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## Wednesday, October 5, 2011

## Chair

**Mrs. Joy Smith**

# Standing Committee on Health

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● (1535)

[*English*]

**The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)):** Good afternoon, everybody, and thank you so much for joining us today. We have some wonderful witnesses.

Pursuant to Standing Order 108(2), we're doing the study of chronic diseases related to aging. I'm sure that will keep some of us on our toes as we're listening to all this inside information.

We're so glad to have with us today, from the Public Health Agency of Canada, Kim Elmslie, director general. Is it Dr. Elmslie?

**Ms. Kim Elmslie (Director General, Centre for Chronic Disease Prevention and Control, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada):** No, it is not.

**The Chair:** Kim is from the Centre for Chronic Disease Prevention and Control, Health Promotion and Chronic Disease Prevention Branch.

And we have Cathy Bennett. Is it Dr. Bennett?

**Mrs. Cathy Bennett (Acting Director, Division of Aging and Seniors, Centre for Health Promotion, Public Health Agency of Canada):** No, it isn't.

**The Chair:** Cathy Bennett is the acting director, division of aging and seniors, Centre for Health Promotion.

I'll give you each 20 minutes or whatever you need. If you want a little bit more time, that will be fine.

Kim, you're the one who is going to be presenting today. Okay, please fill us with all this wonderful information. Thank you.

**Ms. Kim Elmslie:** Thank you so much.

First, I want to start by thanking the committee for inviting us here today. I can't tell you what a pleasure it is for the Public Health Agency of Canada to come to this room and to speak with you and to share with you many of the things we are doing in the agency, working across the country to address chronic disease and specifically to address chronic disease and aging.

[*Translation*]

Madam Chair, honourable members, thank you for the opportunity to speak to you today regarding chronic diseases and aging.

I will provide you with an overview of current federal actions which promote healthy aging and address the increasing chronic disease burden on Canadian seniors.

[*English*]

As we all know, Canada's population is aging. While today people age 65 account for about 14% of our population, by 2036 they will account for 25% of our total population, equalling some 10 million Canadian seniors. The good news is that Canada's chief public health officer in his 2010 report “Growing Older—Adding Life To Years” notes that older Canadians are living longer and having a stronger sense of belonging to their community, and the majority report being healthy.

When older Canadians retire from paid employment, they continue to play vital roles in their communities. I think we all see that in our own communities. Clearly, our seniors are taking action to look after their health and well-being. We can all feel good about that, but there's more to the story.

We also know that while Canadians are living longer, we are not necessarily healthier. Almost 90% of seniors over the age of 65 have at least one chronic disease or condition, the top three causes of death being cardiovascular diseases, cancer, and respiratory disease. Many Canadian seniors are living with chronic conditions such as diabetes, heart disease, cancer, arthritis, Alzheimer's disease, mental illness, respiratory diseases, and obesity. One-quarter of seniors are living with two or more of these diseases or conditions, and that's important, because we often think of our senior population as having chronic disease, but rarely do we think of the numbers of chronic diseases that our aging population faces. Our most vulnerable seniors, such as those who are economically disadvantaged, are at even greater risk.

We all know that chronic disease accounts for a significant burden to the individuals, their families, their informal caregivers, the health care system, and our Canadian economy. The majority of hospitalizations, disabilities, and premature deaths in our country are related to chronic diseases. These diseases cost the Canadian economy about $190 billion annually. That includes costs for medical treatment as well as the cost of lost productivity when our workforce develops chronic diseases or when our workforce is caring for elderly parents with chronic diseases as well as children living with chronic diseases.

When we look at tomorrow's seniors, there is serious cause for concern. Obesity rates are rising in working-age adults. One out of six Canadians over the age of 20—that's about 4.5 million of us—are obese. Diabetes rates are rising. In 2006, just over 2 million Canadians were living with diabetes, but many more are unaware that they have the disease. With earlier onset of chronic diseases, working-age adults are less able to support seniors both personally and financially.

I've told you the good news and I've told you the bad news. Now I'm going to talk to you about what we are doing to create the conditions for healthy aging. This is really what will be of interest to you around this table in the jobs that you are doing. Creating the conditions for healthy aging, preventing or delaying the onset of chronic disease, and preventing complications when diseases occur makes sense at all ages. I want to really stress that with this group because what we are focusing on is healthy aging across a life course. That begins at birth. It does involve ensuring that our children are eating healthily and adopting healthy practices as early in life as we can possibly make it happen, so that across their life course they have the greatest possible chance of continuing to be healthy and delaying the onset of those chronic diseases until well into their 80s or even into their 90s.

Promoting healthier living in children sets the stage for maintaining good health and reducing risks of disease in their senior years. To achieve this, we need to work really closely in partnership with provinces and territories, non-governmental organizations, and business to find ways to collaborate and to improve health across the life course and of course the health of our seniors.

● (1540)

Let me expand a bit on partnership. And why do I want to do that? We always talk about partnership. I want to talk to you a little more about that because achieving good health needs to be viewed as everyone's business. It's not just the business of the health sector. The health sector needs to be working in partnership with a variety of other sectors, including agriculture, as we want healthy food, and transportation, as we want to provide for safe, active, healthy ways that people can move about in their communities. Sport and recreation need to be key partners in this, and the health sector of course needs to be there. But I can't stress enough the importance of what we all refer to as multi-sectoral collaboration if we're really serious about moving the healthy agenda forward.

The commitment to helping all Canadians lead healthier lives is illustrated through a really important declaration. That declaration, called the declaration on prevention and promotion, was endorsed by all federal, provincial, and territorial health ministers last fall. And it sets the stage for unprecedented collaboration among federal, provincial, and territorial governments in supporting good health.

It sets out some principles that are exceptionally important to understanding that health promotion is everyone's business, and that prevention is part of treatment. So we want to instill when we need to use the health services in our country, and we want those health services to also put an emphasis on prevention. When you prevent diabetes you're also preventing cardiovascular disease. So the prevention norm needs to become much more part of the way we think as individual Canadians, but also the way we think about how we design our communities, how we work together, what we do in our recreational time, and how we make healthy choices that can be sustained over time.

At the federal level we have a broad portfolio of work on seniors' issues. I want to come back to seniors for a minute. The National Seniors Council, which was established in 2007, is providing advice on emerging issues and opportunities specific to the quality of life and well-being of our seniors. This council reports both to the Minister of Human Resources and Skills Development Canada and to the health minister. And it's a mechanism for inviting our seniors into the policy conversations, ensuring their voices are at the table as governments tackle health challenges and work to keep seniors active and healthy.

It's not news that seniors are vital contributors to the development of innovative and effective solutions. The age-friendly communities initiative is one that embodies Canada's approach to promoting healthy, active aging. This initiative brings older Canadians into the planning and design of their own communities to create healthy, safe, and supportive environments where they can live and thrive.

The approach is being received enthusiastically across the country and internationally. Since it was first introduced in Canada in 2006, over 560 communities have taken steps to make their communities age-friendly, meaning more accessible for seniors, safer for seniors, and putting seniors at the centre of policy discussions around how we design communities for aging.

● (1545)

Another important step we're taking to address chronic diseases in aging is filling critical knowledge gaps by investing in research that's solving real world problems that are facing individuals, families, and communities. As one example, we've invested $15 million over four years on a national population health study of neurological conditions. This study involves 18 neurological health charities that have come together under an umbrella, Neurological Health Charities Canada. They are working together with the Government of Canada in a partnership to understand neurological conditions in this country. It may surprise you to learn that we in fact don't have good information on how many Canadians have neurological conditions. This study is about getting that information. But it's not just about counting people. It's about looking at the impact of neurological conditions on Canadians in their homes and communities and at what their families and caregivers need to improve the quality of care and the quality of life they are enabling among Canadians suffering from neurological conditions.

Certainly Alzheimer's disease and other dementias related to Alzheimer's disease are an important part of that, as are Parkinson's disease, epilepsy, and the myriad of other neurological conditions that often are hidden in communities. But when you bring neurological health charities together and they start to share experiences about what the impact is of these neurological conditions at the grassroots level, you start to understand the commonalities of impacts. You start to understand what needs are occurring in communities that governments working in partnership with health charities and business communities can actually start to solve.

This study is now in its third year of operation. The amount of research talent that's been brought to bear on this and the amount of community involvement that's been included in this study, in my view, is unprecedented. What we are going to know at the end of this study is going to allow us to look very precisely at where we need to make investments to improve the quality of life of Canadians living with neurological conditions. When we think about Alzheimer's and other dementias and about the aging of the population, we know that we're going to need this information very soon to prepare for those needs.

The Canadian Institutes of Health Research, our premier health research funding agency, is leading the Canadian longitudinal study on aging, which is another really important part of our toolkit in terms of understanding the health, social, and economic issues of Canadians age 45 to 85 over the next 20 years. Information from this cohort of Canadians will inform future decisions and activities related to prevention, health care, and social support.

While we're working to fill these knowledge gaps through the important research that's under way, we're also working with a range of partners to promote healthy aging and to prevent chronic disease. To promote health, we've supported the Canadian Coalition for Seniors' Mental Health. They're developing national evidence-based guidelines for practitioners, making an important contribution to the assessment, diagnosis, and treatment of mental health problems, including the prevention of suicide among seniors. By bringing these issues to the fore and by providing tools for practitioners who are on the ground, we're able to make great strides in prevention, better treatment, and better understanding of the conditions facing our seniors.

We're investing in partnerships that promote the development of conditions for healthy aging. That includes social inclusion, keeping seniors independent, improving their quality of life, helping them understand what they need to do to prevent chronic diseases or to delay their onset, and keeping them connected in their communities.

At a national level, there are a number of important strategies under way to meet these objectives. These include the Canadian partnership against cancer, the Mental Health Commission of Canada, the Canadian diabetes strategy, the Canadian heart health strategy, and the national lung health framework.

● (1550)

Let me mention briefly the work of the Canadian Partnership Against Cancer. Although this partnership is focused on cancer, it's really addressing chronic diseases more broadly. It's a partnership that's uniquely Canadian, and it's being watched around the world because of the approach it's taking. The Government of Canada is providing $250 million, over five years, to support the work of this important partnership.

It's really about mobilizing. I'm sure you see in your communities and your travels that there are nuggets of innovation everywhere across this country. I'm sure you think, if only this were happening at a more national level, wouldn't it be wonderful to see the impacts we could make with these initiatives?

That's what the partnership is doing. It's identifying these islands of innovation, as they're sometimes called, and it's mobilizing partnerships to introduce these innovations on a broader scale. Because the partnership is working directly with provincial and territorial governments, it's bringing those governments that have jurisdictional responsibility for providing services into the early thinking about what will work in their jurisdictions and how we can raise the bar on all of these services so Canadians from coast to coast are benefiting from the innovations happening in some communities across the country.

I encourage you to watch the work of the Canadian Partnership Against Cancer. It's already making a difference. I think we're going to see much more from it in the coming years, as it embarks on some interesting research projects. It's forming the largest Canadian cohort to study risk factors for chronic disease going forward. It's joining up the social care system with the health care system with communities, under new and important projects around innovation and prevention. It's boosting the policy discussion around end-of-life and palliative care.

In our view, public health, in the context of an aging population, provides an opportunity for action. A whole-of-society approach is really what we need. I know that sounds like jargon, but it's true. At the recent United Nations meeting on chronic disease prevention and control, which happened two or three weeks ago, the world talked about chronic disease prevention. World leaders—and our health minister was there at the table—talked about how they can work together and how countries can learn from each other to prevent chronic disease.

Developing countries talked about the double burden of malnutrition and obesity that they're facing. It was quite emotional to hear the issues that developing countries are struggling with around access to affordable medicines, prevention in the context of trying to feed their population, but also seeing their children becoming obese because of unhealthy eating.

This UN meeting put a focus on the action of many sectors that need to come together to address this societal problem. I stress again, it's not a health sector problem. The health sector is part of it, but it's our whole-of-society approach to staying healthy, helping each other stay healthy, and putting in place the programs to support the conditions for good health. This is a norm we have to start to think about.

While we've had success in extending the life expectancy of aging Canadians, it's important to remember that it's not just how long we live, but how well we live. Through working with partners to promote healthy aging and delay the onset of chronic disease, we will continue to take steps toward improving the health and well-being of Canadian seniors.

I'm going to stop there and thank you for listening. I'm looking forward to the discussion that's going to follow and the ideas you are going to put on the table.

Thank you very much.

● (1555)

**The Chair:** Thank you so much, Kim. That was an insightful presentation and a real springboard to start this study. You've given us many ideas, as you've spoken.

We'll start with our first round of seven minutes. Ms. Davies.

**Ms. Libby Davies (Vancouver East, NDP):** Thank you very much, Chairperson.

First of all, thank you very much to the director general for coming today. Many of us are new on the health committee, so it's really helpful to get this kind of overview and snapshot of what you're doing. I really appreciate it, and I feel as if you've spoken very frankly to us and given us a lot of information.

I think my questions and comments are going to focus not so much on the chronic diseases and conditions themselves but on what goes on around them. I was very struck by your figure of $190 billion annually for medical treatment and the impact on the Canadian economy. I know that a number of us met last week with the Neurological Health Charities of Canada and had some very good discussions, and the thing that really struck me when we're talking about these chronic conditions, to take Alzheimer's for an example, is just the impact on caregivers.

So much of our attention is focused on the acute care situation, it seems to me, like the hospital costs and all of that, but these other costs and what we're not doing is just so significant. So it's very alarming to hear that figure of $190 billion. But when you think of what you call informal caregiving, like family members who are having to give up work to provide care to aging parents—the so-called sandwich generation—it's a huge issue in our society. I just wonder, as part of this longitudinal study you're talking about, whether or not there are any particular elements that actually look at this question. What are these associated costs in terms of our not having adequate long-term care, our not having adequate drug coverage, and our being so focused on the acute care situation? What is that actually costing us?

I know that the outgoing president of the Canadian Medical Association, who's here at the Ottawa Hospital, Dr. Turnbull, made a very stark comparison of the cost of an acute care bed and a long-term-care bed—not even a senior at home any more, but someone who's needing to go into a facility.

I'm interested in whether that longitudinal study is looking at that. How often does it report out? If it's over 20 years, there must be regular report-outs. When can we expect the next one?

The other thing I would raise with you is do you have an example of a country that you think is doing a pretty good job on chronic diseases, that you look to and say, wow, that's where we should be trying to get to?

● (1600)

**Ms. Kim Elmslie:** Thank you very much for those excellent questions. I think we're all struggling with the issues you've talked about.

Let me address the neurological health population study and what it can tell us. The study will look at impact and will project impact out over the next 20 years. Within that context, it will look at the economic issues associated with living with neurological diseases.

One of the studies—and I brought the list of studies with me—that's happening out of Dalhousie University is looking at the everyday experience of living with and managing a neurological condition. I'm really looking forward to that particular study, because it will look, at a very practical level, at the health, the social, and the economic side of living with a neurological condition.

In answer to your question on whether we are going to be getting information to help us understand the impact on the economy, both at the level of the workforce and at the level of what they call the macro-economy, yes, we are going to be getting that information. The researchers come together annually to report out on what they're learning. Their next meeting will be in January 2012. It would be great to involve as many of you as could possibly be there to understand what these researchers are finding, because we're just starting to drill down on some of those tough questions on this issue. So there's more to come on that, but I'm happy to share with you the program of research so that you can see with more depth what these folks will be studying and understand how the economic impacts are going to play into that.

On the issue of other countries we can look to, when I look around the world I look at models that are being developed in the United Kingdom, in Australia, and in some of the Scandinavian countries. The Scandinavian countries have had a lot of success in the heart health arena, in reducing cardiovascular disease and cardiovascular disease outcomes, so I think we can go there to learn how to take a population approach to these things.

In terms of the health care system transformations, the U.K. is doing a great deal of work in that area. I think we can learn a lot there. But nobody has this one solved: there's no one country that I would point to and say, boy, they really know how to do this. Of course, that's because our contexts are so different and the way we deliver care is so different, as are the ways in which we deliver prevention and how we've adopted prevention in our various countries.

But the collaborations that are happening in research across the world are really starting to help us identify what we can apply in our own country, based on what is being learned in other countries, and I'm excited about that, especially in the area.... I'll point out Alzheimer's disease because it relates to the topic today, and also because it's just such an important area for us as a country to get our heads around in regard to how we're going to deal with this as our population ages.

● (1605)

**The Chair:** I just want you to keep in mind that you only have a couple of seconds left. We want each person to have their full seven minutes as it's just so interesting, but the next person could pick up on that. To help you out, I'll give you a signal when there's a minute left, if that's okay.

**Ms. Kim Elmslie:** That would be great. Thank you so much.

**The Chair:** All right. We've gone over for this particular one, so we'll go on to the next one.

Mr. Gill.

**Mr. Parm Gill (Brampton—Springdale, CPC):** Thank you, Madam Chair.

I also want to thank the witnesses for coming out and providing this very valuable information.

In your mission statement, there's a mention of surveillance of these conditions. What surveillance systems are currently in place, and how are they impacting patient care and disease prevention or control?

**Ms. Kim Elmslie:** For chronic disease we have a number of surveillance systems in place. We have paid a lot of attention to them in terms of integrating them so that we get information on not only the disease outcomes themselves but also the risk factors for the disease and some of the conditions that are important to developing disease as well.

Our major surveillance program for chronic disease is called the Canadian chronic disease surveillance system. It's a surveillance system that allows us to work with provincial and territorial governments and gather information from their health systems around risk factors for chronic disease and trends in chronic disease over time.

That's a core function that we play. Each year we produce in-depth reports on various aspects of chronic disease to feed back to provincial and territorial governments and to national health organizations, as well as to our own government, so that we can use this information to make decisions. For example, next month we'll be issuing the first comprehensive report on diabetes in Canada. It will look at the full range of diabetes from the perspective of the factors that influence its development—obesity, poor nutrition, physical inactivity—as well as what's happening in the care system around diabetes control and management.

These surveillance products are widely distributed. We use them extensively to inform and target policies and programs. Provincial and territorial governments are the main users of our products, but non-governmental organizations, such as the Canadian Diabetes Association, also use these products to help them understand where they need to be investing their resources, what areas across the country are most vulnerable. For instance, we know our first nations, our aboriginal populations, are highly vulnerable to diabetes and other chronic diseases. We use those surveillance reports to shine a light on where the real problem areas are and how we can best address them.

**Mr. Parm Gill:** That's great.

Would you be able to tell us how Canada compares with other countries when it comes to the rate of chronic disease?

**Ms. Kim Elmslie:** It's hard to make comparisons with other countries, because oftentimes the way we count chronic diseases will differ. Generally speaking, however, our rates of chronic diseases are comparable with other developed countries, such as the U.S., the U.K., and Australia.

We don't know what the rates of chronic diseases are like in developing countries, because they don't have the infrastructure to do surveillance at all, but in general the developing countries are seeing rates grow at about the same pace.

When you think about the causes, it's not surprising. We're all dealing with rising rates of physical inactivity and rising rates of unhealthy eating. We're all seeing rising rates of obesity. The fact that people are overweight and obese is a major driver of increasing chronic disease rates in our population. Those rates are similar in developed countries.

**Mr. Parm Gill:** In your assessment, how do we really fare as a country? Are we above average, are we below average?

● (1610)

**Ms. Kim Elmslie:** I would say we are about average if we compare with World Health Organization statistics. Again, comparisons are difficult to make, because people count these things differently.

**Mr. Parm Gill:** Would you be able to describe some of the initiatives being taken in terms of prevention and promotion around chronic disease?

**Ms. Kim Elmslie:** At the federal level, we have the integrated strategy on healthy living and chronic disease. That strategy addresses healthy living across the lifespan. It includes a specific emphasis on seniors—for instance, in the area of falls prevention. It focuses on cancer, diabetes, and cardiovascular disease, these illnesses being the major causes of death and disability, and it focuses on addressing risk factors like physical inactivity, poor nutrition, overweight and obesity, and smoking. We also focus through that strategy on Alzheimer's disease and the work we're doing with the neurological health charities.

So how do we do these things that we're doing through these strategies? First of all, we're looking at what's common among them so that we can join up the things that make sense and do them in an integrated fashion.

Prevention and management really require that we take action at the national level, at the provincial-territorial level, and at the local level. Good data are what drive good programs. We've all heard the old adage that you can't manage what you can't measure. We spend a lot of our time measuring and providing data and analysis to provincial and territorial governments, communities, and others so that they can take those data and use them to make change in their own local communities or at the provincial-territorial government level.

Federally, we've created a centre of expertise in surveillance, so people rely on us to do that for them. That's the value-added that we bring. We also focus on effective practices and effective interventions in understanding what works and why.

Many of our strategies provide communities with funding so they can test out interventions. Those interventions then can be shared more broadly to be used by others. We call that initiative the "Canadian Best Practices Initiative". It involves a huge number of community organizations focusing on specific aspects that are of relevance in their own communities, so that we can learn from them and scale them up as appropriate across the country.

**Mr. Parm Gill:** Thank you very much.

**The Chair:** Thank you. You're right on time. How did you do that, Mr. Gill?

We'll now go to Ms. Duncan.

**Ms. Kirsty Duncan (Etobicoke North, Lib.):** Thank you, Madam Chair. It's really lovely to be here.

Thank you so much for coming.

I am going to ask about neurological disease. I think everyone knows that the brain is the most vital organ of the human body and that if it doesn't work properly every aspect of life is compromised. One in three—or 10 million—Canadians will be affected by a neurological disease or a psychiatric disease disorder injury at some point in their life. There are no cures for ALS, MS, Alzheimer's or Parkinson's disease and no treatment that consistently slows or stops the course of these devastating neurological diseases.

In the last Parliament we had a subcommittee on neurological disease. I hope they're going to bring it back and I hope the report is going to come back.

I have a very simple question, a yes or no one: Will the government, or Health Canada, or CIHR commit to the national brain strategy that the neurological health charities have been asking for?

**Ms. Kim Elmslie:** It's a simple question with a not so simple answer. What I would say is that about five years ago, the neurological health charities came to us at the Public Health Agency of Canada and said "We really need information. We really need this neurological longitudinal study to understand what's happening in Canada and to understand what we need to be doing going forward."

**Ms. Kirsty Duncan:** So are we waiting for the results of the study? Is that what you're saying?

**Ms. Kim Elmslie:** Certainly the results of that study are going to be foundational to decisions about what we need to do going forward.

**Ms. Kirsty Duncan:** Okay. That's fair enough. That's what I wanted to know.

Will the government commit to an "International Year of the Brain"? This was a motion that was passed here. Will we commit to that in order to raise awareness? There are big conferences coming in the next two years and there is partnering with Europe. Will the government commit to that?

● (1615)

**Ms. Kim Elmslie:** I don't know the answer to that.

**Ms. Kirsty Duncan:** Okay.

Coming back to Alzheimer's and dementia—as you know, worldwide, governments are concerned with the rising tide of dementia. Some 500,000 Canadians have Alzheimer's disease or a related dementia; 71,000 are under the age of 65, and women account for about 72%.

Today, every five minutes someone is diagnosed with Alzheimer's disease. The human cost is enormous, the economic cost is about $15 billion, and in 30 years we're looking at $153 billion. We know if we could merely slow the onset of dementia by two years for each affected Canadian, we could see a return on investment of about 15,000% over a 30-year research effort.

So I'd like to know, what research for Alzheimer's disease is the government investing in?

**Ms. Kim Elmslie:** Okay, good question. Let me see if I have that number with me…. I may have it, which would be great.

**Ms. Kirsty Duncan:** How long is this for, and is it patient-centred?

**Ms. Kim Elmslie:** There may be some aspects of that I'll need to get back to you on.

**Ms. Kirsty Duncan:** Kim, would it be possible to table all that information with the committee?

**Ms. Kim Elmslie:** I will do that. That will make it much easier.

**Ms. Kirsty Duncan:** Yes, I think so. As much information as you can give us on what the research funding is, for how long, and what its aspects are.

One of the things the stakeholders have been asking for is will the government be investing in support and education for caregivers?

**Ms. Kim Elmslie:** Okay. I'm going to take all of that information back and table a response with the committee.

**Ms. Kirsty Duncan:** Okay. Will the government invest in a navigation system to guide families through the complex health care system? If you have a neurological disease—Alzheimer's, dementia—it is next to impossible to navigate the health care system. Will the government be investing in a navigator system?

**Ms. Kim Elmslie:** There's a lot of interest in and work going on around patient navigation for a number of diseases, Alzheimer's being one of them, cardiovascular disease being another. Conversations are going on about patient navigation and where it fits. I will undertake to find out more about the work that's going on in patient navigation as well.

**Ms. Kirsty Duncan:** Could you table that information with the committee as well?

**Ms. Kim Elmslie:**Yes.

**Ms. Kirsty Duncan:** If I could just have those answers, that would be terrific.

**The Chair:** Absolutely.

So to clarify, Ms. Elmslie, you're going to get that information and send it to the clerk. She will distribute it to all the members and Ms. Duncan in order to make sure that everyone has that very important information.

Thank you so much.

**Ms. Kim Elmslie:** My pleasure.

**The Chair:** Now we'll go to Mrs. Block.

**Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC):** Thank you very much, Madam Chair, and thank you as well to our witnesses for being here.

I want to follow up on where my colleague left off. I believe he was asking a question about prevention and promotion. I guess it can be overwhelming to contemplate the broad range of issues that do need to be considered in creating the conditions for healthy aging, as you mentioned, and addressing the increasing rates of chronic disease in seniors.

You mentioned in your report that chronic diseases continue to be the major health burden of our time. Can you describe for me what the federal government is doing to help seniors prevent and manage chronic conditions such as diabetes, cancer, or arthritis? How does your agency work with different groups to ensure that seniors are able to manage, and often able to prevent, these chronic diseases?

● (1620)

**Ms. Kim Elmslie:** I think I'll start by saying that with regard to what the agency does to help seniors prevent and manage chronic diseases, we do that in partnership with a variety of other organizations—I mentioned some of them—but also, of course, and really importantly, with the provinces and territories.

We find that we can be most helpful in bringing information to the table around what works in prevention and what are the effective practices. For instance, the guidelines for physical activity for seniors provides a really good basis on which other organizations can develop their own programs.

Falls prevention is an area where the agency has invested considerable time and resources. If seniors are concerned about falling, they can't be active, can't be part of their communities. Developing falls prevention curricula, for example, where we are ensuring that health professionals are getting trained, ensuring that caregivers are getting information, and ensuring that seniors themselves are aware of what they can do to prevent falls, has been a really fundamental piece of the work we've done.

I'll come back to the age-friendly communities example, because I think it's a really good one in the context of the whole-of-society approach to prevention that I referenced earlier in my remarks. When communities are engaging seniors and when seniors are involved in helping plan the services and supports they need, then they're able to participate actively in their communities.

We were very heartened to see, when we read the report on seniors by Dr. David Butler-Jones, that seniors are reporting that they're in good health, they're engaged in their community, and they're feeling included, all of those things. The initiative for age-friendly communities is one that spreads that possibility much more broadly. We've been very much focused on measuring the outcomes in age-friendly communities so that, again, we can share good data and therefore convince others of the value of applying these approaches in their own communities. Working with the seniors council through our minister's role, with the HRSDC minister, also allows us to bring health issues to the table and engage seniors at that policy level in helping to shape the policy agenda going forward.

I would also say that issues around seniors and seniors health get embedded into all of our programs. Our surveillance programs look at seniors health. Our prevention programs focus on what we can be doing to better equip seniors. We ask this question as a lens on everything we do.

That group in the population is always front of mind to us. They are not only recipients of services, they're also providing services themselves—in the work they do in their own communities, in the ways they teach younger people about how to live in our country and the joy they get from that role.

So we bring a lot of the social side of health into how we deal with seniors issues in our programs.

**Mrs. Kelly Block:** Thank you very much.

I'm glad you mentioned the age-friendly communities approach. I was actually going to ask you about this. I do agree that, as you've mentioned, seniors have been and continue to be vital contributors to our communities.

You also mentioned the attending of a UN meeting and the discussions that were held there. You underscored the importance of partnerships, certainly partnerships with our provinces and territories. But I'm not quite clear in terms of the exact sort of entry into them.

How does your agency actually partner with a province or a territory? Who do you contact in that province or territory? I know that health systems look a little different from province to province. Perhaps you could expand on that a little bit. Then perhaps you could even talk about the partnerships internationally that we may have in order to gain a better understanding of some best practices.

● (1625)

**Ms. Kim Elmslie:** Sure.

On the issue of how we partner with provinces and territories, when the Public Health Agency of Canada was created, an entity called the Pan-Canadian Public Health Network was created. That council is a partnership of the federal, provincial, and territorial governments. The council really does provide the entry point for us into discussions with our provincial and territorial colleagues, and it focuses its efforts on three main areas.

It focuses on healthy living, which obviously includes chronic disease prevention. It focuses on infectious disease prevention and control, and it focuses on building public health capacity. Of course all those intersect with each other, but because we have the chief public health officers or the assistant deputy ministers of provincial and territorial governments around that table, that provides us with the pan-Canadian forum for setting priorities, understanding each other's perspectives, and advancing important joint frameworks or joint agendas to move forward.

A really good example of that is we have developed with our provincial and territorial colleagues a framework for action on overweight and obesity in children. That is a joint effort of FPT governments moving forward together using the levers that are appropriate in each of our jurisdictions to prevent childhood obesity and to share across the country the most effective policies and programs so all jurisdictions can benefit.

On the issue of international partnerships—

**The Chair:** Ms. Elmslie, I have to go to the next one.

We're now going into the five-minute round, and we'll start with Ms. Quach.

[*Translation*]

**Ms. Anne Minh-Thu Quach (Beauharnois—Salaberry, NDP):** Thank you, Madam Chair.

I would like to thank the two witnesses for this information. I have several questions to ask. First, I would like to focus on the strategy for prevention and for the promotion of healthy lifestyles for seniors.

Have you planned to create spaces where people can improve their health and be more active in their communities on a daily basis? We know that prevention among young people involves additional physical and extracurricular activities at school. Will similar activities be offered for seniors in partnership with the provinces, territories and municipalities?

[*English*]

**Ms. Kim Elmslie:** Thank you. That's a really important question.

In the context of the federal role, we're not directly creating those spaces, but through our partnerships and through our support to community organizations and to community work being focused on seniors, that's happening. So many of the projects that we are funding are allowing networks of seniors to come together, and the message around prevention and the tools to help seniors live healthy lives and be supported in their communities are being developed. So the short answer is that indirectly we are facilitating the creation of those spaces.

[*Translation*]

**Ms. Anne Minh-Thu Quach:** Let us stay on the same topic but address the nutrition aspect.

You say that people need to eat better to avoid becoming overweight or obese. Have you established a link with agriculture? Many areas are agricultural or rural. We know that people who work in agriculture have a little bit of difficulty selling their goods on local markets. We are encouraging local food production more and more, particularly as a means of protecting local jobs.

Has a link been established between diet and the agri-food system, namely between the quality of crops and the freshness of products?

● (1630)

[*English*]

**Ms. Kim Elmslie:** That's a really good point you're making and is something that comes up repeatedly in our conversations with the agri-food sector.

We have worked with the Canadian Agri-Food Policy Institute to determine how we can encourage consumption of local food. There's certainly an interest in the agri-food community in being more active in promoting healthy food products and in innovating so that healthier food is available to Canadians.

If you look at what has happened in New York City, for example, the city has taken some really important innovations around healthy food and around the availability of information on menus. They are keeping unhealthy food out of schools but also looking at planning schools so that they're not in the vicinity of fast food restaurants. You may take the unhealthy food out of the school, but if the kids can just walk out and go around the corner and get unhealthy food, you're really not advancing that agenda very far. So all of those discussions —how do we do that better in the context of our partnerships, what can the federal government do to bring folks to the table and facilitate that conversation so we understand what's working well in other places, and how can we apply it in Canada—involve the agri-food sector. They're an important partner for us.

[*Translation*]

**Ms. Anne Minh-Thu Quach:** You said that seniors who are the most economically disadvantaged have more chronic diseases. Are there any diseases that are exclusive to economically disadvantaged individuals? If so, why?

[*English*]

**Ms. Kim Elmslie:** I would say that there are not particular diseases. The fact is that the incidence of diseases like diabetes and cancer, which are driven by risk factors of overweight and obesity, physical inactivity, and unhealthy eating, are more common in these populations because they can do less to reduce their risk factors.

**The Chair:** Thank you for your very insightful questions.

We'll now go to Dr. Carrie.

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

And I do want to welcome back our Liberal colleague. It's nice to have you back on the health committee, even though it's for a short period of time.

I wanted to pick up on what my colleague started off with.

I was a little bit surprised when I saw that number: $190 billion as the cost to our economy for chronic diseases. You might as well be running a government when you're looking at the size of that figure. Again, it was mentioned how it seems that we focus a lot on acute care.

My background, as you know, as a chiropractor...we've always been trying to focus on wellness and prevention. It's nice to see the NDP placed one of my colleagues on the committee as well.

Once you have diabetes, it's too late in many cases, and the cost and the expense of treating it and managing it for the rest of a person's life is huge. The same with cardiovascular diseases.

I wanted to move a little bit towards the prevention and wellness side of things. I was wondering, are you aware of any programs for kids? Is there any research out there on what we can do to get kids thinking about wellness and prevention?

Again, my colleague brought up the jurisdictional issues, because many things that we can do, I suppose, would have to be done at schools, where kids are spending the most hours out of their day. But I was wondering if you could elaborate a little bit on what you see as challenges when we're dealing with the provinces and territories and different jurisdictions we work with.

**Ms. Kim Elmslie:** I'd be glad to, and thanks a lot for the question. It's really important.

I keep coming back to the notion that what we're really trying to do is build prevention into our norm and change our approach from thinking about the health care system to thinking about a health system in which prevention is embedded in every aspect. Let me give you an example. When we talk about education and health, one of the programs we are involved in is the joint consortium for school health. The federal government provides funding to that program, and the provincial and territorial governments are partners in it. Through that consortium, we're bringing health into the schools in a way that is context-specific. It's never one size fits all. Different jurisdictions will have different needs. Different schools will have different needs. But that program is allowing the policy and program discussions to be front of mind as schools develop their curricula, and as they think about physical education and healthy eating in schools. We've joined up health and education.

We're also joining sports and recreation into that kind of partnership. That came about through the work done to develop the declaration on prevention and promotion, which our health ministers signed onto last fall. In that declaration they said that we need to partner up with all of these organizations that can have an impact on disease prevention. Doing that will take us way outside the health system. That's the track we're on now. Education, sports and recreation, health, agriculture and agrifood, transport: bringing these ministries into the conversation is allowing us to start moving down a track that is saying health promotion is everyone's business. If you're focused on economic growth and you invest in health promotion, you're going to improve economic growth as well. The conversation has turned, and it's about programs that are broader.

Prevention as a landmark of a quality health system is another principle that health ministers have signed on to. By doing so, they're saying that we care about prevention in the health care system. While our system was built on acute care, it's not serving the needs of our population any more. The conversation then goes to talking about greater investment in prevention and talking about our health care system from a prevention standpoint.

● (1635)

**The Chair:** Thank you.

**Mr. Colin Carrie:** Do we have another minute?

**The Chair:** Actually we're running out of time. You have about two seconds.

**Mr. Colin Carrie:** I was going to say that you used the term "prevention norm". I've never heard that before, but I liked it. I was wondering if you might be able to elaborate on that and if there was any update on the 2010 declaration.

**Ms. Kim Elmslie:** Sure.

Prevention needs to become the norm when we think about health care. The prevention declaration has become the foundational piece that's guiding our federal, provincial, and territorial work. It's strong, and everyone has bought into it. Internationally, people are looking at it and saying Canada has moved in the right direction. This is the right way to go, and starting with our first emphasis on childhood obesity, we are putting it into action.

**The Chair:** That's a very good question and a very good answer. Thank you.

Dr. Morin, you're next.

**Mr. Dany Morin (Chicoutimi—Le Fjord, NDP):** So many questions, so little time. I'll try to squeeze in as many as I can.

You did answer Anne's question about low-income seniors, but I'm also interested in aboriginal seniors and LGBT seniors. You mentioned that good data leads to good programs. Do you have good data regarding aboriginal and LGBT seniors who might face some obstacles or difficulties that the general population might not face?

**Ms. Kim Elmslie:** I'll have to give you the short answer: no. We don't have good data.

**Mr. Dany Morin:** Is there a plan to find that information somehow?

**Ms. Kim Elmslie:** Yes. In our surveillance work, that's exactly what we're doing. We're identifying where the gaps in data are and how we can do a better job of filling those gaps.

For instance, in the context of our aboriginal populations, we are in a partnership with the Métis Nation of Canada to help them develop their own surveillance system so that the data they gather can serve their own local needs. We see this as a model for other types of surveillance.

I could talk about this for hours; maybe you and I should go for a coffee.

Oftentimes we gather all of this data and then it can't be used at the local level to make real change. We've turned that around with the work we're doing, particularly with the Métis Nation of Canada, to say "Okay, we want to facilitate you in developing what you need so you can use it to make change and transform your local situation".

I'm really excited about that, because I think when we have that in place it's going to be a model for how we do surveillance in other areas as well.

I'm sorry that I can't tell you that we have good data right now, but we don't.

● (1640)

**Mr. Dany Morin:** Regarding long-term care, what's the best strategy that you have found regarding long-term care and seniors?

**Ms. Kim Elmslie:** I haven't found a strategy that I would tout as the best strategy for long-term care. What I will tell you, though, is that a chronic care model was developed by a researcher named Wagner, in the United States, and it's called the Wagner model. It has been expanded and extended, but it's a model that takes chronic disease management out of acute care, out of the health care system, and joins it up with the community. It activates the patient, the consumer, so that he or she becomes an essential partner in their own care. It activates the family so they can provide support where needed, and it creates the partnerships we've all been talking about, so that chronic disease management over the long term, including in long-term care, can be of high quality.

I think we all have concerns at times about the quality of long-term care. These types of models are helping us learn more about how to do that better, but I haven't seen a model applied yet that I would point to as the gold standard.

**Mr. Dany Morin:** You've mentioned that a lot of people don't know they have diabetes. Do you have a strategy to improve the percentage of people who get screened?

**Ms. Kim Elmslie:** Yes, actually, we do.

Many Canadians have pre-diabetes. They have not been diagnosed with diabetes, but they are on that cliff and are about to move over. We've developed a risk assessment tool called CanRisk, which has been adapted from a Finnish tool, actually, and which helps individuals assess their risk of diabetes. It encourages them to seek a dialogue with their health care provider in order to manage their risks in the hopes that they will not develop diabetes or, in the case where they do develop diabetes, to diagnose it early so they can control it and reduce the risk of complications.

**The Chair:** You have about 30 seconds.

**Mr. Dany Morin:** That's good.

[*Translation*]

You spoke about communities that are part of the Age-Friendly Communities initiative. I believe there are 500. Can you provide examples of model communities?

[*English*]

**Ms. Kim Elmslie:** Of community action to promote health of seniors beyond the age-friendly communities....

**Mr. Dany Morin:** Or among them.

[*Translation*]

It could be specific cities or communities that have been very successful or that were particularly effective in implementing the program.

[*English*]

**Ms. Kim Elmslie:** Okay. Particular cities that are going a good job...? I'm not aware of them, but Cathy...?

**Mrs. Cathy Bennett:** Yes, if you don't mind me answering.

**Ms. Kim Elmslie:** Please do.

**Mrs. Cathy Bennett:** About seven provinces are involved in the age-friendly communities, and I would say that the one that has probably moved it the furthest along is Quebec. They have well over 300 age-friendly communities just in Quebec, and that number is growing. So if I had to point to.... While there's a lot of movement going on across Canada, I would say that Quebec is certainly leading the way in terms of looking at indicators, of evaluating what an age-friendly community is. What are those factors? How do we create them and how do we get that information out? As soon as they get it, they're implementing it at their provincial level, so we're seeing this momentum across Quebec in particular, with a large number of those communities.

● (1645)

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

Mr. Strahl.

**Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC):** Thank you.

Thank you very much for coming to speak to us today.

I want to give you a chance to expand on the international partnerships that my colleague Ms. Block asked about. Could you tell us a little bit about the partnerships? We've heard about the provincial and territorial, but maybe you could tell us about the international ones.

**Ms. Kim Elmslie:** I'd be glad to. Let me start by talking about the partnerships we have within the Americas region, with our colleagues in Caribbean countries and Latin American countries.

There's a network of countries that we work with called the CARMEN network. These countries work together to determine how best to make policy change in their own context to support prevention.

As I said earlier, the developing countries have a double burden. They have obesity and they have malnutrition. They're also dealing with infectious diseases.

What our partnerships with these countries does is to bring them together to help them learn from each other about prevention of chronic disease. Most of them are looking at obesity and overweight as a serious situation for them right now. The network develops case studies from each of these countries and then shares those case studies to help advance the prevention discussion and change policy. That's one partnership we have.

We work closely with the Pan American Health Organization on sodium reduction. That's an important international policy discussion. PAHO has taken leadership in the Americas region in terms of bringing business around the table to look at solutions to reduce sodium in foods. That is an issue-specific partnership, but it's a really important one for public health.

With the WHO, the World Health Organization, we're working to build surveillance capacity. Going back to your colleague's discussion around having good data, there are many countries that don't have the infrastructure to gather good data. They can't afford even the basics. Our partnerships with the WHO are helping countries put in place the rudimentary structures so they can use good data to drive their programs.

Those are three. Do you have more, Cathy?

**Mrs. Cathy Bennett:** Yes, I could elaborate on the World Health Organization, which is a key partner in advancing age-friendly communities. In fact, that's where it started; it was through the World Health Organization and it was picked up by Canada and adopted. They are a key role and partner in this, and they have created the global age-friendly network, which links all of these participating countries in this effort.

Also related to age-friendly communities, we work with the International Federation on Ageing. Again, it's to advance those principles and work collaboratively on the age-friendly approach.

So there are two other examples.

**Ms. Kim Elmslie:** And on the research on Alzheimer's disease, if I can say quickly, to Ms. Duncan's point, the Canadian Institutes of Health Research is providing exceptional leadership in an international partnership around Alzheimer's disease to bring the world's best researchers together to accelerate discovery on diagnosis and treatment of Alzheimer's disease.

**Mr. Mark Strahl:** Sticking with the partnership theme, you said you work closely with non-governmental and business partners to find ways to collaborate on seniors' health. Maybe you could give us some examples of who in the business community or non-governmental organizations you've been working with.

**Ms. Kim Elmslie:** The conversations with the business community have largely focused on food and beverage as a first step because we're concerned, obviously, around the healthy eating dimensions of healthy seniors and healthy Canadians overall. The conversations are around how the food and beverage industry can be part of the solution to encourage healthy eating and to reformulate products so they are healthier. Those are the discussions and the partnerships we're trying to build right now.

We also see a broader role for the business sector because they are workplaces with large populations of employees. They could be playing a really important role in education around healthy living and in providing their employees with the tools to adopt and sustain healthy living practices.

So we're coming at it from a number of angles to engage the private sector. I'm happy to say that the private sector is very willing to be engaged in these conversations, and I think it's because they see the productivity dimensions of this argument. To have a productive workforce they need to invest in a healthy workforce, and we're finding good receptivity to that message.

Some corporations are quite innovative in their approaches to encouraging healthy eating and healthy living by providing, for instance, opportunities for employees to have free gym memberships and those kinds of things. Again, we have to remember this only addresses one dimension: these are people who are employed and who are able, therefore, to take advantage of these perks that are offered. We don't want to create health disparities in terms of the population who can't afford such advantages; we can never forget that. But I'm seeing a receptivity by corporate Canada, the business community, to be a partner with government to move forward on these very complex issues. Nobody believes they'll be simple to solve, but there certainly is forward momentum there.

● (1650)

**The Chair:** Thank you, Ms. Elmslie, and thank you, Mr. Strahl.

We'll now go to Madame Raynault.

[*Translation*]

**Ms. Francine Raynault (Joliette, NDP):** Thank you, Madam Chair.

I would like to thank the two women who are in attendance today. This is my first visit here and I listened very carefully to what they had to say.

Since I am the last to speak, many things have already been said.

[*English*]

**The Chair:** Well, we're very pleased to have you here.

[*Translation*]

**Ms. Francine Raynault:** Thank you.

From what you said earlier, aboriginal people have a predisposition to diabetes. Clearly, we are aware of their lifestyle, which has been disrupted over the centuries. They are also living on reserves and are not necessarily active in the labour force.

Do you have a program or help for them?

[*English*]

**Ms. Kim Elmslie:** You're absolutely right. We have a major public health challenge with our aboriginal population and we come at that challenge through a number of mechanisms. Let me give you some examples.

Through Health Canada's First Nations and Inuit Health Branch there is an aboriginal diabetes initiative. That initiative is particularly focused on the prevention of diabetes and good management of diabetes among our aboriginal population. So there are programs that are specific to that challenge.

I'd also point you to programs like Nutrition North Canada, which comes out of the Department of Indian Affairs. Clearly, by doing a better job at getting healthy foods into northern and remote populations, we're creating the conditions for people to adopt healthy lifestyles. We feel that programs like these bring us one step further along the path to creating and supporting healthy communities. There is a long way to go, and nobody sees this as a quick fix. The important thing is that we're starting to see those foundations being built through the programs we have federally, but also importantly through work that the territorial governments are doing individually and together.

[*Translation*]

**Ms. Francine Raynault:** Thank you.

With regard to seniors, I read in your document that most seniors remain healthy if they are involved in an activity in their community. They want to continue to be involved and so they likely pay more attention to their health.

However, it is certain that seniors who left paid work and who are receiving a good pension, something reasonable, can also afford better food. Or so I think. We know that the cost of living is increasing a great deal. As a result, seniors who receive a small pension or who receive only their pension with the guaranteed income supplement cannot afford the best food, the best fruits and vegetables on the market. There are farmers markets in our communities, most often during the summer, that allow us to buy locally grown fresh produce.

Do you have a program to help seniors eat better? They do not have the money to eat well and, as a result, over the years, they become ill; they develop diabetes with all that entails.

The fact that they do not have very much money affects their housing. They live in poorer housing conditions. They live in places that sometimes leave much to be desired in the way of heating in the winter, safety in the summer and so on.

Do you have a program to help them? Do you have any suggestions for what they should do?

● (1655)

[*English*]

**Ms. Kim Elmslie:** I have to thank you, because you've just made my point about the whole-of-society approach. Within the federal jurisdiction, there are things we can do, but there's a lot more that needs to be done under other jurisdictions as well. The access of seniors to affordable nutritious food is one of the elements we're undertaking with our provincial or territorial colleagues. We're not directing our attention to seniors at this point, though. We're working on childhood obesity under the federal-provincial-territorial framework on healthy weights. We're looking at how we can improve affordable access to food in this country. At present, our focus is on childhood obesity, but it applies much more broadly. No, we do not have a specific program. In our federal role we are facilitating the work of provincial and territorial jurisdictions with non-governmental organizations and the business community. This is a collective challenge, and we need to address it as a society.

**The Chair:** This is compelling food for thought and those were good questions. Thank you.

We'll now to go Mr. Brown.

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

I wanted to touch on the neurological aspect of your mandate and Alzheimer's. There has been great interest on that topic in this committee. I wanted to know what are we doing to engage seniors in adopting a healthy lifestyle to delay the onset of neurological conditions. I remember a New Horizons program that encouraged active lifestyles for seniors in the home, whether it was painting or physical activity. It was more of a one-off. I saw two of those pilot projects, and I thought programs like that would be extraordinary to have in all senior homes. I wanted to know if you had any thoughts on how to engage seniors in activities that might delay the onset of Alzheimer's.

**Ms. Kim Elmslie:** That's a good question. It's a tough question.

We are still learning a lot about delaying onset of neurological conditions. Even beyond that, keeping seniors active and providing them with opportunities in their communities and in long-term care facilities, keeping their brains functioning and keeping them engaged are important parts of the work that we care about and that we try to facilitate through our funding programs working in partnership with others.

You make a really important point. The federal government can fund particular projects under particular initiatives, but to sustain those we need partners. We need provinces and territories. We need local municipalities to extend them and keep the funding going and keep those programs in place. Our role through things like the Canadian diabetes strategy, our cancer work, and neurological health charities work is to find those innovative programs that work, to determine whether they are best practices, to determine how cost-effective they are, and then to share them as widely as we possibly can and encourage their uptake. We definitely do that.

We have an innovation strategy at the Public Health Agency of Canada that is focused on just that kind of thing. The agency finds those things that are working in jurisdictions, whether they be at the provincial and territorial level or more locally, and then profiles and promotes them on a more wide-scale basis. Our children's programs, for instance—through the community action program for children, through aboriginal head start, although not applicable to your question about seniors—are examples of programs where the public health agency is funding services to kids, which can then be applied more broadly.

● (1700)

**Mr. Patrick Brown:** In terms of identifying best practices for Alzheimer's, are there any provinces that you've identified that are utilizing innovative approaches or examples that should be embraced through your findings thus far?

**Ms. Kim Elmslie:** Many provinces are doing that. Some of them have their own Alzheimer's strategy. Some of them are focused on Alzheimer's under a seniors strategy. There's actually a lot going on across the country in terms of serving people with Alzheimer's and doing things to keep seniors healthy and their minds working.

**Mr. Patrick Brown:** What types of activities are being encouraged?

**Ms. Kim Elmslie:** Physical activity—keeping seniors active through engaging them in group walks so that they've got social interaction while they're being physically active at the same time. That's a major part of a number of programs. The work we do through ParticipAction is also helping to advance that.

Cathy, do you have any others?

**Mrs. Cathy Bennett:** Yes. Age-friendly communities are an excellent example of looking within a community as a built environment to what can be done to create conditions for seniors to be more physically active, and to what the barriers are. We're learning things such as lighting, width of sidewalks, curbs, those kinds of things that actually do not facilitate seniors being more physically active within their community, but actually serve as barriers. That's the kind of thing we're working at, a community approach to identifying and reducing barriers to things like physical activity.

**Mr. Patrick Brown:** Is there a timeline or a goal you have in terms of sharing best practices or innovative approaches? Through what mechanism would you do that sharing of information?

**Ms. Kim Elmslie:** The mechanism that we use to share best practices is the Canadian best practices portal, which is a web-based portal that is on the Public Health Agency of Canada website. It gathers the best practices that have been evaluated and identified in various topic areas such as injury prevention or diabetes prevention or whatever.

We don't think that goes far enough, so we're working on how we can expand the scale and scope of it and how we can take lessons learned and shine a spotlight on them that really matters to communities picking these up and running with them. At the moment, our main federal mechanism for profiling those is that web portal.

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

We'll now go to Dr. Carrie.

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

I was wondering if you could elaborate about the database that is put together by the Centre for Chronic Disease Prevention and Control. Does it track disease across the country, and are you able to determine whether certain areas have higher incidences of certain chronic diseases than do others?

Could you let us know? We talked about best practices, and I was just wondering what we could learn from keeping statistics like that.

**Ms. Kim Elmslie:** Sure. Our surveillance system on chronic disease does track chronic disease rates and risk factors across the country. So we're able to identify areas where there seem to be higher rates of certain diseases or risk factors, and therefore help our provincial and territorial colleagues by providing that data so they can target their efforts and so we can also target our efforts collectively toward improving prevention in those locations.

We're expanding the work of our chronic disease surveillance system to get a much better sense of issues around hypertension and cardiovascular disease. Our data systems on cardiovascular disease have not been as robust as we would like them to be. Hypertension is an important public health issue in Canada, and of course with an aging population we will see more hypertensive Canadians. The good news—and we learn this through our surveillance programs—is we're among the best in the world at controlling hypertension. So those Canadians diagnosed as having hypertension are getting the drugs they need. Their hypertension is being controlled. But rates of newly diagnosed hypertension are still on the rise, and that is the kind of thing that our surveillance programs tell us. They tell us about those particular risk factors we need to be putting a priority on if in fact we're going to be successful in prevention.

● (1705)

**Mr. Colin Carrie:** With these databases, has anybody ever looked at the different chronic diseases that men get versus those that women get? I know there has been a lot of research, for example, into heart disease, but they tend to use overweight middle-aged guys, and the way that a heart attack presents in a man is different from how it does in a woman.

I look at what we're doing here. I had an opportunity to have a meeting with the minister of health from China, and I was really surprised to see that they're dealing with a lot of the same challenges and issues we're dealing with. So I'm wondering, if Canada has an opportunity to take a leadership role in the world, and if we have these databases, do they actually address the differences between men and women?

**Ms. Kim Elmslie:** Yes.

**Mr. Colin Carrie:** How can researchers actually access that data and start manipulating it? Could you comment on that?

**Ms. Kim Elmslie:** The databases always provide sex-specific information. So they do look at what's different for men and women. We think about cancer rates and lung cancer rates. We know that lung cancer rates in men, although they were rising very rapidly, have now stabilized, whereas we're still seeing a little bit of growth in those rates for women. So yes, we look at that all the time, because as you said, the two sexes operate differently on many different levels, and for chronic disease it's no different. So it's important for us to look at both age and sex as part of the analyses we do.

With regard to the China example, in fact, we share a lot of information with China around chronic disease prevention. With their smoking rates, and so on, they're facing cancer rates going through the roof moving forward. They also have a problem with hypertension. Because we have databases that have been following our population over time and because we understand how these diseases are developing in men versus in women, and since we're also understanding and seeing earlier age of onset of some chronic diseases because of the risk factors that are driving them, we're able to help other countries that are facing chronic disease epidemics that are maybe even worse than ours are.

**Mr. Colin Carrie:** So we do share that data? I know in Canada we're very fortunate. We're a very wealthy country, and we are doing some of the best work in the world. So we actually do actively get out there—

**Ms. Kim Elmslie:** Yes, absolutely. We collaborate. We share data. We share best practices.

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

Now we'll go to Dr. Duncan. And did you have a call, Dr. Duncan?

**Ms. Kirsty Duncan:** First, let me apologize for that. I was doing research and clicked on a video, so my apologies, everyone.

I'm going to pick up on something Dr. Carrie briefly mentioned. I don't know how to do this. We've talked about healthy living across the life range, and this week in Toronto it's Feeding Toronto's Hungry Students Week. On Monday I was on a bus tour, and the idea was to take decision-makers back to school on a school bus, for them to go to school and walk in the shoes of a hungry child.

In Toronto we feed 110,000 children every morning. One out of four of our kids goes to school hungry; 40% of our elementary children go to school hungry, and 63% of our secondary school students do. We know that hungry children cannot learn. We know that when they have food, behaviour improves, memory improves, and cognition improves. If they're malnourished as children, they could have long-term intellectual impairment. The right to access to safe, nutritious food is a right of every individual, and despite this we are one of the few industrialized countries without a national nutrition program.

I appreciate the difficulties with jurisdiction. When we talk about healthy living, generally we talk about diet and exercise. And I wonder how we change that. Are there discussions that are beginning with the provinces and the territories to ensure that our kids go to school nourished, and particularly in our aboriginal communities?

● (1710)

**Ms. Kim Elmslie:** There are two things that come to my mind when you raise that, Dr. Duncan. One is that we're making progress through the Joint Consortium for School Health to bring the health and education needs together from a policy and program perspective. It's not delivering a national nutrition program, but it is saying that we have to treat health and education hand in hand, and we're bringing those two sectors together.

The other thing that comes to my mind when we talk about this—and I'm going to repeat myself—is that many of the things we've talked about today reinforce the roles of different parts of our society coming together. We can make a difference collectively, as opposed to trying to do things in silos or trying to do things that can't be sustained because they're not in our jurisdiction in the first place.

**Ms. Kirsty Duncan:** Yes, partnerships, but it's just....

Dr. Butler-Jones has been very clear. I can't remember if it was his 2008 or 2009 report that noted that if we want to improve health in the future we have to feed our kids, exactly.

Okay, I'm going to switch to later in life. I'm going to come back to the idea that we absolutely need a national brain strategy, a brain health awareness month. We talk about the different conditions. We need to have a focus. People need to understand. We have to raise awareness and education about neurological diseases, and we have to let people know how to prevent them. That's huge.

And the last thing I want to say—picking up on Patrick's question—comes back to the worldwide concern over Alzheimer's disease. Have we thought about having a national office in the Public Health Agency of Canada where, working with the provinces and territories, you develop a national plan? And there could be a round table so you would get input from the caregivers, the families, and those living with these diseases. We could be making greater investment in research, and developing a real plan. And each year it can be reported back to Parliament what successes we have had in that year.

**Ms. Kim Elmslie:** Our first step is the national neurological study. We are working with the health charities—the raising of awareness is an important thing from their point of view. I'm sure you've heard this if you've spoken to them about Alzheimer's and other neurological diseases.

One of the best things they did was form a consortium of neurological health charities. Together, they are much more effective in their message and in their visibility than they ever were alone, and they recognize and celebrate that. So the things that we do at the Public Health Agency of Canada with that group are moving us forward. We are working to identify what we need to do as a country. We are ensuring that we have conversations going with the right people to move the agenda forward. That's where we are right now.

● (1715)

**The Chair:** Thank you.

We've come to the end of our page and we've had some very interesting information today, a lot of food for thought. It was amazing how you had so much information for us today, and this is a very important topic to this committee. So I want to thank you and the committee for an insightful and productive meeting.

With that, I will say the committee is adjourned.

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