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Chair

Ms. Bonnie Brown

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● (1535)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Good afternoon, ladies and gentlemen, and welcome to the 27th meeting of the Standing Committee on Health. Today we're working pursuant to the order of reference of Wednesday, February 9, with Bill C-206, an Act to amend the Food and Drugs Act.

We have witnesses this afternoon. It's my pleasure to introduce the first witness, from the University of Western Ontario: Professor John Trevithick, professor of biochemistry in the Schulich School of Medicine and the School of Kinesiology.

Mr. Trevithick.

Professor John Trevithick (Biochemistry, Schulich School of Medicine, School of Kinesiology, The University of Western Ontario): Thank you, Madam Chairman and honourable members.

I welcome the opportunity to talk to you about some of the work we have done, which has implications for Bill C-206. Our work is focused mainly on aging disease risk reduction. We work on cataracts, and we have become aware of heart disease as being an important aging disease as well that's influenced by antioxidants.

I'd like to take you through this, and hopefully at the end of this story you will have a little better understanding of why it may be important to encourage moderate drinking, from our viewpoint.

In the meantime, I would encourage any members, if you have trouble—because I realize some of these are scientific graphs that I'm showing you—in understanding them to feel free to interrupt. I direct your attention to the screen.

First of all, the concept of hormesis is something that has recently become much more important. It's important for radiation safety, because it's appearing that at low doses some types of radiation may actually be beneficial. The concept of hormesis generally deals with j-shaped dose response curves. In these curves you find a benefit at low concentration but toxicity at high concentrations.

What is actually happening here is shown in a curve a colleague of mine in Edinburgh took, where she looked at the risk—if you look at the vertical scale—as opposed to the number of beverages per day people took. You can see that at one drink per day there's about a 50% risk reduction for cataracts. This holds true for a number of different age groups, all the way from age 50 right up through age 89. So one drink per day seems to be beneficial for cataracts.

A similar kind of risk reduction was found for one gram to fifty grams of alcohol per day. You can see that this again is increasing in risk, from the people who are abstainers, as you go up, to two or three drinks a day. So this phenomenon of hormesis seems to be important.

Why would we find any kind of reduction in risk for people who are taking one drink a day? It's surprising. Usually people think of alcohol as not being too good for you, but maybe there are some benefits to be had.

One of the things we did was to look at the free-radical scavenging by a kind of beverage that a lot of people took last week. It's a kind of beverage called “stout”. We took these curves, ESR curves, which measure the concentration of free radicals. We have different controls. We have superoxide, and then we added stout to the superoxide. Superoxide is a kind of radical we all produce during our normal metabolism in small amounts, but it can be dangerous in larger amounts. For instance, if you are doing organ transplants and you reprofuse the organ, you get large quantities of this superoxide produced. We have also a control for hydroxil radical, and then we added stout to it.

If you look at these curves, you'll see the radicals and what happens to them when we add the stout. Almost all of the radicals disappear. It's the same thing with the hydroxil radicals: when we add the stout they disappear.

In that case, it's interesting to ask why this is happening. Well, it's the polyphenolic compounds in the stout. These are compounds that are normally produced during the process of malting, because in malting barley you're actually producing compounds that have phenolic hydroxil groups, similar to vitamin E. When you roast the barley to stop the barley from growing in the malting process, you extract these components, which are small molecular weight precursors of the cell wall component you have all heard about called lignin.

● (1540)

We have this. So we can actually use a luminescent assay for these free radicals as well. We developed one in which we measured the amount of peroxide by a photochemical reaction, where we're producing photons. These are counted by an instrument that counts the number of photons as a direct measure of the amount of peroxide that was there. If we destroy the peroxide, we get the antioxidant activity.

It turns out that when we look at most of the beverages, we see they destroy over 90% of the peroxide, and they have antioxidant activities over 90.

If that's the case, then we can look at a number of different beers and wines, and we can say a half per cent alcohol beer. You know that ethanol itself has an antioxidant activity for these hydroxyl radicals, so it has a somewhat lower antioxidant activity.

But it would be nice to be able to compare the relative potency of these different beverages we have here. All of these different beers and red and white wines seem to be very strong in their antioxidant activity. That's a good thing. If we could figure out how they were related, then we could look at them.

We can also look at rums. These different rums also have very high antioxidant activity, except maybe this one here, which is a light rum; this one here, which is a white rum; and that one, which is a white rum. So it looks like the coloured component in the rum is important. That turns out, actually, to be a tannin, which is related to the tannins that we have in tea. They have antioxidant activity. Where do we get those tannins? They're extracted from the casks that the rum is maturing in. And the browner the rum, the more antioxidant activity.

What we can do, though, is make a dilution assay, where we use an IC50. We can dilute the beverage. By diluting it to a point where we destroy only 50% of the peroxide, we can figure out how much of the peroxide is destroyed at that level. So when we're looking at IC50, a beverage that has a low IC50 has the most potent antioxidant content, because you're diluting it the most. For instance, .001 beats .01.

If we look at the next graph, where we looked at those same rums, we can see that some of these rums have very low IC50s, and that's good. For instance, Mount Gay Barbados rum, which I got on a vacation, turns out to be one of the most potent. But the light rums, if you look over here, don't have very good IC50s; they're quite high.

That concept is important.

For the antioxidant activity we can look at a number of Canadian whiskies. We can look at Wiser's and a whole variety—Canadian Club being probably one of the best known. They all have a lot of antioxidant activity, but we can compare their potency, and we can say that this Wiser's Very Old is probably the best.

If we look at the beers, we can do the same kind of thing; we can look at the antioxidant activity of all these beers. Some of them, the 0.5% and one of the soda beers, are not very good, but the rest of them all have quite high antioxidant activity—except for a light beer like Bud Light. Light beers don't have as much antioxidant activity. We can do the same IC50 thing. If we have a low IC50 here, we have a very good beer, as far as the antioxidant activity is concerned.

We decided to do a human study. We looked at whether the absorbed beverage antioxidants affect the blood plasma. Can we get a lower oxidative stress in the blood plasma by adding these antioxidants in a beverage, and do the alcohol or polyphenols affect the plasma antioxidant levels? Is there any relationship of these to the hormesis curves that we found?

The human study details were that volunteers were given one or three drinks of an alcoholic beverage after an overnight fast. Their blood plasma antioxidant and alcohol levels were followed for four to six hours. The beverages we tested were lager beer, red wine, stout, and alcohol solution—each had 13.4 grams of alcohol—and an alcohol-free stout to look at these polyphenols by themselves, without the alcohol being there.

● (1545)

If you look at these, you'll see that the only one low in antioxidant activity is the one that contained only alcohol. The others—the red wine, the beer, the stout, even the stout without alcohol—had quite high antioxidant activities.

We can average these results over the period of time. The average antioxidant levels obtained for the four- to six-hour period were compared for one to three drinks. After one drink, the plasma became quite strongly antioxidant. So that's a good thing probably. After three drinks the plasma became pro-oxidant, which is not good. It's sort of like getting a dose of radiation. Except for two volunteers, we found that result. For three drinks, it seemed that alcohol itself appeared to be metabolized to these damaging free radicals, so the alcohol is not a good thing.

You can see that with red wine, one drink is causing positive antioxidants; for three drinks, it's actually pro-oxidant, and so on, except for water with alcohol, which doesn't show any antioxidant effect at one drink, and for three drinks it's actually pro-oxidant.

Another thing we were interested in was rationalizing the heart disease risks I showed you on the first slide, because oxidized LDL cholesterol is a precursor of the atherosclerotic plaque. If you decrease the oxidation of the LDL by dietary antioxidants in animal models, you decrease the atherosclerosis these animals have.

So 30 minutes after consuming stout, we looked at the LDL cholesterol of volunteers. It was 14% more resistant to oxidation by copper than the pre-consumption sample. So it looked as though we were decreasing the oxidized LDL cholesterol, so we would be decreasing the amount of plaque formation. This could explain the 50% decrease in risk of heart attacks for people consuming one drink a day.

We got a little bit different story for heavy drinkers. Two drinkers had antioxidant plasma for a lager beer or red wine; the other ones were pro-oxidant. But for these two beverages, the heavy drinkers did not metabolize the alcohol as rapidly. Because it's a push-pull kind of thing, the antioxidants are fighting the oxidizing material produced by the alcohol. What's happening here is if they don't metabolize the alcohol to the oxidizing materials, the antioxidants can come into play. That's in fact what happens.

If you look here, we have the red wine and the lager beer being antioxidant, whereas the other ones, where they had faster metabolism with the alcohol, were all pro-oxidant. So this is the red wine and the lager beer, whereas with the other ones, the alcohol level goes up and comes down, as we expect.

To conclude, alcoholic beverages contain polyphenols and flavonoids with antioxidant properties. The alcohol itself appears to be metabolized to oxidizing metabolites, so the balance between these two is causing either an antioxidant or a pro-oxidant plasma after you take one or three drinks. The j-shaped curve of risk with increasing beverage consumption is typical of the phenomena I called hormesis. The plasma was pro-oxidant after three drinks of non-alcoholic stout, which we hadn't quite expected. But there are some beverages you can consume that are non-alcoholic, and if they have too much polyphenol in them, that may not be good for you either.

We did a cost-benefit analysis, because we had material from OHIP on the decreased risk of heart attacks and cataracts by age and sex. We did a computer model of this and had productivity savings shown of $10.2 billion for an Ontario cohort, which is 50 to 54 people, in 2001. That is 788,000 people, comparing if the province paid for one drink a day or if these people abstained. It would have almost paid for people to be subsidized for one drink a day. For Canada, this would result in a present value of savings of $402 billion, if you count the total population of Canada. So if Bill C-206 decreases the number of people taking one drink a day, it could result in large decreases in this $402 billion in productivity that we model from this study.

● (1550)

I was surprised, as you are, at this, but it certainly comes out of the computer model and it's a real number.

We make some recommendations for label wording and funding. One drink a day of 341 millilitres of beer or 155 millilitres of red wine, or the same amount of alcohol in a matured whiskey or rum, or something like that, would decrease the risk of heart disease and cataracts.

I'd like to make a plea for better funding for research by CIHR into the health benefits of alcoholic beverages, and not just the bad effects. We've had an extremely difficult time getting this funded. The beverage companies seem to be reluctant to fund it because they're worried about legal cases against them, the sort of situation the tobacco companies found themselves in. Funding could also be available for a Canadian foundation for research into alcoholic beverage health effects from alcoholic beverage companies, just as the auto companies crash test cars to improve safety. We think this is an important thing that the committee should be thinking about. I know it's not exactly part of the bill, but you can make recommendations.

I thank you for your time, and I welcome questions.

The Chair: Thank you, Mr. Trevithick. The questions will follow at the end of all the presentations.

Our next witnesses are from the Canadian Centre on Substance Abuse. We have the chief executive officer, Mr. Michel Perron; the director of research and policy, Patricia Begin; and Mr. Gerald Thomas. I'm not sure which of you is going to make the presentation.

Mr. Michel Perron (Chief Executive Officer, Canadian Centre on Substance Abuse): That would be me. Thank you very much, Madam Chair and honourable members.

I'd like to begin by thanking the committee for giving us this opportunity today to speak on the topic of alcohol warning labels.

The Canadian Centre on Substance Abuse—CCSA, as we're commonly known—was created by an act of Parliament in 1988 to provide a national focus for efforts to reduce the harms associated with the misuse of alcohol and other drugs in Canada. The renewal of Canada's drug strategy in 2003 reaffirms CCSA's position as Canada's national addiction agency.

We are particularly pleased when Parliament turns its attention to alcohol and other drug matters, as these substances represent an important social, health, and economic cost to society. As you know, these substances are underpinned by a complex series of interconnected policies and legislation and they affect all orders of government.

[*Translation*]

The Canadian Centre on Substance Abuse, or CCSA, works with all stakeholders to identify the most practical and effective ways of mitigating the harmful effects of substance abuse.

Over the course of the past year, we have been actively involved in the move to develop a policy on alcohol usage. Specifically, in November 2004, we organized a national workshop where the focus was on an alcohol usage policy. We'll discuss the workshop's findings in a few moments.

This is not the CCSA's first appearance between the Standing Committee on Health to discuss warning labels on alcoholic beverages. In 1996, we gave a presentation during which we endorsed, with some reservations, mandatory warning labels, and put forward the following arguments.

● (1555)

[*English*]

Our conclusions in 1996 before the committee were as follows.

One, research does not support the effectiveness of warning labels in bringing about changes in problematic drinking behaviour. However, it is likely that over the long term they may help create an environment in which other controls, both formal and informal, can develop more easily.

Two, consumer products that have a proven potential for causing harm should be appropriately labelled, and alcohol should not be exempted from labelling requirements demanded of other toxic substances.

Three, warning labels are a passive control measure and should not be seen as a substitute for continued investment in a range of active interventions. Such an investment can only be made in the context of a comprehensive drug and alcohol strategy.

Regrettably, in the nine years since that presentation, there is still no direct evidence that text-based warning labels are effective at changing behaviour, the behaviour of those who misuse alcohol. Here we are referring largely to the seven-year evaluation study in the United States that used surveys to track the effects of their national labelling law before and after it came into effect in 1989.

In October 1996, the major findings of this extensive evaluation were stated as follows:

> that public support for warning labels is extremely high; that awareness of the label's content has increased substantially over time; that perception of the described risks was high before the label appeared and has not generally increased; and that the label has not had important effects on hazardous behaviour, although certain effects may be indicative of the early stages of behavioural change.

These findings confirm that there is no scientific evidence that we know of at this time that verifies the effectiveness of text-based alcohol warning labels for addressing hazardous drinking behaviours.

Given the lack of empirical evidence regarding the effectiveness of warning labels for changing behaviour, it is our second point, as stated in 1996—namely, that drinking alcohol is potentially harmful and therefore should be required to carry consumer warnings like other hazardous products sold in Canada—that we believe is the most compelling argument in favour of mandatory warning labels. As we stated then, we can find no logical justification for why beverage alcohol should be exempted from the requirement made of other harmful products sold in Canada.

That said, it could be reasonably argued—and I'm guessing you've heard this already—that the compelling scientific evidence of health benefits to certain segments of the drinking population, as we've just seen by the previous speaker, arising from moderate alcohol use should also or could also be included on alcohol containers to balance the messaging.

We would now like to discuss a third major point we made in 1996, that alcohol warning labels are a passive response to problems associated with alcohol misuse and should not preclude significant investment in a range of more active interventions such as the one recently undertaken by CCSA.

[*Translation*]

Some four months ago, the CCSA held a national workshop where the focus was on policies relating to alcohol usage within the broader context of the push to build a national framework for action on substance use and abuse. For those who may not already be aware of this fact, this framework is a key component in the renewal of Canada's Drug Strategy. This workshop brought together stakeholders from a wide range of fields to focus on specific initiatives aimed at minimizing the harmful effects of alcohol abuse. The two major approaches to addressing substance abuse problems were compared, that is a public health based approach which relies on relatively unsophisticated measures such as taxation to reduce overall consumption levels and consequently minimize harmful effects on health and society; and the targeted intervention approach which relies on more specific policies and programs designed to address certain kinds of problem behaviour such as drunk driving.

[*English*]

All told, five major topics and strategies were discussed at length at the workshop, including promoting the use of routine screening and brief interventions for problem drinkers or those at risk of becoming problem drinkers; developing and promoting policies to reduce chronic disease, including fetal alcohol spectrum disorder; structuring alcohol taxes in a discerning and purposeful manner; addressing the drinking context and using targeted interventions; and developing a culture of moderation versus a culture of intoxication in Canada.

All the participants at the workshop agreed that we should proceed on the basis of evidence and make recommendations that were balanced and informed by careful analysis of the scientific literature. On this point, the topic of alcohol warning labels was mentioned, but due to the lack of evidence regarding their effectiveness it did not emerge as a viable policy in the final recommendations for action.

What did emerge was a set of recommendations that promote a mix of population health and targeted interventions that the evidence suggests will have the greatest impact on reducing the harms from the misuse of alcohol, while at the same time allowing us to retain the fiscal, social, and health benefits associated with responsible use in Canada.

While we are confident that the strategies identified at the national thematic workshop represent a good starting point for practical efforts to reduce alcohol-related harms in Canada, we would like to suggest that the systematic and inclusive nature of the meeting itself, which allowed diverse stakeholders with competing perspectives to come together to share information and reach consensus, is perhaps its most important contribution to this area. This was the first time in many, many years that this consortium of partners interested in this issue came to the table to discuss issues of common interest.

● (1600)

[*Translation*]

The approach selected is important when it comes to dealing with an issue as contentious and as politically charged as alcohol. We believe that this initiative is most likely to result in an effective, lasting solution to the problems associated with alcohol abuse in Canada.

Having reaffirmed the position first taken in 1996 and expressed a cautionary note about that position, we would like to put forward three related recommendations that, in our opinion, warrant serious consideration.

[*English*]

First and foremost—and notwithstanding the ultimate outcome of your deliberations on labelling—we urge this committee to support and call for the creation of a national task force on alcohol to help promote the recommendations made at the national thematic workshop on alcohol policy last November. It would address a comprehensive list of priorities, including fetal alcohol spectrum disorder and the like. We know that Health Canada is committed to such a process where CCSA would be a co-lead. An endorsement from this committee for such an initiative would be welcome.

Second, should you wish to proceed with the labelling scheme, we recommend that this committee consider recommending that the Food and Drugs Act only be amended to allow for the inclusion of labels, but that their content, type, and format be prescribed by regulation. This would enable the government to ensure that a label reflected contemporary evidence, while allowing future flexibility for change based on evaluative experience. For instance, we recommend considering the use of standard drink labelling rather than the health and safety warnings currently proposed in Bill C-206.

Standard drink labelling seeks to reduce alcohol-related harms by giving consumers information on appropriate serving sizes based on alcohol content and then reminding them of low-risk drinking guidelines. In a sense, we could connect the label with a number of the promotion campaigns that are out there. Standard drink labelling, which is similar to the serving size recommendations required on other consumables in Canada, has been shown to be potentially useful for moderating alcohol misuse among drinkers in Australian.

Finally, we must mention what is perhaps the most important issue of all, and that is resources. On this point we'd like to share a thought. Each year, all orders of government in Canada receive over $5 billion in revenue from commodity taxes and fees associated with the sale and control of beverage alcohol. This does not include sales tax. To put this number into perspective, during the two hours of these hearings today, over $1 million will be taken in by governments across Canada on the sale of alcohol. As such, our third recommendation is that this committee consider calling for an earmarking of these significant revenues to fund a comprehensive and sustained alcohol and fetal alcohol spectrum disorder strategy, as part of the national framework on substance use and abuse.

While these suggestions may seem radical, particularly those familiar with fiscal policy, there is a precedent for this type of earmarking. Quebec already directs 1¢ from every bottle of alcohol sold through their provincial alcohol monopoly to prevention and education efforts. Several provinces now earmark a percentage of their proceeds from gambling for the prevention of problems related to compulsive gambling.

[*Translation*]

In conclusion, let me just say that the process of building a national framework for action demonstrates—and we're firmly convinced of this—that the principal stakeholders want to and indeed can join forces to promote rational solutions based on probing evidence that alcohol abuse leads to complex health and social problems. We urge the committee to draw on this potential during the course of its deliberations.

Thank you.

[*English*]

The Chair: Thank you, Mr. Perron.

We'll now go to Ms. Wendy Burgoyne, the health promotion consultant for Best Start: Ontario's Maternal, Newborn andEarly Child Development Resource Centre.

Ms. Burgoyne.

Ms. Wendy Burgoyne (Health Promotion Consultant, Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre): I'm speaking on behalf of Best Start, which is a program funded by the Ontario Ministry of Children and Youth Services. I want to indicate our support for alcohol labels that discuss alcohol use in pregnancy and indicate the harm that can happen if you drink alcohol in pregnancy.

Best Start is a program that provides supports to service providers who are working on promoting the health of pregnancies, infants, and young children. We've been working on alcohol use in pregnancy since the early 1990s, and in the last four years we've had an intensive focus on this topic.

Some of the projects we've worked on are provincial campaigns, conferences, and physician training programs about assessing and addressing alcohol use in pregnancy. And we just finished a video on screening for alcohol use in pregnancy for family physicians. We also provide training for groups on preventing and addressing alcohol use in pregnancy, and we are sharing information with service providers about how they can approach this issue effectively and sensitively. We have provided training intensively in Ontario, across Canada, in the United States, and in Australia. Much of this training is done on-site. We also provide training by e-mail and by phone.

We had the privilege of working this year with the Ontario Ministry of Consumer and Business Services to help develop the wording and also the images for the new Ontario warning signs about alcohol and pregnancy. You'll see in the folder in front of you copies of the warning signs and a few of the sample resources that were used in the May 2004 campaign about alcohol and pregnancy.

My most recent project related to alcohol and pregnancy has been a contract from the Public Health Agency of Canada to review awareness campaigns about fetal alcohol spectrum disorder, or FASD, across the country—to take a look at the messages, images, and strategies, what was effective, where there are areas of agreement, where there's controversy, and so on—in order to report this information back to others who are trying to raise awareness.

I feel we're in an excellent position to comment on what pregnant women need in order to change their behaviour, and I want to thank you for this opportunity.

Pregnant women drink alcohol for different reasons. Some drink because they lack important information about alcohol and pregnancy. Some drink because of social norms, because of addiction, because of alcohol dependence, or to cope with difficult life circumstances such as poverty or violence. Women may drink because of myths or misconceptions about the kinds of alcohol that are safe or times in pregnancy that may be safe for drinking.

Women certainly need different things in order to address their alcohol use based on the different reasons they have for drinking. There isn't one magic bullet. There isn't one perfect strategy we can use that will address all the reasons women drink. We need to, ideally, have prevention strategies that are comprehensive and share important information about alcohol use in pregnancy, screening for alcohol use in pregnancy, and the care, referrals, and supports that many pregnant women need to actually stop drinking during pregnancy. The Public Health Agency of Canada has an excellent framework for action that covers all these areas.

It's also helpful to take a look at who drinks in pregnancy. Often when we're thinking about alcohol in pregnancy, we're thinking of a high-risk pregnant woman. We're thinking of a woman who is single. She's isolated. She's undereducated, poor, living in a violent situation perhaps, and using other drugs. This certainly is a woman we are concerned about. And she'll need many supports to help her address her alcohol use. It is also interesting to note that women who are most likely to be moderate or daily drinkers and more likely to report that they used alcohol in their last pregnancy are well educated, well employed, and over 30.

The first group I talked about is not amenable to an awareness campaign. This latter group is. They're seeking information, they want to make changes, they have the supports and self-efficacy to make changes based on information alone, which is what an alcohol labelling approach is.

Which approaches are most needed? Certainly we need a range of them. Alcohol beverage containers with labels on them is only one of the important strategies we need. Their role is to inform and remind people of risks. Obviously they can't provide all the supports and all the information that women need to address their alcohol use.

● (1605)

If we look at awareness campaigns about alcohol and pregnancy, we see that the ones that have been shown to be most effective use multiple strategies. They address women who are drinking at lower risk levels, for example, women who can stop drinking based on information alone and women who don't need other supports around their alcohol use.

We certainly strongly feel that federal regulations enforcing labelling about alcohol use in pregnancy show there's a government commitment to this concern and indicate that this is a serious issue for all Canadians.

When we take a look at the numbers, we see one in a hundred of all babies born in Canada is born with FASD, which includes serious brain damage and birth defects. This is certainly a costly and serious issue for all Canadians.

It's also important to take a look at what awareness strategies can do. Awareness strategies are a particular tool and they're useful in doing certain things; they can't do everything. Awareness strategies can influence levels of awareness, primarily; they're very effective in doing that. They can also influence attitudes and social norms and in some cases they can change behaviour.

This is not the primary role or the primary product of an awareness strategy, changing behaviour. You need a combination of approaches in order to see measurable changes in behaviour. In the Best Start campaign, for example, we did a pre and post evaluation survey, and one of the things we were very pleased to see in Ontario was a 65% increase in the number of women of child-bearing age who indicated that birth defects could result from alcohol use in pregnancy. We chose our messages extremely carefully, based on what people knew about alcohol use in pregnancy in Ontario, and with that kind of money we knew we did not want to be reinforcing messages that were already there.

Similarly, alcohol warning labels can be an important part of a broader strategy, reinforcing new information or information that's poorly understood by a pregnant woman. Do alcohol warnings work? Well, I'm sure you've heard from many people who've said they absolutely do not work and from many people who say passionately, yes, they do work. The evidence is mixed. Part of the reason for this is that it is very difficult to measure the effectiveness of single, isolated strategies. If we put up a poster around town, would we expect to see changes in behaviour? Not likely. It's one strategy. If physicians were just screening for alcohol use but weren't helping women, would we see changes in behaviour? Not likely. It's not effective on its own. We need combinations of approaches.

Also, many things can change between a pre and a post. Best Start's campaign was in May 2004. Our pre was in March and our post was in August, so there are a few months in there. During that period of time there was a Best Start campaign, Bonnie Buxton's book was released, and our new warning signs were passing through governments, so many things were happening in the media. The fact that the information on the impact of alcohol labels is confusing should not be a surprise to you. It's confusing because it's very difficult to study, and single approaches are rarely effective on their own.

One of the things it's helpful to think about when we're talking about the effectiveness of warning labels is that some evaluations have shown that there's effectiveness with lower-risk groups. When you only see effectiveness with lower-risk groups, there is a temptation to say it's not working, but low-risk drinking doesn't mean it's safe in pregnancy. Low-risk drinking is a pattern of drinking that shows the individual is less likely to have problems with drinking; it's not related to safe drinking in pregnancy.

In Canada right now, low-risk drinking is defined as up to nine standard drinks of alcohol a week with no more than two drinks a day. This was lowered in the last year; prior to one year ago it was higher than that. This is not a safe level of alcohol use in pregnancy. If some studies—and again, we have mixed information here—are reaching low-risk drinkers in pregnancy, this is valuable. Other strategies definitely are needed for women who are alcohol-dependent.

What do Canadians know about alcohol and pregnancy? Studies show there are very high levels of awareness about some things and lower levels of awareness about other things. For example, 92% of Canadians from the Environics survey in 2002 were aware that alcohol use led to lifelong disabilities. The same study showed that 24% thought moderate drinking in pregnancy was safe. That's not what we would like to see. We would like to see people thinking that no amount of alcohol in pregnancy is safe.

● (1610)

On one hand, I'm sure you've heard arguments that people know this. This is not new information. It's a waste of money. On the other hand, there are things people still do not know, like this confusion around safe amounts, safe kinds of alcohol, and safe times in pregnancy. The messages for the labels need to be selected with care.

We've also seen changes in Canada. There are different rates of alcohol use and different levels of understanding about the risks. For example, eastern Canada—Ontario, Quebec, and the Atlantic provinces—was much slower to get started on prevention strategies around alcohol use and pregnancy and has lower levels of awareness. Quebec has the highest rate of alcohol use in pregnancy, at 25.1%, according to the most recent *Canadian Perinatal Health Report*, compared to the Canadian rate of 14.6%.

In Canada, 77% of Canadians are aware of FAS and have an idea of what it is; only 48% are aware of it in Quebec. Similarly, Quebec has lower levels of awareness about FASD. People there are more likely to think it's safe, and they're less likely to stop drinking in pregnancy. So if you look just at that 92% of Canadians who know alcohol use in pregnancy is risky, there may be a temptation to say there's no need for alcohol labels. But there are certainly differences in awareness and risk behaviour across Canada, and there are certainly myths and misconceptions.

In addition, the western provinces that have been working on this area for a long time have seen steady decreases in the rates of alcohol use in pregnancy. This is also in the most recent *Canadian Perinatal Health Report*. We did not see steady rates in decrease of alcohol use in pregnancy in the eastern provinces—Ontario, Quebec, and the Atlantic provinces.

I don't think anybody who has spoken to you has said there's no risk to alcohol use in pregnancy. The federal government and the witnesses all agree that there are serious concerns. There's no safe time, no safe amount, and no safe kind of alcohol in pregnancy. And certainly the federal government has shown that it's serious about promoting the health and safety of pregnant women and children. We see legislation about warnings on medications, foods, chemical cleaners, child safety restraints, and so on.

Warning labels are an important component of a broader strategy to address alcohol use in pregnancy. It's a social responsibility to warn women about known serious risks of alcohol use in pregnancy. Warning labels show that our federal government cares about children and considers alcohol use in pregnancy to be a serious concern for pregnant women.

Best Start asks that the federal government require warning labels related to alcohol use in pregnancy on alcohol beverage containers.

I'd like to thank you for this opportunity.

● (1615)

The Chair: Thank you, Ms. Burgoyne.

We'll move to the question and answer period. The first ten minutes allocated to the Conservative Party will be split between Mr. Fletcher and Mr. Merrifield.

Mr. Fletcher will begin.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Madam Chair. You'll be pleased to know that my question is brief.

Quite simply, I gather from all witnesses that whatever is done needs to be part of a larger strategy. I get that point and I agree with it. But with Bill C-206, we're asked to vote yes or no on a very specific proposal, and based on the wording of the warning label, which deals with FAS and drinking and driving specifically, I'd like to ask each of the witnesses if they support the bill as it is, yes or no, because that's what we're going to be asked to do as parliamentarians.

That's my question, Madam Chair.

The Chair: Thank you.

Dr. Trevithick.

Prof. John Trevithick: It's clear from the review I wrote on the effects of alcohol on the eye that, at least in animal studies, one beer, to give a level of 100 milligrams of alcohol per decilitre in the blood for one hour, is sufficient to cause retinal damage in rats. So between the second and third trimester, I think it's important that women be very well informed about this because it could result in public health problems. On the other hand, I don't know whether the other health effects are necessarily a part of the warning label.

● (1620)

Mr. Steven Fletcher: So do you support the bill, yes or no?

Prof. John Trevithick: As it's currently written, I couldn't support it completely, because I think it ignores the health effects.

The Chair: Mr. Perron.

Mr. Michel Perron: I realize you have a yes or no requirement, but with the greatest respect, it's not an easy yes or no.

A very compelling case is made. The wording that is currently stated in Bill C-206 could give rise to some operational challenges in the sense of "no person shall sell a beverage containing...." Does that mean glasses should then be labelled?

There are a variety of operational issues that flow from the specific wording that you are to vote on, hence the reason why we did say that consumers are entitled to know about the effects, including the negative effects, of alcohol. Therefore, we said in 1996, and we reiterate now, on that basis alone people should be aware of those issues. We have also stated, as the doctor just indicated, potential benefits.

I'm not sure if this is getting to where you want to go, but I would like to underscore the point you opened with, that you understand this is in the broader context of a strategy. With respect, I don't think just this shows enough commitment. This is a quick fix.

It's important. There is absolutely no question of the merit of the intention here. We all support that, but we don't want people to think, because we have this in place, we've solved it.

Mr. Steven Fletcher: Okay.

The Chair: Ms. Burgoyne, I think you made it clear in your speech that you do.

Ms. Wendy Burgoyne: I made it clear. I don't have the expertise in the other areas. I strongly support the bill with the message about alcohol and pregnancy, and I like the idea that it's not stand-alone, so women aren't feeling that they're singled out in having health risks because of alcohol use in pregnancy.

I would also like to encourage the wording to be defined in regulations based on things that are less well known about alcohol use in pregnancy, information that needs to be shared perhaps about safe kinds or safe amounts of alcohol.

I also want to indicate that in the Environics survey in the year 2000, one of the results was that 66% of Canadians were in favour of warning labels about alcohol use in pregnancy. I've looked at the 2002 report, and either this question wasn't asked in the 2002 survey or it wasn't part of the report; I'm not sure which. It certainly seems the majority of Canadians are in favour of warning labels about alcohol in pregnancy.

The Chair: Thank you, Ms. Burgoyne.

Mr. Merrifield.

Mr. Rob Merrifield (Yellowhead, CPC): I'd like to pick up on that, first of all, with a real, clean question. Where in the development of a pregnancy is a woman in the most danger as far as alcohol use is concerned? I'm hearing conflicting testimony, and that's why the question comes forward. Is there any work that any have done that can clear that up?

Ms. Wendy Burgoyne: There are dangers throughout pregnancy. In the first three months of pregnancy, birth defects can form because that's when the organs, the limbs, and so on, are forming in the baby. Alcohol harms whatever is forming at that time. So if the bones in the wrists are forming or the fingers are forming, that's what will be damaged. So that period of time is definitely a concern.

But the brain develops throughout pregnancy, so there's no safe period of time during pregnancy. We have particular concerns about early pregnancy. There is no safe time in pregnancy.

Also, in the last month of pregnancy, the baby is putting on substantial weight. Almost a pound a week is put on in the last month of pregnancy. So if the mother is drinking heavily during that period of time, the baby can be born at a low birth weight.

Again, it's really important to remember that this isn't just about FAS. This isn't just about children who have facial features, growth problems, and birth defects related to alcohol use in pregnancy. It's also about babies who are aborted spontaneously during pregnancy because of the alcohol use, stillbirths, infants with slightly lower IQ that's not diagnosable.... All sorts of problems go with this. It's not just about the clearly defined syndrome of FAS.

Mr. Rob Merrifield: Do any of you want to differ? Do you all concur?

Dr. Gerald Thomas (Senior Policy Analyst, Canadian Centre on Substance Abuse): I could add that in the U.S. just recently—last week, I believe—the Surgeon General changed a policy they had originally put in place in 1981 that said moderate drinking was okay. They've now changed their position and said that women who are at risk of becoming pregnant should not drink at all, for those reasons.

● (1625)

Mr. Rob Merrifield: I've seen numbers and lingos spun before. We all have; we're politicians. This $402 billion saving kind of sticks out as saying, now, that's an impressive spin of numbers. That's a hard one to buy.

Prof. John Trevithick: The model we have is by age and sex determination of heart attack risk. That is actually incidence in Ontario for heart attacks and incidence of cataracts. The cost of these can be factored in by figuring out how much the hospital costs are and so on, so that we have it all built in to the computer model.

Mr. Rob Merrifield: Are you saying cataracts are caused because of not drinking enough?

Prof. John Trevithick: No, I'm talking about prevention, reduction of risk.

Mr. Rob Merrifield: So if you had a drink a day, you would prevent cataracts? Is that what you're saying?

Prof. John Trevithick: In the first graph it shows there's about a 50% risk reduction for people taking one drink a day.

But for heart attacks, which is where we were dealing with productivity, if you have a heart attack, and you wouldn't have had a heart attack because you had a 50% risk reduction, it works out that on average you might save two years of your life. When you look at that in terms of productivity, the annual salary for Ontario is—

Mr. Rob Merrifield: I could make that same argument by going for a jog a day or a good walk or other things. That's where numbers become really difficult, when you start spinning numbers and coming forward in testimony with a $402 billion savings—I don't know over what time.

I just challenge you on the numbers.

Prof. John Trevithick: This compares people who abstained to people who were taking one drink a day. It turns out, as you probably know, the average beer consumption, for instance, in Canada is 234 millilitres per day. This would mean that only a portion of that $402 billion would be reduced if people stopped taking one drink a day.

I just bring it to your attention as a committee, because it is a way of reducing the health risk. If you pass the warning label bill you may actually not be giving people a benefit. You may be doing them some harm if they decide they shouldn't take one drink a day when it's a benefit to them.

Mr. Rob Merrifield: Fair enough. I just wanted to bring that point out in testimony. It was a statistic that I would challenge. I understand your ideology behind it. We can base arguments on both sides.

I want to get to the actual bill we're looking at, which talks about labelling on bottles as an idea to prevent individuals from abusing it or using it when they shouldn't be using it—obviously, pregnant women. I was quite intrigued with Michael's testimony with regard to your recommendations.

My gut is telling me if we're going to do something in this area, we have to do more than just put a label on. We have to have a comprehensive plan and a program that's going to actually get to where we want to go as a society. If there's anything this committee can do...and perhaps Mr. Szabo would even agree with this, that winning isn't necessarily putting a label on. Winning is actually having pregnant women understand and stop drinking. Winning is having a society understand the abuse of alcohol and the dangers it causes to them and society.

I think you answered this when you answered Mr. Fletcher's question with regard to whether you agree with the bill. I was intrigued with your answer being “no”. Is that where you're coming from? Is that why the “no” is there?

Mr. Michel Perron: My answer, and in the text I indicated this, was that on the basis of information alone, it puts us on the yes side of the balance sheet. If you're going to ask if CCSA is on the yes or no side, given our testimony, we're saying yes, but with caveats and cautions, and those we've spoken to.

The Chair: Thank you.

That's it, Mr. Merrifield.

Madam, you're next.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Madam Chair.

Professor Trevithick, in your study of persons over the age of 40, you demonstrated how normal alcohol usage could produce some beneficial effects. Did you focus in particular on alcohol usage by men to ascertain if it might have an impact on procreation and on unborn children? Research has shown that excessive use of alcohol by women can harm the fetus. Do you believe the same is true for men who abuse alcohol?

● (1630)

Prof. John Trevithick: I'm not sure I understand your question. There are very significant risks, especially for women, associated with alcohol consumption.

Ms. Nicole Demers: Can this have an impact on procreation? After all, the male inseminates the female. Can alcohol consumption affect male sperm?

Prof. John Trevithick: That's a question for researchers. I really can't say.

Ms. Nicole Demers: Can you answer my question, Ms. Burgoyne?

Ms. Wendy Burgoyne: Research has been done on men and their offspring. It will be easier for me if I answer your question in English.

[*English*]

Certainly, men do have an influence on their child's health, and alcohol can affect the quality of the sperm. The damage, though, is quite different. When men drink it doesn't cause FASD. When men drink heavily there can be damaged sperm, which is a change in the genetics of the sperm, so there could be a child with genetic problems. If you compare the two, a child with FAS.....

I'll start at the beginning. It's like baking a cake. If you start off with good ingredients and you bake it well, you end up with a good cake. If you start out with good ingredients and cook it poorly, you end up with a bad cake. That's what happens with FAS. You have good genes coming in from the male and the female, the mother and the father, but during pregnancy harm happens because the pregnancy isn't progressing well. The mother is not eating well. She's drinking and so on. If you start off with a sperm that has genetic problems, it's like starting off with a cake that has poor ingredients, and you can have a child who has problems as well.

The other piece that is critical to think about in this is that the role of the father during pregnancy has a strong influence on the woman's ability to stop drinking. Men's drinking in itself can't cause FAS, but it can cause genetic problems and it can influence the woman's ability to stop drinking.

[*Translation*]

Ms. Nicole Demers: Earlier, you mentioned a poll that had been conducted. I have here some different results. According to a 2002 CROP poll in Quebec, 88 per cent of respondents answered that women should abstain from alcohol during their pregnancy. This does not jibe with your findings. How do you explain this poll's very different results?

[*English*]

Ms. Wendy Burgoyne: In the CROP survey the questions were asked many different ways, so you can look at it and find many different things. I have a copy here. What I can do is underline the portion that I'm talking about in my presentation and I can leave it on the desk here for you.

[*Translation*]

Ms. Nicole Demers: Thank you.

[*English*]

The Chair: Thank you, Madam.

Mr. Savage.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): Thank you, Madam Chair.

Welcome to our panellists. Thank you for taking the time to discuss this important issue.

I'm not normally somebody who preambles his questions as much as some other members do, but I am going to preamble today because I've been intrigued by some of the attention that the bill has brought out. I commend Mr. Szabo for creating this discussion.

I was particularly struck on the weekend by a comment by Dr. David Johnstone, who is a cardiologist at the QEII Health Sciences Centre in Halifax, who said that many studies show that drinking in moderation, of wine in particular, can be linked to improved cardiac outcome. That struck me because David Johnstone was a real champion of tobacco labelling and has been an anti-tobacco champion, with whom I have worked at the Heart and Stroke Foundation. It seems to me that people are starting to say that we have to be very careful about this.

My first question would be to Ms. Burgoyne.

You mentioned that your group is in an excellent position to tell us about what women need. You mentioned the Environics survey in 2000.

● (1635)

Ms. Wendy Burgoyne: I talked about both 2000 and 2002. Most of the time it was about 2002.

Mr. Michael Savage: I'm looking at a survey done by Ipsos-Reid in February of this year for, I believe, the Brewers Council, which asked Canadian women of drinking and child-bearing age which of three approaches they thought would be most useful in reducing the incidence of women's drinking during pregnancy. Fifty-three per cent, given the three options, said an education program through doctors who advise would be the most useful; twenty-eight per cent said having a campaign on television; and only seventeen per cent said putting warning labels on bottles of alcoholic beverages. Of the three options, the warning labels were third.

It seems to me your approach—which is this—makes sense. I wonder if making the beverage alcohol industry put these labels on might in fact reduce the amount of education provided through doctors' offices, through Motherisk, and through some other programs. Isn't there a better way to go ahead and do this?

Ms. Wendy Burgoyne: There are a few parts to your question so I'll try separating them out in responding.

The Environics 2000 report showed that 66% were in favour of warning labels. It wasn't listing what the most important or most effective ways were; it said they were in favour of them. That's why the data is different from that of the Ipsos-Reid survey. Certainly, if you are going to put money somewhere, having physicians screen for alcohol use in pregnancy and assist women with their alcohol use is absolutely critical, but it doesn't mean this is not part of a broader strategy. The effect of the labels on their own will not be substantial. At most, it will be modest, but it is an important part of a broader strategy.

Mr. Michael Savage: Do you believe these services I mentioned, Motherisk and so on, are effective?

Ms. Wendy Burgoyne: Yes, I do believe Motherisk is effective. You know CCSA has a wonderful service about FASD, with information and consultation services.

Mr. Michael Savage: My concern is that we all want the best here. We all want to reduce FASD. We want to reduce drinking and driving. But we have to think of the implications for industry, which is going to have to bear the cost of this. At some point, it seems to me, there may well be a trade-off for industry between saying, "Okay, if I have to absorb the cost of labelling, I can't use the option that I think, and that I'm seeing, is most effective". I wonder if you or perhaps Monsieur Perron could comment on that.

Ms. Wendy Burgoyne: It's difficult to make that kind of decision when we don't know what the costs are relative to the projects they're already funding. Certainly brewers, distillers, and others are funding some excellent services, like the CCSA FAS information and consultation service, like Motherisk, like the With Child Without Alcohol campaign in Manitoba. I don't know the cost of labels versus what they're doing right now. I certainly would hope that if they're putting labels on they're able to continue these excellent efforts.

Mr. Michael Savage: Monsieur Perron may want to comment on that.

You're right, we don't know the cost of this, and that's another concern I have. If this bill passes, we are asking industry to pick up the cost, which could be very significant and could take away from other products similar to this that have an impact on reducing fetal alcohol syndrome. We may make the situation worse instead of better, and that's my concern, in a nutshell.

The Chair: Thank you, Mr. Savage.

Go ahead, Ms. Crowder.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): My question is for Ms. Burgoyne.

We heard one of the industry groups talk about the fact that there were substantially more women than the numbers you had indicated who were aware. I wonder if you could say a little about that. I also wonder if you could discuss whether you've done any work around serving size. I know we're saying for women who are pregnant no serving size is safe, but when people start talking about things like the health benefits of alcohol, we're talking about a fairly prescribed amount of alcohol. I wonder if there's any awareness around serving size as well.

● (1640)

Ms. Wendy Burgoyne: You've asked me to compare the results I've been talking about today with results of studies that have been done by brewers and so on. I chose to focus on studies that have been funded by the Public Health Agency of Canada, assuming that these would be unbiased. To compare studies is extremely difficult because the wording is changed slightly and the audience changes slightly too. Unfortunately, the most recent Environics survey is two years old. We also have results from the Ontario survey from August, which shows similar sorts of results. Some things are well known, but there's confusion in other areas—around safe kind, safe amount, and safe time in pregnancy. Those are the things that appear to be consistent in all of the surveys.

Does that answer your entire question?

Ms. Jean Crowder: Not exactly. Perhaps it might be fair to ask somebody else to comment on serving size—maybe Mr. Perron.

One of the things people say is if we're going to label about risk, we should label about benefit. I'm not a physician, and I know a number of others here are, but my understanding is that a fairly narrow group of the population benefits. People who are on certain kinds of medications don't benefit. Women who are pregnant don't benefit. There are all kinds of issues around people who do not benefit from alcohol.

The second issue is around serving size. My understanding is that serving size is also fairly narrow, as far as who would benefit. I'm wondering about people's general level of awareness around serving size, because it's very difficult for people to judge whether they're having one ounce or....

Mr. Perron.

Mr. Michel Perron: Thank you. Picking up on your last point first—and my colleague Gerald could certainly speak a bit more to it—the study has shown that typically most people over-serve, and their knowledge of what is an appropriate serving size is distorted by the size of the container in which they're pouring the beverage, and a variety of other factors.

The linking of serving sizes to low-risk drinking guidelines—which again is a policy that has come out and been tabled before this committee—is an important element by which we can say that low-risk drinking guidelines apply to certain populations. They do not apply to pregnant women, women who are breastfeeding, or women who are thinking of getting pregnant. So there are some caveats as to whom those low-risk drinking guidelines apply to. But it is an appropriate policy to put in place, coupled with a standard drinking label serving-size type message on an alcoholic beverage container, so you can get a sense of what you're supposed to drink, or not drink in excess of, and be able to compare apples with apples.

With respect to benefit and risk, you're quite right, the doctor certainly can speak to it much more specifically. The fact remains that there are some benefits to alcohol use and moderate alcohol use by certain bands of populations. But there is a commensurate risk and a high risk with respect to young people 18 to 24, with respect to drinking and driving, and where there are very severe consequences that disproportionately affect and increase the costs related to society.

It's not an either/or scenario, much like women. Women are not a homogenous group—I don't need to tell you that. There are very different populations among women that we need to target. Again, the intention is not in question. The hope we have is that we can develop a multi-faceted, comprehensive strategy that reaches out to those we think we can have the most effect on, and that is really among those very targeted interventions where we know people are at greatest risk.

Ms. Jean Crowder: I would agree with you. A multi-faceted approach is important.

If you've talked about the benefits, I wonder if you've also talked about the cost. My understanding is there's a significant cost to inappropriate alcohol use. There's productivity cost for inappropriate alcohol use as well. It would be interesting to see those two numbers side by side.

Prof. John Trevithick: We haven't factored that into our model at all. But I would make a point here about several things. One of my colleagues in the United States has worked most of his life at the VA hospital in Minneapolis. He has been developing simple dietary strategies for preventing liver cirrhosis in veterans, which is a big problem for people who drink too much. He has quite recently developed some fairly good medicines that will have an effect. They also may have similar kinds of effects on preventing damage in fetuses that are exposed before birth to too much alcohol.

On research into these things, like we said, after you take three drinks your plasma goes pro-oxidant. We don't know what's going on there. We don't know what could prevent it. We've tried to get funding for it from CIHR, and we've fallen short a couple of times in getting grants. Since I'm an emeritus professor now I've sort of given up on this. On the other hand, I think it's very important that we continue to look at interventions we could use that would prevent this kind of thing.

You talk about genetic damage, for instance. This is oxidative-type damage that we've picked up. If you can develop some of these drugs, like this friend of mine wants us to test.... We also have a space agency contract to look at radiation damage to astronauts—preventing cataracts in astronauts. The same kind of strategy could apply there, because it's oxidative damage. Alcohol abuse causes oxidative damage. Diabetes causes oxidative damage. So there are a lot of places where more research into this area would be a big help.

For instance, with liver cirrhosis, a recently developed drug called SAM-e that they use to treat people who have beginning liver disease is quite effective. The idea of developing other drugs in this area would be an important contribution, and if we could get more research funding for health effects and health interventions it would be good.

● (1645)

The Vice-Chair (Mr. Rob Merrifield): Thank you.

Mr. Martin, five minutes.

Hon. Keith Martin (Esquimalt—Juan de Fuca, Lib.): Thank you all very much for being here today.

Dr. Trevithick, while the cardiovascular benefits—whose biochemical basis you well articulated—are well known, so too are the utterly disastrous effects of alcohol on the fetus, as we've heard today. I sincerely hope the committee does not confuse the health benefits of alcohol for the non-pregnant individual with the utterly disastrous effects of alcohol on the pregnant woman.

I compliment my colleague Mr. Szabo for putting this on this table. I'm sure his intention, as is ours, is to develop a series of strategies.

I also would suggest in the discussion of labels that these labels have to be simple and clear. For the patients many of us have seen, the 17-year-old young woman who has been pregnant most of the last 52 weeks and is drunk five out of seven days, and only drinks on the seventh day to prevent going into alcohol withdrawal or, worse, going to the DTs, is the individual who needs a clear and unambiguous message not to drink when they're pregnant.

My question is for Madam Burgoyne. You've done some great work on this. I gather this is part of a Head Start-like program. Could you tell us, please, if you have any hard data comparing populations who have been subject to your Best Start program or Head Start-like program? Have you done any comparisons between those two populations with respect to the incidence of FAS and FAE?

Ms. Wendy Burgoyne: In the Best Start program, what we've worked on with alcohol and pregnancy is not direct services to women, but providing services to service providers. We did an awareness campaign and training for physicians, and we provide tools and resources around screening for alcohol use and pregnancy, and so on.

Part of your question is about measuring the effects on the rates of FASD. Since FASD is rarely diagnosed at birth and is largely undiagnosed, there are very few studies that can show consequences of rates of FASD. In fact, if you look at areas of the province where there is really high alcohol use but little work being done on the topic of FASD, people in those areas can say that FASD is not a problem. The sort of thing you hear is, “There have only been two cases ever diagnosed in our district”. But it really is a case of lack of diagnosis and a lack of central recording of that kind of information.

So there aren't studies that show effects of certain actions on rates of FASD.

Hon. Keith Martin: We know that the incidence—and correct me if I'm wrong—of FAE among subsequent children born to a parent who has one child with FAE is about 50%. Would it, in your opinion, be useful to have mandatory reporting of cases of FAE so that resources can be targeted to that parent or parents to prevent further cases of FAE?

● (1650)

Ms. Wendy Burgoyne: That's a really challenging question, because not only does it link her to services, but it also stigmatizes her. It's a very difficult question to answer.

I do think it would be helpful to have a national database of birth defects, of problems at birth, and to have FASD recorded as part of that, because it would help us track the effects of our work. However, if it is tied to one person, it is much more challenging to say whether it's appropriate, respectful, and helpful.

Hon. Keith Martin: Is it not, though, the way in which it's—

The Vice-Chair (Mr. Rob Merrifield): Mr. Martin, Mr. Perron wants to answer.

Mr. Michel Perron: I simply wanted to inform the committee that last week the CCSA and the Public Health Agency of Canada hosted a meeting whereby we published and are rolling out national diagnostic guidelines for fetal alcohol spectrum disorder. So on this very issue you're discussing here it is absolutely critical, one, to have a consistent means of diagnosis, and, two, to be able to record the incidence and prevalence of these diagnoses and have the capacity among physicians to be able to learn from them, and to adapt our guidelines to best reflect that population.

I just wanted to make the point, because it is a critical point that is rolling out as part of the national framework for fetal alcohol spectrum disorder. But again, it is one piece among several that needs to happen.

Thank you.

Hon. Keith Martin: If I could, I will just follow up with one last comment.

And thank you very much, Madam Burgoyne. You'll know this better than any of us, but looking at the head start programs in Ypsilanti, Michigan, or at some of the other work that's been done in Montreal, as well as south of the border, in your or anybody else's experience here, have you seen any hard data or studies showing that adequate interventions at a prenatal stage are useful in working to reduce the incidence of FAE particularly in children? It's my understanding that if we had head start programs—

The Vice-Chair (Mr. Rob Merrifield): Our time is gone, but just give a really quick answer and then we'll move on. We want to give everybody an opportunity.

Ms. Wendy Burgoyne: There are studies of intensive efforts with women at very high risk who are substance using at heavy or binge drinking levels. Those studies have shown that they were able to address their alcohol use and reduce the risk of problems in future pregnancies.

The Vice-Chair (Mr. Rob Merrifield): Mr. Lunney.

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

Picking up on earlier conversations here, more information would certainly be helpful.

One of the things I wanted to ask—and the answer seems intuitive to me—is if you have any statistics on something. You mentioned that one in a hundred babies is born with some form of FASD. What is the breakdown related to age? Do you have numbers on this?

Ms. Wendy Burgoyne: No, there's no age-related breakdown. That's the estimate of the Public Health Agency of Canada. It's actually nine in a thousand, and there is no breakdown by age of mother, which I assume is what you're asking.

Mr. James Lunney: Yes.

It seems that we're talking about two different populations here. At one point you're talking about the cardiac benefits of modest alcohol consumption. Of course, the cardiac events we're talking about are certainly not in young women. But the ones who are at risk of pregnancy and the ones who are less informed obviously are the young women. They're our target group, it seems to me. That's the group we have to somehow reach.

Young people—of course, we were all young once—also seem to be the group that tends to abuse substances. They're experimenting in the world, in their place in the world, and in their power, and they haven't yet learned the tough lessons that some of us learned along the way. So we have to find a way to reach that young and very vulnerable group, and the question is whether labels are actually going to help us in that pursuit.

I am surprised that there isn't some kind of statistic to tell us at least the age. If we have babies with fetal alcohol disorder, they're obviously born to mothers who should be known, and most of the babies should be known and registered. We should be able to determine the age of these individuals. Are you telling me Health Canada doesn't collect these statistics? Has nobody been collecting these statistics?

Ms. Wendy Burgoyne: There isn't a breakdown by age. Some studies have shown that the problem is the lack of diagnoses. If we had consistent diagnoses, early diagnoses, we could take a look at the numbers. At this point in time, a child is much more likely to be diagnosed if they're in an adoptive situation, because the physician is more comfortable bringing the issue up. But that doesn't give us a good picture of all of the children with FASD. It's just based on the physician's comfort level in asking if a child has a history of prenatal alcohol exposure.

Mr. James Lunney: I have another quick question for you, Ms. Burgoyne. You implied that men's drinking could cause genetic damage to their sperm. Was that just your opinion, or do you have some evidence that you can point us to on that?

● (1655)

Ms. Wendy Burgoyne: There is research evidence that men's drinking can damage their sperm.

Mr. James Lunney: And is there some research you can point us to on that?

Ms. Wendy Burgoyne: Yes. I can't quote it off the top of my head, but I can direct it to you.

Mr. James Lunney: Okay, because Dr. Trevithick didn't seem to be aware of anybody and nobody else has really brought any of that forward. And that's just a sideline, of course.

Going over to you, Dr. Trevithick, I found your comment about the antioxidants quite intriguing. You mentioned that you have a colleague or someone working on cirrhosis of the liver, and that antioxidants seem to help reduce the risk. We know there are other powerful antioxidants in nature, in addition to the lignins and the tannins you mentioned, which are found in especially the darker products.

Are you implying that this research would suggest that powerful antioxidants like coenzyme Q10 or all of the plant products—like bilberry for macular degeneration.... Is it possible that these antioxidant plant compounds that are common in nature may help to reduce the risk if they were consumed along with or instead of alcohol, or if we made sure that young people got good antioxidant diets?

The Vice-Chair (Mr. Rob Merrifield): We have time for a quick answer, and then we'll go to Ms. Dhalla.

Prof. John Trevithick: The answer is a quick yes. We've actually tried to encourage the Ontario government or Agriculture Canada to promote black currant and blueberry cultivation on tobacco farms in the area of Malahide Township, in Elgin County. That area is suffering a lot. The tobacco farmers don't seem to be interested in doing it, but the area has ideal soil for that. If you could get a drink of blueberry juice and black currant juice, you could get a whole new industry started in Canada that would actually complement what we're doing in this area.

We've looked at blueberry juice and found it's loaded with antioxidants. It's pretty sour, it's a bit acerbic, but we could start a whole new industry if they got a little bit of government support in the research area and the farmers were encouraged to choose alternative crops. I think there's a lot to be said for this approach.

The Vice-Chair (Mr. Rob Merrifield): Okay. Thank you.

Ms. Dhalla.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Once again I want to thank all of the witnesses for taking the time and sharing your expertise and words of wisdom with us as we make, I think, a complex decision.

My first question is for Mr. Trevithick.

In regard to your study—I think you've done a commendable job, and thank you for sharing some of the details with us—you didn't talk about controls in some of the literature that we received. Could you perhaps expand on what your controls were in the study?

Prof. John Trevithick: The controls for the human study that we showed you?

Ms. Ruby Dhalla: Yes.

Prof. John Trevithick: The control is actually the zero time for the person before they take the beverage.

Ms. Ruby Dhalla: Okay.

Prof. John Trevithick: So the increases were all related to the person's zero-time level of plasma luminescence that was detected by our assay.

So any changes were either positive, if the antioxidant was increased, or we actually got more counts than we'd get with the peroxide alone, if the plasma went pro-oxidant.

Ms. Ruby Dhalla: And who provides funding for your research ?

Prof. John Trevithick: Who funded the study? It was funded by Guinness and Labatt, and it was funded by an unconditional grant so that we could publish whatever we wanted. There was no restriction on us by the company, and that's why I'm saying that we should really have some sort of Canadian-based institute that would fund this kind of thing. It was sponsored by the industry.

Ms. Ruby Dhalla: So you don't think having funding by Guinness or Labatt would in any way bias the results of your study?

● (1700)

Prof. John Trevithick: Absolutely not. In fact, the consultations we had with them improved the project because they suggested several of the additional controls, such as the stout without any alcohol to control for the polyphenals that were present in the beverage without alcohol. That let us separate the alcohol effects from the effects of the other components in the beverage.

Ms. Ruby Dhalla: I have just one last quick question for Mr. Perron.

You mentioned, in regard to this particular piece of legislation, that we need a multi-pronged and multi-faceted strategy that covers a wide variety of areas. I believe Wendy did as well. I think a lot of us on the committee, from our previous discussions with witnesses, are all on the same page. We all want to try to provide people with as much information as possible and prevent them, hopefully, from taking or making the wrong decisions. Do you think this is a start? I've seen some resistance from some individuals in regard to warning labels, and their basic statement is that this needs to be part of a broader strategy, or that this is not the right first step. What would your comments be on that?

Mr. Michel Perron: Thank you.

There have been some recent first steps in that the national drug strategy—Canada's drug strategy in 2003, when the federal government put $245 million towards that—looked at alcohol and other drugs. We've recently completed consultations with the provinces and territories, and they want to work together in a comprehensive national framework to address substance use and abuse, which will couple with the national framework for action on fetal alcohol spectrum disorder.

We've got a lovely document called *FASD: A Framework for Action* at the Public Health Agency of Canada, but we have no money behind it. That was an excellent first step.

Our concern is, and I think I'll be candid, certainly with the caveat we've made with respect to the labels.... If we were to proceed with one, consider doing it by regulation, consider starting it with standard drinking units, and so on. Our concern is, if we do this, perhaps the attention will wane because of having to address other issues. I think we've seen that in other areas. Our caution would simply be.... If I had to put a dollar down first, where would I put it?

Ms. Ruby Dhalla: You wouldn't put a dollar down first on warning labels?

Mr. Michel Perron: No.

The Chair: Thank you, Ms. Dhalla.

Mr. Ménard.

[*Translation*]

Mr. Réal Ménard (Hochelaga, BQ): Madam Chair, I do not have any questions, because the ones I did have have already been answered. I'd like us to proceed to the consideration of motions. As you know, I'm a reasonable man. In future, please bear that in mind.

[*English*]

The Chair: You certainly are. You're just scoring so many brownie points, Mr. Ménard, with everybody today.

Mr. Carrie.

Hon. Robert Thibault (West Nova, Lib.): Madam Chair, rather than brownie points, I would call that bait.

The Chair: It could mean he has a plot or a plan that's coming later.

Mr. Carrie, the floor is yours.

Mr. Colin Carrie (Oshawa, CPC): Thank you, Madam Chair.

I had a question in regard to the statistics that were brought up, Madam Burgoyne. You talked about the differences in eastern Canada compared to western Canada, and they were quite significant. You said the overall Canadian rate was 14.6% and that in Quebec there was the highest rate of alcohol use during pregnancy, at 25.1%. You mentioned that out west the rates are lower, significantly lower, and I was wondering, what are they doing differently?

Ms. Wendy Burgoyne: Again I want to stipulate that the Canadian rate is lower. Quebec's rate of alcohol use in pregnancy is the highest in the country.

What we've seen in the western provinces is a decrease, a steady decrease in the rates of alcohol use in pregnancy for anywhere west of Ontario. What they've been doing differently is that for over a decade they've been having multi-component strategies to address alcohol use in pregnancy, including things like physician training, raising awareness, screening for alcohol use, assisting pregnant women through support, referrals, and so on.

Ontario and the eastern provinces have been much slower to take up this issue. Ontario has only been working intensively on this for four years.

The data I quoted was from the most recent Canadian prenatal report. So we saw decreases in alcohol use in pregnancy in the west between 1994 and 1999. It would be wonderful to have an idea of what has happened in the more recent years; however, this data is not available at this time.

Mr. Colin Carrie: Do you have the statistic for how much it went down out west between 1994 and 1999?

Ms. Wendy Burgoyne: I have the report here, page 6. I'm roughly eyeballing the charts for different provinces. For the prairie provinces, it went down from about 17% to about 11%; British Columbia, about 17% to about 8%; and Ontario, the Atlantic provinces, and Quebec have shown some ups and downs during that time period.

Again, this is a time period when the west was working intensively on this issue and the east had not yet started working intensively on it.

Now, what made a difference? What exactly was it that made a difference?

Mr. Colin Carrie: This is what I know the committee would really like to know. If you noticed, different members of the committee wanted to know where the best bang for the buck is going to be.

So these numbers that dropped 6% to 9% were without alcohol labels. Is that right?

● (1705)

Ms. Wendy Burgoyne: They were without alcohol labels, but they did have intensive awareness campaigns around alcohol use in pregnancy.

Mr. Colin Carrie: Do you have any other data?

I believe, Monsieur Perron, you talked about Australia and how they changed their labels for serving sizes and stuff like that. Do you have any indication? Has it decreased?

Dr. Gerald Thomas: No, unfortunately, they didn't....

We actually have a researcher from Australia in Canada now, out west in B.C. He worked on this early on in the project, and I asked him for an evaluation. He said they didn't really do one.

They did a lot of work early on to determine the fact that people were indeed over-serving and how to structure the message. They did a lot of focus group work to structure the message so that people would understand what they were seeing on the labels and all that, but as near as I can tell, they didn't do a final evaluation.

It has been in place since 1995, so about 10 years.

Mr. Colin Carrie: Okay.

Dr. Gerald Thomas: We have an example, actually, of what one of those would look like, if you want to look at it.

Mr. Colin Carrie: If you want to pass that around later, that would be great.

In the United States, my understanding is that by just putting the labels on, it really hasn't made a big difference. Does anybody here know what costs were incurred to the industry when the labels were introduced in the United States? Does anybody have any idea of those numbers? Do you know?

Mr. Paul Szabo (Mississauga South, Lib.): A lot less than the other things they're putting on.

Mr. Colin Carrie: We've heard a lot of how this will increase the costs to Canadian industries, especially small brewers, and the additional technical problems here by having two languages on, I guess, a more significant label. I'm just trying to get an understanding—again, the best bang for the buck—of what's out there.

Dr. Trevithick, you mentioned that you're not receiving a lot of support from government as far as any research on the positive is concerned. Are you receiving any support from the federal government? Does the federal government have programs that you can draw on?

Prof. John Trevithick: They have programs, but most of them are targeted towards the damaging effects of alcoholic beverages and use at levels that we would consider not healthy, like three drinks a day.

To the point, we saved a bunch of samples from our experiment and we've applied twice to look at the DNA arrays. It would be maybe $100,000 to do this. We have the white cells from these people who took three drinks. We could look at the genes that were activated and the genes that were depressed by this antioxidant level and the alcohol level in these people.

We came in pretty near last in the competition for this in two different committees of CIHR. My feeling is that most people are concerned about damaging effects of alcoholic beverages but not necessarily things that would improve your health.

Mr. Colin Carrie: Thank you very much, Madam Chair.

The Chair: Mr. Szabo.

Mr. Paul Szabo: Thank you.

I appreciate the opportunity of having some input because I appreciate what the witnesses have brought to us. I just want to let them know that I'm very delighted with what the Minister of Health announced in question period some weeks ago. Health Canada is developing a comprehensive strategy to address many of the issues you've raised. There is a commitment, so it's very important.

I simply want to read to you from an article written on alcohol warning labels in pregnancy by experts from the Motherisk program at the Hospital for Sick Children. The article is dated March 2004. On the issue of labeling it says:

> Studies have claimed that the alcohol warning label is ineffective in changing drinking behaviours. However, even if the warning label is not directly effective in changing the pattern of problem drinkers, they are effective in changing the culture of drinking, similar to changing attitudes towards drinking and driving or smoking.

There's a difference between changing behaviour and culture. I think it's important because we've talked about awareness, knowledge, change of behaviour, culture, and the like, and I'm not sure how all those are to be reconciled.

One thing I do know is that there is ample evidence and proof that the United States' warning labels are not noticeable, not readable, and not effective. That is undisputed. All of the research coming out is that labels aren't effective, because look at the U.S. The fact is that those labels are ineffective, and in fact changes have been requested for a decade already and haven't been forthcoming.

So with regard to labelling, how do we reconcile labelling as part of something, and what is the desired effect? As Ms. Burgoyne has suggested, there's no research to say that any one thing is going to change anything, but we don't know about the synergies between a multiplicity of approaches. What can we expect here, and how do we deal with reconciling awareness, knowledge, and behaviour?

● (1710)

Ms. Wendy Burgoyne: I can speak briefly on this.

When we look at changing behaviour, one of the first things we see is a change in awareness. The next thing we see—if we're doing things appropriately—is people trying to change their behaviour, and then we see changes in the rate of that behaviour. What we finally see is a change in chronic health.

So for smoking, first we would see that people know smoking is harmful during pregnancy. Next we'd see people trying to stop during pregnancy. After that we would see a lower rate of smoking during pregnancy. Finally, we might see some impact on low birth weight. Tying this impact on low birth weight back—way back—to that one effective initiative that was taken is really hard.

This is one of the difficult things about the labelling issue. There's a lack of evidence. Evidence is modest at best; evidence shows changes, at best, in some populations. Lack of evidence doesn't necessarily mean it's ineffective. It means in large part that this is very, very difficult to study.

Mr. Michel Perron: Thank you for your question. Clearly, this really does relate to the context of having an integrated strategy to look at this so that labelling is seen as part of a broader prevention and awareness campaign that targets not only the general population of drinkers but also those at greatest risk, whether it's women, whether it's young people who drive. The simplicity of the message for alcohol is not quite there. It is for pregnancy. It's a fairly zero tolerance, if you wish, type of message. For other populations, the message is not quite so easy. It's not so direct.

The fact remains that whatever we do for a label, I think it's important that we link it with broader strategies so the message is consistent. The last thing we want is a message going out here that's going to conflict with one going out there, resulting in more people who are confused—do I drink one drink if I'm pregnant, or not, and what happens if I have...? The call that I think everybody is pretty much making is for us to step back, to do this with some measure of understanding of where it fits in with the broader alcohol strategy, the FASD strategy, where it fits in with the driving while impaired strategy, with the variety of these.

There might not be just one message. There might be different messages at different times. I think, again, the recommendation we're making that the messaging be derived and prescribed by regulation, allowing for some flexibility over time, might accommodate this.

The Chair: Thank you, Mr. Szabo.

Prof. John Trevithick: Undoubtedly, people are reasonably cynical about this because of the problem in the United States. When I was coming up here, I asked the commissionaire at our parking gate what he thought of putting warning labels on alcohol. His comment was that when people are having a cigarette with a drink, it'll give them something to read.

The Chair: Thank you very much, Dr. Trevithick, and thank you, Mr. Szabo.

On behalf of all the members of the committee, I would like to thank our witnesses for coming here and for adding to the body of knowledge we're collecting before we make this decision.

This portion of the meeting is now over. I would ask those people who were here about warning labels on beverage alcohol to leave the room very quietly, because the committee has a motion to deal with right now. If you could sort of tiptoe out, it would be helpful to us.

To the committee members, Mr. Merrifield has asked that Mr. Fletcher's motion be put first, so we'll move now to Mr. Fletcher's motion.

● (1715)

Hon. Robert Thibault: On a point of order, Madam Chair, is it not the usual business that the motions would come in the order in which they appear?

The Chair: Usually, yes, but the vice-chair has to be somewhere shortly, and he wondered if we could do this motion first.

Hon. Robert Thibault: I think it's important that the motion get done today, and Mr. Fletcher's motion may take some time. I don't think we can be rushed through it.

The Chair: That's right.

May I ask the members of the committee, do you feel quite ready to vote immediately on the motion, which has been proposed essentially by the clerk in order to straighten out this procedural difficulty? Is everybody happy about that?

Some hon. members: Agreed.

The Chair: Okay. We will do it first, if everybody is ready.

Can I ask someone to move it?

Mr. Ménard moves it and Ms. Dhalla seconds it.

(Motion agreed to [See *Minutes of Proceedings*])

The Chair: Now we'll move to Mr. Fletcher's motion about extending compensation to all who've contracted hepatitis C from tainted blood.

Mr. Fletcher.

Mr. Steven Fletcher: Thank you, Madam Chair.

I'd like to move the following motion:

> That the Committee report to the House, that it not only continues to urge the government to extend compensation to all those who contracted Hepatitis C from tainted blood, but that it calls on the government to do so immediately, inrecognition of the First Report of this Committee, the recommendations of the Krever Inquiry and the large surplus in the federal Hepatitis C compensation fund.

Madam Chair, this is an important motion. The committee has discussed this in the past and voted unanimously in favour of compensating these victims. This motion is different from the previous one in that the new Standing Orders will allow this motion to be presented to the House, debated, and voted on. I think anyone who is compassionate, anyone who is sincere about compensating these victims, would have no problem in supporting this motion, and I'd ask that all committee members support it.

Thank you very much.

The Chair: Thank you.

Mr. Thibault.

Hon. Robert Thibault: Madam Chair, as you and all committee members know, we support the intent to compensate the victims; we voted for that unanimously. But prior to voting for this motion, we have to consider the facts.

The Minister of Health announced on November 22, 2004, the Government of Canada's intention to enter into discussions on options for financial compensation to people who were infected with hepatitis C through the blood system previous to January 1, 1986, and after July 1, 1990. Representatives of the pre-1986 and post-1990 class asked us to explore all available options for compensation. The government agreed, and the Minister of Health indicated that entering into discussions about options for compensation was the right and responsible thing to do.

This decision was also made taking into account the first report of this committee and the views of the members of Parliament expressed during two debates in the House of Commons in the fall. After the minister's announcement, discussions began immediately and have been proceeding since then.

As members know, these discussions must involve many people, including counsel for those affected with hepatitis C through the blood system previous to January 1, 1986, and after July 1, 1990, and also the joint committee that oversees the 1986 to 1990 hepatitis C settlement agreement, counsel for the provincial and territorial governments, and the judges and counsel for the 1986 to 1990 settlement agreement fund.

I should remind members that at the time of the announcement the minister stated that these discussions would proceed as quickly as possible but that they would take many months. These are complex and difficult issues; as I mentioned, they involve many parties.

The good news is that the discussions are progressing. On March 10, 2005, the federal government's lead negotiator met with counsel for those affected previous to January 1, 1986, and after 1990. The next meeting is scheduled for April 21, 2005. This schedule has been agreed to by both parties and takes into account the work that needs to be done in order for us to reach a compensation agreement that can be presented to the courts.

While I can indicate the discussions are moving forward—

Mr. Rob Merrifield: I have a point of order. I know you're going through some facts, but we've actually been here long enough to know the facts; I don't think we need to review the facts here at committee. I don't see that they're necessarily relevant to the motion before us. We're not talking about the past, we're talking about the present; that's what the motion is all about.

● (1720)

The Chair: That's not a point of order. He can speak for or against a motion as he chooses.

Mr. Rob Merrifield: It has to be relevant to the motion.

The Chair: The speaker decides whether it's relevant or not, and it sounded to me like it was relevant. He's responding to the motion with the government's current position, and it's essentially an update for all of us on a topic.

Go ahead, Mr. Thibault.

Hon. Robert Thibault: While I can indicate the discussions are moving forward, it is important to make clear that all parties have agreed to keep the substance of these discussions between themselves at this time. I think we all recognize this is also the most effective way to move forward.

The motion submitted by the member makes reference to a surplus in the 1986-1990 settlement fund, as has been indicated on numerous occasions. A surplus in the fund, should it be found to exist, does not belong to the Government of Canada; how any surplus is allocated is not our decision to make. The fund is controlled by the courts, and it's the courts that will decide if there is a surplus and, if there is one, how the surplus will be allocated.

The 1986-1990 settlement agreement indicates that the courts will hold a hearing on the sufficiency of the fund in June 2005, or at the earliest possible date thereafter. A case management meeting was held by the courts on February 16 to begin setting out a schedule to determine whether a surplus exists and how it should be allocated. The schedule will include the production and consideration of reports outlining the most recent information about the fund and the class members. This will primarily include actuarial data about the fund and medical data on the progression of the disease.

As I mentioned earlier, discussions on options to compensate those affected with hepatitis C through the blood system previous to 1986 and post-1990 began immediately following the minister's announcement in November. This committee has spoken clearly on this matter. The members of the House have all had an opportunity to speak on the matter. The minister has given a mandate to his negotiators to explore all available options for compensation.

I recognize that these discussions do take some time. I also recognize the importance of moving as quickly as possible and that there are individuals and families involved who are waiting for an outcome. It is the right and responsible thing to do to let the discussions proceed as quickly as possible towards a resolution, and therefore I will not be supporting this motion.

The Chair: Thank you.

Mr. Ménard.

[*Translation*]

Mr. Réal Ménard: Madam Chair, before we vote on the motion which we intend to endorse, I'd like the parliamentary secretary to answer one question. During the take-note debate in the House, the Minister of Health stated that he had submitted to Cabinet a brief consistent with the information imparted to us by the parliamentary secretary. I'm not calling into question the government's good faith in claiming to want to extend compensation.

Can the parliamentary secretary confirm that the Minister did in fact submit a brief to Cabinet? He was hopeful that this issue could be resolved before the summer adjournment. As the parliamentary secretary well knows, we have April and May remaining, because as a rule, the House rises either the first or second week of June.

Can we still hope to see this issue resolved by the month of June, and has a brief in fact been submitted to Cabinet?

Hon. Robert Thibault: First of all, Madam Chair, I can't say if the discussions will have wrapped up before June. We do know that the court is set to rule in June on the existence of an actuarial surplus.

Has a brief been submitted? I don't know, but since the minister has appointed negotiators and that discussions with all stakeholders are well under way, I believe the minister has been given the go-ahead by government to proceed with this initiative.

Mr. Réal Ménard: Therefore, you're optimistic?

Hon. Robert Thibault: Very optimistic.

[*English*]

The Chair: Thank you.

Mr. Lunney has a question.

Mr. James Lunney: I have a comment, Madam Chair.

This situation has been before the House and compensation for people with hepatitis C has been before this Parliament for a long time. Now I hear the parliamentary secretary talking about how they were talking to the lawyers, and it's complicated and it takes time. While we're delaying, some of these victims are dying. It would be nice for some of them to live to see the day of compensation coming.

I think it is a matter that needs to be expedited. I certainly hope the committee will agree to expedite this matter, get it to the House, and move on it, rather than spend another Parliament or two discussing it. Lawyers can certainly carry it on that long.

● (1725)

The Chair: Thank you.

As your chair, I feel that I'm obligated to comment. I think we really should take note of one thing Mr. Thibault has said. The fact of whether or not there is a surplus is a question yet.

Secondly, even if there is a surplus, I don't think it's our money. We could pass all the motions we like. Maybe I'm mistaken.

Mr. Thibault.

Hon. Robert Thibault: I think the operative term in what the minister has said is that he would examine all options for compensation. One of the options for compensation that we as a committee have suggested is using the surplus of the fund should the surplus exist. There can be other options for compensation, such as money coming from the public purse, if those funds aren't there. No doors are closed.

The negotiations are now taking place with the people who would really receive the compensation and the people affected. As many of you probably have, I have many calls from people who are asking to be added to that class. People who are suffering from blood disorders or other things that aren't necessarily hepatitis C have been asking to be added. There are a lot of discussions to be had.

We have asked that the actuarial surplus be taken into account. We have to wait to find out if there is a surplus, and then the discussions have to take place early with the people who control the money.

Lastly, what I should point out is what I've said in my statement. I don't know the details on how those negotiations are progressing. There has been a confidentiality agreement among all partners that they would negotiate this in secrecy, and that's what is taking place.

The Chair: Ms. Crowder has a comment.

Ms. Jean Crowder: Very quickly, I will support this motion. As I understand the motion, it actually says to extend compensation, but it doesn't say from the surplus fund. It only says the surplus fund is one of the factors to be considered.

As my colleagues have pointed out, people are dying as we speak. I would urge that we support this motion and get on with compensation.

The Chair: Mr. Fletcher, as the mover, has a chance to conclude.

Mr. Steven Fletcher: Yes. I'd only like to say that these victims need to be compensated. It's the compassionate thing to do.

We've seen under this government, unfortunately, a government that has ignored committee recommendations. We have Lee Richardson here who's on the environment committee. We saw the environment committee recommend not appointing the former mayor of Winnipeg to the environment round table.

Hon. Robert Thibault: It's irrelevant.

Mr. Steven Fletcher: No. It's relevant because it shows that this government doesn't listen to the committee. There's no reason to believe that it will listen to our original recommendation.

This is a stronger motion. It will bring the debate to the floor. I appreciate the parliamentary secretary's attempt at a committee filibuster, just as the government filibustered at the time when we could have voted on this issue in the latter part of last year.

The government has had plenty of time to deal with this issue. I'd like to point out—

Hon. Robert Thibault: I have a point of order. I don't think it is right to typify my intervention as a filibuster; a filibuster would have been if I had used all the time the committee had and kept it from a vote. I brought information to the committee.

Mr. Steven Fletcher: That's not a point of order, Madam Chair.

Mr. Lee Richardson (Calgary Centre, CPC): It's more like dithering.

Mr. Steven Fletcher: I'll accept dithering.

The refusal to answer the BQ's question on whether it was brought forward to cabinet is disturbing. As the member from the New Democratic Party pointed out, people are dying. This needs to be resolved ASAP, and I encourage anyone who is compassionate and feeling for these victims to vote in favour of this motion.

Thank you.

The Chair: I am sorry, Ms. Dhalla, but there are no more speakers, because the mover always has the final say.

We'll now call the question.

(Motion agreed to)

● (1730)

The Chair: I don't know if you are aware, but we have a tremendous workload ahead of us, ladies and gentlemen. You know we have a government bill, another private member's bill, the estimates, and we have already started our study on Internet pharmacies. In the meantime, the minister has sent a letter asking us to examine another extremely important topic.

I have asked the vice-chairs if they can meet with me tomorrow, and I want to give you fair warning that it looks to me that between now and June we will have some very, very long days of meetings to try to get through some of this. We'll have to get it in some order of priority.

The subject matter of the minister's latest request is an examination of the drug approval process, which is—

[*Translation*]

Mr. Réal Ménard: I apologize for interrupting, Madam Chair, but the Subcommittee on Solicitation Laws is scheduled to hold a meeting in this room at 5:30 p.m. Would you be amenable to our continuing this discussion at our next meeting on Thursday?

[*English*]

The Chair: I'm just suggesting to you that after the meeting of the chair and the vice-chairs, there may come a new schedule that is much heavier than anything you've been used to—if in fact we're going to finish the work that's assigned to us.

Thank you.

This meeting is adjourned.

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