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Chair

Mr. Anthony Rota

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● (1105)

[*English*]

The Chair (Mr. Anthony Rota (Nipissing—Timiskaming, Lib.)): Good morning.

I think we'll get started. We're allowing a little time for the bad weather out there. I'm sure some people will trickle in as we get started.

This morning we have a couple of people from the Department of Veterans Affairs. We have Verna Bruce, who is the associate deputy minister—thank you for coming—and John Walker, regional director general for theAtlantic region. I thank both of you for coming in this morning.

Rather than me going on, I'll let you start. I know you have a presentation here; you can tell us about “Honouring the Pledge”.

Ms. Verna Bruce (Associate Deputy Minister, Department of Veterans Affairs): Thank you very much. I must say, it's a real honour and a pleasure for us to be here.

John Walker, who is currently the regional director for the Atlantic region, spent quite a few years as our director of long-term care. He was the person who travelled with the Senate subcommittee across the country when it did its report on raising the bar. John is with us as our expert on long-term care. I'm sure he'll be able to answer any questions you have.

In terms of your report, “Honouring the Pledge”, we did take it very seriously, and at the end of this session we have a document we would like to leave with you. It's called “Honouring the Pledge - Action Plan”, and it outlines your 25 recommendations and what we have done in terms of implementing them. We believe we've completely implemented sixteen of them, another six are in progress, and five of them are recommendations that really fall within provincial jurisdiction; while we've been doing some work on them, they fall outside of our purview.

Long-term care is a very complicated area because we do provide a series of programs ourselves, plus we top up programs that are available through the provinces. As we have new ministers coming into the department, we do a briefing with them in terms of how the whole system of long-term care works, and that forms part of the basis of what we wanted to do this morning, to walk you through the system.

I'm going to turn this over to John. Again, I encourage you to ask questions.

I understand that we'll try to be out of your hair by about 12:30.

Mr. John Walker (Regional Director General, Altantic Region, Department of Veterans Affairs): First of all, thanks for having me. I look forward to giving a brief presentation, probably 20 or 25 minutes. If at any point in time you would like to stop me so you can ask a question, please feel free to do so. I don't know that it's a complicated field, but it's kind of an intricate field in that a lot of the aspects build one upon the other. What I'm going to do is just take you through an historical overview, then bring you up to the current day.

The history of the Department of Veterans Affairs in long-term care, or institutional care, as it was referred to then, dates back to 1919. At that time, the primary focus wasn't long-term care; it was acute care for the treatment of war injuries when the forces came back from overseas. Just to show the magnitude of it, in 1946 Veterans Affairs had 36 hospitals, referred to as treatment institutions, and at the peak there were 17,000 patients in those facilities. So that's a fairly significant infrastructure we had at that time.

We'll jump quickly from 1919 up to 1963. We did have 18 facilities in 1963, but what we found was that the war injuries were not of an acute nature at that time. The ones we saw were of a more long-term nature, and in the facilities we did have we were finding it difficult to attract and retain qualified health professionals. Despite that significant infrastructure out there, it was aging, and the need for it in an “acute” setting had clearly diminished to the point where it really wasn't sustainable.

At that time, 1963, the Glassco commission directed that the Department of Veterans Affairs transfer its facilities to the community jurisdiction with two guarantees. One was priority access for veterans, and the term “priority access bed” will be throughout my presentation. When you hear priority access bed, essentially you can think of a bed that is reserved for veterans across the country. Nobody other than a veteran is entitled to a priority access bed.

The other guarantee was assurance of adequate community facilities. That meant making sure there was enough community bed stock out there to ensure that the needs of veterans could be addressed through a different mechanism.

We did the most recent statistics on the transfer of the 18 facilities. We have transferred 17 of the 18. The remaining facility is Ste. Anne's Hospital, outside of Montreal, Sainte-Anne-de-Bellevue. It's the sole remaining hospital. We did undertake to transfer it to the Province of Quebec. Those negotiations became protracted, and it was decided that we would retain the facility.

Indeed, there's a significant update and renovation going on right now at Ste. Anne's Hospital. It's a $67 million renovation at that site. So that will see updated rooms, and indeed a new, one-level facility with I believe it's in the vicinity of about 130 beds, which we'll have especially for dementia care. What we're finding now is that a lot of the veterans who are in our facilities are presenting with dementia issues, Alzheimer's, etc. It's upwards of 70% of the people in the beds we have who have some form of dementia.

Now we come to long-term-care beds. Again, these are priority access beds, and where it says “contract/departmental”, the departmental beds, as I've mentioned, are the beds at Ste. Anne's Hospital. We have 4,310 priority access beds in 171 sites across the country.

To augment those beds we have what we call “VIP”, which stands for the Veterans Independence Program. We have approximately 4,000 beds in over 1,500 sites. What we do there is use nursing home beds that are available across the country. What we've found is that the veterans prefer to remain in their own communities, near to their friends and loved ones.

In Canada, there are approximately 220,000 nursing home beds across the country in 1,700 facilities—although if you asked me to go out and count them, I couldn't do it, because by the time I was finished the number would have changed.

● (1110)

We use that bed stock for veterans and pay for the care, minus the veteran's portion. Those are what we call the VIP community beds. In June of 2000, we announced an additional 2,600 beds, using the community beds, which I'll come back to. That is what we refer to as our bed stock or the supply of beds that are available to provide services to veterans across the country.

I think it bears noting again that the community beds are less expensive and the level of satisfaction appears to be as high as it is for the priority access beds, according to client satisfaction interviews or surveys, but the great thing is that they have 1,700 choices, as opposed to 171. The trade-off is that they don't have the veteran status that is associated with the other 171 sites. The level of what we refer to as enhanced programming is not the same in the community beds as it is in the veteran priority access beds. We leave the choice to the veterans. He or she can decide which bed he or she would utilize.

The costs for our program vary significantly from province to province. You'll see there that in Atlantic Canada the figure is $4,000, but I suspect that figure is even higher now. It's less than $1,000 a month in the western provinces. What the veteran pays for what we refer to as accommodation—

● (1115)

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): I'm sorry to interrupt you, but that figure boggles my mind. Why is it $4,000 a month in Atlantic Canada and $1,000 in western Canada?

Mr. John Walker: That's a very perceptive question. It's directly related to the amount of provincial insurance. The cost in Atlantic Canada versus the cost in western Canada would be more or less the same. It's the cost to the Department of Veterans Affairs. It shows you the divergence of provincial support that's available in the west, as opposed to the lack of availability in the Atlantic provinces.

Mrs. Betty Hinton: Thank you.

The Chair: That's a great question.

If you don't mind, we should write down our questions and then ask them all at once, but that was an excellent question.

We'll follow protocol, if that's all right, because I know that your presentation is quite lengthy.

Mr. John Walker: Yes. Okay.

The Chair: Thank you.

Mr. John Walker: It is lengthier than I'd like it to be, but there's a lot to go over.

With respect to what we refer to as our accommodations and meals rate, that is the rate the veteran pays per month, in essence to offset the cost of their meals and accommodations. It's essentially rental charges; that's what we refer to them as. That rate of $786.56 is the lowest rate; it's based on the lowest provincial rate across the country. We want to make sure veterans across the country pay the same rate and pay the lowest rate.

We used to have it geared directly to the lowest provincial rate. If the lowest provincial rate was $700, our rate would be $700, but back about four or five years ago the provincial rates took a significant jump, to the point where they got up to $1,000 at the lowest, so we opted to index our then rate to the CPI. The $786.56 is by far the lowest rate anybody in long-term care in the country would be paying.

If a veteran who is eligible is admitted to long-term care for what we call their pension condition, then they do not pay the $786.56. Their stay is looked after entirely by the Department of Veterans Affairs.

There you'll see the total programming costs are in the neighbourhood of $220 million per year. With increased demand for beds plus the increased costs for each one, we see our costs going up in the range of 8% to 10% per year. It's still a significant file; $220 million is still considerable funding, and it does go up fairly significantly every year.

It is fair to say that back in 1998-99 long-term care was the major preoccupation of our major veterans organizations and committees of this nature. The Senate subcommittee particularly wanted to make sure we found ways to address this. The major issues were an insufficient number of beds—i.e., to make sure there was an adequate supply—and national standards in quality of care. Really, in long-term care there are two issues: making sure you have enough beds available, and making sure the quality of the care that is provided in those beds is at an appropriate level to ensure a good quality of life for the residents.

The development of a national network of priority access facilities: we do have about twenty large facilities across the country, which constitute about 85% of the 4,310 beds. There was a recommendation from the Senate subcommittee on raising the bar, that we utilize those facilities as a network to share information with other long-term-care facilities across the country—this is something we have endeavoured to do, and I'll get to it later—and favour the evolution of our larger priority access sites, which would be the four or five large sites we have across the country, to make the expertise that is available in those sites available to the smaller community facilities across the country.

We developed a residential care strategy. The essence of the residential care strategy was to bring a focus to the long-term-care area instead of our being in a reaction mode, reacting to whatever the crisis of the day was. We did a review of veterans' care needs, which was a significant endeavour undertaken by the department, and the residential care strategy was developed from that to address the needs we identified. The strategy identifies the Department of Veterans Affairs' commitment to quality long-term care for veterans without duplicating the existing quality assurance processes that are available throughout the provincial jurisdictions.

That's a bit of the slippery slope we get there, because with the community beds we are using a provincial resource although we are paying for it. We do have to be cognizant of that element throughout our deliberations.

Just briefly, I can say the residential care strategy guiding principles are to ensure that predominant needs are being addressed, to respect the provincial system jurisdiction, to be able to respond more quickly than we had responded to changing needs of veterans, to focus on quality of care and on monitoring activities, to maximize the expertise in the larger sites, and to encourage veteran involvement in the government structure of some of the PAB sites, the priority access beds. That has to do with veterans facilities in the larger ones where they share a facility with a community nursing home. They wanted to make sure the veterans beds were well represented in the governance structures in each of those facilities.

● (1120)

Really, the first issue we had to deal with was an insufficient number of beds. I've already talked about the priority access beds and the community bed supply that's available out there. Where that becomes important is in our categorization of service for veterans. We have three gateways for veterans to access our Veterans Affairs programs. The first group is pensioners; they get a disability pension. The income-qualified veteran is a veteran of low income—they are also eligible for health care benefits—and there is the overseas service veteran. The overseas service veteran is only eligible for one benefit from Veterans Affairs Canada. It just so happens it's our single most important benefit, and that is the long-term-care bed.

We have about 63,000 pensioners, we have about 43,000 income-qualified veterans, and we have about 100,000 overseas service veterans. Where this becomes intricate is that the pensioners and the income-qualified veterans are eligible for both the community care beds and the 4,310 priority access beds, but the 100,000....

That's a round number because we quite honestly don't have really good statistics. These people have not gotten any benefits from us until they come to us for a bed. These were the people who went overseas and fought, didn't get killed, didn't get hurt, and don't have low income. What was promised to them in 1946 was that when they needed it, they would get a long-term-care bed. But in 1999 all they had access to were the 4,310 beds at 171 sites across the country, which the other 100,000 who had access to the community care beds also had access to.

We made an assumption that the pensioners and the income-qualified veterans had enough supply because of their ability to access the community care beds. However, the overseas service veteran did not. So what we did was, we came up with an allotment of community care beds the overseas service veterans could use, and that number was 2,600. Today approximately 1,600 of those beds are being utilized by overseas service veterans.

I feel that initiative did address the supply issue, and I will quote from the September-October 2000 *Legion Magazine*: “The addition of 2,600 beds solves the problem with the quantity of veterans beds. It is now time...to turn...to the quality of care given” in those beds.

We did one more thing for the overseas service veteran because we did have areas, three in particular—which happened to be Ottawa, Halifax, and Victoria—where there were long waiting lists at our veterans facilities. What we did was to make our veterans independence program and our treatment program available to the overseas service veterans where they could not get an institutional care bed. So they could get the whole VIP program and their treatment card while they waited to get a bed.

● (1125)

What we found was, through not fault of their own the overseas service veteran was not able to access programs to address their health care needs. At this point in time, where we had those three long waiting lists, there would be no veteran with “unmet health care needs”. We were able to do this.

An interesting offshoot happened. We would phone these people who were on this waiting list and say, “A bed is now available for you”. They would say, “I think I'd like to stay in my own home a little longer”, because with the veterans independence program benefits and the treatment benefits they were able to stay in their own home longer than they previously felt they could.

When we phoned those people, the statistics we came up with was 90% of people would rather stay home than go into an institution with these benefits. To put a bit of a cost benefit into it, the benefits that we were providing under the veterans independence program and the treatment program were in the vicinity of $5,000, $6,000, to $7,000 a year, but a long-term-care bed would have cost the government between $45,000 and $60,000 a year. It's very cost beneficial, and the client satisfaction was better with the less expensive option. Based on the results from that pilot project, we made that available all across the country to any facility that did have a waiting list. Today we have approximately 600 people who are utilizing that program.

Our director of research, Dr. David Pedlar, and myself have written a paper on this process and we've submitted it to the *Canadian Journal on Aging*. It's our opinion that this study does have fairly significant implications for long-term care across the country. If we could make available nationally a good home care program, I think we could see results—perhaps not this dramatic, but we could see similar results to this. People, in my opinion, do not wish to go into a long-term-care institution until they have to. Making these benefits available through our programs clearly demonstrated they would much rather stay at home in their own surroundings, with their own family network, than go into an institution where it may be farther away from their home than they like, and they may have to share a room with someone they don't know. We will make a copy of that document available to the committee.

We turned our focus, having what we felt addressed the supply issue, to the quality issue. The things we wanted to look at were things such as safety and security, food quality, access to clinical service, medication regimes, spiritual guidance, socialization, activation, emulation, personal care, sanitation, and access to specialized services. Those are the areas we were interested in and where we felt we needed to make sure that our degree of client satisfaction was as high as we could get it.

We developed those ten outcome standards, and we now ensure that we go into each facility where there are veterans and we do a client satisfaction survey. Last year, 2003-04, in response to the question, are you satisfied with your current situation, 94% indicated in the affirmative. We found that with some 1,700 facilities out there in the community, of which there are veterans in 1,500 at any one point in time, we did not have the staff or resources to go out and visit these people as often as we would have liked to fill out these questionnaires. So we've engaged the services of the Royal Canadian Legion to have their members go out and fill out these questionnaires for us on a contractual basis. As of today, according to the most recent number I have, we have 136 surveyors who go out and visit the veterans in the facilities on our behalf. We do a significant facility review carried out by health professionals in our 21 large facilities.

● (1130)

We do encourage that our priority access beds are accredited by the Canadian Council on Health Services Accreditation. Currently, 93% of the beds in those facilities are accredited. What we're done with the Canadian council is we have incorporated our ten outcome areas into their new AIMS standard. AIMS is an acronym for Achieving Improved Measurement System. It's what they call their AIMS standard. They have a section in there that is dedicated now to veterans, and any facility that has a veteran bed in their facility undergoes a special evaluation based on the veteran's outcome areas.

In addition, I spent three and a half years in our regional office in Kirkland Lake, and we did have fairly significant issues at the three large facilities in Ontario—Sunnybrook, Parkwood, and Perley-Rideau here in Ottawa. We've instituted on a pilot project basis a director of quality care, and that individual is responsible for addressing issues at the local site as soon as they arrive, rather than waiting for them to fester. It has worked very well, in my mind. I won't be naive enough to sit here and say that each and every issue has been addressed, because there will continually be issues. But when we look at how we've evolved from 1998 up until the current day, there has been significant progress, and this director of quality care has proven to be very beneficial. So we are looking at having one in Atlantic Canada and one in western Canada as well for those facilities.

Veterans Affairs Canada supports the various committees in the facilities, and attends meetings with veterans and their families, and there are regular visits by VAC staff.

Earlier I had mentioned the priority access bed network. We've had four meetings where we bring staff from the long-term-care facilities in from across the country, and we have usually a two-day to two-and-a-half-day meeting with them to share best practices and to form a network within the participants. That has proven to be very useful. They feel much more comfortable phoning one another and corresponding via the Internet. So that has worked well. It's the sharing of best practices.

Ste. Anne's Hospital has shared its expertise on dementia care, dysphasia, palliative care, and restraint reductions with several of the other priority access bed facilities. We have established online what we call a community of care where they can go online and share questions and answers and best practices.

In terms of the evolution of the larger priority access bed sites, we have developed a dementia care initiative that assists the other facilities to undergo organizational reviews and staff training with regard to veterans suffering with dementia, because we found that was a very predominant issue throughout our priority access bed facilities. It is an important factor to have an appropriate structure for dementia care, and we have improved several of our facilities in that area. The training we've made available, in 12 sites that have asked for it and we have provided it, they have found to be very useful. So that's one of the things we've done.

To shift to the current day, our primary focus now is to continue with the quality of care issues and to make sure we can do as much as we can in that area. Best practices goes back to our network, and the third one, “one payment, one program”, is an administrative issue. Now with our myriad of program eligibility and payment processes it is reasonably difficult for our staff to figure out which is the most advantageous to use, so we're going to try to streamline that.

● (1135)

In terms of the interim report on the west coast crisis, there were three recommendations for facilities in British Columbia. Those, to the best of my knowledge, were addressed and the recommendations have been implemented. But we continue to work with the facilities that were involved in the west coast crisis, and I believe we've made significant progress there.

The report from this standing committee, “Honouring the Pledge: Ensuring Quality Long-Term Care for Veterans”, essentially has three themes. One theme is improving food service. And I suppose I should just spend a second or two on that one, because it is very difficult. It's very hard to please fifty different people with two meals of choice per day. So those food issues will dog us for quite some time, in my opinion. That's a hard one to crack, because I know even at my family dinner table, with five of us, quite often there are at least two or three of us who don't like what's on our plates. But we will continue to work there. One of the issues that certainly piqued people's interest was the utilization of re-thermalized food. And we have tried, wherever possible, to stay away from that.

Reducing the number of beds per room—we've made significant progress there.

Reducing waiting lists.... In my mind, we've made significant progress in the waiting lists, but there will always be, at one point in time, somebody who cannot get into the facility they want, when they want. That will be ongoing.

We've made those 2,600 beds available. There are still 1,000 that we haven't had to use. When I looked on the weekend, of the 4,310 beds, I believe across the country there are approximately 200 that are empty.

Of the 25 recommendations, 14 are complete, six in progress, and five are partially completed because they fall within provincial jurisdictions and I don't know that we'd ever be able to satisfy them 100%.

If current issues continue, quality of care, standards of care, what we've said is with our chapter in the AIMS standards, and our visits, and our outcome areas, that is what we're going to try to have as our standard of care. Some of the veterans organizations would like to see us have an ombudsman. And then reuniting spouses, that's an emotional issue when it does happen. And indeed, of course with me coming here, it was on the front page of the *Chronicle Herald* on the weekend where a couple was.... But we are doing our best to resolve that situation.

With that, I believe my presentation is done. It wasn't too bad, but longer than I would have liked. I apologize for that, but that is the formal presentation. I'll take questions or comments or whatever.

● (1140)

The Chair: Thank you, Mr. Walker. That was very complete, very well done.

We'll start off with Mrs. Hinton. You have some questions?

Mrs. Betty Hinton: I do, and the unfortunate part is I have them all along and then I sometimes forget what I want to ask, so I've been writing like mad here.

What qualifies a veteran to not have to pay the monthly user charge? That's the first question.

Secondly, I did not read the paper this weekend, but it has been a huge concern of mine. And recommendation 9 of the report dealt with, among other things, efforts to limit the separation of couples, an issue that received considerable attention earlier this year and apparently again this weekend. What measures have been taken by the Department of Veterans Affairs to limit, as much as possible, the separation of elderly couples in veterans care facilities?

So those would be the two main ones, and I know I have others.

Mr. John Walker: I believe your first question is how does a veteran not have to pay the $786.52 or whatever it is. Their pension condition is well documented in their record. If their doctor or the Veterans Affairs doctor can link their need for admission into long-term-care facilities to that pension condition.... For example, if a person was pensioned for heart condition and their need for long-term care was linked to their heart condition, they do not have to pay. We call that being admitted for their pension condition.

Is that all right for the first one?

Mrs. Betty Hinton: That's fine. Are there any other examples?

Mr. John Walker: Every case would be individual, but if a person is an amputee, a double amputee, would they qualify? In many cases they would. But there's an infinite number of possibilities.

Mrs. Betty Hinton: Basically, you're telling me that it is not impossible or even extremely difficult for a veteran to qualify to not have to pay the costs.

Mr. John Walker: It's—

Ms. Verna Bruce: It does have to be linked to the pension condition. That's one requirement. As John says, there are lots of examples, but the reason for being in the nursing home would have to be tracked back to the person's pension condition.

Mrs. Betty Hinton: Thank you.

The second one?

Mr. John Walker: With regard to couples, as I said, we have veterans in 1,500 facilities who can be accommodated with no problem at all. It's the 171 facilities where we have veteran beds reserved that it becomes more of an issue. Approximately 150 of them are what I would call shared facilities with the community, where, to pick a number, there would be 100 beds in the facility and Veterans Affairs would have 15 reserved for veterans.

For example, at the Perley, we did have a case that we were able to resolve last year. Let's say that the veteran was the husband and the spouse was not a veteran. At the Perley, the spouse went into the community side and the veteran went into the veteran side. In the vast majority of cases, we're able to work it out.

Where we have more difficulty is in some of our larger facilities that are uniquely for veterans. There's still a demand for those beds. We're somewhat between a rock and a hard place, because we're not going to separate the couple. Our first preference would be to put them in veteran beds, but in most cases we find community beds through the veterans independence program that can accommodate both.

Mrs. Betty Hinton: Okay. If I'm listening correctly, the problem is when you have a veteran on the veteran side of the hospital, the spouse isn't necessarily a veteran, and the beds are all needed for veterans. Is that when you run into a problem?

Mr. John Walker: That's when we run into trouble.

● (1145)

Mrs. Betty Hinton: Is it possible to put two beds in one room?

Mr. John Walker: We haven't done it. We've generally resisted it in the past, because of the size of the rooms and because the staff and resources are for veterans. To put it into perspective, we have roughly 10,000 veterans in beds across the country. When this issue arises, it's very sensitive and heart-rending, etc., but it does not happen often. In the vast majority of cases, we are able to resolve it. We will resolve the one in Halifax as well; it's only a question of how long it will take.

Mrs. Betty Hinton: It's very easy to play Monday morning quarterback, and that's actually the position I find myself in. To me, the simple solution is to put two beds in one veteran's hospital room and avoid the trauma of separating the couple. They might be a little squished, but I'm sure they could handle the close proximity far better than they could handle the separation.

Mr. John Walker: To date, I am not aware of a couple we've had to separate. Did they get into veteran facilities? I'm not sure. In the vast majority of cases, we're able to deal with it using a remedy that's suitable for all involved. I'm not going to sit here before you and downplay it, because it's something we take very seriously when it comes up.

In working with the provinces, and I've worked with all of them, we have found that they do realize there are compassionate grounds. British Columbia decided in the spring that they were going to separate a couple who were veterans. They tried, and it was in the papers. It wasn't a Monday morning quarterback, but a Wednesday morning linebacker who got to them. They came to their senses and found a way to reunite them.

Mrs. Betty Hinton: I live in British Columbia, Mr. Walker. I remember it.

Do I have time for one more quick question?

The Chair: Actually, you're done. Sorry about that.

Mrs. Betty Hinton: That's all right.

Thank you.

[*Translation*]

The Chair: Mr. Perron.

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Thank you, Mr. Chairman.

Good morning Mr. Bruce and Mr. Walker.

On page 8 of your document, you mention the increased demand. This increase, in normative terms, is it due to the age of veterans, to the aging of the population, as it is the case for the rest of the Canadian population, I presume?

Mr. John Walker: Yes, it is true. The average age of veterans is now 81 years old. It is higher than the rest of the Canadian population.

Mr. Gilles-A. Perron: You say that the costs have increased by 8 to 10 per cent for veterans. Is it around the same as in the provincial health systems, for long-term care?

Mr. John Walker: Yes.

Mr. Gilles-A. Perron: It's around the same thing?

Mr. John Walker: Yes, approximately. A little more than half of the beds, that is 53 per cent, can also be used by the communities. It's just that they are paid for by our department.

Mr. Gilles-A. Perron: There is another thing that really bothers me. I'm trying to get answers, but I don't seem to get them. It feels like I'm walking on eggshells, nobody dares talk. I'll come back to Sainte-Anne Hospital. I keep hearing that we couldn't have good negotiations and get to an understanding between Quebec and the Veterans Affairs department. Can you tell me what happened, or what is happening, with that?

Mr. John Walker: That's interesting. At one point, we had decided that it was better to keep the hospital within the department, because we can use it as a “centre of expertise” for all the other hospitals across the country.

Mr. Gilles-A. Perron: Yes, but you don't have other hospitals in the country, that's the only one available.

Mr. John Walker: I know, but we can use Sainte-Anne Hospital as a resource, a real centre of expertise, for all of the other ones.

● (1150)

[*English*]

Ms. Verna Bruce: There is another part to that as well. If you've been at Sainte-Anne-de-Bellevue, the care is phenomenal. The facility itself is not up to standard, and I think it's fair to say that at a particular point in time the Province of Quebec wasn't overly interested in acquiring an aging facility that did not in fact meet some of their provincial health care standards. That's why we're putting a huge amount of money into renovating Ste. Anne's Hospital. At the end of it, we'll go from having wards with 16 people in them to having rooms that are mostly private and semi-private.

I think it's quite understandable that in this provincial health care system, where the costs are going up, acquiring a facility that's outdated probably didn't meet their needs either. The solution we've come to is something that in fact we've agreed on with the department of health in the province of Quebec.

The Chair: Mr. Bagnell.

Hon. Larry Bagnell (Yukon, Lib.): Thank you.

That was an excellent presentation, so I don't have too many questions.

Did you do any comparison of the costs between your facilities and the ones run by the provinces?

Mr. John Walker: That is a very good question, and it's difficult to respond to because it depends on the model you use to provide the care. For example, at our hospital in Montreal at Ste. Anne's, we use a high ratio of health professionals, nurses, etc., to provide the actual hands-on care, whereas in some of the nursing homes across the country they use licensed nursing assistants—but it depends on the province. The nursing staff and health professionals would only be available once the aids figure.... Say we're in a situation with Mr. and Mrs. Smith where I'm out of my depth and I need the nurse or the doctor....

So to draw a linear relationship between our cost at Ste. Anne's and a nursing home down the street here in Ottawa would be very difficult. But I can say, the ones at Ste. Anne's are more expensive because of the staffing ratio mix we have. In the nursing home world or the long-term-care world, about 80% of the costs are salary costs. If you have a more expensive resource providing the direct patient care, your cost will be much more expensive.

That's not a real good answer to your question, but it's a hard question.

Hon. Larry Bagnell: That's okay.

If the provinces, who I suppose are the experts because they have a lot of experience, have found out that to be more efficient in costs, certain functions would be better covered by a new category of worker.... I think it's the same now as what we're finding with doctors and nurse practitioners, which we're trying to get more of in Canada. But if they've found out, for instance, that a bedpan doesn't need a registered nurse to move, and have changed or adjusted their system as a result, would it not make sense to adjust our system as well?

Mr. John Walker: Where we have just the one facility remaining, what we've chosen to do is to use it with our current staff as a model of expertise, above and beyond what can be provided in a normal nursing home. They can deal with cases of perhaps really advanced and aggressive dementia, whereas other places couldn't. For example, in the Montreal catchment area, if a veteran wanted to go into one of the foyers around the city, they could do that; but at a certain point in time, if their care became too much for the nursing home to manage, the logical progression would be for that person to be moved to Ste. Anne's, where they do have the resources and the expertise available.

It's not really long-term care, but we're getting more and more into the treatment of post-traumatic stress disorder. It's not in here, but Ste. Anne's is going to be a key player in that type of—I'm searching for a word—injury. We call it an occupational stress injury. There's not a whole lot of expertise available across the country on this, because it's literally coming of age now as an illness; I would phrase it as that. We're trying to develop and maintain a real expertise at Ste. Anne's in that particular injury.

There's a whole mix of services available at Ste. Anne's, as the gem in our crown, which you wouldn't find available at other places. So the costs are understandably more expensive at Ste. Anne's.

● (1155)

Hon. Larry Bagnell: I wasn't thinking of those special cases; I was just thinking of the average case.

Is my time up?

The Chair: No, you have another three minutes.

Hon. Larry Bagnell: Does that apply to the long-term care of the ones who are in community facilities as opposed to our facilities? Is it the same deal?

Mr. John Walker: Which part of the deal?

Hon. Larry Bagnell: The same cost comparison.

Mr. John Walker: The veteran would pay the same—

Hon. Larry Bagnell: No, the costs of running the facility.

Mr. John Walker: When we compare Ste. Anne's costs with other costs across the country, it's an apple and an orange. But what we pay—

Hon. Larry Bagnell: No, I wasn't thinking of Ste. Anne's. Are there any other facilities that we're running?

Mr. John Walker: Yes, where we have more significant costs are in the 20 big priority access facilities we have, because Veterans Affairs decided to put enhanced programming into those facilities for veterans, because we feel it's warranted.

It's important to remember that if a veteran chooses, he or she can go to those facilities where they have enhanced programming and more significant costs, but what we find is that given the choice, they will stay in their own home community, where they'll be in a facility with their neighbours and where their kids can come to see them.

I remember that when we had no priority access beds in northern Ontario, once you got past North Bay nobody wanted to go to Sunnybrook in Toronto—but it didn't mean the need wasn't there. When we were able to get beds in northern Ontario—albeit in the community facility—the people wanted them and used them.

I think we've been able to preserve for the veterans a real element of choice here. I think that's one of the hallmarks of our program, and I think it's really something we should stick with.

The Chair: You have 30 seconds.

Hon. Larry Bagnell: Okay, it's a short question.

Related to Betty's question, what percentage, roughly, or number are pension condition?

Mr. John Walker: I will get back to the committee, but when I last looked at that, which was quite some time ago, it was in the neighbourhood of 10%. After saying that, I'm going to say quickly that I will verify the number and get back to you, because it's not difficult to verify; we have it on our computer system, and I will get it. I should have had it, but I don't.

The Chair: I'm going to follow on that. I'm going to dog you with some percentage questions here. I notice the 94% satisfaction rate. On the 6% who aren't satisfied, what is the nature of the dissatisfaction?

Mr. John Walker: It varies, I'd say, from soup to nuts, but the predominant one that we have the most difficulty with is food. Following that would be if they're in a semi-private room and they wish to have a private one. Or if their roommate snores, that's a common one. Those are the types of things. Where they're unsatisfied, it depends on the day that they're visited, but food, semi-private, followed by their roommate would be the three issues that would come up.

The Chair: So it's not the care itself, it's more the conditions that they—

Mr. John Walker: Generally, it's not the care.

The Chair: Okay. Would it be possible to have a sample of the questionnaire that you go through? Could you get that back to the committee?

Mr. John Walker: Yes. Do you want just the questionnaire, or do you want samples of completed ones?

The Chair: No, I don't think it's necessary to have the completed one. I think it's just to get a sample of the questions, just to give us a better idea of—

I understand that. I would feel better if I knew what the questions were, for my own—

Mr. John Walker: We'll be sure to get that for you, but I just don't want to be misconstruing that. It's a blunt instrument.

The Chair: I have another question, while I have the chance here.

I was intrigued by the observation made by Mrs. Hinton on the $4,000 and the $1,000 from coast to coast, or the differences. How much of a difference does that cost? Are you at odds with the provinces? How is that working? I'm looking at the dynamics here, and it just doesn't make a heck of a lot of a sense to me.

● (1200)

Mr. John Walker: What I learned through the six years that I spent in that job was that our health care system varied so significantly from province to province.

For Veterans Affairs Canada, a veteran in a long-term-care facility, per month, in British Columbia costs us in the neighbourhood of $250, whereas in Atlantic Canada it could be $3,500, $4,000, depending on where they are.

I've been at this long enough to know that we can speak with them about it, but they have their own provincial responsibilities and pressures. In Atlantic Canada—and I speak from the advantage of being an Atlantic Canadian—not yet, but in January of next year, Nova Scotia will bring in a program whereby they will not take a person's assets. Previously in that province they would take the money that you had saved, then they would start on the assets.

I don't know if Verna can speak to it better than I can, from her provincial experience. So you would see a lot of migration of seniors to British Columbia for that very reason.

If you're spending $4,000 or $5,000 a month and you live in the long-term-care facility for four or five years, you can go through a significant amount of money. Remember, I said that people don't want to go into a long-term-care facility. Well, for the ordinary citizen that is certainly a reason in Atlantic Canada. If the sons and daughters see their inheritance being dwindled away for that—and this is kind of crass, but it is the truth—they are much more apt to provide care in their own home than they would be if it wasn't the case.

Ms. Verna Bruce: For further clarification, too, we actually top up provincial programs in this area, so our view is that veterans are Canadians, and we provide a standard of care for our veterans that's similar across the country. The commitment that we make is this. Regardless of what the situation is in the province, our veterans only have to pay $786 a month, or if they're in for their pension condition, they don't pay anything, and then the costs fall to the department in terms of providing that top-up. But it's very different, as John says, from one province to the other.

Mr. John Walker: As far as going out and negotiating with the provinces is concerned—okay, Atlantic provinces, you're going to pay for these people—they won't treat the veteran differently from their own citizens. We're essentially building upon the program that's available for each and every provincial citizen. What we have is very much a national program. We have to take the provincial programs with their richness in the west and their lack of richness in the east.

The Chair: Very good. Thank you.

Now we'll go on to Mrs. Hinton.

Mrs. Betty Hinton: Thank you.

I never fail to come away from one of these sessions with a lot more information, and I have to tell you that most often I leave here slightly angry and frustrated at some things that I think would be so simple to fix.

Mr. John Walker: Are you mad now?

Mrs. Betty Hinton: Yes, I'm getting fairly mad. Well, you just managed to shoot a lot of holes in the myth of universal health care in this country. Obviously it's not so.

I want to go back to some of the costs that you mentioned before. I agree with you whole-heartedly. Obviously if people can stay in their own homes or they can stay in their own communities, it's beneficial to all of us. It's beneficial to the veteran or any other senior citizen, for that matter, and it's beneficial to the country.

Did you tell me that under the VIP program, it was $6,000 to $8,000, or did I get the numbers wrong?

Mr. John Walker: It's $5,000 to $6,000 to $7,000—it depends. That is for the veterans independence program, which is for things like groundskeeping, housekeeping, and the lot, plus they have our treatment program, which is the Blue Cross card. This enables them to get 14 programs of choice; perhaps the most significant one is number 10, which is drugs. It's split about 50-50 between the two programs.

We have our submission to the *Canadian Journal of Aging*, which they were quite interested in. It caught their attention, and I'll make a copy available to this committee. It's quite striking, because just on the cost benefit it's marvellous.

● (1205)

Mrs. Betty Hinton: It's fairly significant. I believe I wrote down the second part correctly, that it was between $45,000 and $60,000 per year.

Mr. John Walker: Yes.

Mrs. Betty Hinton: That's a significant difference. It seems to me we're paying far more than we need to pay and doing something backwards, because it's not to the benefit of the veteran, either. It's obviously not benefiting us financially and it's not benefiting the veteran.

Mr. John Walker: I have to make sure I'm crystal clear here. Because now, once all the veterans, the three groups that I've talked about, have been assessed as needing nursing home care, for the overseas service guys, they had the option of what I'm quite proud of, our VIP program that Canadian citizens do not have access to. What I'm saying is the veterans can stay in their home community and on average they go in and they do not stay in the long-term-care facility very long. With the VIP program and the treatment interventions, they do not stay there very long because they do not go in until they're really very sick.

Mrs. Betty Hinton: I have three questions, so I'm going to do rapid fire here.

Do you ever take anybody off the VIP program who doesn't want to be removed because a bed has become available? That's question number one.

Question two: To what extent can the department influence the design of veterans' long-term centres administered by provincial authorities? How much input do you have?

Question three: Has the department succeeded in discussions with provincial health authorities to streamline the decision-making process so that decisions can be taken in a more sensible timeframe?

Mr. John Walker: For the first question, I do not ever remember taking anybody off the list—nor would we. I would be shocked if we did—we just wouldn't do that. It makes no sense; it's a lose-lose situation.

With regard to how much input we have, it certainly depends on the province, but in the big places I mentioned, the 21 facilities having 85% of the priority access beds, we do have considerable influence, but it's directly related, dare I say, to the amount of money we put in.

Recently we've had success in Atlantic Canada because we have built some new facilities where we paid the lion's share of it. In the two western provinces, Alberta and B.C., we have some marvellous facilities out there. Colonel Belcher, in Calgary, is a marvellous facility, as is The Lodge at Broadmead, in Victoria. These are trend-setting facilities, and we have worked with them hand in glove because we have access to resources across the country through our gerontological advisory committee, which can provide them with expert advice on a moment's notice. These people have studied this long-term-care issue around the world.

There's a guy in Australia, Dr. Tooth, who's come up with a really good design for an Alzheimer patient's set-up—for lack of a better word. We've taken it and modified it, but it's really worked well.

I'm sorry, the third question? How much influence have we had with the provinces?

Mrs. Betty Hinton: How much influence do you have? Then I have one really fast comment at the end.

Mr. John Walker: It does depend on the province, but I find we have a considerable influence, in that they know the strength of the veterans organizations. So we're able to have significant influence where we have significant numbers of veterans. Where we only have one or two veterans, by their choice, in a facility of a hundred people, the veteran would get what we call “citizen plus” care, but we can't have influence with 1,500 facilities.

The Chair: Ms. Hinton, we're actually over the time. If you don't mind, we'll probably come back to you in a few minutes.

We'll go now to Mr. Bagnell.

Mrs. Betty Hinton: It's just a compliment.

The Chair: Oh, okay. We can always accept a compliment.

Mrs. Betty Hinton: The compliment is that I applaud your decision to use legion members to go in and have these surveys done, because I believe you're going to get a far more honest answer from a comrade than you are from someone they don't recognize. So good for you, and good for the legions for doing that sort of service.

Mr. John Walker: If I could, a lot of the progress that we've made, particularly in the quality area, has been through partnership with the veterans organizations, to show us what we should do. They worked with us with the Canadian Council on Health Services Accreditation in developing the new chapter that they have in their "Acquiring Improved Measurement" strategy, the AIM strategy. They worked with us hand in glove and they worked with us on the client satisfaction surveys. So it's very much a partnership.

I learned early on that it's much better to have them with us than to have them against us.

Thank you.

● (1210)

The Chair: We'll go on to Mr. Bagnell now.

Hon. Larry Bagnell: Thank you. As a member of our legion, I agree with Betty.

If you havet 96% approval on food, that's pretty good. It's a lot better than the airlines are doing.

The stay-at-home care, that is available in some parts of Canada for the public.

Mr. John Walker: Yes, but I don't know that it's as affluent as our program. For example, I'm not aware of any that provides cutting of grass and snow shovelling. Those seem to be quite simple things, but those two elements are a big factor in people's move from the family home into a condominium. It's a big, big factor.

One little thing on this. The veterans are given so much money to get their lawn cut. Everybody in the neighbourhood might be paying $20 to the kid next door to get their grass cut. The veteran will be offering $8 but will be willing to go to $10. It's really quite interesting to see how precious they see that money we give them and how judiciously they use it. It's very encouraging.

Hon. Larry Bagnell: Back to the $4,000 and the $1,000, basically that is because the western provinces subsidize the care and then don't charge any person staying there, whether they're youth or veterans or the person is from the public. They simply don't charge them as much, so there's a big provincial subsidy, basically. They're not offering less care.

Mr. John Walker: No. I would say the care would be very similar right across the country, and the price would be very similar across the country. It's only who's paying for it. Is it the provincial government paying for it, or, in our case, the Department of Veterans Affairs paying for it? Or, indeed, the citizen's share?

I would say the cost would be similar subject to CPI variations, to reflect the cost of living in British Columbia versus the other less affluent regions of the country.

Hon. Larry Bagnell: What do you think the lifespan of St. Anne's is, once you've done the renovations?

Ms. Verna Bruce: St. Anne's will actually be a very modern institution by the time we finish the renovation project. The plan is for us to build a lot of expertise there around doing dementia care as well as looking at PTSD. We'll take a look at what the needs are for veteran clients there, and when the time comes that it makes sense to sit down and have conversations with the Province of Quebec, we're prepared to do that.

But the actual construction should last for 30 years, at least.

Hon. Larry Bagnell: Do you find anything in your patients or residents that suggests you might be able to feed back into the system to prevent some of the problems they have when they're in your care? For instance, are you finding that certain patients have whatever problems as a result of their service that you could feed back to the military and suggest that if it did this in either their training programs or experience, the veterans might not end up with this condition? Do you see any of that?

Ms. Verna Bruce: One big one would be hearing loss. That was one that actually happened quite a few years ago in terms of the number of veterans coming through with hearing loss.

It's incredible. People who've served in the artillery, obviously, if they have hearing loss, the chances are it's related. So I would say that, certainly with respect to hearing, the military is now very careful in terms of providing hearing protection.

Are there others, John?

Mr. John Walker: None come to my mind that are as evident as that one.

For us, I guess it's the lessons that we've learned through this OSV at-home thing that we find it could be really useful. As far as specific to the military, other than hearing loss, it doesn't readily come to me.

The Chair: Thank you. Very good.

[*Translation*]

Mr. Perron, do you have other questions? No.

[*English*]

Mr. Bagnell? Mrs. Hinton? No. Very good.

Mr. O'Connor.

Mr. Gordon O'Connor (Carleton—Mississippi Mills, CPC): I'm new to this committee, and I don't know the past history, but on the very last sheet you have all these recommendations. Is there any simple list of what these recommendations are, which ones are in progress and which are partially completed, etc?

● (1215)

Mr. John Walker: We have it here to give out, sir.

Ms. Verna Bruce: We do have documents to leave with you.

Mr. Gordon O'Connor: The other question is, what do you think about an ombudsman for veterans affairs?

Ms. Verna Bruce: I guess the view the department has taken is that we probably have some of the best ombudspeople in the world, because the Royal Canadian Legions actually act as ombudspeople and they're all across the country.

Our view would be that we do have a huge number of ombudspeople out there at the present time.

The Chair: Very good, then.

I want to thank both of you for coming out today. It was very informative and it certainly gives us a better idea of where things are going with the program. Thank you very much.

Ms. Verna Bruce: We'll make sure that we get the documents that we've promised to the clerk, ASAP. Thank you for the opportunity.

The Chair: Thank you very much.

Members of the committee, if you can wait a few minutes, I'll simply bring up that one topic and then we'll discuss committee business. We'll cover three quick items, if that's okay. We'll get started.

The VIP program that's come up has had some changes to it. Do we want someone to come in and give us a detailed briefing on it? Do we have questions on the new program? Is that something that would be useful?

Mrs. Betty Hinton: I don't know if there are really significant changes that would warrant having a briefing. If they're only kind of fine-tuning things, I'd be just as happy with a written submission.

The Chair: We don't need a presentation, then, is what you're saying.

Mrs. Betty Hinton: I don't know. I mean, I would bow to the majority. But as far as I'm concerned, unless they're really significant changes, I would just as soon have it in writing as have a presentation.

The Chair: Okay.

Hon. Larry Bagnell: Once we've read it, if we want a presentation then we can ask for it.

The Chair: Okay. That can be done over the break period. I'll ask the clerk to get us a copy. Is that okay?

Mrs. Betty Hinton: Okay. Sure.

The Chair: Okay. We'll have the changes, and we'll see what happens once we get back.

The other thing is that I had suggested something, but Peter is not here to defend himself. Did everybody get a copy of the speaking order on the way it works in this committee? We have round one, round two, and then we go to round three. In round two, it's Conservative, government, Bloc, government, Conservative, government, Conservative.

I was going to suggest that we go straight to round three instead of round two. It's only a suggestion. I know that Mr. Stoffer is usually here, and he does have a few questions.

By doing it this way, it gives a little more evenness to it. I realize that it's not the appropriate numbers game, but I'll leave that with you. At our next meeting, if you want, we can discuss it in committee business. It's only something to think about for the next one.

It came up the other day when he had some questions, and we never really get to round three anyway. It might be a way of levelling it out. Although if it's—

● (1220)

Hon. Larry Bagnell: Are you saying that you'll add him to round two?

The Chair: Basically, yes. It has to be unanimous, that's all there is to it. As long as there's someone who is uncomfortable with it, we won't do it. I only thought it would be a nice gesture.

Mrs. Betty Hinton: I think I can give you an answer.

The Chair: I'll look forward to it, Betty, I really will.

The other thing that came up was we were going to have a meeting and discuss committee operations on January 31. Do we want to have that meeting, or do we want to wait until the week after? It was suggested that we skip the first week back.

Mrs. Betty Hinton: Don't we have someone coming?

The Chair: We have the minister coming.

The Clerk of the Committee: The minister is planning to come on February 7, I believe, the first Monday of the week after we come back.

The first day back is January 31. We don't have anything specifically planned yet for that day. It's a question of whether the members want to have a business meeting to discuss what issues they want to discuss with the minister when she comes the next week.

Mr. Gordon O'Connor: Talking off the top of my head, at that meeting, what about if we lay out where we're going between then and the summer? What are we going to try to achieve? Is it higgledy-piggledy or do we have some plot?

The Chair: I think it's a great idea. Is that okay with everyone? We'll be here at 11 o'clock on January 31 and determine where we're going. If you could put some thought into it, we'll see exactly where we want to go. We've heard from pretty much all the committees up until now.

That's about it for business. There is only one last thing. Best of the season, and I hope everyone has a great holiday.

Mrs. Betty Hinton: A merry Christmas to you too.

Mr. Gordon O'Connor: For those who won't be at the defence committee this afternoon—

The Chair: Oh, is that optional?

Very good. The meeting is dismissed.

Happy holidays.

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