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Chair

Mrs. Joy Smith

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● (1105)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, everybody. Welcome to the committee.

I'm so pleased to have the Honourable Leona Aglukkaq, Minister of Health, join us today.

Pursuant to Standing Order 81(5), supplementary estimates (B) 2010-2011, votes 1b, 5b, 10b, 20b, 25b, and 40b, under Health, are referred to the committee on Thursday, November 4, 2010.

Joining the minister is our very well-known friend from the Public Health Agency of Canada who keeps joining us on a regular basis, Dr. Butler-Jones. Welcome.

From the Canadian Institutes of Health Research we have Dr. Alain Beaudet, president. Welcome, Dr. Beaudet.

From the Department of Health we have Deputy Minister Glenda Yeates.

Minister, please begin your presentation. We look forward to hearing from you.

Hon. Leona Aglukkaq (Minister of Health): Thank you.

Good morning, everyone.

Madam Chair and members of the committee, it's a pleasure to be here to discuss supplementary estimates (B).

Before we get into the details of today's discussion, I would like to thank you for the hard work on Bill C-36, which is now before the Senate. The piece of legislation, once it comes into force, will provide us with the tools needed to recall dangerous consumer products.

Canada's Consumer Product Safety Act will have a profound effect on the marketplace. It will give consumers greater confidence in the safety of the products they find on the shelves of stores everywhere in this country.

We know that the discovery of things like lead in toys has rightly caused parents to be concerned. They know that young children put objects in their mouths as a form of discovery. The new limits on lead content that I announced this week indicate, not only to our industry but to those around the world, that we mean business.

Bill C-36 will give us new powers to deal with those kinds of problems more effectively. The new inspector powers in Bill C-36 are both fair and consistent with those of other federal laws. They are also consistent with the Supreme Court of Canada's decisions on the acceptable scope of inspection powers.

The safety of consumer products is something from which we can all benefit. We are working with industry to enhance consumer product safety and we are developing new tools to help us take corrective actions where problems arise.

While we have given a great deal of attention to that legislation and other safety measures, Health Canada has also continued to focus on the business of funding and administering other programs that protect and improve the health of Canadians.

Health Canada's 2010-11 supplementary estimates (B) include a net increase of $48.1 million, which brings its total budget to $3.731 billion for the current fiscal year.

We recognize the important part that research plays in ensuring the continued health of Canadians. This is why we have provided ongoing support and additional investments to Canadian Institutes of Health Research to support innovative and patient-oriented research that could have an impact on the health of Canadians.

Another important funding initiative supported by our government is an international initiative on Alzheimer's, and $5 million has been added for this purpose. Our government has invested more than $88 million in research regarding Alzheimer's disease and related dementia since 2006, and we are funding a four-year national population study on neurological diseases. In addition, important international MOUs have been signed with our partners from France, Germany, and the U.K. on Alzheimer's research.

I am particularly proud of the accomplishments we have made in the fight against HIV/AIDS. The Canadian HIV vaccine initiative, led by our government, along with the Bill and Melinda Gates Foundation, highlights Canada's world-class HIV and vaccine research expertise.

CIHR is investing approximately $40 million per year in support of HIV/AIDS research. Canadian investigators, supported by this funding, are at the forefront of discovery, improving the health of those infected, and are working toward a vaccine. CIHR continues to invest strategically in HIV research and is actively implementing the CIHR HIV/AIDS research initiative strategic plan. This will ensure continued knowledge development and research capacity-building, as well as the application of new findings in HIV/AIDS research in Canada.

The landscape for health services on population health research in HIV/AIDS is changing in Canada through the support for two centres for research development in HIV/AIDS. These centres are building research networks, addressing high-priority research questions, and building knowledge translation capacity in Canada.

The Public Health Agency's national HIV laboratories and their surveillance and risk assessment divisions are active members of the World Health Organization's advisory network of experts that support the development and implementation of the HIV drug resistance, prevention, and assessment strategy.

The lab is designed as one of the very few specialized HIV drug resistance laboratories in the world. It will also provide training and technical support to laboratory staff in resource-poor countries, and will continue to lead the way in developing new technologies that will facilitate testing worldwide.

● (1110)

This past summer I travelled to Vienna, where I met with international leaders, and particularly with Bill Gates. As a result, our government will help advance the science for the development of a safe and effective HIV vaccine that will benefit those who need it most, and that's all Canadians.

I would also like to take the opportunity to inform members of this committee of the announcement I made yesterday, along with the Bill and Melinda Gates Foundation, on the appointment of Dr. Singh and Dr. Esparza as co-chairs of the advisory board that will oversee the renewed Canadian HIV vaccine initiatives and its research development alliance.

Addressing the health concerns of Canada's aboriginal people comprises a portion of the funding under the supplementary estimates. It is targeted for programs that are helping aboriginal people, especially those living on reserve. One of the commitments in the supplementary estimates is our contribution to the Indian residential school resolution health support program. The Government of Canada is committed to supporting former students of residential schools and their families throughout the implementation of the Indian residential school settlement agreement. Health Canada is responsible for the resolution health support program that is part of the agreement, and we hope this will continue to have a positive impact on the health of first nations people.

We are committed to offering support services that take into account the culture and heritage of aboriginal people. Community-based healing programs, such as those for mental health and addictions, will assist these communities by addressing the health and social challenges they face. These investments represent a total of $5 million.

Additional funds have also been required to help in the transition from the outdated food mail system, which had been in place for more than 40 years. It is being replaced with Nutrition North Canada, a new retail-based subsidy program that will ensure northerners benefit from improved access to healthy and nutritious food throughout the year. Health Canada is allocating $1.5 million this fiscal year and $2.9 million annually beginning in 2011-12 for nutrition and education initiatives under Nutrition North Canada.

We also recognize that the availability of nutritious food and access to it is a starting point for a nutritious diet. These education initiatives will help northern Canadians put nutritious meals on their plates. Nutrition North Canada will be more efficient, more accountable, and more transparent. It will help make sure that northerners get the maximum benefit from the government subsidy for healthy foods. It will give retailers more control over their supply chain and therefore create more competition. That means there will be more incentives for greater quality control.

Fresh foods will get to the shelves sooner, making them more attractive to consumers. Our government is particularly proud of the efforts that have been made in the health promotion. Encouraging a healthy lifestyle is instrumental in maintaining a healthy body. It also means an overall improved quality of life and a healthier Canadian population, while being less onerous on our health care system. This cannot be truer than for young Canadians. Our intention is to encourage them to lead a healthier lifestyle right from the beginning.

For example, we have recently launched a bold new education campaign aimed at 13- to 15-year-olds to teach them about the dangers of illicit drugs. The centrepiece of this campaign is a commercial called “Mirror”, which dramatizes the harmful effects of drugs. It shows a young woman looking into the mirror and seeing what her life would be like if she experimented with drugs. The commercial began running two weeks ago and will be airing until March. During that time, we expect two-thirds of all Canadian teens between the ages of 13 and 15 to see it. This campaign is designed to be a powerful deterrent. Deterrence is an essential component of the government's national anti-drug strategy.

Last week I had the pleasure of meeting Gil Kerlikowske, an important figure in the battle against illicit drugs in the United States. We discussed many issues of common interest that have a bearing on the health of young Canadians and Americans. The most effective way to help Canadians is to give them the information they need to make informed choices. In fact, we have made many announcements in the past and there are more to come in the future about sources of information for parents with regard to the health and safety of their children.

● (1115)

Information and education are also playing an important role in our efforts to curb childhood obesity. Obesity rates among children and youth have nearly tripled over the last 25 years. Obesity increases the risk of developing some chronic diseases, including type 2 diabetes, cancer, and heart disease.

The federal, provincial, and territorial governments recently agreed to a framework for coordinating their approaches to promoting healthy weights among children under the age of 18. We have agreed to focus on making the environment where children live, learn, and play more supportive of physical activity and healthy eating. We will also try to identify the risk factors that can lead to obesity in children and address those issues early in a child's life. We agreed to find ways to increase access to nutritious food and decrease the marketing to children of foods and drink that are high in fat, sugar, or sodium.

An equally essential part of the plan to reduce obesity is the need to promote more physical activity. All levels of government need to be involved in finding more ways for kids to be active, both indoors and outdoors throughout the season.

The campaigns we are currently leading are designed to have an impact on the long-term health of many Canadians. By helping them change their lifestyles or avoid dangerous substances, we can prevent a wide variety of health problems in the future.

Through our nutrition facts education campaign, we are helping Canadians understand more about the foods they eat.

Our children's health and safety campaign strives to help parents protect their children from many potential hazards, and our national anti-drug strategy is helping to prevent young people from experimenting with illicit drugs and becoming addicted in the first place.

In the year ahead, we will continue to develop initiatives that support our long-term vision for health care in Canada, while tending to the short-term needs of Canadians.

I will be pleased to take questions from the committee.

Thank you.

The Chair: Thank you very much, Minister, for your insightful comments.

We'll now go to our first round of Q and As. We'll begin a seven-minute round with Mr. Dosanjh.

We'll have 15 minutes with the minister. I'm sorry.

Hon. Ujjal Dosanjh (Vancouver South, Lib.): Thank you.

Thank you very much, Minister, for being here, and the officials as well.

Minister, I understood from your deputy minister the other day that you have essentially spent no money on mass media for tobacco reduction in the years 2008-2009 or 2010. We understand that at the health ministers meeting you announced, rather abruptly, I'm told, that you would no longer be refreshing the warnings on cigarette packages. I understand that came as a bit of surprise to the ministers of health from the provinces and territories.

Can you tell me who made that decision, when it was made, and how it was made?

Hon. Leona Aglukkaq: First of all, thank you for the question.

I did have a discussion with the federal, provincial, and territorial ministers in regard to tobacco and tobacco labelling.

Before I go into the labelling question, I would note that we continue to invest $15 million across the country in provinces and territories for organizations to deliver their programs for quit lines or advertising promotion, and what not. It's within the $15 million umbrella that goes to the provinces and territories.

Hon. Ujjal Dosanjh: But you're doing none of that yourself.

Hon. Leona Aglukkaq: In regard to tobacco labelling, Canada has been leading since 2001. Some countries haven't even gone to where we have been.

What I said to the provinces and territories was that in light of some statistics we had been receiving on marketing to young people, I wanted an opportunity to re-examine how we were delivering the campaign to combat tobacco. I have not said no to labelling. What I said was that I needed to step back and review whether that was the most effective way of marketing prevention when targeting young people, for example. So we are still there. And Canada is leading with our last tobacco legislation, which has been adopted globally as well.

Hon. Ujjal Dosanjh: Madam, I don't mean to interrupt, but can you tell me who made that decision? Did you hear from the PMO, or was it a cabinet decision, or was it your decision?

● (1120)

Hon. Leona Aglukkaq: I made the decision to examine whether it's the most effective way to target prevention in tobacco. When you start to hear statistics of the nature of more Canadians are smoking contraband, which are sold in plastic bags rather than packaged labelling, I needed to go back and determine whether in fact that was the right direction to go, and we are continuing to examine those options presently.

Hon. Ujjal Dosanjh: Let me go to the 2004 accord. We had agreed on some extension of home care in the 2004 accord.

I understand that this committee did the statutory review of the accord in 2008 and it indicated at that time that there was supposed to be a report prepared in 2006. As yet, in 2008, the committee had not received that report; this committee didn't see that report. Do you have that report? Can you share it with the public?

Hon. Leona Aglukkaq: Do you want to speak to that?

Ms. Glenda Yeates (Deputy Minister, Department of Health): Thank you.

The minister has asked me to address this question. In terms of the home care progress that has been made, there have been a number of—

Hon. Ujjal Dosanjh: Madam, can you tell me whether you have a report that was supposed to be prepared in 2006? That's the question.

Ms. Glenda Yeates: I'm not sure that I'm familiar precisely with the report you are mentioning.

Hon. Ujjal Dosanjh: There was supposed to be a report prepared at the end of 2006 with respect to the progress made on home care expansion. In 2008 this committee wasn't able to lay its hands on that report. Do you know whether that report exists? It's mentioned in the committee's reports.

Ms. Glenda Yeates: There have been a number of discussions with provinces and territories about the use of the 2004 accord investments on home care. There have been a number of reports that have been put out, for example, on the Canadian Institute for Health Information on the progress that's been made in home care. But I'm not precisely aware of the report or the reference to which you're referring.

Hon. Ujjal Dosanjh: "Health Ministers were to report to First Ministers on a staged implementation of the home care commitment by December 31, 2006." Is there a report of that report?

Hon. Leona Aglukkaq: I can answer. I was health minister for the territories, and I don't remember a discussion around provinces and territories agreeing to a staged implementation of a home care program, as health minister for Nunavut at the time.

Hon. Ujjal Dosanjh: Madam, it was in the 2004 report. First ministers agreed that it would be done, and now you're telling me the ministers of health said no?

Hon. Leona Aglukkaq: I'm telling you as a health minister in the Nunavut Territory at the time, because you make reference to 2006, on a staged implementation, that there was never an agreement from the provinces and territories in 2006 on a staged implementation of home care on a report you're making reference to—

Hon. Ujjal Dosanjh: Sorry, I don't mean to interrupt you. I suggest you should go back and read the 2004 accord.

Let me go back to the national pharmaceutical strategy. You are quoted as saying there was no national pharmaceutical strategy embedded in the accord. There is in fact the national pharmaceutical strategy. It was about catastrophic drug coverage, common formulary, and other things.

I understand this committee heard that there is haphazard progress, uneven progress, not coordinated among the provinces, and the ministerial task force that was established hasn't really met that often. Can you tell me what progress has been made on the national pharmaceutical strategy?

Hon. Leona Aglukkaq: Thank you.

The government recognizes the importance of addressing affordable access to drugs, and pharmaceuticals are a shared responsibility of federal, provincial, and territorial governments—

Hon. Ujjal Dosanjh: Recognition is good, madam, but can you tell me what progress you have made?

Hon. Leona Aglukkaq: The federal government will continue to work with the provinces and the territories to fulfill its responsibilities on that. We did discuss this during the September federal-provincial-territorial ministers meeting and we have agreed to—

Hon. Ujjal Dosanjh: Can you tell me what progress you made?

The Chair: Mr. Dosanjh, would you allow the minister—

Hon. Ujjal Dosanjh: She's not answering the question.

Hon. Leona Aglukkaq: You're not listening to the answer—

Hon. Ujjal Dosanjh: No, you're not answering the question.

The Chair: Excuse me, order—

Hon. Ujjal Dosanjh: You're expressing the intention—

The Chair: We're going to go on to the next question if you can't address the chair, Mr. Dosanjh.

● (1125)

Hon. Ujjal Dosanjh: No, I have a question. The question is—

The Chair: Excuse me, Mr. Dosanjh, this is very rude. I just want you to give the minister a chance to finish her answer, so you can get your answers, please.

Can we continue and then ask your next question? I'll give you extra time here.

Hon. Ujjal Dosanjh: Let me re-ask the question.

The Chair: Minister, can you try to answer his question right now —if he'll give you a chance.

Hon. Leona Aglukkaq: Progress has been made under the national pharmaceutical strategy, and the provinces and territories are working on their own priorities. I'll use one example in the Atlantic provinces, where there is a bulk purchasing by three jurisdictions to address some of those types of challenges.

We continue to work with provinces and territories to address our common interest, and the federal government is part of that. We're a huge purchaser of this as well, for first nations health, and we are making progress in increasing access to a number of drug therapies for our population.

In terms of one plan for every jurisdiction, it's not that easy. Each jurisdiction has tackled the national pharmaceutical strategy collectively—British Columbia, Alberta, and Saskatchewan being one, the Atlantic provinces being another, and Ontario is examining with Quebec as well.

So there are different steps being undertaken by jurisdictions that deliver health care and have primary responsibility for these programs.

Hon. Ujjal Dosanjh: I thank you very much, and I'm actually coming to the primary responsibility.

I want to ask what progress you have made on the catastrophic drug coverage, nationally, with the provinces.

Secondly, and more importantly, quite often you answer a question in the House by saying it's a provincial responsibility. I want to know your view of the federal role in health care, other than the fact that the federal government deals with public health, delivers aboriginal health, delivers health to the armed forces and the RCMP. I understand that is the federal role, but other than that, what do you think is the federal role in health care?

Hon. Leona Aglukkaq: Thank you for that question.

I support the Canada Health Act and to implement the Canada Health Act across the country. Health is a collective responsibility—federal, provincial, and territorial—as you know very well. Provinces and territories deliver health care and abide by the Canada Health Act. I'm in full support of the principles of the Canada Health Act, and I will continue to do that.

In addition, this government has also made significant investment in a number of other areas, such as electronic health records and reducing wait times, examples of improving the way provinces and territories deliver health care. We will continue to do that.

Thank you.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Minister, you talked about the $15.7 million for tobacco. I would argue that over the last four years forty cents on the dollar of that has been diverted, and I can provide those figures for you.

What I'm interested in, and what I would like to know, is what warnings were recommended by Health Canada staff, and could those be tabled at this committee, please?

Hon. Leona Aglukkaq: Thank you for that question.

We did a number of studies across the country on what's most effective in terms of warning labels, tobacco reduction, and what not. Again, through that review, we looked at how to target prevention—young people, contraband, flavoured cigarettes, and so on—and our legislation is an example. We looked at a number of ways to improve the tobacco legislation and labelling.

You cannot address tobacco and cancer rates associated with tobacco by the packaging of a cigarette pack. You have to look at it from the broader context of how we keep the tobacco industry from marketing tobacco to youth—through our legislation, as an example.

Ms. Kirsty Duncan: Minister, if I may interrupt, these were picked up five minutes away from the Hill this morning. The question I have, and it's a very specific question, is what warnings came forward from the Health Canada staff, and could they be tabled with this committee?

I'll move on to the next question. I'd like to know how much money has been spent on the renewal process and what agreements were in place regarding provincial quit lines, the numbers for which were to be on cigarette packages.

● (1130)

Hon. Leona Aglukkaq: As I said earlier in response to your colleague's question, I am reviewing how we market and label tobacco before proceeding in light of the fact that we have many ways to advertise and target prevention initiatives. I said I have never taken the renewal of labelling and what not off the table, but I am taking a step back.

There's absolutely nothing wrong with taking a step back to re-examine whether the investment is being made in the right place to make the biggest difference within our prevention strategy for young people.

Ms. Kirsty Duncan: Minister, I'll ask another question. Given the decline in smoking rates, and the government's goal of reducing smoking prevalence to 12% by next year, how can the government justify reducing program initiatives and expenditures, including the elimination of the mass-media component of the tobacco control strategy ?

Ms. Glenda Yeates: We have, as part of our 2009-10 expenditures, over $40 million directed towards tobacco. That's in addition to what we have seen over time, which is that many partners, including provincial, territorial, and municipal governments, have stepped up local and regional efforts on tobacco.

In fact, the total expenditures are quite significant when you combine the federal expenditures with those of the provinces, territories, and other parties. Again, there is over $40 million in 2009-10 directed towards tobacco. We also have partners in the public safety area, such as the RCMP, which spends additional dollars targeted at contraband.

Ms. Kirsty Duncan: Before I finish, I'll just bring this to the attention of the minister. You mentioned that the four-year national population health study of neurological conditions would end in March 2013.

The Chair: Dr. Duncan, your time is up. Can you finish quickly, please?

Ms. Kirsty Duncan: I will, thank you.

Our neurological subcommittee has passed a motion regarding the Year of the Brain. It's a galvanizing effort. Canada is hosting the World Parkinson Congress in 2013, and the European Brain Council will be—

The Chair: That's it. Your question is too long.

Monsieur Malo.

[*Translation*]

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

Welcome, Minister.

Madam, Sir, it’s always a pleasure to have you with us to discuss supplementary estimates (B).

Madam Minister, I will not be asking all of the questions on cigarette package warnings that were raised by my Liberal colleagues, but I must say that this announcement floored us. We knew that for many years now, the Department of Health has been reassessing the need for warning labels and, we believed, and I am sure you agree, that this was necessary as businesses tend to avoid repeating the same ad campaign over and over. Businesses well know the importance of changing their ads often, very often, so that they may continue to have an impact. Otherwise, people just don’t notice them anymore.

However, one of the things you mentioned in your response to the Liberal members sticks in my mind. Essentially, you haven’t abandoned but merely suspended the renewing of warnings so as to permit you to study the question as a whole and to present, rapidly I hope, a global plan to ensure that the number of people addicted to tobacco will continue to fall. Indeed, as we all know, cigarettes are harmful.

My question is quite simple. When will you clearly announce your intentions and when will you present, as you say you will, a global intervention plan that will have sufficient clout to address the problems related to tobacco use?

[*English*]

Hon. Leona Aglukkaq: Health Canada continues to examine the renewal of the health warnings on tobacco packaging, including the possible addition of a pan-Canadian quit-line number. Our department does not consider the hard-hitting health warning messages on tobacco to be a stand-alone initiative. It is much broader than that. We're going to look at combatting tobacco.

Furthermore, the social environment has changed significantly since the health warning messages were introduced ten years ago. We did not have Facebook. We did not have Internet access for young people. We did not have texting. It's a good time for us to re-focus our efforts to ensure that the warning labels reach the largest possible number of smokers while remaining effective and efficient. We are examining innovative ways to complement existing strategies by strengthening our process, using the Internet and social media like Twitter and Facebook to target the highest number of people in the population.

We are examining all that. We have not said no to labelling, but we are taking a broader, silo-free approach to addressing tobacco.

● (1135)

[*Translation*]

Mr. Luc Malo: Minister, my question may have been simple, but you haven't answered it.

When will you stop studying this question and begin to implement the strategy you have been talking about?

[*English*]

Hon. Leona Aglukkaq: I said we're looking at how we promote it. It's not a strategy per se, but we're examining what we're doing now and how best to promote prevention using the other social media networks that are in place, aside from labelling. I'll continue to review that, and hopefully some time in the new year we'll have a decision on it.

[*Translation*]

Mr. Luc Malo: If I understand correctly, this will take another year, will it not?

[*English*]

Hon. Leona Aglukkaq: No, that will be in the new year. The new year is next month, 2011.

[*Translation*]

Mr. Luc Malo: Thank you.

Last week, I asked you a question in the House concerning compensating provinces, that is, financial compensation to off-set the additional costs brought about by the isotope crisis and you replied that the matter was under study.

I see, from the supplementary estimates, that no provision for this has been made. It seems then that you are still at the beginning of your thought process. On September 15th last, The *Globe and Mail* indicated that $33 million in compensation would be remitted to the provinces in relation to the isotope crisis.

Madam Minister, could you tell us where you are in your thought process and analysis of this question so that we can really get a handle on whether or not you intend to compensate the provinces in this matter?

[*English*]

Hon. Leona Aglukkaq: Thank you.

On the medical isotope situation, when we experienced it the last time, provinces and territories put in contingency measures that they agreed to implement in the case of a shortage of medical isotopes. We need to put that out there, because when we were dealing with the shortage, each jurisdiction was responsible for rolling out contingency measures to mitigate the shortage of medical isotopes and the supply chain of that particular product. So provinces and territories and I have had this discussion.

I'll show you a letter I received from Nova Scotia saying they didn't incur any additional costs, so they were not going to ask for additional money because they had implemented their contingency measures. Nova Scotia is the jurisdiction where we have the highest cancer rates in this country.

So if you want to put forward what you incurred I will be happy to review that information in the context of how you implemented the contingency measures we agreed on to mitigate the shortage of supplies. I'm still open to that. I have not received a formal request from any jurisdiction, and some jurisdictions have come forward to say they did not incur any costs so they're not coming forward with additional requests.

Thank you.

[*Translation*]

Mr. Luc Malo: So, you are encouraging every minister of Health to write to you. That's great.

Madam Minister, in your statement, you spoke of nutrition, and particularly of foods that are high in fat. As you know, your department has created a study group on the trans fat content of foods. We have noticed that, at the end of the delay allotted to different companies to significantly reduce the amount of trans fats in foods, much remains to be done.

I therefore wonder quite simply if, considering the importance of sound nutrition, either your government or you yourself intend to enforce regulations imposing limits.

● (1140)

[*English*]

Hon. Leona Aglukkaq: Thank you for that.

I'd first like to highlight the great announcement we made in Toronto that was pan-Canadian with the food industry on the percentage of daily value labelling we introduced so Canadians can better make informed decisions on the sodium level and fat level of any product. We launched that in Toronto and it's now being rolled out on every package you see. It makes it clearer to Canadians what percentage of fat and sodium they consume in the products they buy. This is part of the initiative we're trying to address on transfats, sodium, and what not. Again, this is a first for Canada. It was announced in direct partnership with approximately 40 food industries.

We will continue to assess how effective those types of initiatives are in Canada. We will continue to provide information to Canadians to reduce their levels of consumption of transfat. We will monitor the progress we've made. Regulation is always an option if things are not working. But the approach we have taken here is to work in partnership with the food industry in the provinces and territories to educate Canadians and reduce the levels of transfat in the products sold in Canada.

Thank you.

The Chair: Thank you, Madam Minister.

We'll now go on to Ms. Leslie.

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

Hello. Welcome. It's good to see you all again.

My first question, Madam Minister, is about the federal initiative on HIV/AIDS. In 2004 the federal government promised to sustain funding at $84.4 million annually, and we're only at $72 million. When you last appeared at committee I asked a question about this, and you said that the investments were "substantially more than... $84 million", but last week when Dr. Butler-Jones appeared at committee he confirmed that in fact investments are at $72 million.

Why did you say that we were substantially over $84 million, and when can HIV and AIDS groups expect this promise to be fulfilled?

Hon. Leona Aglukkaq: The information I shared with you was in fact correct. The total to date on HIV is $139 million.

Ms. Megan Leslie: Is that strictly with the federal initiative?

Hon. Leona Aglukkaq: There are federal initiatives through.... There's $72 million in historical allocations as well as the Canadian HIV vaccine initiative. That's $139 million.

Ms. Megan Leslie: Right. But with the federal initiative it was supposed to be—

Hon. Leona Aglukkaq: It's more than $72 million.

Ms. Megan Leslie: It's not with the federal initiative.

Hon. Leona Aglukkaq: There are many federal initiatives. The Canadian institute has invested $40 million in research. The Canadian HIV vaccine initiative is another multi-departmental federal investment, as well as those made through Public Health Agency of Canada departments.

Ms. Megan Leslie: So there is money committed to CHVI, money committed to the vaccine manufacturing facility, which we all know about, but Canadian grassroots organizations know and were expecting that over the course of five years the amount would go up to $84.4 million, and it's only at $72 million. When is this going to be ramped up to $84 million?

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): First of all, the discussion of the dollars was an idea; it was not a commitment. There were not the resources allocated for that. In fact, expenditure review meant that the allocations across the agency were reduced to address a whole range of programs. That was part of the work of the government of the day.

There is more money coming from us in terms of the federal initiatives for communities than there ever was. In 2004-2005 there was $47 million. Prior to that, in the previous five years, there was $42 million. That $47 million is now $72.6 million. So in five years there has been considerable.... In addition to that, there is the CHVI initiative, which has the greatest potential for actually addressing this disease.

● (1145)

Ms. Megan Leslie: Yes. So it was just an idea to get it to $84 million.

Dr. David Butler-Jones: Well, until you actually have the dollars in hand, it's still an idea.

Ms. Megan Leslie: I would call it a government promise.

When it comes to the vaccine manufacturing facility, we know that $26 million was diverted from grassroots community organizations into putting together the vaccine manufacturing facility. Does the government intend to return that money to grassroots community organizations?

Dr. David Butler-Jones: There was no money diverted from grassroots organizations. They got more money than they ever had before. It was not taken away. It was an idea; it was a promise that never came through. We used resources in the CHVI initiative.

Ms. Megan Leslie: I think civil society organizations certainly have a different perspective.

Dr. David Butler-Jones: It was never taken away. There are more resources there for community groups than there ever were, and this government has continued to invest there.

Ms. Megan Leslie: There are differing points of view from civil society; that's for sure.

Madam Minister, in the supplementary estimates we see that there is about $11 million going to the Assisted Human Reproduction Agency of Canada. As you know, we had board members of the AHRAC who had resigned, as well as some current board members and the president, Elinor Wilson, appear here at committee. I'm wondering, after that committee meeting, in light of the allegations of improper spending at AHRAC, are you planning on doing a financial audit of this agency?

Hon. Leona Aglukkaq: I look forward to tabling the audit within the next week or so. I've reviewed it, and there are no concerns there at all.

Ms. Megan Leslie: That's an accounting audit, which is quite different from a financial audit.

Hon. Leona Aglukkaq: What are you asking for?

Ms. Megan Leslie: I'm asking for an audit to figure out where the money went, and not whether the numbers add up.

They're doing an accounting audit—one plus one equals two. What I think Canadians are concerned about is where the money is actually going; what it's being spent on; why there are contracts totalling $80,000 to $100,000 for one person; why most of the staff is contract staff and temporary staff; and how they can possibly be spending $5 million a year when they actually aren't producing regulations. I think the bigger concern for Canadians is where the money is going.

Hon. Leona Aglukkaq: As I said, I'm looking forward to tabling those audits. There are a number of audits happening. This organization has been audited more than any other organization that I'm aware of, and once that information is available, I'd be happy to share it with you.

Based on what I have seen so far, within the financial piece at least, there are no worries. I'm not concerned about that financial audit, which is a requirement of organizations. If you have information that we need to investigate, then come forward. Otherwise, it's allegations, and we're looking and looking and looking and spending resources on audits that may not necessarily be required. So if you have information, share it with me and I'll be happy to follow up.

Thank you.

Ms. Megan Leslie: I'd recommend an audit, which would show you what you needed to know.

Hon. Leona Aglukkaq: But in terms of specifically where you want us to target, let me know. There's funding that is being spent within that organization for ATIPs and they've had to hire contractors to assist in responding to a number of ATIPs—

Ms. Megan Leslie: It's not worth $5 million.

Hon. Leona Aglukkaq: It's a lot of resources, and the decision by the previous government that the head office would also be in Vancouver means there's travel and so on that is necessary.

Ms. Megan Leslie: I'll be very happy to forward my concerns to you.

Hon. Leona Aglukkaq: But on that kind of audit, I can provide information to the members. I know that Dr. Hamm has also been willing to share information. He has shared decisions of the board, the motions of the board members. That has all been public and it is public, so it's available to you.

Ms. Megan Leslie: Okay, thank you.

Regarding Bill C-32, we had a big success with banning flavoured cigarillos and flavoured tobacco products. That was a great success, and I know you and my predecessor, Judy Wasylycia-Leis, worked quite closely on that, but we do have a problem with some cigarillos. What some of the companies have done, as you know, is to take out the filter to make the cigarillos bigger so they can skirt the definitions.

Does the government have plans to close that loophole?

Hon. Leona Aglukkaq: We're investigating that, yes.

Ms. Megan Leslie: So it's only at the investigation stage.

Hon. Leona Aglukkaq: Yes, we have to investigate and follow up within the legislation, the regulations.

Ms. Megan Leslie: Can we look forward to an announcement on that?

Hon. Leona Aglukkaq: I would love to make an announcement on that. I have to wait and see my staff and investigate the process as we discover.... This isn't a moving target, as you know, so we'll be happy to report any findings on that.

● (1150)

Ms. Megan Leslie: Thank you.

I'd like to ask some questions about suicide prevention. As we know, government committed in the throne speech to an injury prevention strategy for children, and we know that suicide is the leading cause of death of first nation children, first nation youth, and the second leading cause of death for youth in Canada generally. Right now, PHAC doesn't directly fund any organizations to raise the awareness of suicide or work on suicide prevention, so I'm wondering if the government has plans to put together a suicide prevention strategy.

Hon. Leona Aglukkaq: You mentioned youth. Our government invested $65 million over five years, and you mentioned a national aboriginal youth suicide prevention strategy. We're providing $285 million over two years to renew the aboriginal health programs in the areas of diabetes and suicide prevention.

Ms. Megan Leslie: A point for clarification. I'm sorry to interrupt, but I didn't hear. Did you say there is a youth suicide prevention strategy?

Hon. Leona Aglukkaq: We implemented, in the period 2005 to 2010, a five-year national aboriginal youth suicide prevention strategy.

Ms. Megan Leslie: Okay. I didn't hear the word “aboriginal”. Thanks.

Hon. Leona Aglukkaq: You made reference to aboriginal, so that's the answer.

Ms. Megan Leslie: I simply didn't hear, so I was concerned there may be something I didn't know about.

The Chair: Ms. Leslie, you have one minute.

Ms. Megan Leslie: Thank you very much.

Do you have plans to create a national suicide prevention strategy?

Hon. Leona Aglukkaq: In terms of the suicide piece, that's part of the work that's being reviewed through the Mental Health Commission. We're taking a broader approach to mental health and suicide is part of that initiative. So yes, we're working through the Mental Health Commission to address the issue of suicide.

Ms. Megan Leslie: Thank you.

The Chair: Thanks so much.

Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair. I'd like to split my time with Mr. Uppal, so if you would let me know at five minutes, I'd really appreciate it.

Minister, I want to thank you for being here again today. I know you've had a really busy week. I've been following what you've been doing as far as safety, particularly for kids. You had a great announcement with cradles and cribs and bassinets, and you had another really good announcement about radon. But I want to ask you a little bit more about the announcement you made on Monday about lead. There has been a lot of talk in the media about lead, particularly in kids' toys and things like that, and I want you to know that everyone around the table here is extremely committed to product safety.

I wonder if you could provide a little bit more information on the lead regulations that you announced on Monday, and also how the proposed consumer products safety legislation will help improve safety for Canadians.

Hon. Leona Aglukkaq: Thank you, and thank you again to the committee for the hard work on Bill C-36. I'd like to also thank the member for the question on the very important issue of lead.

I announced this week the regulations on consumer products containing lead, and these regulations will limit the lead content in certain products, including surface paints on children's toys, mouthpieces or musical instruments, and many other products that children may come into contact with, put in their mouths.

These challenges are another step in our government's implementation of the lead risk reduction strategy for consumer products to establish allowable lead limits in a variety of consumer products, particularly those that are used for children, but not exclusively. One example that we use all the time is pencils. We chew on pencils even as adults. So that's one of the areas we've targeted.

As the member is well aware, our government also proposed the Canada consumer product safety act, which is currently before the Senate, and I hope it will pass without further delay. Once it is passed into law, the act will modernize the government's approach to consumer product safety and include new measures such as the ability of Health Canada to order mandatory recalls of consumer products that represent an unreasonable danger to human health or safety and/or mandatory reporting of incidents or deaths from any consumer products. So we have initiatives like the consumer product safety legislation, Bill C-36, which would really give us the authority to respond and remove unsafe products from the marketplace.

Thank you for the question.

● (1155)

Mr. Colin Carrie: Thank you very much, Minister. I want to thank you as well because last year this committee had the opportunity to travel up north. I think it was the first time ever that a health committee actually got to visit our north. We're doing a study on healthy foods and healthy living, and I noticed that $1.53 million has been allocated to Health Canada for nutrition education initiatives. We saw this hugely up north, but I was wondering what the focus of the funding is going to be, that $1.5 million.

Hon. Leona Aglukkaq: Thank you to the committee for travelling up north. Sometimes by travelling in the north it's easier to get a sense of what some of the challenges are that we face. One of the challenges we do face in remote northern communities, not just in Nunavut but across Canada, is access to nutritious food.

So as part of the new Nutrition North Canada program, Health Canada received funding of $1.53 million to focus on culturally appropriate retail and community-based nutrition education initiatives. Those initiatives will promote healthy eating by developing knowledge and the skills for the selection and preparation of healthy foods bought within the stores, as well as including traditional food, what we call country food, within that education piece. As well, the new funding will stabilize existing efforts at the community level to strengthen education levels in communities and to focus on the retailers for establishing community partnerships to lead in community-wide engagements and promotion through the stores on nutritious food.

I'll just use a couple of examples. We have a plan to develop education plans for each community in the aboriginal languages, for example, working with local stores to promote displays of products and provide in-store nutrition education materials in the local languages to the population we are serving. Health Canada's allocation of $1.53 million is for this year, and next year it will be $2.9 million. We will continue to deliver nutrition education programs through those investments.

Thank you.

The Chair: Dr. Carrie, you wanted to know when your five minutes are up. Well, it's up. Do you still want to share your time with Mr. Uppal?

Mr. Colin Carrie: Please, yes.

The Chair: Mr. Uppal.

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

Thank you, Minister, for taking time again to appear before this committee.

Minister, as you know, neurological conditions are a concern to many Canadians. And as you are aware and as my colleague has mentioned, this committee does have a subcommittee examining neurological issues, including MS, ALS, Parkinson's, Alzheimer's, and autism. Can you please comment on what the government is doing to address neurological conditions in Canada?

Hon. Leona Aglukkaq: Thank you.

Our government recognizes the burden neurological conditions place on individuals, families, and caregivers. This will, I think, increase as our population ages.

Our government has committed $15 million to conduct a four-year study of persons with neurological conditions. The study will fill gaps in information about the state of neurological conditions among Canadians. It will also increase our understanding of the number of people affected by neurological conditions; the impact on individuals, their families, and their caregivers; the health services used and required; and the factors that increase the risk of developing neurological conditions.

As well, a conference will be held at the conclusion of this study to provide information for developing policies and programs to improve the lives of those individuals living with neurological conditions.

Through the Canadian Institutes of Health Research our government has also invested $88 million in neurological research. Canada is taking a leadership role in working with other countries to accelerate research on Alzheimer's prevention and on the development of new therapies to address the public health challenges. In fact, we have signed international memoranda of understanding with France, Germany, and the United Kingdom on Alzheimer's research. They all recognize, as well, that they are facing the same challenges we are. But Canada was able to pull those important partners together to accelerate our research in that area.

Our government has also invested $30 million over five years, with the support of the Rick Hansen Foundation, to support the programs and operations of the related Rick Hansen Institute.

● (1200)

Mr. Tim Uppal: Thank you, Minister.

In your opening remarks you mentioned the mirror commercial. I've had an opportunity to see that commercial, and I think it's very effective. Could you expand on that and tell us a little more about the recent work this government has been doing as part of the national anti-drug strategy ?

Hon. Leona Aglukkaq: This is year three of the national anti-drug strategy, which targets our young people. I would to thank you for your question, because I think this is one example of an initiative our government has taken from which I see great benefits being achieved. We believe that supporting parents in their efforts to protect their families in their fight against drug use by their children is an effective focus.

The national anti-drug strategy is about prevention and treatment for those with drug dependencies. But we care about preventing people, especially young people, from becoming addicted.

I mentioned in my speech that we had launched a program, an education campaign, entitled “drugs not4me”. One element of that is called “Mirror”, in which a young woman is showing the changes in her face and what not from being addicted. We're finding that these types of investments are having a significant impact on young people through new multimedia networks.

Since the launch of this program, we've had over 21,000 youth become part of this network. We're also finding that youth are interacting with youth within the social media on prevention. It's been very effective in reaching target groups and in getting the message to target groups. We're also seeing that parents are part of the network. They are learning what young people are up against and are dealing with in Canada. That was last year's announcement, and we're seeing the results of that.

This commercial, again, is part of year three. It was designed in partnership with young people. We received their feedback that this was the most effective way to target young people in Canada in the area of prevention. In my view, it's been quite successful.

The Chair: I want to thank Minister Aglukkaq for joining us today and appearing before committee, and I want to thank our guests as well.

We will suspend for two minutes, and following that we will vote on the supplementary estimates.

● _____ (Pause) _____

●

● (1205)

The Chair: We will now continue with supplementary estimates (B).

HEALTH
Department
1b—Operating expenditures.....$13,107,832
5b—Capital expenditures.....$1
10b—The grants listed in the Estimates and contributions.....$32,495,404
Canadian Institutes of Health Research
20b—Operating expenditures.....$1,171,618
25b—The grants listed in the Estimates.....$25,896,667
Public Health Agency of Canada
40b—Operating expenditures.....$1

(Votes 1b, 5b,10b, 20b, 25b, and 40b agreed to)

The Chair: Shall I report the supplementary estimates (B) to the House?

Some hon. members: Agreed.

The Chair: Thank you.

The clerk has just informed me that our witnesses for our next panel are not here yet, which is extremely unusual.

Mr. Dosanjh is wondering if maybe we could adjourn. I guess we could do that.

We're checking on our witnesses. Perhaps they didn't want to come in.

I'm suspending for one more minute again while we check on our witnesses.

● _____ (Pause) _____

●

The Chair: We're going to begin, so we can cover our very important topic today.

I'll inform you as soon as our teleconference is connected. They're experiencing a few technical difficulties.

As soon as our guest, Philip Groff, president and chief executive officer of SMARTRISK, is available to us, we'll certainly be able to bring him on board.

Pursuant to Standing Order 108(2), we are studying injury prevention in Canada.

From the Atlantic Collaborative on Injury Prevention, we have Jennifer Heatley, executive director. Jennifer, welcome. We're so glad you could come.

I think we might have Mr. Groff on the line. Mr. Groff, are you on the line now?

● (1210)

Dr. Philip Groff (President and Chief Executive Officer, SMARTRISK): Yes, it seems to have worked this time.

The Chair: This is so nice. I'm Joy Smith, the chair of this absolutely wonderful committee. We're very, very happy to have you today on this very important topic. Welcome.

We also have, from ThinkFirst Canada, Rebecca Nesdale-Tucker, who is the executive director. Welcome. Thank you for joining us. We have Alison Macpherson, board member, and we have Tyler Lisacek, community volunteer. Tyler, I think I've seen you before, and I'm so glad that you have joined us on committee. We've very, very happy to have all of you here.

You'll each have a five-minute presentation. I think I will begin with Jennifer, from the Atlantic Collaborative on Injury Prevention.

Ms. Jennifer Heatley (Executive Director, Atlantic Collaborative on Injury Prevention): Thank you, Madam Chairperson.

Thank you for having me here today. My name is Jennifer Heatley and I'm the executive director of the Atlantic Collaborative on Injury Prevention, or ACIP as we call it for short. ACIP is an NGO based out of Halifax and works to reduce the burden of injury in the four Atlantic Canadian provinces.

After several years of working in the area of injury prevention, I continue to be surprised at its contradictory profile as a public health issue. On any given day, the media often leads with stories of injury in all its forms, but despite the high profile of individual incidents, there is a striking difference between injury and the other leading killers of Canadians.

Research dollars, surveillance systems, and strategies are pale compared to those of other major diseases such as cancer and heart disease. The public's concern about injury, although sincere, has not translated into "movembers" or "walks for the cure". Injuries are still considered bad luck or fate.

What we do know is that preventable injuries, both those that are intentional and unintentional, present a significant social and economic burden in Atlantic Canada and across the country. Over 1,000 Atlantic Canadians die annually as a result of injuries and another 16,000 are injured severely enough that they need to be hospitalized. Overall, this costs Atlantic Canada over $1 billion per year in direct and indirect costs.

Furthermore, injury is an issue that highly impacts our youth. Although injury is the leading cause of death across all ages, up to the age of 44 it is the number one cause of death. For children and teenagers, it is responsible for more deaths than all other causes combined.

Injuries that kill and disable so many Canadians are preventable through healthy public policy and evidence-based strategies. The issue of injury would benefit from a coordinated national injury prevention strategy. National strategies and coordinated efforts have been integral to other high-profile health issues. We need to move beyond attempting to change individual behaviours and work to create safer environments through broader social change.

There is a need for federal leadership to coordinate across sectors, so that injury prevention efforts are comprehensive and take into account the many factors that put individuals at risk for injury. Continuing to create divisions between issue areas or between intentional and unintentional injury is artificial and unnecessary, as the root causes are the same for all.

Although the federal government has recently indicated a planned focus on injury prevention for children, ACIP would encourage an approach that will address injury across ages, population groups, and injury issues. The socio-economic conditions that increase injury risk for children are the same as those that increase risk for other populations and age groups at higher risk, such as seniors and aboriginals. Furthermore, children are heavily influenced by the adults in their lives and their surrounding environments. Safe and healthy children cannot exist without safe and healthy adults, and communities.

Our communities won't be safe until they're equitable. Canada has the capacity to be as healthy and safe as other countries who are leaders in the health field, but we need to make some big changes. We know what the cure for this disease is. If we can come together as a country on a coordinated injury prevention strategy and a series of healthy public policies that address the role that poverty plays in injury, we can address billions of dollars in avoidable health care costs, and, more importantly, an enormous personal burden to millions of Canadians.

Thank you.

● (1215)

The Chair: Thank you very much.

Now we'll have a presentation via teleconference from SMARTRISK, with Philip Groff, president and chief executive officer.

Would you share with us some of your insights into this area, please?

Dr. Philip Groff: Thank you, Madam Chairperson, and thank you to the rest of the committee.

My name is Philip Groff, and I thank you all for the opportunity to speak with you today and to share some information on injury and its prevention.

I'm here today representing SMARTRISK, a national charitable organization dedicated to preventing injury and saving lives. Our mission is to empower you through education, programming, and policy change to recognize and manage the risks of injury in the smartest way possible. We focus most of our programming efforts on young people, as they are at peak risk for injury and are prone to take risks without thinking them through. We believe if we can reach young people, traditionally a tough group to get through to with safety messaging, we could help make them smart risk-takers for life.

Our organization began 19 years ago when our founder, Dr. Robert Conn, a pediatric heart surgeon, became interested in precisely where the donor hearts he was harvesting as a member of a transplant team were coming from. He did some research and discovered they were coming from people like you and me, like our children, our nieces and nephews, people who were healthy and happy one moment, but then due to a bad decision on someone's part, or a poorly engineered piece of the environment, or a moment of inattention were fatally injured and eligible to donate their organs. Dr. Conn realized he could save many more lives by preventing injuries before they happen, rather than trying to repair them in the operating room afterwards. He left surgery and founded SMARTRISK.

Since that initial research of Dr. Conn, the data has not lost its impact. In 2009 SMARTRISK released our second national report on the economic burden of injury in Canada, a report that we have tabled with the clerk of this committee. You will see that in any given year, injury claims more than 13,000 Canadian lives and necessitates more than three million emergency department visits and more than 200,000 overnight hospital stays. It leaves more than 60,000 citizens with some form of personal disability and another 5,000 permanently and totally disabled. The annual cost to all Canadians is more than $19.8 billion, all for events that the research literature indicates are largely predictable and preventable.

At SMARTRISK we've spent the majority of our efforts in trying to protect the youth of this country from death and serious injury. As you've already heard, injury is the leading cause of death from ages one to 44, and between the ages of 10 and 35 a Canadian is more likely to die from a predictable and preventable injury than from all other causes of death combined. Getting youth to manage their risk of injury is not impossible, but neither is it easy. We've invested a great deal of time and research investigating what works and what doesn't when trying to persuade teens to make smarter choices. We've learned through research and talking to teens to avoid negative messages, with an emphasis on consequences that push our audience into denial that these events could ever affect them. We've learned to emphasize the positive benefits of making healthier choices rather than trying to scare teens straight, and we've learned to harness the enormous power of positive peer influence so that life-saving messages are spoken in a language that is native to our young listeners, which no adult remembers fully how to speak. We've also learned the importance of building supportive environments so that the healthy choices are also the easy, popular, and fun choices.

We and our partners at the other national injury organizations have learned a lot about how to prevent injuries and save lives. We have the vaccine; what we lack is the infrastructure and supports to deliver it as widely as necessary.

A number of years ago we facilitated a national consultation with stakeholders representing the domains of surveillance, research, knowledge translation, and community programming to develop a draft framework for a national injury prevention strategy. The resulting document, *Ending Canada's Invisible Epidemic*, called for a pan-Canadian strategy based on six pillars: national leadership and coordination, an effective surveillance system, research, community supports and resources, policy analysis and development, and public information and education.

There has been some development of each of these pillars in the subsequent years, most vividly the leadership shown by CIHR in the development and launching of the strategic teams in applied injury research grants last year, a landmark achievement, as it represents the first time that many researchers in this country will be able to devote themselves to injury prevention research as their primary vocation rather than as a sideline they pursued with passion but little support or recognition.

However, much of the development that has occurred in these areas has been led from outside government, through the dedication of various NGOs. We are still looking for national leadership and coordination on this issue and a commitment to address this epidemic that is commensurate with the magnitude of the burden.

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.”

SMARTRISK, along with the other national injury prevention organizations—Safe Communities Canada, Safe Kids Canada, and ThinkFirst Canada—stands ready to partner with the government on this national strategy.

Thank you again for the opportunity to speak today. I'd be happy to answer any questions.

● (1220)

The Chair: Thank you, Dr. Groff.

We will go to the questions and answers as soon as all our presenters give us their information.

We'll go now to ThinkFirst Canada. We have two speakers here. Rebecca Nesdale-Tucker, the executive director, will be doing the meat of the presentation, and Tyler will be adding a few words.

Rebecca.

Ms. Rebecca Nesdale-Tucker (Executive Director, ThinkFirst Canada): Thank you.

I'm Rebecca Nesdale-Tucker, executive director of ThinkFirst Canada. We're grateful for the invitation to present to you today on this important health issue.

Preventable injury is the leading cause of death for young Canadians age one to 44, and it's a leading cause of death and disability for all ages. Though often considered accidents or acts of fate, most injuries are in fact preventable.

Canada can and must do a better job of keeping Canadian children, our most precious resource, safe. That's why ThinkFirst Canada exists. It was founded in 1992 by renowned brain surgeon Dr. Charles Tator and other committed individuals who understood then and now that—

The Chair: Excuse me. Could I just interrupt you and ask you to slow down for our translators?

Ms. Rebecca Nesdale-Tucker: Oh, sorry.

The Chair: They're good, but they're not that good.

Ms. Rebecca Nesdale-Tucker: I was trying to jam all I could into the five minutes.

The Chair: Just relax. I am generous with the time—

Ms. Rebecca Nesdale-Tucker: Thank you.

The Chair: —but I try to keep it within limits so everyone can be heard.

Ms. Rebecca Nesdale-Tucker: Dr. Charles Tator, our founder, and his committed colleagues, understood then and now that prevention is the only cure for serious brain and spinal cord injuries in this country.

ThinkFirst Canada is a national organization, and we have chapters in every province. We work with our chapters and partners to increase literacy and safety promotion through schools, sports and recreation-based programming, concussion education awareness, and helmet promotion. We develop our programming with an evidence base and with multi-disciplinary committees, and we deliver our message with VIPs, voices of injury prevention, who are injury survivors.

I am delighted and honoured to have Tyler here with me today. He is a VIP with ThinkFirst Ottawa, our chapter here. Tyler is one of our local heroes. He just this week was awarded for being a child activist in the region, and he has spoken to over 8,000 people in the past two years, sharing his story and his life-saving message.

I'm also delighted to have here with me today Dr. Alison Macpherson, who is a leader in the injury research sector in Canada, and a professor at York University. She will share with us some information about the status of injury in Canada.

Dr. Alison Macpherson (Board Member, ThinkFirst Canada): Thank you very much.

It is an honour to be here on behalf of the ThinkFirst Foundation of Canada.

Injury affects all of us. It affects the injured person; it affects the person's family; it affects our health care system profoundly. Injury is a huge public health issue in this country. On average in Canada, 500 children a year die from injuries. That's more than one child a day. These are your children, your grandchildren, your nieces, your nephews. We're all affected.

Every 30 seconds in Ontario, somebody walks into an emergency department for treatment resulting from an injury, so it's really important. It affects our wait times, our hospitalizations, everything.

The impact of injury is lifelong. Having a spinal cord injury can result in paraplegia, decreased mobility for the rest of your life. Having a brain injury, as I'm sure Tyler will share with us, can change your life forever.

The leading causes of injury include drowning, motor vehicle and pedestrian injuries, and falls. All of these have evidence-based strategies that can reduce their incidence or their causes in our population. If we just did what we know works, we'd already make a huge impact. Things like bicycle helmet laws, four-sided pool fencing, playground standards that meet the CSA standards developed here in Canada, rule changes in sports, can all lead to healthier and safer kids in Canada. We know that some populations are particularly vulnerable. Poor children are at increased risk. Our first nations and Inuit children are much more likely to die of injury than our other Canadian children. Children who live in rural and remote areas on places such as farms are also at increased risk.

We rank 32nd among OECD countries in injury prevention, and for a country like Canada, that is not good enough. We can and must do better for our children and for our communities in injury prevention.

Rebecca's going to talk a bit about some suggestions for strategies, which I think are similar to what the other speakers have mentioned.

● (1225)

Ms. Rebecca Nesdale-Tucker: As Dr. Groff and Ms. Heatley said, an all-ages injury prevention strategy has been called for by ThinkFirst Canada and its partners for many years. It was a welcome announcement, then, when the federal Speech from the Throne called for such a strategy for children and youth. The funding of strategic teams and research was also a welcome announcement, and we're also very much looking forward to the renewal and enforcement of Canada's product safety legislation.

We have great opportunities in Canada to lower the incidence of preventable injury. We look forward to opportunities, with increased resources and partnerships, to support greater injury prevention efforts. This can be better achieved with funding at a level more commensurate with the health burden that injury has on our society and in keeping with the resources dedicated to other comparable health issues.

What we would really like to see is resources to sustain a home to lead evidence-informed pan-Canadian action on injury. So we'd like to see that comprehensive approach that Alison referred to. We'd like to see it streamlined with a healthy living strategy. We'd like to see health literacy, including injury prevention, in all Canadian schools. We'd like to see safer sports and recreation so that our kids are healthy, active, and safe, so at the same time as combating obesity we're also addressing injury issues.

In public policy for a safer Canada, we have a lot of opportunities there. Of course, we'd also like to see continued injury prevention research and evaluation.

The Chair: You'll certainly get a chance to add a lot of things as you hear the questions.

Tyler, I think you had a couple of things you wanted to say. Please go ahead.

Mr. Tyler Lisacek (Community Volunteer, ThinkFirst Canada): Could you please repeat the question?

The Chair: Tyler, I just said that if you wanted to say a few things that would give our committee some good insight into what you think we should do for injury prevention, we'd be very happy to hear from you.

Mr. Tyler Lisacek: Giving ThinkFirst or the brain injury prevention associations money so we can reach out to help more public schools and schools in general would be great.

When I got hit, I was one kilometre away from home. I was on my bicycle. I was hit from behind by an SUV going 98 kilometres an hour. That pretty much caused my head to go right into the windshield. I ended up in CHEO with traumatic brain injury and all those other fun things.

Ever since then, with the side effects, the effects of it, the accident's changed everything. Since I got hit, all my friends, since we live out in the countryside, where everyone does aggressive four-wheeling, they don't want me to hang around. If I get hit, it's on them, so they say, “It's better just to take him out of the equation”, so nothing like that. I'm basically not allowed to do anything, anyway, because if I do get hit in the head again I could wind up back in a coma or in the hospital with worse.

It has caused me to do therapies for the past five and a half years. I'm still doing them. I'm on medications. I'm always doing neurology tests. I did some in October for a couple of days every two weeks.

● (1230)

The Chair: Tyler, I'm sure that some of the panel will be asking you some questions. I have to say that your being here makes a big difference to a lot of people.

Mr. Tyler Lisacek: Thank you.

The Chair: I think you are doing really, really well. Wow. You're just a modern-day hero, so thank you for being here.

We'll just wait and see what the rest of the panel has to say. Is that okay with you, Tyler?

Mr. Tyler Lisacek: Yes. I'm better at questions.

The Chair: Well, I think you were very good at the presentation. Thank you so much.

We'll now go into our Qs and As. We will begin with Dr. Duncan.

Ms. Kirsty Duncan: Thanks, Madam Chair.

Thanks to all of you for coming.

Tyler, congratulations on your recent awards. Thank you for having the courage to come. You make a real difference.

Why does Atlantic Canada have a higher rate of hospitalization of children due to unintentional injury?

Ms. Jennifer Heatley: It's difficult to pinpoint exactly why. The most frequent cause of hospitalization of children is falls. We are currently working in the region to develop a falls prevention strategy for children. It is difficult to know why one particular area in the country has a higher rate than another, but there are good cases for various socio-economic factors related to income and education levels. Those are very important factors when it comes to putting individuals at risk for injury.

Ms. Kirsty Duncan: Thank you.

You said we know how to do this. I look at your top five reasons for injury. Can you table with the committee the recommendations you would make to reduce each of these? Is that possible?

Yes? Okay.

The Chair: Mr. Groff is on the line as well.

Ms. Kirsty Duncan: Thank you.

What were the recommendations of the Atlantic report, and what have you done to roll them out across the country?

Ms. Jennifer Heatley: Do you mean the child and youth Atlantic report?

Ms. Kirsty Duncan: Yes.

Ms. Jennifer Heatley: There were a variety of recommendations based on the various injury issues. We haven't worked to roll them out across the country. It's been more specifically in the Atlantic region. We look a lot to policy and environment changes. Since the report was completed, a significant number of policy changes have happened. Examples include ATV legislation, booster seat legislation, and pieces like that. We will look to evaluate their effects.

For the most part we work closely with Child Safety Link, which is a Maritimes-wide injury prevention program, to address these issues. They have used this report to identify where they need to be focusing their work. Falls came out as being responsible for the majority of hospitalizations. We have partners in all four provinces that we work closely with to determine priorities for injury prevention action.

Ms. Kirsty Duncan: Thank you.

Dr. Macpherson, if you could give this committee your wish list, what are the top five things you would like to see implemented immediately to help reduce injury?

Dr. Alison Macpherson: The first thing would be a national strategy to get people on board and working together. I would definitely increase research funding. I am the co-principal investigator of one of the CIHR teams on child and youth injury prevention. Our approach to research is very integrated. We work with non-profit organizations—the four national NGOs—to move forward.

On the actual concrete things that I think you're looking at, I would lobby very hard for bicycle helmet laws that cover all ages across the country—so mandatory bicycle helmet legislation. I would insist that playgrounds meet the CSA standards, because falls are really important. One of the places children fall is on playgrounds. If they fall onto a surface that absorbs the shock they're much less likely to get injured.

I would have four-sided pool fencing for all residential pools so that children, especially toddlers, can't toddle out and drown in them. I would make a concerted effort to protect vulnerable road users, like bicyclists and pedestrians, by having designated lanes that can't be impinged upon by cars; and speed limits in residential neighbourhoods, particularly in school zones, that are enforced and that slow traffic down, so that what happened to Tyler doesn't happen.

Is that enough of a wish list? I could go on.

● (1235)

Ms. Kirsty Duncan: Go on. Put the wish list out there. Please feel free to join the conversation.

Dr. Alison Macpherson: Okay.

I would partner very actively with the Assembly of First Nations and Inuit Tapiriit Kanatami to address injuries in those very vulnerable populations and help them to have a strategy for injury prevention that works in first nations and Inuit communities. It's a huge problem there. They do have people working on it, but they could definitely use some support.

If you talked about falls and things like that, it would be the playgrounds and helping people make their homes safer.

One of the bottom lines I would address is poverty and inequity. I mean, that's a fundamental root cause. It's hard for parents to keep their kids safe and to help them get to school safely if they have to work two jobs. It's hard for parents to buy safety equipment, to buy a bicycle helmet if someone gives them a bicycle, if they don't have adequate income to do that.

I would definitely look upstream at the social determinants of health and I would work actively with policy-makers, such as the federal government and the provincial governments, to keep kids safe—in their cars, on the streets, everywhere they go.

Ms. Kirsty Duncan: Thank you.

I can't read your name, I'm sorry.

Ms. Rebecca Nesdale-Tucker: My name is Rebecca Nesdale-Tucker and I'm with ThinkFirst Canada.

I would very much echo what my colleagues have said at the table.

Number one is that we'd like to see strategic action. It has worked on the international scene in other countries. It simply makes sense to figure out what the priorities are and focus our attention there collaboratively.

As Alison said, whatever we're approaching we want to have a three-Es perspective, so consider the education, the enforcement, and the engineering. Absolutely, we want helmets whenever your head is vulnerable. Whether it's sports and recreation, if you're on wheeled activity, have a helmet on. Have enforcement of appropriate rules across injury cause, and make sure the engineering is appropriate as well. That goes to product safety and to regulation.

Almost every type of child injury requires this kind of multi-faceted approach. We have the solutions; we simply need to implement them.

Similarly with road safety crashes, we want kids in the appropriate child restraints, in the car seat, in the booster seat. We want to lower speeds. That helps pedestrians, helps all different types of vulnerable road users. Then again, the education piece: educate adults, but I also think we first favour educating kids from a young age so they're self—

The Chair: Thank you, Ms. Nesdale-Tucker.

I know we always get some very interesting answers, because we regularly get Dr. Duncan's ask for a wish list from our delegations. It's really interesting, because there's a thread that goes through all of these.

Mr. Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

[*English*]

The Chair: Yes, it's your turn.

[*Translation*]

Mr. Luc Malo: I would also like to thank the witnesses who are here today.

First of all, allow me to quote certain passages from the document entitled: *The Economic Burden of Injury in Canada* presented to us by the SMARTRISK group. This document describes the situation in each of the provinces. Madam Chair, may I be allowed to read what is being said about Quebec. This is at page 103 of the French translation, and at page 99 of the English version. The document states:

> In Quebec, the network of public health organizations has been consistently active within the area of injury prevention for the last 20 years. The injury prevention initiatives in the province are an expression of the Loi sur la santé publique (The Public Health Act) and the Programme national de santé publique 2003-12 (The Provincial Public Health Program 2003-12). The latter document identifies the priorities to be addressed by the public health and social services networks throughout the province.

I will skip a few lines and go to the second paragraph that I will quote in its entirety:

> The initiatives that have been implemented so far have yielded successful results in decreasing the number of injuries and deaths on the road, at home, and in sports and recreation. Successful initiatives have been those that have targeted individual behaviour, produced safer environments, or enforced safety regulations. As it was mentioned above, success has been dependent on collaborative efforts among a wide range of related stakeholders.

And finally, I will read the last paragraph in its entirety:

> To a group of leading organizations in the field of injury prevention in the province, the WHO has offered the designation of "Centre collaborateur OMS du Québec pour la promotion de la sécurité et la prévention des traumatismes (Quebec WHO collaborating Centre for Safety Promotion and Injury Prevention)". The Centre operates under the supervision of l'Institut national de santé publique du Québec, and works closely with the World Health Organization and the Pan-American Health Organization. The Centre addresses the safety and injury prevention needs of the international community as well as those of the international network of French-speaking safety and injury prevention organizations.

Madam Chair, I have finished reading the portion of the report pertaining to Quebec.

● (1240)

[*English*]

The Chair: Before you ask your question, I'll just remind you that we do have Dr. Groff here, who actually is part of SMARTRISK.

[*Translation*]

Mr. Luc Malo: Mr. Luc Malo: Thank you very much, Madam Chair.

In fact, my question goes to Mr. Groff. But beforehand, please allow me to conclude that in view of all of the above, it seems clear that a pan-Canadian strategy is not the best solution for Quebec. In fact, as I mentioned at the very beginning of my presentation, a good number of mechanisms have been put in place over the past 20 years. This is not to say that we should remain static. Because of its effect on an individual, as Tyler so aptly described it in his statement before us, one injury remains one too many.

However, my question to Mr. Groff is linked to what Ms. Macpherson has said concerning aboriginal peoples as well as to certain other statements that were made earlier this week. It was during our first meeting on the subject and it was on the fact that this type of injury occurs more frequently in aboriginal communities than in non-aboriginal populations.

Mr. Groff, has this data collection exercise also been done for aboriginal populations?

Madam Macpherson, what kind of collaborative measures with aboriginal communities do you foresee in order to come up with an efficient strategy?

[*English*]

The Chair: Who would like to respond?

[*Translation*]

Dr. Alison Macpherson: I will also answer.

[*English*]

The Chair: Dr. Macpherson, go ahead.

[*Translation*]

Dr. Alison Macpherson: I will answer in English, if that is convenient.

[*English*]

If we're speaking specifically about the first nations and Inuit population, there have been some strides made. On the question of the statistics for them, the health statistics are not as comprehensive as they are generally for the mainstream population, but the Assembly of First Nations launched the aboriginal longitudinal regional health survey, the second round of which has just been finished, and as researchers we are working actively with them to get some accurate statistics on all types of injury in first nations communities.

Similarly, Inuit Tapiriit Kanatami is working to try to get a really good handle on injuries in Inuit communities, which are mostly in the far north, as you know.

So there is definitely a lack of information, but the key lobby organizations are keenly interested in getting more information, to find out what the statistics are, and to move forward with appropriate steps.

[*Translation*]

Mr. Luc Malo: The communities—

[*English*]

The Chair: Monsieur Malo, did you want Dr. Groff to make some comments?

[*Translation*]

Mr. Luc Malo: Yes, but I would also like to know if the communities are directly involved in these activities.

Dr. Alison Macpherson: Yes, of course.

[*English*]

Dr. Philip Groff: All right, first, to answer the question you had asked about whether data was collected as part of the economic burden research on aboriginal communities—first nations, Inuit, Métis, and non-status Indian communities—the answer is that unfortunately, for this project we were not able to do that level of analysis. The challenge is that the economic analysis we conducted here was conducted based on administrative data sets collected provincially and then rolled out federally across the country, specifically the discharge abstract data set on hospitalizations across the country, vital statistics for death data, and, in the two provinces where it's available, the ambulatory care or emergency department care data.

In a number of jurisdictions across the country, including some of the largest jurisdictions, there are no indicators of aboriginal status in those data sets, so there is simply no way to break down the data to show which members of the populations we were surveying were of aboriginal origin and which ones weren't, and thus we weren't able to do that level of analysis with this report.

Having said that, a number of years ago we partnered with the first nations and Inuit health branch as well as with a number of key NGOs, including ITK and some of the first nations, to do a small cost-benefit analysis in a couple of jurisdictions such as B.C., Alberta, and Saskatchewan, where we did have indicators of aboriginal status, about the cost of injuries in those communities and the potential benefits from some interventions, specifically around falls and motor vehicle injuries in those areas. That report is now quite dated, unfortunately, but I could provide some of those numbers and that information to members of the committee at a later date, if you wish, or I could simply forward the report to the clerk of the committee.

To make a long story short—and I realize I probably already missed that opportunity—the fact remains that when we're able to collect information, we do see a disproportionately high burden of injury among first nations and Inuit population—

● (1245)

The Vice-Chair (Ms. Kirsty Duncan): Dr. Groff, I'm sorry, if I could stop you there, we've run out of time on that question. But if you could send those reports, we'd be grateful. Thank you so much.

Ms. Leslie.

Ms. Megan Leslie: Thank you, Madam Chair.

Thank you all for being here. This has been very interesting.

My first question is for Dr. Groff. This report is fantastic. I'm wondering if you have presented it to the federal government, and if so, what has been their response?

Dr. Philip Groff: The short answer is we've not formally tabled it in the House of Commons. This is the first opportunity, through a House committee, to present the report. We did send copies of the report in advance of its publication to every member of cabinet in the summer of 2009. That is the way we got it to the government.

We do know that our partners at the Public Health Agency of Canada have made some use of the document and have been in contact with us about it.

I thank you for your compliment on the report, and I hope the committee does find it useful in its deliberations.

Ms. Megan Leslie: Have you gotten any response from any members of cabinet?

Dr. Philip Groff: We have not as of yet.

Ms. Megan Leslie: My next question is along these same lines, and it's for everybody.

Yes, we need an injury prevention strategy, I agree, and Nova Scotia can learn a lot from Quebec, apparently. I'm very happy that we could have a pan-Canadian strategy where we could learn from each other.

I'm wondering what the federal response has been to your calls for a national strategy for injury prevention.

Ms. Rebecca Nesdale-Tucker: One thing we're all celebrating is the announcement in the Speech from the Throne regarding the child and youth strategy. As Dr. Groff and others have said, the NGO sector and the Canadian Collaborative Centres for Injury Prevention and Control are looking forward very much to contributing to that and making that a reality.

Ms. Megan Leslie: You say looking forward to contributing, so that hasn't happened yet—you haven't been approached yet?

Mrs. Rebecca Nesdale-Tucker: We have had some conversations with the Minister of Health. We submitted some plans or suggestions to move forward.

Our organizations have participated with product safety renewal, so that's an area we're excited about. And we're delighted that $10 million was awarded by CIHR, but we would like to get further than that, obviously. We'd like to see a centre of excellence for injury in Canada. We'd like to see strategies apply to all ages.

We're very concerned about the vulnerable people in our society, as has been addressed by other members, namely aboriginal and Inuit communities, but we are also addressing the social determinants of health.

Dr. Philip Groff: I would just add that a number of us also sit on a federal-provincial-territorial committee, which is task group of the public health network. It is the expert committee on chronic disease and injury prevention, the injury prevention and control task group. It has also made recommendations to the government through that vehicle, and by invitation we were asked to form this task group.

I guess what we'd like to see is injury getting a higher profile in some of these situations, so that it's not always the add-on, so it's not chronic disease and injury, or substance abuse and injury, but rather that injury would have a home within the government and that there would be people there taking direct responsibility for it and solely for it.

● (1250)

Ms. Megan Leslie: Ms. Heatley, did you want to add something?

Ms. Jennifer Heatley: I can only echo what my colleagues have said. We are definitely in agreement that there is a need to go a bit further. We have a very strong network nationally of collaborators and we work together quite frequently, but we would like to see a formalization and a strong commitment to injury prevention nationally.

Ms. Megan Leslie: You all have talked about specific risk groups, and thank you for bringing in social determinants of health. It's incredibly important, any time we look at injury prevention.

What are some of the techniques or some of the measures that you use to actually reach youth that are hard to reach because they live rurally, they maybe don't have a computer at home to access the website, or there's no local chapter in their neighbourhoods or in their towns, or anywhere near them? What are some of the strategies that you use?

Ms. Jennifer Heatley: In Atlantic Canada we have been working with school-based programs, which we are currently evaluating. We're also looking at expanding those, because we know that they don't necessarily reach all high-risk youth. We are looking to expand into other community programs, such as community-based programs that may be for youth with mental health issues or addictions, or substance use issues, and working to get in those doors and working with them as well.

We all are also partnering this year with first nations and Inuit health branch as well as several of the Mi'kmaq, Malachite, and Inuit communities in Atlantic Canada to hold consultations with those communities in January. We want to hear directly from them. We want to create stronger partnerships between those groups and the injury prevention NGOs, and move forward in that area specifically in our region.

Ms. Rebecca Nesdale-Tucker: I'll give one example from our chapter in Winnipeg. We deliver, across the country, educational programs. ThinkFirst for Kids and Brain Day are two examples. They've been getting a lot of invitations in Winnipeg to go to aboriginal communities, rural and remote communities. There has been fantastic enthusiasm for the presentations they've been able to deliver there. They've had an excellent reception and keep being invited back. It's a problem they're happy to have. What we're trying to do now is make sure that we have the resources to accommodate that kind of travel and that sort of thing. I know that something our colleagues are interested in doing is making sure that we're really reaching the kids most at risk. Every Canadian is at risk for injury, but there are groups that are more at risk.

Ms. Megan Leslie: Dr. Groff, you described the pillars: coordination, education, policy, research, funding. Can you tell us a bit more about surveillance? What does that look like to you? What would that pillar look like?

Dr. Philip Groff: Thank you, yes.

As I'm sure members of the committee are aware, unfortunately, we're in a situation where a lot of the data on injury we have to work from is out of date. It is a couple of years lagging behind.

I think one of the things that needs to happen in surveillance in the immediate term is to really support the finalizing and development of the national coroner's data sets so that we can have comparable death data across the country.

Second, I think there's a real opportunity to collect information in the emergency departments that's useful for injury prevention. We need a national collection of emergency department data, and if we're going to do that, we need to structure it so that we're actually getting more than just administrative information about what resources are being used. We also need key information on what's landing the people in the emergency departments to begin with.

So I would like to see an emphasis on those two areas for immediate development in terms of a national injury surveillance system.

The Vice-Chair (Ms. Kirsty Duncan): Thank you, Ms. Leslie, and thank you, Dr. Groff.

Now we'll go to Ms. McLeod for the final round.

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

Thank you to all the witnesses. Certainly your focus and energy is on something that's hugely important to Canadians. It's a great area to be focused on.

I have a number of things. First of all, I have to say, as a mother of three children who are involved in lots of sports, I always thought that if I could have developed a universal helmet, it would have been great, because between bike helmets and snowboards and hockey.... Certainly for me it was just part of buying the equipment for my children so that they could participate. I think for some families it must be an incredible stretch to have the appropriate helmet for every sport a child might participate in. Anyway, I thought I could design and patent one, but maybe it will be in my next world.

I have two things, and I'll perhaps put them both on the table and then I look forward to the comments.

My first question will be to Tyler. I want to understand a little bit about what he's doing when he goes into the schools and talks to the students.

Could you just tell me a little bit about what you do and what kind of difference you think it makes?

● (1255)

Mr. Tyler Lisacek: Most of them are Catholic schools. The public school board hasn't quite wanted us to do them there yet.

When I go into a school, after the other presentations, I step up to the microphone, and I basically talk to the kids and say that you should wear your helmets. I was like you once upon a time, and this is my story. And then I tell them basically everything I told this committee at the beginning about all my injuries and everything. I tell them that this was a four-second decision. I took my helmet off on a hot summer day when I was really close to home, and this is what changed my life forever. That's basically my presentation.

The doctor does his, from a doctor's point of view, on the brain and everything. I do mine. And then my stepfather, Bob, comes up and tells it from a parent's point of view. He tells them how it was, the whole experience of being called by the police, telling him to go to CHEO, and about the wait and what it's like for the parents and everything.

When we go there and we do all that, usually, at the end, for most of the kids—you can see them when they first sit down—you can really tell that you've given them a piece of information and that they'll think first before they go bike riding, which is the objective of our group.

Mrs. Cathy McLeod: I don't know if formal evaluations have been done, in terms of the two students' perspectives, but it sounds like you're really changing how they think about safety through the presentations.

Next I'd like to focus, as Ms. Leslie did, on what an ideal surveillance system might look like. Tell me about your ideal surveillance system.

Dr. Alison Macpherson: I think I could take that one on. I think the ideal surveillance system is a system that captures injuries close to their real times so we could react quite quickly if we saw something happening.

The ideal surveillance system would include the demographic information we would like to have to help us plan injury prevention programs such as those in Atlantic Canada, Quebec, and across the country. It would include all emergency department visits in every emergency department across the country. For rural and remote communities, where people do not have access to an emergency doctor at the time of the injury, it would include information from the nursing stations and other places.

I think what Dr. Groff mentioned about the national coronial database is extremely important. It's only through the richness of data like that and in-depth death reviews that we can really understand what happens.

I'll give you a brief example. British Columbia used the coronial database to look at pedestrian injuries, and they found that drivers who killed child pedestrians were seven times more likely than other drivers to have had a previous driving infraction on their record. So the potential for intervening with the drivers, instead of trying to teach kids how to cross streets, is huge.

To sum up the injury surveillance system, it would be from the emergency department and the health unit, all the way up to the death data.

Dr. Philip Groff: I'd like to add something to that, if I could.

From the ideal system perspective, for it to be a truly complete system, it has to include not only support for the collection and tabling and dissemination of data but also support for the capacity to properly interpret and use that data. I see an important crucial part of the ideal injury surveillance system being those supports to build on existing capacity for interpretation and use of the data in an effective way.

● (1300)

Mrs. Cathy McLeod: Dr. Groff, are there any provinces, territories, or countries that you think would be the best examples?

Dr. Philip Groff: I think if we look internationally, a number of countries in Europe are very good at the way they collect and disseminate their data and make their data useful. There's a product that has come out of the World Health Organization in Europe, which is a series of report cards on childhood injuries for each of the countries. I know a number of us who were at the international conference in London this summer are trying to develop a similar set of products for Canada. That's one area to learn from.

Within the country there are a number of provinces that are better than others at collecting and disseminating their data. I would say the work that has been done in British Columbia in partnership with the B.C. Injury Research and Prevention Unit on making injury data transparent, easily accessible, and available to all community partners across the province is stellar. We should have similar-looking product available in every province in this country.

Last, I would like to flag that the research team Alison is a part of is working on developing a set of standardized indicators for childhood injury. I think that's really important work, as well.

The Vice-Chair (Ms. Kirsty Duncan): Dr. Groff, thank you. And thank you, Ms. McLeod.

I'd like to thank all our witnesses for coming and Dr. Groff for being on the phone. We thank you for your time, your effort, and your testimony. Thank you so much.

Dr. Philip Groff: Thank you for having us.

The Vice-Chair (Ms. Kirsty Duncan): The meeting is adjourned.

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