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Chair

Mr. Rob Anders

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● (1530)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): I call the meeting to order.

We have yet another meeting of our Standing Committee on Veterans Affairs. I will just read it here: pursuant to Standing Order 108(2), this is a study of the comparison of veterans services offered by members of the Commonwealth and the G-8.

Today, we have as witnesses from the Department of Veterans Affairs, Darragh Mogan, director general of the program and service policy division, and Ken Miller, director of the program policy directorate.

I've seen you before, so this is all a good thing. Just to make sure nobody is left wondering how this process works, generally we allow ten or twenty minutes, and they've been told twenty. If you want to do ten minutes each or nineteen and one, as you see fit, or twenty and zero, that's fine. After that, we take a predetermined list of questions that we've all argy-bargied over. We do that until we're sore or our two hours are up, whichever.

Gentlemen, the floor is yours.

Mr. Darragh Mogan (Director General, Program and Service Policy Division, Department of Veterans Affairs): Thank you very much, Mr. Chair and members of the committee.

Ken Miller and I will divide this up. I'll do the easy part; he'll do the hard part.

This is meant to be sort of VAC 101, in aid of your comparative study of Commonwealth and G-8 services and benefits.

Before I begin the presentation—and it's been handed out to you—for what it's worth, I think this is a very important study or undertaking from the public service point of view. On the one hand, it's based on surmise, but based on experience on the other.

In 2001, Veterans Affairs started off its first of many meetings of what is called the Senior International Forum, comprised of senior executives who are concerned with veterans affairs issues from Canada, the U.K., the U.S., New Zealand, and Australia.

We've had six or seven such meetings. I never would have imagined, being involved in this from the beginning, that they would be such a productive enterprise, and I want to talk to you a little about that. It has graduated up to the political level, where there is now a ministers international forum ongoing in Washington, as we speak, for the ministries of veterans affairs from the five countries. The degree of sharing of experiences, best practices, research, and business innovation have been quite remarkable and have benefited the veterans and their families in all five countries, I am certain.

Some of the results of that sort of collaboration, and certainly when you expand the nature of your study to the G-8 you'll find even more, I'm sure.... I mentioned business innovation. The best practices in service to veterans, be it electronic or in the traditional sense, are a direct result, I think it's fair to say, of our discussion, particularly with Australia.

Each time we get together in the Senior International Forum we outline in considerable detail the issues that each country is facing, and it is remarkable how similar they are. A lot of the advances that all countries have made in the diagnosis, treatment, and recovery from operational stress injury is a direct result of the sharing of best practices amongst the five countries.

The operational stress support system we offer, the peer support system, is now being modelled in other countries. We used the British Ministry of Defence job placement program and mirrored it pretty well to fit the Canadian circumstance in the new veterans charter.

We used the New Zealand case management system, and we're meant to. We get all the value of the research that these people do and that we do for no cost to our individual taxpayers. It's quite remarkable, especially when you look at the size of the U.S. Department of Veterans Affairs' budget in research. It's enormous. It benefits our own veterans and we get that for no cost. So the value of collaboration, and therefore the value of the study that you're undertaking, cannot be overstated.

I won't take you through all the pages on the chart because we'll go beyond our 20 minutes. Some of the pages I think are self-explanatory, or you can ask questions about them during the round of questions.

What I would do is take you to page 7, if I may. Page 7 shows a graph. What you're seeing there is the changing proportion of our population over time, where survivors and Canadian Forces veterans begin to assume a larger and larger proportion of our workload, and therefore should also become a larger and larger part of our policy concern.

If you look at expenditures in the portfolio area, you'll see a very large proportion of disability awards and disability pensions. As you can see there, health care, made up of home care and other VIP services, treatment benefits, and long-term care, is about $900 million. So it's a fair amount of investment, and that investment is made in cooperation with provinces. We don't duplicate what provinces offer. We offer what provinces don't offer, and if they do offer it, we may be engaged in a case management way, but we're not engaged in a payment way.

The administrative costs for Veterans Affairs, I think we've calculated at about 9% of that overall $3.2 billion.

If we turn to page 10, the largest program is the disability pension, and we'll later on come to its new veterans charter equivalent, the disability awards program. That has been in existence since 1919. My sense is it is a very generous system. We have made comparisons to equivalent disability benefits in the other three Commonwealth countries and the U.S., and ours is as generous or more generous than any of the others.

I think we had about 30,000 applications last year for disability awards or disability benefits. So it's quite an active program. Since about half of those pension applications came from World War II and Korea veterans, it gives you an indication that the long-term effects of armed conflict are quite real, and they need to be borne in mind, I suppose.

The war veterans allowance is an income support program. It's not used much any more because it's been largely replaced by the Canada Pension Plan, OAS, and GIS, but there's a small top-up available.

On page 11 I talk about the health care program. The best-known one, and it's been around since 1981, is the veterans independence program. It is the only national home care program, other than the one in Australia, that any of the four countries we deal with have for veterans or their own citizenry, including Canada. It's an extremely effective program, in my view. It keeps many people at home, independent, and in their own communities. It's very popular, and everybody, as you probably know, seems to want to get access to it. That's quite understandable, and it's in many ways quite a good thing. It's certainly quite a strong endorsement of the policy framework for it.

CF veterans can get access to the veterans independence program when the need for it is related somehow to service. Although its utilization is primarily based on age, its eligibility is not. Any Canadian Forces veteran of any age can get the benefit if it is needed.

With regard to treatment benefits, to give you an indication of the scope, there are about 8.2 million transactions a year in the treatment benefit account, at an annual cost of about $260 million. About 110,000 people have the eligibility card. It's used for services from any authorized health supplier in the country. There are in the neighbourhood of 60,000 to 65,000 of them. You don't have to go into a VAC centre to get your health care. You can go next door to the pharmacy or across to whatever is there.

Long-term care is an important element of the service we provide. We can provide it in any number of locations. We have about 3,300 to 3,400 departmental contract beds reserved for veterans. They are in institutions we used to own that we transferred to provinces. The disadvantage is that they are located in about 14 sites, and not all of Canada's veterans are located near those 14 sites. So we also give them access to any community care bed that's available and licensed by the province. That accounts for the 7,400 veterans we have in community facilities. The disadvantage we used to have before VIP came along was that you had to go to one of those 14 sites. If you happened to live in a part of New Brunswick, you'd have to go to Saint John. If you happened to live in North Bay, you'd have to come to Sunnybrook, in Toronto. Now you can stay wherever there is a licensed community bed. It's very popular. Most veterans prefer to stay there.

We have a funeral and burial program in cooperation with the Last Post Fund. The slide speaks for itself. There is an interest in looking at the rates we pay. People are eligible if the death occurred as a result of war service or if the veteran of overseas service can't afford the funeral using his or her own resources.

These are the traditional programs we've had. They are primarily age-related programs. The slide earlier showed relatively rapid growth in the number of younger CF veterans and their survivors. So we had a look at this, along with the Canadian Forces Advisory Council, between 2003 and 2005. What we found was that these traditional programs were not aiding those younger veterans who were making the transition to civilian life. They were experiencing poor transition, fragmented services, certainly a very outdated approach, and many unmet needs. So it resulted—and I'm giving quite a short summary—in quite significant deliberations on the new veterans charter.

At this point, Ken, maybe I'll turn it over to you to take the committee through the new veterans charter.

● (1535)

Mr. Ken Miller (Director, Program Policy Directorate, Department of Veterans Affairs): Thank you, Darragh.

Good afternoon, Chairman and members of the committee.

I'd like to discuss at a fairly high level some of the key features of the programs comprising the new veterans charter. As I know you're aware, the charter and the new programs were first introduced in April of 2006, so we have just two years of experience with the programs at this point.

One of the key design features was to base the structure of the programs on modern principles of disability management, so it was very important to reflect in those programs things like early intervention, achieving the maximum functioning of individuals, and having very integrated case management. All of these things together help transition individuals back to civilian life.

The approach, as you know, is a dual award approach. Simply put, it separates the economic and non-economic compensation; in other words, we have separate programs for earnings loss and separate programs for compensation for pain and suffering as a result of an injury. It's a needs-based approach to programming. What this means is that we have greater flexibility to respond within our authorities to the specific needs of individuals. It also means that those with greater levels of need get greater levels of support, and that's very important, we feel.

The approach also provides more authority and more programming for us to help families. It's very clear that families are directly impacted as a result of military service, so we try to assist in that way as well.

Moving to slide 15, the new veterans charter, in terms of eligibility, applies to Canadian Forces veterans who served after 1947, with the exception of those who served in the Korean War.

I'll just go through each of the program areas very quickly—there are five.

The first is the disability award. This, roughly, is the program that replaces the old disability pension under the Pension Act. As you know, it's a program that pays a lump sum payment in relation to the percentage or degree of disability the individual has. At the 100% level, the current payment is a little over $260,000, and that amount is indexed annually.

The next program area, and probably the cornerstone of our suite of wellness programs, as we like to refer to them, is the rehabilitation program. The intent of this program is to restore to the fullest extent possible the functioning and capability of an individual, recognizing that we cannot assist them in all cases to get fully back to where they were. Certainly, we want to assist them as far as we can, not just in terms of vocational ability but also in terms of social functioning and integration within their families and communities, and so on. The program does it by focusing on barriers and providing elements that assist in removing those barriers, which is really the key to success. It's a comprehensive program that provides medical, psycho-social, and vocational rehabilitation.

I'll turn next to slide 16 and the financial benefits program, which contains a number of different elements. This is the second part of what I referred to as the dual award approach. The first and perhaps most important element of this program is to compensate an individual when there has been a direct impact on their ability to earn a salary from employment. So we have an earnings loss program, which provides 75% of an individual's pre-release salary for as long as they are in the rehab program, or until age 65 if they're seriously and permanently disabled.

We also provide a supplementary retirement program, which provides 2% of all of the earnings loss they received up to the age of 65. That is paid as a lump sum at age 65.

Finally, we've also developed what's referred to as Canadian Forces income support, a program that provides a financial safety net, if you will, for those individuals who are capable of re-entering the workforce, but don't, for whatever reason. It provides a bridge for them to allow them some additional time to make that reintegration.

We also recognize within the financial benefits program that if somebody has sustained an injury and has a disability, particularly if it's a serious one, it can impact their potential career path or its enhancement for the rest of their life. So we provide something referred to as a permanent impairment allowance, paying a monthly amount for life to compensate for that—at least in part.

● (1540)

We also provide, under the new veterans charter, access to group health benefits. It's a gap-filling approach for those individuals who are not eligible to purchase coverage under the public service health care plan upon their release. They now have that open to them when the need is there.

Finally, we have a job placement program, which is all-important for those who can rehabilitate and do have the potential of re-entering the workforce. Getting a leg-up and some assistance in finding employment is very important.

Slide 19, the final slide I'll speak to, speaks to family support. I noted at the front end that this is an important area of our programming. The new veterans charter now gives us some ability to respond.

We do it by involving spouses, when we can, in rehabilitation planning. We provide rehab counselling that includes the family. We can provide case management services to family members. As I said, sometimes impacts come directly to the family member, and they may have some issues for which they would benefit directly. We can provide spousal access to the rehab program for themselves, when the veteran is sufficiently seriously disabled that they can't benefit. In other words, the family should benefit if the veteran can't; that was the logic. We provide child care assistance. If that is needed to facilitate participation in rehab, that's available. Of course, we have a range of survivor benefits, including, perhaps most importantly, the death benefit, which pays the same amount of $260,000 in the case of service-related death, together with the earnings-lost benefit that would have been paid to the veteran had they been injured but survived. There's a fairly comprehensive suite of benefits for family members.

With that I'll turn it back to you, Darragh.

● (1545)

Mr. Darragh Mogan: Mr. Chair, I'll finish up in about 90 seconds.

The glue that holds the programs together, be it the veterans independence program or the rehabilitation program in the new veterans charter, is a case management service, which Veterans Affairs has been offering since 1946 in one form or another. The version we now provide has been refined by our review of the New Zealand experience, where they don't have a lot of veterans programming, as you'll find out, but they have a first-rate case management service.

For those individuals who will tell you as members of Parliament that they have an awful time navigating the system—it's the most frustrating part of dealing with a municipal, provincial, or federal system—this is a service for the most severely disabled and the ones who need it most. It does the navigating for them, and it makes all the difference in the world in terms of the outcome. We're developing this service, and it's a very important element that pulls the programs together.

The mental health strategy is a particular focus, as you will know, with the increasing incidence and attention being paid to PTSD. Veterans Affairs and National Defence have developed a joint mental health strategy. The number of individuals we now have pensioned for psychiatric disabilities is about 11,000, of which 7,200 have post-traumatic stress disorder. That's a remarkable increase in 10 years.

We've responded with a comprehensive continuum of health services, building capacity leadership in collaborative partnerships. The net effect of those words is that we have OSI—operational stress injury—clinics now open in nine cities in Canada. National Defence has five operational trauma support service clinics. We are expanding our services to help family physicians. They are the primary caregivers to deal with individuals. We're now offering services through these clinics to around 2,000 individuals to whom we were not offering any services at all four years ago. We have some distance to go, and I'm sure in your discussions with the G-8 and the Commonwealth, you'll learn lots of ways in which we can improve. And I know you won't be shy in telling us.

The last one is the remembrance programming. It's very important. It's often referred to as the third leg in our stool—the first being the disability awards, the second being health care, and the third being remembrance.

One of the things CF veterans will tell you, if they haven't already, is that they want to be recognized as World War II veterans are. We want them to feel recognized and remembered like the World War II veterans. That's at the heart of our remembrance programming. It involves community engagement in Canada, maintaining international and national monuments, and certainly public information and research. The priorities, as it says on the last slide, are youth learning and engagement, better remembrance and recognition of Canadian Forces veterans, and engaging community and organizations to carry this legacy forward.

Mr. Chair, committee members, that's our presentation. We were 30 seconds under time.

The Chair: Well done.

Now we will go over to the Hon. Ms. Guarnieri, with the Liberal Party, for seven minutes.

Hon. Albina Guarnieri (Mississauga East—Cooksville, Lib.): Thank you, Mr. Chair.

Let me begin by thanking both our guests for being dedicated civil servants who really do deliver for our veterans. When I was Minister of Veterans Affairs I was fortunate to rely on many individuals like you who were committed to the progress of the department's programs.

You have offered the committee a brief assessment of the relative merits of our benefit program relative to other jurisdictions. I was wondering if you could comment on whether there have been continuing efforts to study systems in allied countries to further enhance services for Canadian veterans. In particular, you mentioned earlier study case management and service delivery standards in New Zealand, for instance. Be free to talk about other countries also. Can we say that we've adopted the leading edge in the treatment of post-traumatic stress disorder?

I have one other question I'd like to give you and then allow you the latitude to answer at your leisure. The second question I have pertains to the health care review going on in the department. I wonder if you could confirm for the committee the history of that review specifically. When was it initiated, what were the initial terms of reference, and were the terms of reference changed? And when might we anticipate that this work will actually be completed?

● (1550)

Mr. Darragh Mogan: Thank you, Madam, and thank you for your kind words. They are very well appreciated.

Hon. Albina Guarnieri: They are very well deserved.

Mr. Darragh Mogan: As I mentioned in the opening comments, I think you'll find a very rich ground for comparison by looking at the G-8 benefits and those of the Commonwealth. I'd like to think we've borrowed the best from at least the Commonwealth countries we've talked to, and they from us. One example I gave is the case management system, which is New Zealand. They have a good one because they don't really have any other, other than their pension benefits, so they have to use the community benefits in the North Island and the South Island. Their veterans are not few, but they are far between, and they do a remarkable job. So we've refined our case management system based on theirs, and they were quite fine with that.

We use the job placement program that the Ministry of Defence in the U.K. has used as part of our new veterans charter. It's very, very successful there. The U.S. is looking at our OSIs, our operational stress peer support system...to model it in there. So there are several examples of where this collaboration has made a lot of sense for all the parties. I'd like to think we are in the position of having the best of all four worlds, or all five worlds, and from your review, you'd be able to tell us whether that's an accurate assessment. I think it's been very good.

Certainly all four countries, including us, are very much focused on operational stress and what the effect of that is. We could call it battle fatigue, or whatever it was years ago, but now it's become apparent that it's a very dangerous thing for the military culture just to assume that it's safe and wise for soldiers just to, as it were, suck it up rather than deal with it. We realize the consequences of that attitude of just sucking it up, of how difficult it can be both in doing one's military duties and in transition to civilian life. Focus a lot of attention on there. You'll hear about that in your deliberations, and I think it's having a lot of payoff.

With regard to the health care review—and Ken can elaborate on this—this was announced by the minister, I think, probably in October 2006. There had been some reviews going on through the Gerontological Advisory Council before then, but it had a very intense political focus at that time. The Gerontological Advisory Council and the six veterans organizations released a report that called for a comprehensive review. They had the features of removing all the complex eligibility rules that had built up since 1946. They are very complex and they're very hard to navigate, and the cost of navigating that system...they are resources that could be directed towards care itself. Some of the health outcomes are impeded by that. There are a number of veterans who are not eligible for benefits right now, and there are a large number of veterans who are only eligible for the most expensive benefit, when maybe what they want is a less expensive one closer to home.

So that review has been examining that, and I don't think it's complete yet. I think it's still being reviewed at the political level and the administrative level. I think the standing committee's report on that subject would be very timely if it were to come relatively soon.

I don't know if I've covered all the subjects you wanted me to cover, Madam.

Hon. Albina Guarnieri: Thank you.

[*Translation*]

The Chair: Mr. Gaudet from the Bloc Québécois, for seven minutes.

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

Good day, gentlemen.

Before I go any further, I would just like to explain why my head is shaved. I did it to support Leucan and the fight against cancer. Four or five us had our heads shaved and in the process, we raised $13,000. That's why I look like this. I am not sick. In fact, I'm quite healthy. We did this for the children.

I have a question and I do not know which one of you will be able to give me an answer. Consider the case of someone who lives in a rural area and decides to move to the city to get more services. While living in the country, this person benefited from housekeeping, lawn mowing and snow removal services. If he moves to a condo in town to be closer to people, will he still be entitled to the same services? Will someone still mow his lawn or clear his sidewalk?

● (1555)

[*English*]

Mr. Darragh Mogan: I'll attempt to reply in English, if that's all right, *si' c'est acceptable*.

Living in condominiums has been an issue because the groundskeeping fees are included in the condominium fees. We are reviewing our policy to ensure there is no unfairness to someone, where they're having to pay for groundskeeping but they're not having to pay for it directly; it's in the condo fees. That's being looked at, sir.

[*Translation*]

Mr. Roger Gaudet: I am asking because there is someone in my riding who lives in a rural area and who is planning to move into the city. Truthfully, I was checking to see if he qualified for the same amount that he received while he lived in the country, namely $1,000 for lawn mowing and snow removal services.That is the question I would like answered.

[*English*]

Mr. Darragh Mogan: I don't know that it would be the same amount, but it very well could be. What the fees would be depend on if they're going into a condominium. Veterans Affairs, under the veterans independence program, would pay whatever the costs are to the individual. In places where it's included in the cost of the overall *logement*, it's going to be a little difficult to determine. We hope to have a policy in place that allows us to do that, sir.

[*Translation*]

Mr. Roger Gaudet: Thank you.

Do you not seem to have a lot to say about one of your programs for PTSD sufferers. About two weeks ago, we went to Petawawa and heard how there was a serious shortage of psychiatrists and psychologists. What are you doing to provide services to veterans? They are being referred to psychologist and psychiatrists who are not employed by the Canadian Forces and when they come back with their findings, DND refuses to examine them.

[*English*]

Mr. Darragh Mogan: I don't know.

I can't comment on what National Defence does or does not do. They'll have to speak for themselves.

[*Translation*]

Mr. Roger Gaudet: I agree with you. I am not asking you to comment on what DND does. I am merely saying that veterans, especially those suffering from PTSD, are having a difficult time of it because in Petawawa, there is only one psychiatrist for 7,000 soldiers. Clearly, there's a problem. When a soldier has left the forces, he is referred by Veterans Affairs to a psychiatrist. Subsequently, DND does not accept the assessment.

What kind of services will you be providing to them? That is where I have a problem. You note on page 16 that this is part of the services provided, but you do not say a lot about these services.

[*English*]

Mr. Darragh Mogan: If there is a specific or a general problem with the acceptance of professional advice and guidance, there's no reason that I know of why that should be, sir. If it's on an individual case basis, we'll have to deal with that.

[*Translation*]

Mr. Roger Gaudet: Perhaps I'm not making myself clear. Veterans are not receiving any services. There is a shortage of psychologists and psychiatrists. What services are you talking about? You state in your presentation that you have a program and services policy in place as well as a program policy directorate.

What is it that you do for these veterans?

Mr. Ken Miller: I would like to say something, sir.

[*English*]

It's the question of the availability of professional services that I think you're referring to. That's a reality that's faced across the country. Particularly in areas that are somewhat more remote, access to psychiatrists and psychologists can be a problem.

Our responsibility picks up when somebody releases from the forces. The forces provide access to professional therapy to those in uniform. You're quite right, there can be a problem, depending on where they're located when they release. We try to access professionals who are reasonably close to where our clients are. It's not always possible. We can and do provide access at more distant locations, if it's appropriate and necessary. It's very difficult for us to create capacity in an area where it doesn't exist. But where capacity exists, we can facilitate access to it. We can help the veteran to go where the service is available.

● (1600)

Mr. Darragh Mogan: I'm sorry, I did not understand your question at first. It's a very good one.

One part of the mental health strategy, which we're now working on, is for these OSI clinics to be able to provide a service to family physicians. It requires an individual to have a family physician or access to a clinic. The family physician is not going to be an expert in treating OSI, but he or she will be able to serve as a contact point for someone who is. They will be able to determine the level of illness so that necessary action can be taken, within the capacity of services available in a remote area. They will also be able to determine whether the individual needs to seek treatment in a central area. We're working on this as part of the mental health strategy.

[*Translation*]

Mr. Roger Gaudet: Thank you.

[*English*]

The Chair: Mr. Stoffer.

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

Thank you both for your service. My thanks also to the front-line staff across the country. They do a great job, within the legislation, helping many veterans and their families.

It's rather sad when the director general of the program and service policy division has to say that some veterans don't apply for benefits.

I have a case in point. Mr. Dan Brownlow, a fairly wealthy individual, undertook a court case last year. Before the court case he was denied hearing aids. He just received his hearing aids the other day from VAC. He is quite a wealthy fellow, and he greatly appreciated it. But Captain Earl Wagner applied for the VIP program after his wife died, because he physically can't do the work any more. He was denied VIP because he makes too much money. You're going to have to explain why one person who is extremely well off gets hearing aid assistance from VAC while another person just barely over the limit is denied VIP.

You're right, the VIP program is a fantastic program for those who get it. But many people I deal with, including widows of veterans, are denied this service. That's a matter I'd like you to explain.

Another concern is coming up, and this is something that no one is responsible for because all parties supported the veterans charter. We heard from the previous government, and the current government, that it is a living document. If changes need to happen, they can be discussed and put in place. One of the big concerns is giving someone who is suffering from PTSD a payment in one lump sum. We're hearing stories from across the country about this money disappearing in a year, and there's no other program to help them. Are there discussions within your level about whether these lump-sum awards are advisable? Perhaps they should get a pension benefit instead, so that they can have something for the rest of their natural lives. Emotionally and mentally, many of them simply can't handle $100,000 all at once.

Here's another concern we're getting in Nova Scotia. When a veteran goes into Camp Hill hospital, the spouse is left all alone, and the spouse is not allowed in the Camp Hill hospital because DVA will cover only the costs of the veteran. So in the final months of these people's lives, they find themselves separated from their spouses. The minister told us they're working with the province to find provincial facilities where spouses can be together, which I think is a good idea. Can you tell me how this is working across the country? Is it part of your health care review? In the final stages of their lives, these spouses, especially the elderly ones in their nineties, should have an opportunity to remain together.

I have more questions, but I'll come back to you.

● (1605)

Mr. Darragh Mogan: I'm going to have trouble remembering what they all are.

The earlier one was about why a very wealthy person gets a hearing aid and another person is denied it just because of an income line. One of the problems of history is that it provides two gates into health care. One is a pension gate. If you're disabled as a result of military service, you'll get health care for that injury or ailment no matter what your income is. It's not a function of income; it's a function of compensation for an injury.

The other case is that of someone with a low income, when you served overseas and you have a low income. This is where the second individual probably falls. There are real disadvantages to that. We acknowledge that. We have been, as part of the health review, kind of looking at ways in which we might overcome that.

One thing we can say is that at least those to whom the greatest debt is owed—that is people who actually have war or military service injuries—and those who don't have the means at all to help themselves are covered.

Mr. Peter Stoffer: But both of them are veterans. They both served in World War II, and a veteran is a veteran is a veteran the last time I checked.

Mr. Darragh Mogan: Yes, and I'm only explaining that, Mr. Stoffer; I'm not defending it.

What was the second question?

Mr. Peter Stoffer: It was about disability for PTSD awarded as a lump-sum payment instead of a pension benefit.

Mr. Darragh Mogan: We heard a great deal about this before the new veterans charter was brought in. Politicians and others expressed concern, and we understood that. We will not provide lump-sum money to an individual. We will provide it to the public trustee when it is clear that that individual is going to do harm to themselves or others. But just like the disability pension itself, the old pension, which you can do harm with, too, most have the civil right to have that money paid to them.

We have extensive counselling from a private sector counselling service available for individuals who need to be counselled on how to deal with that kind of money, as I've said before, in terms of individuals who might do harm to themselves or others with that money. I don't know whether that harm rises to the extent of making an unwise purchase; if so, I think I'm in trouble myself.

Mr. Peter Stoffer: But couldn't they have accounts?

Mr. Darragh Mogan: It could very well be that we could invest that money and have it paid out as an annuity. That's a possibility, too. There's nothing preventing that. I don't know of any circumstances in which that's been requested, and I don't know that we've made high enough disability awards for PTSD yet where that might have been a factor. I just don't know, but I can find out.

But it's a genuine concern, sir, and we're at least aware of it.

Now with regard to spouses being admitted to veterans priority access...that's an understandable concern. It pulls at the heartstrings of everybody, and for good reason. Why, in the last days of their mutual life, when they've been supporting each other for so long, should they be separated? That's why it's kind of heartening that so many veterans want to use community facilities where that's not a problem. That's how we solved the problem—when a veteran can stay closer to home, closer to his children, and closer to his spouse if he stays in the licensed nursing home next door rather than going 400 miles away. It's not the perfect solution, but it's the one we're working on and it's the one the minister is committed to.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you, Mr. Stoffer.

Now we're going over to Mr. Shipley of the Conservative Party for seven minutes.

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

Thanks again, Mr. Miller and Mr. Mogan, for coming back. It's good to see you again.

I'm also interested in following up on the health care review. When we had the opportunity to visit some of the bases—and I know you don't deal with Canadian Forces or Defence—our objective was to try to learn how we're going to make that seamless transition from one ministry department to another one. Actually, we have heard that although it is not perfect, there have been incredible advances made. Certainly for the veterans who are in our care, that was great news.

You've said that part of the study is important to you. I'd like you to explain just why you think it is so important that we're doing it.

Secondly, you had mentioned that since 2001 there have been six or seven meetings with five countries. Actually, I think you said they're happening in Washington right now. I don't know if you mean they're actually happening right now or they have accelerated. Are we going to be able to get a follow-up from what has come out of those meetings?

Next, one of the things we've spent a lot of time on here is PTSD and operational stress. Clearly, if there's still a weak link in our health care system, it is likely how we are dealing with that. There's no doubt. Again, we've heard, particularly over the last couple of years or so, that there have been incredible advancements and acknowledgement made by the military to help break the silos down and start that transitional flow of information, so that when someone becomes a vet there is that.

I don't know if you have any comments to follow up regarding where you see it.

I'll just leave it at those three right now, and I don't care which one answers.

● (1610)

Mr. Darragh Mogan: I'll answer until I get into trouble and Ken kicks me under the table. I've been getting a lot of kicks in the last few minutes.

On one of the questions you asked, I alluded earlier to the senior international forum—which includes the likes of me, Ken, and the deputy minister—of five countries, including Canada, Australia, New Zealand, the U.K., and the U.S. We've been knocking ideas around like the ones you'll probably be discussing in this deliberation of the committee. It's very valuable. There's no reason why you cannot have the results of those discussions. I think the minister will probably want to give you those.

So there's the senior international forum of public servants and then there's the ministerial forum. That one is ongoing in Washington right now. It is the supervising committee to the senior international forum. It's had three meetings. The last two were in Paris, and then there's one in Washington. It talks about issues of political and policy concern to all the Commonwealth countries in there—not all the G-8, although there are two or three members of the G-8 in there. So it's very valuable. As I was saying at the beginning, your investigation into that area is bound to pay dividends in your work on veterans in Canada.

On PTSD and OSI, we have made great strides. We have some distance to travel. From my point of view, and I've been at this for a while—some would say since the War of the Roses—the focus should be on recovery. It's one thing to be able to identify a problem and intervene early, but the biggest hope for these individuals is to recover from it as much as possible—both the people who serve and the individuals who transfer to civilian life. So the transition to civilian life for someone with both a physical impairment and a psychological impairment—and they tend to come in twins by the way, one tends to lead to the other—is really very difficult. That's where we're increasingly focusing our energy, as is National Defence. Any advice and guidance you have in that area would be very welcome.

Mr. Ken Miller: I think a lot of your questions focused on the importance of transitioning and what happens at that time. For us that's a very key thing, and it's one of the fundamental reasons we work as closely as we do with our colleagues in the Canadian Forces. It's not just a matter of somebody taking off the uniform and us picking them up. For that transition to work effectively, we really have to overlap in the way we support clients, so that the support begins while they're still in uniform, and we assist them, working with CF. When they actually take the uniform off, we're well positioned to support them with a continuation. The continuity of treatment is very important, and the early onset of treatment is very important.

So I think we have made huge strides in improving those things in recent years, but it's something you always try to do better. Through our collaborative efforts with CF colleagues, I think we're certainly doing that.

Mr. Bev Shipley: On the continuity of systems, one of the things we heard is that the systems for transferring information—whether it's health records or whatever—from one department to the other are not always concurrent or not always the same. As a result—whether it's right or not—that information doesn't travel sometimes; it gets lost or waylaid, and it doesn't get from Defence to Veterans.

Is there an effort to bring those systems together, likely by going from hard paper to digital?

● (1615)

Mr. Darragh Mogan: The short answer is yes. When you do your review of the U.S. DVA, you'll find they have an electronic health record that is remarkable. They'll give you a briefing on that. It's quite a step forward. We're certainly looking pretty hard at that to overcome some of the stovepiping that can go on.

On continuity, we are trying to make sure that an individual who leaves the Canadian Forces doesn't get a different kind of benefit for the same condition as when they were in there. So that continuity of care is a very important initiative as well. You might want to have a look at that in your deliberations and see if that's working particularly well.

Mr. Bev Shipley: Thank you.

The Chair: Indeed, it did run to seven and a half minutes, Mr. Shipley. I apologize tremendously. I jumped the gun at five minutes rather than allowing you the full seven minutes there. Hopefully that half minute counted toward that.

We're now into a regular round of five minutes. I was mentally ahead of myself there. I know it doesn't happen all the time; that's exactly right.

Mr. Valley from the Liberal Party is next for five minutes.

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

I've been trying to figure out when you two gentlemen came before us, but you kept tricking me. You are with Brian Ferguson, individually, so I don't know if you've been here

Mr. Miller, you were here in September. I don't know if you said this, but I'm going to read it: "There is a lot of information about a lot of services to serve a lot of people who need a lot of help." Not much has changed from that. The people need help, but I'm glad to hear that services are improving and you're moving the issues forward. We are grateful for that.

Mr. Mogan, you visited us in May, if not many other times. We talked about how to reach out on your health care review that is going on in your department. How do we do it? We talked about whether we've tried to contact the veteran who is not accessing these services. Whether it was one of us who said it, or maybe it was you, one of the issues we talked about that day was that we thought we could advertise in the papers. Somehow we could try to reach the veteran on the street who is not doing that, because, as you know, we have difficulty with that. Was that ever considered, or was it done in different venues I am not aware of? This was quite a while ago.

Mr. Darragh Mogan: It's a good question. On the direct surveying of people who are not our clients or aren't eligible, I guess we did it by proxy. We were a little concerned about building up expectations, especially among people whose average age is 84, and then, as they often do, political trade-offs have to be made, and we might have encouraged somebody and not done something for them. That was a bit of a concern, but in terms of all the research through the Gerontological Advisory Council and their report *Keeping the Promise*, we were pretty sure we had the problem definition right, and the direction in which to move, which was proposed to us through the Gerontological Advisory Council, was going to overcome some of the problems Mr. Stoffer referred to earlier. This is a very complex, multi-varied eligibility that is very hard to explain and even harder to administer.

To answer your question, we didn't do direct surveys of individuals of that age. I don't think we thought it was going to work out quite that well.

Mr. Roger Valley: In the future we will be serving much younger veterans, so that may be an option for us.

Mr. Darragh Mogan: Yes, and in terms of the younger veteran—and maybe we should have done the survey. I'm just giving you an indication of what the thinking was with the older veterans. We are doing focus groups with the younger ones. We did at the time of the new veterans charter. In any changes we're proposing—and it has been raised that there was a commitment that there would be changes when we got some experience with the new veterans charter—we will be engaging the younger veterans in testing some of the gaps that we think are there.

As I'm speaking, we have an advisory group, the new veterans charter advisory group, made up of the best and brightest in the country and all the veterans organizations and psychological and physical medical practitioners. They are meeting today; they are meeting here, and they're giving us a lot of advice and guidance on what changes there should be to the new veterans charter, and that includes representatives of younger veterans.

Mr. Roger Valley: Good.

On page 12 of your slides, I have a couple of very specific questions. There is $261.8 million in traditional programs, plus the 8,189,893 you serve. Is that number going up or down? Talking about traditional veterans, I assume that number—

Mr. Darragh Mogan: What page is that, sir?

Mr. Roger Valley: It's on page 12 of your slides. The figures at the bottom of the page—8,189,893 transactions, $261 million. Is that number going down considering the challenges many of those traditional veterans are under, such as age?

Mr. Darragh Mogan: The number is going up.

Mr. Roger Valley: Both numbers will be going up every year?

Mr. Darragh Mogan: Yes. We can get you details on that, but the trend line is up. Of course, people of an average age of 85 tend to consume more health care than younger people. The CF veterans who are coming in—some of them haven't come out of the military from service in Afghanistan yet, but when they do, some of them are pretty seriously disabled, and that number will go up again.

● (1620)

Mr. Roger Valley: I'll try to speak quickly because I'm going to get cut off.

I'm glad to hear we're all learning the best practices in the five countries you mentioned. I believe I heard you say, in answer to one of my colleagues' questions, that you feel we're ahead of the curve, or we're right up in the top group on how we're providing services to our veterans. I appreciate that, but I want to go back to what was mentioned by one other colleague about the remote sites, the rural areas.

My riding is in northern Ontario. I appreciate that he said “if” we could have a family doctor; we don't have family doctors in these areas. We're losing them as we speak. We're down to fewer than 25% of what we need for our community, let alone the challenges of a veteran who would move into that area, even the new veterans. We do have one, and I keep saying it around here and nobody ever listens, but I appreciate the huge problem that it is. In every community we already have an active organization that looks after veterans and is an anchor for many of them, and that is the Legion. No matter how we talk about it, we can't find a way to support them. They are the only institutions in these communities that have any ability to deal with some of the veterans.

I don't know the answer. I don't know who is going to have to think out of the box at some point to realize that to help our veterans and make sure there is some kind of anchor in a community, we must make sure the legions are still there. I don't know at what point we will think outside the box. We realize we can't support all service groups, but how do we make sure there is some recognition, some facility—not facility, that's not the correct word—something in a community that doesn't have doctors, that doesn't have many veterans?

The Chair: That's a long question, isn't it?

Mr. Roger Valley: How do we make sure there's something there, some recognizable benefit to the veteran?

Thank you, Mr. Chair.

The Chair: You can take as much time as you like. You're the witness.

Mr. Darragh Mogan: You've raised a very good point.

In terms of thinking outside of the box.... The Royal Canadian Legion has 1,600 branches across the country. They're not all located in big cities. They can be, as you say, the anchor, the cornerstone, for rural communities. Maybe something bold has to happen. It wouldn't be up to me to do it, but change some of the scope of practice rules so that a nurse or a nurse practitioner—someone like that—could visit a legion and handle a lot of things that a family physician would have handled had the family physician been there, and have access to Telehealth, to a centre that can help him or her out as a practitioner. Maybe that's a way. Maybe that's a recommendation that your committee can make.

Something needs to change in order to balance out the access to health services. With modern technology out there, and with so many trained health professionals, it may be possible to make some progress, and not just for veterans.

Mr. Roger Valley: Thank you.

The Chair: All right.

Indulgence noted.

[*Translation*]

Mr. Perron from the Bloc Québécois, for five minutes.

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good day, gentlemen.

I would like to come back to the shortage of psychologists and psychiatrists, a problem alluded to by my colleague Mr. Gaudet. Here is something that often happens. A Canadian Forces member suffering from PTSD is treated by a psychologist while still an active CF member. After leaving the forces, this individual requests that his file be transferred to Veterans Affairs. Veterans Affairs does not recognize the psychologist who has been treating him and he is therefore back to square one.

This raises another question. When are you planning to simplify your forms? Young veterans generally complain that the forms are difficult to fill out.

Your famous 1-800 number also causes some problems. When a young person phones this number, months can go by before Veterans Affairs returns his call and then, he has to talk to another person. The 1-800 number is a complete mess.

[*English*]

Mr. Darragh Mogan: In terms of the question about the continuity of care from the *psychologue* and National Defence, we like to be in a position of never changing a supplier. So if it were possible to have the same *psychologue* who's in National Defence look after a veteran when that person leaves, that would be ideal. The problem becomes the size of the caseload for the psychologists in National Defence. That is why we have these OSI clinics, and we've now expanded them from—

[*Translation*]

Mr. Gilles-A. Perron: The psychologists are not DND employees. The department signs contracts with civilian psychologists. They are recognized by the Canadian Forces, but not by you.

● (1625)

[*English*]

Mr. Darragh Mogan: There's no reason, that I know of, why we wouldn't recognize that.

Mr. Gilles-A. Perron: It's happening.

Mr. Darragh Mogan: If there's a specific case where you know that's happened, if you can send that to me, it won't happen a second time. There's no reason. If that person is a registered supplier with the province and is providing care to an individual, on contract or whatever, we will recognize that. If it's a registered, in this case, psychologist—

Mr. Gilles-A. Perron: Call Dr. Descôteaux, the medical chief at the base in Valcartier.

[*Translation*]

Mr. Darragh Mogan: If there is a problem, I would like to get the name of the veteran involved in order to try and resolve the situation. Based on what you are telling me, there is no reason why he should be having a problem.

Mr. Gilles-A. Perron: What about the form?

[*English*]

Mr. Darragh Mogan: *Le formulaire*?

We're always open to suggestions for simplifying our forms if they're too complicated. There are a lot of things we have to satisfy, of course. One is financial and the other is eligibility. Because our eligibility rules, unfortunately, are very complex, it's not always easy to guess whether a person is eligible or not, unless we know all the details.

We're open to simplifying our forms and letters. If there are any suggestions, I don't think there'd be any problem at all.

Mr. Gilles-A. Perron: What about the 1-800 line?

Mr. Darragh Mogan: Yes, I've heard complaints about the 1-800 line. Frankly, we don't drop calls as a rule. We pick up 90% of the calls within 45 seconds. If there's any problem identified, it can be referred to a district office, and it often is. We have a proactive screening unit in Charlottetown that actually phones people. It doesn't wait for them to phone us. They're usually the ones who are high risk and highly vulnerable. We phone them to find out how they're doing, and if they're having a problem, it will be referred to the district office.

There are going to be times when you phone a 1-800 number when it's going to be extremely busy. I'm not sure what the solution to that problem is, other than continuous improvement. When we started out with the 1-800 number we had a high number of dropped calls. We now have 90% of the calls picked up within 30 or 35 seconds. I can check that out. In terms of call centres, that's almost the best there is.

Mr. Gilles-A. Perron: Do I still have time?

The Chair: You have two seconds.

[*Translation*]

Mr. Gilles-A. Perron: The problem with the 1-800 number is that when a veteran speaks to someone in Canada or elsewhere around the world, the department does not seem to make the connection. It is a slow process and the veterans has to call two or three times. For example, Gilles Gervais from Saint-Jean had to call 12 times and he waited a year and a half before someone called him back. This happens regularly. It would be far more practical to assign names in alphabetical order.

[*English*]

The Chair: Do you wish to respond to that?

Mr. Darragh Mogan: I would have to have some particulars to follow that up, because nobody should ever be phoning 12 times without an answer.

[*Translation*]

This is unacceptable.

[*English*]

I personally have phoned the 1-800 line. I've had staff phone it to check. It will depend on what time of the—

Mr. Gilles-A. Perron: The problem is not in answering; it's after he gives his case. After that, it takes a long time to respond. He doesn't get a response, so he calls again, talks to somebody, yet—

Mr. Darragh Mogan: I understand that. He keeps calling and calling.

I'd have to see. I'm not saying it isn't happening; maybe it is. When you make a call, and when Madam Guarnieri makes a call, it's recorded on the client service delivery network system. That system is forwarded to the district office, so it's immediate—a call comes in. Most of the problems are solved on the phone. If it can't be solved on the phone, it's sent to the district office. If there's a delay in responding there....

I'm not aware of those kinds of delays. If there's a case where that delay has occurred, we'll look into it and make sure it doesn't happen a second time.

[*Translation*]

That is not a problem.

● (1630)

[*English*]

The Chair: Thank you very much.

Maybe in the future we can have members of the committee phone your 1-800 line, tape exactly what happens, time the responses, and then have you before the committee. That would be fun.

Now we're going to go over to Mr. Sweet with the Conservative Party for five minutes.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): My first question is from your opening remarks. You mentioned this executive meeting. I don't recall if you said when that began. Could you tell me when it began, how many countries are involved, and how long it took before the political leaders engaged in it?

Mr. Darragh Mogan: There are five countries involved: Canada, the U.S., the U.K., New Zealand, and Australia. The first meeting occurred in Charlottetown in 2001. I believe there have been six meetings since, and those are with senior officials. The next meeting is in the U.K. in September. This one, the one in Washington, will be, I believe, the third ministerial forum—in other words, the political supervisors of the senior executives. They are meeting in Washington today. They've had two previous meetings. The last one was in Paris.

Mr. David Sweet: And this was facilitated with a real synergy and oneness of mind, you'd say, between yourselves and...?

Mr. Darragh Mogan: It certainly has enabled a great deal of sharing of best practices. It's more than sharing of best practices. We can use an online system. There's no charge to the Canadian taxpayer for getting this. We get all the intellectual property rights from these countries for all the practices they engage in, and they get ours. It has really worked out very well.

Mr. David Sweet: Mr. Perron just alluded to it, but one of the most poignant moments that has happened since I have been on this committee was when we had a room full of people who were suffering from PTSD. We had a very competent captain here. I remember seeing her sitting there, a commissioned officer in intelligence, suffering from PTSD. She explained how trying to deal with the forms from Veterans Affairs actually just drove her more deeply into a funk.

I understand the complexity of accountability and everything, but my question is whether there is a way that, particularly for PTSD—you've alluded to the fact of the extreme increase—cases can be handled with more compassion, so that the person who is looking after the case can say, “Can I come over to your residence and help you fill out these forms?” Could there be some process by which someone from Veterans Affairs can walk a person through, if we can't make the forms simpler?

Mr. Darragh Mogan: Our counselling and case management staff can do that, and they do now, but from what you're hearing and from what I'm hearing in this committee, things are better but not good enough. So we'll have a look at that. We do have a group called the special needs advisory group. That's made up of the most severely disabled Canadian Forces veterans, and those people are both psychologically and physically impaired. They have a lot of points of view to share with us, one of which will be on the simplicity of dealing with our system.

So, yes, I'll make the undertaking that we'll take your advice and the guidance you have been giving here and continue to make improvements.

Mr. David Sweet: Thank you.

There's help for burial costs. I have two quick questions. Is there a substantial amount of take-up on that program? That's in the remembrance program. Is that correct?

And is there any clawback? The federal government pays a death benefit from CPP, I believe. I'm not certain. Is there any clawback there, or was the program designed simply as an income-tested program, so in a situation of real dire need, people will get the help?

Mr. Darragh Mogan: There are two elements to that. The Last Post Fund administers that program. If the death of the individual is related to military service in any way—in other words, in effect, if the individual is pensioned at a degree of 48% or higher—the burial is covered automatically and there's no income test. For individuals who have a low income, other sources of funeral assistance, such as the Canada Pension Plan death benefit, would count against the ceiling, if the ceiling is higher than the Canada Pension Plan death benefit.

Mr. David Sweet: Thank you.

My last question is on the veterans charter job placement program. It's available there, but are we getting a good take-up on it? Are a lot of people using it to get into the workforce?

● (1635)

Mr. Ken Miller: The take-up to this point in time has been relatively low, and we're presently putting some effort into trying to determine what some of the factors might be in that. Some of it may be a matter of timing, and we're trying to find ways to make it available and engage with folks earlier in the process, before they're released. That may be important.

Some of it may also relate to communication and the awareness that individuals may have of the program. Certainly from those who have taken part in the program, we're getting very positive feedback that it's very useful, and that's encouraging. So if we can make more people aware and make it available to more, I think it's a very beneficial program. But to answer your question directly, the uptake has been rather low to date.

Mr. David Sweet: Has the success rate for those who participate been quite high?

Mr. Ken Miller: I don't know the numbers, sir, but I understand it has been quite good, yes.

Mr. David Sweet: Thank you.

The Chair: Thank you, Mr. Sweet.

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

Mr. Todd Russell (Labrador, Lib.): Thank you, Mr. Chair, and good afternoon to each of you. I certainly want to echo the sentiments of my colleague in thanking you for the work you do on behalf of veterans.

I just want to clarify. The department is undergoing a health care review. Is that right? It is conducting one?

Mr. Darragh Mogan: Yes.

Mr. Todd Russell: Can you give us a sense of what the terms of reference for that review are?

Mr. Darragh Mogan: The specific terms of reference are written in sort of bureaucratic language. I'll tell you what the problem was that we were trying to address. I think that's where your question is pointed.

One is complex eligibility. If you look at our eligibility chart, there are 14 different groups and about 33 footnotes. So you have quite a number of variations there. You have to be sort of an astrophysicist to figure it out. The cost of figuring that out means resources not directed to solving problems. It can be quite frustrating for our field staff. It's understandable. It's a patchwork of eligibility based on changes that have had good political merit since 1946. The problem is that in 1946 the people were of the average age of 26, but now they're 86 and they have to go through that kind of complex system. That is one.

The other one is trying to get an integrated system of health care, whereby one person assists an individual all the way through the health care system, so it's more or less a case management model. That was certainly seen to be a problem.

And the other is to make sure that, where possible, we are promoting good health practices, especially when a person is older, because there are a lot of payoffs. That was one of the things noted that we don't have in our programs now. We should have an integrated health service program.

Those are the three areas we were asked to focus on in the health review. We based the review on the report completed by the Gerontological Advisory Council, which is a group of academics, practitioners, and veterans organizations that has been advising the Department of Veterans Affairs for more than 12 years. It produced a report called *Keeping the Promise*, in which these problems—the three I mentioned to you—were addressed.

Mr. Todd Russell: I come from a remote riding as well, where there certainly is a semblance of the presence of Veterans Affairs. Certainly a lot of the people I represent are still striving to have the basics, such as a person, an office, or a bed for a veteran in some location, which in Labrador, for instance, could be hundreds of miles away. But at least it should be in some kind of a common environment, something they're familiar with in some kind of a culturally appropriate setting.

In terms of your health review itself, and understanding that it's a problem or a challenge, are you undertaking anything with a view to improving that for the veteran who lives in a remote area? You mentioned that you understand it and that you know it's a challenge. Is there anything your review is undertaking that would lead to recommendations to help or improve services in some way, shape, or form?

We can make the recommendation here. I think the suggestion made by my colleague, Roger Valley, is a very valid one.

Mr. Darragh Mogan: Yes, it is.

Mr. Todd Russell: Is there something you're doing internally that would help us to help that veteran in a northern, remote, or rural area?

Secondly, and more specifically, if we were to go the route of making a recommendation to work with the legions, what obstacles would we have to overcome? What would we need to do to get there? And what do you perceive to be, from a bureaucratic level, the challenges?

Thank you.

● (1640)

Mr. Darragh Mogan: I'll start. My colleague, Ken, can add something.

Service to remote areas, whether to veterans or others, is always a challenge—and you would know this better than I.

What we can try to do, and have increasingly tried to do, is use electronic access better in remote areas. But you have to have someone there who can actually use it.

Mr. Todd Russell: You still need a place.

Mr. Darragh Mogan: You need a place, but you also need the competence to do it. We increasingly will have staff visiting remote areas or have contacts in those areas for people who are experiencing trouble. We want to make it widely known that we can be called at any time, 24/7, with a problem, and we'll try to solve it right away. We can't perform miracles in remote areas, but not paying any attention to the problem is hardly the response either.

We'd certainly be open to suggestions. It's not a problem just for Veterans Affairs, but also for community service across the country, especially for older people or those with disabilities, or both. Add to that the multiplying effect of a psychological disability in a remote area and it's a real challenge. I understand that, and we're certainly open to ideas. I think the veterans health services review was trying to overcome complex eligibility, not where people choose to live, but we're certainly open to suggestions in that area.

I don't think there's any obstacle to asking veterans organizations to help out. The only challenge is that because of their advocacy role, they need to be at arm's length from government. We have partnership arrangements now with the Legion that don't violate or in any way put an obstacle in front of their arm's-length advocacy role. It seems to work out very well, principally in the area of looking at client satisfaction in all these institutions or facilities for veterans who are housed across the country—all 7,000 of them. I don't know that there's an obstacle there, except, of course, that they need to be able to advocate on the part of veterans to government and they don't want a relationship to government that impedes that, which is understandable.

We're certainly open to suggestions. It is a challenge.

The Chair: We're now going to the Conservative Party of Canada. Mr. Cannan, five minutes.

Mr. Ron Cannan (Kelowna—Lake Country, CPC): Thank you, Mr. Chair.

Thanks to our witnesses. I appreciate the work that you and the rest of the department are doing.

We did have positive news in the most recent budget. I wonder if you could elaborate on those changes, specifically in the veterans independence program.

I represent the riding of Kelowna—Lake Country in the Okanagan Valley, which has a lot of seniors and veterans, specifically widows. I wonder how they could now qualify for the VIP program due to this expansion in the budget of 2008.

Mr. Ken Miller: As background to that, the veterans independence program was first created in 1981. We subsequently did create expanded eligibility for the continuation of the program for survivors of veterans when certain benefits were in place. However, as has been recognized, there was no potential to put those benefits in place for survivors of veterans who either died before the program was in place or who were not in receipt of benefits even though they may have died after 1981.

The focus of the change that was addressed in the last budget was to bring provisions in place so that such survivors could receive benefits. Specifically, the benefits that were put in place are the grounds maintenance and housekeeping. The focus of this was such that the veteran, had they been alive, would essentially need to have been eligible to receive the program had the program been in place before their death. That's a fairly simple determination for us.

It then becomes a matter of eligibility for the survivor. There are two routes to that eligibility. The eligibility is focused on those who are most needy. It focuses first on those who have a disability or have a low income. There are tests related to both of those. If one or the other of those criteria are met, then we can put grounds maintenance or housekeeping, or both, in place up to an annual maximum of $2,400.

Basically, that was the provision you referred to in Budget 2008.

● (1645)

Mr. Ron Cannan: That's encouraging. I know surviving spouses of veterans, and one is receiving the benefit, but the one next door is not. One veteran had applied while he was alive and those benefits were carried on, but with the widow next door, her husband didn't apply and she didn't get any benefits.

What's the income? Is it based on a graduated scale, on a low income?

Mr. Ken Miller: Yes. It's linked to the guaranteed income supplement and their reference levels for minimal salary, and on the disability side it's linked to eligibility for the disability tax credit under CRA.

Mr. Ron Cannan: Okay. I'm moving on to the Last Post Fund. It provides financial assistance, you said, for funeral costs. Could you explain how veterans' families can take advantage of this program?

Mr. Darragh Mogan: There are two ways, sir.

Mr. Ron Cannan: I understand from your PowerPoint deck that it's for “a service-related disability or when service eligibility requirements have been met and there are insufficient funds...”. Is it a monetary threshold calculation based on some sort of GIS calculation?

Mr. Darragh Mogan: There are two ways. One is where it's service-related, in which case the grant is made and the service is provided. The other is where there's a lack of means. There is an asset ceiling involved there. I don't have the exact detail for it, but I can certainly get it for you, and I will.

Mr. Ron Cannan: And how many families have taken advantage of that program?

Mr. Darragh Mogan: I don't have it with me, sir, but it's quite old. This fund is a very old agency. It works on our behalf; it's been around for a while. Needless to say, with the age of the World War II veterans, it's an area that gets a lot of business lately.

Mr. Ron Cannan: You also talked about best practices. Do you have a timeline, when a file is presented to your department, for the turnaround time for adjudicating the file?

Mr. Darragh Mogan: I can give you some examples of that now. For a rehabilitation program, and we're trying to get this down, it's 41 days. I think that's too long, and I think our colleagues think it's too long. A vocational rehabilitation plan is not something you do overnight, but we're trying to shorten that.

For an awarded disability pension, I think it's four months, which is down from eighteen months seven years ago. We've really been working on a continuous improvement there.

For VIP, I think it's thirty days. There are published standards on this, I think, so I'm just giving you examples that I can recall, off the top of my head.

Mr. Ron Cannan: With regard to the new veterans charter, I was speaking with a member who used to be in the RCMP.

I have just one quick question, on the job replacement program. What's the success rate, or has there been much uptake on that program?

Mr. Ken Miller: Do you mean of the job placement program?

As I said in answer to an earlier question, the take-up on it has been relatively low, and I don't have numbers in terms of the success rate. I understand it's fairly high.

We could certainly share that with you, if you're interested in the specifics.

Mr. Ron Cannan: Thanks.

The Chair: Now we go over to the New Democratic Party and Mr. Stoffer for five minutes.

Mr. Peter Stoffer: Thank you, Mr. Chairman.

Gentlemen, I say the following with the greatest of respect.

Mr. Mogan, you just said that one of the problems with DVA is the complexity of eligibility and the minefield that goes through it. Yet Mr. Miller just announced to Mr. Cannan the eligibility for the new VIP program. The reality is that 30% of widows who weren't covered before may be eligible. They have to have a CRA thing, a disability tax credit, or low income.

This drives me absolutely crazy. If you were in my area, and Bill Casey's riding in Truro, and said that to a bunch of widows, they'd be talking your ear off. Why are you basing it on low income? Wouldn't you consider a 90-year-old disabled enough, from old age, not to be pushing a lawnmower around or doing housekeeping?

It's absolutely unbelievable. You just mentioned the complexity of rules and eligibility and then added two more to a new program, when they were assured by government—this isn't to do with you, this is a political one that did it—that all of them would be covered. This is the problem that veterans and their spouses have. When they signed up and joined the war, nobody asked them how much money they had. So why are we asking how much money they make when they require benefits?

If you could change that in your health care review, that, sir, would go a long, long way. A veteran is a veteran is a veteran, and a spouse is a spouse is a spouse. You shouldn't be tacking on rules and regulations for people in their eighties. They simply don't understand it. They're just asking for help.

As you know, and as we've heard before, this is a generation of people who don't like to ask for help. It is a sign of utter weakness when they have to actually pick up the phone and call for assistance. For people in that generation, you can't just tell them, “Well, ma'am, you can't have it because you don't have a CRA credit.” I dealt with one lady who was told by DVA that she had to go and call the Canada Revenue Agency to see if she could get CRA eligibility before she could possibly apply for VIP.

So I just want to let you know that this is a problem.

The other concern I have is with regard to the forms. Mr. Sweet said a good thing on the PTSD forms, that filling out those forms—and I've seen them—can give you PTSD. You don't need to have it because filling out the forms will cause enough problems.

Again, if you can fix that problem, that would be really great.

The other one I have, sir, is that we've heard it from previous governments and the current minister that the benefit of the doubt will always apply when it comes to the veteran. But that's not true. DVA is one of the few departments around that will actually assign you a lawyer to help you go through the maze of eligibility, and the benefit of the doubt only applies if—*if*—the interpretation of the legislation applies to it. And that is one of the things they have. If you want to solve the problem with DVA....

You said in your report that 5,000 clients die every year. That's what you said. And that's true. But the reality is that 26,000 veterans die every year. So 21,000 veterans, including their spouses, are not your clients. We're losing on average 140 veterans a day, and their spouses, yet very few of them, really, are your clients.

Many of these people have never applied for programs because they didn't want to. They're not of that ilk. But when they do apply, I would hope that one of the changes you'll be able to impose and make it quicker will be to ask, “Did you serve?” If the answer is yes, then your answer should be, “How can we help you?” That really should be the criteria: “Did you serve?” Nothing else should have to apply.

Thank you.

● (1650)

Mr. Darragh Mogan: I'm not sure I heard a question there, but I'll assume the question was why the government picked this relatively small group of widows—

Mr. Peter Stoffer: It's not just that; it's also the hearing aid problems, and VIP for Captain Earl Wagner. He is denied because he makes $250 more than the minimum, yet Mr. Brownlow, who's very wealthy, gets his hearing aids paid for by DVA. Explain that to those two veterans, because I can't.

Mr. Darragh Mogan: I can explain what would happen had successive governments since 1946 not added these eligibility groups; a whole bunch of people, more now, wouldn't be eligible than are. I'm sympathetic to the idea that when you have eligibility with all kinds of conditions on it, it gets rather difficult to navigate the system. I accept that. But I think the government has made an estimation that at least 12,000 more people are going to be helped now than were. It's a political judgment about whether it's 12,000 or 30,000.

With regard to forms, we're open to changing those. We don't want to put PTSD sufferers through the bureaucratic mill. That's not the intention at all. So we're certainly open to that.

If we look at why lawyers are being provided, if you ask the veterans organizations in the other four countries, they think it's first-rate that legal representation is provided to individual veterans. It has been provided since 1919; it's almost a birthright for a veteran.

So it may be that the system is complex, but at least it isn't complex to navigate for the individual who has a Bureau of Pensions Advocates representative.

Mr. Peter Stoffer: On the Last Post Fund, by the way, I have a person in Maitland, Nova Scotia, who applied for the program, but on appeal he actually saw the same person who denied him the first time. What it is—

The Chair: Done.

Mr. Peter Stoffer: You apply—

The Chair: You're done.

Mr. Peter Stoffer: Okay, I'll talk to him later.

The Chair: I'd like to follow up. Right now it's a Conservative spot, and unless I see anybody chomping at the bit, I have a couple of questions I'd like to ask—the prerogative of the chair—if I can.

I was very intrigued during some of our previous travelling around the bases, etc. I'm interested in post-traumatic stress disorder and some of the things Monsieur Perron raised in some of our previous committee meetings and whatnot. There was something called “battle mind”, which I guess the U.S. forces refer to with regard to post-traumatic stress disorder particularly. I'm intrigued by that. Could either of you comment about battle mind and put some more meat on the bones of that?

● (1655)

Mr. Ken Miller: I've heard the term, but I must confess I don't understand the full sense of its meaning in that context. I'm not sure I can add much to your question.

The Chair: Mr. Mogan.

Mr. Darragh Mogan: Certainly, preparation for such an engagement requires a certain mental outlook. You must have it or you won't survive in that environment.

When you step back out of that environment into an environment where that's not required, that's one of the real challenges to transition. It affects police forces and it affects others as well. It's a very interesting concept that the U.S. DVA and the U.S. Department of Defense have developed.

I think, Mr. Chair, when you're looking at the U.S. especially, you want to see what detailed studies they've done—and we're aware of them from our research director—on what exactly is involved in the transition to civilian life, what exactly goes through an individual's mind and what they have to go through. Many of them come in when they're 18 and they're not really mature yet, and they leave when they're 38.

It's quite a different experience, for instance, from a wartime veteran, who had a really tough experience but it was only over a three-year period, not over a 30-year period.

So what kind of mentality and psychology does an individual have to adjust to when they make the transition to civilian life?

Mr. Ken Miller: One of the things we are aware of with many sufferers of PTSD is that as they come back to Canada and are trying to deal with the issues, certain things can be triggers. When those triggers or those buttons get pushed, they can be instantly back in the stress situation that caused it in the first place.

One of the things that can happen—and I've heard sufferers talk about this—is that they react as if they were in that different environment. The reaction may be an appropriate reaction if you're under fire in a war zone, but it can result in very inappropriate behaviour and action if you're on a downtown street in Canada somewhere. So we've certainly heard of that.

The Chair: Fair enough. I'm intrigued by battle mind and I'd like to find out more about it.

When we were on a tour of Valcartier, we met a young fellow who was 24, I believe, who had lost the bottom portion of one of his legs. At the time, he was under consideration for $250,000 compensation, but he didn't lose the whole leg, so instead he was being looked at for compensation of $165,000. There was a delay in terms of the decision about what he was going to get and when.

People who had been serving in the military and had been around longer than he had raised the idea that for a young fellow of 24, was it better to allow an option? In other words, $165,000 straight off the cuff for a leg, for the rest of his life type of thing, or some sort of pension system, because he is probably going to live a long life and that might be worth more to him.

What are your thoughts on offering options? I know somebody else raised the question of options as well.

Mr. Darragh Mogan: Yes, it's fair for a person of that age.

One thing I will say, which we couldn't do beforehand, is that you'd have to have had that pension in your hand before we could have helped that person, before the new veterans charter. Right now, we can provide a rehabilitation program and income support to that individual whether they have a pension or not. So that pension gateway, which could take six to seven months, is not necessary at the moment.

In terms of the option about whether the individual would get the lump sum at age 24 or have a continuing payment, certainly it's a possibility that we could provide that as an annuity. There's really no reason we can't do that. The individual will get financial counselling, and it's available to all of them to determine the best route.

What you don't want to do is have somebody make that kind of decision in the course of a very agonizing psychological and physical event, which an amputation is. If possible, you want to allow time before that kind of decision is made.

We're certainly open to having the lump sum paid out as an annuity, if that makes more sense.

● (1700)

Mr. Peter Stoffer: I know what you're getting at, but I think he misinterpreted what you're saying.

The Chair: No, I thought it was a fine response. I'll be the judge of that.

When it comes to health records, we have had some talk about digitization or electronic health records, and you mentioned the U.S. system and its Department of Veterans Affairs. Is there some place you would recommend as being one of the best places in the United States to see their digitized or electronic health record system?

Mr. Darragh Mogan: Well, I think the Walter Reed hospital would be one place, but we can certainly arrange for that through the Veterans Affairs liaison officer and DND here. We can arrange for that to occur if the committee wishes. It would be very good for you to see it.

The Chair: Okay. I think it would be worthwhile.

Those are all the questions I have for you.

Now we're going to the Liberal Party with Mr. St. Denis for five minutes.

Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.): Thank you very much, Mr. Chair, and thank you, gentlemen, for helping us out.

I'd like to go back over some territory that maybe has already been partially covered.

I think it was in the latter part of 2006 that the minister announced, for lack of a better term, an internal review of health benefits for veterans. Now you'll have to help me. I don't remember if he, in the press release announcing it, mentioned terms of reference or a notional end date. We've been doing our best as a committee—with great respect to the wonderful work of our staff and our researcher, in particular, to help us along the way—but we can't compare with the resources of the department. I just wonder if you could remind us of what the terms of reference were and whether the minister said when he hoped to conclude the internal review. Can we be advised when that's going to be done?

We're operating independently, but obviously we're trying to serve the same people, and there would be some benefit in both our reporting and the department's coming to a conclusion in the nearer term as opposed to the longer term. I'd appreciate your help with that.

Mr. Darragh Mogan: Sure. I may have mentioned earlier that terms of reference per se were not given out, and there's no reason why they would have been, but what was put out was sort of the *diagnostic* of what the problems were. Mr. Stoffer and others have referred to complex eligibility. The point is taken. It's very complex, and after 60 years of adding eligibility with all kinds of conditions on it, it gets very hard to navigate. There is a lack of integration and absence of health promotion. Even as people age, exercise, in particular, of any form makes a lot of difference. Promoting a simple activity like that is one of the sorts of problems to solve with a health review.

Ken, maybe you can correct me here, but I don't recall that the minister put a timetable on it. However, obviously because its main target was older veterans, I don't think it was going to be done at a leisurely pace. I can tell you that the review is still ongoing.

Mr. Brent St. Denis: There's no notional deadline as we speak now? You wouldn't be able to say we're hoping to be done by September, for example? Will it be a report? Is it an internal report to the minister only, or is the idea that it would be released to the public, which would allow us, obviously, to have access to it as well? We're always on a learning curve, so I would only say it would help all of us.

Mr. Darragh Mogan: I guess my sense would be that it is a report to government, and by that I think I mean to cabinet. Certainly, the release of that or all parts of it to the committee or others would be at the minister's discretion, I think, so that's where the question should be directed.

Mr. Brent St. Denis: At that time, if the committee requested, and if the chair was cooperative, as usual, we could ask the minister to come and talk about the report he's received, but we don't know when that's going to be. I suppose we could invite the minister to come and give us an update on the report, because he must get interim benchmark updates.

I do appreciate that instead of having terms of reference, one can work from a list of problems, and here our goal is to try to solve all of or as many of these problems as is reasonable in the circumstances.

If I have a few more moments left, Mr. Chair, I'd like to tag onto something my colleague Mr. Russell raised about our local legions. They acted, when they were first created going back to the First World War, as part of a buddy system, as a way to provide some social support to the traditional veterans. Can you describe the relationship, formal or informal, between the department and the Legion? I know there are a large number of veterans organizations, but the Legion sort of stands out as at least number one, I would say, in all of our ridings when it comes to the commemoration and the remembrance.

Is there any talk of working with the legions? As we always renew Veterans Affairs, or try to, I am sure they are looking for renewal as well. Have they changed their own demographics? Will they invite the next generation of veterans in? What is the relationship, and is there any thought to helping them stay strong or become stronger in the future?

● (1705)

Mr. Darragh Mogan: I'll offer a comment, and, Ken, you can certainly amplify.

I just read the history of the Legion; it's called *Branching Out, The Story of the Royal Canadian Legion*. It's a remarkable organization. I've worked in Veterans Affairs for a long time, so I probably should have known this. It was there when veterans needed them after the First World War, after the Second World War, after Korea, and now in terms of reinvention, as it were—or being relevant to the modern veteran—it's been a very, very strong advocate for the new veterans charter and a strong advocate for changes to it as well. I can assure you of that. I'm hearing quite a bit about that. So anything the government can do to enable that organization to carry on, not only in making a contribution to veterans and their families but in making a contribution to their communities, would be laudable.

There are some natural limits because of their advocacy role, but we've directed some of our business to the Royal Canadian Legion, and we've been able to do it so that they maintain their arm's length from us. It's been a great service. With that as a precedent, I don't see why other things couldn't be directed in that area. Maybe they're going to get more involved in the job placement program too.

But sustaining them in all the communities they're now in is going to be a real challenge, given the diminishing number of their founding charter members. It's going to be a real challenge.

Mr. Brent St. Denis: Thank you, Mr. Mogan.

Thank you, Mr. Chair.

The Chair: Thank you.

It seems we're out of questions. Gentlemen, thank you very much for your appearance. If you don't mind, I'm just going to move into the next bit of committee business.

We have a couple of things. We have votes that are coming up very shortly. Also, we have a letter from the Speaker of the House that I would like to read to the committee members, and we can briefly discuss it.

The clerk and I talked about it earlier, and I believe you have all had copies distributed of the letter from the Speaker with regard to the motion Mr. Stoffer moved to designate the room.

I'm just going to read the letter from the Speaker.

An hon. member: We've already read it.

● (1710)

The Chair: Do people want me to read the letter?

Some hon. members: No.

The Chair: Okay, you've read it.

Do you have any comments, thoughts?

Mr. Valley.

Mr. Roger Valley: With all due respect, I don't agree with the Speaker's verdict at all, in any way. We understand what the Memorial Chamber is; it serves a purpose. This room is a place for veterans to come and talk to us. I don't think it would hurt us to do this. I think he took it to the House leaders committee for support of perhaps his own thoughts, and he has a lot of history here. I think the Memorial Chamber, as I just stated, has its purpose and everything else. There's nothing wrong with having a room where veterans can actually come and talk about situations they face. This is designated for them.

The memorial room was done.... The Speaker lets us know very clearly what years and why it was done. I don't see how that impacts us declaring this the veterans room. I have no idea what recourse we have either.

The Chair: Understood. My guess is, talking to the various people—the House leaders and whatnot for the various parties, I would imagine, is where this goes next.

Mr. Sweet.

Mr. David Sweet: Thank you, Mr. Chair.

Of course, I was involved with the discussion and agreed at the time, but I think you know how strongly I feel about tradition and what I spoke about before.

We had the leaders here from, I believe, six veterans organizations when I discussed the tradition in the Peace Tower. The Memorial Chamber being in the Peace Tower, my initial tendency right now—after receiving this letter—is to agree with the Speaker. But because of the nature of the magnitude of it and how he's shed some new light on it, I think it should be cause for pause and some reflection on our parts before we go ahead.

I don't think there will be a restriction, as far as what we had mentioned before, about putting some art in this room. But I do understand about an official designation and how there may be a concern of diminishing what is already there, which is quite grand in and of itself.

The Chair: Mr. St. Denis.

Mr. Brent St. Denis: With respect to the Speaker, I don't know if he was taking advice from the House leaders—we don't know the dynamic that was involved there—but I would politely argue to the contrary. I have two points.

We have the Railway Committee Room. We have the Banking Room. We have other rooms.

I'm happy and proud to have been involved in the preparation of Vimy Ridge Day, and hopefully Peacekeepers Day and so on, and those days, in my view, add to the remembrance activities in the country. They add on to November 11. I've always thought that way.

So it would seem to me that having a veterans room, *salle des anciens combattants*, would enhance.... The Memorial Chamber is not a meeting room. It's just that. I think it's totally in order to have a room so that when the veterans organizations come—or if they're here most of the time—they see it as their room.

What's wrong with appealing and making some additional arguments? If there is agreement, I'd be glad to help Alex add a few points, and everybody else could add their points.

The Chair: Okay, that's fair.

Monsieur Perron.

[*Translation*]

Mr. Gilles-A. Perron: I agree with Brent and Roger. In this forum we defend and help veterans who are still living, while veterans who have died are honoured in the Memorial Chamber. Why do we have a war room in the Senate where meetings of the National Defence committee are always held? We should appeal the Speaker's decision and demand that meetings be held in the veterans room.

● (1715)

[*English*]

The Chair: I'm glad we're discussing this. There are nuances that come out with regard to the arguments, and I appreciate that.

Mr. Stoffer.

Mr. Peter Stoffer: I remember very well the same discussion we had when David Pratt was the chair of the Standing Committee on National Defence and Veterans Affairs, when we moved the motion to have room 362 in the East Block designated the War Room. And I remember the diminishment and the argument of the memorial room, whether it would take away from that. Absolutely not. All it did was state that in room 362 there would be very tasteful, decorative artwork. There would be a small certificate or a plaque from the chair, which is very respectful. Not one person ever accused room 362 of being a memorial room.

This is not to be a memorial room. I would be the first one, like David Sweet, to argue that. This is just a working room so that when veterans, and especially their representatives, come in, they can feel at home and meet, discuss, and talk with parliamentarians—and whomever else, for that matter—about issues of the day that affect veterans and their families.

This is the exact same response David Pratt got. We should challenge them respectfully and indicate to Peter that we do not want this to be a memorial room. That's the last thing we want. We want this to be tastefully decorated so that it indicates to people when they come here that this room is a veterans' working room.

In 2004, when I wrote to everybody about the veterans committee, of having a stand-alone committee, I was told we couldn't do it because of the expense. In 2006, one of the first things the new government did was set up a veterans committee. Expense wasn't a problem then. We're not asking for money. We're just asking for consideration that this be like the Aboriginal Room down below, the Reading Room, and all these other ones that we have, and that this would be respected in those terms.

I think in the highlight of discussions of veterans and their families, this is just one more small way that we as parliamentarians can say thank you to those Canadians who serve. I told that gentleman who was here in uniform the other day, supporting his wife, who was a doctor, that we had a motion to make this room a certain room, but that we hadn't got it finalized yet. You should have seen the smile on his face. He was really proud.

The Chair: It might be worth it for me to approach Mr. Pratt to see how he navigated his way around this.

I realize we do have bells ringing, members.

Monsieur Gaudet.

[*Translation*]

Mr. Roger Gaudet: Why not have the Speaker come before the committee? That would settle the matter.

[*English*]

The Chair: The clerk has indicated there is a precedent for calling the Speaker before a committee. Maybe we should examine a few of these other things first, before we decide to make that call.

Ms. Guarnieri.

Hon. Albina Guarnieri: I think most of my colleagues have made the case I would have made. But if my memory serves me correctly, the vote was unanimous. Committees are a creature of the House, so the House should be supreme.

Maybe we can take it upon ourselves to talk to our House leaders and have them reverse this decision. From my perspective, you can't have too many ways to commemorate veterans. To be quite frank, I don't really buy the argument that's been made in the letter.

Mr. Gilles-A. Perron: The House leaders are afraid to lose their meeting room, because I think they're having a meeting here. This is the real reason.

The Chair: Mr. St. Denis.

Mr. Brent St. Denis: Mr. Chair, independent thinker that you are, I propose that you simply stand up some day and move a motion for the House to adopt. We think you're an independent guy. You're not afraid of repercussions and things.

Mr. Roger Valley: He's an independent man.

The Chair: Fair enough. I'll take that under consideration.

Thank you very much. It will all be considered. We'll visit this issue again.

The meeting is adjourned.

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