Special Committee on Tobacco Control

Hansard Verbatim Report

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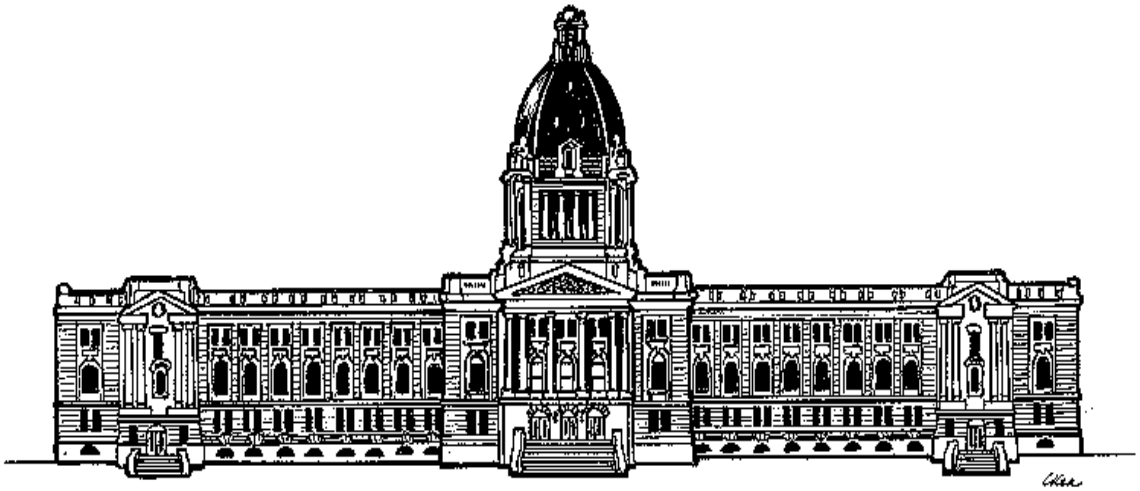

Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

SPECIAL COMMITTEE ON TOBACCO CONTROL
2000

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Published under the authority of The Honourable Ron Osika, Speaker

The Chair: — All right. I'll bring the meeting to order. And the first thing I want to do is welcome you all here today at this hour of the day.

I'm glad that you were able to make it today. I thought with people being in for other meetings and also this being anti-smoking week, that we should get our proceedings underway even though we're not fully ready to go.

And I thought we would use part of this meeting just to get ourselves briefed on some of the things that the Department of Health has been doing so that we get ourselves knowledgeable, get some background on it, and we use the rest . . . or the first part of the meeting just to do some planning.

And I was thinking of doing the planning in this manner. Make a couple of propositions, get your reactions, and then Doreen and I would take it back to our subcommittee and we'd use the ideas that come out of this meeting and set up things like an itinerary and what our research officer should start with and maybe just where the committee should be going.

So I don't have any real decision items today that I'm going to be asking the committee to make. And with that, maybe could I have somebody move the adoption of the agenda.

Mr. Addley: — So moved.

The Chair: — Do we need a seconder? All in favour? Okay.

So we proceed with item no. 1, and that is consideration of a public hearing itinerary.

I did some very preliminary work just to give an idea of what an itinerary might look like, in the mail-out that you got. And there are several questions I guess that occur . . . that come up when you look at an itinerary like that. First of all, is that sufficient? Are these the places that you want to go, or are there places you want to add? Any places that you want . . . think should be deleted? And if there are, maybe we should hear some specifics.

Coming along with that would be, if we're going to do this, are the members of the committee ready to go out two, three, or four days a week? When would a starting date be?

Originally I thought January 31 might be a possible date, but that was a week and a half ago when I came up with these, and the time seems to kind of shrink. And I know that, just in consultation with Greg here, that his office is also quite jammed for time right now. So it would likely be . . . I think January 31 is almost out, at least from my own point of view, and maybe we could target the week after that. But I'd like to hear your ideas on it.

Let's see. And then I think one other thing we might want to consider, while we're talking itinerary here, is whether . . . When we're going out on these public hearings, usually what you're doing is you're gathering information and you're talking to the public about where the committee is going. There aren't any decisions taken.

So one of the things that we might consider is, we don't really need the whole entourage of seven people going to all of these centres. We might just want to send, say, three people. Three might be a minimum, I think, we want to send. So we could do that. We'd probably want to start with the whole works wherever we go, first meeting or two. But I don't think we should necessarily feel bound, although I wouldn't want to turn anybody away if you've got the free time to do it.

Mr. Wartman: — Excuse me, Myron. When you're speaking of three people, you're meaning three members plus staff.

The Chair: — Three members plus staff, yes. Three members of the committee — three or more. Say three to a total of seven.

Mr. Addley: — You're wanting the feedback.

The Chair: — So let's start with feedback to any one of the items that I've mentioned.

Mr. Addley: — I guess my feedback on the list, I think that's a good list. It might be an ambitious list. Because I want meaningful involvement and meaningful input. So perhaps a better alternative would be to scale it back to maybe 10, with openings if there's a strong demand from a community to meet with us. And I think it would be a balance from north-south, rural-urban, that sort of thing.

So I think this might be too many places at this point; so maybe pick the top 10. And the suggestions I have, I mean I've got a couple here that I can give to you if you want it.

The Chair: — Let's hear them.

Mr. Addley: — Okay. Looking at Regina, Saskatoon, P.A. (Prince Albert), Yorkton, North Battleford, Weyburn, Estevan, Moose Jaw — that's eight — and then two others. And then if anyone else wants to . . . would like us to go to that community, we still have the flexibility to do so. So that if suddenly someone in Meadow Lake says please come and meet with us, we've left that space open. But if we automatically go to Meadow Lake and have four people show up and they're doing it just out of feeling obliged, I don't know if that's meaningful involvement.

Ms. Eagles: — I think that . . . I mean I agree with that in principle, but at the same time I think we have to have it so that we kind of touch each area of the province. Like I mean in the ones you suggested, I don't believe there was a place from the west mentioned.

Mr. Addley: — I only named eight.

Ms. Eagles: — Yes, like either Maple Creek or Swift Current or somewhere in that area.

Mr. Addley: — Well, Swift Current would be a good one.

Ms. Eagles: — Yes. You know, and I think we have to . . . I'm not saying that we have to hit all these, but I think we should hit each region of the province to give everybody a fair shake.

Mr. Addley: — Yes, I agree.

Ms. Higgins: — One of the reasons why I had asked in speaking to you before about Moose Jaw being put on the list, I was surprised by the amount of interest just from the publicity of the announcement of this committee. Lots of inquiries, lots of phone calls at the constituency office, people that are interested in making presentations.

And also it has stirred up a great deal of interest in the high schools. Some of the teachers had debates — grade 10, grade 11 — in around in there.

I'm kind of leery of cutting back the amount of places. Or if there is interest . . .Now, I don't know how you decide if there's interest enough to go there before you actually go there. I mean, people have to show up and see how it goes.

The Chair: — Could I just ask Greg to give us a bit of an indication of some past practices on committee outreach of this type.

Mr. Putz: — In the past what committee members have done, just as you indicated, Deb, is that through their constituency offices they gauge whether there's interest, and that sort of formed the basis of the itinerary. And what the committee has done then is advertised in the weekly and local newspapers, announcing that there'll be a public hearing at a certain time, at a certain place, and inviting them to participate formally or just as a walk-in. We make an opportunity for the members of the public, if they are interested and show up and they're hearing something they want to speak to, that they have that opportunity.

But also, by making an announcement in advance, giving them an opportunity to say that they want a time slot and giving them some advance notice so that they can contact the Office of the Clerk in Regina by mail or telephone or e-mail or whatever the process is. And then we assign them a spot to make sure that they have a chance to say what it is that they want to say to the committee. Otherwise there's really no way of knowing how much interest there is in each of these areas.

Now that's one of the things that I suppose we'll be asking the committee researcher once we retain a committee researcher, is to sort of do some of that advanced point work and figure out through some of the stakeholders in this where there might be interest where there's high school SWAT (Students Working Against Tobacco) groups, that sort of thing.

So in the past that's been the way the special committees have tried to determine where there is interest. Often it works; sometimes it doesn't work. Sometimes they've gone to communities and there's been very little interest. But for the most part that's the only way — through the MLA (Member of the Legislative Assembly), through the research, and through advertising — that the committee is able to ascertain what level of interest there might be.

Ms. Higgins: — In Moose Jaw the announcement of this committee actually couldn't have hit at a better time because the health district had just done a study on the whole area. So the figures are in and there is already a couple active groups that have been . . . were working on the study and then have set up strategies and goals for the future. So it all kind of fell in line. So maybe it won't be that great in other places. I don't know.

Ms. Eagles: — Could that be a point to start working from, is the area health districts and stuff like that? Do you think something like that would be worth contacting the CEOs (chief executive officer) of the health boards just to see if there is interest out there? Have them kind of gauge it and ask around.

I mean, I realize that there's what, 32 health boards or something, and we're kind of thinking 10 to 15 spots. But, you know, at the same time it could be a starting point, especially the ones that involve the places listed here in Moose Jaw.

The Chair: — I think what we would do is ask our researcher to make contact using lists such as health boards, school boards, and perhaps RMs (rural municipalities) or municipalities, certainly some of the bigger municipalities, the bigger populated ones. Maybe even places like FSIN (Federation of Saskatchewan Indian Nations) or Indian bands. And we could gauge for the interest on that. I think what we need is a starting point, that we need that 10 or 15 like you say to start with.

Mr. Wartman: — When I read it over I didn't have any trouble with the numbers. I mean I think the impact of smoking is broad. I think that there are groups like restaurateurs who are throughout the province and they're going to want to have their say, and bar owners, etc.

And I think to start with this list with the addition of Moose Jaw, to do the invitations, to gauge the interest and the response with this list is fine, and then to work out our schedule as fully as we can. Like I'm trying to keep this space open as much as possible and I had one question and that was really . . . if we decide that we're going to commit to four days a week of meetings, is it possible to do two locations in a day? Some of these aren't too far apart. I mean I can see here. You know if you were doing Prince Albert and La Ronge, probably there would be a flight there rather than driving and you could handle both of those in a day. Maybe Meadow Lake, Beauval — I'm not really sure of the geography there as well but somebody is. So I'd like to know basically how much we can do.

Mr. Addley: — Okay, I think just to answer that. You can do it but depending on the time of day that you're meeting with people. I mean I think Saskatoon you can be meeting during the day time if you're wanting certain professional organizational input. If you're wanting the community at large, you're going to be in a library at 7:30 at night. So I mean just depending what you're looking for is the kind of input that you'll get. So I mean that's the big question.

And I don't . . .

Mr. Wartman: — That will come more when the interest is gauged by researchers and the team that's setting it up. That would be when you can make the decision about time frames right now.

Mr. Addley: — But it's pretty ambitious to try to do more than one in a day I think. I mean I can be wrong but if you can, that would be great.

Ms. Eagles: — Well then I think geography makes a big

difference. I mean Estevan and Weyburn, places like that, Regina and maybe Moose Jaw or something like that, you could hit a couple a day. But you know in some of the other areas, I question it with the travel time we could get a couple in a day.

Mr. Addley: — But I agree with the idea of having . . . dividing it up and assigning different people. So if we have a committee of two, four, seven, I guess, if we can get three people there, basically if we agree to a dozen, that's six places each person. So, you know, I think that's reasonable to do.

If we can get them all done, you know, four in a week, that's great if it's doable. But I'm not sure if that's possible, if we can clear our calendars well enough.

Ms. Eagles: — And then there's the travelling aspect, you know.

Mr. Addley: — Yes.

Ms. Higgins: — Traditionally how have committees been worked? Have they divided up the province, say? And you know say the people in the South looked after the southern areas, to hit the meetings there. The people in central — I guess not really north . . . (inaudible interjection) . . . No, no. It's fine by me. But like when Myron was talking about, you know, you don't have to have the whole committee travelling around. I mean if it . . .

Mr. Addley: — It's probably availability of the day, and then if you have something on, even if it's in Regina but you could make the Saskatoon one, that's great also.

The Chair: — I'll ask Greg to make a comment on that.

Mr. Putz: — In the past I think I've been involved with three or four of these in the last 10 years or so. The committees in most of the cases have made an effort that as many members as possible go to show that the full committee has an interest in the subject area.

And also the committees have passed motions to reduce their quorum in case not all the members can come, because knowing that members are busy people and have other commitments as well. But normally all the committee members have tried to attend all the meetings so that they have the benefit of hearing first-hand a lot of the testimony from . . . whether it's professional groups or just from the average citizen or high school kids, whatever the case may be.

Ms. Higgins: — So how many days is normal? What's the process we go about? Do you send letters out or gauge response through MLAs or through health districts or whatever the means that we choose? Then we set a schedule and go from there? Like, is there a time frame, Myron, that we're looking at being done or have we set ourselves any guidelines?

The Chair: — Well the committee should report back to the legislature. If we're not done in total we can still come up with a report. But I would think that it would be good if we could sort of target to have this done by the middle of March. I don't think there's going to be any more new material, you know, that would be coming in that we wouldn't have picked up by then. It's a matter of getting out and touching base with people more than anything else.

Now four days a week is pretty onerous. It's pretty hard to get away four days a week. But I know we might say try two days one week and three the next, back and forth. How does that sound?

A Member: — Agreed.

The Chair: — And then some days we might be able to make an afternoon and an evening session, depending on where we're at. If we're in the bigger cities we might even be able to do more than that. Depends how the . . . what kind of demand we have. Suppose we had a demand from a school and public spot.

Ms. Higgins: — Well that's what I was wondering. In the drinking and driving report that was done in what — '95? — I mean they hit quite a few high schools.

The Chair: — You were with them, Greg.

Mr. Putz: — Generally what the committee tried to do was to, as Graham was suggesting, do the high schools during the schools hours. So in the afternoon and give the committee the morning to get wherever they were going. Go to a high school and do something in the high school gymnasium.

And usually there was . . . and that, in the case of the driving, there was the SADD (Students Against Drinking and Driving) groups, that usually they had a formal SADD committee where they made a presentation and other students also expressed their point of view, and then had the public part of the hearings in the evening at a meeting hall somewhere in the town or city.

In Regina, Saskatoon, of course in those ones there were the governments and the more . . . and the interest groups and sort of the professional groups that wanted to make presentations. And those were done right here in the Legislative Building or in Saskatoon at one of the hotel meeting rooms where the committee was staying.

And those were done through the day, as Graham suggested, because those people could get away from work, whereas the general public we tended to book those things so that they would come after supper. And we usually had the hearings from 7 until 10 or 11 in the evening, depending on the demand.

The Chair: — Okay. Any other comments or questions on the itinerary? The way I read this then, we should go for . . . we should try to set it up starting about the second week in February and then we'll try for about two days a week and three days a week.

And start with this list of making sure we're adding Moose Jaw. And my apologies for not having it on there. I thought I did, but I didn't read . . . reread the list. And possibly not starting with Unity for example and possibly maybe leaving one of Meadow Lake or Beauval off. The demand might come later for it though. But maybe we can put those towards the end.

Mr. Addley: — I mean I think we've got to be flexible so that if there's a strong demand from a community that we haven't

thought of, that we have the flexibility to go there.

The Chair: — Okay.

Mr. Addley: — The other thing is just a scheduling issue. Are the spring breaks for students universal in the province or is it different school divisions have separate spring breaks in February? Because I know in Saskatoon there's a spring break coming up and there's no point in trying to access students during that week. And if it's a different week in P.A. or a different week in Regina, we've got to be aware of that too.

Ms. Higgins: — I think Estevan is probably around the end of February; I don't know.

Mr. Addley: — Which?

Ms. Higgins: — Around the end of February.

Mr. Addley: — Yes, that's . . . Ours is too.

Ms. Higgins: — So it's probably pretty close, so . . .

Mr. Addley: — Okay. Well we should maybe work . . . keep away from that if we want to have high school students involved.

Mr. Wartman: — We'd still probably be able to do two days, one side of that and two on the other. I think it's a Thursday, Friday, and then the weekend, and then a Monday, Tuesday, or something like that.

Mr. Addley: — Well if it's universal, then maybe we should not even bother meeting that week. Because, if we've got kids in school when you're in a spring break, even if you're with a professional organization, you may not want to . . .

The Chair: — Well let's just put that down on a list then for the researcher to be aware of, or going through it.

And I think we have enough then to give Greg a start on this and then we'll . . . Doreen and I as a subcommittee then will follow up and finalize. Are we in agreement on that? Good.

Assignments for research officers, second. I have a list which certainly wouldn't be conclusive here, but I thought that one of the first things we needed to do was make sure that the researcher was going to provide us with the facts and the background that we need. Because you get into some places and they'll be asking you questions — well, what are they doing over here? Or what are the regulations in Saskatchewan now?

So briefly I'll just go through this list, asking that we come up with a summary of legislation in other provinces; also background information on tobacco control legislation and regulations in Saskatchewan; a little bit about traditional use of tobacco in First Nations because there's traditional use and then there's the addictive use that we're all familiar with — and they're different.

There have been some settlements and some litigation on the part of governments in various parts of the continent here, and I think it's something that we should get researched so we are up to date on that. A summary of work done by students working against tobacco.

We want to know what the . . . make sure that we're up to date on what the federal government initiatives are on tobacco control. We'll ask the researcher to make sure that they put out . . . that we get a bio of everybody. I know you all have your own, but still we don't have each other's in one spot; it's not a big job.

Now the other things that have been mentioned today. Are there other things that come to mind immediately at this time that we might want to add to the list for the researcher to start on?

Greg, do you have anything that comes to mind that you might want to mention?

Mr. Putz: — Sure. One of the first things we normally ask a researcher to do is to develop a list of stakeholders in whatever the issue is. And they do that by making contacts with various organizations and also consulting with the MLAs if they know what stakeholders on this issue there might be in their constituencies. I mean in this case there are some obvious ones — restaurateurs and bar owners and that sort of thing on one side, and the students is another category of stakeholders. But just developing that list. And that list then helps the committee to determine where they want to go and how they want to approach the issue.

That's one of the main things that the researcher does. The researcher then also does all the follow-up correspondence with that and provides briefing notes to the members on each of these organizations and perhaps an outline of some of the activities that some of these stakeholders have been involved with on a particular issue.

So it's providing briefing notes, background information, developing a stakeholders list. And then once that stakeholders list has been developed, then contacting these stakeholders and inviting them to participate in the process in setting up the agenda. For those we know are interested in speaking to the committee, making sure that they have that opportunity.

So those are the main ones that I can think of offhand.

Mr. Addley: — Just a couple revisions — a summary of other provincial governments' initiatives. And the other one is, and I don't have a good way to put it, but a communication plan. So that it's fine to have the information but also, how are we going to communicate that, you know, even during the work and perhaps after.

The Chair: — Good. Anything else?

Mr. Addley: —I think it's covered in point four, but one of the conclusions I hope that we come up with is suing tobacco companies. And we want to be able to be ready to do that at the end of this, if that's what we choose to do in the committees.

The Chair: — I should read to you again what the ad said, that the research officer to perform the following duties. Analyze written and oral presentations to the committee; identify major issues of concern to the committee; provide brief summary reports; prepare

and answer correspondence; prepare a list of witnesses; provide background material to committee members; assist in the preparation of an itinerary for the public hearing process; and draft a committee report for presentation to the Legislative Assembly.

So any decisions the committee makes then would go into this draft report and to the legislature.

I'll just ask Greg about the process in case we . . . for legislation.

Mr. Putz: — If it's the committee's wish to recommend say a model Bill, piece of legislation that they recommend that the government adopt and have brought into the House, then we also have at our disposal the Legislative Counsel and Law Clerk who would assist the committee in drafting that Bill. And it would likely then be included with the committee report as a model bill — something the committee is recommending, not saying it has to be in detail that way, but a model Bill.

The Chair: — And, Greg, in addition to that, so we have at our disposal, we will have a research officer, we will have the Legislative Law Clerk, and then there's a representative from the Clerk's office. But I understand we may be having some flexibility on that.

Mr. Putz: — Normally it's the Office of the Clerk that does all the background work and also a committee Clerk goes along to make sure that we're covering off everything and making sure the bills are paid and that sort of thing. And also providing procedural advice and organizational advice to the committee.

That would normally be my role but I advised Myron we're a little short-staffed and what we're doing is asking . . . we asked some of the other provinces if they could help us out. Ontario has graciously offered the services of one of their committee Clerks to help us out in the next few months and one of the Ontario Clerks will be coming to join our staff for a brief secondment starting in February. And I've asked that that committee Clerk help out with this committee. That committee Clerk is experienced in doing public hearing processes throughout Ontario so we gain some expertise and some help at the same time.

Mr. Wartman: — Will we be able to have full transcriptions of all the presentations?

Mr. Putz: — Yes, that's another thing. That's an important part of this. It helps the research. It helps the committee especially when it comes time to deliberating on the report. All of our meetings will have *Hansard* in attendance. We'll be bringing portable *Hansard* equipment along and there'll be verbatims of all the meetings. In fact, the committee may want to make a decision to . . . for the witnesses that appear before the committee . . . provide a copy of the transcript to each of those witnesses.

So, I don't know whether it will be Darlene or . . . there'll be folks from the *Hansard* office accompanying the committee everywhere we go. Now it's hard to do a *Hansard* transcript in a meeting in a high school, and in the past we've not done that. And it's the committee researcher's job, as well as the committee Clerk will help out in this regard, getting the pertinent information down because there's just no way of setting up the equipment. It normally takes a formal meeting room setting to give all the commentary. So, in those cases, we won't have *Hansard*. We'll have to rely heavily on our committee Clerk and researcher to get the points. But normally these groups, when they make their presentations, they usually present a written version of whatever they're going to say, so that's helpful. But for the public hearings in the evenings or whenever they are, then we'll have *Hansard* set up and have access to that verbatim of the meeting.

The Chair: — Thank you. Anything else on item 2 about assignments for the research officer?

Ms. Higgins: — I would assume also they're collecting any health data from the Department of Health, like we're having some . . . (inaudible) . . . that would be part of? They'd do all that kind of stuff?

The Chair: — For the research officer? Yes, I think so. And I think you can feel free to approach Greg or myself at any time if you want certain pieces of information. We'll try to . . .

Mr. Wartman: — Will we have any formal presentation by the department? By somebody like David Butler-Jones or someone like that?

The Chair: — Well, we're planning to have a little presentation today.

Mr. Wartman: — Okay.

The Chair: — And if we need follow-up to that, we'll . . .

We'll proceed then to item 3, other committee activities. In addition then to any meetings we might have ourselves or public meetings, are there other activities that the committee members would like to suggest that we should consider as we proceed with the planning? For example, is there other ways of getting information besides going out directly to the bodies involved? Should we be looking at . . .

Mr. Wartman: — Ways that we've used for some other endeavours have been the talk shows. I mean I don't know if you get much light there but once in a while there's . . . you know, for some representative from the committee to go on a talk show, talk about what you've done and take some feedback from the public that way.

The Chair: — One thing that came to mind was one or two of these places that might want to, or schools might want to tune into us, we might be able to say, do something with a conference call or maybe post a site where students could . . . a web site where students might want to just provide input.

Mr. Wartman: — That's actually not a bad idea.

Ms. Higgins: — The one high school in Moose Jaw where the teacher had set up a debate, you know, and the kids had divided up as for and against the whole smoking issue and what restrictions there should be. When I approached some of the kids and talked to them about making a presentation or even doing a presentation more formally and if we aren't in Moose Jaw to send in some type of a brief, they really shied away from

it. But if we did it as a web site or e-mail, we might get a lot higher response, especially from that age group.

The Chair: — Where there was a specific address, Tobacco Control Committee.

Mr. Wartman: — But have a web page done, set our address as a highlight that you can click if they want to respond or send something into us, so they just hit our e-mail and bring it in. And I mean we put the basic elements of what we're about that they can pick it up — maybe some information around smoking — and invite their response, and all they have to do is click on the highlight.

Ms. Eagles: — I think that's a good idea because, I mean, one of the major concerns of this is targeting youth smoking so I think that's an excellent idea, logging onto a web site.

Mr. Addley: — A lot of times too is they have contests so that if you send in an e-mail with your feedbacks and you could even do a survey or a form, you know, if you've answered all of these questions and added your address, we'll do a random draw and you'll win a tote bag from some company that's not related to tobacco.

A Member: — Not Rothmans.

Mr. Addley: — Not Rothmans, I wasn't going to say that but and then that's . . . it's turned into sort of a fun way of gathering a lot of information and raising an awareness in each of the high schools. And that's something that you could communicate to the schools and do it through the media or a higher profile. It could be quite an enjoyable way to get information.

And I think you'd get a lot more impact. You know, you can get several thousand people, younger people sending in these surveys. Whereas if we don't do something like that, we might get a few dozen.

The Chair: — You're suggesting we give them something to respond to, and that way connect with them.

Mr. Addley: — Yes. Even 20 questions, and I mean an opening phrase, their own feedback up to 200 words or something. And put your name, address, and phone number, and if you win, we'd get in touch with you, but your comments will be tabulated — that type of thing.

Mr. Wartman: — I like the idea of the 20 questions on there too. I think a researcher could draft those, do a preliminary draft on them. That sounds good..

Ms. Higgins: — So now if we're planning on getting started by the middle of February, how do we that quickly get the web site going and notices out?

The Chair: — Greg, do you want to answer that question?

Mr. Putz: — I think what I would do is — when we have our researcher in place — is then work with the Department of Education and get . . . if they have a list of electronic mail addresses for the high schools around the province.

What we did with the driving safety, we got the addresses of all the high schools in the province and wrote them all a letter saying: this is what the committee is doing, we're interested in your input.

And I was just looking in this. We did have 104 written submissions — not all from students by any means — but still that was a good number of written submissions to the committee.

But with the web site idea, that's well within the capability of the Assembly. As you know, we do have a web site and we do actually have a Tobacco Control page right now. The only thing on it right now is the verbatim of our last meeting. But we can develop that in any way the committee wants to see it developed, whether it's a survey or a form for them to just write their comments or what have you.

But that is an idea that we can proceed with right away. But the question is, how do we communicate the existence of that? And that would be my suggestion, when we have the researcher we contact . . . We do have some contacts from our previous experience with committees like this in the Department of Education. We'd ask them to help us out.

Mr. Addley: — Did you say you have the e-mail of each of the schools?

Mr. Putz: — We'd ask if they could provide that for us and then we could just e-mail all the schools, advising them what the committee is doing and pointing them to our committee web page.

Mr. Addley: — And also attach a link so that it's right there.

Mr. Putz: — Right. Exactly.

Mr. Addley: — We have to be careful, because you could get 20,000 replies to that.

Mr. Putz: — No, I think our servers can handle that. I forget what the statistic is, but we get a large volume of hits on our web site every day in any event. So we're well equipped for that.

The Chair: — Well that's good. And I think that once we have our plans all set out, once we have an itinerary planned and we have our researcher in place, we'd be in a position then to have a press conference and just announce the whole package: here's where we are, here's where we're going. Everybody would come to that.

Mr. Addley: — Could I suggest you do three press conferences: one in Regina, Saskatoon, Prince Albert, and we would all . . .

The Chair: — Make sure we get local coverage, you mean?

Mr. Addley: — And then maybe even if you wanted to do one locally so that it's all done on one day everywhere. Because I think that's where you'll have the . . . gets people thinking and gets people . . .

The Chair: — Okay, we'll put that to consideration. There may

be a way . . . (inaudible interjection) . . . Well, there may be a way of just dividing it up too. There may be a way of doing that; we'll take a look at it.

Ms. Higgins: — Well, like I don't know what it — Doreen, you know — would be like. But I know, and even with yourself, Myron, . . . But living in a smaller community, even a press release mailed out or faxed out to the local media, we usually get some kind of a response, a phone call at the office or . . . I mean, you know, it's fine that way. Regina, Saskatoon, you might have to do something a little more formal.

Ms. Eagles: — Like I think the smaller towns are pretty much all the same, that if we send out a news release, they get back to us in print or put it on the airwaves.

The Chair: — Any other items or any other comments on item 3? I wonder if our people are here?

Mr. Wartman: — One thing I should ask is, I think this was a concern for Graham. He wondered whether, when I said he was a smart fellow that it got into *Hansard*. So . . .

Mr. Addley: — Okay, with regards to other committee activities, with No Smoking Week coming up and different activities that are throughout the province, do we want to partner with them or do we want to take a hands-off approach until we've done our work.

The Chair: — I'm going to ask Greg for a comment on this but my advice on that would be that you would do what you would ordinarily do. If you're invited to a press conference to attend, please feel free that you can do so as an MLA at any time.

Mr. Addley: — Right, I meant as a representative of this committee.

The Chair: — And you can say that you're a representative of this committee. You can tell them about things that we've already decided. But that's about as far as you can go in terms of what you can say about the committee.

Mr. Addley: — Okay, thank you.

The Chair: — Anything else to add to that? Okay. So we'll recess again.

The committee recessed for a period of time.

The Chair: — I want to welcome the delegation from Saskatchewan Health, and I'm very pleased that our deputy minister was . . . would take the time and come with the delegation. This, Ms. Yeates, is our first meeting with an actual delegation to the committee. We are just in the process right now of establishing our itinerary and our work plan in total. And we think we'll have . . . We'll be ready with a work plan likely within two weeks. We plan to travel the province some time in February.

So just with that little bit of background I'll turn it over to you, Glenda, and ask you maybe to introduce your members. And I think we've all got our names here so you know who we are.

Ms. Yeates: — Well thank you very much for the warm welcome and for the chance to speak to you. And this is a topic near and dear to the hearts of the Health department, and so we very much appreciate the opportunity to be here today.

With me are: Dr. David Butler-Jones, who is the chief medical health officer for the province; and on my left, Marlene Smadu, who is the assistant deputy minister in charge of population health among many other responsibilities; and April Barry, who is the director of health promotion, and tobacco-use issues are within April's purview very specifically.

What we thought we would do today is provide a background presentation — as we understand you had wanted — providing some of the context to some of the tobacco issues that you'll be looking at and its relationship as a health issue. We will be presenting . . . Primarily David and Marlene will be presenting some of the recent data. We do have some detail documents to leave with you as well as the presentations, and then obviously we're happy to answer any questions that you might have of us.

The presentations and data will focus on the direct and indirect costs of tobacco use, which may, we feel, provide some of the base sort of rationale for the need for action on this health topic. We have with you . . . with us as well an example of a framework for looking at tobacco control that has been developed by a federal-provincial-territorial committee, in addition to some of the advocacy groups and interest groups who are interested in this health topic from across the country, and we'll provide that to you for your information.

We do have some data on the prevalence of tobacco use in Saskatchewan particularly, and we'll provide some brief overview of legislative comparisons so you have some sense of where we stand on that particular kind of strategy or vehicle compared to our other provinces and territories.

Tobacco use is the leading cause of, preventable cause of disease and premature death in Canada. It is a very, very serious health issue. It is estimated that — and David will speak in more detail to this — but that more than 1,600 adults die each year in Saskatchewan as a result of smoking.

Smoking in our province kills more people than AIDS (acquired immune deficiency syndrome), illicit drugs, suicides, murder, and traffic accidents combined each year. So in order to prevent this loss of life and improve the overall health status of the province, there is a need for urgent, appropriate, and effective action.

Tobacco use is a societal issue with major implications for the health of both smokers and non-smokers, and the negative health consequences of tobacco use have been well documented and David will give us a bit of an overview of that.

I think one of the things that will come out in our material is that preventing young people from starting to smoke is a very critical step in terms of leading to a healthier Saskatchewan. It's estimated that half of all smokers in Saskatchewan began their tobacco use by the age of 13, and most smokers are smoking daily by the age of 18. And if a person reaches the age of 20 without smoking, we know that he or she is far less inclined to ever be a user of tobacco products.

In our view, a comprehensive tobacco control strategy needs to have a number of aspects. Certainly focusing on prevention will be key; preventing young people in particular from starting to smoke. Cessation is also an important strategic element; assisting existing smokers from stopping smoking.

Thirdly, we think a protection aspect is critical; protecting non-smokers from the health effects of second-hand smoke. And finally, denormalization is part of a national strategy word to deglamorize the use of tobacco and to look to effecting community norms about tobacco and its use.

So those are some of the things that we'll highlight for you in the presentation.

So without further delay, I'll ask David, Dr. David Butler-Jones, to begin the formal part of the presentation.

Dr. Butler-Jones: — Thank you very much. Now do I need to be sort of at this level so the mikes can pick up for transcription and that kind of thing, or can I stand? Can you hear if I stood? Actually, it's probably better sitting so I don't obstruct. So I'll just stay here.

Actually it really is a privilege to be here, and we appreciate the time to speak to you. My role here is, as much as anything, to provide a context for understanding of the impact of tobacco and particularly what has turned out to be the largest preventable epidemic of disease, disability, and death of the last century. And hopefully it won't be the same in the next century.

So again you have, I think, a handout of the overheads themselves. It clearly is . . . I mean there's just absolutely no question about the economic and human costs of tobacco. It is the leading preventable cause of disease and death as Glenda has noted and there are more than 1,600 . . . And it's not just deaths — these are premature deaths. I mean it's deaths before the age of 70; it's not like we all have to die some time. This is like before you really should. And thousands more develop preventable diseases as well. And tobacco smoking also contributes to infant mortality and childhood illness.

Now the next one, I'm just putting up, again this is using data from a couple of sources, the Institute for Health Information, etc., and plots different provinces in terms of their infant mortality rates, the number of doctors per population, their gross domestic product, and their health spending; and basically the only point of this is to say is there's no correlation between any of those in terms of the more you spend doesn't translate into better infant mortality, the more doctors you have doesn't translate into better infant mortality.

And you can use this for a whole range of health indicators. The only point of that is to say that we clearly recognize that the health system is essential but it isn't the only thing that deals with, or provides for, health. And in particular one of the things that we're talking about today in that realm is tobacco. I'm not going to . . . I've just got a couple of little quotes there; I won't bother you with this.

The thing to say about tobacco is it is unique. It is different than virtually any other addiction we deal with for a number of reasons. Firstly, it is powerfully addictive and experts in the United States . . . It's even more addictive than heroin because it gets directly from the mucous membranes, the nicotine gets directly to the brain virtually instantaneously so you have a very strong reinforcing effect in terms of the physical addiction, far more than you get with heroin, say.

There are also direct effects not just for the smoker but for those who are around the smoker because it is something, unlike alcohol which you just take in, others aren't forced to drink alcohol at the same time as you do. Each has obviously other indirect effects, but the point with tobacco is it isn't something that only affects the smoker unless the smoker does so in isolation from anybody else.

There's at least 4,000 chemicals and we know that at least 40 of those cause cancer and there are a range of others that increase the risk of many diseases — toxins, etc.— and the individual develops both a physical addiction and a psychological habit. I know people long after they've kicked the addiction, 10 years later, after dinner they reach in their pocket looking for cigarettes and realize oh, this is really silly.

Because it is so much part of our . . . It has become in this century — or the last century — so much a part of our culture that it is very, very difficult to give up when you're in an environment when that is a very common thing to do, is to smoke, and there are certain times and cues that make it easier. And it really is a 20th century phenomenon. Before the advent of the ability to mass manufacture cigarettes, tobacco was an issue but a relatively small issue. It was only those who smoked the pipe, or for ceremonial purposes. It's really with the second . . . the First World War and the advent of cigarettes and the mass distribution free to soldiers etc., that created a whole new market, and a fast way of delivering the nicotine.

Now if we look at . . . Now this is Saskatchewan data from 1994; it's the most recent data we have. And as you look across, these are the numbers of deaths per year in Saskatchewan from lung cancer, heart disease, chronic lung disease, other cancers, and stroke. And these numbers across the top represent the proportion of lung cancers that are related to tobacco. Okay? So 80 per cent of lung cancers, a quarter of heart disease, 70 per cent of chronic lung disease, etc.

But what is also worth noting, because heart disease is one of the biggest killers of the elderly, that if you get to . . . Like if you're looking at heart disease deaths under the age of 60 in women, for example, it is more than half relate to tobacco. So it is a . . . These statistics include all ages not just deaths at a younger age.

And so we've seen lung cancer rates increase markedly from 1950 until right into the 1990s. And if you are a women in Saskatchewan, or anywhere else virtually in the developed world, the top graph represents breast cancer — deaths from breast cancer — the bottom graph, deaths from lung cancer. And as you can see, there are more women now die from lung cancer than from breast cancer. There's an old story that . . . They used to talk about women who will smoke like men will die like men, and to some extent that's true.

Glenda was referring to this. It's not that there are no deaths from AIDS, it's just that the number is so small in this graph

that it doesn't actually come out as much of a blip. But you can see the comparison between deaths from suicide, traffic accidents, and smoking in any given year. And again these are premature deaths we are talking about.

And just, I put this up, I use this often when I'm talking to community groups and others to sort of point that there's almost an inverse relation between the amount of media attention and the actual importance in terms of health. And so this is actually looking at, if you took 100,000 smokers at the age of 15, what are they going to die of before the age of 70, like prematurely? And about 18,000 of them will die as a result of their smoking; around a thousand in car accidents; a similar number related to alcohol effects; about a little less than a thousand, about 900 from suicide; maybe a hundred and twenty-five from murder. And hantavirus, which is the one that relates to deer mice and there was huge media sort of attention, and we've had a couple of cases in Saskatchewan. And of course mad cow disease which we haven't had any cases yet, but gets everybody very, very excited.

So again with over 4,000 chemicals; I've talked about that. The other thing that makes this unique is that there is no known safe beneficial exposure level. For example if we talk about alcohol, people who drink one drink a day actually have lower rates of heart disease and live longer than those who don't drink at all or those who drink more than say, three a day. So there is . . . I mean even with alcohol there's a level that if you can manage it, that may actually be health beneficial. That can't be said for tobacco.

The thing is it's not just an independent or additive risk. It's not like say your risk from smoking say doubles your risk and then if you're also high cholesterol so that's double, so you got, you know, you've got sort of two plus two, or whatever. It's not an additive risk, and actually multiplies the risk. And part of that relates to reducing physical and immune defences and the interaction. Because all these chemicals interact with many other chemicals in the body and other ag chemicals that you might introduce.

So for example, I'm just looking at one again another sort of popular issue which is asbestos exposure. And if you look at now one, so non-smoker, non-asbestos exposure. Now when I talk about asbestos exposure you're talking about people who work in the shipyards for example, people who are involved in asbestos mining. A fairly high exposure to asbestos.

So a non-smoker, non-asbestos is a one, okay. You take that non-smoker and put them into asbestos exposed situation and their risk of developing lung cancer is between two to six times the risk of somebody without that occupational exposure.

If you just take a smoker walking in off the street, it's 10 to 16 times the risk of the non-smoker. If you take that smoker and make them an asbestos worker, it's somewhere between 40 to 90 times the risk of lung cancer. So it's not just a simply additive thing, it's a multiplicative issue.

And then just something a little more mundane, unless you have one — heart attack. And again looking at different risk factors for heart disease. And this is men and women, though women generally have a lower rate of heart attacks than men. Though it is deceiving because women tend to be underdiagnosed in terms of heart disease because we don't . . . for a long time we didn't expect, we just sort of thought, you know, estrogen protects against heart disease so it's not as big an issue with women.

And then we started to realize that, one, it is a bigger issue than we recognized for a couple of reasons. One is women present differently in terms of they don't have the classic . . . they don't always have the classic crushing chest pain and pain going down the arm and all that kind of thing. So many were misdiagnosed for a long time. It's still less than men, but it isn't as small as we originally thought.

So then you add the risk of if they're a smoker, if they're a smoker plus have a high cholesterol, if they're a smoker and have a high cholesterol and high blood pressure or hypertension, then again these factors just don't add to one another, they increase much faster than that.

But there has been some changes. We talked earlier about the development of the cigarette the first part of this century. We saw in Canada, the US (United States), and Europe, heart disease rates rise exponentially until the 1950s in direct parallel to the increase in smoking and also change in diet and activity.

But we have now seen, since the early '60s into the '80s and the trend has continued, a fall in deaths from heart disease. And that rate was about 30 per cent, had dropped just in that 20 year period. And when they actually analyzed why that happened, about a little less than a third were related to diet change, lower fat, etc., but a quarter because they reduced or quit smoking, about 13 per cent because of coronary care, etc.

And as you can see, I mean coronary bypass surgery, which was the number one operation in the United States, actually accounted for very little of this. It's important, a very important procedure when you need it, but there's a whole lot you can do long before that.

Now I've included in there . . . I'm not going to belabour this, but I always find it intriguing how long the debates have been. This is Asclepius which is the . . . these are two Greek gods, god of healing and the goddess of health. This is sort of the patron god of physicians and the patron goddess of public health and one cannot exist without the other. But it's interesting that our conceptions of health and the contrasts of how we need to blend these things has gone on for a long time. And I won't share that quote.

But to look at effects on babies, smoking has a direct and harmful effect on the fetus and its growth, contributing a great deal to small babies, underdeveloped babies, increases the risk of low-birth weight, stillbirth, and infant death. Infant exposure to smoking has lifetime effects on lung function.

In other words if you take a child who grew up in a smoking household, 20 years later you measure their lung function versus somebody who grew up in non-smoking household, even if they themselves do not smoke, it is worse. And sudden infant death syndrome is . . . some estimates as high as 50 per cent of sudden infant death relates to smoking, not only in the house but also smoking before birth.

So again, I know, I hope I'm not belabouring the point. Many of these things you may have seen before, some you may not be as familiar with, but it is important to restate them. Smoking accounting for about a third of heart disease, 40 per cent of strokes, 660 cancer deaths in Saskatchewan, 10 of whom are non-smokers, and emphysema, chronic bronchitis, asthma, etc.

I think we're open if people have questions as we go along, anytime.

Another one which I find a lot of people don't realize is the impact that smoking has on circulatory problems, what we call ischemic vascular disease, the people who end up losing their legs, etc. And now it's an increasing problem because diabetics . . . if a diabetic smokes, not only do they have the effect of the diabetes in terms of vascular disease, the risk of losing limbs and needing an amputation, the risks of kidney failure, etc. But if they then smoke, they increase their risk of those complications of their diabetes dramatically.

Increased accidents. Again it's an issue of, of when they're . . . you know, smokers when they're driving, they go to light their cigarette. They get distracted. Plus if you . . . in a car, if you have a smoker in a car and you measure — or any enclosed space — and you measure the carbon monoxide levels, if it were a factory you would close it.

Mr. Wartman: — One of the items that was pulled off the Internet was around women who were waitresses in bars where there was fairly heavy smoke, and apparently the incidence of breast cancer among them was phenomenally higher than, than a normal site.

I saw that promoters of other cancers and wondered if you had encountered those statistics or if you . . .

Dr. Butler-Jones: — Yes. No, I actually have a list of some of those. But there is . . . I mean breast cancer, cancer of the cervix, kidney cancer, there are a range of cancers that are . . . It's not necessarily the primary cause but it is a promoter in that disease.

Decreased productivity and stamina. We don't see many professional athletes for example. And it interferes with the body immune system and the normal defence mechanisms.

One of the challenges, for example with lung cancer, is that not just all the toxins but one of the things that tobacco does is kill the cilia. The cilia are the little hair cells that move things out of the lungs — toxin, whatever, you know particles, etc. — and in a smoker those get killed off so it's much harder for them to clear these things, so they sit around in the lung longer and have greater exposure and therefore increase the risk that way as well.

The Chair: — What is that word you used? Those little things that . . .

Dr. Butler-Jones: — Cilia.

The Chair: — Cilia.

Dr. Butler-Jones: — Yes. It just means sort of hair. It's just sort of a Latin word for hair. And there's . . . These cells have little, little, fine hairs and they work in motion. So that if you get, say you get pollens and things into the lung, then they work and clear it, and that's why you get, you know, little . . . most times you don't have that much mucus so you don't actually have to cough. But you . . . It just sort of comes out, you swallow it, and then it's cleared from the lung.

Whereas in a smoker, one of the reasons they have some morning cough is because all these secretions . . . One, they have more secretions; and secondly, the secretions hang around and they have difficulty clearing . . . They can't clear them without coughing.

Mr. Wartman: — . . . a person who has smoked and quit?

Dr. Butler-Jones: — Yes, yes. And I didn't actually bring a graph, but I have a very nice graph that shows what quitting does in terms of what happens within minutes, what happens within days, and what happens within months and years.

In terms of — just a quick one — in terms of the risk of heart disease, it immediately starts to fall because you don't have the carbon monoxide floating around in the blood, etc. In terms of cancers, it depends on the cancer, but because cancers can take up to 10 years or more to develop, you can't really say you're totally clear of your cancer risk till after 10 years. But we do know that even after a couple of years you start to, to move back towards the normal, and it's the same with heart disease.

I just wanted to make reference to . . . because we often talk about smoke and tobacco, and the tobacco that is snuffed or chewed, also has health problems in terms of cancers; problems with bleeding gums and gingivitis, teeth falling out, etc. And likely, because it's an area that we really haven't studied very much, it likely will . . . we will find in the future, though we can't say that until we actually look for it, find some of the similar problems related to tobacco and nicotine on blood vessels, etc.

The Chair: — While you're on that — effects — we also have a lack of information on cigars and pipes.

Dr. Butler-Jones: — Yes. Yes, there is much less information. We know though that, for example, cigars and pipes, cancers around the oral pharynx like the mouth and throat, etc., are much higher. Cigars themselves, because of . . . There's just so much tobacco and the way they process it. I can't remember what the number is, but there is some . . . it's like smoking some phenomenal number of cigarettes in terms of what you actually ingest, you know, if you fully inhale it. But, again, we don't have as much evidence, clearly. And there aren't as many smokers either, I mean, people who are exclusively cigar smokers, because it gets mixed up. And the same with pipe because many of them also smoke cigarettes, and it's hard to differentiate. There are very few that are pure pipe smokers or pure cigar smokers on a regular basis. More than just when you have a baby.

On second-hand smoke, we know that some 300 deaths annually in Canada are from lung cancer in non-smokers. That's what leads to the calculation of ten in Saskatchewan. Increases the risk of heart disease and asthma in non-smokers and it increases the risk of things like ear infections, pneumonia, etc.

When I used to be doing clinical work, half the kids I'd see that come in from an urgent care standpoint, were from smoke. Like, I'm sure — and the studies have born it out — that smoking more than doubles the risk of ear infection. It is more likely that a simple cold goes on to either sinus infection or pneumonia, those kinds of things. And most of the kids — there are very few — it's not that they weren't there, but they were very few kids that I would see with pneumonias, or ear infections who were from non-smoking families. It does happen, I mean, it's not uncommon, but when you look at the relationship between the smoking families themselves, it's much greater.

And two things struck me, because I would always talk to them about it. At least if you can't — just go outside, if you know you can't quit. If you want to quit, I can help you, but if you can't quit, go outside so nobody else has to smoke. Two things. One that I found . . . Often I would see them later and they would say, you know, it was really amazing, I did it for a while and then I quit, because it just seemed like such a nuisance, and the kid's a lot better. Or secondly, the number that would say, I never knew that.

Now there's people that would say you need to quit, but nobody had made the connection for them between their kid's illness and the fact that they were smoking in the house.

Mr. Wartman: — . . . There was a myth going around some time back that if your child has an earache, what you do, you should blow a little smoke into their ear and . . .

Dr. Butler-Jones: — The anaesthetising effects.

The other thing is now, it's not as true — I'm not sure — because we don't have more recent data, but some time ago when smoking was more common, about a third of the kids with asthma, if you could get the smoke out of the house, they never had another asthma attack.

Air quality is an issue for smokers and non-smokers alike. Not only are you breathing your own smoke, but others as well. And I find it striking the number of smokers I know who hate to . . . refuse to eat in a smoking section in a restaurant because they can't . . . you know, they don't mind their own smoke but they don't want anybody else's.

There are issues in terms of not just the desire for protection but the requirement for protection. Certainly if tobacco were a product that somebody tried to introduce today and didn't have all the history and cultural basis for it, it certainly would never have pass muster.

Legislation and workplace policies have clearly proven to be successful. They also assist those wanting to quit to reduce the amount they smoke in buildings. I'm amazed the number of smokers who quit when their office space went smoke-free, and it was just one little assistance to them. And smoking quickly reduces local air quality to unacceptable levels.

It's striking, and this is a number of years ago now, but we actually sort of went into bingos and measured carbon monoxide levels and some of those things, and if it were a factor they would have been closed. I mean people have to work in that, right?

This I find really striking, and that is . . . This is some work that McKeown did in the late '70s looking back. Now this is British data. But the average smoker, 45-year-old smoker in Britain at that time, could expect to live only a couple of months longer than the average citizen in 1840. So all that progress over 150 years almost, was up in smoke.

So the costs that Glenda referred to . . . Now again I must say these are estimates, and as anybody who's ever worked with estimates of costs, they know there has to be a lot of assumptions. And generally when we do this we do it in a way to try to minimize the cost. In other words so that you can't be criticized for including all kinds of things that you wouldn't normally expect to include. So it tends to underestimate the cost.

Depending on what you include, you can move these number up or down. But using standardized methods at least as they've been used by Health Canada, generally are direct costs here in the range of 72 million; indirect costs about 187 million a year; and the total cost in 1997 dollars, about $266 million a year. Revenues, and again somebody may correct me on this and that's quite fair, but my understanding is that revenues from tobacco are about 117 million in Saskatchewan.

I don't want to dwell . . . I guess the other thing is I don't want to dwell too much on the economics because I mean the issue . . . it's like of like . . . I mean we could save a lot of money if we never treated diabetics because they just live longer and keep coming back to the doctor, right? If I'd been allowed to die in childhood from my asthma, you wouldn't have to listen to me today. So I think it's important to talk about the economics, but I really caution against that being the focus, because we end up debating a lot of things about that.

Mr. Addley: — But isn't that a fundamentally different question. I mean if we saved your life and there's a good cost benefit to that, that's one argument. But if we let you die and there's a cost benefit, that's a whole different argument I think. So I mean I don't want to leave . . . I mean I actually put a check mark beside that because I've already been lobbied by a tobacco company that, you know, as a member of government I'm a partner in the tobacco industry because of the revenues that I bring in.

Instantly, I thought, well sure you're publicly paying, you know, the money that I'm getting or the government is taking in is well in this case 117, but I'm paying 266 out. Well I'm not a partner in that. If I am, if this were any other business I'd get out of it pretty quickly, so I want to get out of it quite quickly. So I agree with you that all of the other arguments were very good, but if you make it a dollar and cents argument that we can lower your taxes by X amount a year, if we can diminish the number of smokers in the . . . (inaudible) . . . not enough to take from . . .

Dr. Butler-Jones: — Certainly I mean, I guess part of that too though is . . .

Mr. Addley: — But I am glad that you're here talking today if that . . .

Dr. Butler-Jones: — Actually I am too, but it's . . . but not

everybody may agree with you.

Mr. Addley: — The day isn't over yet.

Dr. Butler-Jones: — But I mean if you look at — and again depending on how you want to cut it — if you look simply at the direct cost in terms of what the health plan pays out versus what you've captured in revenue, you capture more revenue than the health plan pays out directly. But again there are many things that we don't capture, like all this thing . . . all these numbers around children who have needless ear infections or pneumonias. There's a whole range of things that we don't capture in this. Plus then the costs that are borne by the individuals and their families and how the society suffers economically.

Because in fact I mean, I would argue that I've actually contributed a little bit to society over time and others in whatever their realm do as well. And so living a long and healthy life is not a bad thing, it is a good thing, and we all benefit from that even if we do live to collect our pensions.

The other thing which often gets sort of forgotten in the analysis is that there's been some intriguing work looking at the cost of . . . I mean if I . . . if I live longer, most of the cost — the health care costs — are in the last, my last five years of life whether I die at age 30 or I die at age 80. And in fact the kinds of interventions that take place in somebody who is 45 or 46 — like in middle age like me — versus if I were 80 with the same condition, again I'm much more cost . . . I mean it costs more to care because obviously it's a different sort of situation. Whereas when I'm 80, I may just want to say, you know, let's do some good basic things but don't save me at all costs. So they're a whole lot of other complicating factors. So I appreciate your point.

Mr. Addley: — Right, I just want to clarify because what the slide tells me is that the revenues brought in by tobacco is approximately 117 but the cost is 266. Is that what . . . so it's a cost of about . . .

Dr. Butler-Jones: — The cost to society is . . .

Mr. Addley: — 159 a year in Saskatchewan not counting in a whole lot of difference, is that what you're . . .

Dr. Butler-Jones: — Yes. The cost to society using the formula and there's more detail actually in the package that you've got. But it also omits a number of things in terms of other costs . . .

Mr. Addley: — The point's made.

Dr. Butler-Jones: — Yes. And that's really what it is is to make the point. And nationally 15 billion estimate, and then we know, we also know that companies that reduce their smoking, they argue that they get better productivity and certainly the rate of sick time, etc., is much lower in non-smokers than smokers, etc.

So there's several basic themes that underlie why we need to address these issues — the death, disease, emotional, financial burdens, etc. The government does, we believe, have a mandate in serving the public good to improve health, and tobacco reduction does require comprehensive strategy. It's not simply an issue of legislation; it's not simply an issue of education. No one approach or sector can really handle this on their own.

And we know that there's basically two ways to reduce tobacco use — either you quit if you're already smoking, and you don't start if you don't. And so we used to . . . Anyway, we don't like patients who quit due to death. I mean, it's not that we don't like them, but we don't like that option.

Quit programs then need to accommodate the differences amongst smokers because everybody has a different reason for quitting . . . finds different techniques. Some find the patch very effective. Some can tolerate the gum. Some find hypnosis. Some find . . . I mean, there's a whole range of things, but the chief thing is making an environment which is conducive so it's easier to quit than not quit. In other words, if most of the places we go we're not tempted to smoke and our friends don't smoke, we're less likely to smoke ourselves.

Prevention efforts obviously directed to those who aren't smoking yet and trying to catch them early if they are starting to smoke, legislation enforcement is clearly one of the effective strategies. And we have a lot of evidence internationally for that. Not just legislation but a range of measures. There are many examples in Canada and the US, and children actually are influenced the most — are most price sensitive, are most influenced by education and peer support, etc.

The other thing that's interesting. I was in . . . It's interesting to look at internationally. I'm just going to share this story with you because smoking is greatly on the rise in the developed world.

And I was doing some stuff in Vietnam last year and the average income there is about 50 US a month. And you couldn't . . . Every second person had a little stand which was donated to them by the tobacco companies that they sold cigarettes and other things. And a pack of cigarettes was, if I remember right, the equivalent of 25 cents Canadian. They can't make it for that, so they're basically just creating a market. Most interesting.

Mr. Addley: — On that third point, do you have further details or background information or evidence of that?

Dr. Butler-Jones: — Yes. There's actually a lot. I mean we can provide whatever you would like. There's not much in here. You're talking about the international issues?

Mr. Addley: — No. You said children are influenced the most by price increases and measures . . .

Dr. Butler-Jones: — Yes, we can provide you additional information.

Mr. Addley: — I think that would be good for the committee to have because that's sort of our mandate is right on that area.

Dr. Butler-Jones: — And certainly I'm sure if at any time other questions arise that you would like some background information, we would be pleased to . . .

Mr. Addley: — Well that specific one would be very useful.

Dr. Butler-Jones: — Yes. Okay. And that's not . . . I mean that, international issues are kind of a sidebar because they don't directly affect us now, but just to . . . out of interest.

Mr. Addley: — Are they Canadian tobacco companies?

Dr. Butler-Jones: — Well, it's mostly like Winstons, I think.

Mr. Addley: — Okay.

Dr. Butler-Jones: — So there's a lot of information that . . . through the World Health Organization. So if you are interested in some of the issues at the international level, we can find you some information even though it's not directly relevant to the committee. But if you would like something, we can provide that.

Mr. Addley: — I just know that we have a federal person in the room and a lot of times if people commit crimes in other places that they can be held account . . . If Canadians commit crimes in other countries, they can be held accountable here. So not that's that specific is a crime, but if you sell products that are less than what they're worth, it's called dumping them through Canadian connections.

Dr. Butler-Jones: — Yes, yes. Yes. But I'm not sure . . .

Mr. Addley: — Sorry . . .

Dr. Butler-Jones: — No, I'm sorry. We could go on about this.

Mr. Addley: — Yes, I know.

Dr. Butler-Jones: — There's some really interesting . . . I met with the Canadian . . . the person who is responsible for international stuff on the labour side, and it's most fascinating. Studies show we can influence future tobacco consumption. Smoking rates are currently increasing among young people. Smokers who quit reduce their risks of some things immediately. We talked about that earlier. And the financial benefits are everybody benefits from that, pay off your mortgage sooner, whatever.

And in order to address this we need comprehensive strategies, so successful tobacco reduction requires policy and legislation, public education, some accountabilities in terms of the industry and the product itself, research prevention and treatment, and environments to support change.

So that is actually my last overhead and that kind of leads into Glenda's introduction of Marlene unless there are additional questions for me. Thank you.

Ms. Yeates: — David's comments really summarize in many ways a document that's included in your package called *The Need for Action on Tobacco Control*. So many of the more detailed . . . for example, the detail costing, how the indirect and direct costs are done are in that package. And all of the data is footnoted in terms of where the incidence numbers and health numbers come from.

So we've given you all copies, but if you have any further additions we will certainly follow up and get you the pieces on the price effects because I know there is, there's some very good work there that we can pull for you.

Next then is Marlene's going to speak to us about, I mentioned the national framework on tobacco control, and we offer that as something that is a fair bit of work has gone into nationally that you might find useful as a starting point for your own thinking. And also we talked about the need to look at Saskatchewan, the specific prevalence data, and Marlene has that as well.

Ms. Smadu: — Thank you, Glenda, and thank you for the opportunity to present to you today. I will just draw your attention, in your binder there is a full report called *New Directions for Tobacco Control in Canada*. This is the report I'll be speaking to this afternoon as an example of the framework. And you also have in your package the copies of the overheads that I'll using. So I'll just get the first one up. And as David has said, I would be glad to be interrupted with questions or comments if that would suit you.

So the document *New Directions for Tobacco Control - A National Strategy* is provided this afternoon as an example of a broad and comprehensive framework for tobacco control. And it is an example, and I'll be repeating throughout the few minutes that I am presenting that there are other examples of how you can frame the challenges associated with tobacco control in terms of identifying goals and objectives and also the kinds of strategies that would be useful to use. So this is for your background information.

The background of the strategy is that it is a framework endorsed by the federal, provincial, and territorial ministers of Health as recently as September of 1999.

Addressing this problem, that of tobacco control, successfully requires a concerted and comprehensive use of multiple approaches. And I would emphasize at this point that it's intersectoral as well. While as the Health Department we feel very strongly about this issue as a health issue, we recognize that the most effective approaches need to cross department boundaries and sector boundaries. And so there are Justice and Finance and Social Services and a number of other departments associated with this issue.

The framework encourages national, provincial, territorial, and community levels to develop and implement tobacco control plans that are consistent with their mandate. And that no jurisdiction or organization must do everything, and in fact it would be ineffective if one organization or jurisdiction tried to do everything. That there are multiple levels to this approach for tobacco control, which I think you'll see as this unfolds.

There are four key goals of the strategy which Glenda has already referenced. And that is prevention, so we want to help people to not start smoking and we're particularly targeting young people; cessation — persuading and helping people who are using tobacco products to stop; protection — and that's both those people who smoke but probably more importantly those who are exposed to second-hand smoke; and the denormalization, which is really about educating Canadians about the marketing strategies and the tactics of the tobacco

industry and the effects of the industry's products and the hazardous and addictive nature of tobacco industry products.

And I'll just refer back to a comment that David said. That having contact with families that sometimes they don't understand for instance the addictive nature or the effects of second-hand smoke. So that there is a social and cultural issue that we need to address.

This latter goal, that of denormalization, is relatively new. It hasn't been something that's been used across jurisdictions in the past. And you may be aware that British Columbia, in particular, is using this strategy in terms of having tobacco companies indicate the contents of the products, including the hazardous chemicals and toxins that are included there.

Once the goals were identified, the group that prepared the report looked at what kinds of strategic directions would be useful to address and would be aimed at providing a comprehensive and intersectoral and multi-sectoral approach. The directions are intended to provide a basis for planning, implementation, and evaluation of the kinds of action that's taken at all levels — so local, provincial, territorial, federal — and by organizations outside of government. And we've referred to previously in our presentation the number of non-governmental organization or stakeholder groups who have had an interest in this and who are driving many aspects of the tobacco control awareness and planning.

So the strategic directions, I'll go through each one with just a bit of an explanation. Policy and legislation, and certainly that's a key aspect of the work that you as a committee have been charged with. We recognize — and will talk a little bit in terms of legislation the overlap between federal and provincial legislation — that there is a role for both levels of government.

We need to think about, in the area of legislation, everything from the smoke-free public environment, what kinds of responsibilities does the province have for that, vis-à-vis municipalities or other local authorities. Is it important that we look at tobacco legislation in relationship to all of the sectors and all of the departments — which I've already alluded to and you've actually raised, I think, in terms of your questions — in terms of the finances that come in and then the impacts in health costs.

And also in relationship to policy and legislation — which I am sure will . . . has already come on to the screen in terms of the work of this committee — is the issue of enforcement. That with any kind of policy or legislation, if there isn't some understanding of the enforcement requirements and how that will be accomplished, then it won't be a complete picture. It will be very hard to have an impact with that.

Another strategic direction is public education. And David has talked about that in terms of making sure that people have correct information and they understand concepts related to prevention, cessation, protection in the denormalization. We've often focused on prevention and we, I think, have been very conscious of that, of helping people to recognize the risks and helping them to not start. I think we need to increase our efforts in the areas of cessation, and in not a punitive fashion, but in a way that will allow people to deal with the real physical addiction as well as the psychosocial or the psychological norms that have been associated with smoking.

As has already been mentioned previously, the focus of this committee is on youth, and so we recognize that there's a huge issue in having public education that is appropriate for use, not just for the individuals, the young people themselves, but for people who influence young people.

And we also recognize that there are issues in Saskatchewan with public education that's appropriate for our diverse populations, and specifically our First Nations population and Metis who have specific needs in relationship to what information they get and how they get it.

Industry accountability and product control is another of the strategic directions that's included in this framework. The federal government has provided leadership in terms of packaging, promotion, and sponsorship related to tobacco. You are aware of what British Columbia has done in relationship to toxic constituents which I mentioned earlier, and other provinces are looking at legislative action that may be related to industry accountability and product control.

Mr. Wartman: — Marlene, have any regulated places where tobacco can be sold? As you were talking, I was thinking about, you know, we've got our liquor board stores and places where controlled substances are already sold. Any jurisdictions that you know of that have quite strictly regulated where tobacco can be purchased?

Ms. Smadu: — April has pulled her chart out so I'll see whether she can pull that out very quickly. Because there is certainly the issue of licensing offenders and who is a sort of a licensed vendor in terms of having the ability to sell tobacco. Have you got that at your fingertips April?

Ms. Barry: — Yes. I think the majority of restrictions to where tobacco can be sold have been in related to pharmacies. Several provinces have passed legislation restricting the sale of tobacco to pharmacies. Several provinces have restricted or banned the sale of tobacco in pharmacies. Also some of the pharmaceutical associations in other provinces have requested voluntary bans.

But to my knowledge the majority of banning and restricting of sales has been related to pharmacies. We have some . . . by policy some health districts ban the sale of tobacco products out of health care facilities like hospitals, special care homes, etc.; out of their, you know, their tuck shops and that. But generally that hasn't taken place.

But we can certainly do further research on that and get that information back to you.

Dr. Butler-Jones: — Just as a supplement to that. Ontario did discuss the option of sales only from licensed facilities in terms of, like liquor outlets, but chose not to at that time. This was when they were doing the legislation around restricting it in pharmacies and increasing their licensing issues around sale to minors, etc.

Mr. Addley: — Perhaps the pharmacists should dispense the tobacco. Then they can also dispense the information that goes

along with it, so maybe it's a different time.

Dr. Butler-Jones: — Certainly access is always an issue. I mean for example when Ontario went from the chit system where you had to sort of sign something for alcohol and then they go back behind the counter and bring it out to you, went to self-serve, they increased . . . each store that did that increased between 25 and 30 per cent their sales. So access . . . the easier it is to access it, the more likely you are to use it and purchase it.

Mr. Addley: — Is there other jurisdictions that limit tobacco sale within a certain distance between schools? I think there is. Is that presently . . .

Dr. Butler-Jones: — I'm sorry, I can't be definite about that but I think that is part . . . I know it was discussed as part of the legislation in Ontario as well as any sort of signs of promotion, there's also restrictions around that. But in terms of where it actually ended up, I'm not sure, but we can find that out.

Mr. Addley: — So it's probably actually not your area to checking that out. That's probably our thing to check out. It's not really . . . unless you have the information.

Ms. Smadu: — We'll send or will supply whatever we have in that area. It may not be sufficient but it will be what we have so that you can use that as a foundation. Another strategic direction is research, and you can see from the presentation that David made that there is a lot of work being done in this area.

We need to increase the knowledge regarding tobacco and tobacco use, about the industry, and about sort of the marketing and the other tools that are used by the industry, but what those that we need to use in terms of public education and working with people who want to stop smoking or who we don't want to start smoking. That also includes evaluation and monitoring and dissemination of findings, ensuring that it's in a language that people can understand so that it can be used.

And another strategic direction is building capacity, or building and supporting capacity for action, and that's aimed at increasing the ability of individuals and health intermediary committees at the national, provincial, territory, and local levels to take action. And it deals with everything from providing training and resources and technical expertise to ensuring that there is appropriate and complete access to information on tobacco, involving youth as advisers and activists and peer models. And of course the recently formed group in Saskatchewan, that youth addressing tobacco issues is an example of that.

Looking at curriculum in the K to 12 system and ensuring that it includes appropriate information about tobacco issues, and supporting coalition development so that our First Nations groups and Metis groups who perhaps can benefit from the kinds of activities and understanding that other groups have would be supported in their capacity building. And that would be just one example.

So just to sum up in terms of this document, it is a framework that supports a comprehensive, collaborative, and long-term approach to dealing with tobacco control. And it allows us to look at some goals that we know we can collectively aim for, as well as some strategic directions or priorities that we can take that collectively will have an impact on tobacco use in Canada.

It recognizes the intersectoral approach, and I would just emphasize again that while we're delighted to be here, as the Department of Health we know that this is a much broader issue and that it will take a concerted intersectoral and departmental effort to deal with tobacco issues, and that it's also multi-level in terms of government as well as the non-governmental organizations.

We've talked sometimes within the department about it being a menu approach. In each of the strategic directions, there are a number of things that can happen. Any or all of them could be useful, and that if there's a fair bit of choice that we have in terms of how we put together activities within the strategic directions to come up with a comprehensive plan for Saskatchewan.

That completes the overview as an example of a framework that can be used. And I do want to show you some overheads on prevalence and just talk briefly about legislation, but I'll stop now if you have any questions about what I've presented so far.

The Chair: — There being none at this time, I think just feel to proceed, Marlene.

Ms. Smadu: — Okay. I think the issue of prevalence is a very important one and I expect one of great interest. You do have a section in your binder that shows you these graphs, and so I'll just put them on in case you have any questions as we . . . as you look at them, it'll bring them to mind.

This graph shows the current smokers by province, age 15 and over in Canada in '96-97. And Saskatchewan sits at 30 per cent, just over 30 per cent, so just over the national average.

This one further breaks it down to males and females. And of interest, in all of the other provinces the rate for female smoking is lower than the rate for male. In Saskatchewan, they're identical at 30 percent. And when we get into some of the prevalence charts with young people, it's very worrisome to see the rates with our young women.

Then, just current Saskatchewan smokers by age and sex. And it just breaks it down into the men, women, and total by the various age groups, and you can see that the rate of smoking for women in the 15 to 24 is higher than for men. So we've got an issue with our young women who are starting to smoke at a young age.

Mr. Addley: — Is it not given by 15 to 24 and 45 to 64, women smoke more than men percentage wise?

Ms. Smadu: — Why that occurs? Why there's more women?

Mr. Addley: — Like I can understand the 15 to 24, given the advertising. But I don't understand the 45 to 64.

Ms. Smadu: — Well I'll defer to our chief medical health officer. I think one of the things we've talked about in our own, in our department is the fact that you do go through cycles and

that there was a concerted effort for smoking rates to decrease for that period of time. Now whether or not women continue to smoke and continue to survive, I'm not sure what the . . .

Dr. Butler-Jones: — Well there's a couple of factors. I mean the men do die younger faster, at least from heart disease. But also, it's an intriguing thing that for women it is actually more difficult to quit completely. We don't understand why that is but — this is on average, so I'm making a generalization here — but on average women can cut down to five or ten cigarettes a day, but to go from there to zero, it appears much more difficult. And men have an easier time of quitting cold turkey, relatively. So that accounts for part of it.

Part of it may be too, it's an age group when there was very concerted marketing to women in the '60s and '70s and those women are now in that age group. And whether that's a function of the marketing success of that time, it's hard to say. We don't have any clear answers, but those are a couple of the factors.

Ms. Smadu: — Thank you for that question. The prevalence of current smokers by province age 10 to 19 in Canada in 1994, and the breakdown for Saskatchewan, the dark bar is 10- to 14-year-olds at 5 per cent, and the lighter bar is 15- to 19-year-olds which is about 19 per cent. So our total comes in at 24 per cent and that . . . I'll refer to that in another graph a little bit later. And in this, as you can see in the bottom, the current smoker is defined as someone who has smoked at least 100 cigarettes in a lifetime, and has smoked during the past 30 days.

Compared to the other provinces you can see, I think . . . Newfoundland comes out fairly high and that has . . . I think that's been over a long period of time in terms of their high rates. But . . .

Dr. Butler-Jones: — In the East. Yes, generally the East is very much higher.

Ms. Smadu: — And actually Quebec is . . . There are some cultural issues in terms of francophones and rates of smoking.

Dr. Butler-Jones: — Just . . . if . . .

Ms. Smadu: — Do you want me to put that back on?

Dr. Butler-Jones: — No, no, no, don't. Do not change it, but there will be updated figures released on Thursday. Just so you know that and there'll be . . . Health Canada will be releasing them, we understand, on Thursday. We don't have a pre-copy or anything but certainly once they're released we'll make them available.

Ms. Smadu: — Yes, thank you for that.

Dr. Butler-Jones: — I'm sorry?

Mr. Addley: — I shouldn't look at these.

Dr. Butler-Jones: — Oh, you can but it'd be interesting to see because there's not even a hint of what the surprises will be and I'm expecting — expecting some surprises. Certainly the experience in Eastern Canada around when they reduced the taxation, the rates of smoking increased dramatically among young people, so . . .

Ms. Smadu: — In Saskatchewan in 1996 we did a survey of youth between the ages of 13 and 18 and it was actually the Saskatchewan Institute on Prevention of Handicaps who facilitated that survey. Almost 2,500 students were surveyed through the education system with about 18 school divisions and 35 schools participating. And the geographic distribution which you will see on the following graphs is outlined. So the northern region is considered to be north of P.A. The central region is between P.A. and Regina, and the southern region is the area south of the city of Regina.

So this gives us some Saskatchewan information obtained through a survey of youth and in your packages you have these graphs. I'll just point out a couple of the findings. The response to the question: have you smoked cigarettes or cigars? And so that's broken down by province area. We see totals for instance of 38 per cent, 36 per cent, and 30 per cent for males, and 51 per cent, 39.7, and 32 per cent for females. So this is a . . . this survey was done between 13 and 18 age, so we're hitting a pretty focused group in terms of our age distribution.

And you can see the rates for females — for the habitual smokers, who smoke every day. And I won't go through all of the other columns unless you have specific questions about them. And that's just broken down again as a bar graph so that you can see figuratively what this looks like. It's males and females and in the three districts. So females shooting up at the top in terms of the smoking every day.

And this is broken down a bit finer in terms of the age groups. And again looking at males and females with the same range — if you've never smoked, up to twice a month, a few, a week, or every day. And just going across for males, the 13-and-under was 14 per cent or almost 15 per cent every day; close to 30 per cent every day; and 35.4, every day for 16- and 17-year-olds; and up to 49.5 for over 17 years of age.

And then in the females again, except for this last age group, consistently higher rates of smoking every day in the different age groups than their male counterparts. And that is also shown here figuratively in terms of the breakdown of that 13-to-18 age group and there's a lot of food for thought as we look at this diagram.

We also pulled out from that youth survey, chewing tobacco, and we talked earlier in today's presentation that we don't have a lot of information about cigars and pipes but chewing tobacco is, while not the same level of prevalence, is also evident in the responses that the students provided in terms of having, you know, even every day use by young people, which surprised me a little bit when I saw these graphs. And again I won't go through the other charts, it breaks it down for the various areas of the province and takes the age groups into a finer breakdown.

Are there any questions on that in terms of prevalence? As David has said, they will have some new prevalence information as soon as Thursday.

Dr. Butler-Jones: — I guess I always find one of the things

that was striking about this is all of this is illegal behaviour — illegal behaviour. I mean you're not . . . I mean it's illegal to smoke under the age of . . . to have access to cigarettes. So it just . . . I mean that just makes it so much more striking, how effective it's been.

Ms. Smadu: — Yes. And the last piece that I just want to draw to your attention before we open it officially to questions and answers is, in your binder you have a section that talks about legislation and there's a chart that's relatively difficult to see — especially when the lights aren't on — that shows the comparison of legislation components across the jurisdictions, including federal legislation.

And there is just a bit of an explanation at the front. I mean in Saskatchewan, The Minors Tobacco Act, and I'll just clarify what it says when it . . . we have written there, was passed in 1896. Of course Saskatchewan wasn't a province then. It was actually a piece of legislation that applied to the Northwest Territories of which Saskatchewan was a part.

So we've had Minors Tobacco Act since 1896 and it was most recently revised in 1978. And then there's just a bit of an explanation about the federal tobacco Act and the fact that when the federal legislation is stronger than what's in-province, that the federal legislation is what is enacted and supersedes the provincial Act.

If you have specific questions about what's here — very, very superficial information — we will try to answer them; and then if there's other information that we can provide about legislation, we'd be happy to do that.

The Chair: — Do you have detailed information in here about taxation rates per package of cigarettes, per carton, per cigar?

Ms. Smadu: — Where is that, April? We haven't provided that, okay. We do have that information. It's not in your package at this point in time. So that's something that you would like or . . .

The Chair: — Yes, I'd like that, yes. I think that's something we're going to need to know.

Ms. Smadu: — Yes.

The Chair: — And does any committee member have any other comments or questions?

Ms. Yeates: — If I might maybe just before there are other questions. There's one more thing in your package which I should perhaps just bring your attention to.

There is some raw polling data that we have provided. In February of 1999, so nearly a year ago, as part of the omnibus polling, the Department of Health put on some questions related to public acceptance of various public opinion related to smoking restrictions. So in your package we've provided the responses that we had in February of last year to those questions; not wanting to presume that we understood what you might be looking at in terms of options, but we have some information there about public response to various options. So that's provided in your package as well.

Mr. Addley: — So only 6 per cent feel that smoking should be banned in schools and 28 per cent . . . It's page 11, I guess. I'm not sure I understand that. Sixty-two per cent say they are in favour of banning smoking in restaurants but only 28 per cent in day cares?

Dr. Butler-Jones: — It's the way the question is asked, because it's an open-ended question.

Mr. Addley: — Oh, okay.

Dr. Butler-Jones: — Where, you know, if they say we think that there should be limitations they ask, where do you think? So it's off the top.

Mr. Addley: — Okay. So it's not a list and then they make a decision.

Dr. Butler-Jones: — That's right. And what's striking is when you actually talk to people, many of them assume that daycare and schools, it's already banned. So they wouldn't say that in that context.

Mr. Addley: — Yes, okay. Glad I asked the question.

Dr. Butler-Jones: — Yes, it's very important.

The Chair: — Are there any other questions? Now are there any other comments or was there other parts that you wanted to cover?

Ms. Yeates: — No, that's it. Thank you.

The Chair: — For the purpose of the committee, the additional information that you have to provide, would it be possible if you brought us 15 copies of each? And it could be delivered to Greg Putz at the Clerk's office.

Well with that, I want to thank you very much Glenda and David, April and Marlene, for coming. And this has been very comprehensive. We went through a lot of stuff that we've seen before, but of course you never have it in your head when you need it. And some new material too, I think to some of us here. So that was appreciated and appreciate you being able to come with short notice and staying into your supper hour in particular. So I know you'll want to get home, so I extend that appreciation to your families.

Thank you very much and you'll probably be hearing more from us sometime within the next month or two.

Ms. Yeates: — Thank you.

The Chair: —If there aren't other items, I'll entertain a motion to adjourn.

Mr. Addley: — So moved.

The Chair: — All in favour? Sorry?

Mr. Wartman: — Where are we adjourning to?

The Chair: — We're adjourning.

A Member: — Where to?

The Chair: — Where to? Well we'll decide after we adjourn. Okay the meeting has been adjourned.

The committee adjourned at 6:10 p.m.