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Chair

Mrs. Joy Smith

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● (1105)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Welcome to the health committee. It's a pleasure to see everybody again this morning, and a special pleasure to have our guests here.

Pursuant to Standing Order 81(5), we have supplementary estimates (B) 2010-11: votes 1b, 5b, 10b, 20b, 25b, and 40b under Health, referred to the committee on Thursday, November 4, 2010.

We have our witnesses with us. From the Department of Health, we have Glenda Yeates, deputy minister, and Germain Tremblay, chief financial officer. Welcome.

From the Public Health Agency of Canada, we have Dr. David Butler-Jones, chief public health officer, and James Libbey, chief financial officer.

We are expecting, from the Canadian Institutes of Health Research, Alain Beaudet, president, and James Roberge, chief financial officer.

We will begin now, because we need to get our meeting on the way. I'm sure Mr. Beaudet will be joining us in a timely manner.

We'll begin with the Public Health Agency of Canada. Dr. David Butler-Jones.

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): Thank you, Madam Chair.

If I cough a little, it's not because I'm infectious. It's just my asthma. But I'm well drugged, so we'll see how the questions go.

The Chair: That's not very hopeful. We find out you're drugged and you've got allergies and you're not quite with it.

Dr. David Butler-Jones: But the drugs are all legal, just prednisone and things like that.

The Chair: Continue. We have faith in you.

Dr. David Butler-Jones: Thank you.

With me today is Jim Libbey, chief financial officer for the Public Health Agency. I appreciate the opportunity to speak to the supplementary estimates (B) for 2010-11 as they pertain to the agency.

Our commitment to chronic disease prevention and control is among our highest priorities for the coming year and this year.

[*Translation*]

Chronic diseases, such as cancer, heart disease and diabetes, remain the greatest cause of death and disability in Canada.

[*English*]

It is remarkable that much of this is preventable. It demonstrates an ever-increasing need for Canadians to focus on their own health. And it underscores the necessity of collaboration between governments at all levels, their partners, communities, and individuals to help prevent these diseases and to increase awareness and understanding.

In September the Minister of Health announced a landmark declaration on prevention and promotion, including Canada's first intergovernmental framework for curbing childhood obesity.

The declaration is a visionary public statement of our intent. Governments across this country are working together on these crucial issues. We are providing the foundation for much of our future work.

This fiscal year $685.6 million has been allocated to the agency. As I noted in June, we are devoting over $115 million this year to efforts surrounding chronic disease.

[*Translation*]

That includes efforts to increase capacity and knowledge in prevention and control of diseases, such as HIV and AIDS.

[*English*]

It also helps us gather and analyze data on the rates, trends, and patterns of injuries and disease in Canada. As an update since June, the agency will also be transferring funds worth approximately $4.3 million this fiscal year, much of which will complement those initiatives. For example, $600,000 dollars will be transferred to the Canadian Institutes for Health Research to support intervention research and knowledge translation to address chronic disease prevention.

[*Translation*]

There is one other major item I would like to mention before I close.

Breast cancer, as members know, is the most common cancer among Canadian women.

[*English*]

Hundreds of Canadians are newly diagnosed with breast cancer each week. It is imperative that the government continue to support cancer prevention, control, and research, and to do its part to reduce the burden of cancer in Canada.

For these reasons, I am pleased to report that, through a permanent transfer of $3 million to the Canadian Institutes for Health Research, the agency is helping to fund targeted breast cancer research.

[*Translation*]

I am confident this funding will go a long way towards improved survival rates, and improved prevention and quality of life for those suffering from breast cancer.

[*English*]

This represents our single biggest transfer for these estimates. I have only touched the surface of the agency's priorities this year. The H1N1 pandemic, for example, which lasted into this year, solidified our place, we believe, as global leaders in responding to infectious disease outbreaks.

2010 saw the agency continue to build on the lessons learned from H1N1, focusing efforts on continued collaboration with all partners. These efforts will strengthen our preparedness for future pandemics and outbreaks.

Madam Chair, these supplementary estimates show that the Public Health Agency's vision remains constant and relevant to healthy Canadians and communities in a healthier world. All of Canada, we believe, will benefit from our efforts.

Thank you for your time. I will be happy to answer questions later.

The Chair: Thank you, Dr. Butler-Jones. You did very well this morning, considering all the challenges we started off with initially.

We'll now go to the Department of Health to Glenda Yeates, deputy minister, please.

● (1110)

Ms. Glenda Yeates (Deputy Minister, Department of Health): Thank you very much. Good morning, Madam Chair and members of the committee. It is a pleasure to be here today to discuss the supplementary estimates (B) and how these funds will be used to help Canadians improve their health.

[*Translation*]

The funds we will be discussing today will be used for a variety of important programs, many of which have been in place for years and have been proven effective.

[*English*]

Health Canada is seeking a net funding increase of $48.1 million in the following areas: aboriginal health programs, Nutrition North program, tobacco litigation, and medical isotopes.

Most of the increases are strategic investments for us that were announced in budget 2010. Much of this additional funding will allow Health Canada to continue to provide support to Canada's aboriginal people by delivering valuable programs, some of which are provided in partnership with the Department of Indian Affairs and Northern Development.

With respect to the first nations health programs, $32.8 million is being sought for the Indian residential schools resolution health support program. As committee members may be aware, this program provides emotional and cultural health support services as well as professional counselling to former students and their families throughout all phases of the Indian residential schools settlement agreement. Some services are provided directly through local aboriginal organizations, and others are provided by psychologists and social workers who have experience working with aboriginal people.

This investment ensures that Health Canada can fulfill its commitment to provide culturally appropriate mental health and emotional support services to residential school survivors and their families.

Another notable item is $5.5 million for additional health programs in the areas of maternal child health, mental health and addictions, and community capacity for two Innu communities in Labrador.

[*Translation*]

Additional funds are also required to help in the transition from the outdated Food Mail program to the new Nutrition North Canada program.

[*English*]

Nutrition North Canada will support improvements to ensure that northerners benefit from improved and increased access to nutritious food throughout the year. Nutrition North will also support improvements such as education initiatives intended to increase awareness of healthy eating while developing skills for selecting and preparing healthy products from stores along with traditional or country foods. Health Canada is allocating $1.5 million this fiscal year and $2.9 million for 2011-12 for nutrition and education initiatives.

Among our additional investments in these supplementary estimates is the provision of $10.3 million to support the defence of the Government of Canada in ongoing tobacco litigation.Three million dollars over two years is also being sought to support non-reactor-based production of medical isotopes, to look to optimize the use of the existing supply, and to support the development of new medical imaging technologies that do not use isotopes.

In closing, the resources requested through the supplementary estimates (B) will be used to help Canadians maintain and improve their health in these very specific areas.

Thank you for your time, and I look forward to answering any questions the committee may have.

The Chair: Thank you.

Welcome, Dr. Beaudet. We are so pleased to have you here.

Could we have your presentation, please?

[*Translation*]

Dr. Alain Beaudet (President, Canadian Institutes of Health Research): Thank you, Madam Chair.

[*English*]

Members of the committee, as president of the Canadian Institutes of Health Research it's a privilege for me to offer you a report card on the supplementary estimates (B) and use this opportunity to discuss how CIHR has employed its budgetary allocation to ensure fulfilling our mandate to improve through research the health of Canadians and the health care system.

[*Translation*]

As you know, an additional, recurrent amount of $16 million has been allocated to the CIHR budget for 2010-2011 so that we can continue our cutting edge research dedicated to improving the health of Canadians.

[*English*]

Four million of these dollars have been targeted to CIHR's open operating grant program. As its title implies, this program is an open call for research proposals, with no restrictions on areas of research or maximum level of requested funds. All proposals are subjected to the highest international standards of peer review to ensure excellence.

This increase in funding brings total plan spending in this program to more than $400 million.

[*Translation*]

Though CIHR currently supports more than 4,000 multiyear research projects under the program, the demand continues to increase and we are able to fund only a small portion of the proposals that have cleared the bar that our criteria of excellence have set very high and that have been recommended for funding by our committees of experts.

● (1115)

[*English*]

Six million dollars has been allocated to advance the strategy on patient-oriented research. This strategy is a nation-wide coalition aimed at improving health outcomes and service delivery by enhancing the clinical application and economic impact of health innovations and by providing health care professionals and policy-makers with information on how to deliver high-quality care and services in a cost-effective manner.

In collaboration with the provinces, we aim to improve the clinical research environment and infrastructure, set up mechanisms to better train and mentor health professionals engaged in clinical research, and strengthen organizational, regulatory, and financial support for clinical studies.

Five million dollars are dedicated to international research collaboration on Alzheimer's disease and other age-related dementias. As members know from recent debates in the House, like many other nations, Canada's aging population is facing an upcoming tide in the numbers of persons who will be afflicted by Alzheimer's disease and dementia.

The good news is that Canada is already investing in this field and has built an excellent track record and a reputation for high-impact, collaborative health research.

[*Translation*]

These new funds have allowed us to build on our leadership in the area of Alzheimer's disease and related dementias by establishing an international network for cooperation that will allow us to increase our research capacity and to expand our horizons in the area. Already, cooperative projects have begun with France, the United Kingdom, Germany and the United States.

[*English*]

Working closely with the Alzheimer Society of Canada, we have launched funding opportunities focused on the early diagnosis and early treatment of the disease. The long-term objective is to delay by five years the onset of symptoms.

Finally, of the $16 million, $1 million has been allocated to operating requirements to address the significant increase in applications for open operating grants and to address the new patient-oriented research and Alzheimer's strategies.

The supplementary estimates (B) also include CIHR's access to $10 billion in funding over two years from the isotope supply initiative to support research to develop and demonstrate new technologies, to optimize the use of medical isotopes and alternative medical imaging technologies, and to establish a clinical trial network to test new isotopic and non-isotopic tools.

It also includes funding for the Canada Excellence Research Chairs, a program that supports the development of a world-class workforce, which is crucial to the innovation process. It positions Canada as a magnet for the world's top researchers and graduate students and promotes the development and application of leading-edge knowledge. Six Canada Excellence Research Chairs were awarded in health and related life sciences and technologies. Total funding for CIHR for the eight years amounts to $60 million.

The supplementary estimates (B) also reflect CIHR's funding for the Banting post-doctoral fellowships program to offer new, prestigious fellowships at an internationally competitive level of funding to attract and retain top-tier post-doctoral talent from Canada and abroad.

Total funding for CIHR is $1.5 million in 2010-11 and $3.4 million in 2011-12 and ongoing.

I will certainly be pleased to answer any questions.

Merci beaucoup, madame la présidente.

The Chair: Thank you very much, Dr. Beaudet. Thank you to all of the witnesses.

We'll now go into the first round of seven minutes for questions and answers.

We will begin with Mr. Dosanjh.

Hon. Ujjal Dosanjh (Vancouver South, Lib.): Thank you very much, all of you, for being here.

My questions are essentially three brief questions, and they may be directed, I believe, to Ms. Yeates.

First, in terms of the mass media expenditure for tobacco control, we have figures going back many years, even back to 2006-07, in terms of Health Canada spending money in that area. We have no figures for 2007-08, 2008-09, or 2009-10, and none projected in 2010-11. Can you tell us why?

Ms. Glenda Yeates: I don't have those figures here. I will see if we have them in terms of the background.

I have here figures for the tobacco control strategy, generally. You mentioned the years 2007-08, 2008-09, and 2009-10.

Hon. Ujjal Dosanjh: I'm actually talking about the advertising, the mass media campaigns.

● (1120)

Ms. Glenda Yeates: It is the case, according to the figures I have here for 2007-08, 2008-09, and 2009-10, that we had evaluation dollars in those years of about $100,000 per year.

Hon. Ujjal Dosanjh: But you had no mass-media dollars for those years. Is that true?

Ms. Glenda Yeates: That is correct.

Hon. Ujjal Dosanjh: And none are projected for 2010-11.

Ms. Glenda Yeates: That's correct.

Hon. Ujjal Dosanjh: Thank you.

The other question I have is from a document called *Canada's Implementation of the Framework Convention on Tobacco Control* . It's a civil society shadow report.

On page 3 it states that most of the provincial governments have indicated the amount of money they spent from 2005-06 to 2009-10 inclusive. The federal government also spent money, and it indicates what it spent in 2005-06, 2006-07, 2007-08. But no figures are available for 2008-09 and 2009-10. Can you tell us why?

Ms. Glenda Yeates: As you've mentioned, and as the figures I just showed mentioned, we do not have advertising mass-media dollars available. We do have dollars in other areas of the tobacco strategy. So we have dollars, for example, in public education and other areas.

Hon. Ujjal Dosanjh: So would it be fair to say that you have essentially given up on tobacco control—mass media?

Ms. Glenda Yeates: We would not view it that way.

Hon. Ujjal Dosanjh: How would you view it, Madam?

Ms. Glenda Yeates: We are committed to reducing smoking, and we have a number of items that we are currently portraying and doing. For example, we have $15.8 million annually to support tobacco use reduction initiatives across Canada. We continue to collaborate with the provinces and territories—

Hon. Ujjal Dosanjh: Can you tell me how you're using that $15 million?

Ms. Glenda Yeates: Yes, we have specifics here. If we're going to go into this $15.8 million, I might ask my ADM Paul Glover to join me at the table to give us some of the details there.

Hon. Ujjal Dosanjh: I don't really want too many details. I simply want to know where you are generally spending the $15.8 million.

Ms. Glenda Yeates: The breakdown of the $15.8 million includes moneys that we used to support cessation activities. So we have a number of grants and contributions that we use to support local community groups. We've most recently talked to the provinces and territories about making some of the grants and contributions available to them as well, to support their initiatives.

We also have other components in compliance and enforcement, for example.

Hon. Ujjal Dosanjh: Can you give us the details in writing rather than wasting the time here for everyone?

Ms. Glenda Yeates: I would be happy to.

Hon. Ujjal Dosanjh: I don't want to take up time with those details. Thank you.

On my next and last question, in the supplementary estimates document there is funding to support the defence of Canada against third-party claims in tobacco litigation. It talks about document discovery as well as litigation, preparation, and proceedings in the federal government's legal defence against third-party claims.

Can you give us some details about the third-party claims? I'm assuming these are current claims and not potential claims that you might face.

● (1125)

Ms. Glenda Yeates: That is the case. The Government of Canada has been named by tobacco companies as a third party in five cases. Tobacco companies that are being sued directly are in turn claiming that Canada should be held liable, so they are third-partying the Government of Canada.

We are vigorously defending ourselves against the claims being made by the tobacco companies. There's a great deal of tobacco documentation that needs to be gathered. Most of it is in Health Canada, with some of it in Agriculture Canada. So many of these dollars are for the document discovery process.

We are currently being third-partied in the cases of health recovery costs for which individual provincial jurisdictions are suing the tobacco companies.

Hon. Ujjal Dosanjh: Can you give us some details in writing, without disclosing solicitor-client issues?

Ms. Glenda Yeates: I'd be happy to do so.

Hon. Ujjal Dosanjh: On my last question, if I may, there has been a lot of publicity surrounding the abandonment of the expanded warnings on cigarette packages, after doing six or seven years of research and work. My understanding is that the provinces were all expecting the federal government to do this, and suddenly in tobacco control it's only about contraband. They don't have to be mutually exclusive. Contraband is obviously very important to deal with.

Why was this abandoned at this late stage, when everybody was expecting it?

The Chair: Your time has run out, Mr. Dosanjh.

Can you please answer?

Ms. Glenda Yeates: This is not a product that has been abandoned. We are continuing to examine the question of the renewal of health warning messages, so it is still ongoing.

The Chair: Thank you very much.

We'll now go to Monsieur Malo.

[*Translation*]

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

Before turning to the witnesses, I would just like to point out that we also asked whether the minister could appear to help us with these votes. She can have until December 7 to be here.

So I am a little surprised to find out that, between now and December 7, the minister does not have even an hour when she can come to see us. I find that strange, to say the least.

So, I will just—

[*English*]

The Chair: Monsieur Malo, just to ease your mind and make the rest of the week better for you, I have to tell you that she's coming on December 2.

[*Translation*]

Mr. Luc Malo: Oh! Wonderful!

The Chair: There you go.

Mr. Luc Malo: So I will keep all my political questions for December 2, and I will just ask you some questions of a technical nature this morning.

In the past, as you know, I have had questions because we have seen votes added to the health portfolio in order to deal with some backlogs, with natural health products specifically.

The backlog is still there and a new vote has not yet been passed. Some users and producers are worried that the regulations on natural health products will go into effect in their entirety in March 2011.

Is it in fact the Department of Health's intention to put the regulations in effect in their entirety in March 2011? Can you just give us some figures on the applications that still have to be processed?

Ms. Glenda Yeates: Thank you for your question. I think I will answer in English because there are a lot of figures and I want to make sure I get the figures right.

[*English*]

As you mentioned, we have had a backlog in the natural health products area, and we have been working diligently on that.

Maybe I'll start by outlining that we have currently issued over 25,000 natural health product licences, which means there are now over 33,000 products on the market. This is more than the number for over-the-counter drugs.

On how we are addressing the backlog, there has been something of a change in how we're dealing with it, partly because of consultations with stakeholders. We have a new set of regulations that are altering how we deal with this. So we're dealing with the backlog in a different way now, but it's a way that I think stakeholders, including NAPRA, the pharmaceutical association, have found to be quite useful.

Under this regime we have mechanisms that we call the UPLAR—"unprocessed product licence application regulations". They came into force on August 4. These regulations give us the mechanism to temporarily authorize the sale of certain unlicensed NHPs. So once we've been able to assure ourselves that these natural health products meet key safety criteria—and we can at the same time, if we need to, put conditions on their sale—we can allow them into the market. This gives us the ability to move them forward.

We have currently completed 87% of what would have been considered the backlog under the previous regime. We are on target to continue to move these forward, but we now have a slightly different mechanism of counting because we've changed our mechanism. We think the new regulations give us the ability to move things through and deal more expeditiously with natural health products.

● (1130)

[*Translation*]

Mr. Luc Malo: Is the deadline set at March 2011, or are you working on the 30-month rule, as set out in the regulations, as the last date by which all product testing will be complete?

Ms. Glenda Yeates: Yes.

[*English*]

Yes, we are on track for that deadline as per the UPLA regulations.

[*Translation*]

Mr. Luc Malo: The 30-month deadline you set in the new regulations?

Ms. Glenda Yeates: Yes.

Mr. Luc Malo: Great. Thank you.

I would like to talk to you about another backlog. Let me read the warning posted on the Health Canada website. This is what it says:

> Health Canada is currently experiencing a temporary delay in processing applications for an authorization to possess and/or a licence to produce marihuana for medical purposes, due to a sharp rise in the number of applications received in recent months.
>
> To address the situation, Health Canada has implemented a strategy that is improving the efficiency of its review and authorization process and will restore standard processing times of 8 to 10 weeks.
>
> As part of our strategy, our officials have reviewed all operational policies and procedures and implemented several key process changes in order to improve efficiencies and speed up these processes.
>
> We anticipate that the number of applications being processed will increase as we progress with the implementation of our strategy. The Department is making efforts to restore normal processing times by the end of this year.

Now, I see no additional funds to implement or support that strategy. So I gather that you do not need additional funds.

I have two questions. Why was there a sharp rise in the number of applications in recent months?

But you must be aware that, for marihuana, if people do not have their authorization, they can be prosecuted. So, the issue of health aside, there is another problem. What is the strategy you have put in place?

Ms. Glenda Yeates: Thank you for the question.

[*English*]

It is the case that we have noticed an increase, and we are not entirely sure why that is the case. Perhaps there is a growing awareness of the program. Perhaps there is a growing comfort with physicians in terms of recommending that their patients with various conditions access medical marijuana. I don't think we precisely know the reasons for the increase in demand, but we are certainly seeing the increases that have been ongoing and in fact are accelerating at this point.

That has meant, as is noted in the item on the website, that we are in fact not meeting the benchmarks that we set ourselves internally, because we realize this is an important benchmark to meet for individuals.

The member is absolutely correct. We are not requesting additional funding, but to our own reallocation we need to put and train more individuals, so they can respond to the increase in the demand. That is what we have done.

Our strategy has been to allocate and train additional individuals. We've also introduced a very tight tracking system to understand. We track now weekly. I see these numbers, and the branch sees them even more frequently to actually see how many we are getting in each week, how many we are processing, and if we are on track to clear the backlog.

One of the challenges for us is that we try to project what will come in the following week, so we train staff. There are certain challenges in terms of you can't just add anyone on a given day. There's a certain process of training to make sure that people can provide the steps.

That's the strategy we have put in place, and we're working through that.

The Chair: Thank you, Ms. Yeates.

We'll now go to Ms. Chow.

Ms. Olivia Chow (Trinity—Spadina, NDP): Thank you.

I have several areas.

Correct me if I'm wrong, but a few years ago there was a plan to build a non-profit HIV vaccine manufacturing facility. I think earlier this year you decided not to go ahead with it, thereby saving $88 million, something of that nature. Are you transferring that money to the community-based HIV projects? Are you transferring it there?

As I recall, $26 million of that $88 million was taken from the community-based HIV projects. I remember that quite a large number of organizations in the Toronto area that I represent had difficulty because there was a cutback.

I assume some of that funding will be going back to restore or make sure that some of these non-profit organizations would be able to get their AIDS community-based funding. How much is being allocated in that area? How much is committed and how much has been spent so far this year?

● (1135)

Dr. David Butler-Jones: The CHVI initiative was undertaken with Bill and Melinda Gates, together with a number of departments across government, in order to further the development of an HIV vaccine. It's recognized internationally that ultimately that's the way we have to deal with it. The funds were not taken from programs; they were part of our overall budget allocation. In the last five years the money for that program has gone from about $54 million to over $72 million. So actually funding is higher than it's ever been, and we're continuing on that path.

In respect of the decision on the facility itself, there was a call for proposals. There were a number—

Ms. Olivia Chow: I wasn't interested in that one. Of the $72 million, how much is committed?

Dr. David Butler-Jones: None of them met the standard, so now the money is being used for other HIV vaccine initiatives.

Ms. Olivia Chow: What about the $72 million, the allocation?

Dr. David Butler-Jones: That's outside the CHVI.

Ms. Olivia Chow: I understand that.

For the community grants, how much has been allocated?

Dr. David Butler-Jones: For this year, it's over $72 million.

Ms. Olivia Chow: How much is actually spent, out the door?

Dr. David Butler-Jones: I don't know, but we can get that for you.

Ms. Olivia Chow: Thank you.

So you're internally reallocating $200,000 to support the vaccine initiative, right?

With respect to isotopes, for some of the people dealing with cancer, there's still a shortage. Have you had input from the medical stakeholder groups regarding what you plan to do? Is it a short-term or a long-term solution? I see that you are making optimal use of the existing isotope supply. Part of the isotope supply initiative is $4.9 million, and the other part is the $1 million to deal with non-reactor-based production of medical isotopes. Is it a short-term or long-term strategy? Is it affecting the wait times of cancer patients who need the isotopes to get the scan? Where are things at on that front?

Ms. Glenda Yeates: I'll speak to the Health Canada portion, but it is part of a broader strategy. NRCan has some funding to deal with some of the technical issues. CIHR is looking at some clinical trials, to decide long-term questions about the research. For Health Canada's part, there were several things we wanted to know after the isotope crisis. We realized that during the shortages there were groups of people who used different isotopes or different alternatives to isotopes. We wanted to make sure that we had a mechanism to develop policies and protocols to establish when the various alternatives are preferable, and how the various outcomes compare.

So I would say it's in the medium term. It's not the longest-term research that CIHR is funding. It's more applied research—investigating, working with experts, to understand what we can learn from other countries about the effective and appropriate use of isotopes.

Ms. Olivia Chow: Are you satisfied that what is happening is sustainable? Even if you have the alternative, you have to research alternative use, maximum usage of the existing stock. Are you concerned that there's still a shortage?

● (1140)

Ms. Glenda Yeates: What we all learned through the isotope shortage was that there are not many suppliers worldwide. Canada took a leadership role in bringing the international suppliers together for the first time to plan for shutdowns and understand how to manage worldwide supply. We also learned about some of the challenges, about our reliance on these isotopes.

Right now the supply is back up in Canada. We are not hearing any reports of delays. But we need to make sure that in the future there is a diversification of technologies. We need to explore that in the light of the best outcome for patients.

The Chair: Thank you, Ms. Yeates.

We'll now go to Mr. Uppal.

Mr. Tim Uppal (Edmonton—Sherwood Park, CPC): Thank you, Madam Chair.

Thank you all for coming this morning.

The first question will be for Madam Yeates, and after that whoever wants to pick up on them can answer.

Madam Yeates, as the deputy minister, what are you doing to ensure the financial integrity of your department? Do you feel that Health Canada has adequate accountability measures in place to protect taxpayer dollars?

Ms. Glenda Yeates: Thank you very much for the question.

There is a real sense among all deputy ministers that a crucial part of our role is to ensure financial integrity for the department.

I'm pleased to tell the committee that Health Canada has a strong financial management control framework in place. We have a strong internal control division that monitors the effectiveness of our internal controls. As other departments do, we have a departmental audit committee with outside members who are very helpful in advising the deputy on the strength and the completeness of our internal controls.

The Treasury Board Secretariat has a management accountability framework, and they assess every department on the strength of their financial accountability. They've given Health Canada good marks for our financial stewardship and financial management. Very much, there are other Treasury Board policy recommendations, and when we compare ours against those policy requirements, we do well.

We have a strong internal audit function. It's obviously very helpful when external auditors come and look at our programs, but we want to have a strong internal audit function as well, and that is functioning well, as I said, with a number of regular, scheduled audits looking at the highest-risk areas coming through our audit committee. When we do find areas where we think we can improve and where improvement is called for, we take strong action there.

I would note that the Office of the Auditor General, in their audit procedures on our transactions in the latest fiscal year, 2009-10, found no significant new issues for the department; therefore, there was nothing that warranted the issuance of a management letter. That is an important milestone, certainly, for me as the chief accounting officer, but committee members would also find this to be a real vote of confidence in the control mechanisms.

I wouldn't want to leave the committee with the sense that we are resting on our laurels. This is such a critical area for public trust that we want to always continue to push forward and make sure we are continuing to improve our practices, but I feel we have good practices at the moment and we will work to make them even better.

Mr. Tim Uppal: Good. Thank you. That's good to know.

One of the shortcomings identified—

The Chair: Mr. Uppal, may I interrupt you for one moment?

Dr. David Butler-Jones: I'm just not sure... You addressed it to all of us. I would be quite happy to—

Mr. Tim Uppal: Yes, sure. Go ahead, absolutely.

Dr. David Butler-Jones: I would add that in departments across government, clearly deputies have a responsibility for the best use of resources and matching our responsibilities to the capacities that we have.

In public health, the focus on prevention has always been a good investment, but it has not always been the most invested area. In a sense we have duct-taped and binder-twined, and that actually occasionally works, but the point is that whatever resources we have must be focused on the areas that can make the most difference.

Glenda mentioned the calibre of both the internal audit processes and the external audit committees. For example, on our audit committee for the agency we have a former provincial auditor general, a former federal comptroller general, a former CEO, a head of health regions, and a deputy minister. From past lives they bring tremendous expertise not only in the fiscal and financial aspects but also in the links to whether we are spending money in the ways that will deliver to Canadians the best things we can do.

I'll leave it at that. Thank you.

● (1145)

The Chair: Thank you, Dr. Butler-Jones.

Is there anybody else, Mr. Uppal, you want to hear from?

Okay, go ahead.

Mr. Tim Uppal: No, this is good. I will move on now.

One of the shortcomings identified in the Weatherill report was on public communications following an outbreak. What has been done to resolve this shortcoming?

Dr. David Butler-Jones: I now live in Ottawa. The irony of listeria was that I was on the phone every day, all day, but I happened to be in Manitoba at the time, so it was not on television. The image was that I wasn't as involved as in fact I indeed was, and once I got to Ottawa they stopped broadcasting them live.

The point is that what we saw on H1N1 was part of the reflection of the importance of a consistent, visible presence. Whether it's me or whoever is not so much the point; Canadians need to hear, they need to hear directly, and they need to see that the political part of the organization, meaning the deputy, and the chief public health officer, in this case, are working closely, are transparent, and are clear in their messaging. At the end of the day people need to know what we know, what we do not know, what we are doing to find out, what we are doing to address it, and what they themselves can do to reduce their risk.

On H1N1, we've applied many of those lessons and will continue to do so. We actually have a risk communications framework and a number of things in place. We are working with not just other departments; we are also, as you saw during H1N1, working very closely with provinces, territories, the WHO, and others to make sure we all have the information and are able to share that information publicly.

Mr. Tim Uppal: Very good, thank you.

I'd like to hear more about the investment in patient-oriented research. Is this affected by clinical research discoveries made in other countries, and if so, how?

Dr. Alain Beaudet: It's certainly affected by discoveries made in other countries, but I think what we're trying to achieve with the patient-oriented research strategy is to take full benefit of the discoveries that are made in this country and ensure they do impact the health of Canadians. We have a clinical research infrastructure that attracts clinical trials from the private sector, which we are losing to an alarming extent to other countries, particularly Asia and eastern Europe, on one hand, because their prices are not competitive—and I'm not sure how much we'll be able to change that—but also because we're not sufficiently organized, we're over-regulated, we're not sufficiently networked, so we're slow to recruit patients.

It's extremely important to have these investments, if only because they give rapid access to Canadian patients to the newest drugs and they also give the opportunity of maintaining a culture of scientific excellence and evidence-based practice in the milieu of care. Part of the strategy is to increase our competitiveness internationally to attract these contracts from the private sector as well as to ensure that innovations made in this country actually benefit Canadians.

The Chair: Thank you, Dr. Beaudet.

We'll now go into our second round of Q and A's and we'll begin with Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you to everyone for coming.

I'm concerned that $100 million has been allowed to lapse from vaccines, and I'm wondering if there's going to be another $100 million investment, as there was in 2003 and 2007.

Dr. David Butler-Jones: There have been two rounds where there was an initiative recognition federally, some contribution to help the provinces to implement vaccines: the first tranche for a number of childhood vaccines and then the last tranche for HPV that facilitated rapid uptake of vaccines by the provinces and territories.

Moving forward, again this is a provincial responsibility. It was felt it was useful at the time, it certainly did assist, and now we're working with the provinces and territories in terms of the overall frame as we continue to fund and support the Canadian immunization strategy to understand how best to move forward. What the future will bring at the moment is hard to say.

● (1150)

Ms. Kirsty Duncan: In the past the federal government took a leadership role. You can't comment on whether there will be $100 million put back and whether that would be kept separate from the Canadian health transfer to ensure funds are specifically available for immunization at this point?

Dr. David Butler-Jones: Those were both trust funds specifically targeted to provide support for implementation of those vaccines. Those were not ongoing funds. No funding was withdrawn, there was no ongoing commitment at the time. It was for a specific purpose, and that purpose has been completed.

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

Dr. Beaudet, I'm going to ask about the Multiple Sclerosis Society of Canada, which called on the government to provide $10 million for research into CCSVI and MS. Mr. Savoie, president of the MS Society of Canada, said:

> The safety and health of people living with MS is our primary concern. The Government...can play a leadership role in addressing the needs of Canadians living with MS by funding research, including clinical trials in CCSVI and MS. Doing so will both advance research and provide safeguards to those seeking treatment.

I am wondering if that $10 million has been appropriated to the budget of CIHR and earmarked for CCSVI research. I asked about it in the spring. I know we talked about the $16 million. I want to know, please, if $10 million is earmarked for this.

Dr. Alain Beaudet: As you know, we're monitoring ongoing diagnostic clinical trials very closely to determine whether the condition referred to as CCSVI exists, and whether there's an association and an increased prevalence between CCSVI and patients with MS. We're monitoring that closely, not only the studies that are being carried out in Canada but also the ones in the States and international trials as well.

Ms. Kirsty Duncan: I understand.

Dr. Alain Beaudet: As soon as we have the evidence that it is indicated and ethically advisable to carry out a clinical trial, as I said, CIHR will have a request for applications for a pan-Canadian clinical trial when and if the conditions are appropriate to do that in a manner that's safe for Canadians.

Ms. Kirsty Duncan: I appreciate that the process has been established. The question is whether the $10 million that the MS Society has asked for is there.

Dr. Alain Beaudet: Currently there is not $10 million that has been specifically appropriated for that, but as you know, we have a base budget with money for clinical trials. Should the conditions prevail for such a trial to be indicated, obviously then we would take a step with our partners, including the MS Society and also the provinces, to ensure we had the proper resources to fund it.

Ms. Kirsty Duncan: Thank you.

I'm going to pick up on my colleague's questioning about tobacco. I'm wondering if Health Canada has established a research work plan policy or a development work plan around tobacco products—information and regulations—for this year. And if so, what are its objectives, and what is the cost? I'd like to compare it with—

The Chair: Your time is up, Dr. Duncan.

Who could answer that question for Dr. Duncan?

Ms. Glenda Yeates: As I mentioned earlier, Madam Chair, we'll bring back the details on the amounts for our tobacco strategy. When we have that, we can outline the answer to this question as well.

The Chair: Thank you.

Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you, Madam Chair.

I have a few questions. Kirsty mentioned MS, but obviously there's a lot of interest around this table in neurological conditions. We have the subcommittee that continues to meet.

Glenda or Alain, maybe you could tell us a little bit about the current efforts in Canada with regard to neurological disorders and the investments we've seen in this fiscal year.

Ms. Glenda Yeates: Do you want to start?

Dr. David Butler-Jones: Yes, I'll start, because actually part of it is through us and CIHR, in terms of surveillance and getting a better understanding. The government has invested some $15 million towards getting a better sense of what is going on in terms of neurological diseases. CIHR—and actually Canada—has a tremendous reputation in terms of research in this area. I'll leave that to Alain to speak to.

But it does fit when you think of all that we do in public health more broadly and the clinical services that are provided, not only with an aging population but generally with respect to the impacts of mental health and various neurological disorders, towards better understanding them and being able to address them, including appropriate treatments as well as prevention, for even simple things such as Alzheimer's. As people become more educated, we see the rates of Alzheimer's falling. Numbers of people are affected because of the age, but in fact fewer people at a given age get Alzheimer's today than they did ten years ago. And there's a clear relationship between education and mental activity and reduced risk of Alzheimer's.

I'll turn it back others.

● (1155)

Mr. Patrick Brown: That's very interesting. I have just a quick follow-up question on that point. Has that been established through Health Canada research, CIHR research? Are we confident that mental activity is a preventative measure for Alzheimer's?

Dr. David Butler-Jones: Actually, it's not only in Canada but also internationally. Study after study is finding that people who learn languages, who read, who are engaged in their community.... It is not an absolute protectant, but if you look at those with greater than high school education, their risk of Alzheimer's is substantially less than that of those who never make it past grade 10. Those who are engaged in mental activities, as I said, whether they are learning languages, doing puzzles.... And again, in a broad range of things, their risk of developing Alzheimer's is less than that of those who don't keep mentally active. So again, that's a good reason for a good debate around this table.

Dr. Alain Beaudet: If I may, I would add, first of all, that I think you're right. I think brain research is the last frontier. I think we're dealing, in this country, as in many developed countries, with major issues of mental health and also neurological disorders. And with an aging population, a number of these disorders, and particularly neuro-degenerative diseases, including Alzheimer's and Alzheimer's-related dementias, have an increasing prevalence.

We're currently investing over $211 million annually in research linked to the brain. Since 2006 we've invested $88 million in research on Alzheimer's and dementia. As you know, a major emphasis of CIHR is Alzheimer's disease and related dementias. We've signed a number of MOUs with a number of countries to increase our research capacity in that area, to go further faster, as I like to say, by doing it in collaboration with other countries that face the same problems rather than being in competition with other countries. And some of the moneys given to us through the supplementary estimates were actually used for that purpose.

Mr. Patrick Brown: Dave, I think you have another point.

Dr. David Butler-Jones: Very briefly, I thought I mentioned it, but in case I didn't, we've invested $15 million over four years to do the first ever neurological study, to have a better understanding of it. If I didn't specifically say that, I meant to.

Mr. Patrick Brown: The Alzheimer Society had that report last year, *Rising Tide*, and it said that health care costs for the country are going to be $40 billion in the years ahead. Are the measures we're taking today going toward attempting to mitigate some of those costs?

Dr. Alain Beaudet: Well, we're certainly hoping it's going to mitigate. Obviously we're funding a lot of research to understand causes of the disease and to treat it at its roots. We realize this can take time, so in parallel we're really focusing research efforts on early diagnosis, early biomarkers, early imaging markers, which would allow us to treat the disease before substantial neuro-degeneration has occurred.

We believe that if the clinical trials on Alzheimer's disease have not been successful so far, it's because they were carried out on patients who were in stages of the disease that were too far advanced. We believe if we can diagnosis the disease earlier and carry out clinical trials earlier, we will see drugs that allow us to delay the onset of the disease.

Our objective is fairly modest; it is to delay the onset of the disease by five years. But we're talking about huge, huge impacts, both economic and social, if we succeed in doing that.

● (1200)

The Chair: Thank you, Dr. Beaudet.

We'll now go on to Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Madam Chair, Ms. Yeates, I would just like to go back to what was said a little earlier.

What deadline have you set for yourselves to get back to your standard 8- to 10-week processing time?

Ms. Glenda Yeates: If I understand correctly, we were talking about marihuana earlier. We hope to be able to get there in a few months, though we thought we could do so by December. That was our internal target. At the moment, we are still trying to get it done. It will also depend on the number of applications we receive.

At the moment, we are saying a few months so that we can keep up with the applications, but we hope that it will be sooner. I would say by the start of 2011. We hope to be there for the first quarter, maybe sooner.

Mr. Luc Malo: Thank you.

Dr. Butler-Jones, vote 50 is a transfer to Health Canada for the Canadian HIV vaccine initiative.

Can you tell us why the Public Health Agency of Canada is transferring that amount to Health Canada, what impact it will have on your work on the initiative and what specifically Health Canada will do with the funds?

Dr. David Butler-Jones: Health Canada has the expertise in regulations. Internationally, medium-sized countries do not have enough capacity to conduct research and clinical trials, and so on. It's about expertise—

[*English*]

It's really important to ensure that. The countries that have the highest rates of HIV, where clinical trials will be most able to demonstrate a benefit, or not, also do not have much in the way of regulatory capacity. The ability to assist them to have more uniform standards—that the kinds of standards in these countries and our country are more similar across countries—to facilitate the research, and then ultimately facilitate the ability to provide vaccines is a very important component. It fits very well with the initiative itself.

Glenda may want to add to that.

[*Translation*]

Ms. Glenda Yeates: As Dr. Butler-Jones said, it's for training. We think it is important to have regulations.

[*English*]

and the oversight of these clinical trials. We have expertise in that area on the regulatory side, so we will be using that money to build capacity through mentoring and training. We can share the regulatory expertise in the management of these trials, expertise we have in the health products and food branch of Health Canada.

[*Translation*]

Mr. Luc Malo: Thank you very much.

Thank you, Madam Chair. I have no further questions.

[*English*]

The Chair: Thank you very much.

Ms. McLeod.

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

I guess I first have a quick comment. To me, this is such an unusual process, because of course as the municipal politics or health authorities you do really careful planning around your budget. You have your budget set for a year, and then of course you live within your budget. The federal government process with supplementary estimates that sort of pop up throughout the year is quite unusual. So can you talk in general about your budgeting process at the start of the year, and then how you really determine what's going to get added as you go?

Ms. Glenda Yeates: I'll perhaps start with that, Madam Chair.

My background, as I think I've mentioned before at the committee, is as a provincial deputy minister. This process is a little bit different from the provincial process as well, but essentially departments build most of their A-base, the known expenditures that they will have year to year, into the regular budget process, and that's what gets tabled early in the year. But then as we go through, for example, in a budget, we would often be involved with the budget discussions. For example, one of the items in our supplementary estimates this year is to recognize increased demands for programs under the Indian residential school support program. That would have become apparent to us, that the base we had in the budget we didn't feel was going to be sufficient to meet the demands we were seeing, and that's a requirement, that we'd be able to provide those supports for everyone who comes forward. So with that, we would have gone with the revision, essentially, to say that we are seeing greater numbers, and if that then is approved in the budget, then we hear often in a budget announcement a number of those programs, and indeed most of the ones that I mentioned in my opening remarks were things you would have heard as part of the budget. Then the process for regularizing and finalizing the details and getting them before Parliament occurs later in the year through the Treasury Board process in here.

Essentially it's a staged process, partly because of a difference between what things are fundamentally in an A-base that we can deal with at one point in time versus other things that arise later either because they're new or because we have revised estimates, for example.

● (1205)

Mrs. Cathy McLeod: Thank you.

Dr. David Butler-Jones: Just to supplement, I've worked at all three levels of government, and this level of government is the most parliamentarily transparent. Generally you'd have a budget, you work it out, you might transfer it between departments, etc., you'd just work it out, whereas here, all of that comes forward.

In our case, most of it is transfers, where, for example, CIHR is in a better position to manage this program than we are because of their expertise. Normally, at the municipal-provincial level, you just transfer it, but here it is part of a process that you have the opportunity to see.

Mrs. Cathy McLeod: Thank you.

I read an article, and I will perhaps brag slightly about my own community. In this community, because we were talking about chronic disease, Kamloops has one of three of what they call a strategic alliance, and it is a partnership between the health authority and the city where they've trained people who are specialists in exercising and supporting exercise for chronic disease. Again, there are only three across the country. I think they are probably doing amazing work.

If you're not affiliated with a university, how does that ever connect through? If you have some things that are happening that are absolutely fantastic, how does it ever connect through to the CIHR process or the Public Health Agency of Canada's process if it's sort of not formalized, not connected with the university, in terms of you saying "Wow, those are great ideas, let's do a more formal evaluation"? How are we going to not only formally evaluate but look at embedding and ensuring that knowledge?

Dr. Alain Beaudet: I think it's an excellent question, and it's something we're looking at, particularly as we're increasing our investments in primary health care research, where we're starting to look at community-based research, community-based researchers. I think for certain aspects of research, and certainly under the patient-oriented research strategy, we will need to look not only into the large academic health centres but also into community centres that provide the types of services for which research is actually needed.

The Chair: Thank you, Dr. Beaudet.

Dr. Dhalla.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you for coming.

I want to go back to a comment that Dr. Butler-Jones made earlier. You had said that no one had met the standards of the HIV vaccine facility. Was that correct?

Dr. David Butler-Jones: Correct.

Ms. Ruby Dhalla: Could you elaborate on why no one met the requirements? Were the requirements too stringent, or was there not a will to invest in something like this? Did other priorities override this effort?

Dr. David Butler-Jones: No, it was an independent process. It was peer-reviewed. None of the bids met the minimum standard. At the same time, the Gates Foundation had done a review of international capacity. In the intervening year and a half or two years, there was increasing capacity available in Canada and elsewhere.

So we didn't have any proposals that we could fund, because none of them met the standard. At the same time, we realized that there was new capacity out there that could be made use of. So why put money into bricks and mortar when you can further research that will speed up the development of a vaccine?

It became redundant. None were successful because none met the standard. So it became a redundant program—not a wise use of investment dollars.

● (1210)

Ms. Ruby Dhalla: We've formed something here in Parliament called an HIV/AIDS and TB caucus, otherwise known as HAT. It's a non-partisan group that has come together from all political parties. We held a forum with Dignitas on some of the ideas for innovation and investing in HIV/AIDS and TB research. We had a number of individuals and stakeholders from the Canadian HIV/AIDS Legal Network as well. It's an important issue and we had a tremendous turnout.

You've said that you're transferring $152,000 from your department into the initiative. Is that going to affect the department? What types of initiatives is that money going to be used for? Health Canada, I believe, has also reallocated $200,000. Can you elaborate on what you're going to be using that money for?

Ms. Glenda Yeates: The $152,000 is the same money I was speaking of earlier, the transfer from the Public Health Agency. We have recognized a need for mentoring and training on the regulatory side.

There are areas in which Health Canada, rather than the Public Health Agency, has the expertise to help people run clinical trials in Africa, say, where they need the clinical trials but may not have the technical expertise to get some of the regulatory clinical trial approvals. We're offering to help and to bring some people here for training. That is what the $152,000 will be spent for.

Dr. David Butler-Jones: As to the money that the Gates Foundation and several departments contributed, it's in the initiative. Not having to build a structure means that we're able to do a number of other things to support the process, and that's what some of these transfers represent. But they're still in that broad initiative.

Dr. Alain Beaudet: Thirty-four million of this money is actually for AIDS research, particularly research focused on the discovery of a new vaccine. It's also for preparing the low- and middle-income countries for clinical trials, once we have a vaccine. It will ensure that we have trained people to carry out these trials.

Ms. Ruby Dhalla: HIV/AIDS awareness week is coming up next week. Could you table for the committee some of the initiatives that are currently under way? I think it would be helpful.

I had another question for Ms. Yeates on a topic that I believe Mr. Malo touched upon in regard to the natural health products directorate. As a chiropractor in my previous life, prior to becoming an MP, I know that it's an important issue for many people within my network.

You mentioned that with the new regulations, 87% of the backlog has been completed. How many applications do you currently have within the directorate, and how quickly do you see those being processed? The delay in getting them approved has been a huge area of concern for many stakeholders.

Ms. Glenda Yeates: We've had many discussions with the committee about the challenge of moving these products on to market, while assuring Canadians of their safety. This is the reason we went with the changed regulations. We do a safety review, and then we have a 180-day process. Unless we see something very new or unusual that needs to be thoroughly assessed, we can let it on the market in this 180-day—

Ms. Ruby Dhalla: How many applications have you had so far?

The Chair: Thank you very much.

We'll now go to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thanks very much to each of you for being with us again today.

I just want to change the questioning a bit. I know that we've all been hearing a lot lately about the cholera outbreak in Haiti. I think well over 1,200 people have died from it, and certainly thousands more are very ill because of it. I know that Canada has certainly stepped up to the plate and has contributed greatly to relief efforts and ongoing assistance to the Haitian people, but is the Public Health Agency involved in this effort to assist Haiti? Are we doing anything through the microbiology labs?

Dr. David Butler-Jones: There are actually a number of areas we're involved with, in close contact with departments across government not only here but also with our colleagues in other countries.

In terms of the laboratory, the genetic sequencing or genome sequencing of the cholera bacteria is actually something that we did, which helps to identify exactly the potential sources, etc. So we're very much involved in that, working jointly with the CDC in the U. S. on that.

There has not been a request for assistance, in the sense of a team of epidemiologists and others going down, but if we are asked, we are available to go.

● (1215)

Mrs. Patricia Davidson: Okay, thank you.

I want to ask Ms. Yeates, if I could, please, if there is any additional funding in the estimates this year for the impact of environmental conditions on human health. If there is, does it support other efforts designed to address health concerns related to the environment?

Ms. Glenda Yeates: Thank you very much for the question.

Yes, Health Canada partners in a number of ways with Environment Canada and others on the environmental file, because there's often a concern on both the environmental and human health sides. Environment tends to be the lead department, but we are very much, we think, an important partner in a number of environmental activities. Certainly one of the ones that's in these estimates is something that's very specific to air quality.

There is a need for additional research to support the development and refinement of an indicator that would help us measure the connection between air quality and health, because I think that understanding which conditions are linked in the epidemiological research to which air quality indices or air quality findings is critical to taking action. So the research function of a new health air indicator we think is quite important. It would allow us to track changes over time in air pollution levels, for example, and to see what links those might have to the health of Canadians.

So there is actually $240,000 in supplementary estimates (B) for the expansion of this indicator to include other pollutants. It's an ongoing piece of work that we are doing. Currently, we have an air quality indicator for ozone and for particulate matter, but we are working to expand that as part of our overall clean air agenda in terms of the work we do with Environment Canada under the chemicals management plan and the work we do on the environmental and health files generally.

Mrs. Patricia Davidson: Thank you.

That's the end of my questions. Thank you.

The Chair: Thanks, Ms. Davidson.

Now, Ms. Chow, you had another question.

Ms. Olivia Chow: Thank you.

It's really about your excellent northern health initiative for accessible and nutritious food.

Have you considered rolling that out to other parts of Canada that need access to healthy nutritious meals, and especially to children, given that boys are now 16 pounds heavier than they were 20 years ago and girls 11 or 12 pounds heavier? That's substantial. So access to nutritious, affordable, local food is really important.

Is there any movement on this, or are there any learnings from your food mail program on this? Is it community-based? Maybe you could describe it somewhat.

Ms. Glenda Yeates: Thank you for that question.

I'll speak to the Nutrition North program, specifically. In answer to the broader question of the consideration, when health ministers met this past September, there was a real joint coming together on the issues. There was a declaration on prevention and promotion and a focus on childhood obesity and a specific initiative in terms of a framework on childhood obesity.

Now, we have been tasked with coming forward with strategies and with collectively bringing back to the ministers of provinces and territories and the federal government strategies and options. One of the things they particularly asked us to look at, for example, is the marketing of unhealthy foods to children.

Ministers are seized of the issue. I think everyone realizes that this is all levels of government. Everyone is working together at the health minister level. So there may be further things there.

● (1220)

Ms. Olivia Chow: Would any of it include helping some of the local communities provide food in schools, community centres, and child care centres? Child care centres already have food. Kids have to go to school. They show up in community centres, and if they actually got a decent meal in a day, that would be wonderful.

You said any kind of partnership. I know that CAPC is very small. Is there any discussion of expanding it or changing the mandate?

Ms. Glenda Yeates: It's early days, so I don't think we're at that stage. But certainly the partners are looking to understand best practices. I know that some jurisdictions do some of those programs now, and others may wish to learn from them and work on them.

To make the link to Nutrition North, which is obviously a program that is within the Government of Canada's remit and focus, there was a real sense that we should be focusing on this program to try to improve the availability of nutritious food. Our colleague department, INAC, is actually the lead on this program. On moving the subsidies, we had to make some choices about trying to focus the resources on healthy foods. We had an expert panel that looked at, for example, removing food that had high levels of salt or sugar and focusing the supports on other foods.

The Health Canada portion I think is quite important, because in addition to simply making foods available, I think all the best research has told us that it's also about making sure that people have the understanding and the skills, in terms of how to prepare these foods, that might lead people to choose them.

The money in supplementaries is for us to actually work with communities and work with the existing programs to try to build nutrition supports for communities. It may be cooking classes. It may be displays right in retail establishments. It may be community freezers.

The Chair: I think Dr. Butler-Jones has some comments on that as well.

Dr. David Butler-Jones: We actually fund the CAPC and CPNP programs as well as the aboriginal head start program off reserve.

It's back to public health being local and local community initiatives, whether it's community kitchens or different agencies coming together.

Ms. Olivia Chow: [*Inaudible—Editor*]

Dr. David Butler-Jones: Well, there are both. We provide a lot of money, actually, to support those things. But it's not just a federal issue. It is about different levels of government working together and different agencies working together.

In my life as a local medical officer, one of the things we found was that kids were recognized as coming to school hungry, and parents' groups and teachers wanted to come together and put together a program, such as a muffin program or whatever. What I observed is that there were all these regulatory things, and by the time they worked through all the regulations and having kitchens and all this, they ran out of energy. So what we did was bring the inspectors, the nurses, and the schools together and said “Okay, how can we make this easy so that all the energy of the volunteers and the parents can go into actually delivering the program?”

There are a number of things to do. From the agency's perspective, in addition to the kinds of programs we fund, one of the things that's really key, which goes back to, in a way, a previous question, is how you get that information out there. We have the Canadian best practices portal and the chronic disease portal. We're very much focused on evaluations and understanding what works and what doesn't. It is why my annual report is not just a list of the problems but has ways in which communities and organizations can actually address them.

We're seized with the idea that every public health nurse in this country, every inspector, every nurse, and every nutritionist should not have to rediscover what's been learned and what is a good program in Kamloops or whatever.

That is a strong focus. We've reinstituted the preventive practices group. We've done a number of things that I think over the next few years will help so that practitioners, whether they're teachers or public health workers or whatever, have access to the tools that will assist them in actually getting the work done, as opposed to waiting for somebody to get something to happen.

The Chair: We'll now go to Dr. Carrie. You have four minutes, because at 12:30 we will have to go into our business portion.

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

I wonder if you could indulge me a bit.

When I was first elected I was on the health committee, and we did some really good work together. One of the issues we addressed at the time was fetal alcohol spectrum disorder. It is a very important issue. It's something I learned a lot about and took on as a bit of a cause. I was wondering if you could update the committee. I believe we might have made recommendations in 2004-05. Could you let us know what the Government of Canada is doing to help prevent fetal alcohol spectrum disorder, and how do we help people who are actually affected by it?

● (1225)

Dr. David Butler-Jones: Perhaps I'll just start, in terms of the agency's role in this, and then Glenda could speak to the extensive programs that have developed for first nations communities.

This is a huge challenge, obviously. And unfortunately for kids born with fetal alcohol, it is a life challenge; it's not just an event. Some of the things that were recognized were awareness, understanding, guidelines, standards in terms of diagnosis, and what are appropriate therapies and approaches, etc.

A lot of our resources have been focused on ensuring that practitioners, physicians, and others have the tools they need to actually address that. Then we're also seeing the development in the provinces, who actually deliver these services, at not only an increased understanding but an increased focus on how best to do that. Our job is to make sure they have the best tools possible to both understand the condition but also to address it.

Ms. Glenda Yeates: Madam Chair, perhaps I could speak specifically to our efforts as part of our participation in the Inuit health branch. As David has mentioned, all jurisdictions—provinces, territories, and the federal government—are very much aware of the challenge. So we, as part of the first nations and Inuit health branch, have some specific focus here as well.

We invest $16 million annually, as part of an FASD prevention program. We're working on trying to improve awareness. We've done some public opinion research, which tells us that we are actually increasing the awareness in our first nations communities of some of the challenges.

We are working to develop actual support programs that give us culturally appropriate and evidence-based prevention, and early intervention programs. So we're working with some mentoring projects, for example, in certain areas to provide women who are pregnant with some supports. We're also supporting community coordinator positions to increase access for families to multi-disciplinary teams in certain areas.

We're continuing to work with communities. Again, much like other issues, this isn't something the Government of Canada can do for people. It is working with communities, providing them with the support, the knowledge, the information, and the assistance to deal with what is obviously a very challenging and important issue.

Mr. Colin Carrie: I do want to thank you and commend you, because in this committee we did some really good work. We visited the north and we did look at some of the specific issues there, particularly fetal alcohol spectrum disorder. But I also commend you in moving forward with Nutrition North Canada, because when we were up there, I couldn't believe the amount of junk food and things like that.

My next question follows up with Madam Chow.

The Chair: Mr. Carrie, our time is up.

As much as this has been so much fun, we'll have to suspend for two minutes.

I want to thank the witnesses for coming and giving us all this insightful information. It's very much appreciated.

I will suspend for two minutes and then we will go into our business part.

● (Pause)

● (1230)

The Chair: Let's get started, if we could, so we get this very important business completed.

We're starting with Mr. Dosanjh's notice of motion.

Mr. Dosanjh, would you please read it into the record?

Hon. Ujjal Dosanjh: Can we forgo the reading? You have it. The clerk has it—

The Chair: Sure, that's fine with me. I just thought you wanted to—

Hon. Ujjal Dosanjh: No, I don't necessarily want the privilege of having to read it.

The Chair: Let's open it up for discussion then.

Dr. Carrie.

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

I notice that my colleague mentions all the briefing notes and research documents that have been written by Health Canada about the implementation of new tobacco health warnings. This could be quite voluminous, and there may be issues regarding cabinet confidence.

We do have a system, access to information, and I would think it might be a better option for the member to consider putting this through ATIP, as they would take the cabinet confidence issue into account. So I'd like to make that recommendation on that second point.

Does anybody else want to discuss that point? There are a few things I'd like to talk about.

The Chair: Anybody else? Any other discussion? No?

Mr. Colin Carrie: Okay, because we do have that system in place. The next point says:

> A detailed list of names of all the lobbyists and a description of all the lobbying that has taken place related to the implementation of new tobacco warnings, and copies of all the materials provided to the government by these lobbyists;

We put something in called the Federal Accountability Act. I think everybody remembers that was the first big piece of legislation we put in, and he could contact the Office of the Commissioner of Lobbying on that request.

Hon. Ujjal Dosanjh: May I just speak to that point?

Mr. Colin Carrie: Sure.

Hon. Ujjal Dosanjh: I think you're wasting your time. They know what's available and what's not available. They know how to deal with the cabinet confidences when they disclose documents.

Mr. Colin Carrie: Who are you—

Hon. Ujjal Dosanjh: When the officials produce documents, they will take all those things into account. I want to know what lobbyists contacted them. There may be more lobbyists contacting them than the ones who are reflected in the lobby register. I'm sorry.

From my perspective, I have asked for the widest possible information. That's what committees are for, for doing this kind of work. Thank you for letting me know I can go the ATIP route. Yes, I could have done that, but I choose to do it here because the committee's going to be discussing this issue on the seventh.

The Chair: Dr. Carrie.

Mr. Colin Carrie: Again, I would just point out that my colleague did request information going all the way back to 2004. The Federal Accountability Act and the details and the checks and balances we put in didn't come into effect until 2006, I think, or later.

You were the Minister of Health back in 2004. Maybe the quickest thing to do, if you really want that information, is to go into your own schedule. For the time between 2004 and 2006, when we didn't have the Office of the Commissioner of Lobbying or the ability to look at these different things, I don't even know if that information would be available through ATIP and all these other offices. But you might have that yourself, and that would be the quickest way to get that to us for the time from 2004 to 2006.

Madam Chair, with the committee there are ways of getting this through. And he's asked to have it within seven days. This request really resembles an order paper question, and we know that other colleagues around the table have asked for these before. There are reasons we allow 45 days for responses to order paper questions. Because of the volume of what he's asking for here, I would suggest as well that seven working days is unreasonable. For the part between 2004 and 2006, he might be able to pull that out of his old schedule. But he's asking for a lot of information here.

Even in the next question—"All the written and verbal input"—he's talking about verbal input—"the government has received related to the implementation of new tobacco warning labels" as the next point. How does one even provide verbal input in a written form? If somebody is just talking back and forth, how do you provide that in a written form?

And then it indicates any and all deliberations that the government has undertaken regarding the implementation of new tobacco warnings. Again, this is more cabinet confidence. And if you put it through ATIP, they will take all of this into account.

I think, Madam Chair, there is a reason you can put this as an order paper question and give a reasonable amount of time to get the responses to this. This is incredibly unusual.

● (1235)

The Chair: Mr. Dosanjh.

Hon. Ujjal Dosanjh: First of all, may I ask whether we're in camera or out? We're not in camera?

The Chair: We're public.

Hon. Ujjal Dosanjh: We're public. Good. Thank you.

No, I'm not going to respond to any of the concerns my friend raises. He is simply making excuses for non-production or non-disclosure of documents. Officials are very adept at providing documents when and if they have to. Committees have a right. Committees are masters of their own procedure and what they do. Committees can decide whether they give seven days or eight days. I gave seven days because there is a hearing coming up on December 7 with respect to these matters, and if the officials can't provide the documents they'll come back to the committee and give us reasons why they can't provide those documents.

So I'm not going to argue with you, sir, on all of the issues you raise. Those issues can be dealt with by the officials when they're looking into these things. This is what I want disclosed.

The Chair: Monsieur Dosanjh, may I just ask you a question? I don't usually intercede, but you're talking about wanting all this information from 2004 when you were in government to right now, in seven working days. And you want verbal input; you want lobbyists, and details of all the names of all the lobbyists, and all lobbying that's taken place since January 1, 2004. You want how much money has been spent on research, group testing, consultations design. Even Santa's helpers can't work that fast, Mr. Dosanjh.

Hon. Ujjal Dosanjh: Don't you have faith? I thought you had faith.

The Chair: I'm also an INTJ realist: one and one equals two. With all due respect, would you please reconsider? I know you need all this information. Everyone wants to give you that information, but seven working days really is unrealistic.

Hon. Ujjal Dosanjh: How many working days is it between now and the evening of December 6? You can take that many, up until December 6. It doesn't matter to me.

The Chair: That's seven working days.

Hon. Ujjal Dosanjh: There you are. If my motion had been heard the other day, it would have given people more time.

The Chair: Yes.

Go ahead, Dr. Carrie.

Mr. Colin Carrie: I don't think I'm being unreasonable. There is a process, and I know other colleagues around the table have done order paper questions. It gives a reasonable amount of time. Madam Chair, if I could be quite clear about the fastest way and if you would like to see information from 2004-2006, he was the minister. We didn't have the Federal Accountability Act then. I don't know how in heaven's name we're going to go back that far.

You made a good point about giving a written response to something that was verbal. How do you even research that? I would ask him to address this. He didn't want to address my individual points, but how would he even suggest officials give a written response to things that were given verbally?

● (1240)

The Chair: Which one is it, Monsieur Malo or Monsieur Dufour?

Monsieur Malo, go ahead.

[*Translation*]

Mr. Luc Malo: To give two extra days, we could easily put the meeting scheduled for December 7 back to December 9.

[*English*]

The Chair: That is an amendment, then. Are you putting on an amendment to Mr. Dosanjh's motion?

[*Translation*]

Mr. Luc Malo: Yes, Madam Chair, that's what I am doing.

[*English*]

The Chair: Could you give me the wording then, Monsieur Malo, please?

[*Translation*]

Mr. Luc Malo: Here is the wording of my amendment: that the information be submitted to the committee in 9 business days—not 7, and, as an addition—that the meeting scheduled for December 7 be postponed to December 9.

[*English*]

The Chair: The second request is outside the scope, so you cannot do that, Monsieur Malo, but you can say that you would like to have it within nine working days.

[*Translation*]

Mr. Luc Malo: No. In that case, I withdraw the amendment.

[*English*]

The Chair: You withdraw your motion. Then we're back to Mr. Dosanjh's motion now, without your amendment.

Thank you, Monsieur Malo.

Go ahead, Dr. Carrie.

Mr. Colin Carrie: I do think it's reasonable to discuss this, Madam Chair, because I haven't heard a suggestion. I did ask a question, and I think it's reasonable: how do you provide written documentation on verbal input?

Does anybody have any idea of how you could get that information from 2004? All of us know that we did put the Federal Accountability Act in, but this is even before that. Perhaps the best idea is that since he was formerly the Minister of Health, he may have that at his fingertips and maybe he could bring that forward in seven days.

The Chair: I think Ms. Chow was first, and then Mr. Dosanjh.

Ms. Chow.

Ms. Olivia Chow: I think we're going around in a circle. May I call the question?

The Chair: You certainly may do that.

Ms. Olivia Chow: That's what I'm doing.

The Chair: All right. I'm sorry, but I've just been informed that if other people want to speak, they actually can't do that. I have to ask if there is anyone else who would like to speak on this discussion, or can we go to the question?

Then we'll go to the question. The question is the notice of motion as outlined in front of you.

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

Mr. Colin Carrie: Could I ask for unanimous consent on an addendum to this?

Because there won't be anything between 2004 and 2006 that would have to respond to the Federal Accountability Act, I think the most reasonable thing would be that the former Minister of Health could perhaps bring his records of all the lobbyists within seven days to put forward and answer the questions between 2004 and 2006. I think that might be the quickest way to get this information put forward to the committee. Does that sound reasonable? Could we get unanimous consent?

An hon. member: *C'est bon*.

The Chair: So we're asking unanimous consent for Mr. Dosanjh as the former minister to bring all his documents from 2004 to....?

Mr. Colin Carrie: I think that would be the fastest way to get those two years to the committee—

The Chair: To try to help us out to get this research. Okay. All those in favour, please raise your hands.

Mr. Dosanjh, you're not raising your hand.

Hon. Ujjal Dosanjh: It's because I have none. I have no documents.

The Chair: So we do not have....

Mr. Colin Carrie: Could we just have a motion related to that, instead of...?

The Chair: We have to have 48 hours' notice.

● (1245)

Mr. Colin Carrie: Forty-eight hours?

A voice: It's on the same topic.

The Chair: It's on the same topic? Okay, go ahead.

Mr. Colin Carrie: Then I would propose that we have a vote.

Hon. Ujjal Dosanjh: I'd like you to make a formal motion, and we can have a discussion. I'd be happy to defend myself.

The Chair: Mr. Dosanjh, you have to wait until Dr. Carrie's finished.

Dr. Carrie.

Hon. Ujjal Dosanjh: I've never seen anything so silly.

Mr. Colin Carrie: I haven't seen anything so silly either. I agree with my colleague there. But I would make a recommendation that because we all know that our colleague is the former Minister of Health, perhaps the fastest way to get the information to—

The Chair: Dr. Carrie, what is your motion?

Mr. Colin Carrie: That Mr. Dosanjh bring forward his records and information for the period between 2004 and 2006 while he was minister. That would allow the other officials to do their work on the period between 2006 and the present, so that they could answer the questions he has proposed.

The Chair: Is there any discussion on that motion?

Mr. Dosanjh.

Hon. Ujjal Dosanjh: I'll put it on the record that I have absolutely no documents with respect to my time in the Ministry of Health, because I don't carry those records with me. Those records are usually destroyed.

Listen to me, sir. You had your chance.

Mr. Colin Carrie: You're right.

Hon. Ujjal Dosanjh: Most of the documents that come to ministers are shredded or go back to the departments. Therefore, they would have a record. Let me get the department documents and you'll have a record of what I did or didn't do.

The Chair: Dr. Carrie.

Mr. Colin Carrie: Madam Chair, he said that they would be shredded or go back to the department. He's asked for all this information. Now he's telling us it's shredded. If he knew that in advance, why are we going through this?

Let's call the question and vote to see what we can—

The Chair: Ms. Chow, stop laughing. Let's come back to order here.

We will now move that motion. The motion is on the floor.

The motion was that Mr. Dosanjh bring forward those documents. But now we learn that in committee a member cannot be compelled to do that. The House can compel him, but the committee cannot.

So we have that clarified, right? Good.

So that motion cannot go forward, Dr. Carrie.

Hon. Ujjal Dosanjh: I have a point of order. Is there anything this committee can compel a member of this committee to do?

The Chair: Can I finish this motion first?

Hon. Ujjal Dosanjh: I'd like you to check that out.

The Chair: I'm going to deal with the motion first.

Hon. Ujjal Dosanjh: You can't compel a member of the House to appear before you. Now you are compelling a member of the House to produce something that he doesn't even have, something that he's told you he doesn't have. This is absurd.

Can you check the rules, please?

The Chair: I need to go ahead with the motion.

Hon. Ujjal Dosanjh: Even if it's ultra vires? Check the rules, please.

The Chair: Is this a point of order, Mr. Dosanjh?

Hon. Ujjal Dosanjh: Yes, it is a point of order. Check the rules.

The Chair: We'll check the rules. We'll suspend the motion, then. We'll check the rules while we're suspending the motion.

Mr. Malo, you have the floor.

[*Translation*]

Mr. Luc Malo: Thank you.

That being the case, I would now just like unanimous consent from all my colleagues to move the December 7 meeting to December 9 and to give all the people who will have to look for those documents two extra days.

[*English*]

Hon. Ujjal Dosanjh: Let's first move the meeting and then he can make the motion.

The Chair: Dr. Carrie.

Mr. Colin Carrie: I'd be in favour of that.

The Chair: Does that mean that you're withdrawing your motion?

Mr. Colin Carrie: No, but I had another suggestion. Because of the ninth meeting on the draft report, we have an open meeting now. We agreed on an agenda before. Unfortunately, we used up three meetings on Bill C-36. I believe it was healthy living that we had to move forward.

Would it give the officials enough time if we could continue our study on healthy living? I don't think we would like to lose a meeting. We could give you enough time to get back on track with that important study. I would recommend that we put one in on the seventh.

The Chair: Healthy living on the ninth?

● (1250)

Mr. Colin Carrie: I think so. That's what we agreed on.

The Chair: That was around childhood obesity and all those kinds of things.

Mr. Colin Carrie: We just heard today the importance of all those things with Health Canada—childhood obesity. Madam Chow mentioned the—

The Chair: Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Exactly, Madam Chair, we could most definitely use the December 7 meeting to discuss that. But we would discuss it amongst ourselves to decide on the scope of the study that we want to do, and its parameters. As we know, the issue of healthy living is a very broad one. Perhaps we could decide together which aspects of the topic we wanted to study as a priority.

So we could have that discussion together on December 7.

[*English*]

The Chair: Okay, so the agreement is that we'll be doing healthy living and looking at the scope on the ninth.

Hon. Ujjal Dosanjh: May I make a suggestion?

The Chair: Sure, Mr. Dosanjh.

Hon. Ujjal Dosanjh: I move that you hold Mr. Carrie's motion in abeyance, and we agree to switch the meetings of the seventh and ninth around.

The Chair: Okay. I see.

Hon. Ujjal Dosanjh: Then we can amend my motion—I agree to Mr. Malo's amendment—to make it nine working days.

The Chair: Can I clarify?

Hon. Ujjal Dosanjh: Yes.

The Chair: So we will have nine working days, instead of the seven. We have that on the table right now.

Is everyone in agreement with that?

Mr. Colin Carrie: I was trying to make a point that the volume and the ask that my colleague is making is unreasonable. If we do seven days or nine days—just between 2004 and 2006—it will be extremely difficult to provide what he's asking for. We're certainly not in agreement with seven days or nine days either. I think it should be a question on the order paper.

The Chair: Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Madam Chair, if you look at the blues of the meeting, you will see that the committee unanimously agreed to move the meeting from December 7 to December 9 and give 9 days for documents to be presented.

I invite you to go back and look at that. The question was asked and we answered it.

[*English*]

The Chair: There was unanimous consent to put the tobacco meeting on the ninth, but we still have to deal with the time element on that motion. We haven't agreed to that yet.

[*Translation*]

Mr. Luc Malo: Madam Chair, in that case, we really do not need to amend Mr. Dosanjh's motion. We have a motion that was in order and passed. We simply want to give ourselves two more days. If the party in power does not want to allow two extra days, they are free to say no. Let's leave that to one side.

But let's still have the meeting about tobacco on December 9 and, on December 7, the meeting will be a working session on the scope of the study we want to do on healthy living.

[*English*]

The Chair: The request was for Mr. Dosanjh to bring forward those documents to help everything out, but the fact of the matter is that in a committee a member cannot be compelled to do that. The House can compel him to do that, but the committee cannot. So we have that clarified, right? Good.

So that motion cannot go forward, Dr. Carrie.

We'll go back to the motion.

On the ninth we are going to be doing tobacco. On the seventh you want to do healthy living.

An hon. member: Yes.

The Chair: Good, so on the seventh we'll do healthy living.

[*Translation*]

Mr. Luc Malo: It will be an in camera meeting to decide on the extent of the study we want to do.

[*English*]

The Chair: We'll go in camera on healthy living.

So we can cite the committee business you're talking about, Monsieur Malo.

Monsieur Malo: *Voila. Absolument.*

The Chair: Monsieur Malo, we've got you. Good.

Some hon. members: Hear, hear!

The Chair: It's pretty bad when the committee applauds when I actually get it—it's sad actually.

So we'll proceed that way.

For the life of me, I don't know how these people are going to get all these documents in, even in nine days. I might be wrong, but how do we proceed if they cannot do that? We'll deal with it when they come; that's all we can do.

Now we're going to talk about injury prevention. I would like Karin to go....

If you want to prevent your injury, Mr. Dosanjh.... No, I'm just teasing.

We have to pay attention to this. We have to clarify what we're going to be studying on injury prevention. We've talked about childhood and adults, so we need some input from the committee.

Karin.

● (1255)

Ms. Karin Phillips (Committee Researcher): I guess the only question I have is whether we're focusing as well on injury prevention in relation to consumer products. I know that was a topic of a recently released PHAC report. I just wanted to get confirmation....

Mr. Colin Carrie: I think we've covered that already, so why don't we focus on other things?

Ms. Karin Phillips: Okay. That was it.

The Chair: Great.

We've come to the end of committee business today.

Thank you, committee.

The meeting is adjourned.

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