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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, and welcome to the health committee. We're very pleased to have our witnesses here, but before I go to them, I would just like to pass the budget quickly for our witnesses. I'm going to put the motion forward.

Ms. Libby Davies (Vancouver East, NDP): Madam Chair, we also have a point of order.

The Chair: I know. We're going to deal with all of that in committee business, because I want to get the witnesses done. The motion reads: "That in relation to the study of health promotion and disease prevention, the proposed budget in the amount of $38,200 be adopted."

Could I get a mover for that?

Thank you, Dr. Carrie.

(Motion agreed to)

The Chair: I understand there's a point of order.

[*Translation*]

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

I want to introduce the following motion:

> That the committee immediately undertake a study of the impact of the Comprehensive Economic and Trade Agreement (CETA) between Canada ad the European Union on the Canadian health system and on the cost of drugs; [...]

[*English*]

The Chair: Excuse me. That's not a point of order.

[*Translation*]

Ms. Anne Minh-Thu Quach: I just wanted to finish reading it; I only have two lines left.

[*English*]

The Chair: No, we can't continue.

[*Translation*]

Ms. Anne Minh-Thu Quach: But I did submit the notice of motion 48 hours in advance.

[*English*]

The Chair: You're going to move the motion right now, then?

[*Translation*]

Ms. Anne Minh-Thu Quach: Yes, please, because I think that it....

[*English*]

The Chair: Okay. We'll vote on it right now quickly. Go ahead then. You should tell me ahead of time, so I can prepare for it.

[*Translation*]

Ms. Anne Minh-Thu Quach: We sent the notice of motion on Monday, so 48 hours in advance. I think that we followed the procedure.

[*English*]

The Chair: You did do that, but you should have told me that you wanted to do it today, because I assumed that you wanted to do it on a business day. That would just help me out so that we can hear the witnesses.

[*Translation*]

Ms. Anne Minh-Thu Quach: So I will continue reading the motion:

> [...] that witnesses be heard before the committee for at least one meeting; and that the committee report its findings to the House of Commons.

I think it is important for us to talk about it now, since negotiations are in the ninth round, and we still have no information on the impact of that agreement on health care and the cost of drugs. Those negotiations will be completed very shortly.

[*English*]

The Chair: Ms. Davies, go ahead.

Ms. Libby Davies: Thank you, Madam Chairperson.

I'd like to support my colleague in raising this matter.

First of all, to the witnesses, we certainly know and appreciate that you're waiting. We hope you have some patience as we just raise this matter.

I do feel a sense of frustration with this issue of the CETA agreement between Canada and the European Union. We've raised this before. We believe it's a very important issue that the committee should study. We're not wanting to debate the issue today, but we do want the committee to consider the merits and need to have a study and witnesses on this issue. We're calling for just one meeting—possibly two.

I would just ask the witnesses to bear with us, because we have been trying to get this motion before the committee. We have brought it forward—

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): On a point of order, Madam Chair, it is my understanding that we are now moving into a discussion of future business for this committee, in starting to discuss witnesses and the number of days that we might put towards a study. It is my understanding that we usually do this type of deliberation in camera.

The Chair: I will ask all committee members about this. We have a full business meeting on December 14, but today we have our guests in front of us ready to present. All of you know there will be bells ringing and that we want to make sure that we hear our witnesses. I know it's a very important issue. I can appreciate that, and I can't stop you from doing it, but if you insist on doing it, I would ask you to make your comments as concise as possible so we can hear our witnesses.

● (1535)

Ms. Libby Davies: Madam Chair, I'll certainly do that, because we don't want to hold up the witnesses.

I do want to reiterate that it is our right to bring forward a motion to this committee and to have the committee consider whether or not we're going to look at the issue. That is entirely legitimate. This issue of the CETA agreement is something that we've brought up before—

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): A point of order, Madam Chair.

The Chair: Go ahead on a point of order, Mr. Strahl.

Ms. Libby Davies: We want to have it before the committee, and so we're hoping that Conservative members will agree that this is something—

Mr. Mark Strahl: I would move that we go in camera.

The Chair: All right, then.

Ms. Libby Davies: No, it's not legitimate to have something like this in camera. It's a regular motion of the committee. It happens all the time at committees, that you can bring forward a motion and have it debated in public.

The Chair: No. In all due respect, Ms. Davies, would you pay attention, please?

With all due respect, we have our business meeting where this could be done. We know about the shortage of time. If we had a large expanse of time, we would go in camera, but it was a surprise that this was going to happen today, even though it was done 48 hours ahead of time.

I'm appealing to the committee to take into consideration the fact that the witnesses are here. We can deal with this on December 14, when we will have a two-hour meeting. This, I promise you, can be put at the top of the agenda of that business meeting. This is not, in my opinion, what we should be doing now, when we know the bells are going to ring and we will not hear our witnesses.

If we could put this to a vote right now, then, we could maybe get this business finished today, and it won't come up on the business day.

Let's vote.

Shall we sit in camera, then?

This motion is going forward, so all in favour?

Ms. Libby Davies: Madam Chair, I'd like to make a point of order about going in camera.

The Chair: Yours was presented first.

Okay, go ahead.

An hon. member: Can we vote on going in camera, Madam Chair?

Ms. Libby Davies: I'd like to raise a point of order on that.

The Chair: Since this has started, we're going to have to slow down a little bit.

Witnesses, I'm sorry. My apologies to you. I've tried to readjust this. It's not going to be possible to hear you for a few minutes.

Clerk, could you explain the two motions that are there and what we have to do, if they insist on keeping them?

The Clerk of the Committee (Mrs. Mariane Beaudin): We have two motions on the floor presently. The first one was Madam Quach's motion, which is debatable, and votable once the debate is over. But we also have the motion to sit in camera, which is not amendable and not debatable. So I leave it up to the committee to—

Ms. Libby Davies: I would like to call a point of order on that ruling.

The Chair: We can go in camera and do this now. If you want to do this motion right now, we can do it.

Ms. Libby Davies: Madam Chairperson, I have a point of order about our going in camera.

The Chair: Okay, go ahead.

Ms. Libby Davies: I want to raise a point of order on the procedure of our committee to move the meeting in camera.

I know the clerk will probably cite O'Brien and Bosc, second edition, which says, in the context of the types of meetings:

> Committees usually switch from meeting in public to meeting *in camera* (and vice versa) at the suggestion of the Chair, with the implied consent of the members. If there is no such consent, a member may move a formal motion to meet *in camera*. The motion is decided immediately without debate or amendment.

My specific difficulty, though, is with that last line. I believe it's incorrect and has created a series of problematic practices for our committee.

Madam Chair, I could read pages of this, because we do have a procedural point as to why we shouldn't go in camera. But I can forgo doing that, because I know you want to get on to the witnesses, and that's certainly something we agree with.

There's no reason to go in camera, because this is a legitimate motion to come before the committee today. We followed the rules, so either we deal with the motion that is before us.... We feel that our opportunities to raise these issues have been very limited on this committee, so we would like to—

The Chair: Which standing order have we circumvented? You asked to make a point of order, and from what I'm hearing it is not a point of order.

Ms. Libby Davies: This is a point of order about going in camera, Madam Chair, and I'm prepared to read the whole—

The Chair: You were talking about a point of order based on your motion.

O'Brien and Bosc states:

> When recognized on a point of order, a Member should only state which Standing Order or practice he or she considers to have been breached—

—for that point of order

Can you tell me which standing order we have breached for your point of order that we continue this?

● (1540)

Ms. Libby Davies: Well, Madam Chair, I'd have to go through the whole point of order section of O'Brien and Bosc to establish that. If you want to do that, that's fine.

The Chair: Well, you planned this ahead of time, so perhaps you should have had that information at your fingertips.

The other motion is to go in camera.

Can we deal with that one?

[*Translation*]

Ms. Anne Minh-Thu Quach: Out of respect for all the witnesses present, I would just like to know whether the committee supports this motion, so that we can discuss it. We don't have to debate it today.

[*English*]

The Chair: Can we put it to a vote now, Ms. Quach, and get your motion dealt with, then, if you insist on prolonging this? Can we put it to a vote now?

Hon. Hedy Fry (Vancouver Centre, Lib.): What are we voting on, Madam Chair, please? I'm not—

The Chair: We read it out.

Mr. Strahl.

Mr. Mark Strahl: I have a motion on the floor. If we insist on talking about future business, I will insist on having a vote on that motion—

The Chair: —that we go in camera.

Yes, we do have that motion.

There's no point of order, so we're going to vote on the motion to go in camera.

All in favour of going in camera, raise your hands.

An hon. member: Wait, wait, wait—

An hon. member: It's not debatable.

The Chair: It's not debatable. We'll go in camera.

I'm sorry, witnesses. We'll go in camera. I'm sorry we have to do this.

Obviously this was something that—

[*Translation*]

Ms. Anne Minh-Thu Quach: Pardon me, but shouldn't we first discuss my motion?

[*English*]

The Chair: We'll go in camera and deal with your motion.

Ms. Anne Minh-Thu Quach: Can we just go—

The Chair: It's not debatable.

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): She said that our motion must be addressed first.

The Chair: We're going to deal with it right now.

Mr. Dany Morin: No, no. I'm talking about procedure here.

The Chair: Procedure is when—

Clerk, could you explain the procedure, please?

Mr. Dany Morin: Yes, please.

The Clerk: We have two motions on the floor, but there's no order of precedence, or no order for the motions. It's not like in the House where you have orders for the motions. A motion to go in camera has been moved, which is not amendable and not debatable, so we have to put that one to a vote.

[*Proceedings continue in camera*]

● (1540)

(Pause)

● (1600)

[*Public proceedings resume*]

The Chair: I will call the committee back, please, so we can hear our witnesses.

Thank you for your patience. We have a very important topic that we brought you here today for. My apologies for what just happened. We are studying health promotion and disease prevention.

From the Canadian Public Health Association, we have with us Ms. Debra Lynkowski, chief executive officer, and Mr. Ian Culbert, director of communications and development. From the Chronic Disease Prevention Alliance of Canada, we have Ms. Ida Thomas, chair, and Mr. Craig Larsen, executive director. Via video conference, from the Canadian Alliance of Community Health Centre Associations, we have Ms. Jane Moloney, chairperson, and Mr. Scott Wolfe, federal coordinator.

My apologies for the unexpected delay today.

Could I ask the Canadian Alliance of Community Health Associations if you will both be presenting? Will you be sharing your time?

Ms. Jane Moloney (Chairperson, Canadian Alliance of Community Health Centre Associations): We'll be sharing the time.

The Chair: I think what we'll do is go to a seven-minute presentation so that we can hear everybody. Thank you so much.

You may begin now, Ms. Moloney or Mr. Wolfe.

Ms. Jane Moloney: I will begin. Thank you.

Thank you for the opportunity to present today. We are presenting, as you say, on the very important topic of health promotion and disease prevention.

First a little bit about who we are. My name is Jane Maloney and I am the chairperson of the Canadian Alliance of Community Health Centre Associations, CACHCA for short.

CACHCA provides support to community health centres and their provincially based associations across Canada. Currently there are over 300 community health centres across Canada, although they go by several different names from province to province. For instance, this includes centres like Quebec's CLSCs, Saskatchewan's co-operative community clinics such as the Saskatoon Community Clinic, and Ontario's community health centres like the Oshawa Community Health Centre and the Barry Community Health Centre.

We'll describe for you, in a few moments, the main characteristics of community health centres and what unites them across the country. This is important because we know that it is the integration of these core characteristics at the level of front-line primary health care services that provides some of the greatest examples of success in preventing disease and improving health for Canadians and in other countries.

This is especially true for individuals and communities facing complex health issues and barriers to accessing care and support. We believe that expanding the community health centre model and approach offers one of the best opportunities within our health system to improve health promotion, disease prevention, and health outcomes across the country.

The main objective of our association, CACHCA, is to work for improved health and health care services for individuals and families in communities across the country. One of the main ways we do this is by helping governments and regional health authorities to expand access to community health centres, as a cost-effective and successful method for delivering primary health care and improving health outcomes.

In addition to being the current chairperson of Canada's community health centre association, I am the executive director of one such centre, the North End Community Health Centre in Halifax, Nova Scotia. My colleague, Scott Wolfe, acts as our federal coordinator based out of Toronto.

In terms of grounding our recommendations to this committee, we believe that any serious effort to reduce the incidence of disease and to improve the health of Canadians must include a three-pronged approach. We see all of these three areas as essential.

First is the investment in social and environmental protections against illness and disease—what are termed the social determinants of health. This includes government policy to reduce poverty across Canada, to ensure adequate housing and food security for all Canadians, and to prevent the overwhelming impact of other forms of social inequity on the health of all Canadians.

Canada's chief medical officer of health, Dr. David Butler-Jones, is among the overwhelming consensus of health experts around the world, including the World Health Organization, who have identified improved country-level action on the social determinants of health as a top priority to improve health and ensure the sustainability of high-quality health care systems.

The second area is improved intersectoral collaboration among governments and government agencies. This would include legislation, structures, and processes to ensure that government collaboration occurs across sectors and ministries, with a view to ensuring that public policy and service planning are considered from the perspective of their potential impact on the health of Canadians. Here we cite the Province of Quebec's health in all policies legislation, or HiAP, and the Ontario government's cabinet-level poverty reduction strategy, as two examples of action in this area.

The third area is a shift in the planning and funding of our federal and provincial health systems to ensure equitable access for all Canadians to appropriate primary health care. This must include increased and more equitable access to integrated person-centred community health centres. Community health centres provide high-quality, team-based care that is integrated with health promotion programs and community development initiatives.These services offer more than a “build it and they will come” approach by partnering with the community to deliver locally relevant services, programs, and supports that address individual and family needs. Illness prevention and health promotion are intrinsic to this integrated approach.

● (1605)

Again, the three prongs of an effective health promotion and disease prevention approach would include investment in addressing the social determinants of health; increased intersectoral collaboration; and improved access to equitable and comprehensive primary health care through our community health centres.

We would be pleased to help ensure that the members of this committee have access to Canadian and global reports that provide irrefutable evidence on the importance of action on the social determinants of health. These include the 2010 annual report of Canada's chief medical officer of health and the World Health Organization's 2008 World Health Report, which calls for global commitment to addressing the social determinants of health at local and country levels.

Our association joins many others in emphasizing the urgency of the action required from the Canadian government in heeding the recommendations contained within these reports.

That said, we would like to dedicate the remainder of our time today to the third area of these three areas for action that we have described. This is the need for federal and provincial governments to increase equitable access to comprehensive primary health care across Canada through community health centres as a key means of improving health promotion and disease prevention.

Mr. Scott Wolfe (Federal Coordinator, Canadian Alliance of Community Health Centre Associations): Thank you, Jane.

We believe this is where our association, our members, can share unique insights into what it takes at a community level across the country to truly improve health and prevent illness and injury among Canadians and their families.

While healthy public policy, as Jane described, is critical so that we can ensure the fundamental pre-conditions for Canadians achieving health, public policy alone is not enough. Also essential is making sure that our specific health system services are designed and coordinated to reach people and families—

The Chair: I am so sorry to interrupt you, but I've let you go a bit over time. We're going to have to go to our next witnesses. Because of the delay at the start of the committee meeting, I'm having to shorten your presentations because our bells are about to ring, and I want to hear as many witnesses as I can, so my apologies to you.

We'll now go to Ms. Lynkowski, please.

Ms. Debra Lynkowski (Chief Executive Officer, Canadian Public Health Association): Thank you. Good afternoon.

Bonjour à tous et à toutes.

Thank you for the invitation to present today.

In the interest of time here, I will start by saying that we agree very much with our previous colleagues on the urgent need to address the social determinants of health. I'll just preface this by saying that there really are two areas we want to discuss. We want to discuss, first of all, the role of the public health system and public health professionals in creating those opportunities for health. Secondly, we want to talk about the fact that any disease prevention or health promotion initiatives have to be grounded in that comprehensive approach to the social determinants of health.

I have a very quick thing to note. In the spirit of the season, I have brought you a gift. You'll see that we have a poster commemorating the 12 great achievements of public health. The reason we did so is that it's almost a colourful mini-primer on what disease prevention and health promotion are, and what we are talking about when we say that.

What is really critical for us right now is that we're at a pivotal time. We know there is going to be a new health transfer agreement. There was mention of health promotion and disease prevention in the last transfer agreement, but it was minimal. We have an opportunity now to make sure it is prominently profiled in any new agreement. We're urging you in your roles to help make that happen with your colleagues at the provincial and territorial levels.

Quite frankly, as a society we have tended to focus more on personal responsibility, and that is okay. You know, there are thoughts of "I need to exercise; I need to eat properly." But if I don't have clean drinking water, nor the level of income that I need, nor a good education, then we know that ultimately my health is going to be affected. So in terms of personal responsibility, it is a limited strategy unless we address those upstream factors.

Health Promotion 101 says an apple a day keeps the doctor away. In neighbourhoods like Toronto's Flemingdon Park, which has been recognized as a food "desert", you can't get that apple; there isn't a way to access it. You're probably working two or three jobs and you probably can't afford to put your child in day care. That's where health is created and lost.

So what can we do? Public health professionals have a unique role to play here. They're actually the people on the ground level who are helping with that intersectoral collaboration we just heard about. They actually engage communities. They engage the municipality, and they support the development of public health policy.

I will say, it mystifies me at times. Why are we spending 5% on disease prevention and health promotion and 95% on acute care, and then we're mystified by that? We should know we need to invest more, and we need to actually take those words and bring them to life with strategic investments. We have a lot of recommendations, but I'm just going to condense them into a few that you will hopefully remember.

Let's shift the conversation from health care to health equity. You've just heard my colleagues say that much more eloquently than I can, but that's where we need to focus. We need to better coordinate between the Canada health transfer and the Canada social transfer to approach those determinants of health that aren't within the health sector.

Lastly, I make a plea that we have to finally increase the investments in public health. Every time there is some sort of a public health crisis, I'm called here. And that's okay; I'm grateful for the opportunity. But we talk about H1N1; we talk about SARS; we talk about listeriosis. The media calls me a lot, for about a week—and then it just ends, I must say. Then I'm no one's favourite cousin any more. We go back to the status quo and the current funding levels; in fact, we look at potential reductions.

So we really must have a meaningful, sustained investment in public health, both in infrastructure and human resources. I truly believe the federal government has a unique role to play in that, and that all of the answers are already here.

Whenever we pull together our briefs, I always say it seems that we don't have a clear ask, because we're asking for everything. I realize that. That is the limitation of saying we need a shift in conversation, in dialogue, in the system overall. But this isn't a quick fix. I know all of you come from different parties, and that's a good part of our democratic system, but I truly believe this will require long-standing political will from all of the political parties, working together over many different electoral periods, if we're going to make any kind of difference and if you're going to have a legacy.

So if you asked me where we need to start, don't look too far. You have already heard from CACHCA. They stole my speech, thank you—

Voices: Oh, oh!

Ms. Debra Lynkowski: That's good, because it means we're on the same page.

● (1610)

We have many reports, but our failings sometimes as a nation is that we don't implement what we recommend. Others do.

We've heard that we're a country of pilot projects; we know that everyone uses our Ottawa charter. We are heroes beyond our own borders, but we need to start implementing our recommendations. We have the Senate report from 2009; we have the chief public health officer's report; and we have the report by Sir Michael Marmot of the WHO commission.

I'm leaving you with one final thought, and it's on the poster. I hope you take a look at it; it's a really good primer. Since the early 1900s, the average lifespan of Canadians has increased by more than 30 years, and 25 of those years are attributed to advances in public health—the advances that you see so clearly in this poster.

If we want to maintain that legacy and if you want to live another 30 years, I suggest that we need to really focus our conversation strategically and make the investments where they are going to count.

Thank you very much.

● (1615)

The Chair: Thank you for your very insightful presentation, and thank you for being mindful of the time. You can see that the two presentations emphasize the same things, really. Thank you.

We will now go to the Chronic Disease Prevention Alliance of Canada.

Ms. Thomas, please.

Ms. Ida Thomas (Chair, Chronic Disease Prevention Alliance of Canada): Thanks very much. You're going to see even more duplication, I was going to say, but there are certain commonalities between our presentations.

I'm the chair of the Chronic Disease Prevention Alliance of Canada. I represent YMCA Canada, where I am the vice-president for children, teens, and young adults. Accompanying me is Mr. Craig Larsen, our executive director at CDPAC.

For your information, CDPAC is an alliance of nine national NGOs. The CDPAC alliance has a vision of an integrated and collaborative approach to promoting health and preventing chronic disease in Canada. Our key activities include knowledge development and exchange, and advocacy for evidence-informed policy, particularly at the federal level.

Given CDPAC's mandate, our messages today have a decidedly chronic disease prevention lens, and we'll focus on a few key areas of concern.

The first, which will carry my greatest emphasis today, is childhood obesity. Given the global epidemic of childhood obesity, its links to chronic diseases and impacts on mental health, we request that escalated and sustained action towards healthy weights for children and youth remains one of the federal government's utmost priorities.

Factors contributing to unhealthy weights are many, complex, and interrelated. Consequently, a multi-pronged response is required. Imperfect understanding of the full array of factors and the mechanisms by which they work should not stop us from taking decisive action in areas where we have ample evidence.

The first area I'll talk about in addressing this is marketing and advertising to children. The scientific literature is clear: marketing to children influences their preferences and choices. Over 80% of the foods and beverages marketed to children are unhealthy, that is, high in fat, sugar, and salt—and unhealthy food and beverage choices contribute to childhood obesity.

In its current form, the self-regulatory approach to marketing to children in Canada, known as the Canadian children's food and beverage advertising initiative, is insufficient. This initiative does not have a strong uniform standard for its member companies to follow. Member companies are able to determine their own nutritional standards and create their own definitions of what constitute children's programming. This initiative also allows for the use of advertiser created cartoon characters, the setting of easy-to-attain standards, and it does not encompass the increasingly broad marketing environment. To be effective these inherent weaknesses must be corrected.

Quebec's Consumer Protection Act is the only law in Canada that prohibits commercial marketing directed at children. Quebec has one of the lowest soft drink consumption rates in Canada and the lowest obesity rate among 6- to 11-year-olds. CDPAC believes that if the self-regulatory approach cannot be strengthened, then laws should be implemented across Canada that build upon the lessons learned in Quebec.

Another area for action now is the issue of sugar-sweetened beverages. CDPAC commends Health Canada for drawing attention to the links between sugar-sweetened beverages and childhood obesity in its public awareness campaign on children's health earlier this year. Within the context of a multi-pronged response to childhood obesity, one measure that should be considered is taxation of sugar-sweetened beverages. Price increases of sugar-sweetened beverages from increased taxation have been associated with reduced consumption. Such a tax would generate substantial revenues for governments that could be used to support healthy living initiatives. A recent public opinion poll found that the majority of Canadians agree that governments should tax sugary drinks if the revenue from that tax were reinvested in prevention of obesity and for healthy living purposes.

The second area of concern relates to the unanswered call for effective crosssectoral policy-making in Canada, which was referenced earlier. Federal public policy that is developed using the social, economic, and environmental determinants of health lenses will lead to a better return on investment than disease-oriented approaches. As noted at the outset of my talk, the need for whole-of-government collaboration is well supported in the key frameworks guiding chronic disease prevention today.

● (1620)

The third area of concern is the ongoing plight of Canada's most vulnerable populations. CDPAC recognizes that our nation does not have the resources to address all needs, so the opportunity costs must be weighed. CDPAC encourages the federal government not to lose sight of the populations bearing the greatest burden of disease. Canadian data on rates of obesity, diabetes, heart disease, tobacco use, prescription drug use, and suicide paint a distressing picture of life in our aboriginal communities, as we all know. We ask government to strengthen and maintain its investments in healthy living for aboriginal communities, especially in northern and remote communities.

We need a better understanding of the links and pathways among education, health literacy, employment, food insecurity, and chronic disease, and the points at which intervention looks most promising. A coordinating mechanism is needed for evaluation, synthesis, and mobilization of the vast body of real-world evidence that's emerging from many excellent community-driven initiatives at the local aboriginal community level. I think this is a very important role for the federal government.

Finally, we would also encourage the Standing Committee on Health to ensure that the renewal process for the health accord includes a continued and strengthened focus on health promotion and chronic disease prevention, including measurable indicators and targets. CDPAC will be submitting specific suggestions to the appropriate authorities as to how a new health accord could play an important role in chronic disease prevention.

Thank you for this opportunity.

The Chair: We thank all of you.

I have been informed that the bells will start ringing within a minute, so we unfortunately don't have time for Qs and As. But if they don't ring immediately, we'll start. I want to thank you very much for your presentations. This has been very important, especially seeing that common thread between the presentations.

We'll begin with Ms. Davies.

Ms. Libby Davies: Madam Chairperson, I'll be very quick with my question just to give them more of an opportunity.

I just want to pick up on the comments made by Ms. Lynkowski. I thought what you said was very relevant: that we don't implement what we recommend. We're talking about health promotion and disease prevention but also about the delivery model for that, and I can't think of a better delivery model than community health centres. I know that in the U.S. they are really increasing their focus on community health centres.

I want to ask the representatives from CACHCA and Ms. Lynkowski, and also Ms. Thomas, if they could briefly comment on how we could provide a much better model of funding, for example, for community health centres. I ask because, to me, that would be the most brilliant thing to do to increase that interdisciplinary capacity of community health centres, which are closer to home. I wonder if you could just pick up on that and talk about what we could do more of to actually support the community health centres and to make sure we are implementing all of these recommendations that have been around for so many years.

Maybe the colleagues from CACHCA...?

The Chair: Okay. Who would like to take that?

Mr. Scott Wolfe: Thank you very much for the question. We appreciate the kind remarks.

Across the country, community health centres are a patchwork. Unfortunately, both at the federal level and the provincial level, there simply hasn't been a commitment to shifting the emphasis of primary health care towards an integrated approach whereby health professionals—physicians, nurses, nurse practitioners, dieticians, and others—are brought out of their silos into the team setting. So political will in advancing a team-based approach and implementing the mechanism so that collaboration can take place, in partnership with medical associations, nursing associations, and others, is a key step.

I think as well that part of the dilemma faced by provincial governments as one of the key stakeholders in advancing these health solutions that have been promoted for some time—including just this past week by the Honourable Roy Romanow, who recommended community health centres as a key solution to some of our current challenges within the publicly funded health system—is that they often do require bricks and mortar. They do require some form of investment, whether it's retrofitting existing buildings or construction of new buildings. This is something where we see a particularly important role for federal partners. For example, stimulus funding or other projects announced by the government could in fact be put in the service of expanding health solutions, like the community health centre model. That's one example of a federal role—

● (1625)

The Chair: Excuse me, I'm going to have to interrupt you. Thank you.

Thank you so much for your presentations today. I wish we had more time. I have to adjourn the meeting now because we're quite far away from the House of Commons, and we have to get back for votes.

Thank you again.

The meeting is adjourned.

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