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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

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

I'm so pleased to have you all here today. We do have a lot of witnesses today. It's very important that we get all this information, and we're very pleased that we've been able to do that so far.

In relation to the study of the chronic diseases related to aging, I'm going to ask that we pass our budget before we begin the testimony from the witnesses. The motion is that, in relation to the study of chronic diseases related to aging, the proposed budget in the amount of $ 28,700 be adopted.

Mr. Colin Carrie (Oshawa, CPC): I'd like to put forth the motion that we adopt the budget, as read by Madame la président.

The Chair: Thank you, Dr. Carrie.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Could you give us a minute or two to look at the details and see if we are satisfied with that?

[*English*]

The Chair: Basically, Dr. Morin, it is a standard budget; it is a budget to bring our witnesses in. Without the budget we cannot pay the hotels or the airfare. So rather than going over every item, are you satisfied with this?

[*Translation*]

Mr. Dany Morin: Let me just have a few seconds. That should be enough.

Does it include all our witnesses for the fall?

[*English*]

The Chair: It's just for this study. If you look at the budget, it's just for the witnesses who are before us, to pay for their expenses.

I think—for further information—we can have a budget of up to $50,000, and then I have to go to the liaison committee following that.

A voice: I think it's $40,000.

The Chair: Okay, it's $40,000. So this is a very standard budget. But thank you for asking.

(Motion agreed to)

The Chair: Thank you.

Pursuant to Standing Order 108(2), a study of chronic diseases relating to aging, we have a witness from the Canadian Diabetes Association, Aileen Leo, associate director.

Welcome, Aileen. Is it Dr. Leo?

● (1535)

Ms. Aileen Leo (Associate Director, Public Policy, Government Relations and Public Affairs, Canadian Diabetes Association): I could pretend that it was, but sadly, it's not.

The Chair: That's okay. If you're here, you're an expert.

We have, from the Canadian Partnership Against Cancer, Jessica Hill, the chief executive officer, and Leanne Kitchen Clarke, vice-president of public affairs. Welcome to both of you.

From the Heart and Stroke Foundation of Canada, we have Manuel Arango, the director, health policy, and Mike Sharma, expert representative. Welcome.

From the Canadian Lung Association, Christopher Wilson will be joining us. They'll be testifying toward the end, so he'll be coming in a little later. He's the director of public affairs and advocacy. We also have Rosario Holmes, an educator. Thank you so much for being here today, Rosario.

Having said that, we're going to start with a ten-minute presentation. We will begin with the Canadian Diabetes Association. Who will be the presenter for this one?

Thank you, Ms. Leo.

Ms. Aileen Leo: Good afternoon, Madam Chair and members of the committee.

On behalf of the Canadian Diabetes Association, thank you so much for inviting us here today. We are very pleased to join in this discussion concerning those chronic diseases related to aging.

Given Canada's aging population, this study will be essential in the development of policy to care for our senior citizens, many of whom find themselves in vulnerable circumstances due to living with one or more chronic diseases, including diabetes and its related complications. Our remarks here today will focus on the impact of diabetes and its complications on our health care system, our economy, and those living with the disease.

The Canadian Diabetes Association leads the fight against diabetes by helping people with diabetes lead healthy lives while we work to find a cure. Established more than 50 years ago, we are a not-for-profit that has a presence in communities across Canada and we work with a strong nationwide network of volunteers, employees, health care professionals, researchers, partners and supporters. The association promotes the health of Canadians through education and services advocating on behalf of people living with diabetes, supporting research, and translating research into practical applications.

Unfortunately, diabetes is an epidemic in Canada and worldwide. The increasing prevalence of diabetes is dramatic and alarming. In 2010, 7.6% of Canadians, or 2.7 million people, had diabetes. If no action is taken by 2020, almost 11% of Canadians, or over four million people, will have diabetes. In addition, almost one million people have diabetes but don't know it because they have not yet been diagnosed. As well, over seven million people have pre-diabetes, which, if left unchecked, puts them at risk for developing type 2 diabetes.

Today more than nine million people are living with diagnosed or undiagnosed diabetes or pre-diabetes. This means that one in four Canadians is living with either pre-diabetes or diabetes. If those figures weren't alarming enough, by 2020 it will be one in three Canadians unless action is taken to stem this epidemic.

There is a strong link between age and type 2 diabetes, which comprises approximately 90% of diabetes cases. In fact, the likelihood of developing diabetes increases substantially with age. Our clinical practice guidelines generally note that being over 40 years of age and older is one of the key risk factors for developing type 2 diabetes. This is critically important, since, according to Statistics Canada, by 2036 the number of seniors in this country will more than double, to approximately 25% of the population, outnumbering children for the first time.

In addition to an aging population, rising rates of unhealthy weight and sedentary lifestyles, as well as a change in the ethnic mix of Canadians, are all drivers of the alarming increase in the prevalence of diabetes.

Given the relationship between aging and diabetes, it is no surprise that most Canadian provinces with median ages older than the national average have higher rates of diabetes, in particular, Atlantic Canada. For example, Newfoundland and Labrador has the highest median age in Canada, and also the highest rate of diabetes and pre-diabetes. By 2020, while the national prevalence rate for diabetes will approach 11%, in this province it will surpass 14% if action is not taken.

With increasing diabetes prevalence comes an increasing cost, affecting our health care system and our economy. Diabetes currently costs more than $11.7 billion in Canada and will rise to $16 billion by 2020. It's also important to point out that 80% of these costs are due to diabetes-related complications such as heart attack, stroke, kidney disease, blindness, amputation, and depression. These conditions are commonly found among elderly Canadians with diabetes, since the likelihood of developing these complications increases the longer a person has the disease.

Diabetes also costs those living with the disease. With the exception of those living on very low incomes and covered by government support, out-of-pocket costs can approach or surpass $2,000 for type 2 diabetes across income levels and provinces and territories. For those with type 1 diabetes, these costs can be even higher, especially if they use an insulin pump. These costs continue to be a barrier to effective self-management of diabetes. Over half of Canadians with type 2 diabetes indicate that they do not comply with their prescribed therapy due to the cost of medications, devices, and supplies, leaving them vulnerable to complications, which can be life-threatening.

● (1540)

These costs do effect the elderly. Our members who can currently afford these costs have expressed their very serious concern that they may have to compromise their self-management when they retire due to these costs.

We need to reduce the burden of diabetes and related complications. In order to do this, the Canadian Diabetes Association recommends enhanced diabetes prevention and management for elderly Canadians. Lifestyle interventions are effective in the prevention of diabetes in the elderly at high risk for the disease, including moderate weight loss and regular physical activity.

Since diabetes in the elderly is metabolically different, their management and/or therapy should reflect this. Support from health care teams, including doctors, nutritionists, dieticians, pharmacists, diabetes nurse educators, etc., have been shown to improve glycemic control in the elderly.

Nutrition education and exercise combined with medication should be carefully tailored to suit the needs of the elderly and the various sub-populations, such as those at increased risk of hypoglycemia, which is a lower-than-normal blood glucose level.

We also need to address not only the physical health needs, but the mental health needs of elderly people with diabetes. According to the Canadian Mental Health Association, depression in seniors is extremely common. Many challenges they face contribute to depression, including reduced functional ability due to physical illness, mobility impairment, chronic pain, and cognitive and sensory impairment. Other challenges, such as retirement, changes in income, widowhood, the death of friends, and new caregiving responsibilities, can lead to social and emotional isolation. This is particularly important, given that people with diabetes across the board are as twice as likely to be depressed compared to those without the disease, compromising their ability to self-manage.

People with diabetes who develop related complications such as depression are less likely to follow diet and exercise recommendations, check their blood glucose levels, or fill their prescriptions for diabetes and complications. So if you are elderly and have diabetes, your risk of depression and other serious complications is that much higher.

The increasing senior population has also led to dramatic increases in the number of seniors in long-term-care facilities. Seniors in these facilities often have undiagnosed diabetes and related complications, such as mental health disorders. Under-nutrition is also a major problem in these establishments.

In summary, the risk of developing type 2 diabetes and diabetes-related complications is higher for elderly Canadians. Diabetes currently costs Canada more than $11.7 billion, and 80% of this cost is due to diabetes-related complications.

With a growing senior population we must focus on keeping elderly Canadians with diabetes healthy to avoid or delay costly complications, and address the impact of diabetes on our health care system and economy.

Lifestyle interventions are effective in preventing diabetes in the elderly who are at risk for developing the disease. Elderly people with diabetes should have a health care team that provides education and support.

Given that elderly Canadians are vulnerable to both diabetes and depression, measures to address their needs should focus on both physical and mental well-being.

Finally, successful chronic disease prevention and management to support healthy aging starts long before age 65. We invite you to consult our recommendations to stem the course of diabetes in Canada within the *Diabetes: Canada at the Tipping Point* report released in April, contained within your information packages.

Thank you once again for the opportunity to convey our views today on this important issue. We'd be pleased to answer any questions you may have.

● (1545)

The Chair: Thank you very much, Ms. Leo. Those are very profound stats, aren't they? Thank you.

After everyone has presented we'll go to questions and answers.

We'll now go to the Canadian Partnership Against Cancer and Jessica Hill.

Mrs. Jessica Hill (Chief Executive Officer, Canadian Partnership Against Cancer): Thank you very much, Madam Chair and committee members.

I am pleased to be here today with my colleague Leanne Kitchen Clarke to speak with you about the Canadian Partnership Against Cancer.

Cancer is a complex set of over 200 diseases, making a single solution to address the disease a challenge. I'm here today to tell you about some highlights of our work, particularly related to shared priorities between cancer and other chronic diseases and aging.

I would like to tell you a bit about the partnership, since we are a relatively new organization. The Canadian Cancer Society is one of the major charities in the cancer field you'd be aware of; we are not a charity nor an advocacy organization.

We were created by the federal government, in 2007, with an initial mandate of five years and funding of $250 million. We are very grateful that the government recognized the progress being made by the cancer strategy, and it renewed our mandate and funding for another five years, from 2012 to 2017.

All our work is done in a collaborative way, with and through partners across the country. To advance this work we have over 400 advisers involved in working groups and networks from cancer and chronic disease across Canada. This allows us to leverage the expertise that exists in the country and share knowledge, skills, and best practices to have a greater impact. For instance, in the area of colorectal cancer screening, we chair a network of program leads and experts in screening from the provinces to accelerate program implementation in Canada. That has happened through the collective effort of this network.

Our board consists of 19 stakeholders, including provincial deputy ministers, the Canadian Cancer Society, the Canadian Association of Provincial Cancer Agencies, cancer survivors, regional representatives with backgrounds in health and cancer, and an aboriginal person, among others.

The term “cancer control” has a World Health Organization definition, and it broadly covers a population approach to reduce the burden of cancer. Through prevention, screening, and early detection, measuring the performance of the system to inform quality initiatives, and assisting patients and families through the cancer journey, whether they survive or die of their disease, the full continuum is involved in controlling cancer.

I will not be getting into the areas of screening, diagnosis, and treatment today, given the time we have; I will focus on prevention and research. The snapshot I've provided to the clerk does cover all our initiatives, and we will follow up with additional copies for all the members.

In the work of prevention, cancer shares many common risk factors. This is where we collaborate with the Heart and Stroke Foundation and other organizations to advance our collaborative efforts.

Moving to page 4, I'm going to talk a bit about the statistics of cancer and aging. On page 5 you will note that between 2007 and 2031 it is expected that new cancer cases will increase by 71%. The population will only increase by 19% over the same period, with 40% of women and 45% of men developing cancer.

On the next page you will note there is a strong association between age and the increasing number of cancer cases. This is a result of the aging process, in part, and certainly affects the growing number of cases in the population as it's aging.

On page 7 you can see that survival has improved, with relative survival at 62% for five years, and 58% for 10 years. This is very good news, but this means we're going to have a growing population of people who are living with cancers and that the population will largely be an aging population.

The other aspect of this is comorbidity; that is, people living with diabetes and cancer, or with heart disease and cancer. That is one of the factors we are facing as a health care system.

On page 8 you see that we move into discussing the strategic priorities of the partnership. The framework indicated on page 9 is our strategic framework going forward for 2012 to 2017. This describes our vision, which is a shared vision by the cancer community: the goals, mission, strategic priorities, and core enabling functions, along with objectives we are going to achieve in this period.

● (1550)

Most importantly, I want to emphasize our role, which is to leverage the investment that already exists in cancer across the country, which is usually described as over $6 billion. Our funds are to leverage the whole system to be more effective. And that's just the way the strategy is implemented.

We work with and through people to develop collaborative action, to share best practices, and to ensure that people from B.C. can share their best practices with those in Ontario, and Ontario with the other provinces as well. So it's a very collaborative approach.

Quickly, on page 10, in the area of prevention, our major initiative is a strategy of drawing together coalitions linking action and science for prevention. This really supports the prevention efforts across provinces to work better together and to ensure they're able to accelerate action in their jurisdictions in the prevention agenda.

I certainly can provide more detail to the committee about that.

On page 11, we wanted to raise that we've launched a major research study called the Canadian Partnership for Tomorrow Project, a cohort study made up of five regional cohorts. This federated national platform is looking at the interactions between genetics, lifestyle, and environment and will be a major research platform for at least the next 30 years.

Page 12 describes the study. However, the stage we're at right now is that the regional cohorts are recruiting participants. What we see in the next mandate is that we will increase opportunities for Canadians to participate in the study in those provinces and territories where they aren't currently having regional studies, and in addition, we'll be working with the cardiovascular community to deepen the capture of cardiovascular indicators in the study, all of which will make this a very rich platform.

The final thing I'd like to mention is palliative and end-of-life care. Clearly, 50% of patients with cancers will die of their disease and we know many patients and families are not prepared for end-of-life decisions and conversations. So we're working with the Quality End-of-Life Care Coalition of Canada's blueprint for action, to support its efforts to ensure that we are able to advance palliative care in the country.

We also report on the system and we've provided that to the clerk.

We do system performance reports, and this is an important aspect of our work so that we can actually monitor how the system across the country is performing and work with the representatives of cancer agencies and the health care system to look at how they can make improvements that create greater coherence and actually overall respond to the needs of Canadians in the most effective way. We've had two reports and we will have a third in December, the 2011 report, which will also continue to enrich our understanding of how services are being delivered and guidelines are being adopted.

The next slide is just to say what we use to inform our work. We use evidence, we learn from the experience of patients and their caregivers, we have a video series on our portal called “The Truth of It”—stories by Canadians on their experiences—and we engage with the health system and the cancer system to make our changes.

Finally, I encourage you to visit our website www.partnershipagainstcancer.ca or our portal, which is a partner portal with more than 30 partners, called www.cancerview.ca for additional information about the work we've been undertaking in our first mandate.

Thank you.

The Chair: Thank you very much, Ms. Hill.

Now we'll go to the Heart and Stroke Foundation and we'll hear from Manuel Arango, the director.

I'm sorry, is somebody else going to be doing that?

A voice: Yes.

The Chair: So it's Dr. Mike Sharma?

Okay, thank you.

● (1555)

Dr. Mike Sharma (Expert Representative, Heart and Stroke Foundation of Canada): Madam Chair, committee members, on behalf of the Heart and Stroke Foundation, I'd like to thank you for the opportunity to appear before you to share our perspectives on chronic diseases related to aging. I'm Mike Sharma and I'm here as an expert representative of the Heart and Stroke Foundation. I'm a stroke neurologist and researcher, as well as a deputy director, clinical affairs, of the Canadian Stroke Network. Joining me is Manuel Arango, director of health policy at the foundation.

First and foremost, I'd like to express our gratitude to Parliament for a number of initiatives and commitments that will help reduce the impact of heart disease and stroke in Canada, including the recent adoption of new and improved tobacco package warnings, Bill C-32, which prohibits the use of certain flavourings in tobacco products and associated marketing; the commitment to implement defibrillators in hockey arenas across the country; and the commitment to include cardiovascular measures within the Canadian Partnership Against Cancer's longitudinal study of chronic disease known as the "Tomorrow Project".

The Heart and Stroke Foundation is a national volunteer-based health charity founded over 50 years ago, with more than 130,000 volunteers and two million donors. We work to reduce heart disease and stroke by funding research, promoting healthy living to Canadians, and by working with all levels of government to inform and influence health policy.

We're aging. Every day 1,000 people in Canada turn 65, entering a stage of life with an increasing risk of stroke, heart disease, and dementia. The number of seniors in Canada is projected to increase from 4.2 million to 9.8 million between 2005 and 2036. Heart disease and stroke combined are the leading causes of death among Canadians 65 years of age and over, killing over 60,000 seniors annually. There are over 50,000 hospital admissions for stroke in Canada each year. That's one stroke every ten minutes. When you take into account that we don't hospitalize all strokes, the reality is that the number is much greater.

Those strokes that are hospitalized are called overt strokes, which produce acute traumatic symptoms. In addition to this, there are between five and ten times as many covert strokes. These are ones that do not produce acute manifestations but result in disability by other mechanisms. At a minimum, 300,000 Canadians are living with the effects of stroke today.

In view of the time constraints, we've chosen to focus on three main themes: stroke, aging, and economics; vascular disease of the brain and dementia; and, briefly, heart disease and aging.

In Canada, stroke is the leading cause of death and disability, costing $56,000 for the first six months of care alone. Estimated yearly costs are in excess of $5 billion. While 35% of individuals impacted by stroke are under the age of 65, age is the single strongest predictor of stroke occurrence. Stroke occurrence begins to rise at the age of 55, and doubles for each decade thereafter. Stroke results in physical, cognitive, and psychiatric dysfunction. Individuals have an impairment in their ability to make decisions, use language, think, and remember. Thirty percent are depressed at three months. Between one-third and two-thirds require rehabilitation for physical, cognitive, or communication difficulties. Fewer than 50% of individuals with stroke return to work, placing an additional burden on their caregivers and families.

In contrast to overt or large strokes, covert strokes cause functional impairment without producing overt symptoms or abrupt onset symptoms. We know that 95% of people age 65 and older show abnormalities in the brain related to disease of small blood vessels within the brain. Further, a quarter of healthy seniors aged 70 have evidence of small, silent strokes. Similar strokes are seen in 14% of Canadians aged 60. These small, silent strokes result in dementia, which in fact is a vascular disease.

Alzheimer's disease, which is often thought to be synonymous with dementia, rarely occurs alone. The vast majority of dementia consists of a combination of Alzheimer's disease and stroke, which goes by the term "mixed dementia". By 2038, the number of Canadians with dementia will increase by a factor of 2.3, with regard to the 2008 level, which is to say, 1.1 million people. The lifetime risk for stroke or dementia in our country is one in two for women and one in three for men.

The increasing rate of obesity and diabetes, combined with aging of the population, will contribute to an increase in all forms of heart disease, including ischemic heart disease, heart failure, and cardiac arrhythmias. This will strain the health care system and have a major economic impact on the country. As an example, it is estimated that currently there are 500,000 Canadians living with heart failure and 50,000 new patients are diagnosed each year.

● (1600)

What can we do?

There are some changes to the health care system that will help. The Heart and Stroke Foundation is very proud to be part of the joint initiative known as the Canadian stroke strategy, a national initiative that is aimed at improving stroke care across Canada. The strategy has targeted the systematic implementation of best practices, thereby preventing stroke, minimizing damage when it occurs, and improving functional recovery.

In the upcoming health accord the federal government needs to ensure adequate transfer payments to the provinces in order to enable incorporation of the best practices from the Canadian stroke strategy, including the establishment of dedicated stroke units and improved rehabilitation and palliative care services for those living with chronic diseases.

Prevention is key. Prevention can help delay and compress chronic diseases in later life, saving money to the system and the economy and improving the quality of life. Prevention essentially is all about making the healthy choice the easy choice, creating environments that make it easy to live a healthy lifestyle.

Prevention of vascular disease requires addressing a number of risk factors, many of which can also contribute to cancer, diabetes, obesity, and other chronic illnesses. At a high level, prevention includes a healthy diet, physical activity, and avoidance of tobacco.

There are a number of potential measures to address these risk factors, but here are a few we believe we must act on now.

The brain and the heart are the primary targets of high blood pressure. High blood pressure can be prevented by healthy nutrition, especially by reductions in sodium consumption, and increased physical acitivity.

With respect to sodium consumption, the Heart and Stroke Foundation of Canada urges the federal government to act upon the recommendations of the sodium working group, who released their final report last July. In particular, we call upon the government to establish sodium reduction targets for the food industry, with an accompanying monitoring mechanism. These targets should reduce the average daily intake of salt to 2,300 miligrams by 2016. If these voluntary targets fail to produce desired outcomes, we support the implementation of regulations.

Reduction in trans-fat content in our diet is important. Trans-fat content in Canadian diets is much higher than international recommendations. We call upon the government to introduce trans-fat regulations.

Fruit and vegetable consumption is too low in this country and is getting more and more expensive for seniors living on limited budgets. The federal government should ensure that agricultural policy and subsidies facilitate the production and distribution of fresh, affordable fruit and vegetables.

Community design and infrastructure that supports active living is particularly important for older people who have conditions that make mobility more challenging. Appealing, accessible, and safe facilities for walking and cycling will make it easier for Canadians of all ages to enjoy physical activity. Also important is the provision of safe and attractive recreational facilities and parks.

We call upon the federal government to work with the provinces to establish an active transportation fund to provide long-term funding for municipal infrastructure that supports active transportation. We also urge the federal government to renew the very successful Canadian recreational infrastructure fund to ensure continued investment in recreational facilities and parks.

Tobacco is a hugely important risk factor. Smokers have strokes ten years earlier than non-smokers. It is critical that the government renew the federal tobacco control strategy and maintain the annual funding for this strategy at no less than its current funding level of $43 million per annum.

Acute treatment for strokes substantially reduces disability, but must be delivered very rapidly after stroke onset. The most common reason that these treatments are not delivered is delay. We urge the government to support public awareness campaigns that teach people to recognize the signs of stroke and respond appropriately.

Madam Chair, acting on these recommendations will help to reduce the impact of chronic diseases on our aging population and our economy.

Thank you for the opportunity to provide our perspective today before your committee.

The Chair: Thank you very much, Dr. Sharma. That is very useful and rather shocking information, so I'm glad you came today so we can have a discussion with you.

I notice that Mr. Wilson is not here yet, so I'll ask Ms. Holmes if she would like to make the presentation for the Canadian Lung Association.

Mrs. Rosario Holmes (Educator, Asthma and Chronic Obstructive Pulmonary Disease, Ontario Lung Association, Canadian Lung Association): I don't have the presentation that he will make. I have a mini presentation that I can give if it is okay with you.

The Chair: I think that's wonderful, thank you.

Mrs. Rosario Holmes: He was the one who was supposed to present.

The Chair: I understand. Thank you for filling in.

Mrs. Rosario Holmes: I will just fill in a little bit here.

Chronic obstructive pulmonary disease is one of the leading causes of morbidity and mortality worldwide. The impact of COPD is overwhelming in every aspect in our society. This is why there's the need for a global approach. Prevention, diagnosis, and management are the major components of this approach.

Because COPD is insidious and progressive, the symptoms are ignored and sometimes misinterpreted, bringing the patient to a state of isolation, low self-esteem, financial limitations, malnutrition, depression, and death.

In the year 2000, when the Lung Association's BreathWorks program started here in Ottawa, I had the honour to be then working with patients with COPD. I am a witness to the isolation, low self-esteem, financial limitations, malnutrition, and depression of patients who don't have a family, but find comfort and support in the rehabilitation programs.

After the rehabilitation programs, the patients in the maintenance exercise program regain the desire to live. One of my patients even went to buy a table and a chair to have his meals. Before he was only eating cereal and staying on the sofa watching TV. He was so short of breath that he was not even able to make his own meals. Today, he's on oxygen. He participates three times a week in the maintenance exercise program, working very hard, and he is working to be in shape to have a lung transplant.

Pulmonary rehabilitation and maintenance are the most cost-effective and needed interventions for the management of COPD. The Lung Association has now a very special program that can be replicated in various communities to offer the COPD patients the opportunity to learn and to self-manage this chronic disease.

Thank you very much.

● (1605)

The Chair: Thank you very much, Mrs. Holmes.

Now we're going to be going into our Q and As, starting with Ms. Quach.

Would you like to start? So you have seven minutes.

Thank you.

[*Translation*]

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

I would also like to thank all the witnesses who made a presentation.

My first question is for everyone, more or less, since you all said that nutrition, diet and lifestyle are solutions for preventing the chronic diseases we are talking about. Some witnesses talked about agriculture. I think it was Mr. Sharma in particular.

Have you contacted people who work in the agri-food sector across Canada? If not, what has been done? Will you be developing processes, initiatives and programs as suggestions for the government? What can the government do to encourage all that?

I have other questions, but I will let you answer this question first.

[*English*]

Mr. Manuel Arango (Director, Health Policy, Heart and Stroke Foundation of Canada): Thank you very much. That's an excellent question.

Our recommendation with respect to agricultural policy came out of a huge scoping review that was commissioned about a year and a half ago, and it made this important recommendation. We are in the process of reaching out to the agricultural community.

What we do know is that often we have subsidies for corn and soybean production, which end up creating cheap supplies of fat and sugar. That fat and sugar is afterwards used in processed foods, and it makes the processed foods much cheaper than vegetables and fruits. This results in a bit of a perverse situation. What we need to do is ensure that fruit and vegetables are cheaper. We need a similar type of subsidy on fruit and vegetable production. Another example, as well, would be subsidies to farmers, to be able to transport fruit and vegetables to and from their markets.

Very generally speaking, we need the government to use a health filter or a health lens when they look at agricultural policy. We will be reaching out to Agriculture Canada and other organizations to work on this, but very generally speaking, we do need subsidies for fruit and vegetable production. That will make a difference, because, as Dr. Sharma mentioned, seniors are often on limited budgets and that will help with aging and chronic disease.

● (1610)

The Chair: Does anyone else have a comment on this?

Ms. Leo.

Ms. Aileen Leo: We haven't had any direct contact with agricultural producers. On occasion we will work with food producers in certain joint ventures, but we are concerned by the fact, as Dr. Sharma has mentioned, that fruit and vegetables are often prohibitively expensive, particularly in rural, remote, and northern areas of Canada.

We are concerned by the end of the food mail program and the substitute program that was put in its place, because often the subsidies are not passed on to consumers directly. They reside with the distributor. Given rates of aboriginal diabetes, that is a particular concern for us, because it's estimated that aboriginal diabetes rates are three to five times the rates of those found among the general population.

We need to provide affordable, inexpensive, healthy, nutritious food for all Canadians. That includes people who live on reserve, aboriginal Canadians who live off reserve, and also people on low incomes. I don't think it's any surprise that the consumption of soft drinks has gone up quite precipitously, when you consider that soft drinks are often much less expensive than milk. What message does that send to young people, in terms of what drinks they should be consuming?

While we haven't had those conversations directly, we would certainly be in favour of exploring measures to make healthy, nutritious food more affordable and less expensive, because it's well known that up to 50% of type 2 diabetes cases could be avoided with healthier eating and increased physical activity.

Mrs. Jessica Hill: Madam Chair, perhaps I could make a comment.

The Chair: Yes, please go ahead, Ms. Hill.

Mrs. Jessica Hill: We have a few resources and activities that address healthy eating. First of all, we have a public policy directory on our portal, on cancerview.ca, that actually captures public policies that are effectively supporting prevention. One of the resources on that is a resource called *Addressing Healthy Eating and Active Living: A Community Level Policy Scan*. The public policy directory also captures policies at the federal, provincial, and municipal level, and updates it on a regular basis. As municipalities or communities are looking for what they might do in the way of improving their policy directions, they can look at this and they will actually see a resource that's available. It reduces a lot of time for organizations and communities that want to improve their public policies at those levels.

One of our coalitions, Coaltions Linking Action and Science for Prevention, is looking at healthy communities and how to support communities to address the full range of policies—physical activity and nutrition, healthy eating—together in their communities and advancing those directions in their communities. It's more of an integrated approach, where nutrition is looked at as one of the key factors, with physical activity, to move forward.

The Chair: Thank you very much, Ms. Hill.

And thank you, Ms. Quach. Your time is up.

Now, with the permission of the committee, I want to welcome Mr. Wilson.

I've had days like this too, when I just couldn't get there at the right time.

We have begun our first round of questions. With the permission of the committee, could we just pause right now and give seven minutes to Mr. Wilson? Is that okay with the committee?

Some hon. members: Agreed.

The Chair: All right, we'll pause and go and go back to our presenters.

Mr. Wilson, you have seven minutes. Welcome.

● (1615)

Mr. Christopher Wilson (Director, Public Affairs and Advocacy, National Office, Canadian Lung Association): Thank you very much.

I apologize for being late. I was at the Minister of Finance's office and I couldn't tear myself away.

The Chair: Oh, we know that Minister of Finance. We'll talk to him later.

Mr. Christopher Wilson: I certainly don't mean I was seeing him personally, as you well know.

The Chair: Thank you.

Mr. Christopher Wilson: Okay, well, thank you.

I'm Christopher Wilson. I'm the director of public affairs and advocacy with the Canadian Lung Association.

With me is Rosario Holmes, who is an asthma and chronic obstrucive pulmonary disease educator.

I'm going to give you the short version.

The story of lung disease in Canada is really a bad-news and good-news story, if I can put it that way. The bad news is that over six million Canadians suffer from some form of respiratory illness, be it asthma, chronic obstructive pulmonary disease, COPD—it used to be known as chronic bronchitis and emphysema—lung cancer, sleep apnea, or cystic fibrosis.

Lung diseases are not curable. Without good management, they can be extremely debilitating and very expensive to treat. Together, lung illnesses have the highest repeat hospitalization rates and the second-highest acute in-patient treatment costs. To make matters worse, lung diseases are widely undiagnosed and untreated, including an estimated 50% of COPD cases and an astounding 85% of sleep apnea cases. Sleep apnea, for everybody, is a condition in which breathing is obstructed during sleep and it results in chronic fatigue and a host of health problems.

Undiagnosed diseases are poorly managed and they lead to periods of crisis and overall deteriorating health, resulting in high rates of emergency treatment and hospitalization. Thus, respiratory illnesses put a very heavy burden on the health of Canadians and our economy. It's conservatively estimated that between direct-care costs and the costs of disability, lung diseases currently cost $15 billion a year, and in 20 years will cost over $27 billion. This is just for chronic lung disease.

Respiratory illnesses have an especially heavy impact on older people. Prevalency rates for COPD among people aged 65 to 74 are almost triple those for 35- to 44-year-olds. COPD hospitalization and mortality rates rise steeply beyond age 65. Over 60% of asthma deaths in Canada occur in people over age 65. Lung cancer is rarely diagnosed in people younger than 40, and 80% of lung cancer cases occur in people over the age of 60.

Now, it's important to emphasize that older people are also disproportionately affected by some of the key risk factors for lung disease, including smoking, occupational exposures to harmful chemicals, as well as outdoor and indoor air pollution. It's important to remember that the awareness of these risks was much lower when the older generation was growing up, and therefore prevention wasn't practised and people were exposed more often and more severely.

Also important to note, as I'm sure you've heard, is that people with respiratory illnesses, like other chronic diseases, also frequently have more than one chronic disease. They are co-morbidities, which often end up being the cause of death. COPD patients, for instance, frequently die of heart attacks. Lung diseases in the elderly also increase the risk of hospitalization and death from infectious diseases such as influenza and pneumonia, so COPD has been diagnosed as a co-morbidity factor in over 50% of all deaths attributed to influenza in Canada.

Finally, I'll note that elders in first nations, Métis, and Inuit communities are at especially high risk for lung disease as a result of high smoking rates and overcrowded living conditions. As a result, the statistics are very high. The rates of COPD for off-reserve aboriginal people are nearly twice those for average Canadians. Women in Inuit communities have a COPD death rate that is ten times that for other Canadian women. Lung cancer rates for Inuit men and women are the highest in the world, and these rates are rising.

The story here is that in the absence of concerted action, the prevalence of lung disease will only get worse as our population ages in the coming years. The Conference Board of Canada has estimated that the number of people living with various lung diseases will increase by between 33% and 41% over the next 30 years. Seniors will make up most of this increase. Meeting the needs of these Canadians will put enormous pressure on our health care system. It is estimated that by 2020 there will be a 35% respirologists shortage, just as an example.

● (1620)

Fortunately, this is not all gloom and doom. There is good news here and there is real hope. There is hope for the following reasons. First, most lung disease is preventable. Reducing exposure to tobacco smoke, industrial pollutants, indoor air contaminants, and so forth will dramatically cut the incidence of new lung disease. Continued action in these areas will pay off even for people who are approaching their senior years.

Second, many respiratory illnesses can be effectively managed to reduce their severity and significantly improve health outcomes. There is a best practice emerging in Quebec that through patient self-management has cut costs by 38% and disease exacerbations by 45%.

Third, earlier diagnosis of respiratory illness will cut rates of untreated and poorly managed disease. Remember that the rates of undiagnosed disease for some of the most debilitating lung diseases are very high.

Taken together, the gaps in the prevention, diagnosis, and treatment of lung disease present a serious challenge, but they also afford a major opportunity. This is one disease area where we can have a big impact in the short term as well as in the long term through strategic investments.

To achieve the goal of concerted, coordinated action, the lung health community has partnered with the Government of Canada in the national lung health framework, which has developed an action plan for improving lung health, with a focus on improving prevention, diagnosis, and treatment. In its first stage, the framework did a strategic assessment of the state of awareness of lung disease. In the next phase, we are looking to have targeted actions with a high impact on reducing lung disease.

We have three recommendations. The first is to continue support for action on tobacco control and smoking cessation. We believe that the federal tobacco control strategy is important. Second is continued action on air quality. Third, we suggest renewing the national lung health framework.

Thanks.

The Chair: Thank you, Mr. Wilson. Thank you for giving the presentation.

We are going to resume our questions and answers.

Dr. Carrie.

Mr. Colin Carrie: Thank you, Madam Chair.

I want to thank the witnesses for being here today and for participating in our study. I think this is probably one of the most important studies we've ever done. We've had statistics in front of us. The cost to Canada for chronic diseases is $190 billion per year, so your input is really important.

I want to ask my first question to the Canadian Partnership Against Cancer, because you brought up something that I found very interesting. You talked about healthy communities. This past week we were back in the constituency and I attended a luncheon that was put on by a group in Oshawa. They're starting something called “victory gardens”, which used to be grown back in the war, and what they are doing is very cost-effective. We hear about the cost of fruits and vegetables. Well, they are growing their own. It was an excellent luncheon. It was all locally prepared food.

I am wondering what roadblocks are in the way of developing healthy communities. I look at my communities, and I see we are designing communities that have subdivisions where people need to hop in their cars to drive to get their cigarettes and Doritos and bring them back home. I wonder if you could comment a bit more on the concept of healthy communities and partnering with municipal designs. Is there any way you could see the federal government helping in that evolution?

Mrs. Jessica Hill: Thank you for the question, Dr. Carrie.

Actually, one of our coalitions is called Healthy Canada by Design. Peel Public Health is leading that work with other coalition partners. It's very much looking at municipal planning and how we can encourage the planning practices by municipalities to consider what's needed to support both physical activity as well as other aspects of healthy living. They are seeing some real changes in the uptake of their planning practices, not just in Peel, but also in other areas of the country, by supporting this activity.

That's one dimension of it. The other is that there has been work led very much by the Heart and Stroke Foundation in northern communities around the concept of gardens and opportunities to create access to healthy food sources that are much more community-based, and really encouraging community ownership of that idea.

So there are many dimensions that can be tackled in terms of supporting healthy communities.

We have another coalition that's looking at helping kids get physically active. In particular, we have one with first nations communities in Saskatchewan and Manitoba, where we are piloting chronic disease prevention education, with first nations communities by first nations communities. Again there are many levels on which I think you need to engage the community so that nutrition and healthy eating and physical activity are addressed collectively.

Certainly the partnership, through its coalitions, takes a very broad perspective about supporting prevention activities and really looking at those risk factors and how we can accelerate action. So we're going to be looking to how we can support further the Peel Public Health and communities by design to be adopted across the country.

● (1625)

Mr. Colin Carrie: Thank you very much.

I think it would be great if we could raise awareness on that issue, because what I'm hearing from all of the witnesses here—personal responsibility, proper food, exercise, a lot of common-sense things—will help us all as a country avoid a lot of these chronic diseases.

One of the statistics you brought up was disturbing. You mentioned that between 2007 and 2031 it's expected that new cancer cases will increase by 71%. I was wondering why you see such an increase. Is it earlier diagnosis? What types of cancer do you see increasing over the next few years?

Mrs. Jessica Hill: The growth is related to the aging of the population in part, so some of it is unavoidable by virtue of the fact that we are getting older and our bodies are breaking down. However, there are important things we can do—for example, to screen early for the cancers. Colorectal screening is a perfect example of that. In addition, looking at healthier lifestyles and adopting healthier behaviours mitigates risk.

There are so many contributing factors to the increasing rate of cancers. There are definitely lifestyle factors. We also know that infectious agents are a contributor—HPV. There was recently an article saying that there may be bacterial aspects in colorectal cancer.

I think we're unpacking a very complex set of diseases; therefore, action on the prevention side and on the screening side is probably the most important area where we can have an impact.

Mr. Colin Carrie: Thank you very much.

I want to ask a question to the Heart and Stroke Foundation—

The Chair: Just one moment, Dr. Carrie. If you don't mind, Mr. Arango would like to comment.

Mr. Manuel Arango: Yes, thank you.

I wanted to add a little more information with respect to Dr. Carrie's question on community design.

First I want to acknowledge and congratulate the Canadian Partnership Against Cancer for their coalitions program, which they fund to the tune of $17 million annually. We are involved, as Ms. Hill said, in a few of their projects. One of them is with respect to community design.

The member asked what the federal government can do. There are several problems with communities that can sometimes make them unhealthy. There's the fact that they don't have a mixed design, and what I mean by that is they don't have stores near communities. Rather than having to get in your car to drive downtown to buy something, if you have stores, mixed communities, near your neighbourhood, it makes a big difference if they can be walked to.

As well, not having enough sidewalks and cycling paths, walking trails, etc., can make a big difference. We mentioned the need for an investment in an active transportation fund, an infrastructure fund. That would support more sidewalks, walking paths, cycling paths, etc., where they're needed.

Finally, one other piece is further investment in public transit. It might not strike you right away what the relationship is, but on average, in communities where public transit is accessible the typical commuter walks 20 to 30 minutes to get to the public transit, so that increases physical activity. It reduces air pollution, which also is an inhibitor of physical activity. So public transit should also be considered.

Thank you.

● (1630)

The Chair: Mr. Carrie, my apologies, but the time is up.

Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you, Madam Chair.

I'm sorry I'm late. I apologize to everyone. I had another meeting that I couldn't cancel.

Obviously, some of the things you've talked about are on prevention. The tobacco strategy is a big part of it, especially with regard to lung disease. I want to know what you feel about the current commitment to the tobacco strategy. Do you feel that a one-year extension is sufficient, or do you feel there should be a permanent strategy to look at smoking cessation in a real way and in a practical way?

I think it's a large part of cancers and chronic lung disease. It doesn't really matter if you can walk 30 minutes to transit if you have COPD. Those are some of the things we need to talk about.

What are the practical ways in which the federal government can play a role in preventing the chronic diseases you talked about, such as cancer and lung disease? I think you talked about Quebec best practices. What things do you think one can do to help manage people with chronic diseases so that quality of life is assured? They could actually stay out of hospital and be able to decrease medications. All of those quality-of-life issues could be attended to, of course, with the cost of hospitalization being one of them. What are the ways in which you feel the federal government can play a role in moving that agenda forward?

One thing is good management. I know the provinces are responsible for delivering health care, but the 2004 accord talked about jurisdictional flexibility and federal-provincial cooperation in moving this agenda forward. What do you feel are the practical core things that one can do as a federal government?

Mr. Christopher Wilson: Obviously, as you've mentioned, it isn't the role of the federal government to deliver health care services, but we feel there is an important role and it's a role that the federal government has fortunately been playing. First of all, there are obviously areas of direct federal jurisdiction that are critical and have to be attended to, with first nations health being one them. We think there's an important role for the federal government in helping to pilot innovative initiatives that can really make a difference.

I'll speak from the perspective of lung health. To take the example I brought up, it's a wonderful thing that Dr. Jean Bourbeau and his team have done in Quebec. The results are very impressive. It's a little dismaying that after some years of this being well known and recognized, it hasn't extended beyond the boundaries of Quebec. We think there is an important role to catalyze the situation, identify these best practices, and assist in their dissemination. It's not to create federal programs but to see that these best practices are adopted.

There's similarly a serious problem with lung disease. Physicians and other health professionals are not fully aware of the clinical guidelines for treating the disease. I have a very good friend who's in the care of a physician. She has COPD and it's plain to me that her disease is not being properly managed because the physician simply doesn't know what to do. She's resisting treatment because she's independent. No one has told her that if she wants to stay independent, the important thing is to manage her disease properly. It's the key to independence.

This is where best practices such as respiratory, asthma, and COPD educators can have a role. I think there's a role for the federal government in helping to develop and disseminate these best practices. It's one of the things that's happening through the national lung health framework.

● (1635)

Mrs. Jessica Hill: Perhaps I could comment as well about the model we use, which is really a collaborative model with jurisdictions to advance the adoption of best practices, and it's very much as has been raised.

For instance, we have a repository of guidelines on our portal cancerview.ca, and that repository can be shared with all the clinicians in the country. In addition, we have a capacity for collaborative spaces on the portal whereby clinicians from across the country can actually work together in a secure space to discuss the guidelines and their application. That would be available to anyone in the strategies we're discussing, because in fact it's a way of leveraging the investment the federal government's already made to increase collaboration in the country.

We are having a forum on lung cancer screening in November, where we're really looking at some new evidence of the ability to screen, and really asking questions with the provinces about what might be the best use of this technology.

Just to build on the previous witness's comment, we believe collaboration is absolutely critical in this country. It's a huge country with quite a small capacity, and we're going to get much further if we work together on some of these conditions and diseases.

Our coalitions very much focus on the full range of prevention efforts. In this first round of our coalitions, we are looking at how clinicians, physicians, can actually better counsel patients around these risk factors—this is through a joint effort in Ontario and Alberta. We'll learn how that goes, because some of it is really trying to learn how to actually effect change in many of these areas and it's not always clear. We might have the tools, but we don't seem to be having an impact, so how can we do better?

The fundamental part of it is to work with the jurisdictions, the clinicians, the charities, and the patient groups, actually working together to create solutions, implement them, evaluate them and learn from them.

The Chair: Thank you, Dr. Fry.

Did someone else want to...?

Mr. Arango.

Mr. Manuel Arango: I have just one quick comment.

The member mentioned the federal tobacco control strategy. That strategy was extended for one year last March and it's up for renewal again this coming March. We're hoping for a five-year extension, and that's what the government is looking into. It's really key. Without investments in tobacco control you just can't get those rates down and keep them going down.

I would point to two particular initiatives under the umbrella of the federal tobacco control strategy we really need to continue investing in. One is mass media support and funding. It's been a few years since there's been any investment in mass media, a public awareness campaign, so re-funding that part of the strategy is really critical. It was funded to the tune of approximately $25 million several years ago. We need investment back there again.

The other piece is with respect to tobacco taxation. It's one of the most important measures in tobacco control to keep smoking rates down. The tobacco industry has been using the contraband situation as a lever to justify and call for cuts to tobacco taxation. That was done in the early nineties. It didn't quite work. When taxes were cut for a short period of time, rates did go up. So we've got to ensure that we keep taxes up. It's a critical measure.

Thank you.

The Chair: Thank you, Mr. Arango.

Now we will go to Mr. Gill.

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

I'd like to thank all the witnesses, first of all, for taking the time out to be here with us today. I also want to thank you for your hard work and your commitment in terms of helping Canadians.

I'm wondering if each of the organizations can actually share their experience on what they found to be the most effective way to educate the elderly patient and in regard to prevention or management and treatment of some of these chronic diseases.

The Chair: Who would like to take that?

Ms. Holmes, do you want to? Go ahead, please.

Mrs. Rosario Holmes: Thank you for the question. It's very important and I think it's part of the question we had before.

In the Lung Association's case, the most effective way to help our patients is through education. We started in groups, but now we do it one on one. When patients understand their illness—what has happened, where it came from, what the triggers and components are, how to use the medication and all that—we see enormous change in the patients, including they don't have to visit a hospital, even for years.

This has been my experience since I started working especially with COPD and asthma patients. I'm also working with patients going for a transplant. Again, it's helping them understand the disease and where that disease comes from. Then the other part is to just go naturally, because when the patients understand what will happen in their bodies if they smoke—we'd show them all the damage—it's easier for them to stop smoking.

For me, I would say one-on-one education is the best.

● (1640)

Ms. Aileen Leo: Thank you very much for the question. It's very important, because basically self-management rests on how you engage with people living with chronic disease, and the longer you can keep them healthy, the less costs will increase and the less human misery will result as a result of living with a disease.

Like our colleague, we feel that direct education with those living with a disease is the optimal way to educate people, including people over the age of 65. Our presentation referenced that in terms of direct interventions in working with elderly Canadians. We've seen that with what are commonly called high-risk groups, in particular with aboriginal groups through the aboriginal diabetes initiative. They employ community health care workers who live in those communities who can engage directly on a one-to-one basis with people living with diabetes. Other high-risk groups—for example, African Canadians, Southeast Asian Canadians, South Asian Canadians—all have higher rates of diabetes, and peer support workers work very well in those communities as well.

It's important to note that there are diabetes education programs that exist across Canada, but there is actually no set standard for accreditation of those programs. So we strongly support one-to-one diabetes education programs or education in small groups, but there have to be standards underlying those interventions. We've developed those standards, and one of the things we're trying to do is get all provinces and territories to adopt those standards.

The Chair: Go ahead, Ms. Kitchen Clarke.

Mrs. Leanne Kitchen Clarke (Vice-President, Public Affairs, Canadian Partnership Against Cancer): Thank you.

It is an important question that you raise, and there probably isn't one perfect solution. I certainly agree with the other witnesses that one-to-one education is key. That's certainly something that Partnership Against Cancer would support through its interactions with the health system, in particular, cancer centres that deliver care directly to the patients but also consider that the families are part of that care team and can also be very important facilitators and advocates for elderly parents or their own spouses.

We do, through Cancer View Canada and the portal, have a number of resources available. There is a significant number of the elderly or aging population that is online and quite active. So in addition to the education programs at direct point of care, there is an ability for people to access information through online tools, trusted information, and certainly a number of the organizations represented today have very trusted and credible information available online.

We also support partnerships where information exists. In the Canadian Virtual Hospice, for example, a website that provides information to caregivers, particularly around end-of-life issues, there is certainly a point around self-management being the key to good wellness and prevention and ongoing good health for those who suffer from a chronic disease. But many diseases are life-limiting and life-threatening, and we have to address the palliative end-of-life care needs.

The other piece related to our first nations, Inuit, and Métis communities is it is extremely important that the information and resources made available in those communities are culturally appropriate and relevant. It is not a one-size-fits-all solution for rural or remote and far northern communities. Similar to the diabetes educators, there are community health workers in first nations communities who also look at cancer prevention and cancer screening, and we have to recognize the limitations and capacities in those communities. So disease-by-disease solutions are often going to be very difficult for them to implement, given that they are addressing so much burden within the communities also related to social determinants of health, which have been raised here today.

Those are some of the key things that need to be addressed.

The Chair: Dr. Sharma.

Dr. Mike Sharma: I have a brief comment, if I may.

We have some experience with this in a number of facets. I'll stick to one example, and that is with regard to sodium. When we looked at the impact of sodium on blood pressure, stroke, and dementia, we wanted to communicate to people what is the best amount of sodium to take.

The sodium we take in in our diets is in prepared foods. Less than 20% is what you add at the table with your salt shaker. If you read the labels on prepared foods, they can be quite difficult to interpret. It's given as a percentage of recommended daily allowance, and if you try to juggle in your head all the percentages you've consumed in a day, it's quite a feat if you manage it.

The first thing we did—and I think this is one critical principle—is we translated the information into something that was usable. We developed a technique to translate it into a number of milligrams and put that on the website. You may point out that a lot of individuals we are trying to target who suffer from these conditions are elderly, and it is true that there is a smaller rate of penetration of Internet information in that age group. However, their children are very well versed in this. We found that was very helpful to get the families involved.

The second key element, in addition to translating that, was to make it easier to make the right choice. In terms of prevention, we found that if we also took that same information and put it on little cards that could go into your wallet or purse when you're shopping, or on fridge magnets, it suddenly became very easy to get the right things.

● (1645)

The Chair: Thank you very much.

Now we'll go into our second round. It's a five-minute round of questions and answers, and we'll begin with Dr. Morin.

[*Translation*]

Mr. Dany Morin: Since I have several questions, could you please make your answers short?

[*English*]

Thank you very much for doing all the good work you do with the Canadian population.

Do you feel that your charitable tax status inhibits your ability to advocate on Parliament Hill for improvements within the health care system?

The Chair: Who would like to take that one?

Mr. Christopher Wilson: Everybody would like to answer that question, I'm sure, but I'll be brave here and say that it can be an inhibition.

Frankly, I think for the level of national charity that is addressing you today, that's less of an issue for the simple reason that the budgets are so large. There's so much programming going on that you'd have to be very politically focused to break the 10% rule.

However, having spent most of my life working for non-profit organizations, I can tell you that the problem you are raising is a very real one for smaller non-profit organizations. Some of the coalitions that exist on mental health and other issues, by their nature, are not offering programs—their affiliates are—but they need to do advocacy work, and it is an inhibition. That's all I'll say.

The Chair: Mr. Arango.

Mr. Manuel Arango: Yes, I have just a very quick comment. I can't speak specifically to the tax status, but here is a related issue.

A coalition called Imagine Canada, which deals with non-profit organizations in the country, as well as the Health Charities Coalition of Canada, which deals with charities and is a coalition as well, are interested in the promotion of the stretch tax credit.

I can't speak much to it, but I know that this issue has been raised in the past at the finance committee. I would just flag that for you. The stretch tax credit is something you could look into.

The Chair: Ms. Leo.

Ms. Aileen Leo: Very briefly, to respect the time limit, we also support the stretch tax credit and have made that recommendation to the finance committee.

Mr. Dany Morin: Thank you very much.

[*Translation*]

My next question is for the representatives from the Canadian Lung Association.

[*English*]

You mentioned earlier that overcrowded conditions in the aboriginal community increase—

The Chair: Could I just interrupt you? Could people take their BlackBerrys away from their microphones? Then we won't have choice words.

Mr. Dany Morin: Thank you.

Yes, you mentioned that overcrowded conditions in the aboriginal reserves increase lung problems, medical problems. I don't get why. I understand they smoke more than the general population, but why are the overcrowded conditions a risk factor?

Mr. Christopher Wilson: If I may respond, it's a combination of things. You've identified one of the factors, which is cigarette smoke. Overcrowding is also often connected with poor ventilation, so there's general poor indoor air quality, and that often is associated with mould growth and—

● (1650)

The Chair: Sorry, can I interrupt you for just a minute?

Can someone inform me as to why the bells are going off right now?

There's a vote. How long do we have?

I'm sorry to interrupt you, but I have a feeling we will be going back to Parliament very shortly. It depends.

We'll have to adjourn right away, so thank you so much to the witnesses for being here today. It's been very helpful.

My fellow colleagues, I guess we'll have to go back to Parliament.

The committee is adjourned.

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