HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 019 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Monday, December 5, 2011

Chair

Mrs. Joy Smith

Standing Committee on Health

Monday, December 5, 2011

● (1545)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): We'll convene the committee now. I want to welcome our witnesses and thank you so much for your patience, as we were conducting a brief but very important business meeting prior to your entry.

We are studying, as you know, health promotion and disease prevention.

From Health Canada, we have Ms. Catherine MacLeod, associate assistant deputy minister of the health products and food branch. Welcome, Ms. MacLeod. We also have Dr. Hasan Hutchinson, director general, office of nutrition policy and promotion. Welcome, Dr. Hutchinson.

From the Public Health Agency of Canada, we have Ms. Kim Elmslie, director general, Centre for Chronic Disease Prevention and Control. Welcome again. I'm glad to see you here.

From the Canadian Institutes of Health Research, we have Dr. Nancy Edwards, scientific director, Institute of Population and Public Health. Welcome, Dr. Edwards. And we have Dr. Philip Sherman, scientific director, Institute of Nutrition, Metabolism and Diabetes.

We're very happy that you're here to give testimony. As you know, one of you from each organization will give a 10-minute presentation and then we'll go into the Qs and As.

From Health Canada, who would like to present there? Ms. MacLeod.

Ms. Catherine MacLeod (Associate Assistant Deputy Minister, Health Products and Food Branch, Department of Health): Thank you very much, Madam Chair. I am very pleased to be here today with my colleagues from the Public Health Agency of Canada and the Canadian Institutes of Health Research.

Eating plays an important role in promoting health and reducing the risk of nutrition-related chronic diseases. The federal health department has been providing leadership in nutrition since the 1930s and has a long history in health promotion and chronic disease prevention. Documents like the Ottawa Charter for Health Promotion brought in the traditional view of health and spurred groundbreaking advancements in health promotion. Nutrition was an integral part of the health promotion thinking then, as it is today.

We know that Canada is a different place than it was 30 years ago and that our socio-demographic and cultural profile has changed. Today Canadians live in an environment that poses unprecedented challenges to the goal of healthy eating. There has been a significant evolution of the range of foods available in the marketplace. Time pressures faced by busy families have changed the way Canadians eat. That's why we need to create social and physical environments that support healthy eating and make healthy choice the easy choice for Canadians. This requires a comprehensive, multi-sectoral approach that uses a range of policy and program tools and levers.

[*Translation*]

Canada is already making important strides. As Mrs. Elmslie mentioned, the endorsement of a Declaration on Prevention and Promotion by Ministers of Health further emphasizes the importance of making the promotion of health and the prevention of disease a priority for action in all jurisdictions across the country.

The endorsement of the first report entitled *Actions Taken and Future Directions 2011* on curbing childhood obesity at the November 2011 Health Ministers Meeting is also an important milestone in helping to advance healthy eating efforts in Canada.

Action to improve nutrition and healthy eating is a shared responsibility among different levels of government, non-governmental organizations, industry and Canadians. Health Canada has a critical national leadership role to play in supporting healthy eating through the development of national nutrition policies and guidelines, enhancing the evidence base to support policy decisions, monitoring and reporting on what Canadians are eating and providing Canadians with information, through education and awareness initiatives, to help them to make informed healthy eating choices.

[*English*]

● (1550)

The most well-known national nutrition policy developed by Health Canada is likely our *Eating Well with Canada's Food Guide*. The food guide promotes a pattern of eating that will meet nutrient needs, promote health, and minimize the risk of nutrition-related chronic diseases. It's not only designed to help explain to Canadians what healthy eating means, it's also an important policy that underpins nutrition and health policies and standards across the country and serves as a basis for a wide variety of nutrition initiatives. The food guide was developed using the best evidence to translate the science of nutrition and health into a healthy eating pattern for Canadians. Health Canada has distributed nearly 22 million copies of the food guide since its release in 2007. In 2010 the food guide's home page was the second most-viewed page on the Health Canada website.

While the food guide is an important policy that defines healthy eating, it's only one component of a range of actions needed to improve the nutritional health of Canadians. Health Canada's work to provide health professionals with the latest nutritional advice related to prenatal nutrition and infant feeding guidelines are other examples of how the department translates evidence to support and promote healthy eating through specific life-stage guidance. For instance, this year we released revised gestational weight guidelines for health professionals, and consumer materials to help both health professionals and expectant mothers manage weight gain during pregnancy. We're currently working on revising infant feeding guidelines for health professionals through a joint process with the Dietitians of Canada, the Canadian Paediatric Society, and the Breastfeeding Committee for Canada.

Policies and programs that support healthy eating require a strong evidence base and a capacity to measure progress and outcomes. The external community is a significant source of information, nutrition science, and evidence on effective interventions, allowing us to tap into the best and brightest for any given nutrition issue. This broad reach enhances our leadership capacity in nutrition and ensures that the most effective nutrition solutions are delivered to Canadians. A key example is the collaboration between Canada and the U.S. through the Institute of Medicine to support dietary reference levels. They are the scientific underpinnings for national dietary guidance.

Monitoring and reporting on what Canadians are eating, and on the factors that influence food choice and nutritional health outcomes are also major components of Health Canada's work, including the analysis and sharing of nutrition data from the Canadian community health survey, which focused on nutrition in 2004. It was the first time in 30 years that a comprehensive survey was done on what Canadians were eating. This survey will be repeated again in 2015, which will help us to understand changing food and nutrient consumption patterns and see how eating patterns in Canadians align with our efforts to support healthy eating.

● (1555)

[*Translation*]

Healthy eating education and awareness activities are also key components of work at Health Canada. In collaboration with the provinces and territories, we are developing multi-year Healthy Eating Awareness and Education initiatives that will provide clear and consistent healthy eating messages for Canadians. We continue to enhance efforts to improve consumers' understanding of nutrition labelling, through initiatives such as the Nutrition Facts Education Campaign. Earlier this year you may have seen our ads on TV that promote the understanding and use of the Nutrition Facts table, specifically the % Daily Value found on packaged food labels, and encourage Canadians to look for more information on Health Canada's Web site. This campaign is an innovative example of how stakeholders who share responsibility for promoting healthy eating, such as the food industry, health professional associations and non-governmental organizations, can work together.

The Eat Well and Be Active Educational Toolkit, developed with our colleagues at the Public Health Agency of Canada, is an example of integrating healthy eating and physical activity. The toolkit includes the Eat Well and Be Active Every Day educational poster and downloadable activity plans. It is designed to help health educators teach children and adults about healthy eating and physical activity and to encourage them to take action to maintain and improve their health.

Reaching out to other groups, such as health professionals, researchers, policy-makers and academics, allows us to leverage expertise, enhance collaboration, cooperation and alignment of efforts to support healthy eating in Canada. This includes working closely with our provincial and territorial government colleagues.

[*English*]

Let me conclude by stating that healthy eating continues to play an important role in promoting health and reducing the risk of chronic disease. We're committed to continuing our efforts to promote the nutritional health of Canadians.

Thank you very much for the opportunity to present today.

The Chair: Thank you, Ms. MacLeod. It seems like such a simple thing, but it has become very complex now, hasn't it, with our childhood obesity rates in this country.

Thank you for presenting.

We'll go to Ms. Elmslie, from the Public Health Agency of Canada.

[*Translation*]

Ms. Kim Elmslie (Director General, Centre for Chronic Disease Prevention and Control, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada): Thank you very much, Madam Chair.

[*English*]

I'm very pleased to be here today to discuss the importance of health promotion, and to describe some of what we've achieved in this area.

I want to say that your interest in health promotion is very timely, given that 2011 marks the 25th anniversary of the Ottawa Charter for Health Promotion. Some of you may remember—and many of you will not—that this landmark document was the defining moment for us in Canada by establishing a new way of looking at health and at ways to promote health.

I just want to remind you, because it sets an important stage for our discussion, that the Ottawa Charter for Health Promotion identified five areas for action, namely: the development of personal skills so that people could stay healthy; the strengthening of community actions so that communities could support people in staying healthy; the creation of supportive environments; the reorientation of health services to focus and balance the emphasis, so that we include health promotion and disease prevention in them; and, of course, the building of healthy public policy. Twenty-five years later, we can look back and say that we've made a great deal of progress in this country.

Our approach has evolved and continues to evolve so that we are not just treating individuals who are sick, but are placing a strong emphasis on the promotion of good health and the prevention of chronic disease. These factors are becoming more and more part of the way Canadians and their health care providers are talking about health.

Evidence of the leadership role that Canada has played includes the development of the recent Rio Declaration on the Social Determinants of Health. Our leadership role in Canada is also apparent in the Declaration on Prevention and Promotion, wherein Canada's health ministers have committed to work together and, with their partners in other sectors, to build and influence physical, social, and economic conditions that promote the health and wellness of Canadians. There is a spirit of collaboration that has certainly become ingrained across the country, as we recognize that we must work together and must bring other sectors into our collective objectives of helping Canadians to live longer and healthier lives. That foundation is serving us well.

We all know that Canadians experience better health outcomes than citizens of many other countries. Statistics Canada recently reported that the life expectancy in Canada had reached a new high of 80.9 years. We also are proud that our infant mortality rate has declined steadily in Canada since 1982. Based on data from the Canadian community health survey, we know that Canadians are reporting that they believe their health is good, very good, or excellent. Almost 90% of us are reporting that.

Even so, we know that much more needs to be done, and we know that not all Canadians enjoy the same level of health. When we talk about health, we're talking about both the physical and, very importantly, mental health of all Canadians.

The burden of chronic disease—as I've told you before when I've been at this table—is growing. Chronic diseases and injuries are the main causes of death and ill health in Canada. However, we know that a large proportion of that burden can be delayed or prevented. As you also know, the government recently participated in a United Nations meeting at which Canada and other countries around the world unanimously endorsed a political declaration that placed a priority on the prevention of chronic disease, and recognized the need for many sectors to work together to achieve our objectives.

Today I'd like to focus on the upstream action that we are taking, that is, how we are working together to make the healthy choices the easier choices for Canadians, as Ms. MacLeod referenced earlier, so that we can enjoy long and healthy lives.

Let's start with some of the basics. Experience and research tell us that health promotion should begin early, and must continue throughout the someone's life course. Promoting healthy living in children sets the stage for good health and reduced risk of chronic diseases in later years. The prenatal period offers a unique opportunity to set a child on a path to lifelong good health. Canada has done well in providing comprehensive prenatal care and promoting positive prenatal behaviours. For example, we disseminate *The Sensible Guide to a Healthy Pregnancy*, a tool that supports pregnant women in making healthy lifestyle choices. Recognizing that fetal alcohol spectrum disorder, or FASD, can have a profound effect on Canadian families and society, we have also supported the development of the world's first consensus clinical guidelines for alcohol use in pregnancy and a tool kit to identify children and youth affected by FASD.

● (1600)

Just as there is great benefit to supporting healthy pregnancies, we know that investing in early childhood is extremely valuable. Indeed, the World Bank estimates that for every dollar invested in children, $3 in future health savings is realized. Among our investments in maternal and child health are over $112 million annually to support vulnerable children and their families through the community action program for children, the Canadian prenatal nutrition program, and the aboriginal head start program in urban and northern communities. Together, these programs represent important upstream investments. They reach over 100,000 vulnerable Canadians each year.

Along with these important programs, we are also investing in strategic initiatives that support maternal mental health, reduced childhood exposure to tobacco smoke, improved oral health, and the prevention of unintentional injury.

On the latter issue, unintentional injuries are an incredible threat to the health of children and youth. Many of these injuries are related to sports and recreational activities. While we want to ensure and promote activity among Canada's children and youth, we also want them to be active safely. To that end, in March of this year the Government of Canada announced a $5 million investment over two years to support initiatives that empower Canadians to make safe choices. The active-and-safe initiative will focus on preventing concussions, drownings, and fractures and on promoting the safety of children and youth in high-participation physical activities.

We also know, sadly, that mental illness and suicide begin to appear in adolescence and early adulthood, and we recognize the importance of improving the mental health of all Canadians. Through the investment in the Mental Health Commission of Canada, a dialogue has been initiated about these sensitive issues. We're learning more about how to reduce stigma and how to better support Canadians. We continue to invest in programs that increase awareness, strengthen protective factors, and build resilience.

We have invested over $27 million through the Public Health Agency of Canada's innovation strategy to support projects that reduce health inequalities, promote positive mental health, and develop protective factors for children, youth, and families. For example, we are providing funding to support collaboration among the Canadian Mental Health Association, the British Columbia Association of Aboriginal Friendship Centres, and the University of Northern British Columbia to improve the mental health of young aboriginal families. This multi-stakeholder, community-wide approach is intended to counter anxiety and depression among youth and to prevent problem behaviour, such as substance abuse, delinquency, and teen pregnancy.

Similarly, together with the provinces and territories, earlier this year we initiated a pan-Canadian dialogue about childhood obesity. Not only have these conversations raised awareness about this critical public health issue, but they have also served to get people thinking about the part we all must play in a made-in-Canada solution.

As I mentioned earlier, Canadians are living longer than ever before. We know that a longer lifespan comes with an increased risk of chronic disease. But the pressures of an aging population are not unmanageable. We know that health promotion interventions benefit people of all ages, even the very old. Research shows that health promotion for older adults not only improves health behaviours and, as a result, health outcomes and quality of life, but also has very a real impact on reducing health care costs.

● (1605)

Quite simply, healthy seniors makes less use of health care services, and they live longer and better. Studies show, for example, that long-term care residents, often the oldest and frailest of our citizens—

The Chair: Ms. Elmslie, you've gone quite a bit over time. Can you wrap it up, please?

Ms. Kim Elmslie: I'm sorry. I'm going to wrap this right up.

Our oldest citizens can benefit from health-promotion activities.

Let me finish with an acknowledgement that, first and foremost, we must recognize that public health is not just a health issue. Promotion and prevention involve all of us, in many different sectors, at a level of collaboration that perhaps we haven't seen before in this country.

The Chair: Thank you, Ms. Elmslie.

[*Translation*]

Ms. Kim Elmslie: It was my pleasure.

[*English*]

The Chair: Thank you. I'm sorry, but there will be lots of time for questions. It was a very good presentation, but I let you go quite a bit over to try to finish it. Thank you.

We'll now go to Dr. Nancy Edwards of the Canadian Institutes of Health Research.

Dr. Nancy Edwards (Scientific Director, Institute of Population and Public Health, Canadian Institutes of Health Research): Thank you, Madam Chair.

I'd like to thank the House of Commons standing committee for this opportunity to speak to you as you prepare for your study on chronic disease prevention and health promotion.

Chronic diseases are a leading cause of death and disability worldwide and, according to recent World Health Organization statistics, kill 36 million people globally each year. In Canada, it is estimated that 89% of all deaths can be attributed to chronic diseases.

Health promotion and primary prevention are key approaches to changing these numbers. Regular physical activity, healthy eating, eliminating smoking, and reducing excessive alcohol use could prevent up to 80% of diabetes and cardiovascular diseases and 40% of cancers.

The magnitude of the current and anticipated burden of chronic disease is Canada's largest public health challenge. It will require new approaches. Evidence shows that interventions need to consider the broader social, cultural, and environmental factors that determine the health of Canadians. For example, the places where we live, work, play, and learn have profound impacts on our health.

Every child deserves the best start, irrespective of his or her socio-economic circumstances. Social and structural determinants, such as income and income distribution, education, job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety, access to health services, aboriginal status, gender, race, and disability are all critical drivers of health inequalities in Canada and must inform effective interventions.

Because these factors may be present from early childhood and accumulate over time, a life-course perspective is required. Research provides the evidence for the development of effective public health measures that will prevent chronic diseases. The Canadian Institutes of Health Research is committed to the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system.

Notably, one of CIHR's research priorities is to promote health and reduce the burden of chronic disease and mental illness. CIHR has further recognized that health and illness are distributed in inequitable ways across populations. Therefore, CIHR also has a research priority aimed at reducing the health inequities faced by aboriginal people and other vulnerable populations.

These research priorities are being realized, in part, through large new projects that we call signature initiatives. In particular, the signature initiative in community-based primary health care covers a broad range of primary prevention, as well as public health and primary care services within the community, including health promotion and disease prevention; the diagnosis, treatment, and management of chronic and episodic illness; home care; rehabilitation support; end-of-life care, and more. The initial focus of this initiative has been to support research into better systems for chronic disease prevention and management and access to appropriate care for vulnerable populations.

A second signature initiative relates to pathways to health equity for aboriginal people. This initiative aims to increase the capacity of aboriginal communities to act as partners in the conception, oversight, and application of high quality research to reduce the health disparities of aboriginal peoples. Rather than just describing the extent of the problem, the focus at the CIHR Institute of Population and Public Health has been on generating evidence on what policy and program interventions work, for whom and under what conditions and at what cost. This is the only way to curb the burden of chronic disease and to learn about the impacts of existing measures.

The urgent need for intervention research has been recognized by the WHO Commission on Social Determinants of Health and by the Senate Subcommittee on Population Health in its 2009 report, “A Healthy, Productive Canada: A Determinant of Health Approach”.

CIHR has made investments in policy-relevant research related to chronic disease risk factors. For example, Dr. Geoffrey Fong and his team at the University of Waterloo recently received one of the largest operating grants ever awarded by CIHR for the team's ground-breaking work on tobacco control policies around the world.

● (1610)

CIHR's efforts have not been limited to Canada. As noted in the recent United Nations political declaration on non-communicable diseases, chronic diseases are a global health and development challenge.

CIHR is a founding partner in the Global Alliance for Chronic Diseases, and through this international collaboration, we are funding research to support the effective scaling up of interventions related to chronic disease risk factors, such as hypertension. In sum, CIHR is committed to both the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products, and a stronger health care system.

Research can contribute to the generation of evidence-informed, cost-effective, and sustainable solutions that make a difference to Canadians and prevent chronic disease. This is a key area of focus for CIHR within Canada and globally.

Thank you.

The Chair: Thank you very much, Dr. Edwards.

We have very interesting presentations today.

You were going to split your time with Dr. Sherman, so we'll now go to Dr. Sherman for his presentation.

Thank you.

Dr. Philip Sherman (Scientific Director, Institute of Nutrition, Metabolism and Diabetes, Canadian Institutes of Health Research): Thank you very much, Madam Chair. I'd like to thank the Standing Committee on Health for this opportunity to speak about the Canadian Institutes of Health Research's contributions toward health promotion and disease prevention.

CIHR proudly supports basic biomedical and patient-based research. These are essential to improving our current understanding of the causes and the underlying mechanisms of chronic disease. By better understanding the causes, we can determine more effective strategies to address underlying risk factors and thereby prevent disease. CIHR also funds clinical patient-based research to determine the best ways to manage and treat chronic diseases. This type of research provides high-quality evidence to improve clinical practice, enhance patient care, and optimize health outcomes. CIHR is working together with provincial and territorial governments, health charities, academic health care organizations, and representatives of industry to develop a comprehensive strategy for patient-oriented research. This strategy aims to strengthen clinical research and improve the transfer of research evidence into evidence-based practice so that the right patient receives the right treatment at the right time.

This strategy offers the opportunity to move bench-top discoveries to the clinic or bedside and has the potential to radically improve the lives of Canadians suffering from chronic disease.

A compelling Canadian example to illustrate such an impact is the discover of insulin. I recently participated in events to commemorate the 90th anniversary of the discovery of insulin, done in Canada by Drs. Banting and Macleod, who were awarded the Nobel Prize in Physiology or Medicine in 1923. Thanks to this discovery of insulin, today many Canadians with diabetes live long, healthy, and productive lives.

CIHR provides funding to support research across the country that addresses chronic disease. For example, CIHR provided $44 million in 2010 to support Canadian diabetes research, and millions more to support research related to cancer, heart disease, and strokes.

Dr. Edwards already spoke about the risk factors associated with chronic disease, such as lack of physical activity, poor diet, smoking, and excessive use of alcohol. Together with my colleagues from the Public Health Agency of Canada, I want to add obesity to the list of risk factors, because obesity is now a world-wide epidemic. Since 1980, obesity rates have doubled or even tripled in many countries. Indeed, in more than half the countries in the Organisation for Economic Co-operation and Development, more than half the population is classified as being overweight. We don't have reason to be complacent in Canada, because in 2007–08, roughly one in four Canadian adults was obese, and a quarter of Canadian teenagers were obese or overweight during the same time period. A recent international review of the CIHR confirmed that our institute's strategic focus on obesity has had a transformative impact on this field of research in Canada, and that our institute has built a community of obesity researchers of international visibility and international stature.

Much of the obesity research funded by CIHR focuses on prevention. For example, CIHR funds research projects on how the built environment and neighbourhood design impacts obesity, on how tax incentives affect children's physical activity, and how a family intervention program for obese and overweight women during pregnancy and the first year after delivery affect childhood obesity. As examples of outstanding research CIHR has funded, I will cite the work of two researchers who are both undertaking research related to the school environment and its impact on childhood obesity. Dr. Rhona Hanning is looking at the impact of a school-based education program on the consumption of sugar-sweetened beverages and body weight in children. Dr. Veugelers is performing an economic evaluation of a school-based program aimed at the prevention of childhood obesity.

Moving forward, our institute has prioritized research in the area of food and health. According to the World Health Organization, nutrition and micro-nutrient deficiencies continue to be a widespread problem globally, especially among women and children. These deficiencies often co-exist with obesity and diet-related chronic diseases. A diet high in sugar, salt, and saturated fat and low in nutrients is linked to some of the most prominent chronic diseases in Canada, including type 2 diabetes, high blood pressure, cardiovascular disease, stroke, and cancers.

In November of last year, our institute hosted a national workshop to identify research gaps and opportunities in the area of food and health research. This workshop highlighted research related to nutritional vulnerability, emerging food technologies, food policies, food security, and human nutrition. We will soon be launching a research funding opportunity to catalyze food and health research in Canada and build on a recent funding opportunity that we supported in the area of sodium reduction and how it impacts human health.

● (1615)

CIHR's ongoing investments in research will serve to transform health promotion and disease prevention efforts, as well as impact clinical practice so as to improve the health of Canadians and contribute to a stronger and sustainable health care system.

Thank you for your attention. My colleagues and I would be pleased to take your questions, comments, and feedback. Merci.

● (1620)

The Chair: Thank you, Dr. Sherman.

As I said, everyone here has given very insightful presentations today.

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

We'll begin with Dr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you, Madam Chair.

First of all, when I think of prevention, I think about the food we eat. In my opinion, the main problem with food currently, especially where young people are concerned, is the level of sodium contained in food products.

The average amount of salt consumed by the population is 3.4 mg per day. Ideally, according to the recommendations, this should be around 1.5 mg. The maximum level is 2.3 mg; beyond that, there are health risks involved.

Given that the daily consumption average is 3.4 mg, the health of the population is in jeopardy. Indeed, a working group was struck by the federal government precisely to examine that issue. According to the recommendations of this group, the government should impose targets on the food industry. Unfortunately, last month the federal government refused to do so.

My question is addressed to Ms. MacLeod.

Can you attempt to justify that position? It seems to me to be a matter of simple common sense. Mr. Sherman also mentioned the issue of salt. I know that you negotiate with the food industry, but how is it that there are no targets and that the federal government does not want to strengthen targets? This is so important for the Canadian population.

[*English*]

The Chair: Who would like to take that question?

Ms. MacLeod?

Ms. Catherine MacLeod: Yes. Thank you very much.

[*Translation*]

That is a very good question. Where salt is concerned, we have a lot of activities that are ongoing. I will give you an overview.

[*English*]

On sodium, it's a multi-partnership initiative to move forward. This government is very committed to reducing the levels of sodium that Canadians are eating. We've set a target for 2,300 milligrams per person per day by 2016. Working together with provinces, territories, non-government organizations, and industry, we have a three-pronged approach.

The first part, of course, is education and awareness. Individuals have to be aware of what they're eating and of portion control, making healthy choices based on the nutritional value of the food they select to eat. That is the first part. We support education and awareness, of course, and the federal government, with non-government organizations, is developing messages and so on about healthy eating and sodium.

Second is the research component. It was touched on by my colleague a little earlier, who can go into that in more detail, but it has to do with surveillance of the how much sodium the Canadian population is currently eating, and monitoring that as we move forward. That is very important.

Finally, we are working closely with industry, as we have been doing over the last year particularly, to focus on providing technical guidance to help them reduce sodium in processed foods and so on, so that different choices are available to Canadians.

Those are the three key areas in terms of progress for the government on sodium.

[*Translation*]

Mr. Dany Morin: Well, that is one avenue. However, I think that you are underestimating the problem. Last month, the Heart and Stroke Foundation had some very harsh words for you and your lack of action.

Of course your first objective is to better inform the population and to raise awareness. But currently research shows that children as young as one year old are consuming twice the recommended amount of sodium. In the case of young children awareness-raising is not the issue. The food industry has to have some binding targets. The fact is that it costs less to put salt in products to give them flavour. However this is very damaging for the health of the Canadian population.

[*English*]

Ms. Catherine MacLeod: The facts table now contains percentage points for sodium, which will help parents to make informed decisions for their children about which foods are appropriate and where they can make those healthy choices.

[*Translation*]

Mr. Dany Morin: I'm going to change topics.

There is another controversial decision. You decided to go against the opinion of your expert panel with regard to energy drinks. You decided to put these drinks in the food category.

Now that energy drinks are considered to be food, where are they in Canada's Food Guide? All the more so since this would lead one to think that they do not have adverse effects on the children who consume them? And yet the expert panel had strongly recommended that they not be consumed by children. Since they are currently being considered as food products, just like any other food product, where would one find them in Canada's Food Guide?

● (1625)

[*English*]

The Chair: Who would like to answer that?

Ms. MacLeod.

Ms. Catherine MacLeod: Thank you very much, Madam Chair.

That's a very timely question as well. We are very concerned about the use of caffeinated drinks, particularly among children and youth. We recently announced our proposed policy moving forward for energy drinks, and that would be to move them under the food regulatory framework.

We've analyzed a number of sources of information. Yes, the panel also looked at many other countries and jurisdictions, and reviewed the science and evidence base and usage patterns, and so on. We've determined that the food framework will allow Canadians moving forward to make the best decisions around consumption of these drinks, particularly for their children.

It's very important to recognize the need for clarity on the labelling, whether it be warnings for pregnant women or children and teenagers under the age of 18, including how not to substitute the energy drinks for other beverages, and so on. If that is clear, we feel that we'll have more clarity on that front under the food framework. We're also going to monitor over time the consumption patterns and make course corrections as needed.

[*Translation*]

Mr. Dany Morin: I'm going to change topics again.

So we are really talking about health promotion; one thinks of exercise and nutrition. However, when we talk about prevention in the area of mental health, what sort of concrete advice can you give people to improve prevention? I'd like to open up this question in order to find the best possible answer. How does one encourage prevention when it comes to mental health?

[*English*]

The Chair: Who would like to answer that?

Ms. Elmslie.

Ms. Kim Elmslie: Thank you very much for that question.

First, as you know, the government has put resources into the Mental Health Commission of Canada to ensure that we're paying attention, in a pan-Canadian way, to very important issues around stigma and improving the dialogue about mental health. Importantly, the Mental Health Commission is developing a strategy for the country that we expect will be released early in the new year.

The Chair: Thank you, Ms. Elmslie.

We'll now to go to Mrs. Block.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair.

I would like to thank all of our witnesses for being here today. I certainly appreciated your opening remarks.

Ms. MacLeod, I appreciated what you had to say and I'm pleased that we actually are embarking on this study on the heels of the endorsement by the ministers of health of a declaration on prevention and promotion, as well as the endorsement of the first report, Actions Taken and Future Directions 2011, on curbing childhood obesity.

You started and ended your remarks with the same statement, that healthy eating plays an important role in promoting health and reducing the risks of nutrition-related chronic diseases.

Ms. Elmslie, you stated that experience tells us that health promotion should begin early and continue throughout someone's life course, and that promoting healthy living in children sets the stage for good health and reduced risk of chronic disease in later years.

Of course, Mr. Sherman, you highlighted obesity and said that you were adding that to the list, as it has become a global issue.

I understand that our government has made some investments in research to help promote physical activity and obesity, and I know you touched on some of those research projects in your opening remarks. I'm wondering if you could give us some examples of these research projects or pick a couple that you would like to showcase here today.

● (1630)

The Chair: Mr. Sherman.

Dr. Philip Sherman: Thank you, Madam Chair.

CIHR has helped foster obesity research, turning an expert but very small research community into a large pan-Canadian and internationally recognized research funding group. Indeed, a bibliometric study of CIHR-funded obesity researchers has found that Canadian obesity researchers ranked number five in the world in productivity. The number of grants coming to the competition over the last eight years has increased sixfold. Two Canadian universities—Laval University and the University of Toronto—are ranked in the top 20 institutions in the world publishing obesity-related research.

So targeting research on obesity has been a public health issue that CIHR has addressed in a timely manner.

The point made about early intervention is an important one. There is research being done at the Hospital for Sick Children, where I work part of the time, showing that if you intervene on screening time for children, it has a big impact. That intervention has to take place early in life to really have a meaningful impact on body weight, and it has a long-term impact. So one needs to intervene early in life.

I hope that answers some of your questions.

Mrs. Kelly Block: Thank you.

Ms. Elmslie, would you like to take a shot at answering my question?

Ms. Kim Elmslie: Sure. We are doing a number of intervention research studies in communities across the country. Under our innovation strategy at the Public Health Agency, one of our priorities is to test out in communities the types of things that will work to reduce obesity.

The Public Health Agency has made a major investment in figuring out best practices. That will build on work that CIHR and the public health community are doing.

Mrs. Kelly Block: Thank you very much.

We know that obesity rates among children and youth have nearly tripled in the past 25 years. We also know that the Minister of Health met with provincial health ministers very recently and discussed issues around obesity.

I wonder if you can explain to the committee what the government has done to prevent obesity in Canada.

Ms. Kim Elmslie: On the work the government is doing, curbing childhood obesity was named a priority of federal, provincial, and territorial health ministers. Last week when health ministers met they endorsed a progress report and future action.

So the kinds of things we're working on collectively include developing guidelines for schools and public areas where children gather so that we can start to influence the kinds of foods available there. We're working to promote breastfeeding so that moms are breastfeeding to the optimal timeframe. We're working on access to healthy foods, as my colleagues from Health Canada have indicated. It's not an easy topic, but one that's very important. Of course, Nutrition North Canada is a good example of an initiative where we're learning about how to bring more healthy foods into remote populations.

We're working on surveillance. We're measuring childhood obesity and understanding where changes are occurring so we can target populations where the need is greatest. Through our programs, such as Canada prenatal nutrition program, we're working on providing healthy foods and the skills moms need to provide healthy foods to their families.

There's quite an array of initiatives currently under way that has provided us with a really strong foundation.

Mrs. Kelly Block: Ms. MacLeod, in response to my colleague's question about sodium, you mentioned the percentage facts table.

I know that when I buy something in the store, I look at the nutrition facts table. What is the government doing to ensure that all Canadians understand these tables?

Can you explain to the committee how the “percent daily value” works?

● (1635)

Ms. Catherine MacLeod: We're very proud of this project. It involves many different partners. We recently had a campaign focused on increasing awareness among Canadians of the facts table, how to use it, and what it means.

I'm going to ask my colleague Dr. Hutchinson to give us a little more detail on how that's working.

Dr. Hasan Hutchinson (Director General, Office of Nutrition Policy and Promotion, Department of Health): Thank you.

This was an exciting initiative that we launched just over a year ago, last October. It took a while because we put together an innovative collaboration with industry. It was with Food and Consumer Products of Canada that we partnered, and through them we partnered with an additional 34 companies and a number of different NGOs.

We tried to concentrate on bringing Canadians up to speed on how to interpret the nutrition facts table. We know from research that people will look at it, but they don't necessarily use the per cent DV. So we've used a multimedia approach to get the information out there about how to interpret the per cent daily value on the package signs contributed by the different food industries. We have TV ads and print media driving toward our new website, where there are interactive tools to help people walk through that.

The Chair: Thank you, Dr. Hutchinson.

We'll now go to Ms. Sgro.

Hon. Judy Sgro (York West, Lib.): Thank you, Madam Chair, and my thanks to all of you for your presentation and the work that you do to keep us all safe.

Certainly, the nutritional facts labelling issue has been one that has been debated for quite a long time. I don't pick up anything now without looking at this label, and I put down probably 60% of the things I might otherwise have bought. I look at the label and decide that all those numbers are way too high, so I put a lot of these items down.

Where are we with the campaign to get more restaurants to produce the information? How is that going when it comes to public health?

The Chair: Dr. Hutchinson?

Dr. Hasan Hutchinson: This is an area that has a lot of interest. Last year Health Canada, working with some other partners, held a workshop. Food and Consumer Products of Canada was involved. EatRight Ontario and CIHR were also involved. A think tank came together to try to figure out how to make nutrition information available at the point of purchase in restaurants and food services.

A lot came out of that. A report will be available in the next little while. The FPT group on nutrition, of which I am the federal co-chair, formed a working group that is looking at this. We're working closely with the provinces and territories to develop a framework for making nutrition information available at restaurants and food services. That working group was co-chaired by Health Canada as well as B.C.

It's important to note this is not just a federal responsibility. This is a responsibility shared by the provinces and the territories, and we are collaborating in putting together a framework.

CIHR has also funded some research. Do you want to talk about that, Phil?

Dr. Philip Sherman: There is interest in the impact of food labelling in restaurants, and there is the issue of unintended consequences. Some groups, like teenage boys, respond totally differently from others to nutrient labelling, so thought needs to be given to special segments of the population.

The Chair: Is there scientific data for that, Dr. Sherman?

Dr. Philip Sherman: There is.

The Chair: I was just wondering.

Hon. Judy Sgro: Maybe it was just—

Dr. Philip Sherman: Research is under way to understand why teenagers look at things differently. For food labelling, it was teenage boys we looked at.

Hon. Judy Sgro: What percentage of restaurants have voluntarily agreed to participate? I think it is higher in the U.S. than in Canada. Have you any idea of what the percentage is now? That's a difficult issue.

● (1640)

The Chair: Dr. Hutchinson.

Dr. Hasan Hutchinson: Through the Canadian Restaurant and Foodservices Association, they have a voluntary approach to making this information available. The 16 largest companies, which represent about 60% of restaurant sales in Canada, have committed to this and have acted on it in different ways. You have certain companies like McDonald's where you can walk in and see the signs on the side. They have them in the tray liners. You can go on the website. They have pamphlets.

Other members of the association have taken different approaches, but we have a strong commitment by a number of the large restaurant chains to make this information available.

Hon. Judy Sgro: Ms. Elmslie, you had mentioned an issue that I'm quite interested in, the issue of mental health and the need for Canada to really move forward on that issue, especially when we're talking a lot about the suicide of so many young people, which has been in the news a lot.

What do you see the plan being for the next year or two, as to the kind of action that you might be able to take?

Ms. Kim Elmslie: Thank you very much for that really important question.

I'll reiterate once again that the work of the Mental Health Commission of Canada is so vitally important to actions that we will take in the years to come to promote positive mental health and to prevent mental illness. The work they have done on homelessness is really essential to understanding how we can prevent mental illness and promote mental health in street-involved children and youth, and in adults.

We are all looking forward to the mental health strategy that we expect will come forward from the commission early in 2012. That will represent many, many months of consultation across the country with Canadians, with health care providers, with researchers, and other experts, taking all of that into account and looking at what the important things are that we should be doing as a country.

Of course, providing mental health services to Canadians is the jurisdiction of the provinces and territories. Therefore, the work that we do with provinces and territories in surveillance of mental illness is providing reliable data on which to build solutions, but also to monitor the magnitude of change that we can achieve.

Our research efforts in mental health—and I'll turn to my colleagues from CIHR to talk about those—are certainly second to none internationally. We have a great deal of important research under way that is translating what researchers are finding into real-world solutions. That's so important to us as we're trying to deal with mental health problems, which, as you know, do not conform to one-size-fits-all solutions.

So I would say that the work that we're doing is building to a strong crescendo in terms of a very solution-oriented approach, armed with the tools that will enable us to measure progress and really see where we're having an impact.

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

We'll now go to Mr. Gill.

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

And I want to thank the witnesses for being here with us today.

Health Canada emphasizes that the revised food guide is evidence-based. Can you please tell us how the food guide has incorporated the most recent scientific evidence?

Ms. Catherine MacLeod: I'll start this off by giving you a broad overview of how it's changed over the decades.

Of course, the Canadian population has changed and we've had to adjust accordingly. Different consumption patterns, a variety of foods from various cultural backgrounds, and availability all come into play as we look at how Canadians eat and as we provide the best possible advice.

In terms of the scientific evidence and how that has evolved, I'll ask Dr. Hutchinson to add to that.

Dr. Hasan Hutchinson: Sure.

Certainly, when the Office of Nutrition Policy and Promotion—and this actually predates me—was reviewing the old food guide, the 1992 food guide, they really looked at the scientific basis of that and compared it with the new dietary reference intakes that were referred to earlier. This is the work that we do in partnership with the U.S. government through the Institute of Medicine, where we get the requirements for a wide range of different nutrients.

We looked at the best science available there. There had been 14 years of concerted effort by both of our countries to bring those up to date, so we had those, which were new. We looked at the latest evidence that connects the food supply with different chronic diseases and the effects on your health in general. Using that information, there was a very extensive modelling process, where for every age-sex category that's in the food guide, they would produce 500 different model diets, and then look at the distribution of nutrients in there. So it was an iterative process until you really got the best type of pattern of eating, where you ensured that you had the right amount of nutrients, but not too many nutrients as well. So you're really controlling there for things like sodium as well.

That was the process that was entered into, and then it went out for consultation. It went across Canada. I think there were 7,000 people who provided input to that. We had a lot of academics. I was at CIHR at the time and we had quite a lot of input from CIHR, with a lot of different academics at CIHR looking at what had been put forward, and assessing the science behind it. NGOs were assessing it, and the provinces and the territories. So it was really open to very wide consultation, which was incorporated; and in the end, we got the pattern that we recognize now as the Canadian food guide.

● (1645)

Mr. Parm Gill: Thank you.

My next question is to Ms. Elmslie.

In the overview of the report, Actions Taken and Future Directions 2011, one of the statistics in the sidebar of your website mentions that 70% of children are sedentary after school. Could you explore the factors for why that is and how the statistics have arrived at that conclusion?

Ms. Kim Elmslie: Those statistics come from survey data. The Canadian school health behaviour survey is one really important source of data, along with work that Statistics Canada does to look at the patterns of behaviour among our children in the after-school time period.

Of course, there are many factors that contribute to that. For instance, there's kids' interest in video games and the fact that, in some cases, we are more concerned about the safety of our children and therefore tend not to promote, as much as we may have in the past, their running around and playing outside in parks, etc. So there are a number of sociological and behavioural studies that are being done, given those realities of modern life, at how we can shift that paradigm. How can we start to encourage our kids, particularly during that critical after-school time period, to become more active, to be engaged in safe and active play, either through school programs or in their communities? That, in particular, is an important part of the work that we are doing at the Public Health Agency, with our counterparts in provincial-territorial governments, working with the education sector and the sports and recreational sector to provide guidance to communities and parents around allowing their kids to play safely. It's an important priority for us and will continue to be over the next number of years.

Mr. Parm Gill: Thank you.

You mentioned video games. What impact, if any, on physical activities do you notice from interactive games such as Wii Fit and now Kinect?

Ms. Kim Elmslie: That's a really good question. I don't have data on the impact of those more physically active video games, but I'm wondering if anyone—

Philip does. Go right ahead.

Dr. Philip Sherman: I'm a pediatrician who is interested in obesity, so I do follow this. There is a literature on this that the kinds of video games that children choose, or are encouraged to choose, do have an impact on energy expenditure. So it turns out that some of these interactive games really do have a big impact—and, again, it's not one-size-fits-all.

The interesting thing about the Wii exercise is that visible minority teenage girls take to that very positively, whereas boys might go for competitive sports or go to a community centre. So it is a real opportunity to intervene to prevent and treat adolescent obesity, anyway.

There are researchers around the world, including in Canada, looking at the potential of using what kids are playing with, but to reduce and prevent obesity.

● (1650)

Mr. Parm Gill: You mentioned visible minority girls. Why?

Dr. Philip Sherman: The observation is that's the group that had the biggest impact. Why? That's what we need to know next. It was the observation that was made. I can't tell you why.

Mr. Parm Gill: That's interesting.

Also, are there preliminary conclusions from the four research teams studying the effects of exercise on the body and its role in the prevention and treatment of chronic disease? Can you discuss any recommendations these findings will underline?

Dr. Philip Sherman: The work is in progress so we don't have the final evidence. Usually the research is funded for a period of time, typically between three and five years, and then the results sometimes take even a little longer than that. The work has been funded and we're awaiting the results. I'm sorry, but I don't have the....

The Chair: Thank you, Dr. Sherman.

We'll go into our second round of questions and answers now. Remember, we're down to five minutes so the time is a little tighter.

Madam Quach.

[*Translation*]

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

Thank you to all of you for being here.

I have several questions.

Several experts have come to talk to us about health and told us that in order to do prevention and encourage the adoption of healthy life habits, we have to start early, and this also has to happen within communities.

Has the government considered a political commitment, that is to say more funding for facilities in urban areas so as to make improvements and promote the creation of local services?

For instance, in the city of Saint-Rémi, a family-aware policy led to investments in the creation of a BMX bike path and a pool. Some rural communities are looking for funding to create and build community sports centres. All of this not only contributes to the social and cultural life of the community, but it helps to promote active living.

One hears that youngsters spend too much time playing video games. However, if they had easier access to community centres, that would be a positive factor in their lives.

Will the government create incentives or invest in more programs to allow for the construction of this type of infrastructure?

[*English*]

Ms. Kim Elmslie: Thank you very much. That's another very important question—

The Chair: Dr. Hutchinson, I'll give you a minute to say something if you'd like as well.

We will have Ms. Elmslie and then Dr. Hutchinson.

Ms. Kim Elmslie: Okay, thank you.

That is a really important question. In terms of the role of the federal government in this area, we've put our emphasis on the investment in identifying the best practices in communities and in helping communities test ways and innovations for disease prevention and health promotion. Once we are able to identify those important outcomes and those interventions that work, we share those very broadly with municipalities and with provincial and territorial governments, which have the jurisdiction to determine what kinds of infrastructure they are going to invest in within their communities. Our approach has been to take a research and best-practices approach and to share the learnings of that broadly.

The Chair: Dr. Hutchinson, would you like to add to that?

Dr. Hasan Hutchinson: It was actually for the CIHR to respond.

The Chair: Okay.

Dr. Edwards.

Dr. Nancy Edwards: I just have a couple of examples. One is an initiative that we're involved in with the Heart and Stroke Foundation of Canada, which is actually looking at research that targets the built environment. The built environment is something that's so important to promote physical activity in youth, and in older people as well.

There's an interesting project under way in Montreal, which is actually a natural experiment. It's something that was put in place by the municipal government. It involves the bicycles you can rent, pick up, and take. It looks at patterns of commuting and at how people are using these. It also looks at negative impacts, whether there are injuries and so on. It looks at how this is promoting physical activity in our cities. These kinds of studies are very important to us so we can know what it is that needs to be scaled up.

[*Translation*]

Ms. Anne Minh-Thu Quach: Thank you very much.

Among the best practices—several are already known—it has been proven that the presence of infrastructure encourages people to go outside and engage in physical activity.

I would now like to discuss the matter of incentives to encourage people to eat healthy foods. We know that Quebec is the larder of the country. There are many farmers in that province and yet family farms are having a great deal of trouble surviving because of multinationals and large agri-food companies.

Is the government doing anything about that? Is the government encouraging public markets in some proactive way? In my community there is a distribution coop that is having trouble getting the word out. In fact, farms are too small to hire people to work in the distribution cooperatives in public markets. In addition it is difficult for them to get into the large food store chains since they must provide a supply of food products throughout the year. And we know that with our winters it is difficult to supply product the whole year round.

Could the government invest so as to ensure that local food can be offered at good prices, or have some traction in our grocery stores—

● (1655)

[*English*]

The Chair: Mrs. Quach, you've almost run out of time.

Can you answer her question as well as you can within a very short framework, Ms. MacLeod?

Ms. Catherine MacLeod: Generally, that wouldn't necessarily be within the federal jurisdiction, other than perhaps in the north. We can provide some additional information to the committee on what we're doing on that with first nations and Inuit communities in the north.

The Chair: If you can give it to the clerk's office, we'll make sure that everyone gets it.

Thank you for the question, Mrs. Quach. I know time goes by quickly in five-minute rounds. I did give you quite a bit of extra time.

Mr. Brown.

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

I've been hearing some of the comments so far. From the Public Health Agency of Canada we heard that Canadians are living longer and longer, which is a good thing, and that about 90% of Canadians feel happy about their health. At the same time, we look at some of the research we've been presented about the OECD rankings on obesity. How are we getting healthier in one sense, so that we're living longer and people are confident about their health, yet we're 27 out of 29 in terms of obesity? How are we healthy and unhealthy at the same time?

Can anyone enlighten me on this?

The Chair: Ms. Elmslie.

Ms. Kim Elmslie: Thank you, Madam Chair.

Yes, it does sound like a paradox, doesn't it.

When we look at chronic diseases and we think about diseases like diabetes and cardiovascular disease, for example, we see that obesity is a driver for those. So we're concerned that although at this stage we may be seeing that Canadians are reporting that they're feeling healthy, and we are living longer, there's a canary in the coal mine, and that's obesity. Over time, as our young people and young adults are increasingly obese, we are starting to see, for instance, type 2 diabetes being diagnosed earlier. We are starting to see more cardiovascular disease in younger age groups. But we're also really good at treating these diseases. So with more effective treatments, people are living longer with cardiovascular disease, and they're living longer with diabetes. But as the balance shifts, as those risk factors with negative impacts on our health continue to rise, of course the trajectory is expected to change.

I'm going to turn to my colleague to see if Dr. Sherman would like to add to that.

Dr. Philip Sherman: I think that's put very well. An ounce of prevention is worth a pound of cure, if you can. So it's about identifying the underlying causes of obesity, because it does drive diabetes and cardiovascular disease, as you've heard. The earlier one can intervene, the better it will be. It's often hard to identify what exactly is the best way to intervene, and that's what the research is about.

Mr. Patrick Brown: Maybe that's an underlying area of concern for us going forward.

I think of a comment my mother once made to me. She said that when she grew up in Barrie, everyone was out on the street playing sports. Now you don't see that as much, because there's so much other competition, whether it's video games or 300 TV channels.

What should we be doing as a country to help get people engaged in physical activity for their lifetime? When we talk about chronic aging, there are things we should be starting immediately, in children's adolescence, that would help initiate that. What programs could we do to sustain that? Are there any overall suggestions?

● (1700)

Ms. Kim Elmslie: Maybe I'll kick off, and then others, I'm sure, will have suggestions.

Of course, one of the most important things we can do is to work with parents and families and in communities to help set the conditions to encourage more physical activity, and safe physical activity. Injury prevention is an important part of that equation. Some of the work we're doing now in funding communities to help them develop programs that encourage safe physical activity is one area that's important for us, including awareness among parents, and working with the education system. So a year ago when Canada's health ministers endorsed the Declaration on Prevention and Promotion and said that we all have to work together on this, the education ministers were consulted. There's a dialogue with those ministers on what we can do in schools. We have a Joint Consortium for School Health that's very active in encouraging the setting of policies and curricula around supporting physical activity.

So again, there's no magic bullet, no one-size-fits-all, but a number of these types of initiatives, with the family and parents being very important in that equation in getting their kids active and helping them do the things that are going to set those habits for lifelong health.

The Chair: Dr. Edwards.

Dr. Nancy Edwards: I have just a couple of points to add to this. One is that we have to think about this across the life course. Actually, the Canadian Longitudinal Study on Aging that's being funded by CIHR is a good example of where we're starting to look at a cohort of people at age 45 and above, because we know that patterns of physical activity are also very important as you get older. They affect your risk of falls, which is a major factor costing our health care system a lot of money—and a lot of seniors much grief.

The second aspect I'd like to point out is inequities. Not all population groups have the same access to safe environments, to a built environment that's conducive to physical activity, to nutritious food, and so on. This is one area that we've really focused on within our own institute, looking at what it is that we can do about health inequities in the long term.

The Chair: Thank you so much.

Ms. Davies.

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

Thank you to the witnesses for coming today.

I would actually like to come back to the issue of sodium levels that my colleague raised, and why we haven't seen more follow-up and action on this. I think many people were hoping that at the Halifax meeting there would be agreement on this issue. It appeared —at least that's the way it was reported—that it was the federal government that was basically not in agreement on moving forward, on having transparency, and forcing force food producers and so on to include information and move to the new levels.

I think you gave some good general responses, but I think we'd really like to know what the timeline is now, given the discussions that happened in Halifax. What can we expect in a very concrete way in terms of timelines for the new levels? If there isn't some sort of voluntary agreement, why won't the federal government actually move on making this a mandatory thing?

It seems to us to be so basic. We've talked about so many issues here and yet this is fundamental. This is not rocket science. Surely we have to get this to happen as a preventative measure.

The Chair: Ms. MacLeod.

Ms. Catherine MacLeod: The work on sodium is moving forward, including the component with industry I had mentioned earlier.

We've been working and meeting with industry fairly intensely to talk through guidance and approaches. It is an incremental approach, a voluntary approach because we're looking at long-term significant change for Canadians. It's something that will take time to see the results.

That is not to say, however, that there isn't a lot of work under way. It's been done in the last year to year and a half. Focus on education and awareness, for instance, is moving ahead. As I mentioned, the work with industry and the research work on surveillance so that we can really track how much sodium Canadians are taking in, and all that work with the provinces, territories, industry, and non-government organizations are well under way.

● (1705)

Ms. Libby Davies: Am I correct that recommendations were made that were not adopted, even though the provinces and territories actually appeared to be willing to go ahead? It seems that the ball was dropped on the federal end. I certainly don't mean at the civil service level, but at the political level.

It is very disappointing that we don't seem to be making faster progress on this. I think it's been an outstanding issue for years now. Maybe the feedback can go back to the department that it's something that we really need to move on.

The Chair: You have another minute if you want to use it.

Ms. Libby Davies: No, that's fine.

The Chair: Okay.

Thank you so much.

We'll now go to Mr. Strahl.

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

I wanted to talk a bit about aboriginal Canadians' health. We've heard in our other study that the health outcomes for aboriginal Canadians are significantly worse than for others.

What specifically are we doing to address that concern? I know a separate food guide has been introduced. What other educational programs are being introduced so that we're reaching out in an appropriate way to that group, which Heath Canada has a specific responsibility for?

The Chair: Who would like to take that one?

Thank you, Ms. MacLeod.

Ms. Catherine MacLeod: I am happy to give a few examples of some of the work that's under way.

I would suggest that it would be useful for the committee if I were to go back to the first nations and Inuit health branch to get a more complete package for the committee.

Some of the work includes the aboriginal head start program, which you may be aware of. It helps provide support from a health and wellness point of view for children in first nations communities. There is also the maternal child health program, the prenatal nutrition program, and also the fetal alcohol spectrum disorder program. These are but a few examples of some of the specific interventions for that population. As I indicated, we would be happy to provide more detailed explanations of the resources allocated, the program objectives and so on, and how they're doing.

Mr. Mark Strahl: Perhaps we could go back to the issue of sodium. I met recently with a group, whose name I can't remember, that was involved with the food processing industry. We were talking about the sodium reduction initiative, and they indicated that there were significant problems. In some products they've rolled out, they have voluntarily taken the sodium content down, and consumers have reacted very negatively to that.

Can you explain some of the concerns you've heard? Are you taking that into account as you look at sodium? While we want to provide healthier options, are you working with the food processing industry to ensure that we're not hurting them on a retail level?

Ms. Catherine MacLeod: Thank you.

This is why it's been so important for us to have a very open and consistent dialogue with industry on the sodium file. Some products in certain key categories might be very much associated with sodium, and I'll use the example of feta cheese. So the same adjustments can't be applied to foods across the board. It requires a very thoughtful and deliberate approach, depending on the product, the history of that product, the expectations of Canadians, and so on. This is why it's a fairly complex interaction with industry, requiring in-depth consultations.

We feel that the dialogue has been going very well, but it will take time for Canadians to adjust. Generally speaking, an incremental approach seems to be most effective in terms of market accessibility and Canadians' making the right food choices, the healthy food choices, for their families.

Mr. Mark Strahl: Mr. Sherman, do you have something to add?

Dr. Philip Sherman: CIHR was involved in the research aspect of the sodium working group. We were involved with partners in industry on the food science. There's a very strong nutritional science academic community in Canada that's been working in partnership with industry, because, as you point out, humans are acutely aware of changes in salt levels. When you reduce sodium concentrations, people notice it right away. And in certain foods there are issues about safety from dropping sodium. So it's a very complex issue that needs to go by food category when looking at sodium reductions.

● (1710)

The Chair: You have about 50 seconds left.

Mr. Mark Strahl: The more effective approach then, from my perspective, is educating people. I still don't see how, if you reduce the sodium in something, people aren't just going to reach for the salt shaker at the table to make up for it. I guess my question would be this. Is a legislated reduction really going to be that effective, or do we need to move more towards educating people on the danger of a high sodium diet?

Ms. Catherine MacLeod: Certainly the government is not looking at a regulatory solution. It's a voluntary approach that focuses very much, as you indicated, on the importance of education and awareness. That's really a foundational component of the approach going forward.

The Chair: Thank you so much.

Now we'll go to Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair.

I thank the witnesses for being here today, as well as the media representatives, whom we sometimes forget.

I know that pursuant to the regulations, since 2007 it is mandatory that nutrition facts tables be placed on all prepackaged foods. These tables provide information on the calories contained in the food, as well as on 13 nutrients such as fats, carbohydrates, cholesterol, sodium, proteins and certain vitamins and minerals. However, I feel that the nutrition facts table does not distinguish between those substances that should be minimized in our diet, such as saturated fats, sodium and sugar, and those that should be maximized, such as fibre, protein, vitamins and minerals.

Has any consideration been given to this by Health Canada? And do you think that Canadians are generally well-versed in the differences among the various types of fats and carbohydrates and why some are better then others in the diet?

[*English*]

The Chair: Who would like to answer that?

Ms. Catherine MacLeod: I'll ask Dr. Hutchinson to respond to that question, Madam Chair.

The Chair: Dr. Hutchinson.

Dr. Hasan Hutchinson: Thank you very much.

You're right, of course, that it has been fully implemented since 2007. We're coming up to its fifth year soon. Next year we'll be five years in, and Health Canada is certainly committed to doing a review of the regulatory actions with respect to the nutrition facts table.

Those are certainly matters that will be looked at, including whether people are understanding what is meant by the nutrition facts table, whether there should be more nutrients added to it or some taken away, or whether the daily value is the appropriate value. All of those are part of a comprehensive approach we're going to be taking to assess the nutrition facts table in this next year.

[*Translation*]

Mrs. Djaouida Sellah: Madam Chair, I will continue on the topic of sound nutrition.

Doctor, could you talk to us briefly about the results of the campaign you launched on food and consumer products in Canada, the objective of which was to promote education in that area?

[*English*]

Dr. Hasan Hutchinson: Thank you very much.

We have had lots of preliminary results as well. As I mentioned earlier, we launched this about a year ago. It is a very multi-dimensional approach that we're taking. There are TV ads, radio ads, websites, on-package as well, so it's quite broad.

We have been trying to get an idea of the sort of effect we've had. With respect to the on-package, we wanted to have a target of 100 million impressions out there, and we know that we've actually been up to about 300 million impressions in the last year. So with respect to getting the message out there, that is happening. You'll find it on the back of all sorts of different products out there, and there is quite a comprehensive spectrum of different products.

I think I mentioned earlier that McDonald's was one of the companies that came in as well. On the backs of their tray liners they have put forward our messages about the nutrition facts table, and they've had over 90 million impressions on their tray liners distributed across Canada.

We know that Walmart has been running the ads on their in-store TVs for about two or three months.

We've had the Canadian Obesity Network, the Heart and Stroke Foundation, and the Dietitians of Canada. We've had a number of different NGOs incorporate it into their websites. The Dietitians of Canada have also included it as part of their message in their new cookbook. So we really have had quite a reach.

Now, whether that reach has an effect is what we really want to know. We've done a lot there.

As well, what we were able to do in working with an industry association was to leverage their buying capacity for media. With respect to Health Canada, our financial input on that was about $600,000. Through their capacity to do media buys, that was leveraged up to about a $4-million media buy. On top of that of course, we have the on-package. We will get the estimates there, but that's worth millions of dollars as well. In terms of return on investment, we've probably put in about $600,000 for what is probably a $6-million campaign. From that perspective, it's been very good.

The other thing we sometimes get concerned about when we're working with industry is whether they are misusing our messages, but we have final sign-off on the messages. We did do some research with Nielsen, for instance, and we know it has had a fairly good recall—an 18% recall. The important part is that of those who recalled the message, 56% said they would make a behavioural change. I think that means we have the right message.

What we're working on now is the reach and the right media mix as we go forward into year two.

● (1715)

The Chair: Thank you, Dr. Hutchinson, for the very interesting reply.

We'll now go to Mr. Sopuck.

Mr. Robert Sopuck (Dauphin—Swan River—Marquette, CPC): Thank you very much, Madam Chair.

I'd like to explore something that hasn't been discussed, and that's the relationship between personal genetics versus diet and exercise. We all have that mythical Uncle Pete who lived to age 98 and smoked and drank every single day of his life; and then we have cousin Bill, who did everything right and died of a heart attack at age 55. That tells me there is a genetic predisposition to certain health outcomes.

I know this is a big topic, but can somebody address the issue of genetic predisposition versus active things that we can do? All I've heard today is that all of our health outcomes are totally under our control, but I don't think genetic science supports that.

The Chair: That's a very good question, Mr. Sopuck.

Who would like to take that on?

Dr. Sherman.

Dr. Philip Sherman: It is a very good question, and I'll take it on as best I can.

You are absolutely correct. There is a genetic predisposition to body weight...very thin or very overweight. But the obesity epidemic has occurred in one generation, so there is basically a lot more going on than genetics. That isn't to underestimate genetics; it's a very powerful thing that is being looked at as we speak.

It's clear, though, that there are also other things, such as epigenetic changes, that could have an impact in one generation, for example, the impact on mothers and the baby in utero as a fetus, and in the first year of life. Those impacts can have great influence on how you turn out as a teenager and as an adult. It might be that this is why the early interventions you heard about are so critical.

CIHR is funding research on nutrigenomics and metabolomics, that is, the impact on mammals, including humans, in response to various foods and various constituents in foods. There is a great interest in that area, and Canadian researchers are at the forefront in the world in looking at nutrigenomics and metabolomics. Those are fields of research related to nutrition and health.

Did I confuse you with all of those big words?

Mr. Robert Sopuck: No, that's fine.

One thing we have to be cognizant of as we look back at our evolutionary history is that we have a genetic predisposition to really enjoy eating and storing fat. It's what our primate ancestors did, because they never got much fat. We obviously have a surplus of fat in our diets now, but we still have the ability to store fat. I think the same thing goes for salt. So you're up against some pretty powerful evolutionary forces that make us do what we do.

I heard comments about aboriginal communities and urban communities, but there are a vast number of communities that I didn't hear mentioned, and those are our rural and agricultural communities.

Can some of you address the health issues in those communities? I also include our natural resource communities in that category.

● (1720)

The Chair: Who would like to take that question?

Ms. Elmslie.

Ms. Kim Elmslie: Thank you, Madam Chair.

It's a really good question. Certainly the issues facing our rural communities differ in many ways from those in urban communities, as we all know. Health status there, depending on what rural community you happen to live in, may be quite different from that in urban communities.

We know, when we look across the country at health outcomes, that there are differences between urban and rural communities, and therefore we are looking differently at those communities and the types of interventions that work specifically for those communities. It's back to the adage that one size doesn't fit all. We need to consider access to health services in those communities; we need to consider the incentives for physical activity in those communities and how we, as a federal government, provide the research underpinnings and the information around what works when we're looking at chronic disease prevention in those communities.

Mr. Robert Sopuck: Here is one last point. I represent a rural constituency, and thousands of my constituents are absolutely fanatical, mad gardeners. Exploring the relationship between growing your own food, which you can do on a surprisingly small amount of land, and the spiritual and health benefits of doing that is something that I think is worth looking at.

Is there anything in that regard that any of you, with your various organizations, have looked at?

I guess not.

Ms. Kim Elmslie: If you don't mind, Madam Chair, let me get back to you on that. Nothing specific is coming to mind, but it's a very interesting question, and I'd like to go back and talk to my colleagues about it.

Mr. Robert Sopuck: I would really appreciate that.

Thank you.

The Chair: Well, thank you.

You haven't covered the issue, Mr. Sopuck, of hunting. You go out in the woods and you hunt your meat and you can your food. Growing up on a farm, I know the benefits of some of that as well.

We've come to the end of our list of questions from all sides of the House. I want to thank the witnesses for coming today. You've added greatly to what we're trying to do on the health committee.

I will adjourn the committee for today.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Additional copies may be obtained from: Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5
Telephone: 613-941-5995 or 1-800-635-7943
Fax: 613-954-5779 or 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5
Téléphone : 613-941-5995 ou 1-800-635-7943
Télécopieur : 613-954-5779 ou 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca