HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 027 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, February 9, 2012

Chair

Mrs. Joy Smith

Standing Committee on Health

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● (0845)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): I call the meeting to order.

Good morning, everybody, and welcome to the health committee. We're so pleased to have our guests here this morning.

As you know, we're studying health promotion and disease prevention.

We have with us Mary Collins, from the B.C. Healthy Living Alliance. Welcome, Mary; we're glad you're here. Mary is the director of the secretariat. With her is Cathy Adair, who is a representative. Welcome.

From the Canadian Association of Occupational Therapists, we have Claudia von Zweck, executive director—welcome, Claudia—and Mary Forhan, occupational therapist. You're actually the liaison with the Canadian Obesity Network; wonderful.

From the University of Western Ontario, we have Piotr Wilk, assistant professor—welcome, sir—and I believe that would be Dr. Wilk, then, would it not? Yes, it is, and Dr. Martin Cooke is with us as well. Welcome, Dr. Cooke.

Miss Rita Orji will speak as an individual. Did I pronounce your name correctly? Welcome.

We will begin with Mary Collins, please. You have a 10-minute presentation.

Ms. Cathy Adair (Representative, Vice President, Cancer Control, Canadian Cancer Society, BC and Yukon Division, BC Healthy Living Alliance): Good morning, Madam Chair and committee members. We welcome your interest in and commitment to health promotion and disease prevention and we thank you for the opportunity to present our experience and views on what can be done to promote health promotion and disease prevention.

BCHLA is an alliance of nine provincial organizations that have been working together since 2003 to address the alleviation of common risk factors and health inequities, which of course are a large contributing factor to chronic diseases.

British Columbia is a leader in health promotion and disease prevention. We're proud of the fact that we have the lowest smoking rates, the lowest obesity rates, and the highest levels of physical activity. However, if we look at the short-term and long-term projections, we know that B.C. and Canada will fall behind other world leaders if we don't begin taking action and doing some things differently as we move forward.

BCHLA's experience in overseeing $25 million in initiatives that were developed and delivered to address common risk factors and our involvement in policies to reduce health inequities in B.C. have provided us with a wealth of information that we hope you will find of interest and that we believe is applicable to Canada as a whole.

My colleague Mary is going to speak about those issues.

● (0850)

Hon. Mary Collins (Director of the Secretariat, BC Healthy Living Alliance): Thanks, Cathy.

It's a great pleasure to be here with you.

In the short time available, I'm going to highlight several areas we think are of importance. I won't read the brief.

I wanted to start by saying that Cathy and I have just come from the Chronic Disease Prevention Alliance of Canada conference at the Delta Ottawa City Centre, where we heard from an array of experts on these issues. There's a lot of new information coming out of that work, so I would certainly recommend it to you.

Yesterday Dr. David Butler-Jones, the chief public health officer of Canada, spoke at the opening. He talked about how prevention needs to drive the system. This message is increasingly capturing both the understanding and the imagination of policy-makers and of those across the country. Increasingly, finance ministers and health ministers are realizing that the costs of health care are potentially unsustainable if we don't do something to shift that curve over the longer term, and prevention has to be fundamental to those changes. It's not easy, but we are hoping that your committee and your colleagues will help us to achieve that goal.

There was a very interesting recent study in the United States about modelling the health care system. It's in *Health Affairs*. It looked at whether investments in care or investments in prevention really brought about cost changes over the long term. They showed, in their modelling, that within the next 25 years—and we realize that this is long term and that these changes will not take place overnight—investment and prevention are projected to save 140% more lives and reduce costs by 62%. Now, we know that our environment is somewhat different from that of the States, but we would suggest that you could look at similar objectives.

We recognize that we need to integrate the health care system and the health prevention system and that primary health care is fundamental to this objective. An integrated approach to primary care, which includes prevention and an array of health practitioners, is something that many jurisdictions are working on and something that we hope the federal government will continue to support.

We also recognize that the health sector isn't going to do this alone. We continue to preach, I guess you could say, that the issues about chronic disease, which are consuming over 40% of health care budgets, need what we call a "whole of society, whole of government, whole of person" approach. Perhaps you could just think about it in terms of those parameters.

"Whole of society" requires not only the involvement of government, but also of the private sector and of all the not-for-profit health care providers as well. We need better mechanisms by which we bring people together—we're not there yet—to come to good decisions and good conclusions. Again, we would encourage the federal government to help to facilitate those kinds of partnerships of bringing people together.

Also, when I say "whole of government", I don't mean only the health ministry. If you look at infrastructure funding, for example, you need to understand what the impact of any particular infrastructure project may be on the health of citizens, and whether it in fact helps us to lower the curve around health equity. That's one of our biggest concerns: there's a huge gap in health and health outcomes among people of different socio-economic strata.

We would encourage all levels of government, including the federal government, to require that their ministries have performance plans to show what they are doing to contribute to better health among Canadians, and to require that these plans be assessed on a regular basis, in part to review whether there are, in fact, good health impacts stemming from major projects. These assessments must look not only at the environmental factors, which are important, but also at the health impacts of major projects.

When we talk about the determinants of health, which of course we've all known about for so many years, we know that these include where you work, where you play, and where you live. Your economic and social circumstances make a huge difference to your health. We need to think about initiatives that will understand the difference. We tend to be rather skeptical of the kinds of campaigns that use broad advertising; they may help those who are already healthier, but they don't necessarily address the needs of those who are in the poorest health or at the greatest risk of poor health. Sometimes we need to look at more segmented approaches to reach those people.

I know that you're particularly interested in the issues of healthy weights and childhood obesity. We've actually moved our language from saying "obesity" to saying "healthy weights" instead, because there is increasing evidence that saying "obesity" tends to stigmatize people, and we don't really think that's a good idea. There are already enough challenges involved in that area.

● (0855)

I won't go through all of our recommendations; we have quite an array. We have other reports available through our website.

There are a couple of things that are really important. One is to ensure that all Canadians can have nutritious foods, and this is particularly important for children as they're developing. There is a lot of opportunity through school programs to advance those interests.

One thing that's really of concern is that children are being bombarded by television and video messages about unhealthy foods, and there's evidence that this advertising tends to increase.... Children, of course, are not yet sophisticated enough to really know the difference.

Ideally this could be managed on a voluntary and cooperative basis. Unfortunately, the reality to date is that it hasn't really worked. While we would encourage that approach to continue, we really think it ultimately will require regulation. Quebec has done it, and we think what is needed in a more comprehensive way across Canada is restrictions on marketing to children, not only on television, but in commercials, cartoon characters, video games, and things like that. I know we don't necessarily want to regulate everything, but in this area evidence shows that it certainly can have an impact.

Another area has to do with designated taxes. As we know, nobody likes taxes, but there's increasing evidence, which we heard a lot about in the last two days at the conference, about designated taxes. We would suggest excise taxes on sugar-sweetened beverages—not just soda pop, but all sugar-sweetened beverages. Sometimes people think it's just soda pop, but we're not just going after that. Such a measure can make an impact by facilitating people in making wiser choices. In some cases provinces could do it, but there's also an opportunity for the federal government to try to help people make those better choices.

We can't forget the role tobacco and alcohol play; we would urge the federal government to renew the tobacco strategy, which we know is coming to an end fairly shortly. We've made great progress and we have lots of lessons, but we can't let up. We still have too many people smoking, particularly young women, who often associate it with low weight and think it's going to keep them slim. Of course, there's also alcohol; increasingly people are recognizing alcohol as a risk factor contributing to obesity, and also recognizing its connection with chronic diseases right across the board.

In conclusion, we recognize that over the years the federal government has played a leadership role in working with the provinces, the private sector, and the not-for-profit groups in a joined-up approach to promote and inspire the next generation of Canadians to live not only long lives but healthy ones as well.

We thank you and look forward to your questions.

The Chair: Thank you very much, Mary.

We'll now go to Dr. Claudia von Zweck, from the Canadian Association of Occupational Therapists .

Dr. Mary Forhan (Occupational Therapist, Liaison with the Canadian Obesity Network, Canadian Association of Occupational Therapists): Thank you—

The Chair: I'm sorry, Dr. Forhan; are you starting first? Are you sharing your time, then?

Dr. Mary Forhan: No, we're not, actually.

The Chair: You're going to do the major presentation.

Dr. Mary Forhan: Yes. Claudia will be able to answer some questions.

The Chair: Okay, thank you very much.

Dr. Mary Forhan: Good morning, Madam Chair and members of the committee. Thank you so much for the opportunity to present to the House of Commons Standing Committee on Health.

My name is Dr. Mary Forhan. I am an occupational therapist and a researcher in the area of obesity management, prevention, and treatment. I'm here today as a representative of the Canadian Association of Occupational Therapists, of which I've been an active member since 1990. CAOT is pleased to participate in this consultation on health promotion and disease prevention, with a focus on obesity.

The unique contribution to health promotion and disease prevention from an occupational therapy lens is the focus on occupation, which includes but is not limited to physical exercise. Occupational therapy is the art and science of facilitating participation in everyday living, and includes active engagement in meaningful activities or occupations. Occupations include everything people do in their day-to-day lives, such as paid employment, going to school, participating in hobbies and sports, looking after others, and taking care oneself. Occupation is the context in which people develop skills, express their feelings, construct relationships, create knowledge, and find meaning and purpose in their lives. CAOT believes that participation in meaningful everyday activities is important for Canadians through all stages of life, regardless of health or ability.

With the growing epidemic of obesity and the rising number of aging Canadians, the government understands the importance of promoting healthy lifestyles to foster health and prevent disease. Increasingly, research is demonstrating that participation in an active lifestyle fosters both physical health and mental well-being.

As such, CAOT recommends the adoption of a vision by the federal government for promoting health and preventing disease that would include individual and community engagement in active living, thus providing leadership for provinces and territories and broadening the focus from solely health care to include health promotion.

CAOT's health promotion and disease prevention strategy includes the development and dissemination of an active living guide. Together with researchers from Queen's University and McMaster University, CAOT has begun the development of this active living guide.

Active living is a collection of behaviours that promote health and wellness by reducing risk factors associated with chronic diseases such as obesity, depression, hypertension, diabetes, and substance abuse. CAOT defines active living as engagement or participation in meaningful activities that support a way of life in which physical, social, mental, emotional, and spiritual activities are valued. Active living goes beyond physical exercise.

The objectives of the active living guide are in line with this committee's vision to promote the health and wellness of Canadians and prevent illness, as stated in the declaration on prevention and promotion from ministers of health, health promotion, and healthy living from across Canada, which I see was posted in September of 2010.

CAOT's perspective on active living and health promotion could also contribute to the Public Health Agency of Canada's national dialogue on healthy weights. This dialogue is currently under way, as I'm sure you're all aware. CAOT has the capacity to work with the Public Health Agency of Canada toward meeting its benchmarks related to health promotion and disease prevention. CAOT advocates that the federal government recommend the engagement of the Public Health Agency of Canada in the consensus-building, dissemination, and evaluation of the active living guide.

The intent of the guide is to identify the needs of different populations and promote not only physical health but other beneficial factors that contribute to individual health, such as connectedness, spirituality, and community engagement. The guide is intended to promote active healthy living for all Canadians, and pays particular attention to high-risk groups, including children and youth, first nations communities, adults transitioning from work to retirement and older adulthood, and persons with disabilities. The active living guide will provide strategies to address the physical, social, and environmental barriers to active healthy living identified by Canadians in high-risk populations.

Based on research to date, increasing active living is not simply a matter of just doing it. There are several dimensions of activity participation that are important to consider, and what follows are key elements of the active living guide.

● (0900)

Issues such as poverty, disability, and limited English literacy may restrict access or engagement in meaningful activity. Systemic barriers to participation need to be identified and addressed to provide individuals with the opportunity to participate in healthy activities. Having a choice is absolutely critical to whether an individual is motivated to initiate and maintain involvement. Rather than a prescribed schedule of activities, the emphasis in the guide would be on individual choice and preference.

There may be critical points in time, such as graduation from school, preparing for retirement, or the onset of a disability, when activity patterns are disrupted and need to be reconfigured. A framework for promoting participation in healthy activities needs to consider the life stages and transitions, which the activity guide will do.

The meaning of activities may vary depending on the individual's cultural, social, and political context. For example, young persons may be motivated to engage in a specific sport, but will not likely continue if it's not socially valued within their family or their peer group. Providing options for choice and healthy activities across a range of cultural contacts is required.

Balance is another important issue to consider in activity patterns. It is important to consider the points at which activity engagement has a positive impact on health and the point at which too much activity can have a negative effect. Research, for example, points to issues of balance with respect to the screen time of adolescents, the work-life balance of adults, and volunteer work for older adults. The participation in everyday meaningful activities and their impact on heath promotion and disease prevention is a core belief with the profession of occupational therapy. As such, the Canadian Association of Occupational Therapists also recommends that occupational therapists be included in the strategic planning and implementation of creating a new vision for Canadian health promotion and disease prevention.

To summarize, these are the key recommendations from CAOT: the adoption of a vision by the federal government for promoting health and preventing disease that includes individual and community engagement in healthy living activities, thus providing leadership for provinces and territories and shifting the focus of Canadian health care to include health promotion; federal government support to engage the Public Health Agency of Canada to participate in the consensus-building, dissemination, and evaluation of the active living guide; and the inclusion of occupational therapists in the strategic planning and implementation of a new vision for Canadian health promotion and disease prevention.

On behalf of CAOT, I would like to thank the committee for the opportunity to present. We certainly will be open to answering any questions.

Thank you.

● (0905)

The Chair: Thank you very much, Doctor.

We'll now go to Dr. Wilk, please, from the University of Western Ontario.

Dr. Piotr Wilk (Assistant Professor, University of Western Ontario): We'll be sharing our time, so maybe Dr. Cooke will start.

The Chair: You'll be sharing your time. That's wonderful.

Please go ahead, Dr. Cooke.

Dr. Martin Cooke (Research Partner, Associate Professor, University of Waterloo, University of Western Ontario): Good morning, Madam Chair, vice-chairs, and members of the committee. It's our pleasure to appear before you today to help you with this important work.

Rising rates of obesity, as this committee is very well aware, are among the most important public health problems we currently face. Childhood obesity is an especially important issue, as it brings with it a number of risks both in childhood and in later life.

Our current work is on the issue of obesity among aboriginal children. As the committee is also aware, aboriginal children face rates of obesity that are substantially higher than, perhaps more than twice as high as, those of other Canadian children. Unfortunately, we can't offer more precise estimates of those rates, because there is no national-level surveillance system in place to monitor health outcomes among aboriginal children. There is enough evidence to conclude that aboriginal children, regardless of their place of residence or ancestry, are more likely to be obese and are at much higher risk of experiencing the negative consequences of obesity.

Childhood obesity is a potentially major contributor to the health equity gap between aboriginal and non-aboriginal Canadians. This gap in health and health-related quality of life may widen as the current generations of aboriginal children grow into adolescence and adulthood. Moreover, 30% of the aboriginal population is under 15, so reducing the gap in inequality and improving the health of aboriginal populations therefore requires a focus on child health.

Of course, we understand that the committee is likely most interested in understanding what strategies have proven effective in addressing obesity among children, and among aboriginal children in particular. Unfortunately, the current research evidence is unclear on that point. Recently, our colleagues from the Northern Ontario School of Medicine systematically reviewed the literature and found little consensus about what works with regard to reducing obesity among aboriginal children. It seems as though what works depends very largely on the social context.

Currently we have funding from the Institute of Aboriginal Peoples' Health in the Canadian Institutes of Health Research to try to understand obesity among aboriginal children. We are working with the Métis Nation of Ontario and other partners. This research will investigate the effects of key determinants of child obesity at the child, family, and community levels. Our research program is focused on Métis and off-reserve first nations children. At present, more than half of aboriginal children live in urban areas, a population that is rapidly growing.

Although these projects are ongoing, we do have some preliminary results. Both qualitative focus groups with parents and analysis of Statistics Canada data indicate that family income is a key determinant of childhood obesity. However, there's also evidence that many of the social determinants that affect aboriginal children's health may be different from those that operate in the general Canadian population, reflecting cultural and historical differences. For example, controlling for family income and other factors, we found some evidence that children whose parents attended residential schools may be at higher risk for obesity than other aboriginal children.

It also appears that aboriginal children and families living in urban and other non-reserve areas may be more likely to live in neighbourhoods or communities that are underserved in terms of opportunities for physical activity or access to affordable healthy food. We're presently working on modelling the effects of neighbourhood characteristics, including the availability of fresh foods and proximity to recreation spaces.

Dr. Piotr Wilk: As we have heard repeatedly from our first nations and Métis colleagues, healthy weights among aboriginal children cannot easily be separated from other aspects of health or from well-being in a more general sense.

An important point is that the physical health of children is deeply connected to the emotional and spiritual health of the children themselves, of their families, or of their communities. Aboriginal children living in urban areas are affected by policies and programs of a variety of agencies and institutions, including aboriginal-specific agencies, public health units, clinicians, schools, and mainstream social service agencies.

Some children and their families are also connected to first nations or other communities and may spend part of their lives served by institutions in those communities. We are convinced that this health and wellness system can be improved. Currently we are conducting a project funded by the Public Health Agency of Canada that is attempting to improve the way aboriginal children and families living in urban areas are served by those institutions.

Through consultation with community partners and interviews with parents and caregivers, we have found that communities may have considerable resources to provide programming and services to aboriginal children. However, these resources may not always be used to the best effect because of a fragmentation in the system. For example, clinicians and other mainstream health agencies that serve aboriginal children may not always have access to the cultural knowledge required to provide effective programming and may therefore have difficulties retaining aboriginal children and families in treatment or health promotion programs. On the other hand, aboriginal-specific service providers may not have the same access to long-term funding or to the various financial and physical resources that may be present in the community.

We are convinced that by addressing this fragmentation and lack of collaboration, we can improve child obesity outcomes. Our proposed population health intervention is to build a collaborative structure among various community organizations and stakeholders whose work affects health and wellness of aboriginal children either directly or indirectly. By collaborating, local aboriginal and non-aboriginal organizations can use existing resources more effectively and leverage additional ones to improve how they serve aboriginal children and families.

We have started this intervention in London, Ontario, and hope to spread this model to other communities. At this moment, our project includes more than 40 institutions in London and nearby first nations. By actively connecting those partners around the issue of promoting healthy weights, we have been able to create new collaborative programs that would not have existed otherwise.

Perhaps more importantly, the collaborative model that we propose will improve relationships between aboriginal peoples and Canadian institutions that are a fundamental part of the disparities in health. We believe this process will help address some of the factors affecting the relative health of aboriginal people in Canada that are furthest upstream from them.

In closing, we would like to acknowledge and thank all the partnering organizations and the members of our project team. Without them, this important work would not be done.

Again, we would like to thank the committee for inviting us here today. We would happy to answer any questions.

● (0910)

The Chair: Thank you, Dr. Wilk.

We'll now go to Ms. Orji.

Ms. Rita Orji (Ph. D. Student, University of Saskatchewan, As an Individual): With all protocols observed, it is my honour and privilege to appear before you, the honourable chairman and members of the Canadian House of Commons Standing Committee on Health, to share some of my knowledge on health promotion and disease prevention, and more specifically on obesity prevention.

My name is Rita Orji. I am a Nigerian and a doctorate student in the department of computer science in the University of Saskatchewan. I am under the mentorship of Dr. Julita Vassileva and Dr. Regan Mandryk.

My primary research focus is on the influence of persuasive technology in the prevention of chronic metabolic diseases through lifestyle change, particularly the prevention of obesity. Recently I was awarded a Canadian government Vanier scholarship to conduct research on the design of persuasive technologies for healthy lifestyle change with a specific focus on obesity prevention.

I'm here to speak on health promotion and disease prevention, and more specifically on the topic of obesity. I'll be sharing the knowledge I've gained from studying relevant literatures and from some research experiences I've had in actively working in this area over the past two years.

Obesity is a major health concern worldwide, and specifically here in Canada. It has attracted attention from both governmental and non-governmental bodies. According to measured height and weight data from both the 2008 Canadian Community Health Survey and the 2007-2009 Canadian Health Measures Survey, approximately one in four Canadian adults is obese. Also, as of 2008 it was reported that approximately 61% of Canadian adults and 30% of Canadian teens are either overweight or obese.

Sedentary lifestyles and unhealthy eating habits are the two main contributors to the escalation of obesity in our society today. As a result, several worldwide attempts have been made by both governments and private sectors to counter the rising trend of obesity and associated chronic diseases.

The attempts are largely informed by the connections that have been made between obesity and poor health. Being overweight has been found to increase the risk of developing heart disease, diabetes, high blood pressure, mental illness, and in some cases cancer. As the prevalence of overweight and obese people increases, the implication in terms of premature death and burdening the Canadian health care system becomes acute as well.

Attempts at preventing obesity, especially in the last decade, have been targeted on such interventions as public awareness, counselling, and drug use. However, these approaches have not produced the desired long-term sustainable effect, for the following reasons: first, they are not based on the understanding of human behaviour—that is, how behaviours are formed and how they can be altered; second, they are not well integrated into people's daily lives and therefore face the problems of adoption and maintenance; third, they are not cost-effective and therefore face the problem of long-term sustainability; and fourth, they are based on the assumption that humans are rational beings and will always act to maximize benefit and reduce risk.

However, when it comes to lifestyle, we cannot assume that humans will necessarily behave rationally. Rational people would change their behaviours when exposed to convincing information about the negative effects on their health. Most lifestyle-related health challenges, including obesity, that we experience today should not be there, considering the widespread health education and health campaigns, yet this is not the case; it is very hard to make people stop smoking, eat healthfully, and exercise regularly.

A successful intervention for changing human behaviour should be based on the understanding of how behaviours are formed and how they can be altered.

A promising approach to health promotion and disease prevention that has emerged recently is persuasive technology. The goal is to design technology that would change human behaviours or attitudes in an intended manner without using coercion or deception.

Fogg, one of the authorities of persuasive technology, identified three major factors that are necessary for a successful change of behaviour.

● (0915)

These include motivation, ability, and trigger. For a person to successfully perform a behaviour, he or she must be motivated. The person must also have the ability to perform the behaviour and be triggered to perform it. These three factors must be present at the same time for a behaviour to occur.

Generally, persuasive technological solutions to disease prevention are effective for the following reasons: first, they can be integrated into people's daily lives, become part of their daily routine, and cause long-term behaviour change; second, they are based on health theories of behavioural change and motivate people in accordance with their strengths; third, they capitalize on some natural and individual human drives; fourth, they are more cost-effective than all other intervention approaches, such as traditional labour-intensive counselling; fifth, they make it easy to tailor interventions to individuals' needs, motivations, and goals; and sixth, they use the just-in-time approach to provide immediate feedback at the time and place it is needed to persuade.

The appeal of persuasive technology for behaviour change is amplified by the recent penetration of mobile technologies such as mobile phone and tablets. The mobile platform provides a unique opportunity for designing persuasive technology tailored to an individual user's needs and situations.

Mobile phones have become ubiquitous today and are now an important part of most Canadian homes. As of 2010, there were over five billion mobile phone connections worldwide. Specifically, the penetration rate of mobile devices in Canada was around 70% in 2010. Mobile computing holds great potential for motivating behaviour change, because successful intervention for all lifestyle changes will build on technologies that people already use and applications that integrate seamlessly into their daily lives. Mobile phones are part of our personal space; they are proactive and can alert us at exactly the right time.

For people who want to be healthy and have a healthier lifestyle, persuasive technology would make it easier to maintain such a lifestyle. It offers refined and personalized measurements by embedded sensors and delivers feedback accessible at the point of need. For people who are not convinced that they need to change their behaviour, persuasive technology can gradually persuade them through various strategies. Persuasive technology can be designed to expose both the long-term and short-term consequences of risky behaviour. It can also present the benefit of the desired behaviour and compare it in a captivating manner with the short-term gratification of unhealthy behaviour. What is most important is that these benefits and risks can be tailored to an individual's need, thereby amplifying their effects.

Persuasive technology application can be easily integrated into the user's daily life and can offer opportune moments to persuade the user accordingly.

A typical example of a persuasive application is a cellphone that measures an individual's physical activity level and provides feedback and encouragement through an interactive graphical interface.

In conclusion, we reiterate our belief that obesity is an epidemic that requires urgent attention. Although many interventions have been implemented to combat this epidemic, they have not been very successful so far. We believe that technology intervention is a promising approach to combatting this epidemic more effectively. We propose that for persuasive technology intervention to be effective, it must generally be based on sound theories of human behaviour change, tailored to the individual user and usage context, unobstructively integrated into the user's daily life, be easy to use, and be able to intrinsically motivate a user, using various strategies.

This direction for the future of persuasive technological intervention for healthy lifestyle change forms the core of my research. With specific reference to my research, our core interest and focus is on how to tailor various persuasive strategies and theories to users and user groups.

● (0920)

Specifically, it is not only how to intrinsically motivate healthy behaviour change but also how to integrate persuasive technological strategies into an individual's daily life using mobile and handheld devices.

On a final note, I wish to express my gratitude to my mentors, Dr. Julita Vasseliva and Dr. Regan Mandryk, who have been mentoring me thus far in my studies.

Last but not least, I wish to express my thanks and gratitude to you, the chairman and members of the Standing Committee on Health, for reposing such confidence in me and my work as to invite me to share it.

The Chair: Thank you so much for your presentation. We're very grateful for that as well.

We'll now go into our first seven-minute round of Q and A. We'll begin with Ms. Davies.

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

Thank you to all the witnesses for coming here today. I feel we had a very good cross-representation ranging from B.C. to Saskatchewan that included a young student with emerging ideas and technology as well as national organizations. It was a very good representation.

Ms. Collins, I really liked that you started off by quoting Dr. Butler-Jones. I think you said that he said prevention needs to drive the system, which sounds absolutely right on. The multi-billion-dollar question is, how do we change the system, and who does it? Your organization has done some fabulous work in B.C.

I have two questions to all the witnesses. First, in terms of the various roles and jurisdictions, whether provincial or federal, even at the health accords we had in 2004 there was some emphasis on health promotion and disease prevention, and everybody seemed to buy into that idea. What specifically do you believe the federal government now needs to do to follow that up and to make sure those commitments are lived up to?

In the second question I want to zero in on a very specific issue, which is dietary sodium reduction. I don't know if you're aware, but a major letter calling for targeted reductions leading to regulation and signed by 17 major national organizations was sent out in December to the Prime Minister. It seems to me that the work that's been done there has been incredibly important, and we're now in danger of losing it. That one thing, sodium reduction, would be enormously significant in terms of labelling and moving towards clear reductions. I am very concerned that we're losing ground on that aspect. Have you done anything within your groups on that isue, or through the alliance in B.C.? Maybe something very positive is going on in B.C. that you could tell us about and that we could learn from.

Those are my two questions. One is a broad one about what the federal government should do to play its role in changing the system, and the other is specifically on sodium reduction. They are for anyone who wants to answer.

● (0925)

Hon. Mary Collins: I can start, and others will chime in.

In terms of the federal government's role, I think it has several. One is obviously a coordinating and convening role, in the sense that it has a lot of potential to be the leader in bringing parties together. The Public Health Agency and Health Canada do a lot of that, but I think it could be even further developed.

We had hoped that in a new health accord—and I'm not even sure you need to call it a health accord any longer—there would be some goals and some measurable targets everyone would agree to, things that the provinces and territories would agree to try to accomplish over the lifetime of the next accord. I think that is still possible, from what I've heard from various sectors, so if we could bring people together to establish those, we would all know that we're moving in the same direction.

Obviously the provinces, being responsible for health care, play a very big role in this too, but we feel there does need to be national oversight and some national standards that people can agree to. On aboriginal issues, we totally agree with our friends from western Ontario that aboriginal health is a huge issue that needs to be addressed.

In terms of sodium, I don't know if you're aware, but the B.C. government recently had one advertising tranche, and is having another, concerning sodium reduction. We've asked to see the evaluation of those initiatives. We're a little skeptical in that you may be preaching more to the converted, and that's a bit of our concern about the mass advertising approach. I know Health Canada is looking at that. The day before yesterday I was at a session with them concerning some of their plans to continue their work on sodium reduction, working with the provinces, and we felt encouraged by that news. Obviously sodium is a big issue and a major contributor to heart disease and is the one that needs to continue.

To get the food producers to reduce salt, reduce trans fats, and reduce sugars in their foods is really tough. This is the big problem. There are some leading food companies that are committed, but they run into the problem that consumers, in many cases, don't like the stuff and won't buy it, so it's hard for the food companies to justify to their bottom line that they do that.

However, there is some movement. We would certainly like to see more. Again, I think the federal government could provide some leadership by supporting and helping those who want to make progress and want to do things differently. It could highlight those companies, and hopefully the laggards would come behind. When all else fails, regulate. It's not the first choice, but sometimes you have to do that.

● (0930)

Ms. Libby Davies: Would anybody else like to answer?

The Chair: Would anybody else like to comment?

Dr. Forhan, go ahead.

Dr. Mary Forhan: Thank you.

On what the federal government can do to help move health promotion and prevention into the forefront, a truly interprofessional and interjurisdictional approach is needed. We need to learn from models that are working in other sectors that can be applied to health promotion. I'm thinking of health economists, business models, and evaluation models in health services research right now that we can integrate to look at processes of care that are open to taking responsibility for health promotion in the primary health care sector.

As occupational therapists, we are very much into health promotion. We have models of practice that can be very flexible and allow for a move away from a focus on disease to a focus on health and wellness.

I would certainly agree with Mary Collins on outcomes; we need to have some consensus on sustainable outcomes we can measure across Canada and within different areas, regardless of what our focus is on. In this connection, I would really encourage the federal government—and it's a provocative comment, but I'm doing it quite intentionally—to move away from benchmarks of weight and more towards benchmarks focused on health and wellness beyond weight. There is a lot of evidence that focuses—

The Chair: Thank you, Dr. Forhan; I've been trying to get your attention.

Witnesses, when you go over time, I try to give you some notice—

Dr. Mary Forhan: Oh, I'm sorry. I'm looking at nodding heads. There's absolutely no problem.

The Chair: I'm sorry about that, but it's just to be fair to everybody. I'm not trying to interrupt you.

You've made some very good comments. Thank you.

Now we'll go to Mrs. Block.

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

I want to thank all of our witnesses for being here today. I definitely concur with my colleague across the way that it has been a great cross-reference of different viewpoints that have been represented.

I know I have limited time, so I'm only going to ask questions of a couple of witnesses, but I want to thank you, Rita, for your presentation. I'm from Saskatoon, so I think you've made a great choice in the university that you've chosen to do your doctorate studies at.

Having said that, my first question will be for Mr. Wilk or Mr. Cooke, whoever would like to answer.

To put it into context, I'm from Saskatchewan. We have 74 first nations in Saskatchewan. I have two urban reserves that are just basically business ventures in my riding, and while I don't have any large reserves in my riding, I do have the largest population of first nations and Métis urban constituents in the city of Saskatoon, so I know full well the challenges that you've described.

What I want to do is follow up. I know you talked about the grants you've received that focus on obesity among aboriginal people Canada, including the off-reserve first nations children. I want to ask you if you could outline what some of the biggest challenges are for preventing obesity among first nations children off reserve.

Dr. Martin Cooke: I should preface my answer by saying that our intervention plan is focused mainly on improving the way that the system serves these kids. The reason is that the evidence, such as it is, tends to show that the things that are effective are usually developed locally in response to local needs, using local resources and taking local cultures into mind.

We have a collaborative project. Most of our partners are service providers who know what their communities need, be it urban or on first nations, but what the challenge seems to be, as this committee has heard before and was actually said in your 2007 report, is that the system that serves these kids tends to be fragmented and it tends to be siloed. Often neither funding nor general thinking about it doesn't focus on all of the multiple providers that serve these kids, including local educational providers, local public heath agencies, local first nations organizations, the people who design neighbourhoods in the municipalities, and so on. From our perspective, it's important to get these organizations to all have a focus on aboriginal child health and to make a little bit of an organizational change such that they include thinking about first nations and Métis populations when they're designing programs and embed that approach in their organizational culture.

What we're trying to do is to focus on how that whole system works, not necessarily by adding resources but by making the resources that are there work better, essentially.

● (0935)

Mrs. Kelly Block: Are you familiar with the health disparities report written by Dr. Cory Neudorf and Dr. Mark Lemstra from Saskatoon?

Dr. Martin Cooke: I'm not, not off the top of my head.

Mrs. Kelly Block: It would be a great report for you to take a look at in the work you are doing.

My next question is for Ms. Collins.

I want to thank you for the observation you made earlier that there is an opportunity for the provinces and territories, along with the federal Minister of Health, to continue the dialogue around setting standards, indicators, and measurements that will make sure we are getting the results that we want to see and that Canadians deserve out of our health care system. I want to thank you for that observation. We've simply provided some stability and predictability in terms of the funding, but that doesn't preclude the conversation that still needs to happen over the next few years, so I thank you for saying it.

In Saskatchewan we moved forward from a system in the early 1990s that had 400 different boards providing oversight of health care in 32 districts. We went to 12 health regions. When we moved to districts, they implemented a funding formula that was needs-based but that also took into consideration demographics, which changed the funding based on the number of children, women, seniors, and aboriginal people.

They also built in what they called a one-way valve. There was a certain amount for acute care and a certain amount for community care or those community-type programs that were meant to focus on health promotion and disease prevention, and while money could move from acute care to the community-based services, it could not move back. However, the lion's share of the funding always went to acute care, so we felt tension between having to fund acute illness care while trying to look at health promotion and disease prevention. I know my colleague picked up on my exact quote that “prevention needs to drive the system”.

You also said that a shift has to happen and that prevention needs to be fundamental to that shift. My colleague referenced the very good work you are doing in B.C.; I'm wondering if you would take a little bit of the time that's left to tell us about that work.

Hon. Mary Collins: Cathy may want to join me.

I want to mention, because I think it relates to some of the other—

The Chair: You just have a minute. If she's going to join you, I think it has to be pretty soon.

Hon. Mary Collins: Some of the most important work we did in our project was around community capacity-building. We looked at aboriginal communities in B.C. and recognized that a top-down approach wasn't going to work. You had to do it from the bottom up. The Canadian Cancer Society led this effort with community development folks. Within those aboriginal communities, they decided what was most important to them to focus on, whether it was youth leadership, community gardens, or some kind of healthy eating program. There were some really wonderful outcomes from that initiative.

The challenge is—and this has come up in our conference—that Canada is country of pilot projects. We do all these things for two and a half or three years and say, “Isn't this great?” Then the money is gone. Therefore, we need to have greater continuity of funding for a lot of the most promising and best practices.

The Chair: We will now go to Dr. Fry.

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

I want to thank the witnesses for coming. I especially want to welcome Mary Collins, who, as everyone would know, was a Minister of Health at one time, so she knows about all the federal-provincial jurisdictional issues and about pilot projects not leading to sustainable funding. I want to congratulate her on doing some very good work over the years since she's left politics.

There are a couple of things I wanted to ask about. Libby mentioned sodium strategy, and Mary talked about having a provincial buy-in to it. The thing about the sodium strategy is that the provinces have all agreed on what that strategy should look like, and they agreed to it in meetings with the federal government, so the Department of Health and the provinces all have an agreement on regulations for sodium and a sodium strategy.

However, as we sit here and talk about health promotion being important, it has to be more than talk. We have to put some teeth into it. I think that if we want to really do something, we should be looking at regulations, and regulations have not come about, even though the provinces and the Department of Health have recognized this problem and have recommended regulations. That's rather interesting.

Obesity is another one. I'm saying this because we talk about regulation and about having a rule, and although we don't want to regulate everything, sometimes voluntary strategies don't work. Then we have to move into regulations. We've done it very well with alcohol. We did it very well with smoking. You can see good results, and we really need to look at obesity, which causes a huge amount of disease, and at all of them.

I wanted to ask you to expand a little more on the role of regulation in making sure that people have a little tool to help them, because people are going to choose. I wanted to ask you about that.

I also wanted to thank Ms. Orji for her really innovative idea. We're talking about innovation being what drives health care, and this is innovative, because we can reach all youth. We know that sedentary lifestyles and sitting around a computer playing video games, unless you play Wii, really do increase obesity, because you're not doing the exercises you need. Using social networking and an iPhone to help you do that is brilliant. If you have shares, Ms. Orji, I'll buy some, because it's really a fantastically innovative idea.

I also want to thank Ms. Forhan. I wonder if she'd have time to expand a little bit on the idea of measurable goals. This idea was floated about 35 years ago by a health minister, and it has never come about. Everyone is afraid of measurable goals because they're afraid they won't reach them. Well, if you don't know where you're going, as the great Yogi Berra used to say, how are you going to know when you get there? If you set a goal and you fall short, it still means that you know you're getting somewhere, and you can start. Indicators and all of that are useless unless you have measurable goals.

Perhaps Ms. Collins could comment on regulations and the role of regulations.

● (0940)

Hon. Mary Collins: I have just a quick comment, because Cathy would like to join in.

We think there needs to be a joint approach. You need to control the environment for obesity as well as personal behaviour and personal responsibility, and in the environmental side there is a role for regulation, as in tobacco, where it worked well. You need regulation, you need taxation, and you need promotion programs.

In some cases, actually, the private sector prefers regulation, because there's a level playing field. Everybody has to play by the same rules. We actually support regulation in terms of marketing to kids. We think it's going to require regulation. Labelling, as well, should be done through regulation.

Cathy, you wanted to comment.

Ms. Cathy Adair: Mary, you really spoke to it.

Fundamental to health promotion is the combination of regulation, education, community mobilization, and community capacity-building. Really, to have one strategy without the other is going to lessen the chances of success in any of these areas. Tobacco is a very good example.

Hon. Hedy Fry: Dr. Forhan, can you talk about measurable goals?

Dr. Mary Forhan: I think if we're looking at the individual, at the level of the person—I really enjoyed Rita's presentation—and if the goals are more than just knowing whether we achieved those goals or not, but are about finding a nice fit between what is meaningful to that individual—what is consistent with their values, their abilities, and their resources within their communities and within themselves—then all those individual aspects need to be part of that measurement. It's not just one outcome; there are several outcomes within that goal-setting.

In the Canadian Occupational Therapy Association, we use a guide and a tool called the Canadian Occupational Performance Measure, which allows us to quantify goals while taking all of those dimensions into consideration. Then, at the level of a larger population, we can extrapolate to generalizable goals across subsets and subpopulations, based on age as well.

Hon. Hedy Fry: I didn't mention the aboriginal issues that you brought up, but I think one of the biggest things we need to look at is whether aboriginal communities, especially on reserve and in urban areas, have the ability to have the kind of local community centres where there are gyms and exercise programs with good coaches who can teach them how to exercise well and bring about exercise as one of the components that may or may not be missing in a strategy.

● (0945)

Dr. Martin Cooke: Certainly, from what we've seen—and others know much better than we do—there are resources that our local partners are missing or would like to have. That said, part of what we're trying to aim at is finding ways in which the community, and the system as a whole, can make use of the resources that already exist in the community. I agree that access to things like spaces for healthy physical activity is really important; at the same time, in a lot of cases those can be arranged. They do exist in one way or another; otherwise, with access to some specific funding, they can be developed. It's more about the networks and the way the system itself works to get those spaces used by the people who need to use them.

The Chair: Thank you, Dr. Cooke.

We'll now go to Mr. Strahl.

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

Thank you all for your presentations. It's good to see B.C. represented here as it is at the table in this committee.

Mrs. Block talked about 74 first nations in Saskatchewan. I think I have 40 in my riding alone. I have visited a number of them and I have seen the difficulty. Ms. Fry asks whether they have access to the same level of leisure activity, leisure centres, and recreation centres; some communities in my riding have 1,000 people who are an hour's drive from a community that has 2,000 people in it, so it's very difficult for them. They have a band office with a health centre attached to it, and that's about it.

My questions are about that kind of situation. How do we reconcile that? You talked about local services. Often the community itself is, as I said, 1,000 people and does not have a lot of local infrastructure. How do we overcome those challenges? As you say, you want it to be community-driven, but there's not the expertise, there's not the capacity. How do we go about serving those aboriginal Canadians?

Dr. Martin Cooke: As I said, our focus is on children who are living primarily in off-reserve areas, although we recognize that those children are often connected in important ways to nearby first nations. Certainly others would know much more than I do about the situation on reserves, and especially more geographically distant reserves. For example, our colleague John Henhawk, from the Southern Ontario Aboriginal Diabetes Initiative, is here in the audience. They would know much more than I would about that aspect.

If you look at London, Ontario, as a community in general, there's a lot of capacity, and there are lots of possibilities for better cooperation between provincially funded programs and municipal organizations and the local first nations. There are important historical reasons for the difficulties in that area, which we acknowledge, but that's what we're trying to change.

Mr. Mark Strahl: We've heard from numerous witnesses that the socio-economic status of the family in which a child finds himself or herself affects the the child's health. How does an off-reserve aboriginal child compare to the same child living down the street in a similar situation, in terms of their current health outcomes? Is it comparable or is it different?

Dr. Martin Cooke: We can only speak in terms of averages, of course. The outcome we're interested in here is obesity, and in this case it looks as though an off-reserve aboriginal child probably has about twice the risk of obesity. We can't really think of obesity as separate. Obesity comes bundled with a whole bunch of other health risks. In some ways it's more of an indicator than it is an outcome itself.

In any case, the risks are much higher, and we think that's related to neighbourhoods and resources in neighbourhoods, as well as to the income of those neighbourhoods. For example, it's related to living in a neighbourhood where there may not be safe space to play. It's related to family income as well, time available for supervision—if you think of lone parents, for example—and to access to healthy food in the neighbourhood. It's a complex multi-level issue for sure.

● (0950)

Mr. Mark Strahl: Rita, I was interested in your presentation as well. I'm sorry that Patrick wasn't here; I know he has developed some mobile applications as well, although not, I believe, at the same level as what you're looking at. I am aware that some apps already in existence can track your calories and your fitness and all the rest of that.

What have you seen? What is the uptake? How many people are using these apps? How effective are they? What is your research doing to go beyond this stage? Are you looking to coordinate those sorts of things? There are some products out there already. How are you looking to take this development to the next level?

Ms. Rita Orji: The main difference between what I'm going to be doing and what I am doing—what exists now—is that the apps to track calories or to do some other stuff, such as motivate people to exercise by measuring their goals, as in making them commit to probably a weekly goal and track it, might not touch what is important to the person.

What we're doing differently is that we want to study the human being and understand the person's behaviour—the behaviour of either the group or the individual—to understand what is of interest to the person.

One of the models we have is trying to understand the eating behaviour within a group. We want to understand the determinants of eating behaviour. What is interesting is that we found that what motivates that group of people is gaining weight. What we want to do is to motivate people along the lines of their interest. We're building the model primarily based on behavioural change theories or health theories. It's going to be different from what you see outside, because it's going to be practically based. It will be based on how behaviours are formed and how they can be changed. You'll be using something that is motivating to yourself personally and that talks to your own particular need.

Most of the apps out there are generic, aren't they? I just use it for me; it doesn't do anything to me. It doesn't even act on what I believe. However, if what motivates you is the probability of gaining weight, whereas another person cares a lot about disease and some other person cares a lot about the physical outlook, if I want to talk to you, I'm going to project the outcome of your behaviour based on what is of interest to you. That is the trigger; that is what makes the magic.

Mr. Mark Strahl: I'm looking forward to using that when it comes out.

The Chair: Thank you so much.

We'll now go into our second round. It will be a five-minute round. We'll begin with Ms. Quach.

[*Translation*]

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

I thank all those who have come to provide us with some crucial and, I would say, original, information.

Most of you have talked about social determinants and their effects on diet, as well as on activity. You also talked about the importance of acting very early, right from childhood, regarding advertising, access to places to move, and healthy eating habits.

Where diet is concerned, we have been trying for years to take more preventive action. There is Canada's Food Guide and campaigns promoting physical activity in schools. In light of the growing obesity epidemic in Canada, many experts say that we should have more regulation. According to them, we can no longer rely solely on voluntary action, on everyone doing his bit. It is no longer enough.

There is talk of agri-food regulation designed to promote access to healthy and nutritious, and at the same time local, food. Indeed Canada has lots of farmers, truck farmers, growers and breeders. Do you have any thoughts on this? Do you know of any plan under which Canada-wide regulation has promoted access to healthy food, but whose funding has been stopped?

[*English*]

The Chair: Who would like to take that particular question?

Hon. Mary Collins: I can comment on that a bit. There are lots of projects going on across this country. If you come to our conference, you'll see posters and presentations of all kinds on fascinating things that are going on around food security.

I don't think there's a magic bullet. I think it requires a number of different approaches. As examples, a lot of places in northern British Columbia are looking at new ways of growing food. I was meeting with folks recently on how to use waste from some of the wood products to fuel greenhouses in the north so that they could be producing fresh food there. These kinds of innovative approaches need to be addressed.

As for food in schools, we had some very successful farm-to-school projects in northern and remote communities in British Columbia. They really helped to change behaviour in the children and they influenced their parents as well to get children to eat healthier foods.

A huge amount of work is going on in the area of food security, but underlying it, when you talk about the social determinants of health, is still the ability of people to buy fresh food and good food. That continues to be a challenge, particularly in northern and remote areas. The B.C. government has been working on a pilot project to subsidize food; I'm not sure that approach is necessarily going to answer the problem. I think it may help, but you still have to get people motivated to buy the fresh food.

The other side of that equation concerns how we can help raise those with the lowest incomes. In B.C. we've been advocating increases in the minimum wage, which has happened, and living wages. My dear colleague from the Canadian Cancer Society is from one of the first organizations to implement a living wage, and they did so not only for their employees but for all their contractors. We have other examples in B.C. We think this is something that is going to keep growing out there too. It will make a big difference.

● (0955)

[*Translation*]

Ms. Anne Minh-Thu Quach: You talked about incentives, consumer prices. Might the government have a role to play with regard to prices in restaurants and grocery stores? Could it promote access to local markets? You talked about community gardens. All that is linked to physical activity. If there are more local markets, people are going to get there by means other than cars, and this is going to get them moving.

Ms. Orji, I find your approach truly original. Today's young people all have cell phones and play a lot of electronic games. I wondered whether you had done any studies to determine whether this affects girls or boys more. Where is it most effective?

[*English*]

Ms. Rita Orji: Actually, we did a study comparing girls and boys, but presently we are more focused on eating. We want to understand what has meaning for the boys and what has meaning for the girls. I want to work based on what is meaningful to somebody. It's not a case of using force; we don't want to change people using force. We want to motivate along the lines of what has meaning for you.

We found that what matters to girls is different from what matters to guys. Particularly, a girl is more interested in her physical lappearance, so if you tell her that something is going to make her look look ugly and become unattractive, this, as superficial as it might sound, is the main thing they care about. They don't really care about getting a disease sometime in the future, or the probability of getting diabetes or something; those things don't have meaning.

You just have to find what the main thing is that has meaning for the person. To a guy, for instance, having a disease probably makes a difference—

The Chair: I'm sorry, Ms. Orji; I'm going to have to cut you off. You've gone over, but it's very interesting. Thank you.

We'll now go to Mr. Gill.

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

I also want to thank the witnesses for being here and for the wonderful presentations.

My first question is for the Canadian Association of Occupational Therapists. Could you please discuss your organization's initiatives? Have you developed any in terms of aiming at obesity?

Also, in your experience, how much time is spent by occupational therapists on obesity-related issues, and has this amount increased in recent years? Where do you see the trend going?

Dr. Mary Forhan: Thank you.

It's a great question I'm very passionate about.

About 15 years ago, I was the first occupational therapist in Canada to officially work in the area of obesity management. Since that time I've been able to mentor a number of emerging therapists who are now taking on the role. It is an emerging area. It's a very natural fit and it doesn't require us to do any additional training. We have the skills and the knowledge; what was lacking was the integration of those skills in the area of obesity prevention, management, and treatment.

I've done a lot of work with the association in developing education at conferences. Our association has a position statement that helps to guide practice. I'm currently editing a textbook that will be available across North America for occupational therapists and students to be able to use around occupation and obesity. It will have a management, prevention, and treatment focus. We currently have leaders in the area of obesity in Alberta, and there is a bariatric strategy through Alberta health services. One of the leaders in that field is actually an occupational therapist, who is responsible for a health network out there and is taking on the responsibility of training other therapists to work in that area.

I'm involved in interprofessional education that's available to all health science students. It is focused on rehabilitation and it's available to students across Canada. It's out of the University of Alberta and out of McMaster University. Our numbers are small, but as a profession we're small.

I can't specifically tell you about proportions, because when we identify our area of practice, obesity would be embedded within acute care, community care, long-term care, and primary care, but we are exposed on a daily basis to working with individuals who have obesity and we are high profile in the area of obesity. I am on a high level with the Canadian Obesity Network, representing the occupational therapists of Canada, and I lead several projects through them and put that occupational therapy lens on everything we do. Although we're small, we are very active in promoting what we do in that area.

● (1000)

Dr. Claudia von Zweck (Executive Director, Canadian Association of Occupational Therapists): I can add that although a number of occupational therapists in Canada may not specialize in the area of obesity management, the mandate of our profession is to help people to do the occupations that are important to them every day and allow them to engage in things that are going to help them to be active in their environment. What we've heard from other witnesses today is the importance of looking at the barriers individuals face, helping them to address those barriers, and finding the most successful solutions, which are the solutions that address individual needs. That's where occupational therapists are working with individuals, groups, and populations in order to allow them to engage in those occupations and have that healthy lifestyle. Although it's not always necessarily geared towards obesity, it's geared towards active living, which feeds into the whole issue.

Mr. Parm Gill: Thank you.

My next question is for Rita.

Rita, are you able to discuss with us some of the challenges you may be facing in developing this application for computers or smart phones? How do you intend to market this application to the general public?

The Chair: I'm sorry, but we only have about 30 seconds, Rita. That doesn't give you much time.

Ms. Rita Orji: Some of the challenges concern how to project the future outcome of the behaviour, to make the person actually.... If you're going to take a stairway instead of taking the elevator, in one month what is going to be the impact on your life? What motivates people is outcome. In behaviour change, you don't see the immediate outcome. If you're able to show somebody what is going to happen in one month's time—that is, how is your behaviour right now going to convert into an outcome in one month—it is going to be a big motivator. One of the challenges we are facing right now is how to actually do this in terms of healthy eating, which is kind of complicated.

The Chair: Thank you.

We'll now go to Dr. Morin.

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

Rita, earlier you spoke regarding the difference between boys and girls. I want you to please finish what you were saying. You were about to start on what boys want.

Ms. Rita Orji: Okay. As I was saying, girls are really more interested in....

For example, suppose I have some girl who is a smoker. She smokes and she doesn't have a reason for doing that. When I went to talk to her, I said, "Why do you smoke?" She said, "It's fun, and I just want to do it". I said, "You might get some disease and die". She said, "That's nothing new. Something's going to kill you anyway", so that didn't work. The next time I told her, "You know what? You're going to get cancer of the mouth, and guess what? Women who get that are going to be unattractive, and nobody will kiss you again".

That was the main thing. It worked. She refused to leave my room because she wanted to know more. She asked me what it looks like. She set out all the pictures to see what cancer of the mouth looks like, and she said, "That is really horrible. Rita, this is horrible. I would prefer to die". I said, "No, you're not going to die. You're going to live with this for a while".

It was interesting that this was actually what worked for her. For the next month she didn't smoke, but the downside is that she's also afraid of gaining weight, because at times when you change one behaviour, another one comes in. She's obsessed about adding some weight, so her fear was that if she stopped smoking, she was going to add weight. I said, "There's another way you can manage that".

What I'm trying to say, in a sense, is that finding out what motivates people is actually the key to behavioural change. When I found out girls are more interested in their physical looks, I wanted to show them how they were going to look in a month's time if they continued eating burgers on a daily basis.

● (1005)

Mr. Dany Morin: What about boys?

Ms. Rita Orji: From the model we have, boys care more about disease, but they also care about looking healthy. Most boys of a young age care about their attractiveness, but to boys attractiveness doesn't mean weight; it means the body's appearance, the general body build. Therefore, if I want to motivate a guy, I might not just focus on the weight; I might focus on the general appearance, the body build and stuff like that. That is what drives the boys.

What we're going to build for them is like this. If you want to build them up, you might want to create a model that makes them want to build their muscles. We want to tailor it to people's health needs, and for boys, that means creating a model that makes them choose building muscles. For somebody who wants to look good—and most of the guys want to build their bodies and build muscles—if you get an opportunity to channel someone into that aspect, they are so enthusiastic about it.

That's one of the things we're doing.

Mr. Dany Morin: Thank you very much.

[*Translation*]

My next question is for Martin Cooke.

A little earlier, your colleague and you were talking about long-term investment in prevention programs aimed at aboriginal populations. Can you give us more information about the current situation? You are not the first representatives of agencies talking to us about the lack of reliability regarding investment in programs designed to prevent disease and promote health. Tell us more about your current needs and what you are asking the Canadian government for to ensure the continuity of these good programs, be they pilot projects or very useful projects for aboriginal communities.

[*English*]

Dr. Martin Cooke: I'm not sure. I don't know that we have any expectations of government in this respect. What we're trying to do is show that we have a model that we think can improve how systems work; I guess we would hope that this model would be replicated. We recognize that local contexts are always very different and that they matter, and that the collaborations and everything else will be different. However, we hope that some element of the model of the process, through breaking down barriers and improving collaboration among all partners and all elements of this complex public health system, can improve the health of indigenous children in our communities. It's the idea that this might be a model that can be used in other areas.

The Chair: I'm sorry, Dr. Morin; we're about there.

My colleagues have graciously allowed me a question, so thank you.

I'm very interested, Ms. Orji, in what you have to say and in your research. I like what you have to say about motivation, because I think that whether we are young or old, that's what makes us do what we're supposed to do.

There is a disconnect between the younger generation and the older generation. Our demographics are showing that most of the population in our country are going to be of the older generation in a couple of years; that is, there will be more of the older generation than there will be young people. That's the first time this has ever happened in Canada.

You talked about social media. Have you thought about how you would make the older generation aware of social media, about how they can apply it and how they can make it easy for them? I worked with a group of seniors and introduced them to the computer and a few things like that; once they got going, there was no stopping them. Some of these seniors really need to be motivated to do physical activity; in fact, this morning I was learning how to swim. I never swam in my life. I did six laps this morning, and my hair looks like it.

Could you give us some input into that area?

● (1010)

Ms. Rita Orji: Our study showed that a good number of the older generation are not so effective at the use of computers, but when it comes to mobile phone use, they are almost at par with the younger generation. Most of the apps and interventions we're going to be designing are going to be running on phones. They can be used by anybody, older people and younger people alike. That's why we feel that applications for mobile phones are the in thing. They are the way forward, because mobile phones go with people wherever they go. They're something anybody can use.

The key here is that you don't have to learn it and you don't need to buy anything extra. You just have it with you. When something extra needs to be attached to the cellphone or the person, it adds another difficulty to the behaviour you want to promote. However, if I'm able to get it into the phone you're already using, then if you know how to dial a number, you can use the application. We're actually targeting the whole group, both the old and young generations.

That's why I said that mobile phones are going to be the future. They're going to be the in thing that everybody can use. You don't need any extra thing. You don't need to learn. There's almost zero learning curve involved.

The Chair: I'll carry this a little further. You know that, and now we know it because you've come to committee, but how would you let the public out there know? There might be a suggestion that you could you give that information to each of the MPs or people like that, and they could put it into the ten percenters and spread the good word around, because physical activity is the key to managing chronic disease. We've heard that over and over again in our committee. It might be something to consider looking at for your research, because it would narrow the gap.

What do you think about that?

Ms. Rita Orji: It's a good thing. I think part of what we're doing today is getting it to the public. Then we've got a couple of publications we're going to be having outside, although I wouldn't believe everybody will have access to them. We also hope to make it as public as we can by attending forums and showing the results of what we've done. We hope to design some things, evaluate them, produce the outcome, and get it outside as a publication for other people to read. By doing that, we hope to create an awareness of the added capability that mobile phones and some other applications have in changing people's lives, and more specifically obesity.

The Chair: Thank you. I have another minute, so I have one more question. It relates to the aboriginal sector.

My son is married to a full-blooded aboriginal girl. I know there's a community that is very concerned about the welfare of the young people and about obesity. How do you get that educational component to these young people? It seems to me that a lot of the kids don't even know what healthy eating is about; they're obese because they like pop and they like chips, and the parents encourage them to go out and buy some. How do you get that education to them?

Dr. Martin Cooke: Certainly that's something we hear from our partners. Our co-coordinator of this project, Teri Morrow, is a dietitian whose job has been health promotion among urban aboriginal children, for the most part.

My best answer is that it depends on what's going on in that community. Local folks know how to do that and how to make it most meaningful, I think, but I'm an outsider as well.

The Chair: Thank you. I'm out of time, so I have to go to Dr. Morin.

Mr. Dany Morin: I think my question was misunderstood earlier, so I'm going to say it in English.

Mr. Wilk, in your presentation you mentioned long-term funding for programs, right? Can you tell us more about the current situation, and what you wish from the partners, the government or whomever, in order to increase long-term funding for good programs?

● (1015)

Dr. Piotr Wilk: Yes, I can talk on behalf of our partners in London, Ontario, because that's who we have heard from. Definitely one of the major complaints was that very often their funding would be for specific programs and would last for maybe a year or two; then the funding would be gone, regardless of whether the program was successful or not.

Definitely, there has to be some sort of structural change in the way successful or good programs are funded; oherwise, you create a hope, because something is being done at the community level, and then you take that hope by taking that programming away. It's not only the fact that it is not creating a positive trend at the community level, but also it's disappointing for our partners, who think they are being deprived of those things that were given to them before. Probably some sort of continuation in funding would be much better.

Mr. Dany Morin: I suppose that when funding stops and the program must therefore also stop, the expertise of the team, which after a couple of years has become great, is lost when the team is dismantled.

Dr. Piotr Wilk: I would completely agree with you. We are finding ourselves in a position where we are basically trying to find an answer to a question that maybe someone answered a few years ago, but there is no record and there might be no institutional retention of that knowledge. For that reason, there definitely has to be some change at the system level, rather than just at the individual level.

Mr. Dany Morin: Mary Collins, you also talked about this. Could you give us your experience?

Hon. Mary Collins: We would certainly ask the federal government to continue robust funding for the various agencies—CIHR and the different agencies that are supporting research projects—and perhaps have them look at the term of funding for many of these.

The other thing we've been very pleased about, of course, is that the cancer prevention strategy was renewed.

Perhaps we should look at a more integrated strategy around chronic disease prevention, rather than disease-specific or risk factor-specific, because we're recognizing it needs to be integrated. We should think about how the federal government might be able to provide funding through research organizations to do some on-the-ground kinds of research that will yield some really robust outcomes.

Mr. Dany Morin: With our current financial situation and with compression everywhere, I'm afraid that money devoted to research or to good programs will be cut. In health care when money is tight, prevention is the first thing that is cut, and the government focuses on acute care, which is not a good long-term solution.

Hon. Mary Collins: I agree. We would certainly plead that prevention is the last thing that should be cut, and the programs to support those kinds of activities. Otherwise, we're just going to continue in this cycle of ever-increasing health care costs.

Mr. Dany Morin: Thank you very much.

The Chair: Thank you very much.

Now we're going to suspend. Committee, we're going into our business section.

I want to thank you very much for your presentations. I would kindly ask you, if you want to speak to anybody, to do so outside the doors, because we need to start our business right away.

Thank you so much. We'll suspend for one minute.

[*Proceedings continue in camera*]

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