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Chair

Mr. Rob Merrifield

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● (1540)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): I want to thank you for coming. I think this is our ninth meeting on childhood obesity, so I appreciate you coming to the committee to present.

We have with us today Lisa Oliver from Simon Fraser University. From the University of Toronto we have Valerie Tarasuk; and from KMH Cardiology and Diagnostic Centres we have Arvi Grover.

We'll go in that order. We want to thank you for coming, and we're eagerly awaiting your presentations to the committee.

We'll start with Lisa.

Ms. Lisa Oliver (Ph.D. Candidate, Department of Geography, Simon Fraser University): I have passed out a PowerPoint presentation as well as an article.

The Chair: I think we all have that.

Ms. Lisa Oliver: I would like to thank you for inviting me here to speak to you about this important topic. I'd also like to thank the committee for choosing to address the issue of childhood obesity this fall.

I'm a health geographer, which means I investigate how the local places where individuals live shape their health status. My research focuses in particular on how the neighbourhood environment influences childhood obesity by structuring opportunities to engage in activities that promote or inhibit weight gain.

I've been invited to come here today to present findings of my research on neighbourhood socio-economic influences on childhood obesity published in the *Canadian Journal of Public Health*. I would also like to acknowledge the contribution of Dr. Michael Hayes, who was co-author of this work. This research uses data from the Statistics Canada national longitudinal survey of children and youth.

Neighbourhood socio-economic status is measured from unemployment rates, median family income, and percent without post-secondary education. It is divided into four equal categories or quartiles, from low SES to high SES. Measures of overweight and obesity are based on children's heights and weights and use of body mass index cut-points from the International Obesity Task Force. Heights and weights are based on parent and self-reports.

The graph on page 4 shows the prevalence of overweight and obesity by neighbourhood SES among children and youth. First, a social gradient in overweight is apparent, in which the prevalence decreases from 41% in low SES neighbourhoods to 27% in high SES neighbourhoods. Similarly, the prevalence of childhood obesity systematically decreases from 19% in low SES neighbourhoods to 10% in high SES neighbourhoods. This pattern is also evident for obesity among youth.

I want to emphasize that the low category represents the bottom 25% of neighbourhoods in Canada. It does not represent only extreme poverty. Neighbourhood effects are real and persist after controlling for parental education, family income, and the child's age and gender.

The graph on page 6 indicates the likelihood of a child being overweight, adjusted and unadjusted for family factors. The solid bars show the likelihood of being overweight, adjusted for family factors. They show that relative to living in a high SES neighbourhood, a child is almost 1.3 times more likely to be overweight if they live in a low SES neighbourhood. This shows that neighbourhood effects are real, and a child is more likely to be overweight if they live in a low SES neighbourhood, independent of their family circumstances. Thus neighbourhood effects are not solely due to the clustering of low socio-economic status families in disadvantaged neighbourhoods.

What can be attributed to neighbourhood factors? The next few graphs provide some evidence to explain this pattern. The graph on page 7 shows the percent of parents reporting a lack of safe parks and playgrounds in the neighbourhoods. Again we see a similar pattern where a lack of safe parks and playgrounds is highest at 27% in low SES neighbourhoods and systematically decreases to 9% in high SES neighbourhoods. This is a three-fold difference in safe parks and playgrounds between the highest and lowest quarters of neighbourhoods in Canada.

The graph on page 8 shows the percentage of children and youth not participating in organized and unorganized sports. Organized sports include activities such as hockey or gymnastics. They have coaches or instructors and typically involve fees. Unorganized sports do not have coaches or instructors and include activities such as street hockey or simply playing in parks and playgrounds. I want to point out two things about this graph.

● (1545)

First, among children aged five to eleven, there was a clear graded relationship between participation in organized sports and neighbourhood SES, in which the percentage of children not participating is highest, at 52%, in low SES neighbourhoods and decreases to 30% in the high category. This is a substantial difference in non-participation rates between the highest and lowest quarters of neighbourhoods in Canada. It could be due to factors such as lack of programs in these neighbourhoods or to parental barriers, such as the ability to pay or to provide transportation for children to attend such programs.

Second, while non-participation rates are similar across all neighbourhoods for unorganized activities, the previous graph suggests that children in low SES neighbourhoods may undertake such activities in less safe environments.

Over the last few months, I have expanded upon this research by examining the emergence of neighbourhood disparities in obesity and overweight as children age. This research is important because if we can identify when these neighbourhood disparities emerge, then we can develop policies to address them.

Using the same data, from the national longitudinal survey of children and youth, but following children over time, the graph on page 9 shows the development of overweight and obesity by neighbourhood income among a cohort of children aged two and three.

First, among children aged two and three in 1994 there was no clear relationship between overweight and neighbourhood income. Second, when these children are assessed four years later, aged six and seven, a strongly graded relationship is apparent between neighbourhood SES and overweight and obesity, and this persists when children are aged ten and eleven.

The key findings of this research are that neighbourhoods with lower SES have higher levels of obesity, less participation in organized sports, and a lack of safe parks and playgrounds. Neighbourhood disparities in overweight and obesity seem to emerge between the ages of two and ten.

I have been asked to discuss what the federal government might do to address neighbourhood inequality and childhood obesity. Effective policy, I think, will require the federal government to take an active leadership role, involving both provinces and municipalities and other stakeholders as well.

Federal government support for the establishment of universal programs for physical activity through targeted support to municipalities may be needed. Universal programs run through community centres may begin to address the graded relationship between neighbourhood SES and non-participation in sports programs, and additional targeted programs may be required to improve participation rates in low SES neighbourhoods, which are very low right now.

I encourage the federal government to take an active role in reducing barriers to participation in physical activity for children. Targeted support could be directed towards municipalities or provinces to reduce such barriers. For example, providing transportation for children to and from home to recreational programs may increase participation, especially among children living in low SES neighbourhoods or families, and the elimination of user fees for programs, especially among low SES children or low SES neighbourhoods, may improve participation.

Increasing children's participation in unstructured activity is considered important to reduce childhood obesity, and improving the safety of parks and playgrounds would likely improve participation rates in unorganized physical activity. Targeted support for municipalities to address safety concerns relevant to their neighbourhood is needed.

For example, supervision of parks and playgrounds during after-school hours may improve safety and encourage use. Implementation of traffic calming in neighbourhoods, and especially around parks and playgrounds, may increase safety.

Without such initiatives, efforts to increase unorganized physical activity may meet with little success or could even have unintended consequences, such as exposing children to hazards.

Also, policies to address neighbourhood inequalities in overweight and obesity should focus on young children.

In conclusion, all Canadian children should be able to grow up in neighbourhoods with safe parks and playgrounds and opportunities for physical activity. Addressing childhood obesity will require policies that focus on the neighbourhoods in which Canadian children live. The federal government should take an active role in such initiatives.

When formulating anti-obesity policy, I'd encourage the federal government to ask what this policy will do for children living in low-income neighbourhoods. Effective anti-obesity policy must be relevant to children living in low-income neighbourhoods.

● (1550)

Again, thank you for inviting me here to speak to you about this important issue.

I would also like to thank the Statistics Canada research data centre program, which provided access to the micro-data files of the Statistics Canada NLSCY, which this analysis was based on.

The Chair: Thank you very much for your presentation to the committee. It was well received.

We'll now move to Dr. Tarasuk. The floor is yours.

Dr. Valerie Tarasuk (Professor, Department of Nutritional Sciences, Faculty of Medicine, University of Toronto): Thank you.

I was under the misperception that I was going to be making a PowerPoint presentation today, so what you have in front of you is a handout. It focuses on the relationship between low income and healthy eating. If you would draw your attention to it, I'll use it as I walk through some of the data I want you to be attentive to.

First of all, I would like you to take a look at page 2 of the handout, which is our understanding of the relationship between income and food purchasing. If you take a look at this graph, there are a couple of things I want you to notice.

First of all, as income rises, the purchasing of fruits and vegetables steadily increases. This is data based on household food expenditures from the food expenditures survey conducted by Statistics Canada. As income falls—as we get to the low end of that graph—what you can see are perilous drops in food purchasing, in particular for fruits and vegetables, and also for milk products.

The lines on this graph come from simply dividing food purchases according to the four food groups in Canada's food guide. When we break open those food groups and do a more careful examination of what's being purchased within those categories, what we see are more patterns that raise concern about healthy eating habits and how they are apparently privileged habits for Canadians.

When we break open those categories, what we see amongst the meat and meat alternatives group, for example, is that low-income Canadians are more likely to be purchasing higher-fat meats. As income rises we see the increased purchasing of lean meats. Similarly with milk products, as income rises households are more likely to be purchasing low-fat milk. Breakfast cereals are also more likely to be purchased by people with higher incomes.

So there are very clear income patterns in the nature of food purchasing among Canadian households.

As we translate those food purchasing behaviours into nutrients, we also see clear evidence of a social disadvantage amongst low-income Canadians. As income rises, the amount of nutrients in the food that is being purchased also rises. Amongst low-income households, if we look at what they're purchasing in stores, we see foods that are higher in energy density and lower in nutrient density. I can talk more about those two terms later if you want me to.

So our picture is one of a very clear income pattern in relationship to the kinds of foods that households are able to purchase.

Another window through which we are able to take a look at issues of income and their impact on healthy eating behaviours is through the food security measurements that have been included in recent national surveys. In your handout you have three questions that appeared on the 2000-01 Canadian community health survey, questions asking people how often in the last 12 months they worried about not being able to get enough food because they didn't have money for food; how often did they not eat the quality or variety of foods that they thought they needed because they lacked for money; and worst of all, how often did they not have enough to eat because they lacked for money. When those three questions were put on a national survey a few years ago, 3.7 million Canadians said “yes” to at least one of them.

The pattern of who is responding affirmatively to these questions is very clear. As we look at the adequacy of household incomes, it's very apparent that as income adequacy deteriorates, the likelihood of families reporting food insecurity rises dramatically, so much so that by the time we get to the bottom end of the economic spectrum, almost half of Canadian families are reporting food insecurity problems such as identified in those three very simple questions.

When we go a bit deeper in terms of asking the question of who it is who's saying they were having problems getting enough to eat or lacking the quality of foods that they think they need because they lack money for food, the pattern is even more disturbing. As we look at their sources of income, we can see, as you can see on page 11 of your handout, that the likelihood of somebody reporting problems of food insecurity on these surveys is triple if they are on social assistance. They are almost four times as likely to report often not having enough to eat if their main source of income is social assistance.

Another population group that is at particularly high risk for food insecurity is the one supported by federally run programs like employment insurance.

● (1555)

You'll note also on page 11 that those who appear to be protected from problems of food insecurity in our population are seniors. On that I would applaud you all as a positive statement on social policy, but that's the only positive statement I'll make today.

Before I move on, let's talk more about social assistance. Why is it that people on welfare are so likely to report problems of food inadequacy and food insecurity? It is because welfare rates, while managed at the provincial level, are all substantially lower than our notions of poverty. Across this country repeatedly, when people compare welfare incomes to any measures of expenditures required for meeting basic needs, we find that welfare rates are woefully inadequate. It would appear that the provinces are in a race to the bottom.

Other federal or provincial policies of particular relevance to the problem of food insecurity amongst low-income Canadians are the gutting of funding for social housing; the restructuring of employment insurance; and the national child benefit supplement program, which was a promising program when it was announced as a way to offset the ravages of child poverty in this country, but one that has been clawed back from welfare recipients in most provinces so that it has absolutely no impact on their health or well-being.

Why does this matter in terms of childhood obesity or health? It is because we know that people who are reporting food insecurity have substantially poorer dietary intakes. From examinations of dietary intake data, we also know that in households that are food insecure, there's evidence that mothers will sacrifice their own intakes for the sake of children. In fact, children—and particularly young children—are among the most advantaged in these households, but even there, there are indications of compromises in intake. The definitive analysis on this relationship has yet to come to you, because we are still in the process of examining the most recent Canadian community health survey, where we have nationally representative intake data.

The relationships between food insecurity and health are also cause for concern. Cross-sectional analyses repeatedly demonstrate associations between household food insecurity and poorer mental, physical, and social health and well-being amongst both children and adults. There is some evidence of problems related to body weight, although again we'd caution you that in terms of childhood obesity, those results need to wait until there's more analysis of this current CCHS data set.

I'll leave you with just a couple of comments from some research that we have in the field now in Toronto. We're currently doing a study funded by CIHR, looking at 500 low-income households in twelve high-poverty neighbourhoods in Toronto. We are simply going into low-income neighbourhoods, going up to the doors of market rental and subsidized housing units, and knocking on the door. If someone has a child under the age of 18 and if they have a low income—and we are using a very generous threshold there—we invite them to participate in an interview. We get 66% of them agreeing to that interview, and they provide some insight into the prevalence and the experience of food insecurity amongst low-income families in at least one major urban area.

There are three things I want to highlight from that study. The first is that with our methodology, we find that 65% of families that we are encountering are reporting problems of food insecurity. When we look at the issue of food retail access—which I know is an issue this committee has dabbled in—we can see that the access to food at major discount supermarkets differs between these twelve high-poverty neighbourhoods. There absolutely are differences in the urban core in terms of access to food retail opportunities.

However, when we look at food retail access in relationship to food insecurity, we find no relationship. When we look at it in relation to the purchasing of fruits and vegetables, again there is no association. So while I know food retail access is a major concern in some areas, I would caution you against making too much of that as you think about problems of accessing food for low-income Canadians. From our research, we would argue that this is more of a problem of purchasing power than it is one of food retail access.

We've also taken a look at the impact of community food initiatives, such as food banks, community gardens, community kitchens, and school feeding programs. While we find some participation in those programs by the families we've interviewed, in no case do we see any evidence that participation in those programs is protective. In fact, it looks like it's absolutely irrelevant in some cases.

Lastly, because of the way we've sampled our families, we've looked at the issues of subsidized housing and housing affordability. What is it that seems to determine which families are most likely to report problems of food insecurity in this sample of 500 low-income families in Toronto? Two things: income and housing affordability.

● (1600)

To summarize, then, I have tried to make the case to you as quickly as I can that the inadequacy of household incomes for low-income Canadians is a serious barrier to healthy eating. I believe that barrier in many ways reflects a failure of social policy. The fact that we can find such extraordinarily high rates of food insecurity amongst particular subgroups of our low-income population, defined by simple markers like welfare, speaks strongly to the failure of any semblance of a social safety net to protect those at the bottom end of the economic spectrum from very serious food problems.

The levels of food deprivation that we're documenting, the levels of nutritional compromise that we're documenting, are a real concern. They speak strongly to the need for federal leadership around income support programs, to ensure that people actually have enough money to buy the food they need to feed themselves and their children.

Thank you.

The Chair: Thank you very much. I appreciate that, and I'm sure the committee will have some questions for you.

Now we move on to Dr. Arvi Grover, a cardiologist and director of the International Heart Institute.

Dr. Arvi Grover (Cardiologist and Director, International Heart Institute, KMH Cardiology and Diagnostic Centres): Thank you. Last but not least.

I've been a cardiologist for some time, and I've been speaking about obesity to my colleagues, also for some time. I have submitted to the committee a brief that outlines the issues dealing with childhood obesity, particularly pertaining to the South Asian population, as I've been asked to speak on today.

The Chair: Just for the committee's information, the brief has come to us but it's only in English. We'll get it translated and get it passed around.

Dr. Arvi Grover: Okay, so you do have it, or at least some of it. The important members have it.

Mr. Dave Batters (Palliser, CPC): Mr. Chair, I'd just like to ask people in the room whose mother tongue is French if it's acceptable that the documents are only in English. If the documents were only in French, I wouldn't find it acceptable and we wouldn't be able to continue. I'd like to pose that question to Madame Gagnon and Madame Demers, with respect, to see if they find that acceptable.

The Chair: Just to make it clear, they are not distributed. I have a copy here. The clerk gave it to me, but it's only in English. We'll get it translated for the committee.

Dr. Arvi Grover: It's actually my fault. It was a late submission. I apologize.

● (1605)

Mr. Dave Batters: Not a problem, sir.

But do we have copies of his comments in English right now?

The Chair: No, we can't distribute it until it's in both languages.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Could you be more precise about what you mean. You said that the important members of the committee have it. What do you mean by an important member?

[*English*]

Dr. Arvi Grover: I believe it's important, but—

Voices: Oh, oh!

[*Translation*]

Ms. Christiane Gagnon: Did you mean the chairman?

Some voices: Oh, oh!

[*English*]

The Chair: I'm going to call that comment out of order.

It'll be fine. Just continue with your presentation. We'll follow along without a script.

Dr. Arvi Grover: So I'll put the boxing gloves away.

I will outline for the next few minutes some important issues that everyone should be getting....

Some interesting statistics have come out. Foremost, we already know that South Asians are at an increased risk of cardiovascular disease. Further research has also determined that South Asian children not only have an increased prevalence of childhood obesity, they also have precursors for diabetes known as insulin resistance. I'm going to touch upon some of these issues.

Another interesting statistic that comes to mind is that the earliest age at which atherosclerosis, which is a form of plaque that forms in the blood vessels of the heart, has been shown to manifest is actually between the ages of three to ten. Having said that, put this together with the pandemic we have of obesity starting in children, and we have to try to come up with ideas to address this.

Other interesting statistics have come from the International Obesity Task Force, and they have suggested that by 2010, over half of North American kids will be overweight or obese. Now, when we hear this statistic we always look to our neighbours down below and say, well, it's really a problem of the Americans, their eating habits. In fact, the same group has looked at the prevalence of obesity that is rising in our children in the U.S. and in Canada, and it is rising by 0.5% in the U.S. and by 1% per year in Canada. In fact, between 1981 and 1996, American childhood obesity has doubled, but it tripled in Canada.

We know that overweight and obese kids have nearly an eightfold increased risk of developing high blood pressure and high cholesterol, not to mention diabetes, which goes hand in hand with childhood obesity. Once you develop diabetes, you are considered at a very high risk, increasing your risk of strokes, heart attacks. In fact, children who are obese, adolescents particularly who are obese, over the next twenty years, have a doubling of mortality. They're at a twofold increased risk of dying.

Speaking of the South Asians particularly, there is interesting research that has come out, some through England, some through Canada. I will mention a couple of interesting studies to you. One comes out of Birmingham. They noticed in Birmingham that 12% of Caucasian teenaged girls aged 14 to 16 and 23% of the boys were found to be overweight or obese; however, these proportions increased to 42% and 41% in the South Asian population in the same age group.

I've already mentioned to you that the same age group in children in the South Asian population, for some reason, already have precursors for diabetes, whether or not they're obese. Taken together with the obesity, that raises their mortality and morbidity figures quite significantly.

Other recent studies have suggested that there are not just genetic factors, but there are environmental factors that go hand in hand with children becoming obese. One such factor they have determined—and this was published recently—was that watching more than eight hours of television per week led to the development of obesity in young children. Also, when they looked at the age bracket between two and four years of age, they found other parameters, including parental obesity, that is, kids are now looking at their parents, finding them to be obese. They are accepting that body habitus much more so than if their parents were of standard body habitus.

Another parameter they found was short sleep duration. Less than 10.5 hours per night at age three was linked to the development of obesity later on in the children's lives. Early development of body fatness in preschool years was also related to development of childhood obesity and later consequences.

● (1610)

Certainly, there are genetic factors that play a role. However, the main message that we must maintain should be that it is the environment. It's not enough to say it's a genetic tendency that explains the recent rise in the prevalence of obesity in our population.

You've heard of some nutritional and other socio-economic parameters as to why this could be occurring. But what we need to do, of course, is to adopt a nutritional and healthy lifestyle. If we take Singapore as an example, they developed what's called a trim and fit scheme. It was a comprehensive ten-year program that actually began in 1992 and continues today. It featured teacher education, training, assessment of students, a program that involved reducing sugar in beverages that children consume, and more physical activity during school hours. They re-evaluated the program recently. They found that not only were these kids becoming more fit, but the prevalence of obesity was much less.

Some key points are outlined in the brief you will have. I will end with some tips we have for parents, especially South Asian parents.

One is to respect the child's appetite. Children do not need to finish every bottle or every meal. I don't know if many of you have had the opportunity to eat with a South Asian family, and looking around there's only one South Asian amongst us—shame on you guys—but what you'll find is that due to the cultural tendencies, the parents will make the kids finish their meals. Moreover, they will actually encourage them to take seconds and thirds. It is considered rude to not finish your meal, to leave any scrap on your plate. However, this is not the case in the non-southern areas. Some other Southeast Asians also have similar cultural tendencies.

We also need to tell the parents to avoid pre-prepared and sugared foods. What are these? We're living in an era where everything is at a fast pace. We're all busy professionals, and as a single, busy professional, sometimes I find myself going to the grocery store to purchase these pre-prepared foods, where all I have to do is microwave it or take it out of the can and heat it up. These types of foods are very high in calories, and high in preservatives, which leads to other problems.

Another piece of advice is to limit the amount of high-calorie foods kept in homes. If you ever visit a South Asian home, all you need to do is open up a few of the kitchen cabinets. There is always what's called a junk food cupboard. These junk foods aren't necessarily what we see in the non-South Asian population. They are not necessarily only pretzels. They are deep fried, full of preservatives, packaged foods that actually come from the South Asian countries and are bought locally in our grocery stores, even places like Loblaws.

We need to provide ample fibre in the child's diet. We need to be aware that we cannot reward action by food, by sweets. This is done quite a bit in the South Asian population. To encourage their children to finish their homework, or to encourage them to do something else, they'll give them a piece of something sweet. We also shouldn't offer sweets in exchange for finishing meals.

We should limit the amount of television viewing—and I've already outlined a study that dealt with this—encourage active play, and establish regular family activities, and this particularly applies to the South Asian population.

A recent study suggested that unless we get the parents involved with the education required to help their kids lose weight, to help them participate in the activities required for the kids to lose weight, it isn't going to be as successful.

There are a couple of other behavioural modifications that I want to mention. Recent studies have also suggested—and this was published two weeks ago, I think—self-monitoring, checking weight every day. Before, we used to say there was no need to check our weight every day, that we were becoming too obsessed. But in fact that auto feedback is an excellent tool to help not only the children but their parents realize what impact the interventions they are making are having on their kids.

For the sake of time, I'll end there and leave the rest for the question and answer period.

● (1615)

The Chair: Thank you to all the panellists.

I will now turn it over to the question and answer period, starting with Ms. Dhalla. You have ten minutes.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you very much to all of our panellists. I have a couple of questions, the first to Lisa.

You mentioned in your presentation some interesting statistics from some of the research you have done in terms of the correlation between socio-economic status and the prevalence of kids being overweight and being obese. From the research you did, what types of indicators did you find actually contribute to it? You talked about having a low socio-economic status, and then you went on to also mention mothers who were single.

What barriers do you find in those types of low socio-economic households, with those types of parents, in terms of the dietary factors or advice they are providing to their children?

Ms. Lisa Oliver: They don't have dietary intake data in this study from the national longitudinal survey of children and youth, so unfortunately we can't look at the dietary advice, at those types of things, using this data set.

Ms. Ruby Dhalla: Would you have any indication from your own research?

Ms. Lisa Oliver: I haven't looked at any research on dietary intake yet to comment on what type of dietary advice parents in low-income families are giving their children.

Ms. Ruby Dhalla: On page 11 of your presentation, you speak about a variety of different recommendations in terms of reducing barriers to participation in organized sport. What do you think the number one factor is for these children not to be able to participate in organized sport in some of those lower socio-economic brackets?

Ms. Lisa Oliver: In some low-income neighbourhoods, there may be no programs for children to enrol in. There hasn't been a systematic study, but especially in low-income parts of cities and in rural communities, you may have few opportunities. You may have parents working long hours, not having the time to organize groups to organize these programs, so that could be one problem. Second, with parents working long hours, it could also be transportation or not having extra money to get their children to these sports. This is another barrier aside from being able to pay for these activities.

Ms. Ruby Dhalla: To Valerie or Lisa, we know that the government today—I think just a few hours ago—issued a report on its tax credit promise to encourage children...and lower obesity and overweight demographically within the children's environment. What are your thoughts in terms of the $500 tax credit? From reading it, it adds up to about $76 per family per child. Do you think that type of initiative is going to encourage children across the country and encourage families to participate in organized sport, especially among these lower socio-economic demographics, which have a very high rate of obesity and overweight children?

Ms. Lisa Oliver: I think it will encourage some families to enrol their children in these activities, knowing they'll get a tax credit. If we look across the socio-economic gradient and we think, who is going to benefit the most, if you're living in a neighbourhood with activities to begin with, you might be more likely to enrol your children in these activities because they're there. If there are no activities, you might not even be able to spend this money, or if you don't have the $500 up front to put your children in these activities.... It will definitely increase physical activity, but there could be some situations—if we look at the graph on page 8, if it's being used more in high-income neighbourhoods and less in the low, we could even increase our disparity; we could increase the gradient if it's being used differently among higher-income families and in higher-income neighbourhoods. We could even see a widening.

● (1620)

Ms. Ruby Dhalla: Valerie.

Dr. Valerie Tarasuk: I didn't hear the announcement, but you're saying $500 a year per child or per family?

Ms. Ruby Dhalla: A tax credit, per family.

A voice: Per child.

Ms. Ruby Dhalla: Per child.

Dr. Valerie Tarasuk: Per child, and the question is what impact would that have on low-income families?

Ms. Ruby Dhalla: Just before you answer, the reason I touched on that question is that throughout your presentation you talked about how our social policy has not provided economic security for families, and at the end of the day, this has resulted in an increase in obesity. This committee is looking at different recommendations to address the issue of childhood obesity. We as a committee need to hear the right solution or recommendation. The Conservatives have put forward the tax credit. Is that a step in the right direction?

Dr. Valerie Tarasuk: In the face of abject poverty, any money is welcome, but what is sorely lacking from so many policy initiatives that happen as tax credits is any intelligent analysis of how much money is needed. When you look at the comparisons between people's incomes and their actual living costs, what we desperately need are programs that fill those gaps. The arbitrary dropping of amounts of money that are computed through some other calculation that isn't targeted toward the needs of those groups...all money is helpful for someone who doesn't have any or has very little, but the idea that we could see a measurable effect of something that's small...those things invariably end up looking like drops in the bucket. There needs to be a point when the pendulum swings and we start to see tax credits or redistribution schemes, when the dollar amounts are calculated based on some evidence of need. In that case, we'd probably figure out that somebody needed way more than $500 a month. Certainly the people we study do. Others probably don't need any money, and if they got an extra $500, the most we could expect is what Lisa suggested, maybe some exacerbation of inequities.

The Chair: Thank you very much.

Madame Gagnon.

Just a second. There are a couple of minutes left, and I thought she was done. We'll have Mr. Temelkovski.

Mr. Lui Temelkovski (Oak Ridges—Markham, Lib.): First and foremost, thank you to all of you for your presentations.

Dr. Grover, you mentioned that this is very important and may be distinctly different from one community group to another. You mentioned Southeast Asians. Is there data that shows the difference among groups within Canada?

Dr. Arvi Grover: The data I was speaking of had to do with two parameters, two variables. One was the prevalence of obesity and the second was the prevalence of hyperinsulinemia. That is the pre-diabetic state I was alluding to. Those are the two parameters that have really stood out.

Most of the data I mentioned came out of Britain. They haven't looked at this enough within the Canadian population for me to have accumulated any data on it. We—including me—have looked at it in the adult population, and we know from this that there are certain parameters we need to also follow in children. But it hasn't been prospectively studied in Canada.

Mr. Lui Temelkovski: Would you say, following that logic then, that we will need an educational program that would specifically target different groups?

Dr. Arvi Grover: I think the educational program not only needs to target different groups; it needs to target different tiers within each group. By that I mean we need to first educate ourselves on the need to become aware that this is an epidemic, a disease state.

You must understand that for the longest of times, everyone, including the medical community, looked at obesity as a cosmetic state, as a physical thing—we're out of shape; it doesn't necessarily indicate that we're going to die. We now know that, independently, it is associated with sudden cardiac death. This information is relatively recent and has only become disseminated into the medical community. It has not had the same impact in the community just yet. So we need to educate not just different communities in a different way, but within the community we need to educate the physicians. We need to educate the teachers, the urban developers, the planners so that they can plan more playgrounds and more parks.

All of this is a multi-tiered answer to what you're really asking for, but in general, yes, we need to be specific and sensitive to each community. For example, people in the Japanese community eat a lot more fish. We know that consumption of omega-3, for example—and the American Heart Association and the ACC have also documented this—is associated with fewer events. They may not be as likely to have cardiovascular deaths as, say, those individuals who don't consume such products.

So there are certain unique needs among the communities, yes.

● (1625)

Mr. Lui Temelkovski: Maybe I could ask—

The Chair: No. Thank you very much.

Madame Gagnon, you have five minutes.

[*Translation*]

Ms. Christiane Gagnon: Good afternoon. Thank you for being with us today.

You made interesting presentations today and spoke about several factors that can have an impact on obesity.

I would like to address my question to you, Ms. Tarasuk, because you are among those who see a correlation between socioeconomic factors and obesity. You mentioned that people need helped so they can have a higher income.

As parliamentarians, what measures could we recommend to the government? Are you in favour of more concrete measures, for example giving money to parents who could then decide where to spend it, whether on sports or on buying better quality food? How could we be more proactive in reducing the incidence of obesity?

[*English*]

Dr. Valerie Tarasuk: If I understand your question correctly, you're asking about the idea of allocating money directly to families, as opposed to programs where you're effectively pulling children out of the family and enriching their environment elsewhere.

I think it's very, very important that we target families, not individuals within families. We have a lot of programs now that are isolating a member of the household. The Canada prenatal nutrition program is a prime example of that. We also have other kinds of programs, such as CAPC, where we're identifying vulnerable groups but then enriching the life of one member of the household—the child, a pregnant woman, an infant up to the age of six months or something like that. I think those programs have very little potential to ameliorate the problems of poverty within the family as a whole and therefore with the individual who is being targeted. So I think it's very important that money go to the families.

One thing we've noticed in our research in Toronto, which is very worrisome, is that when a family is struggling to put food on the table, that's only one of a multitude of problems they're facing. Sure we find people in severe situations using food banks, and we also find the odd person whose children are attending some kind of school feeding program, but at the same time, those people are delaying payments of bills and they're having utilities or services, like telephones, turned off. There are other kinds of compromises happening within the household.

When you give money to the family to take them to a higher level of living, our analysis tells us that everything rises. We can expect to see more participation in physical activities. We can expect less stress in that household, so a more nurturing environment for those children. We can also expect to see better food on the table.

But for us on the outside to try to micromanage that circumstance by saying put the money towards foods or physical activity is very inefficient compared to what we can do if we say that we're going to provide enough income to meet their basic needs and then we'll provide supports to help with other issues in their household.

[*Translation*]

Ms. Christiane Gagnon: House prices have been skyrocketing and owners have been increasing rents.

Could a social housing construction program have a positive impact on people's quality of life by leaving them more money to buy food?

[*English*]

Dr. Valerie Tarasuk: I couldn't agree more. However, I should flag something for you. We have work that's now under review for publication and the work we're doing with families in Toronto. Both of those pieces of work, one looking at the survey of household spending and the other working directly with low-income families, raise serious questions about our notion of affordable housing.

There is no question that the amount people spend on housing has a direct impact on what's left for food. As income deteriorates, that has a major implication. Conventionally, in Canada, as in many western countries, we've defined affordable housing as 30% of income going to housing. For people who are living in subsidized housing, it is structured in such a way that they are paying 30% of their income for housing. If their income is very low, 30% is too much. If those families are also on welfare, that's why we find high levels of food insecurity among families living in subsidized housing.

While subsidized housing is an incredibly important way to mitigate the ravages of low income, to enable low-income families to achieve basic nutrition needs, it is important that we do the math. We need to take a look at exactly how much money is left for food and whether that is enough. In some cases, incomes have fallen to such a point that 30% of income for housing is too much to enable people to still put food on the table.

● (1630)

The Chair: Thank you very much.

Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chair. Thank you very much to the witnesses for their very interesting presentations.

In particular, I found the recommendation on crime and the ability to feel safe in one's neighbourhood, which I think was in Dr. Oliver's presentation about neighbourhoods, or maybe it was one of the other gentlemen's, an interesting one. I believe that's on page 12 of your slides, and certainly there's a feeling that over the last decade or so that neighbourhoods are becoming less and less safe.

I think it's a good reminder for our friends over in Justice that perhaps some of the work they're doing in conditional sentencing, or trying to take that away, or raising the age of consent and ensuring that sexual predators don't enter our country, such as has happened in the situation that we find ourselves in, in Ontario.... But my question goes to things about.... You said subsidized transportation, and we do have a tax credit going toward transportation, mass transportation, that was also part of our platform commitments. I would be interested in the comments of the panel on that.

Also, there is a bill in front of the House right now, Bill C-283, that deals with the labelling of food products, asking companies and producers to show what is in the foods. There is some question about the practicality of that bill and if it would actually have an impact. I wonder if some members of the panel could comment on Bill C-283.

I found the comment about Singapore interesting. Singapore has a unique reputation. I think I wouldn't want to be caught chewing gum there.

However, I wonder if a comment could be made about how we could in Canada do things that are tangible. I think we're all sold on the need to deal with childhood obesity, but what, tangibly, can the federal government or provincial governments do that will make an impact on the lives of children, that will improve their health outcomes?

I'll throw those out on the table and look for your replies.

Ms. Lisa Oliver: Sure. The first question was about neighbourhood safety.

● (1635)

Mr. Steven Fletcher: Yes.

Ms. Lisa Oliver: I was very surprised when I looked at my data and saw such extreme differences among parents, in that around 27% in the low SES neighbourhoods report that there is a lack of safe parks and playgrounds in their neighbourhoods, compared to 9% in the high.

I think if you do want to encourage children to be active in their neighbourhoods, something needs to be done to address the issue of neighbourhood safety, so parents feel confident that their children will be safe outside. There are real hazards for children being outside, such as high-traffic neighbourhoods where children can be hit by cars. So there are real physical dangers to children's health in many neighbourhoods.

There is also the idea of a fear of crime, and crime in parks especially I think for many parents. One policy that could be implemented at the municipal level is to have supervised park hours, so maybe two hours after school there would be a parent or an employee of a community centre there watching, so that parents feel safer having their children in this environment for a couple of hours after school so they can run around and do activities.

I think we need to address the issue of safety and the neighbourhoods in which children are living to encourage physical activity.

I think transportation is one barrier, especially among children, to get to physical activity programs. A recent paper just published using the same data set that I used, the national longitudinal survey of children and youth, found that children where both parents are working full-time have higher rates of obesity and I believe less participation in sports. It is thought that with the parents both working so many hours, they cannot transport children to school. Funding, for example, for municipalities to hire a school bus and drop children off at their homes and pick them up might be one way to support families in having their children be active.

Mr. Steven Fletcher: Would—

The Chair: Your time is gone, but I don't know if there's anyone else....

Are there are any other panellists who want to answer? I'll allow that, but no more questions.

Dr. Arvi Grover: I wouldn't mind answering on the labelling issue. The labelling issue is actually a form of behaviour modification.

The Chair: Go ahead then, very quickly.

Dr. Arvi Grover: I think it is practical. In the different communities I've seen, both South Asian and other communities, where they have begun labelling them from the source, it has made the consumer aware of the exact caloric intake. The consumers and the public in general need to be aware that a certain number of calories equals a certain weight. For example, 3,500 calories is roughly equal to about one pound. That is a gauge system. It is an auto-feedback system, and it is a form of behaviour modification. I strongly agree with that.

The Chair: Thank you.

Mr. Martin, you have five minutes.

Mr. Pat Martin (Winnipeg Centre, NDP): Thank you, Mr. Chair.

Thank you to all the witnesses.

I represent a very low-income riding. It is actually the poorest, statistically, in Canada, where 47% of all the families and 52% of all the children live below the poverty line, so I'm heartened in a way to hear that there seems to be a growing consensus about the association between low income and this health condition that you called an epidemic or a pandemic, Doctor.

I'm really concerned. Largely the face of poverty in my riding is aboriginal. It's North American Indian, off-reserve people who are leaving the desperation of the reserves and trying to find a better life in the inner city of Winnipeg. The conditions that you're talking about are just rampantly apparent in that population. There are more and more people in wheelchairs because of amputations due to diabetes, due to the health conditions, due to diet.

We're looking for concrete recommendations to put into a report. The first thing I'd ask you about is this. We worked very hard in the last Parliament to get a ban on trans fats. We worked with Dr. Yves Morin, a senator, and Dr. Wilbert Keon, also a senator—both known cardiologists—and we got it through Parliament. Parliament did vote not just to label trans fats, but to ban them. Then we struck a task force; it spent eighteen months and finally came back with a recommendation: ban them. Don't just label them—ban them.

But I can't get any witness, when I've been here at this committee—doctors, professors, PhD students—to say as a directive to this committee that our report should ban trans fats or that the report should say to implement the recommendations of the task force to ban trans fats. Can you please help me get it on the record to ban trans fats?

A voice: That wasn't very subtle.

Mr. Pat Martin: I've tried subtle. It didn't work with any other witnesses.

The Chair: Is anyone going to help him out?

Dr. Valerie Tarasuk: You bet. I don't know that there's a relationship between trans fats and childhood obesity, but I know enough about trans fats to be completely supportive of your recommendation to ban them, and I know enough about nutrition labelling to know that labelling foods “trans fat-free” does not remove trans fats from the diets, particularly of low-income people. So if you want a health measure that is actually experienced across the board, rather than a measure that simply exacerbates health inequities, then banning is the right thing to do.

However, if you get to the point at which this government agrees to ban trans fats and actually takes action, it's really important to make sure there are measures in place so that the prices of foods do not rise as a result of particular sectors of the food industry having to incorporate new production methods. For example, we've done a lot of work in my group on the prices of margarines, and right now we know that the cheapest margarines you can buy are the margarines that are laden with trans fats. We know that the people in our study are most likely to buy those cheap margarines. If this ban ever comes into existence, it will be really important that the price of margarine not triple.

● (1640)

Mr. Pat Martin: That's a good point. Thank you.

The Chair: Does anyone else care to comment on the trans fats side of things?

Dr. Arvi Grover: I would love for it to be banned. Just practically, realistically speaking, all the crackers and junk food make up probably about 20% or 25% of most grocery stores, and their income is dependent on that. I agree with the previous comments that once you remove such a large income source, they are going to want some form of retribution.

Mr. Pat Martin: You'd still have cookies, but they wouldn't be made with partially hydrogenated vegetable oils.

Dr. Arvi Grover: Yes, it's easy to put in theory....

The Chair: I would like to say to the committee that we will have the Canola Council coming. I believe the Canola Council has a solution for where we're headed on this. I think we'll have a more extensive debate on trans fats and some of the solutions—like our Canadian invention, which I applaud.

Mr. Batters.

Mr. Dave Batters: Ms. Dhalla talked earlier about the child fitness tax credit. I'd like to ask your reaction to the government's universal child care benefit. This is the $1,200 per year given to parents for each child under the age of six. This benefit is taxable in the hands of the lower-income spouse, which for low-income Canadians means it's a tax-free amount of money—$100 a month for each child under the age of six. We've established that there is a clear link between the level of income and the quality of a Canadian's diet. I think the links are clear, and you've presented good evidence to back that up.

Nutrition and nutritious food have to be considered an important part of child care. If someone takes their child to a neighbourhood day care provider, nutritious food is vital as part of that child care. This benefit is going to help all families in Canada.

We on this side of the table believe strongly—and I think all members of Parliament would agree—in an effective social net for those who need help in this country. That's critical. There will always be a scarcity of resources. When I ask for your comments in thirty seconds, I suspect that part of the answer will be that there needs to be more. We will always say there needs to be more. But I'd like your reaction to the universal child care benefit. It provides direct money to parents, which will improve their income and thus their diet.

We know that increased income equals an increased quality of diet equals a reduction in patients with type 2 diabetes, heart disease, and, frankly, bypass and angioplasty business for Dr. Grover and his colleagues.

That's my question to all three of you. Will the universal child care benefit help in this equation? It's true that there's always a scarcity of resources, and there could always be more. But will that amount of money help combat what we're talking about here today, which is better health outcomes for Canadians?

● (1645)

Dr. Valerie Tarasuk: You've structured the question to get us to say yes. Of course, if you give poor people more money, they'll have more money than they had before you gave them some. You're talking about $1,200, and that means $100 a month. I'm talking about deficits that amount to several hundred dollars a month. You're asking if the child care benefit will help their diets. Honestly, I wouldn't want to try to evaluate the impact of such a trivial increase in their income on their dietary intake. It would be impalpable.

The levels of deprivation we're talking about are substantial. These tax credits you're describing are politically attractive, because they're across the board. But honestly, if you want to address these problems, you've got to do the math and figure out how much money people really need to put food on the table. An arbitrary amount that's calculated through some gross population-level thinking doesn't necessarily net the kinds of impacts we need. We're describing serious problems. You're saying resources are always scarce. I want to tell you to show us some leadership. We have a serious problem, and all our data show that the problem is getting worse.

Mr. Dave Batters: Sure, but in my province of Saskatchewan, this government has now delivered, in terms of child care, four times the money the Liberal government had delivered in terms of their child care plan. That's leadership. As I prefaced in my question, granted, as you're going to tell me, we can always be doing more, no question, but this is real money that's going to help in this equation.

I wonder if the other two panellists would like to comment.

The Chair: Mr. Batters, your time is gone, but I'll allow a quick answer.

Ms. Lisa Oliver: The tax credit could help with diet, but the point of the credit is to take care of children, not to provide food for families. A low-income family might take this $1,200 and use it to buy food, but still the child care has not been addressed.

I don't think the money should be used for food. It should be used for child care.

The Chair: We'll move on to the next questioner.

Madame Neville.

Hon. Anita Neville (Winnipeg South Centre, Lib.): Thank you very much.

Thank you for your presentation. I'm not usually a member of this committee, but I'm very pleased to be here today.

I wasn't going to take this line of questioning, but I really want to know from you what steps you think the federal government can take. I want to put it in the context of the two policy initiatives that have been referred to already.

We've just heard about the supplement to families for child care, which is really, in my mind, a family allowance. Yesterday I happened to be part of a presentation that indicated that it was the single-parent family who received the least amount if they were...for comparable families earning $50,000. The least benefit of all applied to two-earner families between $30,000 and $40,000.

So even for child care, or for however everyone chooses to use that $100 a month, it is those you're referring to who have advantage from it. There's also the fact that the child tax supplement of $249 has been removed.

Earlier we heard about the tax credit for sports. Very recently I was approached by a community club in my own community of Winnipeg, where, I've been advised, what's actually happening with the tax credit—they're gathering some information for me—is that those who have are registering for sports, and those who don't have, who were once subsidized, are not now coming forward for sports registration. To my mind, this all has a negative impact on low-income families.

I found your presentations very interesting. Do you have any constructive suggestions in terms of low-income families? Obviously there's increasing employment insurance and increasing the social safety net, but what within the federal jurisdiction would you advise this committee to recommend to government?

● (1650)

Ms. Lisa Oliver: In terms of my research that looks at neighbourhoods and obesity, it can be difficult, maybe, for the federal government to implement something at the federal level to influence all neighbourhoods in Canada. Different neighbourhoods have different needs, so there may not be a one-size-fits-all policy for all places. All neighbourhoods may not have the same issue with crime.

So different places have different factors from place to place. But I would like to see the federal government take initiative on this issue and perhaps engage in a dialogue with the municipalities about what factors in neighbourhoods are influencing their communities. So there should be a dialogue with provinces and municipalities to address this issue.

Hon. Anita Neville: Okay. Thank you, Professor.

Professor Tarasuk, can you comment?

Dr. Valerie Tarasuk: I think there is no way out of it. If you want to make an impact on the extraordinary health disadvantage that is faced by low-income families, you have to tackle the adequacy of their incomes. I think other kinds of programs—tax credits that are targeted or labelled, targeted interventions—are simply a waste of taxpayers' dollars. We need to be targeting the problem, and the problem is inadequate income.

Those people can be identified easily. Every time there's another national survey, we find the same thing. It's not hard to pick these people out of the pot.

There are ways for the federal government to have an impact on family-level income through income redistribution. The national child tax supplement was an attempt at that. It didn't work, because the federal government enabled provinces to claw back that money, but—

Hon. Anita Neville: Not all of them did.

Dr. Valerie Tarasuk: Not all of them opted to do it, but everybody had the opportunity, and sadly, many took it, so it didn't have the impact on welfare recipients that we would have liked to have seen.

I think that has to be the route, to get more money into the pockets of low-income families. Honestly, I think other attempts at pigeonholing and targeting are really very inefficient. They're much cheaper, obviously, but they have way less impact on the problem.

Hon. Anita Neville: Thank you.

The Chair: Thank you very much.

We'll go to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Mr. Chairman.

I'd like to thank each of the witnesses today. I certainly have enjoyed their presentations.

In this committee, through the past few weeks, we've heard a lot of different areas being addressed. Certainly today's area is focused on low income and the inability of low-income families to purchase what we're going to call good food, or nutritious food, or non-fattening food, and so on. I think that's a huge issue. We all recognize that.

Valerie, you talked about—I think this was in your report—your preliminary results and the 65% who reported food insecurity in the past twelve months. I think you said that you used a fairly generous income threshold. What threshold did you use, do you know?

Dr. Valerie Tarasuk: Yes. The income variable that has been appearing in recent years in Statistics Canada publications is something called household income adequacy, and there are five levels to that. If you look at some of the other graphs in my presentation, you'll see that we've used that variable to talk about purchasing power or the likelihood of food insecurity.

Mrs. Patricia Davidson: Right, but do you have a dollar figure for that?

Dr. Valerie Tarasuk: It varies depending on the household size. That's one of the good things about that measure. So we have taken the third level of the five-level variable. The majority of Canadians are sitting with incomes at levels four and five. We went as high as number three so we could include the working poor in our study, and in fact we did.

Mrs. Patricia Davidson: Okay, that's good.

I have a further question for you, then.

So you didn't use the top or the bottom; you used the middle, basically.

Dr. Valerie Tarasuk: Yes.

Mrs. Patricia Davidson: Okay.

We know that social assistance rates are set by the province. It's a provincial responsibility; it isn't a federal responsibility. But we've talked a lot about it here today. Do you know what the different thresholds are across this country? I think they are different. I don't think they're the same in all provinces.

Dr. Valerie Tarasuk: Yes, that's true.

Mrs. Patricia Davidson: Is that an area that we need to have discussions with the provinces about? I think you've indicated in some of your responses that we need to tackle this threshold. So how do we do that when it's not our responsibility?

● (1655)

Dr. Valerie Tarasuk: Well, it used to be a federal responsibility and you gave it away.

Mrs. Patricia Davidson: Well, that might be, but that doesn't help.

Dr. Valerie Tarasuk: Okay, but it's gone now. I get that part.

A voice: Did you give it away?

Mrs. Patricia Davidson: No, I didn't, but somebody might have.

So do you have any suggestions, and can you tell me what the different thresholds are across the country?

Dr. Valerie Tarasuk: One of the difficulties in doing research in this area is that the numbers differ. If you take Ontario, as an example—that's where I live, so I know their welfare program best—there are two kinds of welfare programs. There is something called Ontario Works, and then there's something called the Ontario disability support program. So there are two tiers of welfare, differentiated by notions of the ability of the recipient to join the labour force.

People receiving these higher levels of welfare payments are presumed, through some medical diagnosis, to be unable to join the labour force in the same way that those in the lower levels perhaps could. So there are differentials. They're all over the map. It varies depending on the household type and size.

Mrs. Patricia Davidson: But there is a basic amount in Ontario.

Dr. Valerie Tarasuk: But your question is what these thresholds are. They vary across provinces.

I love your idea that federal members would sit down with your provincial colleagues to start to talk about how to repair this mess. While the levels vary by province, nutritionists do these calculations and look at the cost of a nutritious food basket locally and contrast that to the welfare rates and ask whether people can afford to buy that basket. What we see is that it doesn't matter whether that nutritionist is sitting in Alberta, or whether she's sitting in Peterborough, or whether she's in St. John's. The answer is the same: no, they can't. And they're out by hundreds of dollars.

So while the numbers vary, so do the costs of living in these jurisdictions.

Mrs. Patricia Davidson: Do the differences in thresholds in the different provinces show any correlation with the differences in the numbers of childhood obesity cases in those provinces?

Dr. Valerie Tarasuk: I don't know. We've tried to look at the differences in the thresholds and the relationship to food security rates. We can see some patterning, but we haven't got it mapped out yet. Part of the problem is that even when we do those calculations, we're getting different levels of welfare in different parts of the province. And we're trying to factor in housing costs, because we know that a difference in housing costs between areas has a huge impact on the usefulness of that welfare rate in relationship to food. So it's a very complex system.

From everything else that we've done, in my heart I believe that yes, we must be able to eventually see an effect where higher welfare rates in the context of affordable housing will give us less food insecurity and therefore less childhood obesity and fewer other kinds of health problems that are associated with abject poverty and unhealthy eating habits. But methodologically, this is a very hard thing to get our hands around.

The Chair: Thank you very much.

Madam Demers, go ahead, please.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): I have two questions, one for Dr. Grover and another for Ms. Tarasuk.

Dr. Grover, I really liked your presentation. I think that what you said about young people from Southeast Asia who from a very young age tend to be more likely to have serious illnesses later in life is very important. I know that in some Southeast Asian countries, I would probably win beauty contests because obesity is considered a very important criterion. If you are rich, you are obese, and the fatter you are, the richer you are.

I don't know how you could address this problem. I believe that education must begin very early in life at every level.

The Internet site for the hospital where you work mentioned that last year, 92,000 cups of coffee, 42,000 pounds of french fries and approximately 10,000 pounds of hamburger were served, all of which are foods that cause the diseases you treat. Doctors, hospitals and dieticians need to be the first to be informed and to ensure that proper diets are served.

Ms. Tarasuk, I listened carefully to what you said, because it is important. You are right to see a correlation between poverty, child obesity, inactivity, etc. However, we are speaking here not only of obesity, but also about *Canada's Food Guide*, which is about to be published.

In this guide, Health Canada does not factor in the 25% of calories we eat that come from foods other than those described in *Canada's Food Guide*. These are things like ketchup and condiments, wine and sugary food, including candies and other similar items. Health Canada tells us that it is not important and that if we do not mention these foods, people will not eat them.

Do you think that this is wishful thinking? Is Health Canada correct in not including these items, which represent 25% of all calories, on grounds that if they are not mentioned, people will not eat them?

● (1700)

[*English*]

Dr. Arvi Grover: Thank you, and I'm flattered that you did research on my hospital. However, before you point fingers at my hospital, you should point fingers at the cookies you guys are serving.

Voices: Oh, oh!

Dr. Arvi Grover: Actually, on a number of occasions I have met with our hospital CEO and the nutrition department in dealing with this very issue. To be quite honest, the answer I kept getting back was money. They feel this is what most people want. They want French fries and burgers; they want the high-caloric, high-fat meals that will fill their bellies. However, they have started a change because I've threatened them on several occasions, and a lot of the threatening had to do with educating them. We have to educate ourselves.

To answer the other question you were asking, how can we institute some change within the various communities, it is a multi-tiered approach, and we have to educate the masses. We have to get into their community places of worship perhaps and do some form of educational sessions or seminars that at one sitting will provide them with education, not just for the parents but for the children, so that they can have some semblance of an idea as to what disease state we're speaking of.

Again, as you said, for most people it is the shape of affluence. The bigger you are, the more affluent you are. In Africa and in some parts of Asia, this is what is felt, but we have to change this. Even in the South Asian communities, it has changed. If you go to India, Bangladesh, or some of the other countries, they have already adopted that change. They've already started to exercise; most of the children have become more fit.

However, the immigrants who came from those countries have held onto their values from whenever they came, and they maintain that this is the way they're going to live.

So we have to do a lot of groundbreaking to help change these habits.

[*Translation*]

Ms. Nicole Demers: Thank you.

[*English*]

The Chair: The time is gone, but I'll allow a very quick answer, if you like.

Dr. Valerie Tarasuk: Very quickly, in response to your question about Canada's food guide, it is important to recognize that this thing is not a prescription. It's not the same as if you went to a dietician and were given a diet that was a menu plan. All it's doing is mapping a pattern of eating that to the best of our knowledge would meet with nutrient requirements, so that it would ensure nutrient adequacy.

As for that other foods category, should there be more direction there? Probably there should be. But what we know from the very careful modelling work that was done with the people in Health Canada to generate those other numbers—the number of servings for fruits and vegetables, for milk products, and those kinds of things—is that this is a very rational model. If people were to follow it, it would certainly achieve the nutrient levels we want.

Whether there should be some caveats in terms of the other foods category is debatable. Remember, it is not a prescription. Probably if we want to make those kinds of caveats, a more important place to do that is on the label.

The Chair: Thank you very much.

Mr. Lunney, you have five minutes.

Mr. James Lunney (Nanaimo—Alberni, CPC): Great. Thank you very much.

Thanks to the witnesses.

That was a very nasty but astute observation, Dr. Grover, about the trans fat cookies, which have snuck into the room here. But I give you kudos for picking up on that. We sometimes hope the witnesses won't notice those.

I want to take it another way here.

Human Resources and Social Development Canada has undertaken and examined, among other socio-economic factors, the issue of food insecurity and the growing number of families that require emergency food aid:

> Health experts have noted than an alarming number of obese children are also malnourished. The phenomenon is being reported amongst the poor where diet is dominated by "empty calorie" snack foods and sodas, which are both inexpensive and filling. Despite consuming significantly more calories per day than recommended, these children are not obtaining much-needed nutrition from their food.

If you agree with this observation, please address the phenomenon of the malnourished, obese child.

I'll address this question first to Dr. Grover. Might we liken this to a pregnant woman who has a growing child within her, with great demands on her to supply for that child, and the cravings she is experiencing may in fact be the appestat looking for nutrients that are missing in her diet?

● (1705)

Dr. Arvi Grover: Valerie addressed this in her—

Mr. James Lunney: Can I finish my question? I'm almost there.

Would you see value in providing simple multiple vitamin and mineral supplements for low-income families to help them overcome some of the deficiencies?

Dr. Arvi Grover: While what you're saying does make sense, and I think supplementation is important, I don't think it replaces the proper meal and the proper intake. It would be giving them the wrong idea, that it may be okay to eat the junk food and then simply take the supplements.

The same thing happens in the medical field. For example, when I give an individual anti-obesity medication—there are a couple of pills out there—what tends to happen is they go back to eating their own junk food, they start eating their pastries and cake, because now I've given them the magic cure. I fear this may occur if what we do and how we educate the lower socio-economic groups is telling them to eat what they want, eat the junk, eat the empty calories, and then take the vitamins.

Mr. James Lunney: I'm not saying instead of the other advice, but we're all recognizing the challenges of getting good nutrition into low socio-economic people. My question actually is a serious one, in spite of the laughter from others at the table. It's a serious question.

Might this not help get some nutrients into people who have serious deficits and whose appestat is requiring them to eat a whole lot of empty calories? It may in fact improve their clinical outlook.

Dr. Arvi Grover: In fact, supplementation is indicated, and the guidelines do support their use in a variety of groups. Whether they are suffering from malnutrition, whether they are obese, or whether they are actually healthy, they still require some form of supplementation. Pregnant women require supplementation of folic acid, for example, or some iron.

I do agree that this is required, but the majority of what I think... and what Valerie was also getting at was that as our understanding and as our socio-economic status is increasing, we tend to buy better types of food. We tend to buy foods that are more nutritious. I think that is really where we should focus, to be quite honest.

Dr. Valerie Tarasuk: I have nothing to add to the comments by Dr. Grover.

Mr. James Lunney: Finance Canada has asked the committee to evaluate taxation of unhealthy foods. Let's call it a fat tax, a snack tax, or a junk food tax. Is that an approach that you think might be helpful?

Dr. Valerie Tarasuk: I have read some of the earlier submissions to the committee, so I see that the idea of a fat tax or something like that has been bandied about in this group. I think the price tag of food is only one part of the packaging, and before you go down that path you should explore the other aspects of the package.

Certainly, from a low-income perspective, anything that makes food more expensive is a bad idea, if it's food those people need. From that perspective, I think there's no question—and I know others have spoken to you on this point—that to make the foods that low-income people purchase more expensive is only to exacerbate their food insecurity.

At a broader, population-wide level, the question about whether a fat tax would have an impact on diet...I would strongly urge you, before you go any further on that, to take cigarettes as the model—which clearly it is for this discussion of a negative tax—and remember that long before we started raising the price of cigarettes, we had warning labels on them. We don't have anything like that on food. You can buy cookies and crackers that advertise themselves as being trans free. You can get twizzlers that are fat free, as always. So there are a lot of mixed messages now with the current food labels. Way before you start to tinker with the price tag, I think a lot could be done with the rest of food packaging to start to send messages around what foods might be conducive to a healthy body weight and which ones really aren't.

The Chair: We've had one round of questioning. Mr. Martin has asked for a quick one-minute question, and then I remind the committee that we have three motions to deal with before the end of our committee meeting.

● (1710)

Mr. Pat Martin: Thank you, Chair.

I only wanted to get it specifically from you folks. We're looking for concrete recommendations to put into the report. One of the things that has been brought to our attention is that in British Columbia, P.E.I. and Norway, they have a free fruit and vegetable program in their schools.

They were pilot projects in B.C., P.E.I., and I think in some of the northern regions of Ontario. Jamie Oliver in the U.K. is a champion for trying to get healthier food in the schools.

Would you make that a recommendation to this committee, that this is one direction we should take?

Dr. Arvi Grover: When you say free fruits and vegetables, does that mean that we've already eliminated from all of the schools all of the candy and pop machines?

The problem is, when you're given a choice, it's like saying this is good for you, take it. You tend to grab things that you desire more, and if the option is still available to these children, by having those machines readily available, they will opt for them, even though the fruits and vegetables are free.

Having said that, of course, it is mainly in the higher socio-economic groups. Those, perhaps, in the lower socio-economic group may be more apt to and, finally, be eating the right types.... I think that's still a good idea, but I think it has to go hand in hand—

Mr. Pat Martin: Get the junk food machines out first.

Dr. Arvi Grover: Exactly. Yes.

The Chair: I can actually add a little bit to that, because we tried that out on this committee. We tried to get rid of the cookies. There was a revolt, if the committee remembers. We had to add more than just fruit and vegetables; we had to add the cookies back.

Dr. Arvi Grover: So you guys are worse than kids, then.

The Chair: Worse than kids, and it's a high socio-economic—

Mr. James Lunney: On a point of order, let the record show that there are also fruit and vegetable sticks over there.

The Chair: Yes, but I've noticed the choices, and the cookies may be winning.

But the point is well taken. I guess it does speak to human nature, and all of us have our vices.

I want to thank the panel for coming. Your testimony has been well received and very valuable to the committee. Please accept our thanks for that, and we'll reserve the right to perhaps question you further on some things if we need to in the development of our report.

Thank you very much.

We'll have a very quick pause and then we will get into the motions.

● _____ (Pause) _____

●

● (1715)

The Chair: I'll ask the members to take their seats, and we'll get on with the motions that are before the committee.

There are two motions before the committee. Actually, we have three motions, but two of them are very similar. I know some in the committee said they'd have to slip away a little bit early, so we'll take the two that are similar—that's Ms. Dhalla's and Ms. Gagnon's. I don't know if they've worked out between the two of them if they want to introduce them individually, but let's take the first one.

Ms. Dhalla, if you want to introduce it, we'll go from there.

Ms. Ruby Dhalla: I guess everyone has had a chance to read the motion. Just very quickly, because I know some people have to leave, it transpired from the fact that we heard contradictory stories from Health Canada and from witnesses.

I don't know if my colleagues have also received an e-mail that I believe was sent by Dr. Freedhoff, but it stated that Mary Bush from Health Canada had stated that Dr. Arya Sharma had provided some advice in terms of the food guide and had made a few points in regard to the guidance on calories. Dr. Sharma says that he did not provide that advice to Mary.

So in terms of ensuring that the food guide is reflective of the needs of Canadians and in terms of the topic our committee is studying, I have issued a motion to ask for the following: a draft copy of Canada's food guide, prior to it being released; a list of the stakeholders and organizations that were consulted and the respective suggestions they put forward; and a list of the questions that were put forward for these consultations.

The Chair: Okay, we have a motion on the floor.

Mr. Fletcher.

Mr. Steven Fletcher: Does Ms. Davidson want to go first?

The Chair: Ms. Davidson.

Mrs. Patricia Davidson: I just wanted a point of clarification on what Ms. Dhalla was saying. I didn't catch everything.

I'm sorry, I missed what you were saying in the preamble to your motion.

Ms. Ruby Dhalla: I thought the mike was on. I had just basically—

Mrs. Patricia Davidson: It was, but I guess I wasn't paying enough—

The Chair: Was this an e-mail that was sent directly to...?

Ms. Ruby Dhalla: I believe it was sent to...this is one of the issues of how this motion came to fruition.

The Chair: No, but just a technical—

Ms. Ruby Dhalla: In terms of this particular e-mail?

The Chair: Was it sent to the committee, sent out by the committee, or was it sent—

Ms. Ruby Dhalla: No, it was sent to the committee, I believe. Did other people receive it?

The Clerk of the Committee (Mrs. Carmen DePape): It was sent out to members directly by Dr. Freedhoff. I'm having it translated, and as soon as I get it I will send it out to everyone.

The Chair: So we don't all have it, is what you're saying.

Ms. Ruby Dhalla: It was a contradiction between what Mary Bush from Health Canada said versus what the people who were supposed to be doing the advisory on the caloric counting stated.

The Chair: So one is saying one thing and one is saying the other.

Mr. Fletcher.

Mr. Steven Fletcher: Mr. Chair, first of all, this does seem to be similar to Madame Gagnon's motion, so I wonder if we're going to end up talking about this over and over again.

In regard to the food guide, just so we are all clear, extensive consultation activities have been undertaken as far as the revision process is concerned. The activities included two rounds of cross-country meetings with over 1,000 stakeholders and an on-line consultation involving over 6,000 respondents.

Health Canada is reviewing lists of stakeholders consulted during those meetings and lists of stakeholders who were invited to participate in the on-line consultation in order to determine whether it has permission to release any personal information on the lists, and we will get back to the committee on that. The synthesis of the report and questions from the on-line consultation and meetings will also be available.

Now, this has been a three-year revision process and it's nearing the end. There is currently a finalizing of the revised guide with, hopefully, a release date shortly, and the department will be pleased to share the guide with the committee at that time.

This has turned into a very complex exercise. A comprehensive strategy to deal with childhood obesity is partly why we are studying this issue as a committee. However, I think we have to be practical here, as with government, we do delegate these types of activities to officials and departments. I agree it's important for the committee to have the opportunity to question and ensure that the process and consultation have been undertaken.

However, as I mentioned at the last meeting, if we get into this, a camel is a racehorse designed by the committee. It's not going to be perfect, but it'll be better than what we have. So it would be most appropriate to leave it up to the experts, and they are the people in Health Canada who have developed it.

● (1720)

[*Translation*]

Le président: Ms. Gagnon.

Ms. Christiane Gagnon: Thank you, Mr. Chairman.

Several health specialists have presented observations and recommendations about *Canada's Food Guide*. We asked three or four people who are acting in an advisory capacity about it. The problem is that they have serious conflicts of interest because they are part of the industry.

Earlier, the Minister of Health was asked about the independence of a number of people who make decisions and who have an influence on the decisions made by ministers. We are in the same situation.

I would like us to have the initial 2006 preliminary version, as well as the 2007 version. I received another e-mail from some doctors telling me that the direction taken with respect to other foods goes beyond the question of calories. Other matters that were submitted to us would tend to indicate that there are concerns about *Canada's Food Guide*.

Generally speaking, does the guide meet people's expectations in terms of advice to combat obesity?

On the contrary, it would demonstrate transparency. You suggest leaving it to the experts, but if I were to leave it to people who are part of the industry, it's not the same thing. Those who have come to tell us these things are not just anyone: they are Dr. Freedhoff and Mr. Bill Jeffery. I respect the expertise of these doctors. In any event, we would like to be ready for the publication of the guide.

Ms. Bush, whose tenacity I respect, has led us astray. These two doctors tried to exert a degree of pressure in an attempt to influence the direction taken by the guide. She said that we could not make any changes to the guide. And yet, she told the committee at the outset that we could still make recommendations. Now we find out that the process is over, because that is what she told a number of witnesses.

This is worrisome. When *Canada's Food Guide* is published, I would like to be able to analyze the process and ask for some advice, as was mentioned by Mr. Fletcher, the minister's parliamentary secretary. It is understandable that he should want to reassure his minister, but we as a committee have some monitoring work to do. We need to be confident that the decisions being made are as well-informed as we are being told.

● (1725)

[*English*]

The Chair: I just want to remind the committee that it's Thursday evening and many of us have to catch planes, so we are going to close at 5:30. We have three motions, so keep that in mind when we're having the debate.

Mr. Lunney.

Mr. James Lunney: Thank you, Mr. Chair.

Ms. Dhalla raised the issue of Yoni Freedhoff. Can somebody confirm for me whether he actually appeared before the committee? Okay. So it was his presentation that you referred to. I referred to it the last time as well.

He raises some very good questions about energy in and energy out. In fact, I asked that question to the Health Canada officials at the last meeting on this matter. So his views are certainly important.

I also asked the question because he sent us an e-mail from Boston, where he was attending the Obesity Society's annual meeting. He had brought along Health Canada's food guide and asked Dr. Walter Willett, who is another expert and chairman of the department of nutrition at the Harvard School of Public Health, to comment on fats.

Again, he's raising some very good issues, and I agree with that, but the purpose of the committee is to address the issue of childhood obesity, not to redraft the Canada food guide. While I agree that what I heard about the Canada food guide—which is a small part of what we're trying to accomplish here in addressing childhood obesity—causes me some concerns, I have very grave doubts that this committee has a mandate to redraft the Canada food guide. We probably all agree that it would be a worthwhile and interesting pursuit if we had time to study it, but it's beyond the mandate of the committee at this stage.

I know members were concerned about having a few extra meetings to hear witnesses who want to appear to discuss the childhood obesity issue. I fail to see, with all due respect, the advantage we would gain from trying to get the Canada food guide here at committee prior to its release so we could somehow redraft it. I fail to see that we actually have the time or the mandate to address that. Therefore, I encourage honourable members to consider that.

We have heard about the extensive consultations Health Canada has undergone on the food guide, whether we agree with it or not, in order to get to this point. I would ask members to consider that in voting on this issue.

The Chair: Ms. Dhalla.

Ms. Ruby Dhalla: I don't think it's the intent of the committee to take over the mandate to redraft the food guide. The parliamentary secretary, Mr. Fletcher, stated very eloquently that the revisions have been there for the last three years. As we study the issue of childhood obesity, the food guide and the type of information being provided to Canadians is of paramount importance. We have seen from numerous presentations that the dietary advice being provided to Canadians has a tremendous impact, so I think the committee has a responsibility to ensure that adequate consultations have occurred.

I would request the chair to call the question.

The Chair: We have others, but the question has been called. Our time is just about gone, but if that's the will of the committee....

Mr. Steven Fletcher: There hasn't been just one revision. I think it has gone through many iterations, so Dr. Dhalla's comment that revisions have been on the table for three years is not exactly accurate.

If the intent is not to revise the food guide—and not through the officials' work—what's the point of bringing it forward? That is of concern.

I can see the chair is looking forward to cutting me off, so I'll stop.

● (1730)

The Chair: I just checked with the clerk, and you cannot call a question when there is other debate on the floor.

Ms. Davidson, Mr. Fletcher, and Ms. Gagnon are all on the list here, so I'm going to allow that debate to continue.... Actually, our time is gone. I don't see how we can do this in the next minute.

[*Translation*]

Ms. Christiane Gagnon: I would like a vote.

[*English*]

The Chair: Just to let the committee know, the next meeting is on October 31. Half the meeting is on diabetes. In the next half, we could take up all of these motions in detail.

[*Translation*]

Ms. Christiane Gagnon: We can vote, Mr. Chairman. Otherwise, we will continue to stand our ground.

[*English*]

The Chair: We're not going to cut down debate until it's over, so I think that's fair.

[*Translation*]

Ms. Christiane Gagnon: We no longer wish to debate the issue. We know that you want to maintain your positions and we have ours. Nothing will change, even if we were to discuss it for a half hour on October 31.

I think that we need to vote now. That way, you will not influence us and I will not influence you.

We need to be realistic, don't we?

[*English*]

The Chair: Okay, that's your opinion.

Ms. Davidson.

Mrs. Patricia Davidson: Ms. Dhalla, I'm still a little confused. Was the article you said your motion was based on the same one Mr. Lunney was referring to? Was it the one we had at committee the last time? In the article, the doctor had sent the information in, and he had spoken with his colleague from the States. After looking at the draft, he thought some things weren't taken into consideration in the Canada food guide. Is that the document you're referring to?

Ms. Ruby Dhalla: My motion was not based on a sole individual or e-mail. The motion was based on hearing a number of witnesses in the committee who stated that they were not consulted about the food guide, aside from the pictures and packaging. We heard a different view from Mary Bush, who came in from Health Canada. The motion is based on ensuring that the food guide is reflective of the needs of Canadians.

Mrs. Patricia Davidson: The comments we were getting were probably legitimate. The people who were making them felt they had not had an opportunity to contribute. But they were looking at a draft that was put out for comment. They were not looking at a version in which the comments had been taken into account. I think that was part of the confusion.

The Chair: I can see debate continuing. I don't want to cut the debate. My honest uneasiness about this is that a letter that was referred to the committee, which I'm not sure all of the committee received—

Ms. Ruby Dhalla: Mr. Chair, my motion is not based on that particular letter or e-mail.

The Chair: I realize that, but it was a significant part of your accusation that the information we had from the department was inaccurate. Because of that, I'm a little uneasy about calling for the vote if our time is gone and we still have debate. That's my uneasiness about it. On October 31, I think we would have that information. We could have a long debate at that time, because we'd have an hour to be able to discuss the three motions.

Ms. Ruby Dhalla: The e-mail is irrelevant to the motion. The motion, as I have stated repeatedly, was based on testimony from a number of individuals and stakeholders. This committee is studying childhood obesity. We have a responsibility to do the right thing. If some of our colleagues on this side of the table want to pursue debate, I would request that we call the question so that we can move forward with other committee business next time.

The Chair: I see more hands for debate. Our time is gone and I'm reluctant to go any further.

Mr. Steven Fletcher: I still haven't got an explanation from Ms. Dhalla on the objective of her motion. Unless you're trying to do a revision in committee, what is the objective of doing the officials' business?

I'm disappointed that we didn't deal with Madame Demers' motion first. It is the most important of the three motions.

Madame Gagnon, you have a motion that is almost the same as Ms. Dhalla's.

[*Translation*]

Ms. Christiane Gagnon: We want to stop prolonging the debate and vote?

I simply want the preliminary draft, which could be presented once again at the next meeting.

[*English*]

Mr. Steven Fletcher: But what about your motion?

[*Translation*]

Ms. Christiane Gagnon: We are prolonging the debate for nothing, because even if we were to continue to discuss it for another hour, we would not be able to convince you. You do not want to vote for the food guide for the time being. In another week, you will still not want to vote for it.

We need to vote immedaitely.

● (1735)

[*English*]

Mr. Steven Fletcher: I just want to know the answer. I want to know the answer to the question.

The Chair: Through the chair, so....

Mr. Steven Fletcher: Sorry.

I have a question for Ms. Dhalla. What's the objective? If you're not going to do the officials' work, but yet you want to see it before the final copy, then the only reason you would want to do that is to do the officials' work.

Ms. Ruby Dhalla: All of us on the committee have enough work to do on our own, but as we study the issue of childhood obesity, I think it's the responsibility of members of the committee to ensure proper consultation and dialogue has been done. As Ms. Gagnon said earlier on, when people from Health Canada spoke, they said there are no opportunities for any further revisions of this draft. I would suggest we have always worked in cooperation and collaboration with the health committee and recommend we discuss this next time. We'll spend another two hours and we will not be able to move forward on our agenda.

I request the chair call the question. After hearing the debate of how we are going to move forward, we all know by this point, and I don't think Canada's food guide is a partisan issue. It's a non-partisan issue, and we have to ensure that the food guide reflects the needs of Canadians to send out the best possible message. So I would once again request that the chair call the question.

The Chair: I'm going to do this one more time. I see one more hand. If there's another hand after this, I'm going to call the meeting over. If not, we'll go to the vote.

Mr. Lunney.

Mr. James Lunney: I'd like to know from Ms. Dhalla if she wants the food guide...we can ask for things. It doesn't mean it's going to be...we have no mandate for this to be provided. It would be very irregular for Health Canada to respond to this, but if they did, are you asking if we have time for the committee to review this, or take committee time to study this issue? How many committee meetings will we commit to studying Canada's food guide before we get back to our study on obesity, or are you suggesting that we add ten more meetings to our childhood obesity study to study Canada's food guide? What exactly is the suggestion? Shall we add two or four or six meetings to study the food guide and to bring in more witnesses on that subject? Is that part of the intent?

The Chair: Okay, I see more hands going up. I'm going to call the meeting over and we'll take this up next time.

Go ahead, if it's a point of order.

[*Translation*]

Ms. Christiane Gagnon: We could filibuster, Mr. Chairman.

[*English*]

Mr. Lui Temelkovski: Either we deal with it now or we set up the agenda for the following meeting to deal with this motion at the beginning of the meeting rather than at the end.

The Chair: That's exactly what I said. The next meeting is wide open for at least an hour.

Mr. Lui Temelkovski: It was said earlier we would deal with it later; we want to deal with it at the beginning of the next meeting.

The Chair: We have a very short—and I explained this—delegation on childhood obesity, the special meeting that Mr. Batters had asked for. Half of that meeting is open for debate on this, so certainly there is no problem.

The meeting is adjourned.

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