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Chair

Mrs. Joy Smith

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● (0845)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): We're going to begin now.

Good morning, everybody. Thank you for being here.

We want to have a special welcome to our witnesses. As you know, we're doing the study on health promotion and disease prevention, and you're a very important part of our study today. We're anxiously waiting to listen to your presentations.

From Consumer Health Products Canada, we have Mr. David Skinner, who is the president, and Mr. Gerry Harrington, who is the director. Welcome.

Ms. Rebecca Nesdale-Tucker, of ThinkFirst Canada, is going to be arriving, I think, in a few minutes.

From the University of British Columbia, we have Dr. Paul Kershaw, human early learning partnership. I understand you have a presentation.

Mr. David Skinner (President, Consumer Health Products Canada): I have a PowerPoint.

The Chair: A PowerPoint, yes. You know that the presentation is ten minutes, just to make sure the PowerPoint coincides with that.

By video conference, we have Ms. Pamela Fuselli, executive director, Safe Kids Canada. Welcome, Pamela. Can you hear me this morning?

Ms. Pamela Fuselli (Executive Director, Safe Kids Canada): I can. Thank you very much.

The Chair: We're very pleased. I know when we have the PowerPoint, you won't be able to see the PowerPoint that comes up, but you'll be able to hear it.

So we're good to go now. We'll start off each with ten-minute presentations, and we'll begin with Mr. David Skinner, please.

Mr. David Skinner: Thank you, Madam Chair and members of the committee, for allowing us the opportunity to be here today to participate in this study of health promotion and disease prevention.

Consumer Health Products Canada is a century-old trade association, representing the makers of products Canadians use to practise self-care, including OTCs and natural health products. Our members' products account for the vast majority of sales in this $5.3-billion market, and range from lip balms and sunscreens to cold medicines and pain relievers, vitamins, and herbal remedies.

CHP Canada's mission is to advance evidence-based self-care. We believe this will not only lead to better health outcomes for Canadians, but contribute greatly to the sustainability of our health care system.

I will introduce now Gerry Harrington, who will take you through some more detail and some statistics about how that can happen.

Mr. Gerry Harrington (Director, Public Affairs, Consumer Health Products Canada): Thank you, David.

Consumer health products have an important role to play in thoughtful health promotion and disease prevention strategies. OTC medicines and natural health products are vital elements in the toolbox Canadians have access to when they practise self-care and engage in the management of their own health.

An ever-increasing body of evidence supports the role that consumer health products play in disease prevention. Nutrients like omega-3 fatty acids and vitamin D have been shown to have a considerable impact on the incidence of non-communicable diseases such as heart disease and cancer, and OTC nicotine replacement therapy has shown to be an effective means of reducing tobacco consumption, another major cause of morbidity and mortality.

In Canada we're especially fortunate to have a consumer health product environment in which physicians and pharmacists play an exceptionally important role. There is strong evidence that Canadians avail themselves of the advice of pharmacists in particular to help them select and use consumer health products appropriately to a much higher extent than in other populations. For example, self-care-practising Canadians are three times more likely to rely on the advice of pharmacists in product selection and use than their American counterparts, and are significantly more likely to do so than their European counterparts. This is something Canadians do by choice. It shows that they're eager to use the tools available to them, such as the advice of an available and accessible front-line health care professional, to help them practise responsible self-care.

The Canadian government also has a direct role to play in the role of Health Canada to ensure that the products available to consumers are evidence-based, and that their labelling provides reliable information on which Canadians can base their treatment decisions and usage patterns. So Health Canada, in its regulation of both OTCs and natural health products, has a critical role to play to ensure that Canadians are making decisions about the use of these products that are evidence-based and consistent across all product categories.

Our main purpose today is not to underline the important role that consumer health products themselves play in the health of Canadians and the sustainability of the health care system. Our main purpose is really to highlight the overall importance of self-care more broadly. In this study on health promotion and disease prevention, as in most of the issues the committee explores, self-care plays or can play a critical role in influencing the outcomes in question and the cost at which they are achieved.

At a time when we struggle to get the most out of the $200 billion that is dedicated to providing health to Canadians, it is alarming to think of just how little policy consideration is given to the management of the biggest single resource in our health care system, which is Canadians themselves. That's right. When most of the academics who study these things tell us that between 80% and 90% of the health care interventions are self-care interventions, the system's most valuable resource is in fact the patient.

Allow me to illustrate that point with findings from a study conducted for CHP Canada last year. This study examined the behaviour of Canadians who suffered from three minor ailments: colds, headaches, and heartburn or indigestion. Looking at cold sufferers in particular, we found that of the 7.1 million Canadians who suffered from colds in April 2011, 12%, or 850,000 Canadians, made appointments with their physicians. The annualized cost of those doctor visits and the associated prescriptions and laboratory costs exceeded $1 billion.

We're not suggesting that all of these doctor visits were inappropriate; in fact, they can play a very valuable role in health promotion and disease prevention. But we can take a look at these doctor visits and get a sense of the opportunity they represent by looking at ways of potentially reducing the impact.

We looked at the 16% of those Canadians who went to the doctor, despite reporting mild symptoms from their colds. So it's a fairly arbitrary number. We looked at a target for reducing those doctor visits. If we took 16% of the 12% who went to the doctor and encouraged them to practise self-care instead, we would free up enough family physician access to provide primary care services to 500,000 Canadians. That's 10% of the five million Canadians who currently don't have access to primary care physicians, and of course all of the health promotion and disease prevention opportunities that this represents.

● (0850)

Now, I'm not suggesting that the role that Canadians play in their own health is something that is ignored by this committee or by the other policy bodies that impact the Canadian health care system. Nothing could be further from the truth. For example, many of our fellow witnesses in this study have spoken to the importance of promoting healthy lifestyles, including diet and exercise, in order to achieve our health promotion and disease prevention goals. But in the grand scheme of things, what proportion of our health policy discussions take into account the self-care considerations underlying a given issue from the perspective of the everyday Canadians who want to take greater control over their own health?

In this age, exploding with new and ever more accessible sources of information on health, what are we doing to help ordinary Canadians navigate through the maze of sometimes valuable, sometimes misleading, and sometimes downright dangerous sources of guidance on self-care? How do we help them differentiate between the good and the bad, and then integrate and act on critical decisions, on the guidance that is of real value and relevance to them? How do we ensure that the critical decisions and investments being made on health infrastructure, such as electronic health records, are done in a manner that empowers Canadians to make a more meaningful contribution to their own health and well-being?

CHP Canada doesn't have the answers to all of these questions, but we urge the committee to recognize the importance of giving them due consideration in this study and in all of the work that you do. Last year, former deputy minister of health and Bank of Canada governor David Dodge wrote an extremely thoughtful and thought-provoking analysis of the future of Canada's health care system in which he urged Canadians to have an adult conversation about the sustainability challenges the system faces. CHP Canada believes that self-care, the decisions and actions that people take to manage their own health, is a vital part of that conversation.

Thank you.

The Chair: Thank you very much.

Now we'll go to ThinkFirst Canada. Ms. Rebecca Nesdale-Tucker, please.

Ms. Rebecca Nesdale-Tucker (Executive Director, ThinkFirst Canada): Thank you very much. And thank you very much to the committee for the opportunity to speak here today.

Health promotion is such an important issue, and preventable injury is the leading cause of death for young Canadians under 44. Indeed, it's a leading cause of disability and death across a lifespan. We often consider injuries to be accidents or acts of fate, whereas research tells us that most injuries are in fact preventable. And Canada can and must do a better job at protecting our greatest resource, our children.

That's why ThinkFirst Canada exists, and Safe Kids and the other national organizations that address this issue. We were founded in 1992 to reduce serious preventable injury in Canada. We're a national charitable organization, with chapters in every province, and we're working to collaborate more in the territories. We work with our chapters and partners to increase health literacy and safety promotion through school, sport, and recreation-based programming, concussion education and awareness, and helmet promotion.

We develop our programs with multi-disciplinary committees, by drawing from different sources of expertise, and we deliver our messages with what we call VIPs, who are the voices of injury prevention—and they are injury survivors.

Keeping Canada's children safe should be everyone's concern. Trauma and head injuries, in particular, are at epidemic levels, and of course we've seen that in the media throughout the past couple of years. In Canada, injury is the leading cause of death and a major cause of hospitalization for children and youth. Injury kills an average of 290 Canadian children age 14 and under each year. It's estimated that 21,000 children are hospitalized for injury each year, or approximately one in every 300 children. Injury kills more children and youth than all other diseases combined.

The impact of injury on these children is often life-long. Head injuries alone account for substantial changes in learning ability, including delayed cognitive development in children and behavioural challenges. Children with spinal cord injuries may require wheelchairs full-time. This can inhibit their ability to play and severely limit future employment opportunities.

● (0855)

The Chair: Excuse me. Can I interrupt you for a minute? You're going too fast for the interpreters. Can you slow down a bit?

Thank you.

Ms. Rebecca Nesdale-Tucker: In terms of overall child injury rates, Canada lags behind most OECD countries in tackling this problem. In addition—this is from Smartrisk—unintentional injuries cost Canada approximately $20 billion per year.

The great tragedy is that most of these injuries are predictable and preventable. Protection can be as easily afforded as wearing a properly fitted helmet and buckling up appropriately in a car. Our framework for injury prevention is the three E's, at least three: enforcement, engineering, and education. Enforcement includes rules, policies, laws, and regulations, which are important. Engineering includes vital safety devices, such as helmets, car seats, and safer built environments such as CSA-regulated play spaces. Education includes awareness, the self-care that my colleagues were talking about, but also awareness of what the risks are and how to best protect yourself. And that's for the caregivers for a child and also at the individual level.

The top 15 causes of fatal injuries for Canadian children and youth are largely preventable, and these include passenger injuries in motor vehicle crashes, choking and suffocation, drowning, pedestrian injuries, poisoning, and falls. Safe Kids may be telling you more about these.

All Canadian children and youth are at risk for injury. Children and youth at special risk include boys, aboriginal children, Inuit Canadians, and also those of lower socio-economic status. Children in remote and rural areas may be more at risk. This can be because of lack of access to injury prevention but also distance to care. An all-ages injury prevention strategy has been called for by ThinkFirst Canada and its partners for many years. Our partners in this effort include Smartrisk, Safe Communities Canada, and Safe Kids Canada. Together we are calling and will be continuing to call for a national strategy to address child and youth injuries and indeed injuries across the lifespan.

We really welcome the announcements from the last federal Speech from the Throne, when a prevention strategy for children and youth was announced. This led, of course, to active and safe initiatives, which we really appreciate. We also appreciate the funding of strategic teams for injury prevention research, including the STAIR grants—“strategic teams in applied injury research”. This has been an important milestone, but we have a lot further to go. We look forward to the realization and renewal of enforcement of Canada's product safety legislation, and we'd also like to see the new CSA standard for ski and snow helmets regulated.

Our vision is a Canada that enjoys the lowest rates of injury of any nation in the world. Right now, we're in about 22nd place out of 28 OECD countries, and that's cited in the Leitch report. We look forward to opportunities to lower the incidence of injuries. On a high level, that would be the three strategies: health literacy, including injury prevention; safer sports and recreation; and public policy for a safer Canada. We'd also like to see continued injury prevention and research and evaluation. One thing we've been calling for, for some time, is a national entity to address this problem. With increased resources and partnerships we look forward to an entity, Injury Canada, that can be a focus for these efforts. With funding levels more commensurate with the burden on society, we can better achieve our goals.

We see this entity taking a leadership role in coordination and collaboration, including researching injury prevention, taking a knowledge broker role, and developing strategies to encourage potential stakeholders to act.

We believe that a pan-Canadian strategy should adhere to the principles of keeping a societal focus and therefore should direct efforts to those who are in greatest need, including the social determinants of injury.

Thanks again for the opportunity to speak here today.

● (0900)

The Chair: Thank you so much. We appreciate all your insightful comments.

Now we'll go to Dr. Paul Kershaw and we'll get that PowerPoint going.

Go ahead.

Dr. Paul Kershaw (Human Early Learning Partnership, University of British Columbia): Thank you very much for the invitation to present today.

As I travel across the country, encouraging Canadians to think more about promoting health rather than treating illness, more and more I say that boils down to thinking a lot like our national animal. Now, some have heard senators recently critique our national animal for being a dentally deficient rodent, but I think such critiques are all wet. Our beaver is a builder to be proud of, because when do we notice beavers? We notice beavers when they build dams. The thing is, no beavers live in those dams. Beavers build dams because the dams create reservoirs, and if those reservoirs are deep enough, then beavers gain efficiency because they can swim faster than they can walk on land. If the reservoir is deep enough, beavers gain security out of the reach of predators. And if the reservoir is deep enough, they also gain ample room to build woodsy little lodges as homes for their individual beaver families.

Then what happens when cracks appear in the dam? Well, like all good managers, beavers adapt. They come and repair the hole in the dam, not because any individual beaver stands to gain, but because the entire community of beavers depends on that dam to safeguard their shared standard of living.

I think that in Canada that kind of beaver logic has served us well for most of our history. By the 1970s we had spent a long time building our own national policy beaver dam. We had built public schools and universities, we had built veterans benefits, workers' compensation, and unemployment insurance. In the sixties we put in place our old age security plan and our hospital insurance and capped it all off with a Canadian public pension plan and the Medical Care Act. It is a policy tradition we all must be proud of. You know it better than most Canadians, and I encourage all of us to remember it.

But as I travel across the country I also ask what we have done since. There is no doubt that we've continued to build our markets and expand our banks, and what not, which have allowed us to weather the global recession better than most countries. But on the social policy side, we also see two somewhat worrisome trends. If you look at municipal, provincial, and federal revenue as a share of GDP, it has gone down by about $90 billion since 1980. Simultaneously, our expenditures on medical care have gone up about $47 billion as a share of GDP, which then crowds out our ability to use policy to adapt to the declining standard of living for the generation raising young kids.

I can show you that decline in three simple facts. It turns out that for young couples in Canada, household incomes are stalled between 1976 and today. They are stalled even though we have far more young women contributing employment income today than we did a generation ago. With that stalled household income, they have to pay for housing prices that have gone up across the country by 76%—and in my province, 150%—which leaves the generation raising young kids squeezed. They are squeezed for time at home because they're having to devote so much more adult time to making a household income that is stalled; they're squeezed for money even when they're not technically poor, because of the rising cost of housing; and they are squeezed for services like child care, which grow instrumentally more important when you need two earners to make the same level of income that one often could a generation ago.

That squeeze is happening even though the economy has more than doubled in size, producing on average an extra $35,000 per household, which does help to explain why it has become easier—although not easy—to retire. For those age 55 to 64, across the country incomes are up 18%. Wealth is up because if you owned a home in the seventies and eighties, and they almost doubled in price, that is very helpful for your personal wealth. Poverty has been dropped among seniors from 29% in 1976 to less than 5% today.

While personal financial circumstances of people approaching retirement have improved, that group of people is leaving larger government debts than they inherited as young people in the seventies. The debt-to-GDP ratio has now doubled since 1976. We've made no progress on our carbon dioxide footprint per person in this country, even though the constraints of global climate change have become more familiar to us.

This brings me back to our national policy beaver dam. Because we have not managed to adapt to generation squeeze, there is indeed a huge hole in that national policy beaver dam. The reservoir is draining out. As a result, we have a generation raising young kids that is increasingly stuck in the mud, leaving almost one-third of our children arriving at kindergarten vulnerable, either physically, socially, emotionally, or in terms of their ABCs and one-two-threes.

● (0905)

And all of the research shows us that vulnerability when one reaches school contributes to far higher rates of school failure and/or incarceration as a young person or a young adult, and in their thirties, forties, and beyond to a range of health ailments, whether it's obesity, high blood pressure, mental illness. By our fifties and sixties it contributes to coronary heart disease and type 2 diabetes, and in our final decades to premature aging and memory loss.

That is a bad generational deal, made worse by the fact that organizations like UNICEF routinely, over the last decade, have ranked Canada among the worst industrialized countries when it comes to investing in families with young children. We are only going to overcome this poor international ranking if we move from a bad deal to a new deal for families, and ask for baby boomers across the country to get on board for that better deal for their kids and grandkids.

A new deal means getting back to some basics in Canada. It's about ensuring that we still have the family at the heart of Canadian values, while acknowledging the diversity of households that exist from coast to coast to coast. It's really about using public policy to encourage people to spend more time together and possibly less on stuff. It's about promoting genuine choices for women and men alike to be able to succeed in the labour market and at home, rather than talking about that balance being a possibility but leaving it a fiction for so many. It's about using policy to promote personal responsibility.

I believe we live in a country context where most of us think that Canadians should do all they can to pay for and care for their own, but here's the deal about the generation raising young kids today: those under age 45 work longer hours than any other group of Canadians. They then go home and perform more unpaid caregiving hours than any other group of Canadians. So by any traditional metric, their work ethic is impressive. But despite that impressive work ethic, they are still struggling to maintain a standard of living that often one person could achieve in the labour market a generation ago. We could never use public policy to remedy that in its entirety, but we could at least mitigate the new challenges.

I think that would require three public policy changes that need to compete with our approach to illness treatment through medical care for today's scarce resources. As public policy change number one, we need new mom and new dad benefits that would allow all parents—dads as much as moms, including the self-employed—to share up to 18 months at home with a newborn and to make that affordable, not cost the equivalent of a second mortgage from your disposable household income. Thereafter we need to make it affordable for moms and dads alike to have enough time in the labour market to deal with rising costs of living and stagnant wages. You do that by putting in place $10 quality child care services that make it affordable for people to rely on stimulating, nurturing programs that supplement and never replace what parents do at home. Last but not least, these two public policy changes need to occur in the context of a greater commitment to either flex time, or since we're all talking about when we should be retiring now, I'd call it let's have longer work lives, because we're living longer, but shorter hours of work per year. The typical Canadian works 300 more hours per year than the typical Dutch, Norwegian, or German citizen. We can change that in part by tinkering with our full-time employment norms, saying instead of it being 40-plus hours per person per week, can we get it closer to 35 hours? That extra five hours to ten hours a week can make a great deal of difference in terms of balancing the squeeze at home.

At bottom, it's a question of what kind of Canada we want. I ask Canadians to consider, is it one that ignores all of the negative health implications of a Canada that has a growing breach between those approaching retirement and those younger, or is it one that will once again commit to working for all generations?

Thank you very much.

● (0910)

The Chair: That was extremely creative, and I have a new appreciation for our toothy friend. That's wonderful.

Dr. Paul Kershaw: Exactly. They're not the dentally deficient rodent.

The Chair: Now we'll go to Safe Kids Canada, Ms. Pamela Fuselli.

Ms. Pamela Fuselli: Thank you very much for the opportunity to speak today and to share Safe Kids Canada's views on disease prevention and health promotion.

Safe Kids is a national leader in preventable injury. By building partnerships and by using a comprehensive approach, we work to advance safety and to reduce the burden of injury for Canada's children and youth. We welcome the opportunity to share with the committee our opinion that addressing injury prevention is a key component of a sustainable health care system in Canada.

Despite its devastating impact, injury remains an invisible issue in the health care system and with the public. Few are aware, as my colleague Rebecca mentioned, that unintentional injuries are the leading cause of death for those aged one to 44 and that they kill more children and youth than all other diseases combined.

The numbers are shocking and revealing. In 2004, injuries claimed over 13,000 lives and accounted for over 200,000 hospitalized visits and 3.1 million emergency room visits. Furthermore, sustained injuries to Canadians led to nearly 70,000 disabilities. Each day approximately 60 children are admitted to a hospital for an injury. And every month, 25 children die from an injury, which is the equivalent of one classroom.

These sustained injuries, which are potentially fatal, place immediate and unplanned demands on the system, resulting in a significant allocation of health resources for treatment as a result of injury. No part of the health care system is untouched by an injury. Emergency room visits, wait times for services such as orthopedics, community-based care, family physicians, and acute-care and rehabilitation services are all involved in responding to the short- and long-term impacts of injury.

For injury survivors, the need for care and rehabilitation of the injury and the potential for permanent disability can have far-reaching impacts on health, education, social inclusion, and the family's livelihood. Many are left with ongoing physical, mental, or psychological disabilities, which have a major impact on their lives and on the lives of their families.

The financial cost of these injuries is also very high. Injuries to children and youth, aged birth to 19, cost Canada's health care system $5.1 billion in direct and indirect costs annually.

Unintentional injury is a leading public health issue that directly impacts the health, well-being, and quality of life of those injured and their families, communities, and the greater society, as well. Nevertheless, injury is often neglected, and investment has not been equal to the magnitude of the problem. The reality is that injury prevention has not kept pace with other public health interventions, such as tobacco control or infectious disease prevention programs.

Currently, health care dollars tend to be focused on disease treatment, not prevention. The amount of resources and the priority given to health research for injury research is proportionately minuscule when compared to the huge economic and social burden. And it is somewhat tragic, given that almost all injury events are both predictable and preventable.

A number of years ago it was estimated that injury received one per cent of research funding, and not much has changed since then. The challenge is balancing the immediate needs of people seeking medical advice, treatment, and care with the possible future benefits accruing from disease prevention and health promotion.

We know that effective strategies for injury prevention save lives, substantially reduce health care costs, and offer a high return on investment. The cost of primary programs is much cheaper than treating a child, sometimes for months, because of a preventable injury. Studies have shown that a $46 child safety seat generates $1,900 in benefits to a society, and a $31 booster seat generates $2,200. A $10 bicycle helmet generates $570, and so on.

Attention must be paid to aspects of health that include preventing individuals from requiring health services in the first place, thereby alleviating pressures on the system overall. We know that unintentional injuries are often described as accidents, something we have no control over. In reality, as I've said, we can predict and therefore prevent unintentional injuries.

Injuries generally result from combinations of adverse environmental conditions, equipment, behaviour, and personal risk factors, any and all of which can be changed. It is estimated that 90% of injury deaths could be prevented if known proven strategies were implemented.

● (0915)

To address the injury burden, Safe Kids Canada, along with other national, provincial, and territorial organizations, strongly encourages the government to take a leadership role. As you've heard, Canada currently ranks disappointingly on the OECD nations for deaths from unintentional injuries. It's estimated that if Canada had enjoyed the same injury rate as Sweden between 1991 and 1995, 1,233 children would not have died, between 23,000 and 50,000 would not have been hospitalized, and more than 250,000 children would not have visited emergency rooms.

The time for action is now. Human resources and funding at a level more in line with the burden of injury on society and more in keeping with resources dedicated to other comparable health issues are urgently needed. We recommend a comprehensive approach based on the principles of national leadership and coordination, a strategy that should include leadership in data and surveillance, coordination and collaboration, injury prevention research, working with NGOs to broker knowledge in Canada, developing a strategy to engage potential stakeholders to encourage full investment and engagement, and increasing awareness of and attention to the injury prevention problem in Canada.

Enacting a pan-Canadian injury prevention strategy would not require starting from scratch; rather, it would build on existing structures and activities. Both within and outside Canada, initiatives and strategies have been in place for some time and their efforts should be applauded. However, we urgently require government leadership, with collaboration from NGOs, to facilitate coordination and efficiency. In establishing and funding a national injury prevention strategy and thereby setting priorities and accountabilities, Canada could position itself at the forefront of health promotion and disease prevention, both at home and abroad.

Internationally the principles of prevention and health promotion have been acknowledged as the most effective means to address persistent health issues, requiring long-term and coordinated strategies. Most notably, in May 2011 the World Health Organization adopted its first ever resolution on child injury prevention. The resolution calls for child injury prevention to be recognized as a key determinant of health in children. The resolution also calls childhood injuries a major threat to child survival and health, and notes that injuries are often a neglected public health issue, with significant consequences on mortality, morbidity, quality of life, and social and economic factors. The WHO further recommends that a government agency take on the leadership role in child injury prevention, and this is based on the acknowledgement by member states that child injury prevention should be part of each country's plan for child and adolescent health, and that child injury prevention should be integrated within child survival programming.

Countries that have created injury prevention strategies and programs have seen a 50% reduction in injury rates over a 20-year period. In general, countries that use a combination of broad approaches in addition to encouraging a culture of safety and displaying strong political commitment have made the greatest progress in reducing their child injury burden.

The injury prevention community has been encouraged by recent government investment in injury prevention. As we heard in 2011, the government committed to a $5 million investment over a two-year period into keeping children active and safe by focusing on community-based activities. The major focus of this investment is on injuries such as concussions, drowning, and fractures—all important. However, significant reductions in injury rates can be achieved through more concerted national coordination and investment.

Health promotion, coupled with preventative measures, not only advances the overall health and quality of life for Canadians, but also improves the sustainability of the health care system by creating significant cost savings in the long term. The cost of inaction, when it comes to safety and the health of Canada's children, youth, and adults, is simply too high.

Thousands of lives could be saved each year. We're pleased to share our experience with you in order to achieve our mission, which is fewer injuries and healthier children, and a safer Canada.

The Chair: Thank you very much, Ms. Fuselli. I would like you to please forward your sources in your presentation, where you got your numbers from. If you could, forward those to the clerk, and the clerk will disperse them to the committee.

● (0920)

Ms. Pamela Fuselli: Absolutely.

The Chair: Thank you so much.

I want to say to the committee that we will be going until 10:15. At that time we'll suspend to go into committee business.

We're now going to start with our first round of seven minutes Q and A, and we'll begin with Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson, and thank you to the witnesses for being here and on the video conference today.

I guess if Canada were doing a bang-up job on health promotion and disease prevention we wouldn't be having this meeting today. It's certainly a big topic. I guess the crux of the problem is that it's something we all talk about, but we don't seem to do much about it in terms of where money goes or how we organize our health care systems and so on. I think it's a good opportunity to have a discussion about that.

Mr. Kershaw, I did want to focus on a couple of comments you made. I did quickly read your article from *The Vancouver Sun*, I think when it came out. You make some very good points, but there's one thing I don't quite agree with. I could be interpreting this wrongly, but I get the sense that you pit medicare against other social spending and say that it has to be either/or. I think the information that we've looked at shows that in actual fact, medicare costs, relative to the GDP, are pretty stable over a long period of time. It's the associated health costs like private drug costs, like other benefits, that are skyrocketing, particularly the drug costs. So I think we do have to differentiate.

I would certainly agree with your three policy choices. I think they're absolutely critical in terms of health promotion, healthier families, healthier communities. But it seems to me that nobody is saying the status quo in the health system is okay. It's very much under challenge. I think our challenge is to strengthen medicare and to make sure that we are focusing on disease prevention, on keeping people out of ERs, having much better community health centres, primary care reform, and so on.

I just wonder if you could clarify that when you say let's consider a cap on medical care spending. I think you say the greatest barrier to social policy is medical care. I have some concern about how you pose that question, because I see them as part of the same package. It's like here's the pie, and yes, the pie has shrunk because public revenue has gone down—you're totally correct on that—but then how do we make the pie more efficient?

Could you address that?

Dr. Paul Kershaw: I think in many cultural contexts outside of Canada there isn't necessarily a trade-off between medical care spending that's oriented around illness treatment and other public policy and social policy spending. But in Canada we've run into a bit of an issue. Our greatest social policy achievement is indeed our medical care system, which allows us to go from coast to coast to coast, and we will go to the wall for individuals to treat their illness when they become sick. But that is crowding out space for our thinking about doing something even more impressive—preventing them from becoming ill in the first place.

Between 2007 and 2010, over a recession, we watched as public—not private—investment in medical care went up by $22.5 billion a year, phased in over those three years. That's over a recession. Simultaneously, we don't see an appetite among Canadians to increase taxes to do other things. If Canadians generally are pretty modest in wanting tax growth but we are seeing dramatic increases in medical care, then yes, our greatest social policy achievement is now actually a huge barrier to innovating and adapting public policy for the day in today's context. So it's impossible for people who have to be elected to actually raise that argument, because just 10% to 15% of Canadians trust you. More of us trust new-car salespeople than trust you, which is just a terrible reality. So we need people like me trying to put the provocative questions out—

The Chair: Point of order, Dr. Kershaw.

Voices: Oh, oh!

Dr. Paul Kershaw: All right, I'll bring that study next time, and I can show it to you on my computer.

But this is the issue. Because there's so little respect for politicians, having difficult conversations about the policy issue about which we are most proud is now difficult. I think we need to either say we're open to increasing taxes moving forward, in which case medical care doesn't have to be in opposition to other things, or if that's not on the table, then we do have to pose the question of what we owe one another through our medical care system, and what we might do differently to create space to make us healthy in advance, as opposed to treating illness after the fact.

● (0925)

Ms. Libby Davies: Thank you for your answer.

Just to follow that up, I think part of that equation is to have a fair and progressive taxation system, and we've been calling very strongly.... There are people prepared to go out there and speak the truth and to point out that because of the shrinking pie.... Just look at the corporate tax cuts. You mentioned the $90 billion we've lost. The corporate tax cuts alone I think have been $60 billion. If we're not contributing to a fair taxation system, then the burden is increasingly on middle-class and poor families, and it stretches the system to the limit.

Again, I think the analysis that we bring to the debate is really important. I would argue that yes, there are tough questions, but I think there are some pretty clear answers we can move towards. The trouble is getting the government to agree to that. As you know, there was in effect a cap put on that was tied to GDP, and the provinces didn't even get to talk about that; it was just slapped down. So this is very much part of the debate that we're having.

The Chair: You can comment on that. You have one minute.

Ms. Libby Davies: If you want to add anything more, please do. It's a fascinating debate.

Dr. Paul Kershaw: I'm the kind of academic who's willing to say that if we want to spend more in some areas a cap on medical care spending may be appropriate, especially if it's targeted at going at GDP, which is effectively what we're talking about after 2017. Even between now and 2015-16 we will see medical care spending go up publicly, just through the Canada health transfer. It's $7 billion a year.

Are we confident that this investment will actually get us the biggest bang for our buck when we want to have a healthier society? It's no longer clear to me that an additional investment in illness treatment is the way to be promoting health when we are reasonably strong at doing medical care already, yet we have a range of policy issues, not the least of which is policies for families with young kids, in which we are consistently ranked terribly poorly.

The Chair: Thank you very much.

Dr. Carrie. And you'll be sharing your time with Mrs. Block, right?

Mr. Colin Carrie (Oshawa, CPC): Absolutely. Thank you very much.

Dr. Kershaw, I come from Oshawa, and I would be happy to sell you a brand-new Camaro with cylinder deactivation that will help our greenhouse gases.

I want to thank the witnesses for being here today. You're talking about something that's near and dear to my heart. I came from the wellness prevention background, and I like the talk about personal responsibility. I think we really have to start focusing on that.

I liked what Mr. Harrington said about 80% to 90% of our health care being patient-oriented. I'm wondering if you could expand on that a little bit. What are other countries doing internationally to help encourage self-care, from a policy stance?

Mr. Gerry Harrington: I think probably the best example of the most aggressive policy being pursued is in the United Kingdom. In 2000 the then Blair government issued a new ten-year plan for the National Health Service, which is roughly equivalent to what we loosely call medicare. In that blueprint, that ten-year plan, there were four pillars upon which they based the entire exercise. One of those pillars was self-care. It was recognized from the very outset, in the very structure of the plan, that self-care was an integral part of the entire system. It was not something that happened outside the system, which I think is one of the challenges we face in Canada.

In pursuing that, the U.K. government set a lot of goals around providing new opportunities. It really was a two-part exercise. One was to provide new opportunities for Britons to practise self-care. One of the things, for example, in the consumer health products area was that the government took a very aggressive stance on examining medications that were on prescription and those that might be made available for self-care in the form of OTCs.

Over the course of that decade the U.K. fairly quickly became one of the world leaders in prescription-to-OTC switching, which is a regulatory exercise. They involved health professionals such as pharmacists and physicians in the decision-making of what products would be appropriate for switching to consumer status, and by doing that they really expanded the range of options that consumers had.

Towards the end of the plan there was a greater focus, as well, on addressing the consumer behaviours—the behaviours of U.K. citizens. One of the challenges they faced is that the structure of the NHS itself provides incentives to rely on professional care because you have your prescribed medicine and your doctor visits paid for under the insurance schemes. If you choose to go to a self-care option, you're on your own and it comes out of pocket.

There were schemes attempted. For example, in Scotland there was a minor ailments scheme approach, where the role of the pharmacist was compensated. As a baby step between full self-care and physician care, the idea was to shift some of that burden for minor ailments away from the doctor's office, or the surgery, as they call it, and into the pharmacy, by providing compensation to pharmacists for their interventions on minor ailments.

There were a variety of approaches, and I guess what it really came down to was that there were two real branches to the strategy: one was to provide more options, and the other was to encourage behaviour change.

● (0930)

The Chair: Thank you.

I think Mrs. Block has a question too.

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

I want to thank all of you for being here today. It's been incredibly interesting hearing from you. I think so many of your comments are bang on, in terms of where we are today with our health care—or illness care—system that we have in place. We know that we are living longer, but not necessarily healthier.

I think the observations that you've made, Dr. Kershaw, are right on, in terms of being able to demonstrate whether the amount that we are putting into the health care system is actually getting us the results that we need.

Mr. Harrington, your comments around self-care certainly support that we do need to address the tension that we have within our system between illness care and looking at health promotion and disease prevention.

I thank you so much for those comments. As my colleague said, it's a very interesting debate and a very timely one for us to be having.

I firmly believe that on the heels of the introduction of medicare there was meant to be a second phase, which would encourage individuals to choose healthy lifestyles. I think that's the conversation we need to have, and I'm so thankful that we're doing this study.

I know that both of the other presenters spoke as well to the fact that health care funding has been focused on treating diseases rather than prevention.

The question that I want to pose is to Ms. Nesdale-Tucker. It was around the comments that you made regarding health literacy. You said that Canada can and must do a better job in protecting our children, and obviously we know that by doing that we will be making investments in the future of our health care system. I just want to give you an opportunity to talk a little bit more about health literacy, and perhaps the strategy that you are implementing in order to do that.

Ms. Rebecca Nesdale-Tucker: I agree with my colleagues about opportunities at the medical level, as well, to increase that interchange. At ThinkFirst Canada we work in schools and we work with a range of medical practitioners and VIPs, as I mentioned, to get the message to children, their families, and their teachers that there are ways to protect yourself from serious brain injury and other traumatic events, and that these are not fun situations to be in. It's not cool. You may not think it's cool to wear a helmet, but it's far less cool to have a brain injury and have your mom looking after you for the rest of her life.

We try to speak to children on that kind of level, but we also see there are opportunities to increase health literacy through a discussion with the Canadian public. My colleague Pamela spoke to that as well—the awareness of Canadians.

Do Canadians know that the greatest risk to them for death, up to the age of 44, is a preventable injury? I think it's rare that people would know that, and that there are preventable ways you can avoid a lot of suffering. What we see is that we're going to pay for this anyway, so you can pay for investments in children's safe play—

The Chair: Can you wrap up your comments, please?

Ms. Rebecca Nesdale-Tucker: Other ways to connect with the medical system would be a prescription for a helmet, as well as a well-baby visit—

The Chair: Thank you very much.

Dr. Fry.

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

As my colleague Ms. Block said, it's very interesting, the diversity of interventions that we have this morning in witnesses. I wouldn't want to ask Dr. Kershaw about the issue of funding, because we well know that the problems with medicare are not simply about funding. The problems with medicare are about making the changes that we need to make in terms of how we deliver care, where we deliver care, who delivers care, and that is really what we should be talking about.

If you're going to have a lot of people who, as they live longer, become chronically ill, then you need to be able to have multi-disciplinary family primary care clinics with a whole range of people delivering care, in an appropriate scope-of-practice manner. And then you're going to also talk about making sure that you don't let chronically ill people go to hospitals. If they don't get management of their chronic care outside of a hospital, it's the hospital that causes the increased costs, and of course the illness. By sitting around in a hospital when you could be at home or in a community care setting, you're going to get all kinds of secondary diseases that come on to you, including infections.

What I wanted to follow up on was something that you did say. I think one of the things that we tend to get the squeeze on in terms of talking about health promotion and disease prevention is that as you transition to keeping people healthier, there is still going to be a whole generation of people in that generation who are going to be as sick as others because that prevention didn't come before. So you have to have a point in time, as you transition, where you're going to be doing both. And I think that is the issue we're facing now. As we transition, there's going to still be the high cost of spending until maybe ten years from now, when it starts to kick in on health promotion and disease prevention.

What you said, though, that really struck me very hard is the squeeze of that generation—the 35- to 45-year-old generation. You talked about a lot of other social programs that must come in place, and the one about ensuring family leave is a really important one. Norway did this three years ago, and the result not only in terms of savings, but in terms of mental health and in terms of just basically a healthier population is an extraordinary one.

They have the 18 months for leave, as you suggested, to look after kids at home, but the man—the father in the family—must take six months of that. They give you an 80% salary when you go off. People don't want to take time off if they're getting 50% to 55%, so you're looking at increasing the cost of social spending to achieve results ten years down the road, in which case they're going to have to find the money now.

That's a problem most governments are faced with: trying to find that extra money now to create a better whatever ten years down the road. How do you see that happening? How do you see people doing that transition? That is, as far as I'm concerned, the core of the issue. How do you spend more money now in that simple generation so you can save down the road in the next generation, when prevention and promotion takes a dip?

● (0935)

Dr. Paul Kershaw: There's no doubt that the investment in smart family policy to promote a healthier population isn't going to yield savings in the health care setting for young kids for 10 or 15 years. It is a medium-term investment.

That's the issue about health promotion all along. At some point we need to start.

We've been looking at a range of short-term issues that Canadians are paying for in the absence of having this new deal for families. The business community actually happens to be one of the biggest payers for the status quo. What I mean by that is when generation squeeze comes to work, they bring their time, service, and income squeeze with them, and that means a number of things. First off, they're more likely to be absent in any given year from the firm, on a given day. And who pays for that? Our employers.

That costs the business community about $2 billion a year. Then, thousands upon thousands of employees, more often than not women, say it's just too difficult to balance the caregiving at home and the responsibilities on the job. So they say “Forget it, I'm going to leave the firm for an indefinite period”, and then firms have to pay about another $1.5 billion to $2 billion to go out and recruit, retrain, and wait for the productivity of a new person to get up to the place where it was for the person being replaced.

Then, because people are squeezed, they're more likely to have greater work-life conflict, which leads to more stress, and then adults are going to the medical care system now for drugs, or to our physiotherapists, etc., more regularly. Who pays for a large part of that? Our employers, through our benefit plans.

In combination with the chief financial officer at Sierra Systems and two of his chartered accountants, my team at UBC has estimated that the business community right now is paying over $4 billion a year for the squeeze on the generation raising young kids. We can get short-term returns, and this is just the business community, by investing in a new deal. Then there are the returns coming back in some ways to government through better use of education dollars, less on crime, less on poverty reduction, because these policies will actually eliminate poverty for kids under age six, even though it doesn't do anything through welfare.

● (0940)

Hon. Hedy Fry: I wanted to ask a question about the whole idea of injuries to kids. I think this is something people have not discussed. I was really glad you brought it up, because so many of those injuries, not only to kids but also to seniors, are very preventable, and they can cost a lot of money in the long run. With seniors, when they break a hip, that's it. If you're a 70-year-old, when you break a hip you become dependent on the system, because you have all these added complications.

How do you see a national strategy for preventing child accidents or childhood illnesses? What form do you think that would take? What are the elements of it?

Ms. Rebecca Nesdale-Tucker: We appreciate the work you've done with helmets in skiing. We would see research as a pillar, we would see public awareness as a pillar, and we would want policy to be a pillar. We want to wrap up the three E's: enforcement, engineering, and education. We would like to see work with the NGOs. We'd like see to a leveraging of efficiencies. We should all use the same numbers, the same messages—it's evidence-based. Those are some of the pillars we'd like to work with.

The Chair: Thank you, Ms. Fry.

We'll now go to Mr. Gill and Mr. Brown, who will share their time.

Mr. Gill.

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

I want to thank all the witnesses for being here with us and for providing us with such wonderful presentations.

My first question is for Pamela from Safe Kids Canada. I understand our government passed a Consumer Product Safety Act last year. How will this legislation help to prevent not just injuries but also illnesses among our children?

Ms. Pamela Fuselli: We were involved with the Consumer Product Safety Act. What it does is take a precautionary principle perspective. It requires manufacturers to keep records and report incidents. It also gives the government the power to ban a product. Previously, there was only a negotiated ban with industry. While that has worked to some extent for the larger retailers, it doesn't get those really dangerous products off the market, like those sold in second-hand stores or smaller retail outlets. What we need is a more reactive system, a number of different options for government to address, and a mechanism to make parents aware of products that have been recalled. This way products that have been recalled are going to get off the shelves much faster.

Mr. Parm Gill: Can you tell us how much of your information is tailored to adults and caregivers, as compared with the children themselves?

Ms. Pamela Fuselli: Safe Kids Canada focuses on parents of younger children. Our information is with the parents and caregivers, because they're the ones making the decisions on purchasing the safety gear and ensuring that their children are wearing it. They are the ones who tell children they should be wearing a bike helmet and buckling up every time they get in a car. They're the ones who are going to be setting the rules and enforcing them. Our approach has been to focus on parents and caregivers, getting them the information they need to make safe choices.

Mr. Parm Gill: In your online strategic plan you mentioned that aboriginal, rural, immigrant, and economically disadvantaged communities are at an increased risk of injury. What techniques have you employed to communicate with these groups, and what challenges do these communities face?

Ms. Pamela Fuselli: We've done a number of different activities in this area. A number of years ago we launched an ethnocultural program that investigated what languages were spoken most in ethnocultural communities in the Toronto area. We selected three. We have limited funding, so we were looking at a pilot project for this. Instead of just translating the material from one language to another, we spent a lot of time with these communities, understanding their needs and their cultural norms, and really translating the materials in such a way that they are culturally relevant. What we learned was that in some communities it was very important to put information about contacting emergency services as well as the actual safety information that we wanted to communicate. We've done a bit of outreach to that.

In terms of rural areas, I've been very active in engaging with the agricultural community and looking at children living on farms, because not only are they living in a home and exposed to the same general injuries as other children living in homes, but they are also living in a workplace. It's the only scenario that we have in Canada like that. They are at most risk under age five because they're taken onto the work site very often for purposes of child care. They're taken there so they can be watched while someone else is engaged in work.

I sit on a couple of committees on that, and I'm trying to get guidelines out to parents around the most appropriate child development ways to engage their children in farm work, if they are going to do that. For the younger ones, there are guidelines to look at options for child care, such as creating a safe play space on their property while they're working.

● (0945)

The Chair: Ms. Fuselli, I'm sorry to interrupt you, but Mr. Brown has a question, and we're running out of time.

Go ahead, Mr. Brown.

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

In regard to health promotion, I have a question in general. What advice do you have for this committee, given the fact that there are so many more distractions for young Canadians? I remember my mother saying that Wellington Street in Barrie, where she grew up, used to be full with kids playing after school. You don't see that any more. You see kids using their video games and watching TV. Instead of there being one channel, there are 300. So the culture we have right now encourages a more reclined lifestyle.

How do we get young Canadians actively involved in sports? When we were studying this before, one mention was of these complexes in Nordic countries where the whole family can do their different activities. Do you have any general suggestions for us on the best ways to do this, through the scope of the federal government, and realizing that we're a jurisdiction that at times is detached from direct recreation? Obviously we looked at the physical fitness tax credit, but are there other things we could be doing to encourage that healthy lifestyle? Do we want to have young Canadians actively involved in sports for their lives?

The Chair: Who would like to speak to that?

Ms. Rebecca Nesdale-Tucker: My colleagues talked about child care. We found at Injury Prevention that a safe space can reduce injuries. National child care programs and investments in infrastructure can certainly help. Another way is the federal government investment in active and safe programming. My colleagues and I want kids active. We want them out there playing. So what measures do we need to make sure that kids have the gear they need and the rules they need? Continued investment in that will be fruitful. Maybe there are other opportunities, such as affordable child car seats and helmets, and tax exemptions from those essential safety items. We make immunization available to Canadian children. What about other essential items, like helmets?

The Chair: Thank you so much.

We're now ready to go into our second round. This is a five-minute round for questions and answers, and we'll begin with Madam Quach.

[*Translation*]

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

I want to thank everyone for coming here today to discuss disease prevention and health promotion. It is very important to determine what must be improved and what the government can do as a leader in health.

With all due respect to the witnesses who have made presentations today, I would like to move the following motion:

> That the committee undertake as soon as possible a study of the federal government's role in sustaining health care funding after recently announced changes to the Canada Health Transfer; that this study look at the importance of federal collaboration with the provinces and territories in exploring measures of accountability in health care practices across the country; that it hold at least five (5) meetings on this study to hear witnesses, including the Minister of Health [...]

● (0950)

[*English*]

The Chair: Excuse me. We're doing business later. We're in a business meeting and our witnesses have come; I'm puzzled as to why you didn't wait for the business meeting part to do this.

[*Translation*]

Ms. Anne Minh-Thu Quach: I think this topic is so important that it should be debated publicly. I followed all the rules so that I could move this motion now, and I think it's very important to debate this publicly, so that Canadians can be informed about all these issues.

[*English*]

Mr. Colin Carrie: Point of order.

The Chair: To go in camera.

Mr. Colin Carrie: Yes. If we're going to be discussing it, we should go in camera.

To remind the member—

[*Translation*]

Ms. Anne Minh-Thu Quach: I was not finished, madam.

[*English*]

Mr. Colin Carrie: —we actually did have an urgent meeting on this that she unfortunately decided to call but did not decide to attend. It was fully debated and it was voted on. So if she'd like to go in camera to discuss this, let's do it.

The Chair: The request is then to go in camera.

Ms. Libby Davies: I have a point of order.

The Chair: We'll put it to a vote.

Ms. Libby Davies: No, no, I have another point of order.

Mrs. Kelly Block: It's not debatable; it's a motion to—

The Chair: It's not debatable.

Ms. Libby Davies: I have a point of order. You have not brought down the gavel yet. I have a point of order.

The Chair: No, it is—

Ms. Libby Davies: Madam Chair, I have a point of order that I'd like to raise. We've not gone in camera.

The Chair: We have to put it to a vote immediately.

Ms. Libby Davies: No, Madam Chair, I'd like to make a point of order.

The Chair: All in favour of going in camera?

Ms. Libby Davies: I'm entitled to make a point of order.

The Chair: All against going in camera?

Ms. Libby Davies: I'd like a recorded vote.

The Chair: The motion is defeated. Sorry, the motion is carried.

We'll go in camera.

I'll excuse the witnesses, please, and we'll deal with the motion. Then we'll bring you right back in.

[*Proceedings continue in camera*]

● (0950)

(Pause)

● (1005)

[*Public proceedings resume*]

The Chair: Mr. Lizon, you're next.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you, Madam Chair.

Thank you, witnesses, for coming this morning.

I would like to continue on injury prevention. Before I ask the question I'll make a comment.

I think that parents are becoming more and more protective of their children. I remember growing up, and at a very young age I was looking after myself; I was playing. I have children, and I have grandchildren now. Honestly, if I saw them doing what I did when I was young, I think I would really have a heart attack or something.

I understand we have to work and do everything to prevent injuries, especially in young people, but don't you think we're walking a very fine line, and by overprotecting children we're making them less independent? How do you balance this?

You mentioned safe playgrounds or safe places, and wearing helmets. I ski, and I see young people skiing wearing helmets. There are a lot of accidents on the ski hill, not necessarily related to the lack of equipment but due to speed and in many places overcrowding. How do you deal with that?

Ms. Rebecca Nesdale-Tucker: I agree with you that balance is very important.

We want people to know the real risk, the actual risk. For example, a child won't learn a lot from having their hand burned, so let's look at it head-on. In skiing and snow sports we want kids to wear helmets, but we have a standard in Canada that hasn't been regulated yet that could provide additional measures of safety. On the provincial and territorial levels we could regulate that helmet use and look at the reduction in collisions too—the overcrowding you talked about. So it's not just one factor like a helmet; it's also the entire environment and the supervision of that environment.

We don't want to overprotect children and limit them from playing and learning, but we want to have healthy and safe environments for them to do that. I don't think there's a positive learning outcome from a broken neck or a severe brain injury. We want to keep kids aware of how they can protect themselves, and then keep them on positive risks—risk-taking to better themselves in society, rather than risks that could harm their bodies for a lifetime.

Mr. Wladyslaw Lizon: Thank you.

Dr. Kershaw, in your slide presentation I liked your story about the beaver. However, I don't like beaver dams, because I have to stop, get my stuff out of the canoe, and carry it over the dam. So I don't have really good feelings about beaver dams.

On one of your slides you mentioned that life causes problems related to a squeeze on kids under six. You list school failure, pregnancy, high blood pressure, coronary heart disease, and diabetes. In my view, they are all related to lifestyle, and lifestyle does not necessarily depend only on a squeeze. Can you elaborate on this?

● (1010)

Dr. Paul Kershaw: This slide summarizes a range of studies that show what it means for Canadians when they come to school at age six and are vulnerable, either physically, socially, emotionally, or in terms of their ABCs and one-two-threes. It summarizes a range of studies showing that early vulnerability relates to a range of social problems, like school failure or criminality, or health issues later on in life. Then the question is, what causes that early vulnerability?

I think we have to be careful to not just describe this as a lifestyle, as if there's some life that parents today are choosing, and it's those bad decisions of individual parents. That would mean that today we have a generation of parents who are just worse than they were a generation ago. There's very little evidence to suggest that's the case, but there's a ton of evidence to show that so much has changed from the mid-seventies to today.

Those changes include the fact that wages are going down, in particular for men, so even though we have way more adult time devoted to a labour market, households don't have any more income if you control for inflation. Income doesn't stretch further than it did in the past because housing prices are so much higher. Then people need to take on an additional mortgage to pay for things like child-care services that allow one or both parents to be in the labour market.

If we want to address these things on the screen, we need to get our family policy right.

The Chair: Thank you, Mr. Kershaw.

We'll now go to Dr. Morin and Ms. Quach. You'll split your time, with Ms. Quach first.

[*Translation*]

Ms. Anne Minh-Thu Quach: I think that I had one minute left to wrap up my comments. So I will use that minute and then yield the floor to Mr. Morin, who will use his five-minute period. Thank you.

Mr. Kershaw, I found your presentation very interesting. I continued reading while you were talking. You also tackled social determinants of health. We know that the daycare program and the local community service centres have greatly contributed to improving the situation in Quebec.

What do you think the federal government's priorities should be? Which health determinants should it invest in?

[*English*]

Dr. Paul Kershaw: This is a really good question. The federal government could pick any one of the three policy changes I propose, but given the way federal-provincial relationships work right now, it would make most sense to intervene on the new mom and new dad benefits, because currently a lot of that happens through employment insurance. Then of course provisions would need to be taken to make sure that the advance policy decisions that Quebec has already taken don't get penalized for their early action. So that would be one place, the new mom and new dad benefits.

I think as provinces go down the road of doing more on child care and employment standards, you would need the federal government to take seriously how we improve our national child benefit supplement to make sure that, as hours are changing for some families, that doesn't compromise their after-tax income, and the national child benefit supplement is a really easy way. You could triple that and you could end poverty for kids under age six.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): I am going to let my colleague ask her other questions. I know that she had several. So I am going to let Ms. Quach have my floor time.

Ms. Anne Minh-Thu Quach: Thank you.

Let's talk about childhood injury. There are many individual rules for each type. Once again, the federal government needs to get involved in order to establish Canada-wide standards. How could the situation be improved in the most effective way that would also be the most easily applied to all the provinces?

In addition, our population is aging. At previous meetings, we talked about modifying people's physical surroundings, so that streets would be safer and people more physically active. All that promotes better human health and helps avoid falls. What do you suggest, Ms. Nesdale-Tucker?

The question is also for the Safe Kids Canada representatives. Ms. Fuselli, what do you suggest?

[*English*]

Ms. Rebecca Nesdale-Tucker: So here is one area in terms of regulations. You mentioned risks to children and safer environments. A lot of types of injuries are going down, which shows that some injury prevention is working. But there are some really high-concern areas—snowmobiles and ATVs, for example. So the federal government and Health Canada may want to look at that in terms of opportunities with helmets—for toddlers, maybe speed skating, ski, and snow, the whole range of helmets—but also ATV use by children. They're very heavy vehicles.

We ask children to wait until 16 to drive a car, for example, but younger children are on ATVs. They can flip over and cause crushing injuries that children cannot survive and go at speeds that children's small bodies aren't ready to handle. So ATVs and other vehicles of that nature are something the committee may want to consider.

● (1015)

The Chair: We were supposed to suspend at 10:15, and we have an extra motion that has just come up as well for committee business that we haven't discussed yet. But I'm going to extend the committee for five minutes just so that we can get a couple more questions in.

Is that okay with you folks? Okay, thank you.

Mr. Strahl.

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

I'll get my questions out there and allow the witnesses to respond.

My question follows on the comments of my colleague, Mr. Lizon. As a parent myself, I certainly take notice of the reports. You see in professional hockey a high level of awareness now on concussions. You read reports about how in minor football there are undiagnosed concussions all the time and how in soccer heading the ball is causing concussions. I played some of those sports, but for your own kids you're much more protective and you ask whether organized sports are worth it. You say your kid's not going to play in the NHL, so you wonder whether you want to put him in those risky situations.

So how do you balance between educating people on the risks while preventing people from saying their kid is just going to play Wii instead of playing active team sports or sports that would put them at risk? How do you balance those things? Maybe Safe Kids Canada could answer.

The Chair: Ms. Fuselli, if you have anything you want to say, just raise your hand so that I know you want to comment.

You do? I thought you might.

Maybe I'll start with Ms. Tucker, and then I'll go to Ms. Fuselli.

Ms. Rebecca Nesdale-Tucker: Certainly at ThinkFirst we want kids to stay active and safe, including in team sports. Some of it's the age-appropriateness of the risk strategies. We find that if you eliminate bodychecking at younger ages, as they have in the States, Ontario, and Quebec, there's a lot more safety.

We find that up to 25% of kids in a junior hockey league in a season could experience concussions. There are ways we can prevent this. We want to make sure there's a prevention of collisions. There's the "no hits to the head" rule at Hockey Canada. There are environmental, rule-based, educational, and equipment ways to mitigate these strategies. If the parents know them, and the coach knows them, and the kids know them at age-appropriate levels, this can inform safer play—and fun play. It's more fun to play when you're not injured, because you stay in the game longer, right?

Mr. Mark Strahl: Right.

The Chair: Ms. Fuselli, do you want to make a comment now?

Ms. Pamela Fuselli: Yes, sure.

I echo ThinkFirst's information. It's taking what is most effectively proven by evidence. In terms of best practices, it's not a one-size-fits-all. A good example is the helmet. A helmet on a head is a protective piece of safety equipment for someone on a bike or in a sport. For someone on a playground, it actually is a strangulation hazard. So we can't say that a helmet is a protective piece of equipment that you need to wear every day, all the time. We're not asking for measures that are outside the realm of what the evidence shows.

Also, as we learn more about diseases and about what causes different diseases, we adjust the treatment. The same is true in prevention. There were things we didn't know years ago. We didn't used to wear seat belts, for instance. Now we do.

All of the children who engaged in all of the things we did as children and who were injured or killed aren't here to tell those stories. It's all of us who did actually come through it okay who can say, "Oh, we used to do that as kids, and we were fine." Well, we were fine, but a lot of children weren't. Now that we know the interventions that work, we can implement them. I think that is what has to be the focus.

The other focus is preventing serious injuries. It's not the bumps and bruises of regular play and life but the serious, life-altering injuries that we want to really pay attention to.

● (1020)

The Chair: Thank you.

Mr. Skinner.

Mr. David Skinner: Actually, probably one of the most pertinent things we deal with all the time is trying to find the balance between regulating on something and educating on something. There are two aspects to health and wellness and promotion. One is how to eliminate risks or how to reduce risks, and the other is how to promote the positive. So there's the negative and the positive.

From my experience, for example, I was writing the standard for child-resistant packaging for medicines back in the late 1970s and early 1980s. So we have child-resistant packaging as a regulated thing, to try to provide the consumer with something that will help them, but we find that child poisoning still happens. It's not because of the closures; it's because people leave open bottles out. So there's the whole education part. Without one, the other is never really very effective. You need them both.

It's the same thing on the promotion side. While you can talk about risk reduction, it's also actually the positive side. In an environment where we're trying to create regulations that might address how people can do better things for themselves, it's often really not necessarily the best tool; although regulation has its place there, it's a lot about promotion and communication. It's an environment where, I would say, self-care matters in the debate.

When that environment comes to the fore, then there's a lot better decision-making on whether or not to just regulate it, and then "out of sight, out of mind", versus regulate it and communicate.

The Chair: Thank you, Mr. Skinner.

I want to thank all of the witnesses for coming today. Thank you for your patience at that interruption.

We do have quite a bit of business to get covered, and we only have until a quarter to the hour.

I'm going to suspend the meeting for one minute.

[*Proceedings continue in camera*]

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