House of Commons
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 037 • 1st SESSION • 39th PARLIAMENT

EVIDENCE

Thursday, April 26, 2007

Chair

Mr. Rob Anders

Standing Committee on Veterans Affairs

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● (0905)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Order.

We're doing selection of witnesses with regard to Bill C-287, which is Mr. St. Denis' bill.

Mr. St. Denis, I'll let you lead off.

Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.): Chair, I don't have any strong feelings that we need to have a long list of witnesses. I think shorter would accomplish just as much.

I appreciate the suggestion, and Gilles can speak to it, about the Canadian Peacekeeping Veterans Association. They have Ottawa staff, I think. Tom Hoppe is here. I think it would be appropriate to ask them.

Initially I thought maybe Canadian Heritage, but it seems they really don't have opinions on it. They will only be involved with the half-masting of the Peace Tower flag if Parliament deems to create a non-vacation heritage day for recognizing peacekeepers.

Apart from the peacekeeping veterans and the Legion, I don't really have strong feelings about anybody else. I'll leave it to the committee.

The Chair: All right.

Mr. Shipley.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): I'm wondering, Brent, one of the things we found in going through our other discussions on the ombudsman, and certainly in our bill of rights discussions, is that if we don't invite—I mean, there's the Legion, but there are the other associations involved with it. I see they've been included here. I don't think your intent is that we spend four or five meetings on this; I think it's to actually move ahead.

Mr. Brent St. Denis: Find a consensus to do it or not.

Mr. Bev Shipley: Why don't we set a date and put out to the organizations that they are invited? We'd lock it in for that day, and if they all come, we'll allocate them a certain amount of time. That way they're included.

The Chair: Mr. Perron.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): I might have a middle-of-the-road solution.

[*English*]

Mr. Bev Shipley: We're plugged in and ready to go. We don't want to miss a word you say.

[*Translation*]

Mr. Gilles-A. Perron: Mr. Chairman, I might have a compromise for the issue under discussion. I think that we should hear from the Canadian Association of Veterans in United Nations Peacekeeping, because they are the blue berets. We should probably also have Mr. Chadderton, from the National Council of Veteran Associations in Canada. He is the link between all those associations. We would satisfy Bev by inviting Mr. Chadderton, because she thinks they should all appear. I think that all of us, including myself, want to act as fairly as possible and as quickly as possible, without spending a lot of time and several meetings on this. I think that one meeting is required.

● (0910)

[*English*]

The Chair: Thank you, Monsieur Perron.

Mrs. Hinton.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): I agree with both of my colleagues. I think the invitation has to go forward to the group of witnesses we have listed here. If they're able to make it, that's wonderful. If they're not, I think Mr. Chadderton will make a pretty fine representative of all of the groups. I think we owe them the courtesy of inviting them so they have an opportunity to speak if they so choose. If we end up with two witnesses, then so be it, but at least we've extended the invitations.

The Chair: Mr. Sweet.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): With the kind of input that we've been experiencing, Mr. Chairman, I think we should send a broad invitation to make sure the consultation is broad. As Ms. Hinton just said, if two show up, at least we've extended the invitation, and particularly to the identified peacekeeping organizations.

Actually, I can see reasons why all of the ones I have looked at need to be invited. There are more current vets. There are older vets. I just think it would be better for the list that we have here.

The Chair: Mr. St. Denis.

Mr. Brent St. Denis: I think that's a fair discussion. It's like an auction—here's the day that we're doing this. If they come, great. If they can't, I think we should invite them to send a letter or a note, so they will have a chance to participate even *in absentia*.

The Chair: Mr. Gaudet.

[*Translation*]

Mr. Roger Gaudet (Montcalm, BQ): I have a brief question. Would you invite them all to the same meeting?

[*English*]

The Chair: Potentially, the first panel would be invited for Tuesday, and the second panel would be invited for Thursday next week. I sense that we are keen or that we have an understanding that we want to invite the first panel. So far I'm not sensing that we are keen to invite the second panel. I don't know. I would appreciate feedback on that, though.

Mr. St. Denis.

Mr. Brent St. Denis: I think the first panel is more for veterans. The second panel, the World Federalist Movement Canada, I don't have any strong feelings about. I don't know. I don't see the need for the second panel myself.

The Chair: I was just looking at the back of the page here.

Mr. Brent St. Denis: I don't personally feel a strong need for the second panel.

The Chair: Going once—

Mrs. Betty Hinton: Volunteers with peacekeeping—would you be all right with not having them here?

Mr. Brent St. Denis: They're the peacekeepers association. Those are the bureaucrats.

Mrs. Betty Hinton: The Peacekeeping Centre and the Peace Building Coordinating Committee.

Mr. Brent St. Denis: Yes, but those are not veterans.

Mrs. Betty Hinton: All right.

Mr. Brent St. Denis: They're NGOs and the like.

Mrs. Betty Hinton: If you're comfy, I'm comfy.

The Chair: I sense, then, that the consensus of the committee would be to invite all the people on the first panel for the Tuesday, if we can get them for that day. If they can make it, great. If not, then at least they've had the invitation.

A voice: Send a letter.

The Chair: Yes, that's what I said.

Mr. Sweet.

Mr. David Sweet: There's just one other thing. Should we invite departments that are involved, departmental officials from DND, Veterans Affairs, and Heritage Canada?

The Chair: From what I understand, Heritage Canada does not feel as though they're directly implicated with regard to the issue at hand, whereas the other two have not been approached or talked to. Really it's the will of the committee.

● (0915)

Mr. David Sweet: I'll throw it out, then, that we should advise them. We should invite them, as well, to give their input.

The Chair: All right.

Mr. Shipley.

Mr. Bev Shipley: How much flexibility do we have in terms of inviting? Say we put out the invitation to the departments and to the first panel, but out of the departments we get the two, and out of the panel we get two. If we set two days, we're going to have two come in for two hours and another two for two hours.

If we end up finding out that we can put them all in the one day, then let's try to do that. I just don't see the need for two hours with DND and the VAC officials.

Similarly, if it ends up that there are two or three vet organizations, in the two hours we can use five witnesses. In other committees we are on we've had six witnesses.

I don't know if that's a fair request to the staff in terms of organizing that or if that's acceptable to everyone for consideration.

The Chair: Just to let everybody know, Mr. St. Denis gave his apologies. He's heading off to consider a transport issue, I think.

Monsieur Perron.

[*Translation*]

Mr. Gilles-A. Perron: Let us not forget that this bill has, I believe, two clauses. It's really just motherhood and there is nothing in it that anyone could really oppose. I think that everyone around the table would acknowledge that the only issue is the date for the National Peacekeepers' Day. I think that is the only point that we might have to discuss because I recall that when the debate was held in the House, everyone agreed on this except the day. Would it be the 1st of August, the 23rd of September, etc.? If one goes back to the statements made in the House, I believe that is the only point of contention one would find. The bill should take a maximum of one day. That is why I think that if we invite as many witnesses as possible they will be coming here for nothing. We just want to know what date they prefer.

[*English*]

The Chair: I guess, Monsieur Perron, it's based on the interjection of Mrs. Hinton, that if they choose to come, they probably have some interest in it.

What I sense so far, then, is that we invite the first list here, along with Veterans Affairs Canada and DND. If it turns out that we can fit it into one day, then we'll fit it into one day...hopefully, the Tuesday. Is that fair? Okay.

Monsieur Perron, I remember at the last meeting that you were interested in the issue of concurrence and what have you. I know you've spoken to the clerk with regard to this matter. I'll let you have the floor, if you wish to pursue this.

[*Translation*]

Mr. Gilles-A. Perron: I think that the committee members are in agreement to vote on our ombudsman report as soon as possible. My goal is to use the most effective means to force the House to include this report on the list of items they will be voting on. I would like to have a discussion on how we can do this, if we want to do this, and so on. That is what I wanted to raise this morning.

● (0920)

[*English*]

The Chair: Okay. Do we have any discussion on that matter?

Mr. Shipley.

Mr. Bev Shipley: I'm maybe missing something. My understanding is that process with the ombudsman is in place. The selection for that individual is likely happening. I'm not sure of the date, but maybe that's what you're trying to find out.

[*Translation*]

Mr. Gilles-A. Perron: I'm wondering if the government will take our ombudsman report into account, an issue that was unanimously voted on in the House, and that was calmly and seriously discussed and debated. Could this end up like the Canada Veterans Charter? Do we run that risk? That is one of my concerns and one of my questions. Will the veterans affairs minister follow the recommendations in our unanimous report? If the people on the other side can confirm to me that the veterans ombudsman process will be based on —even if it is not necessarily identical to—our report, then I can live with that. If not, then I cannot live with that at all. I have some concerns. Given what happened during Easter break, I am somewhat wary. Is it a yes or is it a no? Will Mr. Harper do another Canada Veterans Charter trick? That is my concern and I am being honest enough to tell you this amongst ourselves rather than making a public statement. I am doing this with an extended hand and an open mind. We worked on this and it should at least result in something.

[*English*]

The Chair: I'm going to recognize Mr. Sweet next, but all I can say for certain is that I know the person's in the process of being hired.

Mr. Sweet.

Mr. David Sweet: Just a point of clarification. Could the clerk tell us how long the government has to respond when we submit a report for recommendation. Is it 60 days?

The Clerk of the Committee (Mr. Alexandre Roger): We didn't ask for a government response in the report.

Mr. David Sweet: Is that not automatic when a report is submitted?

The Clerk: No, it has to be decided by committee, when the committee reports to the House, whether they're going to include a government response or not.

[*Translation*]

Mr. Gilles-A. Perron: I would like to add my two cents' worth. The report tabled in the House is suspended in mid-air somewhere and no one can take it into account. That is what I find the most unfortunate this morning. I believe we undertook this work conscientiously. It has no legal authority, and there is no pressure on the government. Did we do all this for nothing? I believe and hope that we did not.

[*English*]

The Chair: It sounds like you're starting with something, Mrs. Hinton, so I'll let you carry on with that.

Mrs. Betty Hinton: Well, of course it would be taken into consideration. I know that the minister is also awaiting our recommendations on the bill of rights, because that's not completed yet either. We've made it very clear that's the direction we're going in as a government, but this committee has a great deal to say about that, and I'd love to see this committee finish its work.

The Chair: All right, then. I don't know where that leaves us.

● (0925)

Mr. Roger Valley (Kenora, Lib.): Well, it pretty well leaves us with "Fool us once, shame on you. Fool us twice, and we're going to have more to say."

The Chair: That's one way of wording it, Mr. Valley.

Monsieur Perron, I hear where you're coming from. If you want to, move a motion and give us a written motion to that effect. I know that you've talked with the clerk with regard to having me move the motion. Since this is essentially coming from you, while I understand and appreciate where you're coming from, I would leave it to you that if you want to move the motion, you can move the motion, and then have the committee consider it and vote on it, if you will.

We'll have Mr. Shipley and then Mr. Sweet.

Mr. Bev Shipley: I think it might be a helpful beginning to find out if, as a committee, we could get the status of where the process is. I think we all want to know where it's actually at in terms of the ombudsman coming into effect. Looking at our recommendation, we can maybe take from some of the comments how it has been modelled. If that would be helpful, I wouldn't have any issue with trying to get an update on the status on that.

I don't know if that meets your requirements, but it may be the first step. At least we'll get the opinion, then, either of the department or the ministry.

The Chair: Just following up on what Mr. Shipley is saying, I'm going to ask a question. Is your suggestion to bring forward a witness from the department to talk about it?

Mr. Bev Shipley: No, it isn't. It's to get the status. That may come as a letter from the chairman to the minister's office on where we're at in the selection of the ombudsman. I don't know—The discussion about how that individual has likely been hired, the mandate, will be in terms of the recommendations we laid out. It might be helpful.

The Chair: Mr. Sweet and then Mr. Valley.

Mr. David Sweet: Mr. Chair, through you to the clerk, since we did not do that when we submitted the recommendations, can we do it after the fact and request a response from the government on the recommendations?

The Chair: He has to check.

The Clerk: I'll find out right now.

The Chair: Fair enough.

Mr. Valley.

Mr. Roger Valley: Do we have anything scheduled for Thursday at this point?

A voice: Not that I'm aware of.

The Chair: The poor clerk has to be a multi-tasker.

Mr. Roger Valley: I'm wondering if we have anything scheduled. If we don't have anything scheduled, let's ask the minister to come on Thursday, instead of writing us a letter.

The Chair: Right now it appears we have witnesses for Tuesday. If we can get all our ducks in a row for Tuesday, then we would have Thursday free.

Mrs. Betty Hinton: What about Mr. St. Denis' bill?

A voice: I thought we were dealing with Tuesday witnesses.

The Chair: One would hope the whole issue could be dealt with in one day.

I'm not opposed to asking the minister, but I don't know what his schedule is and whether his time will permit it.

Mr. Roger Valley: We can ask him and we can decide.

The Chair: Mr. Shipley.

Mr. Bev Shipley: When do we wrap up Mr. St. Denis' bill? If we're going to have witnesses on Tuesday, we're not likely going to have the discussion on Tuesday. Would Thursday not be the day to be doing that?

Mrs. Betty Hinton: That's what I thought.

The Chair: I can't predict the will of the committee, sir. Sometimes it takes a course of its own.

Mr. Bev Shipley: It's just a question that I'm putting out. If we're going to have the witnesses, let's keep the parameters around that. If we're going to do the discussion on a bill, let's have the witnesses in, have the discussion and get the bill put forward. That, to me, makes sense.

● (0930)

Mrs. Betty Hinton: It takes precedence, anyway.

Mr. Bev Shipley: We now have another request, and that's fine, but let's not keep plugging things in. We still have our health care discussions. I think that's significant enough. That's a large project.

I don't think we should have days when we're saying we don't have anything. I think it's about the committee sitting down and getting our witnesses lined up to continue on—after PTSD, then health care.

Mrs. Betty Hinton: You mean finish the job?

Mr. Bev Shipley: I would suggest that Tuesday, after we have the witnesses, let's have our discussion on Mr. St. Denis' bill and get that wrapped up. If we need to have a discussion about where we're at on the ombudsman, I don't know that we need the minister. Let's try to find out where the status is. And if the interest is to keep moving on health care, which I think is significant in this committee, I would like to line up the witnesses and keep going.

The Chair: We'll have Mr. Valley next, but I believe the clerk now has an answer to Mr. Sweet's question.

The Clerk: Yes.

You were asking if we could have a government response. We can table another report asking for a government response to our ombudsman report, and then the 120 days would start when that second report is tabled in the House.

Mr. David Sweet: So we're just tabling a duplicate report?

The Clerk: No, we're tabling a different report. Say tomorrow we table a report asking that the government respond to the ombudsman report; it's a different report. It's just a report asking for a government response, that's all. The 120 days would start when this report is tabled, say tomorrow.

Mr. David Sweet: Okay.

The Chair: Okay, fair enough.

Mr. Valley.

Mr. Roger Valley: In this place, answers are extremely rare. If you want to get an answer, ask the person at the top.

I think there's no reason, if we're dealing with Mr. St. Denis on Tuesday—We've all heard ministers come before meetings. They rarely come for more than an hour. They have busy schedules. Let's get him in for an hour, have an hour to discuss it, and then finish with Mr. St. Denis' request.

We're not going to get him here and grill him for two hours. That's not going to happen. An hour is lots of time to deal with these issues.

The Chair: Okay. Now, to be honest, on this issue I think I've heard one for and—

Mr. Roger Valley: Three against?

The Chair: Yes, something like that. I'm trying to weigh how many it was on that side.

I understand where you're coming from, Mr. Valley. There are a few different options on the table.

Mrs. Hinton.

Mrs. Betty Hinton: I'm looking at the agenda you put in front of us today, and part of it is planning for future business. We've had a couple of discussions already.

We're going to deal with Mr. St. Denis' bill. I think we've agreed on that. We're going to call witnesses. We don't know right now how many responses we're going to get, so we're not sure if it's going to be two meetings or one meeting. We haven't finished the bill of rights, and we haven't got into detail on the health care review, which is very important to our senior veterans.

I'm going to try to say this as politely as possible. The committee dictates its own will, but if we're going to go back and forth and up and down, I don't think we're going to get anywhere. I'd like us, as a committee, to decide. Are we going to hear witnesses for Mr. St. Denis' bill, and then when that's finished, are we going to finish the bill of rights, and after that's finished, are we going to move on to the health care review, or are we going to go back and forth and up and down?

The Chair: We are now at 9:30, and I believe we have a witness on audio.

I'm going to propose this. We have a witness, let's be courteous to our witness, and deal with that. Tuesday we'll be into Mr. St. Denis' bill. Depending on how that goes, if we deal with it within that committee meeting, it allows us to ask the minister, or whoever it is, at the end of Tuesday's meeting, for Thursday. Let's play it by ear in terms of how Tuesday goes.

Mr. Roger Valley: I don't agree with Mrs. Hinton. I thought it was clear to us, through Bev's comments, that we were going to deal with it Tuesday, that the witnesses are dealt with Tuesday. We had nothing on the schedule.

The Chair: Mr. Valley, I know. You've expressed that three times, and I appreciate that.

● (0935)

Mr. Roger Valley: Maybe the fourth time you'll listen.

The Chair: I understand. I'm going to ask, please, that we go to our witness.

I'm assuming we have Dr. Victor Marshall on the other end of the line.

Dr. Victor Marshall (Chair, Gerontological Advisory Council): Yes, you do. Thank you.

The Chair: Wonderful.

Thank you very much, sir, for appearing as a witness, at least audio-wise today.

I'm sure you know this is all pursuant to our Standing Order 108 (2), a study on the veterans independence program and the health care review.

Just for everybody's edification, you are the chair of the Gerontological Advisory Council.

Dr. Victor Marshall: Yes, I am.

The Chair: All right. Sir, the floor is yours.

Dr. Victor Marshall: Thank you very much for inviting me to address this special committee.

I'll make some brief remarks. I'm quite sure I won't take 20 minutes, and then I'll be happy to answer any questions you might have.

I thought you might, in the first place, wonder why you're speaking with someone from Chapel Hill, North Carolina, so I'd just like to give you a little background on myself.

I am a Canadian. I was born and raised in Calgary—Calgary West riding, by the way. While pursuing my BA at the University of Alberta, Calgary, as it was called at the time—that was the last graduating class before it became the University of Calgary—I was in the reserve officer training program of the Royal Canadian Navy Reserve, so that's the UNTD, or the University Naval Training Division. I was commissioned in the naval reserve, but I went on the inactive list when I went off to the United States to do my PhD. Then I returned to Canada for an academic career, first at McMaster University for eight years and then at the University of Toronto for twenty years. It was during that period, in fact ten years ago, that I was appointed chair of the Gerontological Advisory Council of Veterans Affairs Canada. In 1999 I moved here to the University of North Carolina, where I direct its Institute on Aging, but I have continued to be asked to chair the Gerontological Advisory Council, and it's frankly an honour and a privilege to do so.

I want to begin by telling you a bit about the Gerontological Advisory Council and its mandate, and how this led to the report that we issued last November called *Keeping the Promise*. I'll then highlight the main principles and features of the report before turning it back to you for questions.

The Gerontological Advisory Council will celebrate its tenth anniversary in July. Its members include representatives of the three veterans associations that are focused on the traditional veterans: those from World War I, World War II, and Korea; people from the health care sector who provide services to these veterans or who otherwise have experience with long-term care; and the leading Canadian researchers in aging and health.

Veterans Affairs Canada asked us for advice, and I am pleased to say our advice has been, for the most part, taken, and we think it's had an impact. From an academic point of view, I can tell you that's rare, and we're pleased about that.

Our mandate is formally restricted to the traditional war veterans from World War I, World War II, and Korea. As I'm sure you all well know, the average age of the World War II veterans is now about 83 years old, and that of the Korean veterans is 73 years old. That's why we're a gerontological advisory council. A few years after we were established, a Canadian Forces advisory council was established for the remaining veterans. As chair of the Gerontological Advisory Council, I sat as an observer with that council, the Canadian Forces Advisory Council. Its chair, Dr. Peter Neary, sits as an observer on our council as well.

We're an arm's-length council, and our mandate is specifically limited to giving advice when we are asked for it. I do confess that from time to time, we have exceeded our mandate by giving advice not specifically asked for, but we're really not supposed to do that. In no way do we speak for Veterans Affairs Canada.

About two years ago, we were asked by the department to give an assessment of their services to the traditional veterans and our best advice as to how to improve these services. Any recommendation that we make has to pass three tests, in a sense, given the nature of the council. It has to meet the needs of the veterans' groups, as they see them. It has to be realistic in terms of the clinical and health care experience of the providers, and it has pass the scientific criteria that are so important for the academic researchers on the council. I believe it's fair to say that the recommendations in *Keeping the Promise* have passed these three tests and are therefore recommendations for reform, based on what is known as evidence-based practice.

Building on the momentum of the Veterans Charter, which focused on the Canadian Forces veterans and drew on recommendations from the Canadian Forces Advisory Council, we reviewed existing arrangements for the traditional veterans and developed a framework outlining the best ways to support health, wellness, and quality of life for the estimated 234,000 war service veterans.

In *Keeping the Promise*, then, we have outlined some basic principles. Currently, 40% of war service veterans receive Veterans Affairs Canada health benefits, and we take the position that all war service veterans who could benefit from VAC services should be eligible. In other words, a vet is a vet is a vet.

● (0940)

We wanted to start from first principles. We commend the department. It's made a lot of great progress and innovations in serving veterans, but we wanted to look at the state of the art in gerontology and geriatrics. What is today's wisdom about the best way to provide services for an aging population? We also adopt a social determinants of health perspective, which is very Canadian in its origin. Health, wealth, and social integration are seen as the major factors leading to well-being in later life. This builds on a framework adopted both by Health Canada and by the World Health Organization in its active aging framework. We also adopt a life-course perspective, which is very common in the field of social gerontology, but it means that to understand people in the later years, you have to understand where they've been over their lives. If you want to influence what happens to people in later years, it doesn't hurt to start early.

Early life events can produce delayed adverse health outcomes, as the general PTSD literature and also the Australian research on Korean War veterans that we cite in our report, attest. This implies that health promotion and disease prevention should be an important component of VAC services. That recommendation would be consistent with the federal health program review recommendations. We also take an ecological perspective. A chart on page 9 very graphically shows this. This places a veteran in the context of his or her family and community. It rests on the principle of trying to provide care programs close to home. I think most importantly we advocate for a program based on needs rather than on the complex service-based eligibility requirements that now exist.

We maintain it is neither feasible nor necessary to relate a current health condition in the later years to a specific war service related event. I might say that when all the university professors and experts on aging came on the council, they were truly astonished looking at the complexity of the table of eligibility. We couldn't believe it was that complex. The state of the art and thinking about the delivery of health and social services is to move as much as possible to needs-based criteria with carefully developed screening.

When putting all this together, we saw the need for a new way to organize a comprehensive integrated health and social services system for Canadian veterans. We sketched a plan based on two well-evaluated service delivery systems from Quebec. We developed this plan with the idea of getting to veterans early; that is, before serious frailty or disability occurs. With the average age of World War II veterans at 83 and Korean veterans at 73, it's impossible to be too late. It's almost too late to be early with this population. But experts in health promotion and disease prevention stress that it's never too late as well as never too early to initiate health promotion strategies that will produce positive results and be cost-effective.

The recommendations we made are in the report, and they're summarized in nine bullets. I want to highlight the three key recommendations for you. The first is that Veterans Affairs Canada should combine its current three health and social programs into one called Veterans Integrated Services. Second is that services be available to all veterans who served in the Canadian Forces during World War I, World War II, and Korea. A vet is a vet is a vet. Third is that services be expanded to include early intervention and health promotion services, more extensive home supports, and a wider range of residential choices.

I think *Keeping the Promise* is an important report showing how to go beyond the new Veterans Charter that was implemented in April 2003 and targeted at reforms and services for Canadian Forces veterans.

● (0945)

We are well aware that the Canadian Forces veterans are themselves aging. The average age of the Canadian Forces clients of Veterans Affairs Canada is actually 53. Particularly in the health promotion area, our recommendations could be very useful to guide services for these veterans as well, and frankly, while our mandate is to give advice regarding the traditional veterans, we quite deliberately and explicitly in the report suggested that the program we're outlining could have many benefits for services for the Canadian Forces veterans as well.

The current initiative—the health care review—will be drawing on this report, and in fact we've established two committees to assist in implementing our recommendations so that they could be helpful in this regard.

One of these committees is in the critical area of health promotion. The other will deal with the development of a screening instrument that can be used to direct veteran clients to appropriate levels of care.

When we formally released *Keeping the Promise* last November, I was proud to have standing beside me representatives of every one of the veterans organizations. They have all endorsed *Keeping the Promise*, and needless to say, the council hopes that government will be sympathetic to our recommendations.

That concludes my remarks.

Thank you.

The Chair: Thank you very much.

We now have some committee members who would like to ask some questions.

First would be Ms. Guarnieri from the Liberal Party, for seven minutes.

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

Dr. Marshall, first let me thank you for your insights regarding your extensive experience, for leading the work of your advisory council, and for being a force for continued analysis and improvement of veterans affairs programs.

My first question addresses the goals of your proposal for veterans integrated services that would, and I quote from your press release,

> —be more comprehensive, flexible and responsive than VAC's current health programs; reach more Veterans and families; help them enhance their health and well-being; and give them access to more appropriate health and social services when they need them.

Essentially, from what I understand, you are calling for a further redesign of existing programs that would change eligibility criteria, allowing more veterans to qualify, and at the same time provide a broader range of services to thousands more veterans.

I wonder if you have a sense of how long it should take administratively to implement the changes you are proposing, and how many months would be required to set up new regulations and add the appropriate systems and resources to deliver these new services.

Dr. Victor Marshall: Yes. I will try to answer some aspects of your questions, which are good ones. When it comes to implementation, that is something the department itself would have to grapple with. I don't have the expertise on the timetabling of moving through the legislative process.

I could just say that the recommendations in our report are being considered in the current exercise that's going on. We are actually hoping for the system that we're proposing, but you need some good assessment tools, because if you're going to expand the services based on need, that doesn't mean everyone will get services. They have to have a demonstrated need, and we need better assessment services for that. We do hope that actually by the early summer we'll be well on the way to being able to recommend specific assessment tools for that.

The general organizational principles already exist in the province of Quebec. As I mentioned, we drew very heavily on two of the programs in the province of Quebec that have been not only implemented but well evaluated, so it's not like creating a system that's totally new.

I'm sorry, I just can't tell you in terms of the legislative process how much time that would take. The other component that would need to be worked on is that there would be some retraining aspects for Veterans Affairs Canada staff to fulfil the three roles that we outlined in the process, at the different levels of care.

● (0950)

Hon. Albina Guarnieri: Dr. Marshall, I asked you to estimate the time to market, if you will.

You stressed two points in your discourse, in your previous intervention. You stated that action needs to be taken immediately and that the war-service veteran population is declining at a rate of 2,000 a month.

I wonder how you would regard the government's decision to carry this health care review into 2008, and to only then begin implementing changes. Given that the timeframe for the health care review is being dragged out for another year, what changes do you think could be implemented immediately to meet the needs of veterans today, and what can and should be done now in advance of that review?

Dr. Victor Marshall: I think if we're not moving to a needs-based principle right away, then somehow trying to simplify the table of eligibility would help.

To be very specific, for the spousal benefit for the VIP I don't see a reason to wait to do away with that restriction, which is that you have to have been enrolled in the program from 1981 before a spouse can become eligible on the death of the recipient. I think there is general widespread agreement that is a good thing to do. It's going to take some money, but I don't see why that couldn't happen in advance of the completion of the review.

I also think health promotion is very good business in the sense that it's really quite well established now that a number of health promotion interventions are very low cost, and if more veterans were referred to health promotion interventions that already exist in the community there would be long-range cost savings in the sense of keeping people healthier longer.

We would really advocate that eventually, as soon as possible, a strong evidence base be used. There are a lot of health promotion interventions that are sort of people's favourites and they may or may not work, but it's not really established exactly the extent to which they work.

On the other hand there are a number of programs that work very well and have been shown to work very well. We call these evidence-based programs. A turn towards those programs would be useful as well.

Hon. Albina Guarnieri: Given the timeframe that now appears to be set in stone, the number of veterans who will actually benefit from your proposed changes will be far fewer than the 220,000 or so that we have today.

I wonder if you can comment on the appropriateness and the quality of the services we provide to widows, as they are a rising percentage of the clients.

● (0955)

Dr. Victor Marshall: It was a good thing. The VIP is sort of like a flagship program. It is a wonderful program. It's really a model program, I would say, a service program that Veterans Affairs Canada organizes.

It used to be, of course, that if the veteran and his or her spouse were receiving those benefits and the veteran died, they would continue for one year. Now they continue for the life of the spouse, except that there's this restrictive provision.

You can have the situation where someone has spent their whole life taking care of, let's say, a husband who had a war-related injury. Still, now, some of these people are not eligible for the continuation of the services because of this artificial timeline. That's the easy one, I think, to work on, as far as I'm concerned.

We really think it's important to place the veterans in a family context. Even if you think of operational stress injuries and PTSD kinds of things, there are clearly effects on families. When veterans have PTSD there's an increased risk of spousal abuse and things like that, and of course the increased burden of caregiving on the spouse.

So we really think that the unit of analysis should be the family, not just the individual veteran.

Hon. Albina Guarnieri: Thank you for your insight. My time is up.

The Chair: Thank you very much.

Now we are going to move on to Mr. Gaudet, with the Bloc Québécois, for seven minutes.

[*Translation*]

Mr. Roger Gaudet: Thank you, Mr. Chairman.

I haven't had time to read all of your brief. Why did you call it "The Future of Health Benefits for Canada's War Veterans"? There's also Bosnia, the Gulf War, Afghanistan—

[*English*]

Dr. Victor Marshall: Yes, that's a very good question. The term "war veterans" is in common usage at Veterans Affairs to refer to this group for which our council is mandated to give advice: World War I veterans—I think there are still three remaining—World War II veterans, and the Korean War veterans. We have had Bosnia, and of course we have Afghanistan right now.

This is not an official position of council, but let me just say that I, myself, find it difficult to make a distinction between Canadian Forces veterans and traditional veterans. Again, as we say in the report, we think a veteran is a veteran is a veteran. If you've worn the uniform and put yourself at risk for your country, you should be considered a veteran. The distinction may have had some administrative usefulness, and it may still have some administrative usefulness. But in terms of the kinds of needs any of these veterans are going to have, we think they're the same, whether they've been in peacekeeping or peace enforcement or in actual, formally defined wars. But we had to live within our mandate as a council for the war veterans.

[*Translation*]

Mr. Roger Gaudet: Thank you, Mr. Marshall.

How do you analyze post-traumatic stress disorder for young war veterans? Does your document cover this?

[*English*]

Dr. Victor Marshall: The council did not do an analysis of post-traumatic stress disorder or operational stress injuries for the young veterans, because that would have taken us beyond our mandate. Again, there is this other council, the Canadian Forces Advisory Council, and we would have been going beyond our mandate if we had explicitly done that.

I happen to be, personally, as are a number of members of the council, aware of PTSD issues for younger veterans. I have actually been analyzing some Canadian data on PTSD. But the council itself really was limited by our terms of reference, so we did not consider the younger veterans with PTSD.

● (1000)

[*Translation*]

Mr. Roger Gaudet: Mr. Marshall, there are not very many war veterans sitting on the advisory council. There is one: Mr. Kenneth Anderson, a war veteran from the Canadian army, navy and air force. The purpose of this committee is to come up with something for war veterans. However, I don't see very many people amongst the committee members who have served.

[*English*]

Dr. Victor Marshall: Again, we are the advisory council for, basically, the World War I, World War II, and Korean War veterans. The three major organizations of veterans for those traditional veterans groups are all represented on the council.

Now, in terms of this report, we met with all the other—I think six—veterans organizations, and they all have endorsed this report, as I mentioned. They were there when we publicly released it. So they support the report. The other veterans organizations are all represented on the Canadian Forces advisory council.

The Chair: Thank you very much.

Now we'll move to Mrs. Hinton from the Conservative Party for seven minutes.

Mrs. Betty Hinton: Good morning, Dr. Marshall. Thank you very much. It's been very informative. I've tried to speed-read your report, but I'll have an opportunity later on to go through it in detail. It seems that you did a great deal of work, and it sounds to me like you enjoy very much what you're doing.

There were a couple of comments I would like to correct for the record. You suggested that the new Veterans Charter was implemented in 2003, and it was in fact implemented in 2006. It's a minor detail.

I think you also indicated that you're aware that Veterans Affairs is trying to move forward on this health care review. Our committee is supposed to be dealing with the health care review as well. We have run into a few little snags. We were sidetracked by the PTSD issue. It is a very important issue, but we haven't yet started the health care review. Hopefully that's going to happen very quickly and this committee will have an opportunity for some serious input into which way we're going.

What do you think the committee should actually concentrate on when we eventually get to this health care review? That's the first question.

The other thing I'd like to say is that I like your approach very much. You say that in order to know where a vet is going, you need to know where he came from. That makes tremendous sense to me. I think the approach you're taking is admirable.

On the second question, do you have any idea, having done some research, what the cost would be to once again expand the VIP? As you said, we did this once as a government already when we included the widows from 1981.

Dr. Victor Marshall: I think that broadening the eligibility criteria would be the thing to focus on. But if you do that, there would be more people coming into the system. Now, most of these people would be coming in at very low levels of contact with the system.

When you have time to read the report more slowly—not speed-reading it—you'll know we're advocating a single point of entry to the system. In many cases, a first screening would lead to referral to an early intervention specialist. This is for someone who doesn't really have heavy care needs but who could probably benefit from health promotion interventions. The interventions themselves would most likely be delivered not by Veterans Affairs Canada personnel but by programs that are already existing in communities. You still need some training of Veterans Affairs Canada personnel within the health promotion area in order to capture people in that area.

So I think the first thing I'd say is about eligibility. You should go to a needs-based system right away. That does require some in-house training of the what we call the early intervention specialist, the care coordinator, and the high-needs-care manager. They don't need training, but they need organization.

In terms of the costs, we were actually asked to make our recommendations without having cost considerations explicitly in mind. In the sense that if you're going to recommend A you have to take away B in order to remain cost-neutral, explicit cost projections were not part of our job. That's something we'd turn over to the department to struggle with.

However, let me say what would probably happen if our recommendations were fully implemented. There would be some modest increases in cost, but because, as has been pointed out earlier, the older veterans are dying off at a few thousand a month, these costs will curve down. So initially there are higher program costs, but it's like a bubble: they're going to pass through the system as the traditional veterans die. That is also the reason we'd like to see the thing implemented as quickly as possible, so we can get benefits to them before they die. But we do see it as an up-and-then-down phenomenon.

We also think that the health promotion aspects of our program should actually lead to enhanced life expectancy. We do know that most health care costs of older people are actually incurred, you might say, in the dying process, in the two or three months before death. But the older you are when that period of terminal decline occurs, the lower the costs that are incurred. So there are further savings. By keeping people living healthier into their older years, you will also have savings.

I can't put a number on it, but I would anticipate a rise and then a fairly quick and steady drop-off, as the clients die.

● (1005)

Mrs. Betty Hinton: Dr. Marshall, I envy your not having to consider costs. It would be a wonderful position to be in. I also agree with you that this is an issue that should have been dealt with more than ten years ago. We are on the right page now. We are moving forward. I also agree with you completely when—you didn't actually say the words—you made the suggestion, which I've made for many years, that there is a cost savings if you are able to keep a veteran, or any senior for that matter, in their home where their quality of life is better. They're not being displaced. Early intervention and all those sorts of things make a much better departure from this world, shall we say. No one deserves to have a smoother road than a veteran does. So we're on the same page with that one.

Dr. Victor Marshall: I'm glad to hear it.

Mrs. Betty Hinton: To sum up, you said you want this committee to look at broadening the eligibility and early intervention.

Oh, he's holding up the sign; I have to stop now.

Dr. Victor Marshall: Yes.

Mrs. Betty Hinton: That's it?

Thank you.

The Chair: Thank you.

I try to do what I can.

Now we go to Mr. Valley with the Liberal Party for five minutes.

Mr. Roger Valley: Good morning, Doctor.

The report is very intriguing, I'd say, from the time I've had to spend with it. It seems to make an awful lot of sense. In your call to action, some of the words you use remind us of what we're supposed to be doing. I'll read from your last paragraph: "—there is no time for extensive debate. —we must act quickly, and we must act now. It is time to keep the promise."

It's been six months since the report was handed out. My first question is who asked for the report? Was it something your organization felt they should do, or were they asked to do this?

● (1010)

Dr. Victor Marshall: I was asked by the deputy minister to do this, so I don't know exactly if the request came from him or from higher than him. The deputy minister asked us to do it.

Mr. Roger Valley: Do you recall when that was? I'm just wondering how long the report took, because it looks quite extensive.

Dr. Victor Marshall: It took us a while to get going. Once we finally made the commitment to do it—we're a bunch of volunteers, you know—we actually managed to put together the report in maybe ten months. There was a lot of work. We had Dorothy Pringle, who's a former dean of nursing at the University of Toronto, and who just received the Order of Canada, by the way. She's a member of the council. She led the committee and the subcommittee of council. We had a chance to consider things in three successive council meetings over the space of a full year. So I guess you could say a full year from the beginning with discussion of it in council, through the committee work, through massaging at council meetings, and finally with council giving the blessing.

Mr. Roger Valley: So the report of November 2006 started roughly in November 2005?

Dr. Victor Marshall: That's right.

Mr. Roger Valley: Thank you.

I have just a quick question. I may have heard you wrong, but I want to clarify, and Ms. Hinton just alluded to this. You were asked to make recommendations purposely without costing. That was asked for by the deputy minister at the time too?

Dr. Victor Marshall: The without costing part came from the ADM.

Mr. Roger Valley: Was that in the original intention of your report, or did it come later?

Dr. Victor Marshall: I'm sorry, it came from the deputy minister as well. I beg your pardon.

I'm sorry—what was your last question?

Mr. Roger Valley: I just wanted to know who had asked you that, and I think you clarified it by saying the deputy minister. Do you remember the name of the deputy minister at the time it was asked for?

Dr. Victor Marshall: There was a change of personnel. It was a woman—Oh dear, I'm sorry.

Mr. Roger Valley: That's okay. I just want to try to clarify where the report came from. You've done an awful lot of good work here.

Can you tell me your own impression—and I realize you're a bit removed—of what's happened in the six months since the report? Have you had much feedback from the department?

Dr. Victor Marshall: We had a sense that things were moving slowly for a while but are maybe picking up steam now. The department has basically indicated that it is strongly supportive of the report, and it thinks it's a great report and it will be useful. I think it's been made clear that it's advice. It's doesn't necessarily have to be the blueprint in the department's eyes, but it will input strongly into that.

Mr. Roger Valley: Going back to your statement about the call to action, there's no time for extensive debate. You've done the work. We know some of the answers that need to be happening. Repeatedly today you have said we need to get to a needs-based system. You said that when your group actually looked at the table of eligibility, you were incredulous at how complex it was. Can you explain that a bit?

Dr. Victor Marshall: I don't have the table in front of me now, but you've probably seen it. When we first look at it, there's a list of benefits that can be received, down one axis of this table. Then there's a list of different categories of people who can receive different kinds of benefits, if you can link it to war service, different categories for different—the merchant marine, for example. But there are several categories across. The total grid is something like an eight-by-twelve table, so there are that many different cells of eligibility on this table.

The biggest problem we have with it is that for many of the benefits you have to be able to link it to something that happened to you in war service. That's the problem. We think it doesn't make sense. For example, there's epidemiological evidence that we cited in the report that musculoskeletal diseases are more prevalent in people who had war service. So you could assume that had something to do with what happened to them during the Second World War.

A lot of musculoskeletal problems arise only in later life, so to ask someone now to try to relate that condition to something that happened to them when they were in overseas service in Italy or Normandy or whatever just doesn't seem reasonable, but it also doesn't seem necessary. If the person had the military service and has the need, we think it should be met.

● (1015)

The Chair: Thank you, Doctor, and thank you for the report.

Mr. Roger Valley: That was fascinating.

The Chair: On to Monsieur Perron with the Bloc for five minutes.

[*Translation*]

Mr. Gilles-A. Perron: Good morning, Mr. Marshall.

I read your report quite quickly because we only received it this morning. It looks very good. I have one concern: could this report apply to our seniors, to citizens of Canada and Quebec? I can tell you that there are some very sad cases within civil society—I'm not talking about war veterans. Take, for example, the case of my father who died at the age of 76 from asbestosis because he worked in mines, underground, his whole life. This was a work-related illness. It's almost just as dangerous to work underground in the Abitibi mines as to be engaged in combat on a battlefield.

I would like you to comment on this. How do you think your program could apply to average citizens, to the seniors of Canada?

[*English*]

Dr. Victor Marshall: Thank you for that question. Certainly I know members of council have often said about this report and other recommendations we have made that we see Veterans Affairs Canada being in a good position to show leadership for all Canadians. Along with Health Canada, Veterans Affairs can develop programs that work and demonstrate that they work, which then could become a basis for extension to all Canadians.

How that would happen over time I'm not sure, but the general principles that apply to aging veterans apply to all aging Canadians, we think.

[*Translation*]

Mr. Gilles-A. Perron: I have another more practical question, Mr. Marshall. Do you have an idea of how much more the implementation of your recommendations would cost if the program were extended to the whole of the senior population? Would the cost be the same as it is now? Would there be an increase in costs? We need to take taxpayers' money into account. How much more would it cost, if the costs were higher?

[*English*]

Dr. Victor Marshall: First of all, we did not explicitly consider costs, and we were asked to outline a general system that would be the best system in principle. We recognize that any system costs money, but the idea would be to try to get as close to that goal as possible.

What I said in response to the earlier question, and this is just a guess, because the council has not done the costing, was that there would be an increase in cost, but it would be like a kind of bubble, because there would be more services going to these veterans, but the older veterans, the ones who are the target of our report, are dying, as we note in the report, so those costs would not be long term.

Let me add one other point. There may be more cost to Veterans Affairs Canada through implementing such a system, but that doesn't mean there would necessarily be more cost to Canada as a society. There are three kinds of costs: Veterans Affairs Canada costs, health care system costs, and other costs related to health. If you keep people healthier, you can have savings there. Some of the costs of these programs might end up being borne by Health Canada, or if they're borne by Veteran Affairs Canada, it will mean lower costs coming through other aspects of the health care system.

I'm afraid that's as far as I can go with costing, because that's something we leave up to the department itself.

● (1020)

[*Translation*]

Mr. Gilles-A. Perron: Thank you, Mr. Marshall.

I have another question that my colleague, Roger Gaudet, raised. There is a group of war veterans that are especially dear to my heart. They are young people in their 30s suffering from post-traumatic stress disorder.

Could your study be broadened in order to determine whether or not the Department of Veterans Affairs is taking adequate care of these young war veterans?

[*English*]

Dr. Victor Marshall: It could be extended. Again, the council was formed to give advice on these traditional veterans. There was the other council, the Canadian Forces Advisory Council, established for the Canadian Forces to give advice regarding the Canadian Forces veterans. We give advice when we're asked. We could pursue that issue as well, if asked.

I should say there's a lot of research going on now in the department. One thing our council has done is it's been very supportive of increasing the research capacity of Veterans Affairs Canada. They now have a great research unit there. It's home-based, under Dr. David Pedlar in Charlottetown. But there's a strong research group as well at the hospital at Sainte-Anne-de-Bellevue. A lot of research is going on in PTSD that could be supportive of recommendations similar to those we're making in our report.

[*Translation*]

Mr. Gilles-A. Perron: My time has run out.

[*English*]

The Chair: Thank you very much.

Now we're on to Mr. Shipley with the Conservative Party, for five minutes.

Mr. Bev Shipley: Thank you.

Thank you, Dr. Marshall, for being with us this morning.

I want to go back a little to the 40% who are eligible at this point in time to have the access to the services we're talking about. You're saying that a vet is a vet is a vet, and I think all of us would agree with that.

In your recommendations, do you see from the discussion around this—and I think the answer might be there when I get an opportunity to go through it—that this is a model that can be used not only for our traditional veterans, but also for our new veterans?

Dr. Victor Marshall: Yes, we certainly do outline that. I don't know exactly what page it's on either, but we do explicitly suggest that. For one thing, all veterans are aging. Aging is not just something that happens to people over the age of 80. As I mentioned, not for all Canadian Forces veterans, but for all the Canadian Forces clients, their average age is already 53 and climbing. So that's an aging situation.

We do explicitly say in the report that we think the report could be of great use to the so-called younger veterans, or the Canadian Forces veterans, and moreover that is very well recognized by the other veterans groups that have really been strongly supportive in endorsing this report. They see its principles as useful for the Canadian Forces veterans as well.

● (1025)

Mr. Bev Shipley: As you heard I think from some others, we've been having some preliminary discussions around our health care, starting with PTSD and some of those issues concerning that, and with what we can do in terms of prevention, access, before, after, all of those things that we can actually do to prevent a complete breakdown of an individual and help that person back before they get to that certain stage.

When we talk about the 40% and their having the access to professional people to expand that health and promotion and to early intervention specialists, if we were to open that up, and the other 60% of the ones you're talking about, plus if we talk about the new veterans, the current veterans, to expand that health to the specialists —There's a concern across the country and in the provinces. Where do we get the specialists?

Dr. Victor Marshall: Right. These would be specialists in health promotion and disease prevention. Those are two flip sides of the same coin. If you get health promotion going, you're going to prevent disease.

There are a number of training programs across the country producing people who are expert in the area of health promotion itself, so that would be one possibility, but there are other health specialists you could build this on. For example, in the allied health sciences, such as occupational health or physical health, or from nursing, for that matter, there are strong health promotion components now in those health professions that could be tapped.

What we're talking about in terms of Veterans Affairs Canada personnel is that you'd need probably a few actual specialists trained in health promotion, say to a master's level, but then there could be some training of Veterans Affairs Canada personnel in health promotion to the point where they could make the referrals. We would have screening instruments developed, and then they could make referrals to community-based health promotion programs, which exist in many forms across the country.

Where Veterans Affairs Canada would play a real role is by focusing on the health promotion programs that really have demonstrated benefits, rather than ones that just make people feel good.

Mr. Bev Shipley: I think, too, there are a number of the preventatives that actually take us right through to the natural orthopedic doctors. I think one of the biggest issues is to try to get the preventative, to keep them, and I guess this is part of your report.

Just before I go any further, actually, I want to raise something that you mentioned. I didn't realize that all of this advisory committee was voluntary, and I just think that we as a committee need to commend you on your busy schedules, when we look at the quality of individuals, for taking the time for our veterans and for other people of Canada, for what you've done on a voluntary basis. That's just a comment.

Dr. Victor Marshall: Thank you. I'll pass that on.

Mr. Bev Shipley: The guy with the clock just put his hand up, so I will maybe get another chance. Thank you, Doctor.

The Chair: I'm the evil man with the clock.

We will now go to Mr. Valley of the Liberals, for five minutes.

Mr. Roger Valley: Thank you.

I would agree with you, Mr. Chair, you are the evil man with the clock.

Doctor, the report was issued in November. I assume it was put on a website somewhere.

Dr. Victor Marshall: Yes, it is.

Mr. Roger Valley: I don't believe, from the reception I see from all my colleagues, that any of us had seen this before. I don't know why we missed it. It's our job to understand what's happening with veterans. For whatever reason, we should have looked at it last November. I know we were busy with other schedules, but that's no excuse; we should have paid attention to this before this fact—and if someone has, I apologize to them.

I'm going to take some of your words and I'm going to make a statement, and then I'd like you to correct me. You've said that 234,000 war veterans are still alive and 40% of them are receiving health benefits. The statement I would make is that from what I gather from your comments, all 234,000 war veterans should receive benefits if they need them. Is that statement fair?

● (1030)

Dr. Victor Marshall: Yes, it is. I want to emphasize, “if they need them”. Again, a lot of them won't. A lot of people are robust until they die at the age of 90 or whatever and aren't going to need any. So we want and need criteria; we still want criteria of eligibility, but not based on anything other than need.

Mr. Roger Valley: So when we look, again, at the statement I read out before, there's no time for extensive debate. This whole report can be shaken down to that: “if it needs to be”. If they need it, they should have it, that's the criterion for a veteran.

Dr. Victor Marshall: That's what we believe. You hit it right.

Mr. Roger Valley: I echo the comments by my colleagues to thank your volunteers.

Has your organization had a chance to discuss your report or the activity or lack of activity since you released it?

Dr. Victor Marshall: Yes, we did have one meeting a few months ago in Charlottetown.

Mr. Roger Valley: Any other plan of action?

Dr. Victor Marshall: Yes. At that meeting, we were asked if we would form two committees to help in moving forward with the report. One of them is going to deal with screening. Again, the academic gerontologists and the health services people are familiar with screening. This committee is going to be meeting in about two weeks in Toronto. It is going to be tackling the issue of exactly how the screening instrument would work for this project. Its mission will be to have that report ready for consideration by the council, which is meeting in the first week of July. It meets twice annually as a full council.

The second committee that was established coming out of our meeting this spring, which was an extra meeting we had of council, is on the health promotion aspects, where we think we need to get more precise. That committee will be reporting to the full council in July.

Mr. Roger Valley: When they report to the full council, if they're public reports, would it be possible to send them to the clerk of our committee? We all acknowledge this is a new committee and maybe we're not on all the mailing lists we should be, but we would like to know if there's any public comment out of those committees or your overall committee when you meet. It would be nice for us to know.

Dr. Victor Marshall: I agree with you. Since we give our advice, effectively, to the minister through this structure, my job would be to pass that on as a request. I can't release reports myself, but I can recommend that they be released. I'm sure they'd be happy to do so.

Mr. Roger Valley: You could release them if they're public, but I agree with you, you have to go through the channels. We'll make that request to the minister himself too. When it's public we'd like to know about it, and again, we'll have to do a better job of keeping track of your work.

Thank you for all your commitment. Thank your volunteers from us.

Dr. Victor Marshall: Will do. Thank you.

Mr. Roger Valley: Thank you.

The Chair: Now over to Mr. Sweet with the Conservative Party for five minutes.

Mr. David Sweet: Thank you very much.

Dr. Marshall, I want to echo what has already been said. It has been one year, with volunteers, and the robustness of this report is excellent. Thank you very much.

I have also had the experience of having a father who served in the military during the Second World War. He came to live with us, when he was 71 years old, with a cane, with glasses, and hardly able to go up and down stairs. He has now moved out. He goes up and down stairs with vigour. He does not wear glasses—he got laser surgery for his eyes—he threw the cane down, and now he coordinates a walking program at a shopping mall, and frankly, he can probably outrun me.

● (1035)

Dr. Victor Marshall: That's outstanding.

Mr. David Sweet: Yes. So of course I was listening with fascination about the health promotion programs. I want to ask you about that, but I also want to agree with you that I think one of the things the departments have to do is step back and look at aggregate costs.

You mentioned two provinces in your report. Could you tell me what those two provinces are that do not pay for veterans' long-term care?

Dr. Victor Marshall: I can tell you one of them off the top of my head, and that's Nova Scotia. I just cannot remember what the other one is. I am sorry. I could find that out for you if you like.

Mr. David Sweet: Thank you, Doctor.

There is one thing I wanted to ask you, because I did not want to assume what you meant by health promotion programs. I am looking at the screening tool you have. It is quite simplistic, the one you have on page 35. Do you feel that those are deep enough questions to solicit enough answers to really find out how you can intervene with services?

Dr. Victor Marshall: No. That's why we have this committee. I think what we've come up with is going to be part of a screening tool. There actually will be more than one screening tool. But the PRISMA-7 screening tool that is used, on page 35, which is from one of these projects in Quebec, is the kind of thing that, literally, someone with five minutes of training could actually administer if someone called in to Veterans Affairs Canada. Right? But there will have to be other components.

That is why this committee will be meeting on that. Then there will be more. You get screened to one level, and then at that level you might be screened more intensively. So we have to come up with the right package of screening tools. The department already has several different screening tools it uses for people to help tailor services to their needs. We are looking at all of those, but we are also looking at other tools.

Mr. David Sweet: Thank you, doctor.

There have been a couple of questions about younger veterans. I appreciate that the scope of your research was for older veterans.

With the different consciousness of physical fitness we have now in this generation, do you think there is a higher level of awareness of continuing and good practices of health promotion among this new generation of veterans?

Dr. Victor Marshall: You know, I would like to think that there is. This may be wishful thinking. I have been in the health promotion field since I came to the University of Toronto, I guess. We had, actually, the first health promotion master's program in the country. This was back in 1978.

I really would like to believe, and the data would show it, that there is increasing participation in physical activities by younger people and that it is extending somewhat in the later years. But the data are not that strong yet.

As you know, fitness is one thing. Related to fitness, but also related to nutrition, we have an epidemic of obesity going on. I really notice it in the U.S., where it is worse, but I've seen the data for Canada, as well.

So I think it is getting marginally better in the fitness area. It is not getting better in the nutrition area, and we have a long way to go.

Mr. David Sweet: Okay. At least we know there will be a lot less transfat, anyway, over a lifetime.

Dr. Victor Marshall: That's true.

Mr. David Sweet: I began by telling you that I wanted to ask you about health promotion programs. Am I visualizing your description the right way? You're suggesting that you would have a counsellor at Veterans Affairs who would be able to hook you into health services, dietary counselling, gyms, pools, and that kind of thing. Is that what you mean by health promotion programs? Could you just expand on that, please?

Dr. Victor Marshall: That is basically correct. I don't know how much you've been able to pick up on this ecological model that we have in the report, but it's also possible that, for example, at the local area offices of Veterans Affairs, additional steps could be taken to enhance, let's say, physical fitness, at a community level. So you could have people from Veterans Affairs taking some leadership in motivating communities to increase the conditions that make it possible for people to walk more.

There are programs like this that work at that level, at the community level. For example, you do walking surveys. You assess sidewalks for accessibility. Are people going to stumble over them or are they good for walking? Are there curb cuts and things like that? Then you work with town councils, for example, to improve those conditions and make sure that people have safe places to walk, adequate lighting at night, and things like that.

So it could be at that level as well, but basically, it would be a referral process but a referral that is knowledge-based. Again, you're not going to refer to just any program. You're going to refer to a program that is known to be efficacious.

● (1040)

The Chair: Thank you.

We'll now go over to Mr. Shipley for five minutes with the Conservative Party.

Mr. Bev Shipley: I'm going to turn it over to Mrs. Hinton.

Mrs. Betty Hinton: I have a couple of questions.

This has been a most interesting discussion today. Even though you're not physically here, it feels as though you are.

Dr. Victor Marshall: Thank you. I wish I could be there.

Mrs. Betty Hinton: This is not, by the way, a new committee, but it's the first time we've ever been a stand-alone committee, so maybe we have a little bit to learn here.

I have had an opportunity to read your report. I just haven't read it thoroughly. It's like reading Coles Notes on a book. But I assure you, I am going to go home and read this from cover to cover now. It has been very enlightening. You've also reinforced, for me, anyway, the need for this committee to move forward with the health care review. The dragging out that was referred to has sort of been caused by some who have an interest in different parts of health care and are going off in a different direction.

In order for us to actually have some serious input as a committee, I think I hear you saying it's time for us to move forward, that you want us to get moving on this so that we can actually make a difference for veterans. Is that an accurate assumption?

Dr. Victor Marshall: Absolutely it is. As I said, you'll find the veterans groups big allies in this, including this report. They've read it, they know it, and they support it.

We really do have this sense of urgency. In fact, I really regret that I didn't move the council forward to produce this report ten years ago instead of waiting as long as we did.

Mrs. Betty Hinton: Don't feel badly at all. You've done a fantastic job, and as my colleague said earlier, the fact that you're all volunteers speaks volumes about the way you feel about people and how you care.

You're in the United States practising at the moment, you said.

Dr. Victor Marshall: Well, I'm not a medical doctor. I have a PhD in sociology. But yes, I direct the Institute on Aging here at the University of North Carolina, where we're part of a national health promotion network that focuses on evidence-based practice in health care.

Mrs. Betty Hinton: Right.

Because you are in the United States, and I know they have some different views of health care from those we embrace wholeheartedly here in Canada at this point in time, I'm wondering if you see any benefit, when we do get involved in this health care review in a serious way, to us bringing in practitioners such as naturopathic physicians whose practices are basically preventative, versus allopathic physicians who do more care after the fact?

When you talked about preventative medicine, what kind of people would you like to see us talk to?

Dr. Victor Marshall: A lot of it can just be done by people who don't actually have training in one of the traditional or complementary health professions such as those you mentioned. Public health people are being trained in this area in departments of public health, in Canada as well as here.

There's a new name for it now. It used to be called "complementary medicine", but it's more "partnership medicine" now. I can't remember the buzzword, but increasingly there is evidence that it's beneficial for people in the traditional areas, such as allopathic medicine and nursing and physical therapy, let's say, to be working in a broader context, in partnership with people from chiropractic and naturopathy, and things like that.

So, sure, I think that's the wave of the future.

Mrs. Betty Hinton: Wonderful, okay.

Because we are going to come to an end fairly soon, is there anything you'd like to leave with us? Is there something you may not have had an opportunity to say during the session today?

Dr. Victor Marshall: No, but I do want to express my appreciation to all of you. I was also able to appear in person before a Senate committee in the summer, and had the same reaction there, as all of you really dug into this report. I appreciate the kinds of questions you were asking and your commitment to this.

We really want to see something happen, "we" being all of us, not just the veterans groups on our council, but also the service providers and the academics. We are just so aware that time is running out.

One thing I would just illustrate is that the academics had to learn. Of course, at the beginning, when the council started ten years ago, we wanted to do another study. Right? The veterans groups basically said to us, we're dying. So we've relied on knowledge that's already there rather than conducting new research.

So it's time for action now. That's my last message, I think.

● (1045)

Mrs. Betty Hinton: You have my assurance, Dr. Marshall, that I will do my very best to deliver that message to all members of this committee, that we need to move forward quickly with this health care review. We have veterans who are waiting for us, and there can be no higher priority.

So thank you very much for your time, your effort, and all your hard work.

The Chair: We are having something distributed shortly, but I'd like to use the chair's prerogative to get in a couple of questions.

You mentioned—and I was intrigued by this—that there is a higher incidence of musculoskeletal diseases among veterans. There is a greater prevalence among war service veterans than the general population, I think is the way you stated it. I am intrigued. Do you have any theories on that?

Dr. Victor Marshall: Well, it may be related to things like.... Again, I'm not a medical doctor, but we do have Dr. Robin Poole, who is an expert on these things, on our council, and he probably would have better theories than me.

I imagine that if you're trudging through Normandy, or maybe worse, trudging through the mountains of Sicily and Italy, as the Canadian army did, that could be a pretty rough life. I could see that resulting in minor stress fractures, and so forth, that you would live with for a while and that you may not even notice until later in life. I think that could be a big cause of it.

Again, you couldn't track that back; it really hits the crisis point when someone is say 83 years old. I think it would be ridiculous to try to track that back and say, "Well, I was riding in this tank in Italy and it was a bumpy road". I don't think you can track it back; but that's my guess about the kinds of connections that would account for that.

That's in the chart on page 13, by the way—figure 5 on page 13.

The Chair: Okay.

I'm also wondering what types of diseases those are. You generally call them musculoskeletal diseases, but what are those?

Dr. Victor Marshall: In the chart it refers to diagnoses of arthritis and rheumatism. But as the report says, "Arthritis may be more common in older veterans than in the population at large because injuries to joints, particularly the knees, ankles, hips, shoulders, hands, spines and feet, usually cause the onset of osteoarthritis in later life". It also points out that "These types of injuries are common in military training and on the battlefield, but their consequences (i.e., osteoarthritis) may not occur until decades after the injury...."

The Chair: I know I am belabouring the point here, but minor stress fractures.... My understanding is that when a bone heals, it actually calcifies more intensely along the line of a fracture than it does in the rest of the bone. But these things, even though they may be calcified, lead to arthritis and rheumatism, as you say, and all these other issues.

Dr. Victor Marshall: Again, I'm handicapped as a sociologist here; you're beyond my expertise. But as I said, we do have Dr. Poole. There are other physicians as well, but Dr. Poole is on the council, and he's really one of Canada's leading experts in arthritis, in fact. He's part of the Canadian Arthritis Network of the Canadian institutes for aging and health.

The Chair: Okay.

Well, it seems that we're going to have to make our goodbyes. We've had a wonderful opportunity to question you.

Thank you very much for your participation. I want to echo yet again—and I know many committee members share this—that we deeply appreciate the fact that you're doing this in a voluntary capacity and the work that has gone into your study. It will factor, I'm sure, quite well into the study we're undertaking on health care review.

We're going to revert over to doing some setting of the agenda and various business things for the last few minutes of the meeting, but thank you very much for your participation.

● (1050)

Dr. Victor Marshall: Thank you very much. I've really appreciated the chance to talk with you.

Goodbye.

The Chair: All the best.

Okay. Now, I think we dealt with some of the issues with regard to how we're going to proceed on Tuesday.

Monsieur Perron, you have a letter here. This is the first time I've seen this, by the way. Do you want me to read this, or do you want to read it?

[*Translation*]

Mr. Gilles-A. Perron: No. It's a letter that we received from our clerk, by e-mail, and that appears to contain a type of accusation against yourself, Mr. Chairman. I would like to know what's happening. It says that the Hon. Chairman stated that the SISIP, the Service Income Security Insurance Plan, does not fall under the veterans committee's responsibility. My question is whether or not that is true? Second, what should we do with the letter that we have all received?

[*English*]

The Chair: Okay. I'm going to continue with reading the letter, because, honestly, it's the first time I've seen it. Okay—

> —I beg to differ, it is the clients of Veterans Affairs that are affected by this, it is the Veterans Affairs monthly benefit that is wrongfully deducted.

I think we've dealt with this before.

> If these points do not make it this committee's responsibility, then we, the disabled veterans, will be the ones that will have our argument fall on "deaf ears". The Standing Committee for National Defence isn't concerned with this issue, they are only concerned with Afghanistan, and rightfully so, as their attention should be on those still in uniform. I respectfully request that the committee as a whole, not just the Honourable Mr. Stoffer, stand up and demand action on behalf of this country's disabled veterans. Thank you.

I think Mr. Stoffer has raised this issue before, and I think we dealt with this issue before. So I don't know where you want to go with this issue, Mr. Perron.

Mr. Gilles-A. Perron: I just want to know, are we going to reply to this gentleman, making our statement or something like that, or do we just leave it to die?

The Chair: Well, I think the issue has been dealt with by the committee before. This gentleman, or Mr. Stoffer if he were here, could take umbrage with it, but the issue has been dealt with.

Mr. Gilles-A. Perron: Okay.

The Chair: Monsieur Gaudet.

[*Translation*]

Mr. Roger Gaudet: I have a quick question. If we have already dealt with this it should be in the minutes. Perhaps I wasn't there. If it is in the minutes, perhaps it could be pulled up.

[*English*]

The Chair: I'll let the clerk respond here.

[*Translation*]

The Clerk: The minutes mention the witnesses and the motions that were passed. They include the topic of discussion and the study in question. That is all that is contained in the minutes and there is no further detail. Testimonies and anything that is said in committee is also available. For example, Mr. White could probably find what is being said at this very point in time on the Internet.

Mr. Roger Gaudet: Fine. Thank you, that answers my question.

[*English*]

The Chair: All right, I think we're about at time now. As I said, Tuesday we'll come back for consideration of Mr. St. Denis' bill. We'll have witnesses as best the clerk can see fit to schedule and tighten them in, and we'll see whether or not we get through that.

An hon. member: [*Inaudible—Editor*]

The Chair: Well, this is at the will of the committee in some respects.

I think at the end of the meeting on Tuesday, if we have entirely dealt with the bill and answered any questions and dealt with it as we see fit, then we can broach that subject for Thursday.

Mrs. Hinton wishes to respond.

Mrs. Betty Hinton: I have just a comment.

This committee decides its own destiny, and as I said to you earlier in the afternoon, we're going to deal with Mr. St. Denis' bill because it takes precedence. We have to deal with it. So I'm very much in favour of that. I'm very much in favour of listening to witnesses.

I want to get to the health care review. Dr. Marshall just told us how important it is, and I'm wondering if you think bringing the minister takes precedence over starting this health care review. I'm just looking for what direction you want to go in, because when we set this agenda at the beginning of the year, we had some very specific items we were going to deal with, and we've not yet got to the health care review.

So are we interested, still, in going to the health care review, or do we want to go down a different road? I'm just looking for direction from you.

● (1055)

Mr. Roger Valley: I take direction from what Dr. Marshall said, and I see it very clearly. He's saying there's no time for extensive debate. There should be some action on this report.

Mrs. Betty Hinton: That's exactly what I just said.

Mr. Roger Valley: So the first thing we'd like to ask the minister is what kind of action he has taken on the report. I think it's important to get him here.

Mrs. Betty Hinton: That wasn't why you were asking to have the minister come.

Mr. Roger Valley: I asked to have the minister come, and there can be any number of reasons. We hadn't discussed this at that point. If we're done with the bill, there's no reason the minister can't be asked to come. If his schedule doesn't allow it, that's fine, he'll tell us that. But if we don't have anything else for Thursday, I think it would be important to have him in front of us.

Mrs. Betty Hinton: So do you want to talk to him about health care? Is that what you're suggesting?

Mr. Roger Valley: We'll decide that on Tuesday.

The Chair: I imagine this debate will probably erupt again at the end of Tuesday's meeting. Then, once again we'll take a tally of what the numbers are on the various sides. We have some vociferous voices on either side, and we'll see where it goes.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

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