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# Standing Committee on Health

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**EVIDENCE**

## Tuesday, November 30, 2010

## Chair

**Mrs. Joy Smith**

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● (1100)

[*English*]

**The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)):** Good morning, everybody. Welcome to the Standing Committee on Health. We're very pleased that you're here today. Pursuant to Standing Order 108(2), we're doing a study on injury prevention in Canada.

There is going to be a 10-minute presentation from each of our organizations.

We will begin with Jane Billings.

First of all, let me introduce who we have here. We have, from the Public Health Agency of Canada, Sylvain Segard, director general at the Centre for Health Promotion. We have Jane Billings, senior assistant deputy minister of the Planning and Public Health Integration Branch.

From the Department of Health, we have Athana Mentzelopoulos, director general of the Consumer Product Safety Directorate. And we have Denis Roy, project officer at the mechanical and electrical hazards division, Consumer Product Safety Directorate.

We have, from Safe Kids Canada, Pamela Fuselli, executive director.

Welcome to all of you.

We will begin with Jane Billings, senior assistant deputy minister.

**Ms. Jane Billings (Senior Assistant Deputy Minister, Planning and Public Health Integration Branch, Public Health Agency of Canada):** Good morning. Thank you, Madam Chair.

[*Translation*]

I want to thank this committee for the opportunity to speak, and to acknowledge this important examination into injury prevention.

The work of this committee constitutes a critical step to improving our ability to reduce rates of injury and to improving the health of our population.

[*English*]

I will provide a very brief overview of the size and scope of injuries in Canada, add context about who is involved in addressing this issue, and then describe how the Public Health Agency is contributing to the efforts of reducing injuries among Canadians.

Injury has been defined as damage to the body caused by the sudden transfer of energy that is beyond the body's resilience. That's a fairly unhelpful definition, if I may say so. I think most of us know what we mean here. Injuries may be intentional or unintentional. Unintentional injuries are caused by events such as motor vehicle collisions, falls, drowning, and poisoning. Intentional injuries are caused by violence, such as violence against children and women, and self-inflicted harm, sometimes leading to suicide.

They happen to Canadians in every setting: at home, at the arena, and at work. Many of these injuries are preventable. Injuries are an important health problem in Canada. They are the leading cause of death for Canadians between the ages of one and 44. This is for both unintentional and intentional causes. For every death there are 16 hospital admissions, and too many of these result in impairments and disabilities, such as blindness, spinal cord injury, and intellectual deficit due to brain injury. Unintentional injuries are responsible for the majority of these injuries.

● (1105)

[*Translation*]

Motor vehicle crashes are the leading cause of injury deaths for most age groups. However, in older adolescents and in youth, suicide ranks first. Interpersonal and family violence is also of concern. Finally, falls are the leading cause of non-fatal injuries, and they are especially frequent among older Canadians.

[*English*]

In addition to causing human suffering, injuries impose a large economic burden. A recent study by SMARTRISK, based on 2004 data, estimated that the total economic burden of unintentional injuries in Canada for all ages is $19.8 billion per year. This figure includes $10.7 billion in direct health care costs and $9.1 billion in indirect costs, including lost productivity due to premature death and disabilities.

Injuries affect health care utilization in other ways. Injuries contribute to crowded hospital emergency rooms. Emergency surgeries for serious trauma cases contribute to wait times for elective procedures. Injuries resulting in long-term impairments and disabilities impact workforce participation and overall productivity.

I would like to take you behind some of these statistics to discuss those most at risk. For infants up to one year, suffocation is most often the cause of injury death. Injuries of various natures continue to be the leading cause of death for children, teens, youths, and adults up to age 44. In 2005, three Canadian children died from injuries every day, for a total of more than 1,081 deaths each year, and over 34,000 children were admitted to hospital.

Motor vehicle collisions, falls, drowning, and poisoning are the leading causes of unintentional injury for children and youth. Most injuries to infants and young children happen at home. For older children and adolescents, many injuries are related to sports and recreational activities. Workplace injuries start to occur among older adolescents and youth as they enter the workforce.

[*Translation*]

For older adults, falls are an increasingly serious risk. In fact, a third of all seniors experience a fall every year, and falls account for more than half of all injuries among Canadians aged 65 years and over. Many factors contribute to these falls: from biological factors such as visual impairments and balance problems to environmental factors such as ice and snow as well as hazards in the home.

[*English*]

The data also show that Canadians living in northern communities, aboriginal individuals, and families of lower socio-economic status are most likely to suffer injuries. Unintentional injury rates are three to four times higher for aboriginal children than for other children in Canada. Suicide among youth is very high in first nations communities, with rates five to seven times higher than for non-aboriginal youth. Suicide rates among Inuit youth are eleven times the national average. These statistics are particularly troubling when we consider that more than half their population is under 25 years of age.

But injuries are preventable, and I am pleased to say that over the last few decades, injury death rates have been reduced dramatically —40% since 1980. Much of this impressive decline is due to reductions in fatalities caused by motor vehicle crashes. This is good news, and we are seeking to reduce other types of injuries in Canada by applying the lessons we learned from the success of our road safety efforts.

[*Translation*]

In a 2001 UNICEF Report on Canada, our country ranked 18th out of the 26 OECD countries that reported child injury death rates. We should turn to the leaders in the international community in order to learn about the best practices that have contributed to their low injury rates.

[*English*]

We already know much about many interventions that have been proven to work and are cost-effective. For example, reducing the speed of traffic in some circumstances can reduce the frequency of motor vehicle collisions. Wearing seat belts reduces the risk of injury for those collisions that do occur. I have two other examples drawn from the United States. Every dollar invested in installing and maintaining residential smoke alarms provides overall savings estimated at $65. Every dollar spent on child restraints and bicycle helmets can save nearly $30.

We must also, however, anticipate the challenges that face us in coming years. For example, by 2031, as baby boomers age, older adults will account for almost a quarter of the population, and direct health care costs for fall-related injuries in this population are projected at $4.4 billion. This is more than double the $2 billion cost of these falls in 2004, when only 13% of the population was older than 65.

What are we doing about this at the Public Health Agency?

First, let's recognize that injury prevention is not just a health issue. Preventing injury is a responsibility for many in different sectors, in numerous federal departments, and in all levels of government. I'll name just a few examples of federal actors outside the health portfolio: Transport Canada, with a key role in road safety; the National Research Council, which sets building codes and safety standards; and Labour Canada, which plays an important part in workplace safety. Provinces and territories are heavily engaged on many fronts, and several provinces and territorial governments have adopted injury reduction strategies in recent years.

There are also many non-governmental organizations engaged in injury prevention. Some, like Safe Kids Canada, represented here today, are fully dedicated to the issue. Others, like the Canadian Agricultural Safety Association, focus on specific areas of injury prevention. And still others, like the Canadian Red Cross and the Canadian Pediatric Society, include safety and injury prevention as one of the elements in their mandate.

How does the Public Health Agency fit in?

● (1110)

[*Translation*]

We see ourselves as an agent of change. We have access to a multi-faceted approach to surveillance and data collection, knowledge development and dissemination, as well as collaboration and coordination. I will explain each of these in detail.

[*English*]

Surveillance is the ongoing, systematic use of routinely collected health data to inform and guide timely public health action. The Public Health Agency of Canada uses data from a variety of sources to profile injuries. In addition, we gather data from two of our own programs: the Canadian incidence study of reported child abuse and neglect, and the Canadian hospitals injury reporting and prevention program, a computerized information system that collects and analyzes data on injuries to people, mainly children, who are seen at emergency rooms in eleven pediatric hospitals and four general hospitals in Canada.

The agency acts as a centre of expertise for knowledge development and dissemination on certain issues, and we develop and disseminate this knowledge to a wide range of audiences, from professionals and policy-makers to individual Canadians. For example, our Division of Aging and Seniors provides advice and support for policy development and conducts and supports research and education activities to reduce the number and severity of falls.

The agency provides support to and participates in the Public Health Network, of which I'm sure you've heard before from Dr. Butler-Jones; it is the network established by federal, provincial, and territorial governments following SARS to be a vehicle for different levels of government and experts to work together to improve public health. We have under PHN an expert group on chronic disease and injury prevention, which does a great deal of work in building the knowledge base, facilitating prevention efforts, strengthening capacity, and monitoring and evaluating.

[*Translation*]

Along with the work being done by the FPT bodies, the Public Health Agency of Canada plays a role in convening stakeholders from outside the government.

For example, in 2009, the Public Health Agency of Canada co-hosted an Injury Prevention Stakeholder Workshop, which was attended by 50 high-level leaders representing various levels of government and other sectors. The workshop resulted in the creation of a series of recommendations on how all parties could work together on collective efforts.

● (1115)

[*English*]

Thank you.

We would be pleased to respond to your questions.

**The Chair:** Thank you very much.

Now we'll go to Athana Mentzelopoulos, from the Department of Health.

**Ms. Athana Mentzelopoulos (Director General, Consumer Product Safety Directorate, Department of Health):** Thank you, Madam Chair, for the opportunity to appear today to discuss the consumer product safety-related aspects of the Public Health Agency's "Child and Youth Injury in Review, 2009 Edition".

As you said, my name is Athana Mentzelopoulos. I'm director general of the Consumer Product Safety Directorate at Health Canada, and I'm accompanied today by Denis Roy. He is a mechanical engineer who works in the mechanical and electrical hazards division of my directorate.

The "Child and Youth Injury in Review" is an important publication for those who work in product safety. It helps to increase the public's awareness of the dangers that consumer products can pose, and it has helped us in our ongoing efforts to make products, and particularly children's products, safe.

Any product can pose a risk if it is used inappropriately. No doubt you have heard this truism in a variety of forms. Water, for example, is essential for life, but drinking a profound volume of water can be fatal. Equally so, no product can substitute for a parent or a caregiver.

In my area of work, one of our ongoing priorities is to inform consumers about the appropriate use of products. It is essential to follow manufacturers' instructions for use, for example. We also routinely issue reminders about safe use of and practices related to consumer products, and we frequently advise consumers about risks posed by consumer products, either as a result of their normal use or because of unseen or unintentional hazards.

Some recent examples of our work have been the series of warnings we have issued about the presence of lead and more recently of cadmium in children's jewellery. We have also continued to remind Canadians about safe sleep practices for infants, including the need to ensure that infants sleep in a crib that has been properly assembled and is free of bumper pads, pillows, and other decorations.

In the Consumer Product Safety Directorate, we regulate certain products and classes of products, and wherever we cannot sufficiently address and mitigate a risk through regulations, we have prohibitions. This is the case for, among other things, toys.

In Canada, safety requirements for toys are currently specified in the Hazardous Products Act and its associated regulations. Under this act, certain toys are prohibited, while others are restricted. There are requirements concerning the size of component parts of toys, allowable stuffing materials, and limits on the presence of lead and toxic substances, among other requirements.

It is the responsibility of manufacturers, importers, distributors, and retailers to ensure that they are complying with the Hazardous Products Act and the regulations. Product safety officers routinely monitor the marketplace and take appropriate enforcement action on toys and other products that contravene the legislation. We also have a laboratory, the product safety laboratory, that examines potentially hazardous products in order to assess the nature and degree of any hazards.

In our work on product safety we are attentive to the normal and foreseeable use of products. We consider dangers posed by consumer products to be those unreasonable hazards that are posed by a product during or as a result of its normal or foreseeable use and that might cause injury or death. There is a reasonableness standard that must be adhered to and that guides our work.

As many members here today know, Health Canada is currently proposing to change the legislative framework for consumer product safety. That legislation is now before a Senate committee.

As I mentioned, we currently work in the context of the Hazardous Products Act. That legislation is 40 years old and is a framework that only permits us to react to risks and hazards as they emerge through the preparation of regulations and prohibitions.

On the basis of this legislation, we have developed specific and very prescriptive regulations for toys, a prohibition on baby walkers, regulations for cribs and cradles, limits on the use of lead in children's products, requirements for teethers and rattles, and a prohibition on yo-yo balls, among many other things. All of these regulations and prohibitions will be transferred to the Canada Consumer Product Safety Act, should it pass, and the level of protection they afford will be maintained.

The proposed Canada Consumer Product Safety Act—the CCPSA—will fundamentally change and improve the way we approach product safety in Canada. Bill C-36, the CCPSA, includes a number of elements that will help us to further strengthen consumer safety. It has a general prohibition against consumer products that are a danger to human health or safety. It would also require industry to report product-related incidents and would give the government the authority for mandatory recalls. That's something I know members here are very familiar with.

● (1120)

These authorities all support a three-pillar approach to product safety: active prevention, targeted oversight, and rapid response. These are essential pillars to our program, because we have a post-market regulatory regime for consumer products in Canada. That means there is no requirement for certification or for approvals by government for industry before they introduce new products to the market.

We need the tools in the CCPSA so that we can generate product-related intelligence that will be the basis of an early warning system when problems with the product emerge. In the future, should the CCPSA pass, we will be able to act quickly and proactively at the first signs of emerging product-related problems. Rather than necessarily going through the process of developing regulations to deal with product-specific hazards, we will be able to use the general prohibition as part of our step-wise enforcement to act quickly when we have determined that a danger to human health or safety exists.

Given the post-market nature of the consumer product market, the rapid innovation in consumer products, and the insatiable desire for new products and new design, work in product safety is never done. The CCPSA is one element of the government's food and consumer safety action plan. Through that plan, we have also been resourced for more inspectors, more outreach work to consumers and industry, and more work in the area of standards development. Through its elements, the food and consumer safety action plan is building a consumer product partnership in which industry is more aware of its obligations for safe products, consumers have more information about the products they are purchasing, and government has more flexible and modern powers to help ensure safety.

The Hazardous Products Act has served us well over recent decades of work. We have a significant body of regulations and prohibitions, and we also have an aggressive work agenda for modernizing some of those regulations and for developing new ones.

Just yesterday, our minister announced new changes to regulations under the act that will restrict the amount of lead in a variety of consumer products, including children's toys. We are also currently involved in a project with the United States and the EU, and more recently Australia has joined, to improve safety standards for corded window coverings. Our requirements in Canada for these products are already among the strictest in the world, but we are working with our international partners to address certain hazards posed by Roman shades and by roll-up blinds.

We also have ongoing initiatives to improve our toy regulations, including dangers posed by small, powerful magnets; to address infant bath seats, potentially to regulate them; to improve our already world-leading regulations for cribs, cradles, and bassinets; and to review potential standards for ski helmets. Most of all, we are looking forward to the passage of the Canada Consumer Product Safety Act and to the changes the legislation will bring to product safety in Canada. We are hopeful that our focus will soon turn to implementation of that legislation.

Thank you, Madam Chair.

**The Chair:** Thank you.

We'll now go to Pamela Fuselli.

**Ms. Pamela Fuselli (Executive Director, Safe Kids Canada):** Thank you for the opportunity to speak today and to share Safe Kids Canada's views on injury prevention, focusing on our area of expertise: children and youth. We're extremely pleased to see that the committee on health is undertaking a study on this important public health issue.

Our vision is fewer injuries, healthier children, a safer Canada. Our mandate is to lead and inspire a culture of safety through the implementation of evidence-based strategies, healthy public policy, and education.

In Canada, unintentional injury remains the leading cause of death among children ages one to 14, more than any other cause. The top causes of death for Canadian children and youth are largely preventable. These include motor vehicle crashes, threats to breathing, drowning, pedestrian injuries, poisoning, falls, and a multitude of injuries in homes.

The numbers are revealing. In 2004, the latest year for which this information is available, unintentional injuries for all ages cost Canada's health care system approximately $19.8 billion in direct system and in direct costs annually. Approximately $4 billion are specifically related to unintentional injuries in children and youth.

On average, the equivalent of one classroom per month of children aged 14 and under are killed in Canada each year, another 60 are hospitalized for serious injury each day, and hundreds of thousands are seen in emergency departments every year.

The prevalence of injuries in Canada is alarming, and this number is staggering, yet consider that many experts believe that these numbers significantly underreport the true burden. Some estimate that five to ten times that number of children and youth suffer severe trauma and preventable injuries every year.

Injuries are not acts of fate or accidents. They do not have to happen. The majority of injuries are predictable and preventable. Bumps and scrapes may be a part of childhood, but serious injury resulting in death or lifelong disability is something that no child and their family should have to bear. Many of those who survive serious injury are left with disabilities, both physical and emotional. This stress on the child and their family and the community cannot be underestimated. Lost time at school for children and at work for their parents is just the tip of the iceberg.

In 2007 the World Health Organization strongly recommended its member countries develop and implement national injury prevention strategies. Canada can become an international leader in injury prevention. On March 3, 2010, in the Speech from the Throne, then Governor General Michaëlle Jean read the following statement:

> To prevent accidents that harm our children and youth, our Government will also work in partnership with non-governmental organizations to launch a national strategy on childhood injury prevention.

Safe Kids Canada issued a media release encouraging this commitment to strategic action. This announcement was an important first step for the Government of Canada, and it lays the critical foundation for achieving progress in one of the most pressing health issues faced by our country, but more action is needed.

Health professionals, researchers, private sector leaders, not-for-profit organizations, and Canadian families have long awaited a coordinated approach that mobilizes their collective experience and knowledge to prevent the devastating lifelong changes that injuries place on children every day in this country.

In order to accomplish a substantial reduction in preventable injuries and loss of life due to injury among Canadian children and youth, Safe Kids Canada calls for the establishment of a national injury prevention strategy, a strategy that must include surveillance, measurement, leadership, adoption of healthy public policy, educational activities, and environmental changes.

The public health network's injury prevention and control task group, of which we are a member, developed a vision statement to frame and guide its work, which included the following: we see a Canada where injury is understood to be predictable and preventable, where governments, business leaders, and academics work together to ensure healthy public policy, enhance community capacity, support individual skills, and take all appropriate action to reduce the likelihood of injury and death; we see a Canada where an injury-causing event, when one occurs, is not dismissed as fate but seen as an important opportunity to learn, where important new knowledge and best practices for prevention are generated and translated into effective action; we see a Canada that enjoys the lowest rates of injury of any nation in the world.

● (1125)

Canada's children and youth do not enjoy the health that Canada is capable of providing. Injury is not seen as an indicator of child health, as it should be. Comparative data with other countries suggest that market improvement is both achievable and necessary. Canada ranks 18th out of 26 international OECD countries in terms of injury and mortality for children and youth. There's an urgent need for a strategic approach to injury prevention in Canada.

I will conclude with one final thought from a recent report issued by the Canadian Institutes of Health Research. In Canada there are more than five million women of child-bearing age, and their children will add to the eight million children and youth in Canada who represent the future of our country. An implemented national strategy can keep the future of Canada safe.

Thank you.

**The Chair:** Thank you very much.

We'll now go into our first round of Qs and As for seven minutes. We'll start with Dr. Duncan.

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

I'm really concerned about suicide in first nations and in our Inuit youth. I'm wondering, what is the actual rate per hundred?

**Ms. Jane Billings:** We brought large tables of stats, so we'll just look that up.

● (1130)

**Ms. Kirsty Duncan:** Well, maybe I'll go on. What's the last year we have data for?

**Mr. Sylvain Segard (Director General, Centre for Health Promotion, Public Health Agency of Canada):** That would be 2004.

**Ms. Kirsty Duncan:** So 2004, for tracking suicide in first nations and Inuit...?

How do the rates compare internationally? I know the World Health Organization has been concerned about suicide in our communities.

**Ms. Jane Billings:** The suicide rates for our aboriginal youth, especially on reserve, are significantly higher than those in the rest of Canada and also of other countries. It is not a story we're proud of.

We're working actively with the First Nations and Inuit Health Branch in Health Canada. We're working actively from the Public Health Agency with them on interventions and programs that may work, that may help to bring down the suicide rates. There have been some very successful examples, largely by giving the youth hope, by improving the governance in the communities, by giving them a future and alternatives. But it is not a short process.

**Ms. Kirsty Duncan:** No. Perhaps you could table with the committee what the actual rates are.

How long have we known that suicide was higher in these communities? When did we actually know this? And how long have we been tracking this information?

**Ms. Jane Billings:** That's information that we'll have to get from the First Nations and Inuit Health Branch. We've been tracking, though, for at least a decade. And we've known it's been higher for some years, for that point in time. But we can get you the exact dates from FNIHB.

**Ms. Kirsty Duncan:** Okay. I'm concerned that we don't have anything past 2004, when this is such a serious problem.

Could you table with this committee all programs that have been developed to specifically target reducing suicide in communities, and against that, how suicide...? Is it increasing? Is it decreasing? How is it changing? And then, what have we invested, and where? I guess I want to know where, going forward, these investments have to be made in order to get real change.

**Ms. Jane Billings:** The First Nations and Inuit Health Branch has a very significant program directed towards aboriginal suicide and health promotion among aboriginal youth. So we will provide you with the information on that program.

**Ms. Kirsty Duncan:** Thank you.

I'm wondering if I could ask Ms. Fuselli what the leading causes are of unintentional injuries in youth adolescents in Canada and how this data compares internationally.

**Ms. Pamela Fuselli:** The leading causes of death to children and youth in Canada.... We're talking about under 14 years with this data set. Drowning is the leading cause, then motor vehicle crashes, followed by suffocation. And they're fairly close: drowning, 15%; motor vehicle, 14%; and suffocation, 13%. In terms of hospitalization, falls are the overwhelming cause of hospitalization for children and youth: 37% of hospitalizations.

**Ms. Kirsty Duncan:** What would be your top three recommendations to reduce drowning?

**Ms. Pamela Fuselli:** For drowning, you have to look at the different age groups for very young children. Bathtubs are the location where we see a lot of the drownings happening, so it's supervision and educating parents that not even for a second can they leave the room to answer a phone or grab a towel. The use of bath seats provides a false sense of security, so it's not to use those as a device, if at all; people put their children in bath seats and feel like they can run out for just a second, when in fact that's not the case.

For older kids, it's backyard pools, especially in urban areas. The best evidence that we have from research right now is for four-sided pool fencing with a self-closing, self-latching gate. What that means is that the home currently, in most bylaw,s forms the fourth side of the pool enclosure, which means that any children living or visiting those homes can gain access to the pool because there is no fence between the house and the pool with a gate. The scenario that we see most often is children drowning in their backyard pools when they're not meant to be swimming, so this isn't during a swimming event generally. They're gaining access to the pool from the home.

● (1135)

**Ms. Kirsty Duncan:** What federal action would you like to see to help reduce drownings in this country?

**Ms. Pamela Fuselli:** I would like to see a comprehensive four-sided pool fencing bylaw across the country. We have sporadic bylaws, municipal and provincial, at this point, but I would like something that's comprehensive and standard across the country. Certainly, education around the priority that drowning is one of the leading causes of death.... I don't think most people know that.

**Ms. Kirsty Duncan:** Education is provincial, but swimming used to be a pretty significant part of grade 3 education, for example. I consider it one of the life skills. How do you feel about teaching swimming as a life skill?

**Ms. Pamela Fuselli:** I think it's part of that comprehensive approach. I think both parents and children should know how to swim. Parents should actively supervise the fences, obviously, which is a big intervention that works. Also, knowing how to get emergency care if something occurs.... We call it layers of protection, so you have a number of these different mechanisms in place to reduce drowning.

**The Chair:** Thank you.

With the permission of the committee, can I just ask a question?

Ms. Fuselli, you were talking about fencing around a pool. From what I understand, in some—well, in most—provinces and municipalities, they have a regulation where you have to have a six-foot fence around the pool. I'm talking about my province of Manitoba. It might be different in other provinces. That is my first comment.

**Ms. Pamela Fuselli:** Most bylaws or provincial laws are for only three-sided.... It's not four-sided pool fencing. When you look at the legislation, it actually is the pool enclosure, but the house can form the fourth side of that enclosure.

**The Chair:** I see. Thank you.

We'll go on to Monsieur Dufour.

[*Translation*]

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

I wish to thank the witnesses for their presence here today.

Ms. Billings, in the beginning of your presentation, you said that in consideration of the aging baby boomers, health care costs are projected at $4.4 billion.

First of all, do you think that the government is aware of these expenses and that it has the means to handle them?

Furthermore, have measures been taken not only to prepare for the aging population but also to reduce the number of injuries by the elderly?

**Ms. Jane Billings:** Thank you for your question.

The expenses you speak of concern all levels of government in Canada. As everyone knows, hospitalization and health expenses are the governmental expenses with the fastest increase.

[*English*]

I think it's fair to say that no governments are ready for this type of increase in costs, and therefore it's very important that we continue to do what we can to prepare, through education, training, and prevention of injury, as we go forward.

As Pamela said, injuries are preventable. They're not accidents, so the more we can, through education methods and training, prevent these costs and prevent injuries, the better off we are for the individuals and for the system.

With respect to what we're doing now, the Chief Public Health Officer's report for 2010, which just came out a month ago, deals with aging. In the report, there is quite a lot with respect to how we should be looking at preventing falls and preventing injuries among seniors. It also addresses the whole spectrum of the aging population and how we should be looking toward aging in a healthy fashion and keeping our elderly in much better shape as we go forward. It's a very good report. We hope it gets the coverage it deserves. Thank you for the question.

● (1140)

[*Translation*]

**Mr. Nicolas Dufour:** Thank you very much. This subject is becoming increasingly important. Take the people in my riding as an example. The aging of the population has been duly observed. It is the same situation all over Canada.

In your opinion, do concrete measures exist to reduce the rate of injury in the elderly?

**Ms. Jane Billings:** Absolutely. Concrete measures include, for example, providing information on fall prevention in the home and on vision improvement for the elderly.

[*English*]

Key among the elderly are falls, either falls outside or inside the house. It's ironic, though, that as people get older, they don't see as well. When they don't see as well, they fall. They don't see the obstacles either in the house or outside the house. Within the house, we're working with non-profit organizations on education on how to make environments safe for seniors, to ensure they have the aids: handles in the hallways; up the stairs; help to get out of bathtubs; age-friendly showers, for example. And how to take care outside—the icy sidewalks we have at the moment are not good for seniors.

I think a lot of the literature shows that once somebody has a fall, especially when they're in their seventies or eighties, and they break a hip, it's pretty much downhill from there.

It's extremely important to take these measures and to get the information out. The annual report that Dr. David Butler-Jones has released does have a section on concrete measures that we need to take collectively—governments, individuals, organizations, and the various environments we live and work in—to help keep seniors safe.

[*Translation*]

**Mr. Nicolas Dufour:** Thank you.

There was one aspect of your response that I found particularly interesting: the desire to have these aging individuals remain in their homes. It is a matter of ensuring that there are no problems in their place of residence and encouraging them to live at home.

I will now address the child injury death rates. With this respect, Canada is ranked 18th among the 26 OECD countries.

Who is ranked highest among these 26 countries? Do channels exist in which we can communicate and share with these leaders in order to observe what they have done right and try to emulate it ourselves in the future?

**Ms. Jane Billings:** It is a disgrace that 17 countries surpass us in terms of injury prevention. Incidentally, injury rates in Canada have dropped by 40 percent since 1980; this shows that we have made improvements. The other countries, however, are still better.

At the Agency, we are studying the approaches implemented by the other countries, the majority of which are European. Nordic countries, for example, have implemented more dynamic methods. Our territory presents a problem that is particular to us. The injury rate in the North is higher. If we did not take this into consideration, our position would have been more favourable.

● (1145)

**Mr. Nicolas Dufour:** So the communities from the North have clouded the issue. Do you have any numbers that do not take into account the Northern community?

[*English*]

**The Chair:** Monsieur Dufour, you must pay attention to the chair. Your time is up.

[*Translation*]

**Mr. Nicolas Dufour:** As you know, Madam Chair, I have many questions.

Can she answer quickly?

[*English*]

**The Chair:** There you go. I know, Monsieur Dufour, but right now you're finished.

Now we'll go to Ms. Leslie.

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

Thank you all for being here today.

My first question is picking up a bit on what Ms. Duncan was talking about, but suicide generally, not only in first nations and Inuit communities. We know that suicide is a significant form of intentional injury in Canada, particularly for first nations and Inuit Canadians, but also for youth. Then we also see links with a rising rate of suicide with seniors and suicide with gay/lesbian and transgender youth.

There isn't a national strategy to address suicide, as far as I know. We've been looking. So I'm wondering, is the government considering one? If yes, tell us about it. I'd be excited. If no, why not? I know a lot of community groups, a lot of civil society groups, have been saying this is what we need. We need a coordinated approach.

**Ms. Jane Billings:** I think we agree with you totally in that regard. However, the Mental Health Commission is working on its overall strategy. My understanding is that it will include a large element on a suicide strategy. So we're working with them.

**Ms. Megan Leslie:** Can I ask you about that? I know the Mental Health Commission.... Suicide is only a line in their mandate. It doesn't seem to be a big focus of what the commission is doing. I'm interested to hear about this, that they're actually taking on the suicide piece.

**Ms. Jane Billings:** My understanding is that we're supporting them in what they are doing. We, of course, do a lot of work with respect to the surveillance that...as we've noted, our data is a little out of date at this point—the surveillance, the analysis, the evidence, the interventions—but overall, we're really looking to the Mental Health Commission in that regard.

**Ms. Megan Leslie:** Can you tell me if they're tackling it broadly, or if they're targeting specific groups like youth or first nations? Do you have that information?

**Ms. Jane Billings:** I can't answer that.

Sylvain, would you?

**Mr. Sylvain Segard:** We've been maintaining contact with the commission on a regular basis and have encouraged them to take a broad look at the issue of suicide prevention by thinking about all the protective and prevention factors that should be considered. Instead of directing their attention strictly at suicide-related causes and focusing on a suicide response, it is part of the equation and it requires consideration of a variety of tools and initiatives. To have a comprehensive approach to mental health in Canada, to have suicide lines and counselling and the proper framework in the school environment and other environments so that our kids grow up healthy and understand how to recognize mental health, mental wellness, and so on, they are looking at a more comprehensive package.

I couldn't answer specifically whether or not they're looking at a specific aspect of suicide, or a breakdown for a targeted group. That's a question that perhaps you would want to ask them in due time.

**Ms. Megan Leslie:** We look forward to it. Thanks. Canadians around the country will be excited to know about that.

With the surveillance system you talked about, you said that you're routinely collecting health data to inform and guide timely public health action. I'd like to hear more about what that system looks like, what kind of information you're collecting, and I would specifically also like to know if you're collecting segregated or—I don't know the right word—delineated information about specific groups. For example, people living in poverty are at much higher risk of injury, as we've heard a few times. People living on reserve are at much higher risk. So I am wondering how the information is organized, I guess.

**Ms. Jane Billings:** The committee on several occasions has posed questions to us on our surveillance system, which is the accumulation of many different sources of information. Some we gather, some of it other organizations gather, and some Statistics Canada gathers, either on their own or on our behalf.

In some of the injury prevention information, we have these cards. We have a lot of information on various causes of death—by sex, age group, and injury. We also have some data on the various income classes, and that largely comes from Stats Canada.

We use and analyze data from StatsCan on mortality. From the Canadian Institute for Health Information, we have hospitalization data. We also gather information from the Canadian Red Cross—for example, we get our drowning information from them.

We have a system—the Canadian hospitals injury reporting and prevention program—from which we gather information. We support that program. On the family front, we also have the Canadian incidence study of reported child abuse and neglect.

So we work with StatsCan, with CIHI, and with Canadian coroners and medical examiners. All of them support us on the Canadian coroner and medical examiner database, which we also go into.

So we really gather data from just about everywhere we can, and in some cases we support the gathering of these data directly.

● (1150)

**Ms. Megan Leslie:** Do you feel that your sources are comprehensive enough, or are there gaps you're looking to fill?

**Ms. Jane Billings:** Every time we do some analysis or try to answer questions like the ones posed to us today, we find that there are gaps in some of the striations, some of the geographical spread, and in some of the timeliness. In an ideal world, we would be able to collect uniform data that would be comparable across the country.

Surveillance and the adequacy of data are a key support in the ability of the public health network, and the expert group under it, to prepare analyses, compare Canada with other countries, design workable interventions, and gather evidence to evaluate our work. Surveillance is a challenge throughout the organization, and we work every day to make it better.

**The Chair:** Thank you, Ms. Billings.

Ms. McLeod.

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

I would like to pick up on my colleague's line of questioning as it relates to surveillance. In this day and age of computerization, if you looked at the hospital injury reporting system—and that's from eleven pediatric hospitals and four general hospitals— I would think some of our small, rural hospitals that are servicing our north might provide a whole new dimension of data.

Are our provinces streaming into one system that they will feed federally? Are our public health units feeding into the provincial system, so that provinces are getting a pretty good perspective on what's going on? Can you talk a little more about that?

**Ms. Jane Billings:** I'd be pleased to.

The collection of uniform data across the country is still in the development stage. The Canadian government, along with the provinces, has invested a large amount of money in the development of electronic health records. The provinces and territories, together with our agency, are working on a system called Panorama, which CIHI has supported to the tune of about $100 million so far. That system is ready to go in some provinces. It will facilitate the uniform gathering of health records, which would allow much better transferability of information and much better management of patient files. It would also allow provinces, territories, and the federal government to get that direct information. But it's some years away.

I think B.C. is ready to test a pilot and their new modules. We're working with them on the steering committee looking at standardization development—what the needs are, what the various modules are—but it's not there yet.

Each province and territory is a little different, and they each have some pluses and minuses in what they're able to gather.

● (1155)

**Mrs. Cathy McLeod:** So if where we're going will probably be electronic medical summaries, will data from hospitals feed into Panorama? Is that part of the concept?

**Ms. Jane Billings:** That's part of it.

**Mrs. Cathy McLeod:** And specific data around injuries and ages—

**Ms. Jane Billings:** Right.

**Ms. Cathy McLeod:** So ultimately there is a vision of an electronic solution to surveillance.

**Ms. Jane Billings:** There is absolutely a vision. But the complexity of implementation is enormous because this means that individual doctors' offices and all the individual hospitals are really going to have to change how they keep records.

It doesn't sound that difficult, especially since many of our doctors are in the information age, but in fact the transformation and the cultural change is very demanding.

**Mrs. Cathy McLeod:** I think we've done a remarkable job in terms of moving forward in areas like car seats, in terms of cribs and putting your baby to sleep. I think we've done lots of great work. I think we're doing some good work in terms of falls with the elderly.

Of course, I live in the middle of the mountains, and I also live in more rural and northern communities. We've made good progress in some of the easier areas, but I look at the 14-year-olds in my community hurtling down the mountains on their mountain bikes and into the parks. We talked about injuries all being preventable, but I don't know. There are some sports with some inherent risks, and I think mountain biking is probably one of the bigger ones.

Do we really focus on some other areas, recognizing there are probably going to be some injuries we're going to be able to impact less in terms of rates?

I don't know who could answer that one...maybe Pamela.

**Ms. Pamela Fuselli:** You're right, there is a variation in terms of risky activities that people can undertake.

There are ways to mitigate the serious injuries. When I talked about bumps and bruises and scrapes and things like that, that's not the type of injury we're interested in mitigating. It's the life-threatening, life-long disabling types of injuries.

So even with the mountain bikers going down the mountains wearing the correct gear and knowing the terrain and where they're going over that next hill, there are definitely steps that can be taken so they can still engage in those types of activities but do it in a safe way, and perhaps if they do fall—

**Ms. Cathy McLeod:** Safer.

**Ms. Pamela Fuselli:** Safer. So they fall off the bike, but they're wearing a helmet or they're wearing the right gear for whatever sport they're engaged in.

We have made good strides in terms of car seats, but motor vehicle crashes with child passengers remains one of the top three causes of death in Canada. We still have a lot of work to do in terms of getting those known, effective interventions embedded in the Canadian culture.

One of the things we want to do more of in terms of the at-risk populations, like those living in the north, is to learn...because obviously a car seat on a snowmobile is not the right intervention. What we don't know is what does work up there.

So it's what does work, what protective things are those communities already engaging in, and what can we evaluate and engage with them in recommending for those communities? We know they're probably doing things that are keeping their children safe; we just don't know about them, or they haven't been evaluated. There's lots of work still to be done.

**Mrs. Cathy McLeod:** Okay. If I have another quick second, when we were looking at our comparison with other countries, I think they used the word “aggressive”—aggressive strategies.

Perhaps you could talk a little more about what aggressive strategies these countries are using, and in terms of north versus the rest of Canada.

**Mr. Sylvain Segard:** I guess what's aggressive to one may be modest to another. But what we have to understand is that in the Canadian context, as a federation and with the separation of responsibilities, our ability to have a comprehensive—call it aggressive—or effective approach requires collaboration amongst many sectors. In a recent workshop that PHAC sponsored, bringing together representatives from provinces and all sectors of the injury prevention area, it was concluded that in the Canadian context, to be fully effective, it will require coordination of messaging, loose coordination of a cohesive response, and similar objectives and priorities so that we can make a concerted effort in given areas and slowly chip away at it.

That being said, I think as Madam Billings pointed out, the summation of the efforts that Canada has made over the last 30 years has been quite spectacular in reducing the injury rates overall. Are we the best? Not yet, and we have much, much more work to do, but we're definitely trending in the right direction on many injury types.

So I think we can.... Through initiatives like the PHN's review and work collaborations with the provinces, this group on injury prevention has looked at what other countries are doing and is trying to extract the best practice from other countries and see how we might adapt them to a Canadian context.

● (1200)

**The Chair:** Thank you, Mr. Segard.

We'll now go to our second round.

Five minutes, starting with Dr. Dhalla.

**Ms. Ruby Dhalla (Brampton—Springdale, Lib.):** Thank you very much for your most interesting presentation.

I wanted to touch upon something that my colleague, Megan, spoke about, an issue that became very personal in our constituency. We had a young woman by the name of Nadia Kajouji, who my colleagues around the table may know of, and perhaps you have heard of, who committed suicide. She was a student here at the University of Ottawa. Her brother, Marc, in her memory, subsequently got involved with a great organization called Your Life Counts, which was founded by Rory Butler. They've done tremendous work trying to reach out to young Canadians, helping them change self-destructive and addictive behaviours.

We've had a chance to meet many, many times with them. They've come forward and presented to an all-party committee as well, and some of the stats they provide are alarming. There are youth 15 to 24 years of age who are dying daily. They found from their research that there is a young person dying almost every 90 minutes, and in an entire year in North America they identify almost a million young kids who are committing suicide.

So when you take a look at all of those stats, and you realize that suicide has become the second leading cause of death amongst youth, it is quite surprising that we don't have a national suicide prevention strategy. And in talking to organizations like Your Life Counts and the tremendous work they're doing, it is also disheartening to hear that they have no funding and no support and no resources being provided.

Now on the question that my colleague had asked, you said that the Mental Health Commission was in the process of developing...is it a support mechanism? Is it a national prevention strategy? How is your particular organization with the Public Health Agency of Canada going to be involved? Is the work that the Mental Health Commission is doing going to provide a national strategy? Is there going to be funding put in place? Are there going to be support and resources? And lastly, can organizations such as Your Life Counts expect some coordination or collaboration with government to continue on the great work they're doing?

**Ms. Jane Billings:** Thank you. I'll answer the latter part of the question first, if I may.

At the moment, I don't think we're dealing with Your Life Counts. We run a number of contribution programs and we do fund organizations, not for their core funding as a rule, but to do research in areas that are of mutual interest.

Most recently, we have asked for proposals from a number of NGOs like Safe Kids Canada, ThinkFirst foundation, SMARTRISK foundation, and the Canadian Agricultural Safety Association, in terms of specific areas in which there are some gaps. For example, we have asked Safe Kids Canada if they would be interested in adapting some of the European child safety guidelines to be used in Canada. We've been in conversation with them about that. In addition, at our workshop last December, we drew together about 50 different people from different organizations, territories, provinces, and educational organizations to really kick-start some of the discussion on what needs to be done overall on injury prevention, including suicide.

At this point, it's premature for us to know what exactly the Mental Health Commission is going to do in framing suicide within its overall mental health strategy. As Sylvain said, we are in communication with them and working with them. We are very hopeful that when they do come out with their strategy, it will have an articulated national suicide element and it will be put forward to the government to see whether there are funding needs. But at this point, it would be premature for us to answer on their behalf.

● (1205)

**Ms. Ruby Dhalla:** So where would organizations like this go within government to be able to get funding and resources and some mechanism of support for the actual delivery of services? You are saying that you guys focus only on research, which is great, but for a young person who is even in contemplation, you can have all the stats and the research in the world, but they're going to need tools to gain back either the self-confidence or empowerment or whatever the case may be to help them not make that wrong decision.

**Ms. Jane Billings:** At the federal level we focus on surveillance, knowledge development and transfer, support for research, filling the gaps, and working on the leadership role with the provinces and territories.

The actual service provision is at the provincial level and often the municipal level, so we'd encourage organizations to go through every door they can find, and to come to us if there are areas of interest for which they want to work up some best practices, but likely to go to other levels of government for actual funding support for the service delivery, such as youth help lines and those types of things. We might well be interested at some point in working on some of the tools, seeing what works in other countries and what they might be looking at, and also giving you the evidence.

**The Chair:** Thank you very much.

Ms. Davidson.

**Mrs. Patricia Davidson (Sarnia—Lambton, CPC):** Thank you to our witnesses here today. Certainly this is an extremely important and interesting topic that we're looking at this morning. I appreciate you being here to bring us the perspective that you have.

I was interested to hear in the opening remarks, and I think it was referred to by a couple of you, that among the OECD countries, 17 are doing better than we are. Certainly I agree with you that that does not make us feel very good, and we certainly need to be doing better.

We've also heard this morning that we're using 2004 data, I believe. That data is six years old now. So I have a couple of questions surrounding that. Are the other countries that we're being compared to using 2004 data? What stats are they using? Do you think that data is in any way reflecting the reality that is out there today? Or is the situation in fact better or worse than what it might have been in 2004?

**Ms. Jane Billings:** Our data is from 2004-05. Much of it circles around the census, so that we are linked to that type of cyclical information. I would be guessing to say which way it was going, but it would be based on these different little bits and pieces that we get in. We're hopeful it's gone down.

There's been a huge effort through organizations like Pamela's and other organizations, and some coordination among the provinces and territories, to bring this down. The regulations have also been tightened up virtually across the country on car seats and boosters so that bigger children are now in boosters. There has been much done in terms of education about car seat safety. In many cases of car accidents, the children might have been in car seats but those weren't installed properly. So there's been much education there.

There has been a great deal of education around water safety in recent years. There has been a large emphasis on bicycle helmets and safety for those types of things. We still see trampolines in our neighbours' backyards, which gives me a certain worry. I don't think I would go that direction myself as a parent. But my sense is that we probably are improving because there have been many steps taken. In addition, Athana talked about the improved regulations on product safety and consumer safety that are coming into place.

● (1210)

**Mrs. Patricia Davidson:** Do you have any sense of what era of data the other countries might be using that we are being compared to?

**Ms. Jane Billings:** Most of them use census data as well.

**Mrs. Patricia Davidson:** You've talked quite a bit about some of the successful initiatives. We've talked about car seats and bike helmets and those types of things and the product safety legislation.

Are there other things, or could you elaborate any more on those? Ms. Fuselli, from your perspective, what do you see as successful initiatives?

**Ms. Pamela Fuselli:** I think we have seen successful initiatives in and around some of those leading causes of death. There is always more to be done. In the case of booster seats, three provinces still don't have booster seat legislation. We're now seeing some evaluation from the provinces that do have legislation that has been in place for a couple of years as to the difference in the injury rates for that population.

We know when we address in a strategic way environmental initiatives, education, and enforcement, if it is by legislation or standard, those are the types of areas where we see injuries starting to be reduced. When there is that attention, the priority, the funding and resources put to it, we start to see the numbers decrease.

We also have to be careful with pedestrian injuries. We see the numbers going down, but we know that may also be an exposure difference. If people aren't walking as much, we are then seeing pedestrian injuries reduced but not for a good reason. That's why injury needs to be linked to a number of different health issues. It needs to be seen in the overall child health picture as an indicator of health. The link of injuries to environmental and mental health, obesity, and nutrition is quite close. Safe Kids Canada has been forging links with organizations like Active & Safe Routes to School, and ParticipACTION, to integrate our messaging with healthy, safe activity. For example, issues like falls still need to be addressed. Falls are the leading cause of hospitalization.

Falls in the home and falls in playgrounds result in an enormous number of injuries. It's a little less concrete, so we need to turn our attention to—

**The Chair:** I'm sorry, Ms. Davidson.

We'll now go to Mr. Dufour.

[*Translation*]

**Mr. Nicolas Dufour:** Thank you, Madam Chair.

Before I begin, I would like to thank Mr. Segard for acknowledging the role of Quebec and other provinces in this matter. This can sometimes be forgotten by some of our colleagues.

Ms. Billings, I would like to continue the discussion on the Northern community. If we did not consider the Northern community in these calculations, where would Canada be on an international scale? Do you have any numbers that would indicate this?

**Mr. Sylvain Segard:** We do not have this data on us at the moment. It is surely possible to try and tell the difference.

One of the main factors distinguishing the Great North is the nature of the activities that people engage in there. Many are related to the work of extracting primary resources. Incidents are linked to these types of activities rather than to ones that occur in urban settings. There will be a notable difference in this respect.

If the committee is interested, we can return with this information at a later time.

**Mr. Nicolas Dufour:** Yes, precisely.

From our discussion, I understand that the problematics exist primarily in the Great North. Therefore, if we are to make a move, if the committee produces a report, it would be very important to note that the actions we take target the Canadian North.

[*English*]

**Ms. Jane Billings:** I think what we indicated was that the rate of injury was higher in the north, and particularly the rate of suicide. Of course, the population is much smaller, so the absolute number of injuries is higher in the south than it is in the north.

It's the rate that's different. Taking those out still isn't enough to move us right up to the top of the pack, but we would certainly move up somewhat.

● (1215)

[*Translation*]

**Mr. Nicolas Dufour:** My next question is for the representatives of Health Canada.

Ms. Mentzelopoulos, you mentioned earlier that you have safety officers for the purpose of monitoring products. How many safety officers do you have altogether?

[*English*]

**Ms. Athana Mentzelopoulos:** I believe I talked about this when we appeared before you on the Canada Consumer Product Safety Act.

[*Translation*]

Currently, we have 46 inspectors, to which we are adding 26 new inspectors thanks to funding from the

[*English*]

food and consumer safety action plan. We are in the middle of the implementation of that plan. At the end of it, we will have doubled the number of inspectors across the country to 90.

[*Translation*]

**Mr. Nicolas Dufour:** I remember very well having discussed this in past committee hearings. That being said, you will understand that, for me, this is important. If we enact a law to ensure that products meet certain standards, we must see to it that officers on the ground make sure that this law is respected. I think that goes without saying.

Do you think that the number of officers we give you is sufficient?

[*English*]

**Ms. Athana Mentzelopoulos:** Yes.

[*Translation*]

**Mr. Nicolas Dufour:** To give us an idea, how many visits or inspections can you give in a year? You can give us a range.

[*English*]

**Ms. Athana Mentzelopoulos:** I would appreciate the opportunity to provide that information to the committee afterwards. I didn't come with that information. My apologies.

[*Translation*]

**Mr. Nicolas Dufour:** Thank you very much.

As did my colleague, Ms. McLeod, a little earlier, I will talk about your "aggressive" plan.

You said earlier that you have "a significant body of regulations and prohibitions" at your disposal, and you added that you have "an aggressive work agenda for modernizing some of those regulations and for developing new ones."

Can you give us an overview of the new regulations you would like to create?

[*English*]

**Ms. Athana Mentzelopoulos:** May I just clarify? Are you speaking in the context of the Canada consumer safety action plan?

[*Translation*]

**Mr. Nicolas Dufour:** Yes.

[*English*]

**Ms. Athana Mentzelopoulos:** With the new legislation, we will have a suite of new tools that we don't currently have with the Hazardous Products Act. They include mandatory recall, which we don't currently have. They include the ability for us to demand tests and studies from industry at the highest levels of trade. We will have a general prohibition that states that industry cannot sell products that pose a hazard. For me, personally, the element that I think holds the most possibility in this context is mandatory reporting of incidents related to consumer products. That will give us intelligence about issues, injuries, and incidents that are happening with products early—soon—before we start to see a larger number of such incidents. And it will give us the information we need to respond quickly.

We are currently working on the implementation plan for the legislation. One of the things we have to consider is the balance between what the general prohibition can do and the extent to which we will continue to generate—and we do generate very vigorously—new regulations and prohibitions. The consideration there is that consumer products is an area where there is rapid change and where we see, frequently, an emerging hazard that sometimes in your wildest imagination you couldn't have anticipated. That's the beauty, in my view, of the general prohibition, and that will be where we put a lot of our work.

But we still plan to develop regulations. We've just yesterday done a first tranche of regulations for lead, and that's part of a four-phase lead reduction strategy.

**The Chair:** Thank you.

We'll go to Dr. Carrie.

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

I'm finding this very interesting. In my life before becoming a politician, I was a chiropractor, and I used to see a number of injuries. It would be every year, whether they were from being out boarding or skiing. I've seen trampoline.... I've seen all kinds of falls on the ice. And I've come to the conclusion that living can be incredibly dangerous to your health.

I was wondering what you have seen. You put forward some numbers. Drowning is at 15%. Motor vehicle accidents are at 14%. I was surprised to hear you say that there are three provinces that don't have regulations for car seats. Suffocation is at 13%.

What have you seen as some of the very successful injury prevention initiatives and programs that have been out there, not only in Canada but around the world?

● (1220)

**Ms. Pamela Fuselli:** There are a number of successes, and I think it starts with a strategy. When we look at the EU countries, the ones that have been most successful in reducing their injury rates are the ones that have a plan, a plan with priorities, with resources, and with measurements. So generally, that's what I would say.

When we look at things like drowning, we look internationally at New Zealand, which implemented the four-sided pool fencing and saw its deaths due to drowning in young children reduced to virtually zero. So there are different strategies for different injuries, and that's where we rely on the surveillance data.

But we also rely on the data collection systems, like the CHIRPP data and the Canadian agricultural injury report, which provide us with contextual information. As injury prevention people, we need to know more than only the absolute numbers. We need to know what's happening around those issues. Around drowning, we needed to know that it was children accessing pools when they weren't meant to be swimming, so we could then look at what's effective in terms of strategies for implementation.

There isn't sort of one-size-fits-all. It depends on the injury issue that you're talking about.

Ms. Billings talked about the good practice guide that we're interested in, Canadianizing it from the European Child Safety Alliance. Basically, that goes through leading causes of death and looks at what evidence there is for effective interventions and then provides some case studies. My vision for Canada would be to have a document like this so that people working in injury prevention, in public health, in policy, will have some type of standardized information so that they can make good decisions, whether it's on education, whether it's on policy, or whether it's on environmental change.

**Mr. Colin Carrie:** It sounds like it's really a coordinated effort.

I have a question for the public health agency. We heard about the pools. I remember when I had my pool, we had all four...and that made a lot of sense to me. Why wouldn't municipalities have that as a mandatory thing? Obviously, you're partnering with Safe Kids Canada, but who else are you partnering with? Are you partnering with the provinces, the territories, the municipalities, to get this information disseminated? Some of it sounds like a lot of common sense that simply isn't getting out there.

**Ms. Jane Billings:** We're partnering at many different levels. One element of the partnership that has been crucially important to us across a number of different public health issues has been the Public Health Network expert group that panellists sit on. That's an area where we pull together experts from the associations, from academia, from the provinces and territories, to work on injury prevention and chronic disease prevention in a very orderly fashion in terms of setting a work plan, getting the agenda, gathering the evidence, making recommendations for interventions, and learning more about best practices. That serves to bring the jurisdictions onto a common page and acts as input to many of the strategies where we're working far better together with the provinces and territories. As a result, when the ministries of health announced this past fall, their declaration on health promotion, injury prevention, and prevention with an emphasis on obesity and injury prevention...the action plans being developed under those will be common across many of the provinces and territories and will rest on a lot of the work that the expert group does.

In addition, we have cross-department initiatives in the federal government on family violence, for example, where we're working with a number of departments on the federal family violence initiative. We also work with Transport Canada on helmet and road safety. We use their numbers, for example, on a lot of the traffic accident information. So we have networks that go across the federal family, so to speak, to try to get the various partners in.

Increasingly, we are working with the Federation of Canadian Municipalities on obesity prevention, healthy cities, and of course injury prevention, and what they can do in terms of standards.

**The Chair:** Thank you, Ms. Billings.

We'll now go to Dr. Duncan.

**Ms. Kirsty Duncan:** Thank you to you all.

I don't know if this is correct, but I'm able to check stats here. This is 2007 data. It notes that since Nunavut was first formed in 1999, 233 in the territory have taken their own life, of a population of 30,000. If that's correct, that is absolutely devastating. That's about 0.8%. I just think we need to really focus on making real change here.

I'm going to ask about brain injuries now. Nationwide, there are about 34,000 brain injuries that lead to hospitalizations here in Canada; 6,000 will be permanently disabled as a result. We know for older children and adolescents that many injuries are related to recreational activities and sports. We know the young brain is more vulnerable.

I'll start with Ms. Fuselli. What would be your recommendations to this committee, a new federal action that we could take to perhaps reduce concussions in youth because of that vulnerability, and also because of new data looking at concussions and what it potentially can mean long term?

● (1225)

**Ms. Pamela Fuselli:** With my colleagues at ThinkFirst Canada and the Brain Injury Association of Canada, there has been an explosion of new information around concussions and sports injuries in particular.

For me—I'm not an expert in brain injury—the continued focus in terms of the cross-sectoral engagement is essential: the researchers, the physicians who are seeing the trauma, the rehab, and those living with brain injuries. But as with any other injury, the research is the most important, and the data, because that's what informs what we do that is effective going forward.

So a focus on an injury like a brain injury, which is lifelong, has a huge impact—and we are just learning the extent of these injuries. We continue to support the work of those experts in the area to find out more about what is most effective and to support that on a national basis.

**Ms. Kirsty Duncan:** Where are the gaps in data collection? For example, if you don't go to the emergency and you go to your physician the next day, that data is not captured. So where are the gaps, please?

**Ms. Jane Billings:** There are data gaps in terms of the electronic health record, so we know we're not gathering—

**Ms. Kirsty Duncan:** Can we specify what the gaps are, please?

**Ms. Jane Billings:** Well, we know there is underreporting in terms of the less serious injury that doesn't get picked up. With our networks going through some of the hospitals and emergency rooms, we know there is other data that we're not picking up. So we know our data isn't complete across a range of the various injury categories.

**Ms. Kirsty Duncan:** And is there more work that we could be doing in terms of raising awareness, more work in education? People think football, they think hockey; they may not think gymnastics or diving.

**Ms. Jane Billings:** There are a number of factors at play here. Part of the issue with some of these injuries is that group of...I would say the teenaged boys and those in their early 20s who think it's not going to happen to them—they're invincible, helmets are sissy, and they'll bounce back. And of course that doesn't happen.

There are a number of associations or organizations, particularly in the brain area, that are trying to improve the tools we have for education, to improve the role models for safe sport, particularly for that group.

**Ms. Kirsty Duncan:** Could we be doing this through a federal communications program? For example, if you have children in sports, parents don't always.... That may not have been their sport and they may not know some of the risks that are involved. I think it's important to get that information out.

**Ms. Jane Billings:** A number of recommendations came out of the workshop we had a year ago December.

● (1230)

**Ms. Kirsty Duncan:** Could you let us know what they are?

**Ms. Jane Billings:** There was a huge thirst for strong leadership across injury prevention in a number of areas. There was a recommendation from this group that we develop a unified plan to address injury prevention in all its facets, and to strengthen the applied research to identify the effective interventions. So we are working with those organizations on what might be in that plan and what some of the priorities are. We hope to be much more articulate about what those might be in the future.

**The Chair:** Thank you, Ms. Billings.

Mr. Brown is next.

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

There are a few things I'd like to ask about.

I was curious when we talked about education campaigns specifically among seniors. I realize you've put information on the Health Canada website. I think of my own grandfather, who is 93 and would have no idea how to check the Health Canada website. He doesn't own a computer.

We talked about hip injuries. He has a car lot. He jumped out of a car and broke both his hips 10 years ago. In retrospect, I think at 83 you shouldn't be jumping out of cars. Now he goes to his car lot in a walker and continues to work. But obviously tips for seniors on how to avoid injuries would be very helpful. I think of all the health costs associated with injuries to seniors. Obviously there are significant costs on the health care system for simple injuries that lead into other complications.

What's the most effective way to have education campaigns among seniors? What do you find is working, given that we can't depend on digital methods?

**Ms. Jane Billings:** When we design a campaign, we identify who the audience is and how they get their information, and that varies for every age group. In the Division of Aging and Seniors we have several target groups that we want to get information to on the best interventions. One group is the health care providers, meaning both the medical practitioners and the caregivers in nursing homes or in individuals' houses. That's one tranche of audience. We also want to get the information to the seniors themselves, as well as to their families, so that their families will know what to look for and will be able to take care of their elders in an effective manner.

When we do that, we'll go in a number of different ways. We will work with a lot of the associations in the provinces and territories to make sure they have effective information and guidelines for practice. We'll go, for example, to the aging associations and to the college of physicians with information that can be disseminated to their various memberships. We'll do brochures that can sit in doctors' offices or in places where people go to shop. Examples are drugstores or the shops that sell equipment for older people.

In addition, we will use the web, because that layer of parents and kids will use the web to get information. Then, of course, we use documents like the public health officer's annual report.

We use speeches. Increasingly we've been giving speeches to groups such as associations of caregivers and nursing associations, for example, but it will differ with each one, and each year we have different programs in terms of what our target audiences are for that year and where our strategies might be.

**Mr. Patrick Brown:** Do you engage in advertising too?

**Ms. Jane Billings:** We do, but on a very limited basis. For example, we had a radio, TV, and newspaper advertising budget for H1N1. Currently we have a campaign out on getting your flu shot, which is coordinated with the provinces, but it's really expensive. That goes on the radio too. As well, we have the child safety campaign that's on right now.

**Mr. Patrick Brown:** How does Canada compare internationally in terms of education campaigns specifically for injury prevention in seniors? Will there be any data about how...?

**Ms. Jane Billings:** We don't have those data. I'm sorry.

**Mr. Patrick Brown:** Okay.

Are there mechanisms to compare or collect best practices? Is that something we're looking at doing in the future?

**Ms. Jane Billings:** When we're looking at a campaign, we look at what the other countries are doing in terms of interventions and what they find successful. That will be a number of different items. Whether it's training the trainer, getting the applied research out there, or making sure we're hitting the right audiences, we'll look at what other countries have done. I don't think, though, that at this point we're contemplating doing a regular canvass of, say, the marketing campaigns of other organizations.

We do take part in a lot of international conferences. For example, at the International Union for Health Promotion and Education, which is triennial, last year we learned a lot about what other countries are doing in a number of different fields, including aging in seniors. We bring that all back, and we have our nets out to other governments in terms of best practices. We also work through the WHO and PAHO in terms of trying to get that information.

● (1235)

**The Chair:** Thank you.

Thank you, Mr. Brown.

We'll go to Ms. Leslie.

**Ms. Megan Leslie:** Thank you.

We heard a lot about partnering and disseminating information and data collection and action plans, but we heard Ms. Fuselli actually say that we need a national injury prevention strategy. There are numerous not-for-profits, governments, and community members who are looking for that. In the throne speech, this government committed to an injury prevention strategy. Can you give us an update on the actual strategy? When can we applaud its roll-out?

**Ms. Jane Billings:** We're hopeful that we'll be able to come forward in the near future with that strategy. It was announced in the Speech from the Throne, and we are working actively with the various organizations to put it together. As Ms. Fuselli stressed, this has to be a collaboration, so we need to ensure that we are doing our best to pull people together, working on the interventions and preparations. It's taking time.

**Ms. Megan Leslie:** Would I be correct in assuming that PHAC would be monitoring the strategy?

**Ms. Jane Billings:** Yes.

**Ms. Megan Leslie:** So it will be coming out in the near future?

**Ms. Jane Billings:** We hope.

**Ms. Megan Leslie:** Do you have statistics on the direct costs to the health care system resulting from things like emergency room visits and hospitalization because of injuries?

**Ms. Jane Billings:** We have the report I referred to that calculated the costs at almost $20 billion per year. We can provide that to you.

**Ms. Megan Leslie:** I'm looking for smaller categories. How is that information collected?

**Mr. Sylvain Segard:** I'm not sure. As for the actual breakdown within the report, we'll have to look it up. It's been a while since I've looked at it.

**Ms. Megan Leslie:** I'd love a copy of that. Thanks.

Yesterday, Health Canada introduced new restrictions on the amount of lead in products, but there wasn't any mention of enforcement. There was no mention of more resources for monitoring, for enforcing these new regulations. I'm wondering how the government will ensure that these regulations are being enforced.

**Ms. Athana Mentzelopoulos:** The new regulations become part of the body of regulations that we enforce on a cyclical basis. We are currently in the process of doubling the number of our inspectors. It's an area to which government has allocated some resources. We do cyclical enforcement through a process of intelligence gathering, and we review our regulations periodically.

Part of the intelligence is to assess where we expect to find non-compliance. That's what we're going for. Sometimes we have to explain why we have found a high level of non-compliance. It's because that's what we're looking for, and that's the basis of our cyclical enforcement efforts. So these regulations become part of the cyclical enforcement plan, and we continue to do a lot of outreach to industry. We expect them to comply with the regulations. We'll make sure that industry is aware of them. I think to a large extent they already are.

We will also inform consumers. There are thousands of retail outlets in Canada, and we can't have an inspector at every retail outlet. We try to make sure that consumers are equipped with the information they need. When they see something suspicious, we want them to ask questions and let us know. It's important intelligence for us.

● (1240)

**Ms. Megan Leslie:** This was a good announcement. But I imagine it will greatly increase the amount of work that you folks are doing. We read reports about lead in baby bottle nipples, and in places that I wouldn't think to look for lead. So I would expect this to put extra pressure on you guys. Do you think it'll be okay with just the cyclical system?

**Ms. Athana Mentzelopoulos:** As well as the follow-up on complaints, yes, because we don't send our inspectors out only to look at compliance with one regulation. It's not that now we have these two new lead regulations we'll have to add a layer of enforcement.

Our inspectors are schooled in the full body of the regulations. So if, for example, they're visiting a particular retail outlet where there might be a range of consumer products, and there often are, our inspectors are on the alert for all possible non-compliance. They'll look at products to see what the surface coding is. They will also be looking at toy regulations: are there small parts that are in non-compliance?

I did an inspection myself with officers in Edmonton. We went into a liquidation warehouse type of place and they looked at everything. We went through every row. I found the non-compliance. I was very proud of myself.

**Ms. Megan Leslie:** Way to go.

**Ms. Athana Mentzelopoulos:** Small parts.

**The Chair:** We'll now go to Mr. Uppal.

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

Thank you, witnesses.

I'm going to start with an observation. When I was playing hockey as a youngster, there was an awareness of hitting from behind, but not as much. Now, a lot of the younger players have a stop sign on the back of their jerseys and it's a continuous reminder to not hit from behind, because there are obviously serious injuries that can happen.

What does it take to go from general awareness and good sportsmanship to something like that, and possibly the next step of stopping that? There are hundreds of leagues across Canada and different organizations to deal with. Not all of them are under the same body. How do you deal with something like that?

**Ms. Jane Billings:** We deal with something like that in a number of ways. First of all, it's gathering the information that there is serious injury from that type of activity in a sport, gathering that information from a number of different sources, including from the sports associations. Then it's a matter of working with the provinces and territories in the first place, and with the associations, to make them aware of the damage caused by that particular injury. But at the same time, what we would be doing is identifying those interventions to stop that type of activity.

Certainly with hitting from behind, if the hockey associations across the country were to ban it and, with the referees, to penalize heavily those players who hit from behind, that would stop pretty quickly. We are seeing moves in parts of some of the more junior associations to stop it. It needs to move up to the national level, because, again, you need the example of those leaders we see on TV, that they're stopping doing it and are being penalized heavily when it happens. In one of the hockey games on the weekend—professionals—there was a strong hit from behind and it wasn't called. So what type of message does that send?

Did you want to add?

**Ms. Pamela Fuselli:** The challenge also is the culture of safety. It takes a long time. You can look to tobacco as another public health issue that's taken quite a long time to become ingrained in society as a whole and to be accepted as something that shouldn't be engaged in. There still are people who do, but....

I think what we have in front of us is.... Safe Kids has been around almost 20 years, so we've been at this for a while, and it takes quite a long time for that to become ingrained in the societal culture, which is why one of our mandates is to try to lead and inspire that culture. By doing that, as Ms. Billings indicated, we need leadership, we need champions, we need a communication mechanism to get the information out there, but also the solutions. It's not only the problem. We have to tell them what is effective and we have to try to engage those who have the ability to influence those who are in that area.

● (1245)

**Mr. Tim Uppal:** Another example that comes to my mind is trampolines. I think it's now mandatory that you have to buy the walls around it; they must come together. Previously, there were just trampolines with kids flying off the edges.

Another question is further to my colleague's comment about seniors not being able to check the website, on which you have all these initiatives to reach out to seniors. Have you done the same thing with different cultural communities, in different languages?

**Ms. Jane Billings:** In a number of areas we have reached out to different cultures, in different languages.

For the seniors, I'm not aware that we have, and that's probably an area we need to improve on. Sylvain can tell me I'm wrong, I hope. But I'm not aware of it.

We have in certain things. In some of the cancer areas, our data have shown significantly different risks in different cultural groups. and we have absolutely provided information and reached out to those communities and associations. This is where I think we would find some of our data gaps, in terms of the analysis, to show where there are differences as well.

**Mr. Tim Uppal:** I'm thinking of the recent awareness campaign concerning car seats having expiry dates. As a parent of two small children, I didn't even know that. Now I have to go and check the expiry date.

Is it planned to include that in other languages, or trying to reach out as much as possible?

**Ms. Pamela Fuselli:** Safe Kids has done some outreach to ethnocultural communities in a very limited way. Because of the way we're funded, we have to rely on the sponsorship we get in order to fund our activities, but we have reached out in terms of home safety issues and car seat issues to a number of ethnocultural communities, only in the Toronto area as a pilot. We have also done focus groups with them to understand that this isn't a translation of information directly, word for word. This is an understanding in the cultural context and is important information in the way it's framed. It may be the same messaging we're giving out on our website in English, but it's in a story framework or it's on the TV and radio that that community listens to and respects and where they go to get their information. But we are only touching the tip of the iceberg at this point.

**The Chair:** Mr. Segard.

[*Translation*]

**Mr. Sylvain Segard:** Thank you for giving me more time.

[*English*]

I think it's safe to say the coverage is uneven in terms of reaching the special needs community and cultural communities and so on. Where the agency has a programming base, such as in the area of children, where we have the children's community programming and the pre-nutrition program, these programs that have some injury prevention aspects to their work will try to translate material where they can and where the demand justifies and so on.

For the seniors, we don't have an established funding base. We do our programming on what we fund through our existing budgets, and we are operating more on an opportunistic basis to collaborate with different organizations around Canada to move forward in certain areas. There have been some examples where we have done some translations in different languages, but it is not systematic.

**The Chair:** Mr. Uppal, one more question, quickly.

**Mr. Tim Uppal:** Fines versus education—I'm talking maybe car seats for children. Education works. How much do we have to rely on ticketing people for not properly having children in a car seat?

**Ms. Pamela Fuselli:** From our experience, the legislation itself, without any kind of enforcement, has a positive effect. With enforcement, there's even more of an effect.

We have a public line that we get inquiries on, and there is some degree of importance given to those issues that have legislation attached to them. So it's not an either/or. Education is absolutely necessary, but it's not the entire picture. The legislation is important to give an indication as to the importance of an issue and in and of itself is effective, but the enforcement takes that level even higher.

**The Chair:** Thank you so very much.

I do want to thank the witnesses. We've gone through two full rounds now and there's not enough time to go through a third round. But I think we've exhausted a lot of the questions the committee had today on this very, very important topic. I want to thank you all for being here to give us the insightful information that you have.

With that, I will adjourn the committee meeting today.

The meeting stands adjourned to the call of the chair.

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