

Testimony of:

**Bill Jeffery, L.L.B.
National Coordinator of the
Centre for Science in the Public Interest**

**Before the
House of Commons Standing Committee on Finance**

Pre-Budget Hearings

**November 24, 2004
Ottawa**

**Centre for Science in the Public Interest
Suite 4550, CTTC Building,
1125 Colonel By Drive
Ottawa, Ontario
K1S 5R1
Tel. 613-244-7337
Fax: 613-244-1559
Email: jefferyb@istar.ca**

Thank-you for the invitation to appear before the Committee.

About the Centre for Science in the Public Interest

The Centre for Science in the Public Interest (CSPI) is a non-profit consumer health advocacy organization specializing in nutrition issues with offices in Ottawa and Washington, D.C. Our Ottawa health advocacy is funded by over 100,000 subscriptions to the Canadian edition of our monthly *Nutrition Action Healthletter* that are mailed to the homes of about 1,140 residents in each riding outside Québec. CSPI does not accept funding from industry or government and *Nutrition Action* does not carry advertisements.

Since 1997, CSPI urged Health Canada to mandate nutrition labelling for pre-packaged foods;¹ the final regulations were published in January 2003.² Since 2002, we have been advocating further reforms to help further reduce the enormous human and economic toll on Canadian society caused by diseases related to diet and physical inactivity.³

The need to better address preventable chronic non-communicable diseases (such as heart disease, diabetes, certain forms of cancer, osteoporosis, and obesity) has been acknowledged in three consecutive *Speeches from the Throne*,⁴ the communiqué of the September 2004 first ministers' conference on healthcare,⁵ and three recent communiqués of the federal/provincial/territorial ministers of health.⁶ Hopefully, the upcoming budget will give effect to these commitments. The bulk of our recommendations for policy reform and program initiatives find support in reports published recently by the World Health Organization⁷ and the Canadian Population Health Initiative,⁸ and are explicitly supported by two dozen health and citizens groups collectively representing two million Canadians.⁹ However, today I am only speaking on behalf of CSPI.

The Toll of Diet-Related Disease

The portion of chronic diseases related to diet- and physical inactivity causes, every year in Canada, 21,000 to 47,000 premature deaths, shortens the average Canadian's healthy life expectancy by about 5 years,¹⁰ and costs the national economy \$6 billion to \$10 billion¹¹ in terms of health care expenses and lost productivity.

If unchecked, rising obesity rates and ageing baby boomers are likely to further increase those avoidable costs to our healthcare system, gradually fetter access by seniors to diagnostic and treatment services, exacerbate waiting times for care, and strain our children's and grandchildren's capacity to finance public healthcare. The time to act is now; while many health benefits of improved nutrition and increased physical activity occur in the short term (such as decreasing blood pressure and improving serum cholesterol profiles by reducing saturated/trans fat and sodium consumption), others take longer (such as reducing cancer risk by increasing fruit and vegetable consumption)

Since 2000, tremendous interest in public health has focussed almost exclusively on fears about infectious diseases in animal and human populations caused by contaminated water, SARS, BSE, Avian Influenza, and West Nile Virus.¹² However, only a few dozen deaths have been attributed to these outbreaks, or about 1/10th of 1% of the deaths attributable to disease caused by poor diet and physical inactivity during the same period.¹³

While funding the pursuit of cures and the best treatments for diseases such as cancer, cardiovascular disease and diabetes is essential, dietary improvement and increased physical activity offer tremendous untapped potential to reduce the human and economic burden of preventable disease, and both diagnostic and treatment waiting times.

The Effectiveness of Upstream Prevention Measures

A recent report of the Auditor General of Canada noted that "preventative health activities are estimated to be 6 to 45 times more effective than dealing with health problems after the fact."¹⁴ In 2000, Agriculture and Agri-food Canada researchers predicted that the new *mandatory* nutrition labelling rules for pre-packaged foods will facilitate healthful improvements in dietary choices that would, in turn, produce economic savings of over \$5 billion during the next two decades, or an average of \$¼ billion per year in health care savings and productivity gains.¹⁵ That amounts to a 2,015% return on investment based on the costs of implementing the label changes.¹⁶ What policy-maker or legislator could resist accepting this kind of windfall for the private and public purse?

Though showing impressive potential – that, incidentally, is being emulated in many other countries¹⁷ -- food label reform is not a panacea for diet-related disease; it is estimated to reduce diet-related disease by approximately 4%,¹⁸ leaving much room for further improvement.

Health promoting policy reforms related to sales tax and advertising, and program initiatives to promote healthy eating (such as publicly funded mass media advertising and publicly-funded preventive health care services) would be extremely useful, but would not be panaceas either. As health policy analysts learned from their tremendously successful efforts to curtail smoking, integrated, multi-pronged approaches work best. So there is a critical role for the Minister of Finance to play in health promotion when he is crafting the next budget.¹⁹

Many of the measures we advocate do not involve the expenditure of public funds but, instead, employ regulatory tools to help internalize the costs of selling high-calorie, nutrient-poor foods, or products that promote sedentary living.²⁰ In that vein, we urge this committee to support and encourage efforts of the Minister of Finance and other Ministers of the Crown to advance legislative and regulatory reforms to, for instance:

- ban the use in food of trans-fat-laden partially hydrogenated vegetable oil;
- improve labelling of objective health-related information on food packages and restaurant menus;

- restrict advertising directed at children;
- control the mass-marketing of breast-milk substitutes;
- insist on truth-in-advertising regarding the long-term safety and effectiveness of weight-loss products and programs; and
- ensure that occupational health and safety protection also reflects health promotion imperatives (particularly in workplaces where most jobs involve sedentary work).

Indeed, all policy reforms and spending initiatives should be vetted to assess the implications they pose for health, including the effect on diet and physical activity.

Recommendations

I would like to highlight four specific recommendations that are directly relevant to the federal budget, namely: the taxation of food, the deductibility of corporate food advertising expenditures from taxable income, funding for preventative nutrition counselling and lactation consulting services under Medicare, and funding for mass media campaigns to promote healthy eating and physical fitness.

1. Shifting sales taxes from healthful to unhealthy foods: Currently, at least 33% of Canadian food sales are subject to GST, drawing at least \$1.5 billion in federal tax revenue.²¹ The federal *Excise Tax Act* appears to partly acknowledge the importance of nutrition by imposing taxes on candy, soft drinks, and snack food. However, federal sales tax law promotes unhealthy diets by imposing GST on healthful food choices such as low-fat milk, and vegetable dishes when sold in restaurants, as well as club soda, fruit trays, certain sizes of bottled water, etc. sold in retail stores. Meanwhile, many unhealthy foods are tax-free (i.e., zero-rated for GST), such as sugary breakfast cereal, trans-fat-laden shortening, high-fat cheese, coffee cream, and chicken wings, sold in retail stores.

At least two peer-reviewed studies advocate that sales tax laws in the United Kingdom and the United States be amended to better serve nutrition promotion goals.²²

- **Recommendation:** Amend the federal *Excise Tax Act* to remove financial incentives to consume unhealthy foods, and disincentives to consume healthful foods²³ to ensure that GST rules reflect and reinforce health promotion objectives of the Federal Government, not undermine them.²⁴ (If changes to the rules governing GST are predicted to have regressive effects, the Minister of Finance should modify the existing GST/HST Credit to offset adverse effects on low income Canadians.)

2. Reforming rules governing deductibility of advertising expenses from food company taxable income: According to ACNielsen, \$720 million was spent to advertise restaurants, food, and alcohol in 1998.²⁵ The vast majority of food advertisements are for nutrient-poor foods, like hamburgers, french fries, sugary soft drinks, and sugary cereals, while fruits and vegetables and whole-grain foods are scarcely advertised at all.²⁶

Recommendation: To help encourage a more nutrition-promoting blend of food advertisements, amend the *Income Tax Act*²⁷ to:

- permit companies to deduct from taxable income 300% of expenses incurred to advertise nutritious foods such as low-fat milk, fruits and vegetables, and whole grain cereals;
- limit to 50% of advertising expenses incurred the permissible deduction from taxable income for the promotion of nutrient-poor foods, such as alcoholic beverages, soda pop, french fries, doughnuts, candy, nutrient-poor snack food, and any product containing high amounts of saturated fat, *trans* fat, sodium, or added sugars; and
- retain the existing rules to govern advertisements of other foods;

3. Funding preventative health-care services under Medicare: Publicly-funded nutrition counselling services are typically only available to patients after they have been hospitalized for diet-related diseases (such as following a heart attack). Similarly, despite the evidence of the nutritional superiority of mother's breast-milk for infants, publicly-funded services of lactation consultants are typically available to new mothers only in hospitals immediately after birth, not after being discharged from the hospital when the most critical need for those services arises.

Recommendation: Conduct a feasibility study, jointly with the provinces and territories, of an initiative to publicly fund the services of:

- qualified dietitians for periodic preventative nutrition counselling services, especially for those at risk for chronic diet-related diseases; and
- qualified lactation consultants for mothers whenever necessary during the first six months of their infants' lives.

4. Public Education: The public resources devoted to supporting independent, objective health promotion (in schools, health care services, and the mass media) is puny in comparison to the private resources dedicated to mounting extensive, daily barrages of commercial advertising for nutrient-poor foods.

Recommendation: The federal government should (possibly in cooperation with the provincial and territorial governments) fund, at the level of \$100 million per year, an intensive, mass media health-promotion campaign (like the recently de-funded *ParticipAction* program) by:

- sponsoring advertising and public relations efforts to promote nutrition, and physical activity messages on nationally televised TV and radio programs; and
- designing model community-wide fitness and nutrition campaign for implementation by local non-profit health organizations, as well as federal, provincial and municipal governments.²⁸

Balancing Freedoms

The spared human suffering and the predicted economic pay-off of these tax reform and program initiatives should not be lightly ignored or dismissed on the basis of anecdotal evidence or ideological orientation. Whatever human “liberty” is disturbed by giving fruit and vegetable sellers preferential tax benefits, or requiring that consumers pay GST on Froot Loops and chicken wings (but not on fruit trays and bottled water) should be weighed against the grave loss in human liberty caused by chronic diseases that lead to death, disability, increased health care costs, and lost productivity. Federal government policies and programs should reinforce, not undermine, federal government advice to Canadians about diet and physical inactivity.

Conclusion

Preventative disease risk-reduction measures designed to improve nutrition and increase physical activity could also act as a bulwark against the rising health-care costs associated with the ageing baby boom population. As demographer David Foot noted,

*The Canadian health care system...has a bias toward acute care -- that is, the patient gets help when disease causes a serious episode of ill health. The system doesn't focus enough on preventative medicine to avoid such episodes.*²⁹

As such, policies aimed at preventing disease can improve both the health of Canadians and the health of public finances on both sides of the ledger by decreasing health-care costs and increasing productivity of Canadians. In short, health-promotion measures are both socially and fiscally prudent.

Thank-you.

ENDNOTES

¹ See: Key developments in CSPI's mandatory nutrition labelling campaign (updated January 2003) at <http://cspinet.org/canada/timeline.html> .

² See: "CSPI Applauds New Nutrition Label Rules" news release issued January 2, 2003 at: http://cspinet.org/canada/new_rules_01022003.html; and *Regulations Amending the Food and Drug Regulations (Nutrition Labelling, Nutrient Content Claims and Health Claims)*, S.O.R./2003-11, *The Canada Gazette, Part II*, Vol. 137, No. 1 (January 1, 2003) at 154-403 available at: <http://canadagazette.gc.ca/partII/2003/20030101/pdf/g2-13701.pdf>

³ See, for instance: CSPI's "Proposal for an Effective Integrated Pan-Canadian Healthy Living Strategy" available at http://cspinet.org/canada/pdf/PanCdn_EffectiveStrat.pdf

⁴ Speeches from the Throne to open the 1st Session of the 38th Parliament on October 5, 2004 at 8 (see: http://www.pm.gc.ca/grfx/docs/sft_e.pdf); to open the 3rd session of the 37th Parliament on February 2, 2004 at 7 (see: http://www.pm.gc.ca/grfx/docs/sft_fe2004_e.pdf); and to open the second session of the 37th Parliament on September 30, 2002 at 4 (see: <http://dsp-psd.pwgsc.gc.ca/Collection/SO1-1-2002E.pdf>).

⁵ "A 10-year plan to strengthen health care" news release issued by the first ministers on September 16, 2004 in Ottawa (see section on "Prevention, Promotion and Public Health"). The communiqué is available on the Prime Minister's web-site at: <http://www.pm.gc.ca/eng/news.asp?category=1&id=260>

⁶ The federal/provincial/territorial ministers of health first announced plans to develop an "Integrated Pan-Canadian Health Living Strategy in Banff on September 15, 2002 (see their news release: http://www.hc-sc.gc.ca/english/media/releases/2002/2002_58.htm). That commitment was reaffirmed by the ministers in Halifax on September 3, 2003 (see their news release: http://www.hc-sc.gc.ca/english/media/releases/2003/2003_67.htm), and again in Vancouver on October 17, 2004 (see: http://www.hc-sc.gc.ca/english/media/releases/2004/2004_52.htm).

⁷ Including: *The Report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases: Technical Report 916*, (Geneva: World Health Organization, 2003) (available on the Internet at: http://www.who.int/nut/documents/trs_916.pdf); and Resolution 57.17 of the 57th session of the World Health Assembly passed on May 22, 2004 adopting the "Global Strategy on Diet, Physical Activity and Health" (available on the Internet at: http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf).

⁸ Raine, K, *Overweight and Obesity in Canada: A Population Health Perspective*, (Ottawa: Canadian Population Health Initiative of the Canadian Institute for Health Information, 2004) esp. note the conclusions at pp. 57-61. The Canadian Institute for Health Information is an independent, pan-Canadian, not-for-profit organization working to improve the health of Canadians and the health care system by providing quality, reliable and timely health information. It is funded by federal and provincial ministries of health and some health care institutions.

⁹ See CSPI's proposals and list of supporting organizations, *supra* note 3.

¹⁰ In its October 2002 *World Health Report*, the World Health Organization estimated that average healthy life expectancy can be increased by approximately 5 years in countries like Canada by adequately addressing diet and physical activity-related factors: blood cholesterol, blood pressure, overweight, low fruit and vegetable intake, childhood and maternal malnutrition, and physical inactivity. Table 4 in the annex of the *2002 World Health Report* shows that, in Canada, the loss in *healthy* life expectancy (due to all risk factors) at birth is approximately 9.4 years (averaged for men and women). See: http://www.who.int/whr/2002/en/whr2002_annex4.pdf And Table 10 shows that, in developed countries, 55% of all-risk-attributable Disability-Adjusted Life Years (DALYs) were lost due to "childhood and maternal undernutrition" plus "other diet-related risks and physical inactivity". See: http://www.who.int/whr/2002/en/whr2002_annex9_10.pdf So, 55% of 9.4 years is 5.17 years.

¹¹ See: "Health Canada announces new mandatory nutrition labelling," news release issued by Health Canada on January 2, 2003 in Ottawa (see: http://www.hc-sc.gc.ca/english/media/releases/2003/2003_01.htm) which estimated

the annual cost of diet-related disease to be approximately \$6.3 billion. CSPI estimated the death toll for diet-related disease by extrapolating from estimates for annual deaths due to inactivity-related disease and the costs for diet-related disease. Katzmarzyk, et al. “conservatively” estimated both the number of annual and the health care costs attributable to physical inactivity to be 21,340 deaths and \$2.1 billion annually. See: Katzmarzyk PT, et al. The Economic Burden of Physical Inactivity in Canada. *Canadian Medical Association Journal* 2000;163(11): 1435-40 at 1438. We are not aware of any published estimates of the annual number of deaths attributable to diet-related disease in Canada, however, based on Health Canada estimates of the economic burden of diet-related disease, we estimated it to be roughly 25,400 deaths per year. It is unlikely that the number of deaths and costs associated with inactivity and poor diet are completely additive. Accordingly, we report the combined burden of these preventable causes of chronic disease as a range.

¹² According to Health Canada’s West Nile Virus Surveillance database for the years 2002-2004, 34 human deaths were attributed to the disease in 2002 and 2003 and none in 2004. (See: <http://www.phac-aspc.gc.ca/wnv-vwn/>). According to the Naylor Report, SARS caused 44 Canadian deaths in 2003 (See: National Advisory Committee on SARS and Public Health, (David Naylor, Chair), *Learning from SARS: Renewal of Public Health in Canada*, (Toronto: Health Canada, October 2003) at 20 (see: <http://www.hc-sc.gc.ca/english/protection/warnings/sars/learning.html>). And the contaminated water supply in Walkerton, Ontario caused or contributed to the deaths of seven Canadians in 2000 (see: Hon. Justice Dennis R. O’Connor, *Report of the Walkerton Inquiry*, (Toronto: Queen’s Printer for Ontario, 2002) at 51 (at: <http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/walkerton/part1/>)). Avian Influenza, Mad Cow Disease (BSE) have not caused any human deaths in Canada

¹³ 85 deaths due to three infectious disease outbreaks in the period 2000-2004 divided by even the minimum number of deaths attributed to poor diet and physical inactivity during the period, (85,360; *supra* note 11), is equivalent to 1/10th of 1%.

¹⁴ Auditor General of Canada, "Health Canada: A Proactive Approach to Health," chapter 9 in *Report of the Auditor General of Canada -- 2001*, (Ottawa: Auditor General, 2001) at 3.

¹⁵ Agriculture and Agri-food Canada, *Costs and Benefits of Nutrition Information* (2000) at 4. See also the summary of these conclusions in the *Canada Gazette*, *supra* note 2.

¹⁶ The prevention dividend = \$5.3 billion benefit from label changes / \$263 million costs of modifying labels, or 2,015%. See: *Canada Gazette*, *supra* note 2 at 386.

¹⁷ For instance: Argentina, Australia, Brazil, Canada, Israel, Malaysia, New Zealand, Paraguay, United States, and Uruguay cited in Hawkes, C, *Nutrition Labels and Health Claims: The Global Regulatory Environment*, (Geneva: World Health Organization, 2004) at 12. The European Union is also considering a mandatory nutrition labelling regime for implementation by member countries.

¹⁸ According to Health Canada (*supra* note 2 at 386), mandatory nutrition labelling for prepackaged foods is estimated to save the economy \$5 billion over twenty years, and the total economic burden of diet-related disease is approximately \$6.3 billion per year. Therefore, the reduction in costs associated of diet-related disease achieved by instituting mandatory nutrition labelling is predicted to be: \$5 billion / (20 years * \$6.3 billion/year), or 4.0%.

¹⁹ Two years ago, the federal-provincial-territorial ministers of health made a commitment to develop an “Integrated Pan-Canadian Healthy Living Strategy” to tackle diet- and inactivity-related disease. *Supra*, note 6. To date, no policy recommendations have been released.

²⁰ See, for instance: CSPI’s “Open Letter” to Prime Minister Paul Maritn and the provincial premiers regarding the first ministers conference on health, dated November 5, 2004; and CSPI’s “Proposal for an Effective Integrated Pan-Canadian Healthy Living Strategy” available at http://cspinet.org/canada/pdf/PanCdn_EffectiveStrat.pdf

²¹ See the definition of “basic groceries” in Part III, Schedule VI of the *Excise Tax Act*, R.S.C. 1985 c. E-15. (see: <http://laws.justice.gc.ca/en/e-15/text.html>). Statistics Canada estimates that, in 1996, approximately 28% of the average Canadian’s food budget was spent on food services, and approximately 5%-10% is spent on retail foods subject to GST (chiefly, sugar preparations, carbonated beverages, and potato chips and similar products. See: Statistics Canada, *Food Consumption in Canada - Part II, 2000* (Catalogue No. 32-230) at C-6 and C-7. So, an average of at least \$730 per person was spent on foods subject to GST in 1996. Taxed at a rate of 7% for 30 million Canadians, these foods produce GST revenue of at least \$1.5 billion annually. However, according to the Canadian Restaurant and Foodservice Association, \$41.2 billion was spent on foodservice sales in 2001 (See: CRFA, *Foodservice Facts 2002*, (Toronto: CRFA, 2002). Considering most of this food is subject to GST, and the per capita expenditure level is nearly double the Statistics Canada estimate, the actual amount of GST generated by food and restaurant sales may actually be closer to \$3 billion annually.

²² A. Leicester, F. Windmeijer, *Briefing Note No. 49: The 'Fat Tax': Economic Incentives to Reduce Obesity*, (London: The Institute for Fiscal Studies, 2004) (see: <http://www.ifs.org.uk/consume/bn49.pdf>); and M. F. Jacobson, K. D. Brownell, "Small Taxes on Soft Drinks and Snack Foods to Promote Health," *American Journal of Public Health* 90, 6 (2000): pp. 854-857.

²³ Our proposal for revising the current *Excise Tax Act* definition of "Basic Groceries" to bring the principles underlying the decade-old GST rules into accord with modern understanding of the relationship between diet and disease can be found in our recommendations to the Romanow Commission (at http://cspinet.org/canada/pdf/romanow_submission.pdf at PDF pages 15-23).

²⁴ We are not advocating, as some might, that the GST should be replaced with the old federal Manufacturers’ Sales Tax, or simply abolish the GST and make up the shortfall in revenue with progressive reforms to income taxes. What we are proposing is that, as a consumption tax, the GST be used to advance government health promotion objectives rather than hamper them. The reforms we advocate could be very nearly revenue neutral depending on precisely what nutritional standard is set for acquiring exempt status (i.e., GST zero-rated) under the *Excise Tax Act*. That is, a strict standard would lead to increases in GST revenue, and a very loose standard would lead to decreases in revenues.

²⁵ McElgunn J. Canada's top 25 advertising categories. *Marketing Magazine* September 27, 1999:44. Also, a 1991 survey of programming, less than 9% of food ads were for dairy, fruits and vegetables (excluding french fries) See: Østbye T, Pomerleau J, et al. Food and Nutrition in Canadian ‘Prime Time’ Television Commercials. *Canadian Journal of Public Health* (1992) 84(6) 370-74.

²⁶ See, for instance, : Østbye T, *supra* note 25.

²⁷ *Income Tax Act*, R.S.C. 1985, c. 1 (5th supp.)

²⁸ Such kits might include: model advertisements for print, TV, and radio; contacts for local self-help groups, support and counselling; information about risk factor screening and education; ideas for designing and promoting community events and creating walking trails, and cycling paths, etc.

²⁹ David K. Foot, *Boom, Bust & Echo 2000*, (Toronto: Stoddart Publishing, 1999) at 232.