute of Medicine report is recommending in the United States that the mandatory national standard of sodium be applied. Has there been any update to that? What's happening in the United States?

Dr. Pipe.

Dr. Andrew Pipe: I would perhaps defer to Stephen, who may be more familiar with that.

To my knowledge, there has been no further evolution of the standard that you describe at this point.

Mr. Stephen Samis: I would say that's the case. Last week in Washington there was a national nutrition summit that involved the FDA and a variety of regulatory bodies in the United States. They were looking at issues related to sodium, transfats, fats, and obesity, etc.

I know there is a lot of work going on right now in a variety of federal agencies, but I still don't think there's any promulgation of regulations in the U.S.

Ms. Joyce Murray: Thank you.

I'll make just a personal comment. I think if the recommendation was that every Canadian for a month not eat anything that has a label, nothing from a bottle, a can, a package, or a restaurant, we'd all change our taste for salt within a month. That may not be a practical recommendation.

I mean, it is frustratingly complex. I understand the absolute necessity of including the industry in the discussions. I want to acknowledge the good intentions and the hard work of the salt working group. But it does make me wonder, due to the terms of reference of the federal government to the salt working group, whether this hasn't been only almost like a delaying tactic, as opposed to an action approach. That's especially when it has precluded recommendations of mandatory regulation.

I guess I'm still wanting to get some clarity in terms of this committee's recommendations. I don't want to put you on the spot, Stephen or Dr. Pipe, but do you believe a committee that has a major component representing the 75% of consumption that is so laden with salt.... Would that working group actually be able to make recommendations to eat fresh food and eat foods without labels that have not been processed? Or is that kind of counter to the very make-up of the group?

I mean, are we going to get recommendations that are going to really take action, fast and effectively? Or by the nature of the group are we going to have it predisposed to the waiting and the careful, slow “we can't change peoples' taste because it takes years” kind of report?

● (1030)

Mr. Stephen Samis: I would have to say, on behalf of the foundation, that as a member of the working group it's difficult for me to answer that question without undermining perhaps the representative of the Heart and Stroke Foundation who's on the group. So I'm actually going to defer the question, because we—

Ms. Joyce Murray: Okay, who's not on the salt working group who can give a frank comment to that question?

Mr. Stephen Samis: Yes, and that's why I defer to Andrew. Thank you.

Dr. Andrew Pipe: Well, I think it is unfortunate that the repertoire of opportunity, if I can use that rather convoluted phrase, that the committee seems to be taking seems very specifically to preclude any form of regulation. I say so because frankly some forms of regulation would be very helpful to industry. It would create a level playing field. It would allow those responsible members of our food industry who are demonstrating very distinct leadership in a number of areas to do so with even more vigour, knowing that they're not going to be blind-sided by individuals who will just take advantage of the fact that there is no regulation.

I'm a very strong believer in comprehensive approaches to public health that involve voluntary approaches but also some degree of regulation. We have in Canada some sparkling examples from the food industry of leadership on the sodium issue, and I think you're all familiar with those. But it just seems to me so sadly ironic that we are spending some of our programming resources, such as on some of the things we're doing in the Champlain area of eastern Ontario, to run television commercials telling Canadians how to take processed foods and to make the canned foods they buy safer. Something's not right with that picture.

Ms. Joyce Murray: So what recommendations should the committee make to really encourage people to open their eyes to the value of cooking and eating fresh foods, or eating closer to the natural product, so the processed food industry can catch up to what we need—which is less salt in our food?

Dr. Andrew Pipe: Well, I would put it the other way around. Frankly, the realities of 21st century life, as we've all heard, are that many of us eat food in a variety of settings and for a variety of reasons. So I think there's a fundamental public health responsibility to optimize the safety—and I use that term quite deliberately—of the food that is available to us in all of those kinds of settings. I say this because I realize that harried families, two-parent families, and working parents are obviously going to take advantage of the food opportunities that are afforded to them by the hospitality and the food industry. I think we have to help the food and hospitality industries make the healthy choices in the constitution of their products.

Ms. Joyce Murray: I'm not suggesting that it's either/or. I'm wondering if a recommendation around both is something you would endorse?

Dr. Andrew Pipe: Absolutely.

Ms. Joyce Murray: Thank you.

The Chair: Thank you, Ms. Murray.

We'll now go to Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Madam Chair.

I was going to ask Mr. Reaman about the challenges facing his industry if we perhaps do move too fast. What are the challenges for your industry, and perhaps for prepared food as well?

We're looking at different models around the world, such as in Finland and the U.K., who were way off the charts when they started and are not even down to where we are today. We are now moving ahead and are taking a leadership role here in Canada, but I can see the challenges facing restaurants, for example. You could have restaurant A providing low-sodium food, but at the end of the day, if the food tastes awful and costs a lot, maybe from a marketing standpoint as a business model that company would have challenges actually staying in business, because at the end of the day, the consumer chooses what foods they want to purchase and where they want to go.

Are there health risks if, let's say, the government just mandated that by this or that date you had to have certain things done? Are there options out there in terms of the anti-bacterial and preservative issues you mentioned on which we could get started now?

Maybe Ms. Tanaka and Madame L'Abbé could comment on that, but we'll start with you, Mr. Reaman.

● (1035)

Mr. Ron Reaman: Sure.

Well, I think the first threat is that if we don't have consumer acceptance of our products—which goes to your point earlier, Ms. Davidson—you may just drive consumers to add salt post-purchase. So if we're trying to achieve a public health outcome, which is reduce Canadians' intake of sodium, then it needs to be considered with a holistic approach. Just flipping a switch overnight and asking the food industry to dramatically reduce the sodium content in their food offerings is not going to get us there, because you're going to have a pendulum effect and a reaction from consumers who do not accept that immediate, dramatic reduction. So that's the first thing I'd say.

The other thing about food service, in particular, is that at the end of the day we are a consumer-demand-driven business, as I said earlier. Customization and substitution are hallmarks of our industry. You and I can walk into a restaurant and order the same thing off the menu, but we are ordering two different meals, because I want an excess of this and less of that, and you want more of this and less of that. Customization and substitution literally define what we do as a business. So again, if we don't cater to our customers' demands, then we will face an economic threat. So yes.

Mr. Colin Carrie: Madame L'Abbé.

Dr. Mary L'Abbé: I can't speak of the specific challenges per se from an economic point of view for the food industry, but I can tell you about a couple of things that came up at the research meeting that I think are germane to the argument.

The food industry doesn't always have an idea of what level of sodium it can go down to, whether it's cheese or cured meat, before it starts risking safety. We've gotten used to certain levels of sodium. It actually now has to find us that data to say how low it can go and not compromise safety. Some of that data is actually missing because historically that's just the level the industry has been using for a number of years.

That's another important aspect. We're waiting for some of that data to occur over the next couple of years, which will have big implications for both the restaurant and the food industry, and the packaged industry as well, so that we know where we can go.

Mr. Colin Carrie: I commend the dairy industry and other industry leaders that are moving that forward, because I do see, in Canada, compared to internationally, we are moving ahead on a very important public health issue. So I am looking forward to the recommendations that you bring forward.

Ideally, as a father with three small kids, I'd love to see my kids always choose the carrots and the apples, and stuff like that. But even when we put those things in the lunch, they come back. The kids go out and eat what they want, as do all Canadian consumers. So whatever we can do to look at the safety and health, that's our greatest challenge and our greatest interest.

Thank you.

The Chair: Thank you, Dr. Carrie.

Might I just ask one more question about this? Is that okay with the committee?

Dr. Pipe, I'm one of those free-grazing *homo sapiens* you referred to, and I just wonder, why don't we use a salt substitute? If we did, would that be as injurious to our health as using salt?

When they had the margarine-butter debate, they decided margarine was better, and now we're hearing that butter is better. So I'm not sure that we always make the right choices based on science.

What's your opinion of that?

Dr. Andrew Pipe: Just to be sure I understand the question—

The Chair: In terms of salt substitutes, are they as dangerous as salt, or could they be healthier for Canadians?

Dr. Andrew Pipe: There are a number of ways you can influence "mouth feel", as the food scientists would term it, by adding things that enhance the flavour or increase the viscosity and the palatability of food. But overall, the significant amount of sodium found across a whole array of foodstuffs is such that this is a bit of a non-starter. I think it's far simpler to actually reduce the sodium content of foods, added as part of the manufacturing or processing.

● (1040)

The Chair: Thank you.

Ms. Leslie.

Ms. Megan Leslie: Oh, goodness, I wasn't expecting that. Thank you.

The Chair: Well, this is your treat today. You're new to the committee.

Ms. Megan Leslie: What a treat. It's because I'm new. Thank you, Madam Chair.

I have a question for Ms. Tanaka. I wonder if you can help me understand why there are different sodium levels in something such as breakfast cereals in the U.S. versus Canada. Do you have information on that?

Ms. Phyllis Tanaka: No. That again would be information specific to an individual corporation and their corporate decisions. In large part, they develop their product profiles to suit the consumer audience they're addressing. But this isn't an issue that a trade association manages. That's individual corporate—

Ms. Megan Leslie: So it's not because of regulation or....

Ms. Phyllis Tanaka: It could be for a number of reasons. I really don't know why individual companies make those choices. It has to do, in large part, with the audience they're addressing, the consumers and the country they're working in.

Ms. Megan Leslie: Thanks.

I'll open this up to whomever would like to answer. In October of this year Canada is hosting a stakeholder meeting for the World Health Organization specifically about sodium. October might as well be tomorrow; it's pretty soon. What things could we do here in Canada to actually show leadership before October?

Ms. Phyllis Tanaka: I'm not sure. The only World Health Organization meeting I know of in October is related, I think, to bisphenol A, not sodium. The working group hasn't been made aware of any pending meeting. That one I know of, because it's another file I manage. But on sodium, I'm not aware of any.

Ms. Megan Leslie: As far as I know, we're hosting one in Calgary. There will be three stakeholder meetings on three different aspects of sodium. The final one is on iodization. The other two, as far as I know, are about reduction generally.

Have you any ideas on how we could come out, as the host country for this meeting, to demonstrate some leadership internationally?

Ms. Phyllis Tanaka: The working group is well placed to demonstrate leadership. We've been working very hard. It might look like we're slow, but we aren't. Within Health Canada, the leadership that's been provided to the working group will complement the World Health Organization process that will take place. So I look forward to that.

Ms. Megan Leslie: I saw a couple of others reach for their mikes.

Dr. Mary L'Abbé: I would just echo one comment. Given the work we've done, it might be a unique opportunity for other countries to learn what it has taken us two years to learn so that they don't have to go through the same phase. They can catch up. Just as we have learned from some of the experiences in the U.K. and Finland, they can benefit from some of our experience getting to where we are. That might be a useful role Canada can play at that meeting.

Mr. Stephen Samis: I was going to say many similar things. We can profile the work we have done through the working group, and we can also highlight some of the lessons learned.

The government could also begin an education campaign. It would be a great time to launch an education campaign to start educating Canadians about sodium and how to reduce sodium intake. That is part of the working group's deliberations. It would be a great opportunity to roll that out.

Ms. Megan Leslie: It would be an early rollout. Thanks.

Mr. Reaman.

Mr. Ron Reaman: While I'm not a spokesperson for the sodium working group, nor can I speak on behalf of Health Canada, it is my understanding that there will be a report issued shortly. We will have that report out in the public domain. It could be a great document for us to centre some communications on.

Ms. Megan Leslie: Mr. Pipe, I saw you reach.

Dr. Andrew Pipe: It would be a wonderful opportunity to talk about comprehensive health promotion—healthy public policy—which involves, very often, more than just voluntary approaches, in general, to health policy.

When I say comprehensive, I'm not talking about being overriding and authoritarian and so on. I'm talking about using the best offices of government to ensure that those responsible members of the corporate community in the food sector are rewarded for their leadership, because many of them are showing distinct leadership in this area. Unfortunately, their ability to express that leadership is not being enhanced, because there won't be a level playing field, the kind of level playing field that can only occur, I would argue, with some sensitive and strategically developed public policy in this area.

● (1045)

Ms. Megan Leslie: With respect to comprehensiveness, Ms. L'Abbé, from the perspective of the working group, has the working group been working with other branches or agencies or aspects of Health Canada? We had testimony previously that, yes, salt is very important, but we also need to consider things like obesity. Is there an attempt by the working group to try to have that comprehensive reach by working through other agencies?

Dr. Mary L'Abbé: The approach very early on was to have the working group be quite comprehensive in its makeup. We are fortunate that we have advice and input from groups like the Heart and Stroke Foundation but also from many other areas of government. The Public Health Agency participates. We have representatives from provincial governments and representatives of the chief medical officers of health in the provinces. They bring that knowledge and those linkages with all those activities and actions that are going on so that we do have a sense of the best—

Ms. Megan Leslie: Are you linked with other health issues, such as obesity?

Dr. Mary L'Abbé: We aren't specifically, in the sense that we won't be able to address things like obesity through this.

Ms. Megan Leslie: Right, of course.

Dr. Mary L'Abbé: Obviously, we don't want our actions to jeopardize or be in conflict with other activities. We're sensitive to it, but we are not specifically addressing our recommendations to address those other health questions.

Ms. Megan Leslie: Will you be distributing your recommendations to other branches of Health Canada?

Dr. Mary L'Abbé: Absolutely. Health Canada, being the provider of the secretariat, has been a tremendous resource to the members of the working group. When we've needed information, they have, on our behalf, started developing targets and analyzing the food supply for us. Absolutely, they have been fully engaged in this process.

Ms. Megan Leslie: Thanks.

Ms. Savoie, I am interested to follow up to allow you time—

The Chair: I am so sorry. I've given you extra time just because it's your first day.

We'll now go to Ms. McLeod.

Mrs. Cathy McLeod: Thank you, Madam Chair.

I want to pick up on one comment that Ms. Savoie made, and that was you talked about doing some work with cheddar cheese—

Ms. Megan Leslie: That was my question.

Mrs. Cathy McLeod: —because that's the major consumer product. Do you see through that work that you would actually perhaps have agreement of all the cheddar cheese makers to jointly work towards a reduction in sodium?

Ms. Nathalie Savoie: The research that we are funding is jointly funded. It's dairy industry funding to get the knowledge, and after that, it's up to the cheese makers to use that knowledge to develop the cheese that will have a lower sodium content. They are more the facilitators. As the nutrition arm of the dairy industry, we're strong supporters of this research.

Mrs. Cathy McLeod: So you would be perhaps encouraging the different producers?

Ms. Nathalie Savoie: We would make this research truly available. We work very closely on knowledge transfer with dairy processors. We have common committees where we can discuss these issues. We would make sure the knowledge is available to cheese makers.

Mrs. Cathy McLeod: Thank you.

I think my next question is for Mr. Samis.

I was talking earlier about that panel. Of course, if you are really going to be diligent about that panel in terms of everything you and your family are consuming, it's not easy. I think it takes a really motivated consumer to do that.

I look at your little check symbol. That's certainly an easy mechanism. When you are giving the Health Check, are you looking at many different components? Could you talk briefly about what creates something that justifies a Health Check? What are the different components?

Mr. Stephen Samis: Sure, thank you.

I would agree with you that the nutrition facts panel is confusing. The federal government could do something immediately to help Canadians make healthier choices at point of purchase with respect to the facts panel, and that is to standardize the portion size on the nutrition facts panel, which is something we suggested in our earlier remarks.

It's confusing now. It's not standardized, and we need to make that easier for Canadians. When they're picking up two products that look similar, they should be able to have the same portion size on them. That's something we would say the government can do.

The Health Check symbol is put on a variety of products based on a variety of criteria that are contingent on whatever that product is. It contains both healthful and the more unhealthful elements of the product. One element might look at sodium and fibre and fat, another one might look at sugar and sodium, so it really depends. Some of the ingredients would vary.

Breadstuffs, for example, would have sodium levels. They would also have a certain amount of fibre requirements, etc. The criteria are pretty complex, and there are about 80 different categories of the criteria, based on the food and based on what makes sense. You wouldn't necessarily have fibre in something that doesn't make sense, but you certainly would in some of the breads, etc.

The criteria are clearly stated. They change over time and they change as the food guide changes. We brought in sugar criteria when the food guide said to avoid added sugar, in the absence of any kind of federal advice around sugar. So they're changing constantly, and we have to make those clear to the companies so that over time they have to adapt their products to meet the changing nature of the program.

That's one of the real benefits of having a program like the Health Check. As we've been migrating the sodium targets down over time, for example, the companies are given, generally speaking, about 14 months to reformulate their products to meet those targets. We've made some pretty significant changes to the sodium levels recently. Some of the companies have dropped out. They haven't been able to meet the targets. Others have reformulated to meet those targets.

One of the things we find very interesting is that a number of companies, as they're considering bringing products to the market, are meeting with us now to find out what those targets are, so they can formulate the product in such a way that it meets the target and they can get into the program.

So it does have an influence, certainly, on the healthfulness of the food supply.

● (1050)

Mrs. Cathy McLeod: What percentage of companies that produce and put things on the shelves partner with you in terms of these discussions?

Mr. Stephen Samis: As a voluntary program it's pretty small. We have about 2,200 products in the program now, and probably about 200 companies. Generally speaking, there are about 30,000 items in a grocery store; not all of them are foodstuffs. But I would say we probably have about 10% of the food products in a grocery store in the Health Check program at this time.

The Chair: Thank you, Mr. Samis.

We'll now go very quickly. We have just a couple of minutes.

Ms. Murray, you had a quick question.

Ms. Joyce Murray: Sure, thank you. Since there is time, I'll take that opportunity.

We've heard again and again from some of the witnesses that mandatory makes a level playing field. If all the different places that salt is in food are going to be reduced at the same time to change people's taste, it's impossible to do that on a voluntary basis. That's what I heard from some of the expert witnesses.

The sodium working group started with the recommendations of the Institute of Medicine at the National Academy of Sciences, so it essentially didn't have to develop the levels. You're coming out with a report, so you've been using your time to develop a strategy of how to do something and by when and so on.

After the report, is the sodium working group the only major initiative of the government, and does the sodium working group continue? How do we go forward past this voluntary mechanism if the only group empowered by the federal government has those handcuffs on it? Or can the working group recommend the money that's needed to do the research and education that may not already be available, and tools such as mandatory regulation as a following step?

That's a complicated question, but I'm trying to look past this report and how we—

The Chair: Ms. Murray, you'll have to hurry, please.

Did someone want to answer that question?

Dr. Mary L'Abbé: I'll answer it partway.

I recognize our terms of reference, and one of the important aspects I think will help position us well for the future is the part of our terms of reference that calls for a monitoring program. I think that monitoring program and its publishing of the results of how we're doing will be an important component of however the government or the working group allows us to move forward. The publishing of those results and the monitoring of how things are occurring over time will be a very important component of our way forward.

● (1055)

Ms. Joyce Murray: So can the sodium working group, in its recommendations, recommend that government consider mandatory regulations? Even though it's not in your particular mandate, can you recommend a process to at least look at that and see whether that's the road the government should go down, or can you not use that word?

Ms. Phyllis Tanaka: One aspect of the voluntary prong is important to note. It's not just willy-nilly voluntary; it's a structured approach whereby we're sitting down and looking at the food categories and developing targets.

Secondly, we have built into—

Ms. Joyce Murray: Excuse me, I just want to clarify. That means no to my question about whether there is any ability of the sodium working group to use the word “mandatory” maybe in a next step after their mandate?

Ms. Phyllis Tanaka: Built into the terms of reference is that through implementation, when we monitor, we monitor to see if the strategy is working. And if it isn't, we are mandated to come back to the table as a working group, evaluate where we see failure, and make new recommendations.

Ms. Joyce Murray: And how many years would that be before this group could say this isn't working and they need different terms of reference?

Ms. Phyllis Tanaka: We're in the process of setting up target dates along the way. Right now on the table—and probably it will be sorted out at our next May meeting—2012, 2014 are likely going to be times built in when we look at what's happening, not just with the reduction of sodium but with consumer education and research to see if we're moving along the way we should.

Ms. Joyce Murray: So it could be four or more years before that's addressed.

The Chair: Mr. Reaman, I think you wanted to make a comment. Would you go ahead, please? We'll end it after your comment.

Mr. Ron Reaman: Very briefly, I want to underscore that one of the central tenets of this entire undertaking is that we are looking at a long-term gradual approach to reduce sodium for many reasons that we've already talked about and that I won't revisit.

Ms. Joyce Murray: Okay. Thank you. That's what I'm contesting. Is a long-term gradual approach really the only path?

Mr. Ron Reaman: We believe so.

The Chair: Thank you, Ms. Murray.

I'll bring this committee meeting to an end.

I want to thank the witnesses so much for coming today.

Dr. Pipe, I understand you have to rush out to catch a flight. We're very thankful for your input.

The committee is dismissed.

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