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Mr. Rob Anders

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● (1105)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good morning, ladies and gentlemen. Welcome to yet another meeting of the Standing Committee on Veterans Affairs.

Today we're continuing to study the veterans health care review and the veterans independence program. Our witnesses this morning are Willie Lirette, president of the Fédération des aînées et aînés francophones du Canada, as well as Marc Ryan, who is the first vice-president, Ontario. Then from the International Federation on Ageing, we have Greg Shaw, who is the director, international and corporate relations.

The way it works generally, gentlemen, is that you have usually 20 minutes in entirety. However, I understand it's been set up so that there are 10 minutes each. So committee members will have a full 30 minutes of testimony this morning, if you so chose. And then after that, we have a pre-arranged roster of question asking between the various parties, and I will adjudicate that.

And the big question of course, gentlemen, is that I think we're generally all in favour of extension of the veterans independence program, but it's a question of how much.

So the floor is yours.

[*Translation*]

Mr. Willie Lirette (President, Fédération des aînées et aînés francophones du Canada): Thank you, Mr. Chairman. It is a pleasure for me to be here today. This is the first time I appear before a committee of the House of Commons and I expect it will be a great experience.

On behalf of the Fédération des aînées et aînés francophones du Canada, I would like to take this opportunity to thank you for appearing today before the Standing Committee on Veterans Affairs of the House of Commons. Further, I would like to congratulate you for taking the initiative in trying to improve the situation of veterans and seniors. The seniors' population will continue to grow significantly over the next 20 years. So it is important for the federal government to do what it can to improve the well-being of Canadian seniors.

The Fédération des aînées et aînés francophones du Canada is a non-profit organization whose membership is comprised of 12 francophone seniors associations representing over 3,300 members, including the Mouvement des Aînés du Québec and the Quebec Federation of Senior Citizens. We work closely with all our members to ensure that francophone seniors throughout Canada are able to access quality health care and services in their mother tongue.

We would also like to take the opportunity today to share with you our experience in the area of health care, and we hope that all our contributions will enlighten you and help you find new ways to improve the quality of health care and services available to veterans.

We would also like to point out that our area of expertise concerns first and foremost francophone seniors. We do not work with veterans in particular, but that may change over the coming years. However, it is fair to say that many veterans are members of our provincial associations and benefit from the services we provide.

In our experience, here are the main issues we have identified in the area of health care for francophone seniors living in a minority situation. First, if you look at the statistics, it can be said that, based on all the determinants of health, francophone seniors living in a minority situation are greatly disadvantaged compared to anglophone seniors. For example, data collected in Ontario reveal that 43% of francophone seniors are lower income, compared to 27% of anglophone seniors. Further, 36% of francophone seniors do not have a high school diploma, compared to 24% of anglophones. We do not have the figures for the other Canadian provinces, but we believe that the data would be similar elsewhere.

It is always very difficult for seniors to have access to services in French. According to a recent study conducted by Dr. Louise Bouchard and Valérie Bourbonnais of the University of Ottawa, 66.2% of francophone seniors living in Ontario do not speak their mother tongue with their family doctor. That's over half. Further, the study reveals that francophone seniors are more likely not to have a family physician than anglophones.

We have also learned from talking to people in their communities that seniors often face huge health challenges. It is extremely important for seniors in general to grow old at home, and even more so for francophone seniors. For instance, I recently had the opportunity to speak with a francophone senior from Manitoba who lives in a small, predominantly francophone, village several kilometres from Winnipeg. She explained just how afraid she was to have to sell her house for health reasons and to be forced to move into a nursing home, the closest one being about 100 kilometres away from her house. Even worse, it did not provide any services in French. That's when I realized just how vulnerable this francophone senior lady was to being uprooted from her community and ending up completely isolated from the francophone community.

In New Brunswick, when the time came to build a new home for veterans in Moncton, the responsibility for the project was given to the Régie régionale Beauséjour, namely the francophone regional board. As a result, the centre provides excellent services in both official languages. But that would not have happened if the home had been built in a place like Saint John or Fredericton. But since it was built in Moncton, which is bilingual, bilingual services automatically became a priority. But that's not the case elsewhere in the country.

So the lack of home care services in French is a major challenge for all seniors, but especially for francophone seniors.

Seniors want to stay at home, but in order to do that, they need home care services.

The support, or rather the lack of support, for natural caregivers—which can also apply to veterans—has repercussions on the health of seniors. Because there is a shortage of services in French, francophone seniors often have to turn to an informal support network when they need home care, which points to the importance of having a solid support network for natural caregivers, but unfortunately this is not always the case.

The lack of francophone nursing homes for francophone seniors is also a huge concern for these people. Back home in New Brunswick, the situation of seniors who are stuck in regular hospital beds and who are not in nursing homes is a major problem. The same holds true for veterans in New Brunswick: there are not enough places to accommodate them.

To address these different types of problems, the Fédération des aînées et aînés francophones had to be creative and find new ways of reaching out to seniors, and to do it with very few resources. So to achieve this goal, we had to develop a strategy based on certain principles. Let me mention a few of them.

Seniors must be much more than simply "patients" within our system. We have to create strategies which involve seniors, which allow seniors to be consulted, and which allow them to contribute to finding solutions to certain social problems which will arise over the coming years.

For instance, we have created a community support program which trains senior volunteers who are leaders in their community, to help the most vulnerable seniors, or those who are in the poorest health, to help them find services in French. The project was very successful, but it was only funded over nine months. Although the program had to end, I believe that had it received the appropriate level of funding, it would have been extremely beneficial and would have saved the health care system a lot of money.

Next, it is important to focus on prevention and health promotion. In my province, for example, less than 1% of the total health care budget is spent on prevention. All of the money is spent on healing, and that's a major problem. Seniors don't want to wait to get sick before something is done. That is why we organize health forums in francophone communities. They are extremely successful and well-attended by many seniors. It is good for francophone seniors, who often feel isolated, to get out and participate in such events. It gives them the opportunity to exchange stories and put their own health care situation in context. These get-togethers are good for seniors' mental and physical health.

We must also take advantage of the know-how and experience of retirees. In that regard, the Fédération des aînées et aînés francophones du Canada is currently working with each provincial association, and with each territorial and provincial federation, to develop an intergenerational health care plan of action for each province and territory. We believe that implementing these plans of action will help prevent illness and improve the health of seniors. As an aside, the program has until now also taught grandchildren about growing old. So by becoming involved in activities to improve the health of other generations—grandchildren, young parents, and so on—seniors who involve themselves are much more inclined to take better care of themselves, and being in contact with other generations will only be good for their physical and mental health.

As for the specific situation of veterans and the health care services they receive, we believe that it is important for the federal government to look at models in which veterans and their families can contribute more within the system and express their opinions as to how to provide better services.

● (1110)

Let's compare that to a situation where parents are involved in their children's school. If parents are involved in the school, chances are that school services will improve because of the parents' feedback. Consequently, we believe that if veterans or seniors in general are involved in their area of health care, if they can be involved in the decision-making process, it will improve the system.

We need to get away from the traditional doctor-patient model to allow patients and their families to have a say in the health care choices they make. People are increasingly talking about personal choice in health care, and studies have shown that when patients have a greater say in the type of health care services they receive, they recover more quickly. Therefore, patients must be involved in the healing process.

We would have liked to speak at length about certain other initiatives, but we hope that we will have the opportunity to do so during the question and answer exchange.

In conclusion, I would like to thank the committee for having given us the opportunity today to talk about the needs of Canada's francophone seniors. I also believe that many of our needs are the same as those of anglophone seniors. We therefore hope that the different solutions we have proposed will help you to develop new models to improve the quality of health care to veterans and their families.

Furthermore, I would like to end by congratulating the federal government which, like some provincial governments today, has appointed certain ministers or senators specifically to look after the needs of seniors. We are very pleased that Senator Marjory LeBreton was appointed to this position and that we can now meet with senior-ranking government officials who are open to seniors' concerns.

I might add that when you go to Ottawa, or to any other province, you have to knock on 10 or 12 doors because everyone has a file involving seniors or veterans. We do not have the human or financial resources to do all of this. So at least one door is open for us here, in Ottawa, and we can show up to meet with Ms. LeBreton, whom in fact we already met with.

Once again, thank you. We would be pleased to answer any questions you may have. The brief time we have had to make this presentation was not enough to provide you with more substantial information such as statistics or research papers. But we can talk about that another time.

● (1115)

[*English*]

The Chair: Just to let you know, you've used up about twelve and a half minutes.

So the others may carry on, please.

[*Translation*]

Mr. Marc Ryan (First Vice-President (Ontario), Fédération des aînées et aînés francophones du Canada): I would just like to add to or go over a few ideas. My president spoke about New Brunswick. I would like to take the opportunity to speak about the Montfort Hospital, which serves veterans and National Defence. Once again, this is a bilingual institution which is able to provide services in both official languages.

Elsewhere in the country, another contribution should be underscored, that of the Société Santé en français. This association does outreach in minority language communities throughout Canada. It has proven its mettle in the past five years. I believe that currently, it is in the process of setting up health services in French throughout the country, in areas where this situation is precarious.

The absence of long-term residential care centres is truly a problem. It is an iceberg that is looming before us but that we have not yet hit. As the Ontario president of this association, I can assure you that elsewhere in the country, this is a problem that is going to become more serious and that will not be easy to resolve, because we're dealing with departments that deal with municipalities, housing in general and an entire range of support programs. So the problem is far from being resolved.

In addition, Mr. Lirette spoke about community accompaniment which, in minority language areas, is very important. Thanks to community accompaniment programs, we can often delay the institutionalization of people who are gradually losing their autonomy. The long-term care centres cost the health system a great of money. This being said however, it is still important to have these centres.

Finally, allow me to describe very briefly the health prevention days that we organize and for which we request funding so that we can organize others in all minority language areas. At the beginning of the day, we present the technical aspects of a given disease, for example, heart diseases or Alzheimer's. Then, there is always a nurse who takes people's blood pressure and blood samples. People are notified that this day will be taking place and we usually have some 100 to 250 people in attendance. This first part of the day is very technical. Then, we talk about nutrition. Later in the day, we invite either a policeman or a social services representative, to discuss abuse of seniors. Usually, the day ends with an entertainment type of presentation.

In closing, intergenerational programs are designed to reach out to isolated seniors. Francophones in minority language areas throughout the country have a pressing need for such programs.

I don't want to take any more time, thank you for your attention.

● (1120)

Mr. Willie Lirette: I would like to add that the aging population is a problem with a bright side. All governments, whether federal, provincial or territorial, have trouble realizing that in 20 years, we will be faced with a major problem in terms of replacing the labour force, because many seniors will no longer be on the labour market. The government seems to have trouble accepting the idea that it needs to prepare for this major influx of seniors into the population well ahead of time. I think that this population segment of seniors will reach 20% in a very short time. Once that happens, what services will be available?

I know that governments are elected for four or five years on average, and that often programs or projects are planned over this same time period. Governments seem to forget that problems can take on massive proportions in 15 or 20 years. As concerns this idea of planning programs ahead of time or helping governments deal with these situations, I have not yet heard an answer from elected officials, whether at the provincial or the federal level. This is a major issue, especially for the federal government. It must consider setting up something tangible that will help us in 10, 15 or 20 years because the problem will be very real at that time. We have not yet felt its full impact.

I am now ready to answer your questions.

[*English*]

The Chair: All right, thank you very much.

Now we're over to Mr. Shaw for 10 minutes, if he wishes.

Mr. Greg Shaw (Director, International and Corporate Relations, International Federation on Ageing): Thank you very much. It's a pleasure to be here today. It's my first time presenting to a committee in Canada. As people can probably hear from my accent, I'm not Canadian. I'm originally from Australia, but I've presented to certainly a few parliamentary committees in my time, when I was in Australia working with the Australian health department.

I'm the director with the International Federation on Ageing. The organization is 35 years old. It's been in Canada for 15 years. It is one of four premier NGOs that have general consultative status at the United Nations and deal specifically with issues on aging.

We generally focus not on disease-specific issues but really on the social issues around aging. We're a facilitator and bridge-builder between government, NGOs, and best practice, looking at what's happening from a country-by-country perspective in terms of programs and policies that support seniors.

It's certainly welcoming that this particular committee is looking at the issue around veterans, because the veterans issue is not only an issue in Canada but also in many other countries, and I can certainly give some perspectives from the Australian veterans care system during questions and answers. But what I want to focus on today is some aspects of the Gerontological Advisory Council report of November 2006 and some of the recommendations that this particular body was making, particularly when we talk about veterans and the demographic of veterans as it currently is today, and the tendency for governments to look at an illness model of care rather than looking at a wellness model of care.

The International Federation on Ageing certainly encourages governments and supports policies and programs that look at models that support wellness and interventions to actually reduce disease burden.

As Willie indicated, governments don't spend a lot of money on health prevention and health promotion, because the results that you see from those things are generally long-term and the health benefits aren't necessarily realized in the short terms of governments.

There isn't enough effort done in most countries around health and wellness programs. There are some aspects of the veterans home care programs here that have taken some leadership and worldwide recognition, such as Canada's falls prevention programs and early interventions around falls prevention, which certainly supports and benefits veterans.

The other issue that I think is of major concern is the support that carers receive, who are the people at home supporting the veterans who need some form of support. I think in the last 10 or 15 years there's been a greater emphasis on the support that home carers, or the spouses and families of seniors, provide and add to the cost savings of government. Programs that support specifically those carers certainly are encouraged, and I know there are some very good models, both within Canada and outside Canada, that really focus on how to support the carers of those veterans to maintain them to be independent, or for them to remain within the community or at home for longer.

In doing that, what governments certainly have recognized, and there's a great move away from residential care to more home-based community support programs.... The issues for seniors around those home-based community support programs are these: Where do I get information about those programs? Who do I make contact with, and are there single points of entry or single points of referral? Are there some consistencies from one province to another around those referrals, particularly to home care programs?

● (1125)

The issue of a one-stop shop, in terms of an assessment and referral component, is certainly an initiative that is welcome, and which the Gerontological Advisory Council has recommended. People only look for these services when there is a crisis and they don't know where to go, but if there's a one-stop referral assessment point that looks at the issues not only of the veteran but of the whole family and the infrastructure of the family, and they make the referrals to the appropriate services, it certainly puts the families and the veterans themselves at ease in terms of, if there is an issue, where they need to go.

We do have to recognize that people only access these services when there's a crisis, and when there's a crisis they need support and service tomorrow. So it's an issue of how to get information out about what services are available. The NGO community across Canada and returned service league organizations have a vital role to play in informing veterans about the range of services that are available, and not only to inform veterans about the range of services available but to start talking among themselves about the inequities of services across provinces in Canada. That's the same in many other countries where health jurisdictions are done at a provincial level.

In terms of what are some of the trends that are happening, if we look at veterans' home care programs—I'll give an example of Australia—what they're looking at is using multidisciplinary teams for assessment so you have a single point of entry for assessment. Those assessments are uniform and eligible right across the country. They also maintain an amount of money for packaged care services, so they can actually support families and the veterans with what they would call a community aged care package, or a veterans aged care package, which could buy in the range of services that a particular veteran might need to keep them at home for much longer. Certainly the emphasis is how we keep people as part of the community where they live and where they've contributed for as long as possible. The issue that was highlighted of people having to move to go into long-term care or other care facilities is not only an issue in Canada, but is also an issue everywhere, and it's an issue around the multi-culturalism of senior populations in countries.

In terms of looking at the range of programs and services, there has to be an emphasis around health and wellness. It will certainly, in the long term, reduce the cost burden of governments in terms of the cost of care, or it will limit the cost of care to a much shorter period when you start looking at long-term care costs. If we look at world trends in developed countries, only about 4% to 5% of people who are over the age of 70 today will go into a long-term care institution. There are many people out in the community who will remain in the community, and only through an issue around health will there be cause for intervention and generally hospitalization.

If there aren't that many people going into residential care, why aren't they going into residential care? It really is because of the movement around developing community-based services that support the people to remain independent at home for a lot longer. It is also about developing programs and services that promote independence and health and wellness so as to reduce the disease burden in the longer term.

Case management is another issue that was discussed by the advisory council in its report, and it's a model that has been followed and adopted in a number of countries. The issue around case coordinators or case managers is the caseload that they end up having to take on. In the Australian system where we had case managers for a geographical area, the burden on those case managers was quite significant, and it was recognized very early in the piece that the particular program was underfunded, because case managers were trying to support 70 to 90 people on a weekly basis, which was just out of the realm of their particular possibilities.

● (1130)

I think the issue of uniform access, or access to services that doesn't necessarily discriminate, is an important one. If I'm a veteran and I'm living in Manitoba, I want to know that I can get the same level of access to services, whether it be health care services or services that can support me at home, that I can if I live in Prince Edward Island.

Nationally, that's an issue for the Canadian government to look at, and even the NGO sectors, to start talking about what the differences are. What are the services that I can get in Manitoba as opposed to Prince Edward Island, for argument's sake? I think those are issues that do need to come to the forefront.

Having a national veterans program certainly overcomes many of those issues, and having programs that are funded independently by the Department of Veterans Affairs goes to much more of a uniform model. But for other seniors, it's not necessarily uniform.

So I'd certainly like to commend this committee for looking at how they might support, review, and improve the quality of care for veterans. I'd be very pleased to respond to any questions or talk about some international perspectives.

The Chair: I am so impressed. That was 29 minutes and 48 seconds. Can you believe that? If only committee members could be as good with their time as our witnesses today. Well done, gentlemen.

We have party rotations here. First is the Liberal Party of Canada, and Mr. Valley, for seven minutes.

Mr. Roger Valley (Kenora, Lib.): Thank you very much.

Thanks for coming in this morning.

I find it a bit ironic for us on this end of the table that we're talking about aging. We all aged quite a bit last night. We had our Christmas party and we're feeling a little older this morning.

I can definitely sympathize with some of Mr. Lirette's comments. I serve a riding that is very rural, very widespread, with very small communities. You talked mainly about the services you're trying to provide and languages and everything else, but I'm sure that even in northern Quebec and other places in Canada, not only in my own riding, we get to where there are no services. We almost take anything we can get. Personally, in my home community, we don't have enough doctors. We have three doctors. There are supposed to be 16 serving there.

With the challenges of serving people as they age and with all the complications that come when you don't have services and you have to travel, it gets tougher; and then when we put the veteran into the mix, with all the issues that they can have, it just gets harder and harder.

So I definitely sympathize with all your efforts, and we're lucky we have people like you who are trying to provide these services. That's one of the strengths of Canada, that there are groups that try to step forward and bring everybody together.

I have some questions for Mr. Shaw.

I shouldn't generalize, but one of the things we do hear from some of our veterans is that they don't feel well served by the Department of Veterans Affairs. They feel that there are gaps and flaws. In your experience, is that a similar thing for veterans around the world? Is it similar in Australia? Do they feel that they're well served? We have guests up from the United States once in a while, and they don't feel that they're well served by some of their veterans departments when it comes to health care. And of course, problems always compound as we age.

● (1135)

Mr. Greg Shaw: If you asked veterans anywhere, they would probably say they're not well served by the veterans affairs department within their own specific countries.

Primarily, it is around the disbursement of access to service and who delivers those services, because no one agency in any one country delivers the range of support needs and services, from basic maintenance and support that one would need, to health care needs. Those are delivered by a range of agencies and organizations, with little regard for single-point entry of access, single-point assessment, or comprehensive assessment. So even veterans within the Australian system certainly would be saying exactly what veterans here are saying, that they're not necessarily well served.

It's because veterans affairs departments are generally trying to look at the health care needs and issues on a national perspective, because it's generally a federal responsibility within government. But in many cases, a lot of the services are delivered through provincial, state, and territory governments. So there are always some differences from province to province or state to state, and getting the national coordination is somewhat difficult.

So veterans, whether it be in Denmark, or in Australia, or in the U. S., would probably say similar things. But I think what Canada is doing in reviewing and looking at how to improve the access to health care and services is certainly going to support veterans as they age.

Mr. Roger Valley: Thanks.

I should have mentioned that one of the issues I have in my riding is that there are huge language issues, but they're generally not French and English. I have Cree and Ojibwa, because 60% of my riding is first nations. I have one of the largest populations of first nations in Canada, so there are all those other things that mix in.

When you think that a veteran comes home, and he's been serving with the Canadian Forces wherever, he speaks English or French, or he has the ability to do both. The problem is quite often recognized by people who don't speak either language in my riding.

It is a problem. But how do we get the information out? You talked about bringing the information to the people. We're not allowed to. There are privacy laws in Canada. For us, as members of Parliament, we can't get a list of the veterans in our ridings. We deal with issues. We deal with the Legions and everything else. But to get that information out before we get to that one problem, which is, as you emphasized a couple of times.... It is only when a crisis happens. So how do we build those networks when we're not allowed access to information?

This is for anyone who would like to answer that part.

Mr. Willie Lirette: I'm not aware of that situation. But to emphasize more what you said before when you talked about services in the language of your choice, the Government of Canada and the Société Santé en français have a good program going on. There is the development of professionals, for example. And one example out of that is the medical school that we now have in Moncton, a French medical school, which will train people in all kinds of professions to serve the community.

● (1140)

[*Translation*]

This is a means that the government has implemented to help train professionals and then ensure the presence of French services throughout the country. This agreement will expire in the spring, if I remember correctly, and it will have to be renegotiated. This is where the government should be aware of the success of Société Santé en français throughout the country and that it must be renewed in order to answer the questions you asked earlier.

As for veterans, I have made an effort in the past few days to obtain more information, because we were not necessarily aware of their situation. I have been told that the red tape is considerable. These people get discouraged and professionals are required to fill out the applications and help them in their quest for services. I remember the work done by Ms. Bradshaw when she was an MP, to set up the Centre de santé des anciens combattants in Moncton. I think it took three or four years for a decision to be made, and the veterans were on the fifth floor of an old hospital. Now, the service is excellent, but too much time has to be spent on paperwork for the provincial and federal governments.

In New Brunswick, we too have what is called a new government. In January, it eliminated all income from its list of eligibility criteria for admission into a nursing home, even veterans' income. Before January 1, when a veteran was obliged to go into a long-term care centre, this took up all his income, and his wife remained poor. I was told yesterday before leaving that in New Brunswick, this problem has been partly solved. But I think that your committee will have to see how these veterans' wives are treated when their husbands are admitted into a long-term care centre. Do they become poor? If you look at all women who did not work outside the home and who raised large families, whether they be the wives of veterans, fishermen or farmers, those are the poor women in Canada.

We have just learned that over 200,000 people are entitled to the Guaranteed Income Supplement but do not receive it because they were not aware that they were entitled to it. This is why we are urging the government to give us the means to go door-to-door and to make people aware of these things. This takes human resources. To date, the provincial government has made efforts in the area of social services and we have added many names to these lists, but there are still some 200,000 people who are entitled to the GIS. We have no way of contacting them. It seems to me that in the federal government's data base, they must be somewhere and we should be able to determine their circumstances. All we have to do is find a technological means of giving them this supplement, without their having to hire a lawyer in order to claim their benefits. I just wanted to add that comment.

[*English*]

The Chair: Thank you very much.

And now we're going to the Bloc Québécois, Monsieur Perron, for seven minutes.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good day, gentlemen. It is a pleasure to have francophones at the table, for once, so that we can talk a bit.

There is a consideration that touches me deeply. We talked about veterans of a certain age, but we mustn't forget our young veterans who are suffering from psychological trauma. However, I'm going to confine myself to so-called traditional veterans.

First I'd just like to give you a short history lesson. I want to send a message: on Monday, I will turn 67. So please don't forget to wish me happy birthday on December 10.

In my youth, the paternal grandparents were traditionally entrusted to the care of the eldest son and the maternal grandparents were entrusted to the care of the eldest daughter. That was the rule of thumb in Quebec society at the time.

This Quebec tradition was handed down to me, because of my venerable age. My mother-in-law died in hospital, but after her husband died, she came to live in my home. I took care of her without any government assistance. That's the way I was brought up.

But things don't work that way any more. We take old people—that's what I call them and that's what I consider myself—and we put them just about anywhere. Efforts have been made to establish a system so that these people can remain in their homes as long as possible. I approve of this system 300%, but it needs to be improved because old people are happiest in familiar surroundings.

I would now like to provide a bit of technical information to Mr. Shaw. I think that Quebec's health and social affairs system is the most advanced of all the Canadian provinces. For example, where else in Canada can you obtain assistance to build or adapt a co-generational home? Such a thing exists in Quebec. Where else in Canada can you find a system similar to that of our local community service centres, the CLSCs, that exist in Quebec and that offer health care to people in their own homes?

An intergenerational situation is difficult because many people would like to care for their parents in their homes. We can help them physically, but when they need health care, we are unable to help them because we are not experts and that is where the CLSC comes in.

I think that health care should be developed at the provincial level, with a federal tax rebate for families who provide health care to their elderly relatives, including veterans. Elderly people need home care, but we need the tools to provide it, and I think they are lacking.

Mr. Lirette, the politics 101 course that you gave earlier is highly accurate. Governments and politicians rarely think beyond the next election. They pass legislation with a view to being re-elected, instead of looking forward like any self-respecting company and trying to see where this country and this society will be in 50 years.

It is important to stay on the right track even when seeking to bring about change.

Those are the comments I wanted to make. If you wish, you may make other comments, or agree or disagree with mine.

● (1145)

Mr. Willie Lirette: I wouldn't go so far as to say that your health care system is better than ours. Each system has its own areas of expertise. But I get the impression that we also have what you described, and that other provinces do as well.

According to the most recent statistics on the health of Canadians, or local health boards across the country, there are still major problems, such as wait times to see a specialist. In New Brunswick, we have something called extramural hospitals, and we are the only province to have this type of thing. It's an asset for us. Indeed, as soon as a patient is discharged from the hospital, the patient receives care at home until he or she is well again. This program has been around for 20 or 25 years, and it works very well.

The aging situation you described is a real problem, and governments must stop and take its full measure, because one day they will have to deal with it. And if no plans have been made, we will be stuck with a major problem on our hands.

● (1150)

Mr. Marc Ryan: Mr. Chairman, I might add that in Ontario we are creating a system based on LHINs, Local Health Integrated Networks. They will bring together related services in a system resembling Quebec's local community service centres, which you are familiar with.

That being said, the problem remains for your anglophones in Quebec and our francophones in Ontario, namely—

Mr. Gilles-A. Perron: I'm sorry.

Mr. Marc Ryan: I don't want to get into Quebec's situation. I did not want to give you—

Mr. Gilles-A. Perron: I'm sorry. In Quebec, sir, there are eight hospitals for anglophones; and there's only one francophone hospital in the rest of Canada!

Mr. Marc Ryan: That's correct, sir.

Mr. Gilles-A. Perron: In any Quebec hospital, you can receive services in English, which is not the case for the rest of Canada, dear friend.

Mr. Marc Ryan: I agree, I will not challenge that.

However, in Ontario, we have taken great inspiration from the Quebec model for our approach.

The francophone minority in Ontario has a small problem: in some areas of the province, the LHINs are comprised of community leaders, so what happens when there are only 1 or 2 francophones on a board of 15 members? Francophones might therefore have serious concerns about whether services will be provided equally in both languages.

That being said, there is an alternative solution which we mentioned during our previous discussion. The Société Santé en français has thought of ways to make services more readily available to the public.

This is true for Manitoba as well, up to a certain point, and elsewhere, such as in British Columbia.

Mr. Gilles-A. Perron: That has been in existence since the 1970s.

Mr. Marc Ryan: That's right.

Mr. Gilles-A. Perron: It's been 35 years, specifically since 1974.

[*English*]

The Chair: Thank you very much.

Now we'll go over to the New Democratic Party for five minutes. Please go ahead, Mr. Stoffer.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chairman.

Thank you, gentlemen, for coming today.

One of the concerns in dealing with World War I, World War II, and Korean veterans—mind you, we only have one World War I person left—is the fact that when they joined the service, a lot of them had minimum education. It could be grade four, grade five, grade six. In World War II it would have been a little higher, but generally these people aren't what you would call academics; they were just your average Canadian, working for a living, and they joined the service.

Many years later, when they became elderly and were applying for services, they had to fill out the forms, and sometimes you need a Philadelphia lawyer just to figure the forms out. Would you not agree or suggest that when government sends out forms or information to people, the forms should be simple to understand, easy to fill out, and uncomplicated? That's my first question.

As you know, some of these individuals suffer from what in the old days was called shell shock, but now it's post-traumatic stress disorder. We had heard in a previous meeting from people who suffer from PTSD that filling out the forms on PTSD itself causes a tremendous number of problems. I'd like your advice on that.

Second is the situation of money. A lot of these veterans, you know, are really self-reliant. They're stubborn and independent. As they say, “I'll shovel my own damn driveway”, but they have a heart attack and die and leave the spouse behind, and then you've got a problem, right? As you said, sir, they need help—today.

Some of the concern, of course, is that when they reach age 65, some of their pensions are reduced from other pensions because of the way those programs were set in place years ago. I'd like your opinion on what the deduction of their pensions means, what the loss of some money at age 65 means, and what the lack of opportunities for pharmaceuticals means, because a lot of these people require access to pharmaceuticals, and depending on which province you live in, you may or may not get covered for something. Years ago in Nova Scotia you couldn't get covered for Aricept, which is for Alzheimer's, but in New Brunswick you could, so people were asking if they had to move to New Brunswick to get this care.

Those are some of the ongoing concerns. No federal or provincial government is going to solve all the problems overnight, but I think collectively we can. I'd like your advice or your discussion on those words, please.

Thank you.

● (1155)

[*Translation*]

Mr. Willie Lirette: As concerns forms, when people submit applications for benefits or for federal government projects... I have been involved with seniors' associations and I have been a member of the Fédération des communautés francophones et acadienne du Canada for 20 years. We have recommended countless times to government officials to simplify the questionnaires so that people can complete them more easily. You know, the illiteracy rate in Canada is very high, this is a serious problem and nothing is being done about it.

For example, last week, I received an application form for New Horizons, a program to help eradicate senior abuse. As a provincial organization, should we hire someone to fill out this form? It requires vast knowledge of "bureaucratese"—if you will pardon the expression. As volunteers, we are not capable of filling out this form. I learned the next day that this program only has funding of $1.8 million for all of Canada. So we decided not to go ahead with the application because there is insufficient funding. Everyone in Canada is going to fight for a small portion of the $1.8 million allocated to counter senior abuse. We gave up because it would have cost us more to fill out the questionnaire than the money we would have received.

The high illiteracy rate is a major problem and one that is not always understood by government officials. I understand why: these officials are learned experts in the area, but that does not meet community needs. As volunteers, we are often called upon to help people fill out their application form for the Guaranteed Income Supplement, for example. It is a serious problem for these people.

You referred to veterans who have a low level of schooling. They are not always available. When they listen to the radio, watch TV or read the newspapers, they don't always understand what they are reading because it is not their everyday vocabulary that is used. In this regard, I think that it is a serious problem.

Mr. Marc Ryan: I would like to talk briefly about post-traumatic stress disorder.

When a soldier applies to the Canadian Forces to obtain the status of veteran, I am convinced that psychologists analyze his file. In addition, before soldiers are deployed abroad, their abilities are evaluated to a certain extent.

I firmly believe that all veterans should receive follow-up for a minimum of 10 years, during which professional psychological treatment should be offered automatically and on a mandatory basis. As we know, there are after-effects from combat. That's my opinion concerning post-traumatic stress disorder. As concerns education, I agree with you.

I am now going to speak about poverty among veterans. To prepare myself for today's meeting, I spoke with some friends who are veterans. One of them asked me to tell the committee that in 1967, the government of the era combined the veterans' pension and the National Defence pension, which means that today, some 40 years later, this friend of mine has seen his income decline by 22%. This figure can vary between 20% and 30%. Today, a more sophisticated term is used: withholding. My friend asked me to request that the government abolish this withholding for members of the Canadian Forces.

To ease the pressure of poverty on veterans, this withholding could be eliminated.

● (1200)

[*English*]

The Chair: Yes, of course.

Mr. Greg Shaw: If I might make one comment or a couple of very quick comments, I certainly recognize the issue around access to medications across Canada, and it's an issue for veterans that there isn't a uniform access to medication charter in this country. It does depend on where you live as to what medications you're eligible to receive, whether they're priority one or priority two meds. I think that's an issue that does need to be addressed.

I think the other important point that needs to be recognized is that with the Second World War veterans we're talking about a cohort of people. I think you could talk to them, and probably nine out of ten would say they don't need or want for anything and their health is not as bad as John's health and they're not old. It's all relative. Most veterans today come from a background of fighting for what they have, not asking for help, and they continue not to ask for help even when they're in dire circumstances. They would probably prefer to die shovelling the snow in their driveway.

So it is an issue on how you get information out and communicate to veterans groups and organizations that people have eligibilities and access to services to support them. It's a way of packaging and selling things that is not a handout to veterans.

One of the examples I can give you is from Australia. Veterans were more comfortable paying for a service than receiving a service for free. If they were going to receive personal care at home, they would be much happier paying $5 a week than receiving that service for free, because they're not interested in receiving a handout. Australia does have a co-payment system, as low as it is, but the take-up of services is probably quite a bit higher in terms of access to services by veterans because they don't see it as a handout.

That's my comment.

The Chair: God bless their generation.

All right. Now we're over to the Conservative Party and Mr. Shipley for seven minutes.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Mr. Chair.

Thank you to the panel for coming out today.

This is part of a discussion we've been having for quite some time about not only VIP but also post-traumatic stress. In the midst of it, we've brought in an ombudsman for veterans, which this country has never had. It was one of those gaps in services for our veterans that has now been filled, I guess you might say. So we're thankful, and we know that they also are thankful for that.

Things sometimes get to the point where veterans have issues in terms of getting services. I think we all agree that we have to, that we need to, quite honestly in government at all levels—I can't speak for the provinces, but I have to make some assumptions about federal, and I was involved municipally—make things less complicated for people in terms of forms. We need to continue to try to improve on what we do to simplify, to make forms understandable, to not just try to prove to people how bright we think we are by developing these complex forms.

Mr. Shaw, I very much appreciated your presentation, along with your nice lingo and language.

Can you tell me, is there a coordination of recommendations? When we talk about veterans, we talk about veterans in Canada, but there are veterans around the world, especially in our free and democratic countries. Is there a coordination—of communication, of packaging, of what works best—across borders?

Mr. Greg Shaw: There certainly is dialogue, not generally at the government level but at the bureaucratic level within government. I know that when I was in government, I had many delegations from other governments around the world visiting my office to talk about programs and services in Australia.

As I read them, the veterans services or veterans programs available here for veterans are very similar to the programs and services available to the veterans in Australia. They're packaged differently, but they're similar to services around the world.

I think there is more of an acceptance to look at models from outside your own borders and your own country. It's the same for many countries. The federal government in Australia isn't necessarily interested in what the west Australian provincial government is doing in terms of falls prevention because the federal government has a better falls prevention program. But our falls prevention program federally is modelled very much similar to the Canadian falls prevention program.

So there is a transference of knowledge and information across countries, but it's probably not enough. There aren't enough avenues or venues for governments to really talk and dialogue about good practices that are happening in other countries for veterans.

● (1205)

Mr. Bev Shipley: If you had some thoughts or recommendations on how that might be improved and what we could do as a veterans committee to support or to help move some of that to a next level, I would appreciate that. It doesn't have to be today, but I would appreciate that very much.

I think all of us agree, and certainly the veterans agree, that it is good if they can keep their independence longer within a community, within their own social structure. I was very much interested in your comments about what has happened in Australia with aging veterans who actually don't want a handout, who want to feel worthy, who want to pay for it.

Obviously there will be some who can't, but I think in Canada we tend to think that we have to not do those sorts of things and give people their independence. One thing that happens, though, is that to keep people in their homes, whether it be in their homes or in a seniors complex...and you know, quite honestly, in some places that works well. They actually are with other people of the same age, enjoying recreational facilities and the entertainment that comes with it.

But we have trouble in Canada, as I think many do, with the numbers of professional people in our towns. We don't have doctors in our towns, and we don't have some of the other professional people needed. Obviously when we get to veterans, we have the same issues if we're going to provide some of these services to our veterans to keep them longer in their homes.

I'm wondering if any of you have any thoughts on how we can coordinate or work with the public sector to try to make sure we have professional services for our veterans who need those services that will help keep them in their homes.

I don't know if there is an answer, quite honestly.

Mr. Greg Shaw: I could give you an example. If you're talking about specific programs and services that are managed or supported through the Department of Veterans Affairs, government, in a number of countries what they do is actually license care providers to be the delivery arm of the packaged services they deliver.

In Australia there would be probably 2,000 organizations that are licensed to be providers of veterans' home care programs. So it doesn't matter whether you're in a small rural town or whether you're in a large urban setting, there are NGOs or organizations that can deliver those services. It might even be through what we would classically know as a bush nursing post in Australia, where it's in a very small indigenous community and the only infrastructure is a small nursing post that those services would be delivered through.

So there is a way of delivering and packaging services, but it's a question of how you get that national consistency.

Mr. Bev Shipley: I know that in Ontario we have the VON, which is just an amazing and incredible organization that's focused around treatment, but they've branched out into many different aspects of home care. It is amazing what they do, because of the volunteerism and because of the funding that they raise just in the community because of their good work.

I believe I'm out of time. I'll maybe get back. Thank you.

● (1210)

Mr. Greg Shaw: Could I make one quick point?

The Chair: Witnesses are allowed all the discretion in the world.

Mr. Greg Shaw: There is always, I think, a disadvantage when you package up the health care needs of older people as opposed to the care needs of older people.

If you're talking about medical interventions and if you talk about leaving people in long-term care facilities, the amount of medical intervention they need in a long-term care facility would generally be under one hour per week. All the rest of the care is really social, personal care. It's not a medical intervention. So I think there is a problem when we put all of the health care and social care into a health model or health budget.

The Chair: All right. Thank you very much.

Now we are back over to the Liberal Party of Canada, and Mr. Russell, for five minutes.

Mr. Todd Russell (Labrador, Lib.): Thank you, Mr. Chair.

Good afternoon to our witnesses.

I listened with quite a bit of interest to your presentations. The demographics are that we're an aging population within Canada itself. I think there are some statistics showing this is the case even within our military. We have an aging military.

It is very timely that you have come before this committee and presented the evidence that you've presented.

I want to ask some very specific questions. They may seem simple.

What's your operating principle for a senior? When you say “senior”, who are we referring to? In government sometimes when we talk about youth, it goes anywhere from 14 to 18, sometimes to 25, and for some programs it could be up to 35 for applicability reasons.

What do you classify as senior?

Mr. Greg Shaw: In terms of my organization, we classify senior... it's a life course. It is a life course approach to aging. So if we were in Sierra Leone, I don't think any...actually, there are a couple of males who are under the age of 37 here, but all the rest of us would probably be dead. So if you're in Sierra Leone and you're a male, at 37 you are probably considered old. If you're in Japan 70 is considered old, or older. But if I speak to our main representative at the United Nations, Helen Hamlin, who this year turns 87, she would say she's not old.

Governments make an arbitrary benchmark around aging. In Australia, if you're an aboriginal, at 50 you're considered a senior or you're eligible for what someone at 65 would be eligible for.

Mr. Todd Russell: I can understand there are cultural sensitivities around the concept of aging. I am sure that must be taken into account when you do your studies on aging, the impact of aging, what is required, the services, and that type of thing. Specifically in Canada, what are your operating principles, so to speak?

[*Translation*]

Mr. Willie Lirette: There are about three different categories. There are those who are aged 55 and over and who are still in the labour force, there are the baby boomers who are better educated, have greater financial resources and are more professional, and then there are people of my age, 75 and over, who are retired, often illiterate, and who often have a different concept of senior than we do.

In our association, we accept members from the age of 50. That is how most seniors' associations in the country function. However, we cannot offer the same activities or make the same demands for baby boomers as for veterans, for example, who are usually much older. Many Legions are closing their doors because there are not enough veterans. Many seniors' clubs are having the same problem: they are not adjusting their activities to the new retirees that we call baby boomers. The latter are computer-literate, play golf and enjoy different activities than do older people.

In my opinion, we must take into account all three of these categories.

● (1215)

[*English*]

Mr. Todd Russell: Let's say 50 and up, then you're somewhere in the senior category. What portion of our veterans would meet that sort of test, 50 and up? Does anybody have that number?

Mr. Marc Ryan: How many?

Mr. Todd Russell: Yes, of our veterans. People have different notions of veterans as well. Is that figure available?

Mr. Marc Ryan: I wouldn't have the statistics on the veterans who are 50 and up. But I believe the statistics are in existence for 65 and up. They're easily identified because of Service Canada and those statistics-gathering techniques and the method of counting.

Mr. Todd Russell: I come from a very rural riding, Labrador. There are a lot of small communities spread out along the coastlines, some in the interior. I think we have something akin to the bush nursing post in Labrador.

Has much study been done on a comparison between services available in urban and rural remote or northern remote areas? What has been found? Is there a lack of services generally or a lack of availability or access in rural remote as compared to urban areas? What kinds of suggestions do you have about that?

I'm sure the Australian experience must be similar, given the huge dynamics of the country. It has the same feel as Canada. I'm wondering what you can tell us about that urban and remote rural mix.

[*Translation*]

Mr. Willie Lirette: There is no doubt that there is a difference between services offered in rural areas and those offered in cities. For example as concerns Moncton, where I come from, the rural population comes to Moncton to obtain services. New Brunswick's three major hospitals are located in Moncton, Saint John and Fredericton, the northern part of the province. I am sure that the same problem exists in Ontario, Alberta and Newfoundland and Labrador.

Another problem in rural regions is the lack of public transit. In cities, public transit exists. Based on the 2006 population statistics published by Statistics Canada, seniors and the population at large from rural regions tend to move to capitals or large cities. Services are more readily available there, especially treatment for cancer and other diseases.

In New Brunswick, there is a veterans' hospital, but it is located in Moncton. This means that veterans from the northern part of the province must move to Moncton and end their days there. The rural versus urban situation is a definite problem.

[*English*]

Mr. Todd Russell: I'd like to hear Mr. Shaw on that.

Mr. Greg Shaw: It's not that. If you're in a rural or remote area you certainly are disadvantaged in terms of access to health care. It doesn't matter what country you live in. It's the same everywhere. It's a question of what services are available to get people to health care services and what services can be developed that are going to support people within their own community.

I think there are some good examples of very small community nursing posts and nursing stations that certainly do support small communities. In some rural settings, people have access to general health care more quickly than most people in cities have access to health care.

There are both disadvantages and advantages. If you're talking about specialist care, clearly specialist care is delivered in major urban settings. So there's got to be transport and support mechanisms to get people to those specialist care networks. I don't think any government can say we will have equal access to specialist health care, no matter where you live. No government can do that.

The Chair: We'll now go to the Bloc Québécois, to Monsieur Gaudet, for five minutes.

[*Translation*]

Mr. Roger Gaudet (Montcalm, BQ): Thank you, Mr. Chairman.

I am lucky because my mother turned 98 in October and I spoke to her last night at 10:00 p.m. She is in great shape. Mr. Perron was talking about this. Our father died at home and we would also like that to be the case for our mother. I think it's a matter of attitude, but it is quite probable that it will be different with the baby boomers. We tend to congratulate each other because nobody else congratulates us very often. So let's give ourselves a pat on the back.

Mr. Marcel Gagnon travelled across Quebec to study the situation of seniors and the Guaranteed Income Supplement, and I believe that other provinces were also involved. It was a good thing. In fact, one of our MPs, who is a priest, is also doing the same thing.

I wonder whether we should not also undertake a travelling study with regard to veterans. I don't know. We should perhaps launch a crusade to inform veterans of their rights. Last week, we met with someone who, for seven years, has tried to be recognized as a veteran. He served in the armed forces for 20 years. He fought in the war in Bosnia. In fact, he fought in several wars. So he has been trying for seven years, and he still has not been recognized as a veteran. This means he does not get a pension, and he also suffers from post-traumatic stress disorder.

This is what I'd like to know. In your opinion, how can we best help these people? As you said, it will probably be quite different for baby boomers. I get the impression that it's not the member of the Quebec Federation of Senior Citizens or of the Fédération des aînées et aînés francophones du Canada who are causing a problem. Rather, I think it's those people who are not members of these organizations.

I don't know what to do. A little earlier, you suggested a solution familiar to the government. I would like to find solutions. I think that we all know what the problems are. Now we need solutions.

I would like all three of you to respond.

● (1220)

Mr. Willie Lirette: It is not easy to find solutions. Research tells us what we need to do. I don't have this research with me now, however. Last week, I attended a conference on research into aging which was held in Ottawa. Every researcher said that seniors had serious nutrition and health problems. If I want our associations to work with veterans, I will have to contact them, which is something we have not necessarily done.

Many veterans are members of our associations. But they are simply regular members, and do not have the status of veterans. It's important to find out what it is that veterans want, who they are and what their problems are. I had the impression that the new veterans' hospital in my area had addressed that problem in the province. I don't know what the situation is elsewhere in Canada.

The solution is to see what is being done at the local level and to trust people. Our association has a network of 300,000 people, including the Quebec Federation of Senior Citizens. We could really help seniors and I believe we can do a better job than government. We have good projects, but once they're over, we don't have the means to carry on. When we have a nine-month project and we study a situation, such as elder abuse or transportation problems, once the project is over, there is no follow-up. We find solutions, but we cannot apply them. I'm talking about small, short-term projects which do not necessarily meet the needs of seniors at the local level.

The problem is that the government studies the issues, develops projects, and once the projects are over, it washes its hands of them.

Mr. Roger Gaudet: Mr. Ryan.

Mr. Marc Ryan: Mr. Gaudet, I would like to add the following. If you and I, together with the seniors' organizations in your riding, used electoral lists to find out exactly where neglected seniors are living, we could put together a group to meet with them. I think that's the solution. I would not want to indoctrinate them politically—

Mr. Roger Gaudet: No.

Mr. Marc Ryan: All I want is to see if they have needs and to define these needs. It's what I would call screening. But when you try to do screening, there can be problems with the Privacy Act. In my view, it is easiest for our small community organizations to reach these people, in their homes, rather than with a purely federal program.

● (1225)

Mr. Roger Gaudet: And you, Mr. Shaw?

I'm interested in hearing Mr. Shaw's response to this. Since he works for an international organization, I would like to hear his solutions.

[*English*]

Mr. Greg Shaw: There is a mechanism to track veterans. You're not always going to get feedback or access to veterans.

I'll make a point. My father was a Second World War veteran. He never belonged to any returned service league association, but he was known as a veteran because he held a gold card in Australia, so we knew—all the veterans in Australia.

Generally there are ways to get information to inform government about issues and needs of veterans. I look at the network of returned service league associations that exists worldwide, and there must be returned service league organizations across Canada that can come together to inform government of the issues of veterans, whether it be concerning what specifically government is looking for or something else.

Within the Australian sector, we consulted heavily with the NGOs supporting veterans about the issues and health care needs and the programs needing to be developed to support their ongoing needs. That was an ongoing review process. The minister for veterans had an advisory council that reported back to the minister on the needs of aging veterans.

The Chair: Thank you very much.

Mr. Hawn has been incredibly gracious in standing in for Mr. Sweet for this meeting. He came over with me from the House of Commons. Of course he's very much involved with the national defence committee on a regular basis, and what have you.

Subbing for Mr. Sweet, it is now his chance to ask a question, with the committee's consent.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you very much, Mr. Chair, and thank you all for being here.

As a veteran, I want to make a quick comment on the clawback thing, and then I have a couple of specific questions for Mr. Shaw.

There is no clawback. What has happened is that when veterans retire, they go from one source of retirement pension, which is under the Canadian Forces Superannuation Act, plus the bridge benefit, until they hit age 65. They now get it from two sources: the Canadian Forces Superannuation Act plus the Canada Pension Plan.

The Canada Pension Plan is designed to replace the bridge benefit. The amount of Canada pension somebody gets will depend on what they've done from the time they retired at, in my case, age 47 until reaching age 65. If somebody has done very little to qualify for CPP over that period of fifteen to eighteen years, then the CPP they get is going to be smaller.

It's not a clawback. Both programs are working exactly as designed; we're getting exactly what we paid for from both.

We can go back and argue with the design, if we wish, and that's fair, and going forward that may be something somebody might want to look at. But the personal contributions people would have to make in the military would go up very substantially, and they would probably not be happy with that.

It's an emotional issue, and I understand that, but the facts around it are not well appreciated by a lot of veterans. I get people pinning it on me, as a veteran and now a member of Parliament, and asking, “Why aren't you supporting it?” Well, guys, go back and look at it; it's working exactly as it was designed. Argue with the design if you want, but we're getting what we paid for.

That said, Mr. Shaw, you have some good experience, obviously on the Australian side and on the Canadian side now, with exposure to both systems. Can you give us a couple of examples of strengths and weaknesses within the Australian system and the Canadian system, with a view to things we might look at and should be considering here?

Mr. Greg Shaw: Certainly I can talk about some strengths—and weaknesses.

The Australian system is a national health care program. The entire health care program is nationally administered and delivered through the state or territory governments, but it really is controlled at the federal level. The aged care system in Australia is also a federal system and is controlled and delivered federally. Veterans services is exactly the same.

The advantage is that you get consistency. You have a national health care system; you have a national pharmacare system. People have access to the same level of services, and regarding the costs of those services, it doesn't matter where you live.

But there are some disadvantages, areas where the Canadian system has advantage over the Australian. The Canadian system of delivering health care offers greater opportunities for innovation and development of best practice, because governments provincially can step outside of things that are happening in other provinces and develop their own programs.

While it's an advantage, what I don't see is that the good practices that occur are being translated to other provinces. Is anyone here from British Columbia? B.C. has a very good program for seniors called ActNow BC. I've spoken to people in six or seven different provinces and asked if they knew anything about ActNow BC. They have never heard of it, yet it's a very good program.

That's my point. You have a great system here that encourages innovation and good practice, but you don't share it; we don't learn from it. In Australia, we hinder innovation, because it's a totally federal system.

● (1230)

Mr. Laurie Hawn: Thank you for that.

This is a pretty specific thing. It's a situation I was not dealing with, but that was around just last week. We talked about access and making information available and about checklists for where you get service, and so on. One thing I would throw out as a suggestion and to get your comment on is the idea of a checklist at death for veterans —not for the veterans themselves, but for the veterans' spouses.

I was in a situation last week in which a close friend of mine had passed away from cancer, and his wife was dealing with it. She had three people assisting her, three fellow veterans. One was a former chief of the air force and the two others were very senior officers in the air force. They had a real challenge in piecing together all of the things that a widow in that situation, who is obviously under stress, needs to deal with in terms of all the benefits and everything that's there.

It would seem to me that Veterans Affairs Canada should have a one-stop checklist—we talk about one-stop shopping—with all the things you need to do or all the agencies you need to contact. Some of them aren't within DND. Some of them are within DND, but there's the Canada Pension Plan and a whole bunch of different things.

Has anybody contemplated a checklist upon the death of the veteran to help the survivor?

Mr. Greg Shaw: In a number of countries where they've developed single access points for veterans with information on services, they would generally have that information available for widows. One of the issues in many countries is that once the veteran dies the widow is quite generally entitled to all the benefits, pensions, and so on from the deceased spouse. It's a minefield for those people to go through, in terms of wanting to know.

In countries that have developed a central point of referral, quite often it's for information or counselling lying within the departments of veterans affairs, and that's where it occurs.

Mr. Laurie Hawn: It doesn't occur here, and I think that's something we should look at.

The Chair: Fair enough. Thank you very much.

Now we'll go back over to the Liberal Party, to Mr. St. Denis. for five minutes.

Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.): Thank you, Mr. Chair.

Thank you, gentlemen, for helping us out today.

The comments that Mr. Shaw made in the most recent conversation with Mr. Hawn contained a very important point, that being the lack of a system or a regime to share best practices. That's unfortunate, because delays in adopting best practices potentially hurt the people who.... They are lost opportunities.

In the last meeting we had a witness from the Gerontological Advisory Council, and there was a researcher with the department. They talked about some pilot projects that involved tracking a group of veterans and in some cases their spouses. I think it included B.C. These people were on track to get older and go to a nursing home without any home care, whether it was just shovelling a driveway or helping with the grass or cleaning a house. We don't automatically associate these things with health, but I think most of us certainly would agree that they are health-related. If you're not strong, you can't cut the grass. If you can't cut the grass, it's less possible for you to stay at home. It can be a vicious cycle. They also tracked a cohort of veterans, in some cases with spouses, who did have home care. They did an analysis. This is a crass measure of success, but they used monetary cost. What was the cost to the country of one group versus the other, on average? They found that on average, those who got home care cost the system less.

Now, add to that the quality of life, of being able to stay in your home longer—even until your final hours, if possible—versus having to live in a home. Those are difficult to measure, but they are certainly benefits.

From either of our two delegations here, or both, is it your view that the study represents, anecdotally, the truth? It comes back to best practices, because we should be adopting this generally—not only for veterans but generally. Does it make sense to help people to stay at home longer, not only for quality of life but for cost?

● (1235)

[*Translation*]

Mr. Willie Lirette: All the research indicates that what you have said is true. The more the government helps us to promote health, for instance through a physical fitness program...

We have a program called "*Grouille ou Rouille*", 'Move or Rust", which has been in existence for 30 years without receiving any government funding. In southeastern New Brunswick, 700 people participate in this program. We have just convinced our new government just how important this program is for maintaining good health.

All the research supports what you said. The longer seniors are active and independent, the less it costs the health care system. This is a fact that is supported by research throughout the country. However, there still is not enough money in this type of health promotion.

I mentioned earlier in my presentation that in my province less than 1% of the total health care budget is spent on health promotion. The rest goes towards finding cures.

We have many exercise and health promotion programs, and forums on health. Health Canada has supported us greatly in this area. However, it seems that the federal and provincial governments do not realize that health promotion is important.

Recently, there was talk about giving us a program on elder abuse, but there was not enough money for us to develop a good national program which would mirror the one we have.

Yes, it's true, and research proves it. I can produce other research if you want showing that home care reduces the cost of health care, and this is important to seniors who wish to live independently as long as possible.

Mr. Marc Ryan: Every study shows this, and any investment the government makes in home care is done because it's much cheaper.

[*English*]

The longer we can keep someone at home, the better it is in terms of cost. There's no doubt about it.

There is a checklist, which is yay long. There are just so many services—I've gone through this exercise with my own parents—as to cutting nails, taking baths, and all of these things as we age that we can do less and less. With a number of things, we approach a time when it's beyond home care.

[*Translation*]

That's when spaces in a long-term care facility... We need a home for these people. It's a very relevant issue. This is just the tip of the iceberg: soon there will be a great number of people who cannot be cared for any more by their natural caregivers. What's more, there are no spaces. Waiting lists are already very long.

● (1240)

[*English*]

Mr. Greg Shaw: What is shown through the provision of home care services is that traditionally when people were looking at moving to nursing homes or long-term care facilities, 15 to 20 years ago, they were seen as accommodation options. Mom can't cope at home anymore, because Dad's gone; it's too much work, so she needs to be in a nursing home. And that was the only option. So the average length of stay of a nursing home resident 15 years ago was probably five to 10 years.

If you talk about the average length of stay of a nursing home resident today, I'm not sure what the statistics are for Canada, but in Australia it's less than two years. When I started in the health department, it was five years. So you can actually measure the success of your home intervention programs by the decline in the average length of stay in a nursing home.

It would be great if the average length of stay in a nursing home was under a year, because we know that people are being supported at home for much longer, with only very short-term interventions in a very unfamiliar setting in long-term care.

The Chair: Thank you.

Now we're moving over to the Conservative Party. And Mr. Cannan, I just want to say thank you very much for having accommodated Mr. Hawn.

Mr. Ron Cannan (Kelowna—Lake Country, CPC): Oh, it's a pleasure. We're all a good group here working together to improve the quality of care for veterans. I think for all that's our goal. I appreciate our witnesses being here today for our meeting to see how we can move that agenda forward as soon as possible.

Mr. Shaw alluded to it, and I'm very familiar with the ActNow BC program, as I come from British Columbia and represent the area of Kelowna—Lake Country, which has demographics of the highest senior population in Canada, according to the CMA.

Looking at it from a veteran's perspective, we talk about improving quality of care—the old ounce of prevention, pound of cure. There's reference to some reports of quantifying, and I know that it's very difficult. I spent nine years in local government, and coming to the federal government...we don't do long-term planning. In local government there's usually a 20-year plan, and in federal government, as you alluded to, you don't look at the long-term perspective.

One of the challenges is the partisan nature, and it doesn't matter which party is in government. I think it's always a realistic perspective of provincial and federal politics. How do you see that being overcome? Do you have some quantifiable studies where you can actually show the figures? We know from a common sense and logical perspective that it is, but have you been able to do any studies over a time period of 10 to 20 years to actually quantify that research information?

Mr. Greg Shaw: There have probably been a number of research projects around the differences of how health care or home care is delivered, whether it's federally or provincially.

You're talking about municipalities having 20-year visions and federal governments having four-year visions. I think a lot of the visioning comes from the senior bureaucrats within government. There's no doubt about that. They're the long-term strategic thinkers and they generally help shape programs and services and relate with other provinces around what's going on. And the government either supports or doesn't support that agenda.

I think some of the difficulty is that new governments are elected and come into place and do want to change things, and they do change things marginally. They don't necessarily pick up on good practice that has happened elsewhere. And it's a challenge for government; there's no doubt about that.

For all parliamentarians I think there has to be a mechanism where people put aside their party relationships—provincial relationships, federal relationships—to actually talk about the common good of a target population or cohort, and that, in this particular case, is veterans. How do you come together to actually support cohesively the support of veterans so they receive the same level of service where they are? While there's probably been a number of reports that talk about the disparity and differences, I don't think probably much research has been done on how those things can actually come together.

● (1245)

Mr. Ron Cannan: I appreciate that.

My colleague has one quick question, and I have one more supplemental.

Looking at the veterans independence program that we have today, does either of you have any recommendations to put forth in terms of how we can improve the program or any additional services that should be added to the program? You mentioned a multi-disciplinary, one-stop shopping perspective.

Mr. Greg Shaw: There are always ways that you could improve programs. Certainly for the veterans themselves, it's getting access to information easily. So a single-referral access point would certainly be beneficial for the veterans themselves.

Having a multidisciplinary team approach to assessment that actually looks at early intervention in terms of health promotion as well is certainly a key, right through to the geriatrician who can look at the geriatric health care needs of older people, but it would include a social worker. So a multidisciplinary assessment team certainly would help, so that people aren't being referred to multiple sources from time to time.

The other challenge, I think, is getting assessments accepted nationally. If my mom is going to move from Montreal to Toronto, she's going to have to go through a whole new assessment process; it doesn't matter what service she needs. So there's no portability of assessment processes or acceptability of what other people do, and I think, somehow, a single referral and assessment point with national acceptability would be a good thing for veterans.

Mr. Ron Cannan: That's a good point. We have that same problem with the trades. Trade barriers are one of the big stumbling blocks interprovincially in our own country.

The Chair: Just to let the committee know, we would be reverting over to the opposition, but the given member is not.... Bear with me. I don't think I'm officially allowed to refer to who's not here, but you know what I mean.

So now it goes back over to the Conservative Party and Mr. Sweet, and then it's followed up by the Bloc.

Mr. Sweet.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Thank you, Mr. Chairman. I have just two brief questions.

I regret that I wasn't here earlier to hear all your testimony, because certainly what I've heard right now has been very good.

Mr. Shaw, I understand that a question was asked earlier comparing Australia and Canada, but how many countries have you had experience in, in analyzing geriatric care globally? Lots?

Mr. Greg Shaw: Lots, yes.

Mr. David Sweet: Okay, good. That's all I wanted to know. As I said, I wasn't here earlier and didn't know your experience and credentials.

Mr. Greg Shaw: We've worked with research institutes all across the world in terms of issues around older people.

Mr. David Sweet: Okay.

I guess it's probably not fair to say that home care is emerging, but because of what appears to be some time it's taking to actually implement it, it's still an emerging practice. Where do we stand internationally, in terms of the other countries you've looked at, in getting on board with this idea that my colleague had mentioned earlier, that it makes very good sense morally, ethically, and financially to have more residential care for seniors?

Mr. Greg Shaw: It's hard to make direct comparisons country by country, because health care systems operate differently, but if I talk about some good models or good practices, the move is away from residential care. The move is for governments not to be involved in the delivery of residential care services. So you don't have nursing homes anymore that are owned and operated by government or provincial governments, in many countries, and that has been a move over 15 to 20 years, the reason being that it's difficult for a government to implement and measure itself against quality improvement or quality assurance principles, and it's very difficult for government to criticize itself.

Governments that have recognized that have looked at strengthening quality assurance systems within home care and long-term care, but the delivery of those systems is very much within the private sphere or the not-for-profit, non-government sphere. Governments are packaging services much more that look at making the services fit the basket of needs that the veteran has, rather than the veteran having to fit to the basket that the government has. So they're packaging care services to what they might call a community aged care package, in a number of countries, and those packages are worth about $12,000 or $13,000 a year, but those packages contain a whole range of services based on an assessment from a multidisciplinary assessment team. They're good things that certainly happen.

The move away to more residential settings of long-term care facilities, to make them more like home, certainly has been an emphasis for 10 years.

So those are a couple of comments.

● (1250)

Mr. David Sweet: I'll just zero in on one thing, because we had some previous witnesses whom I'd asked, and it wasn't part of the study they had done.

In the models that you've discovered, are there some cost-benefits in those suites of services to having home visits by physicians, where now you have the apex of the professional services in actually being able to monitor precisely how long this person can stay at home and still be in good health and well served?

Mr. Greg Shaw: Multidisciplinary teams, which are established by governments or funded by governments, do the visits into individuals' own homes and meet with families and the individual care recipient to go through those assessment processes, and certainly that's beneficial.

More and more within the health care system, the general practitioner is not going to individuals' homes, particularly older peoples' homes anymore, so they're still having to go to a general practice in public hospitals or their local clinic. But if they're looking at development of services to support them as they age, they're referred by their GP or an independent, me or you, to an independent multidisciplinary assessment team that is, in a number of countries, funded either by provincial governments or by federal governments.

Australia has 56 multidisciplinary funded teams across Australia to do assessments around that issue, which is a federally controlled system.

Mr. David Sweet: Do the other witnesses have anything to say, Mr. Chair?

The Chair: If they wish.

[*Translation*]

Mr. Willie Lirette: There are different systems in each province.

In New Brunswick, for the past 30 years, we have had what we call home care services or the extramural program. It works well. This program provides care to patients once they leave the hospital, for as long as they need it. Services offered include physiotherapy, social services and all medical services required, except for services from a physician, who does not go to the patient's home. However physicians will go to long-term residential care centres. This is a service offered by the program. Naturally, the extramural program, because it offers care in the patient's home or in a nursing home, places less stress on the regular health care system, for example, on hospitals. Patients who, 10 years ago, had to spend two weeks in hospital now spend two days. This means that more beds are available.

However, there is a problem: some seniors are hospitalized while waiting for a space in a long-term care centre because they have lost their autonomy. This is a major problem that all provinces are currently experiencing. There are too many seniors taking up hospital beds that are thus not available for emergencies. This is a major problem in both hospitals in Moncton. Over 200 elderly people are awaiting spaces in long-term care centres, but there is simply not enough room.

Also, seniors are now in better health, living longer and have less need of services. There are only 2, 3 or 4% of all seniors in long-term care centres because they have lost their autonomy. All the rest are active in society, and the longer we can keep them active and independent, the less it will cost our health care system. This is a fact proven by research, once again.

● (1255)

[*English*]

The Chair: Now we go to the Bloc Québécois, and Monsieur Perron, for five minutes.

[*Translation*]

Mr. Gilles-A. Perron: First, sir, I would like to thank you for your testimony. I share your concerns about health care for seniors. Like you, I think that we have and we will have more seniors in society because people's longevity has greatly increased over the past 25 years.

I am a great believer in home care and I am aware that major efforts must be made in this regard, because natural caregivers lack assistance. There are not enough medical personnel to provide services in people's homes, there is a lack of funding, and there are many areas that must be worked on. Like you Mr. Lirette, I hope that the provincial, municipal and federal governments will start developing a long-term vision rather than focusing on the next election and working only to get re-elected. We need a long-term plan.

Those are my comments on what you've said. If I have forgotten something, feel free to comment.

Mr. Willie Lirette: I know that time is running out, but you referred to natural caregivers. Most of us here would not have the skills required if all of a sudden a member of our family, our spouse, for example, became incapacitated and we had to care for him or her. What we recommend—

Mr. Gilles-A. Perron: I would like to clarify something. What I mean by a natural caregiver is someone who cuts hair, mows the lawn and other things like that. There are also medical caregivers. That is another group.

Mr. Willie Lirette: Natural caregivers, for the most part, are spouses or other members of the family. We recommend a training program even before these things occur in a family. I don't think anyone is ready to provide such care or do all this work. For the past few years, we have been asking the governments for training programs for natural caregivers.

Mr. Gilles-A. Perron: I agree with you.

[*English*]

The Chair: We have a very short period of time left, and I'd like to try to get some other issues dealt with very quickly.

I thank our guests tremendously for their appearances today. I think your testimony has been very useful with regard to the questions we're addressing and the report we hope to put out shortly.

Please forgive us if we now turn toward some travel issues coming up for the committee.

Thank you very much for your appearance.

● (1300)

Mr. Greg Shaw: Thank you very much.

The Chair: Thank you.

Committee members, you just had the papers passed to you. All we're really looking for is approval by the committee so we can take this to the Liaison Committee.

We discussed this previously and passed a motion with regard to travelling to see some of these facilities across the country. It's broken up into three. Two of them are day trips.

The one for Quebec City requires we have a plane to make it there and back. So you have that, for about $30,000.

There's also one to travel to Petawawa, which should be a little bit easier in terms of ground transportation. And that's looking at just under $2,000.

Then we have the visits to Shearwater in Nova Scotia; Goose Bay in Newfoundland and Labrador; Comox, British Columbia; and Cold Lake, Alberta. That more lengthy and complicated trip is $134,000 and change.

If you wish, you may ask questions, or we can have a discussion about it. No? Fairly straightforward?

Mr. Sweet.

Mr. David Sweet: I have just one thing, because it would be disingenuous of me if I wasn't on the record when I mentioned the $130,000 last time for Afghanistan.

Certainly, in service to our veterans, we want to do the best we can to investigate all our concerns in giving recommendations to the government for PTSD. It's $165,000. It's a cost. We need to invest it, considering it's a number of.... How many sites are there? Six in total?

The Chair: I suspect, Mr. Sweet, having been the committee's arguer at liaison last time, that cost considerations were not the primary reason we weren't able to carry that off, although I know you mentioned that in previous discussions on the motion. I told Mr. Valley that if at some point he wishes to bring forward an idea of travelling to Cyprus for the debriefing that happens with regard to post-traumatic stress disorders for people serving in theatre, that may be looked upon more favourably.

Anyhow, this is what we have before us today. We have Mr. Sweet's—

Mr. David Sweet: Just a comment.

The Chair: —intervention or comment.

Sorry, Mr. Cannan, yes.

Mr. Ron Cannan: Thank you, Mr. Chair. I'm just clarifying: 16 people can go to Quebec City for one day?

The Chair: Mr. Cannan, the way I see it, sir, is that it's the full committee in each case, in all cases. So there have been no exceptions made with regard to that, and that's including, of course, the clerk, the analyst, etc.

You're asking why?

Mr. Ron Cannan: Why is it $30,000 to fly from here to Quebec City and back?

The Chair: I think if you flip around the back page, you'll see that it's a matter of flights. One is ground transportation, the other is flights.

Mr. Ron Cannan: Is that a charge, though?

The Chair: Yes.

Mr. Brent St. Denis: Members who can, and wish to or are so inclined to, can offer their points. It still costs, but at least we're not using two budgets.

The Chair: That's a fair point.

Mr. Cannan, if you wish to use your Air Canada points, you are more than welcome to.

Mr. Ron Cannan: It doesn't cost $1,600 to fly from here to Quebec City. I could fly across the country for cheaper than that.

The Chair: I'm going to let the clerks and the researcher respond.

The Clerk of the Committee (Mr. Alexandre Roger): When the logistics officer called, that's the quote we got for the time of year when we're going. Obviously if we find that a charter is cheaper, the money that is over budget will come back in that case. But we always go with what is cheapest. That is the quote we got. If members use their points, as was mentioned, then the money comes back as well.

So it's just a budget maximum so that we're safe.

Mr. Brent St. Denis: I'll help out my friend Ron. Perversely, it's cheaper to travel from B.C. to here. With my riding, I fly from here to Sudbury and then I drive two hours to home. The flight from Sudbury to here return is almost this much, and it's a fraction of the way home to B.C. It's perverse, but that's the way it is. This doesn't surprise me.

The Chair: Mr. Valley.

Mr. Roger Valley: The points option may be for some members. It's certainly not for me. I don't have enough points. I'm always out.

On the other side of the coin too, it costs a lot more. I have four planes every week, so it's $2,700 to get me here every week. It's very expensive to come from where I come from.

The Chair: I understand. I'm very fortunate that I live in a hub, in Calgary.

Yes, Monsieur Gaudet.

[*Translation*]

Mr. Roger Gaudet: I would just like to point something out to Mr. Cannan. It costs $846 to go to the Magdalen Islands from Montreal. To fly to Vancouver, it costs $600. I am in Quebec, and the flight between Montreal and the Magdalen Islands lasts 1 hour and 45 minutes. The flight between Montreal and Vancouver lasts five hours. That means it costs less to fly to Vancouver than to the Magdalen Islands.

[*English*]

The Chair: Such is the nature of volumes with regard to air traffic. These are situations of market supply and demand, gentlemen.

Do I have approval from committee to take this to liaison, then?

Some hon. members: Agreed.

The Chair: Thank you very much.

[*Translation*]

Mr. Roger Gaudet: If they don't agree, we'll choke them.

Voices: Oh, oh!

● (1305)

[*English*]

The Chair: For some reason, I didn't get translation. He's joking. Okay, fair enough.

The meeting is adjourned.

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