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Chair

Mr. Rob Anders

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● (0905)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good morning. This is yet another glorious meeting of the Standing Committee on Veterans Affairs.

This morning, pursuant to Standing Order 108(2), we are pursuing our study of the veterans independence program and the health care review.

We have, as witnesses this morning, Mr. Brian Ferguson, the assistant deputy minister of veterans services; and Darragh Mogan, the executive director of the service and program modernization task force.

I know at least one of you is incredibly familiar with the procedures here at the committee, but we usually allow our witnesses about 20 minutes. So it could be 10 minutes each, if you'd like, or it could be 19 minutes for one of you and one minute for the other, if you wish or see fit. And then you get a chance to hear all the questions our committee members have to put to you.

So, gentlemen, the floor is yours.

Mr. Brian Ferguson (Assistant Deputy Minister, Veterans Services, Department of Veterans Affairs): Merci. Thank you very much, Mr. Chair.

I will deliver our only remarks from the department this morning.

[*Translation*]

Thank you, Mr. Chairman.

I am pleased to be here today, in my capacity as Assistant Deputy Minister, Veterans Services Branch, to discuss the work currently underway within Veterans Affairs Canada on the Veterans Health Services Review.

[*English*]

Let me start by saying that Veterans Affairs Canada has a long history of modifying programs and services to better respond to the evolving needs of veterans. In the early to mid 1900s, veterans returning from World War I, World War II, and the Korean War were greeted with a suite of benefits and services to help them successfully reintegrate into civilian life. Since that time, eligibility for benefits and access to services have been extended to include a broader group of veterans. New programs have also been introduced, including one of our most successful and popular programs, the veterans independence program.

First introduced in 1981, VIP, as it has been known, is a national home care program providing services such as housekeeping, grounds maintenance, personal care, and nutrition services to help veterans remain independent in their homes. Its goal is achieving nothing less than healthy living within the community. It is modeled on a graduated health care approach that emphasizes early assistance to prevent clients from becoming unduly dependent on the long-term health care system, allowing them to live with dignity, security, and comfort in their own homes for as long as possible.

Today, approximately 98,000 veterans and primary caregivers—74,000 veterans and 24,000 caregivers—benefit from VIP services, at an approximate cost of $274 million a year. This is a fraction of the cost of providing these individuals and veterans with beds in long-term care facilities. More importantly, it has allowed them to remain in their homes, not only helping them to maintain their independence but ensuring a high quality of life in their later years.

Those who care for veterans, primarily widows, can continue to receive for a lifetime the same housekeeping and grounds maintenance services the veteran benefited from before death or being admitted to a long-term care facility. This recognizes the contributions that these caregivers made in caring for the veteran, often at a great sacrifice to their own health, and their continued need for support to remain in their homes, often in the very home they shared with the veteran.

In spite of the changes made over the years to try to better respond to the needs of war veterans and their primary caregivers, the reality is that further action is required if we are to make a difference in how these veterans live out their remaining years.

Over the years our programs have incrementally evolved to meet clients' changing needs. The result is that we are faced with complex eligibility rules and a system that leaves some veterans without the care they need when they need it and where they need it.

The goals of the veterans health services review are threefold. First, we are examining the changing health needs of our aging veterans to identify gaps and barriers in meeting service needs. Secondly, we are soliciting input on areas where significant improvements could be made. The feedback from this committee will be a critical input in this regard. Thirdly, we will be developing appropriate proposals for change, which our minister will take to government for consideration.

I want to emphasize that we are not in a position to provide you with the results of the review today, as we are fully engaged in the process of analysis and policy development. However, we are most anxious to hear from you about how to make the review a success.

I understand that Dr. Victor Marshall, who is the chair of the Gerontology Advisory Council, spoke to you last month about the council's work. The sum of Canada's most distinguished experts on aging, seniors, and veterans issues, including representatives from the major national veterans organizations, the council provides the department with advice on how best to support the health, wellness, and quality of life for our traditional war veterans from World War I, World II, and the Korean War.

Its report, *Keeping the Promise: The Future of Health Benefits for Canada's War Veterans*, advocates for veterans' access to health services on a needs basis rather than on the entitlement basis that exists today. It also recommends integrating VAC's current three health care programs—treatment benefits, the veterans independence program, and long-term care—into a veterans integrated services approach that provides a full continuum of care.

The critical importance of early intervention and health promotion is also emphasized. The council's report and recommendations are helping to guide the work of the veterans health services review.

Currently, the department is exploring how to provide more streamlined access to health services to more veterans. We want our veterans to age as well as possible and to receive the most appropriate care based on need. To get the best outcome, VAC is examining how appropriate health benefits could be targeted to clients based on assessed needs. We are taking a careful look at the appropriateness of disability pensions and low income as the only gateways to access our health care program. For example, and this is a possibility, eligibility could be based on a combination of military service and need. In simple terms, a veteran is a veteran is a veteran.

● (0910)

It is often difficult to relate current health problems to a specific event or a situation that occurred during military service 50 or more years ago. We also recognize there are latent, long-term health effects of military service that create need today. It makes sense to provide health benefits that allow our veterans to stay independent for as long as possible, wherever it is they choose to live. By doing this, VAC can delay and often prevent the need for long-term care. This means developing a program that is flexible, where the level and intensity of service could be increased depending on need, and that is what we are looking at.

The department is continuing to work closely with the Gerontological Advisory Council to develop tools to assess client care needs so that appropriate benefits can be targeted to meet specific needs. With their expertise and evidence-based health promotion, the council is also advising on the design of a healthy aging strategy so we can support veterans in maintaining or improving their quality of life.

We are looking into the types of support and assistance that will help veterans remain independent as long as possible, even with a chronic illness and disability. Ultimately the veterans health services review is about meeting the needs of those who have donned a uniform in service to our country. Knowing that the outcome of this work is critical to veterans and may also serve as a legacy for the care of seniors in Canada, we are devoting the time and effort necessary to make sure we get the best possible outcome. It is the logical next step in the department's evolution.

[*Translation*]

It is similar in scope and importance to the New Veterans Charter, which represented the most comprehensive transformation in Veterans' programs and services in 60 years. It has the potential to be an excellent foundation on which to respond to the health needs of younger Canadian Forces Veterans to come.

Thank you, Mr. Chairman. I would be pleased to respond to any questions that the Committee may have.

[*English*]

The Chair: Well, thank you very much.

All right. Our first person up would be Mr. Valley, with the Liberals.

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

Thank you for coming this morning and appearing before us again.

You mentioned the changes Veterans Affairs goes through as it tries to adjust to new programs, new realities, new veterans, different issues. I'm sure you're aware of the fact that we face the front line of complaints. I've often wondered, when we see the veterans or their families come in through the doors and the complaints are there, how many are happy whom we don't know about—and I assume there are quite a few of them. We don't get to see those people, so thank you for the effort you're making.

I'm always wondering, and I'll keep going back to it ad nauseam, about delivering the services in the far-flung areas of the country. We notice on maps...and I can't remember right now who spoke to us and showed us the distances between offices and all the services that are provided. We know there are contract services out there in provincial hospitals and for all these other services.

Can you suggest to me how we're changing and how we're trying to...? Health care migrates to the larger centres. In my riding I don't have a large centre, and there are many instances like that right across Canada. As the services become more and more condensed in the larger areas, how do we provide services in those areas to make sure they have access to it?

● (0915)

Mr. Brian Ferguson: That's an excellent question and a continuing challenge for us, as you can appreciate and have highlighted in your question.

We have a set-up across the country where we have 50 client service teams now that are established in localities that are designed to serve the vast majority of veterans.

In the instances where we have people living in rural areas, those client service teams are still responsible for the rural areas for which they provide services. Actually, we invest in our area counsellors to go out to visit those individuals in their communities.

We are also investing in what we call proactive screening. In other words, for the aging veterans who live at home, we attempt to call as many of those as we possibly can on an unsolicited basis each year to determine how they're doing in their home. If they're doing poorly, from the screening tool we have, that we use over the phone, we send a work item through our computer system directly to the line staff who live closest to them, and they go out to visit within a short period of time.

That system seems to work relatively well, but it doesn't solve completely the issue. We're continuing to look, for example, at provinces and others with innovative approaches, such as telehealth and those other mechanisms, which we are factoring in, by the way, into our veterans health services review, as elements we should consider in our policy development.

Mr. Roger Valley: You just mentioned that you actively contact the veterans. I don't have it—maybe it's my own fault—but is that list available to MPs like me who could actually touch base with some of the veterans in our ridings?

Mr. Brian Ferguson: We have some privacy issues there. We'd have to look into that, but I can get back to you on what we can do to help you in that regard. I know there are privacy issues. We cannot reveal names or people's conditions.

Mr. Roger Valley: I'd like to contact them, but I can understand the privacy issues. So you're telling me that Veterans Affairs contacts every veteran.

Mr. Brian Ferguson: We attempt to contact every veteran. We don't have the resources to contact them all on an annual basis, but we're working to get there. We've made that a goal of the department. When you combine the people who come through the door looking for our services and those we call, a very high proportion of our veterans are reached.

Mr. Roger Valley: Thank you for that.

You mentioned in your comments that you have three goals. You ask if we are soliciting input on areas where significant improvements could be made, and you say that feedback from this committee is important.

How do you go about getting feedback from the rural areas? We'll do our job at the committee, but how do you go to places like Red Lake or Sioux Lookout, where there might be only one, two, or three veterans? I'm using my riding as an example. How do you get into those remote sites to find out?

Mr. Brian Ferguson: Darragh, do you want to answer that question?

Mr. Darragh Mogan (Executive Director, Service and Program Modernization Task Force, Department of Veterans Affairs): Thank you very much.

There are a couple of ways. We have a pretty close working relationship with the Royal Canadian Legion. It has about 1,400 branches across the country. The last time I checked they weren't too shy about letting us know what they're hearing on the ground. Our counsellors travel to places like Sioux Lookout and occasionally Red Lake, and if they hear things they let us know. They too don't seem to be very shy about informing us.

So I think the veterans' network is pretty good; it's not ideal. To some extent computer technology is helping us, but I don't think it has matured to the stage where we have an absolute guarantee that the same sort of information is coming in from Red Lake as from central Toronto. That's not a reasonable thing to tell you.

But I think it's pretty good, and our deployed counselling staff is key to that. The fact that veterans organizations through our long-term care program are engaged in doing quality assurance across the country really helps us too, because they aren't restricted to the urban areas when they go out to look at quality assurance in long-term care.

● (0920)

Mr. Roger Valley: Thank you.

So if I ran advertisements in the paper about the process we're in, asking for input from the veterans in my riding, I could pass that on to you.

Mr. Darragh Mogan: I think it's fair to say we'd really welcome that.

Mr. Roger Valley: Okay. I think that's something I'll do.

You mentioned the report *Keeping the Promise*, on the future of health benefits—I think it's from veterans integrated services. We just had that discussion with the individual. I was happy to know that we'd worked on it; I wasn't particularly happy to know that it hadn't been brought to my attention. The report has been out for quite some time. So you're telling us that you're working with that and you're actively involved with the Gerontological Advisory Council.

We didn't get that impression when we spoke to him. Maybe I'm being a bit unfair, but I got the impression that he made the report and they have more work to do. I didn't realize they were working closely with Veterans Affairs. The impression I got, rightly or wrongly, was that they had made the report and hadn't heard back. Can you correct me on that? Do I have the wrong impression?

Mr. Brian Ferguson: Certainly they are continuing to work with us. In fact, after the issuance of the report we had a special meeting with them in Charlottetown. Darragh could give some further details on that.

We are continuing to work with them. They've been very active over the years as an advisory council to the department. In fact, we run a lot of our key policy changes through that group to get the best advice we can. Certainly they've been very active on this file with us.

Darragh, do you have anything to add?

Mr. Darragh Mogan: We've had three meetings now with the Gerontological Advisory Council since the release. We have two more meetings planned. One is on the assessment service we might use through the health review, and the other is on what form a health promotion program may take. So if Dr. Marshall left the impression somehow that the liaison wasn't active, it might have been true for a little while, but it's certainly not true now. I think he'd be very firm on that.

Mr. Roger Valley: I don't mean to put words in his mouth, so I won't do that. Maybe it was my incorrect impression.

Mr. Darragh Mogan: I don't know whether it was, but for the record, it's safe to say they've been functioning as an advisory group for us for 10 years. He said in his remarks—and I think it's true—that we do the vast majority of what they recommend. Why wouldn't we? They're the best and brightest in the country in that area. The veterans organizations are on that council, and they are not shy when it comes to making their points of view known.

The Chair: Thank you.

Next is Monsieur Gaudet with the Bloc for seven minutes.

[*Translation*]

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

Good morning, gentlemen.

Have you reached any agreements with the provinces concerning services to veterans?

[*English*]

Mr. Brian Ferguson: In general terms—and Darragh had comments on this—the department operates by topping up the services that are given to Canadians by the provinces. So if a province provides services to its citizens up to a certain level and those individuals, because they're veterans, are entitled to more than that because of our responsibilities, we will pay the province to provide those additional services. That has been a long-standing working arrangement right across Canada for many years. In essence, that's sort of the way we've been working. It's been practice and policy for years and years.

Darragh, do you want to add to that?

[*Translation*]

Mr. Darragh Mogan: We do have agreements with virtually all the provinces concerning the provision of health services for veterans.

Mr. Roger Gaudet: Thank you. You have 50 task forces for the country as a whole. It seems to me that's not a lot, considering the size of the territory. Do you intend to increase that strength or leave it as is?

● (0925)

[*English*]

Mr. Brian Ferguson: We established those client service teams based on our assessment of the need in areas across Canada. So each client service team is located in a geographic area of Canada where it can serve roughly 4,300 clients. We have increased the number of client service teams over the last year from 48 to 50, in recognition of a growing workload. We also analyze the workload of each team on a continuous basis, so if demand is going down in one area, we seek to move resources to another area where demand is going up. So we keep a constant watch on that.

Our feeling at the moment is that that's a pretty good size of operation for what is required out there. But we keep on top of it, and if we find any areas that are lacking, we have a look at them within our overall structure.

[*Translation*]

Mr. Roger Gaudet: When do you plan to table Mr. Marshall's report?

You say this in your speaking notes:

> I want to emphasize that we are not in a position to provide you with the results of the Review today as we are fully engaged in the process of analysis and policy development.

Around what date do you think you will submit that report to the government, and when do you expect it will make it accessible to veterans?

[*English*]

Mr. Brian Ferguson: We're hoping to be able to do so in the fall of this year. We've been working very hard on the report for a number of months. It's a very complex subject area, but we're hopeful about getting something to the minister in the fall.

[*Translation*]

Mr. Roger Gaudet: You also say the following in your presentation:

> To get the best outcome, VAC is examining how appropriate health benefits could be targeted to clients based on assessed need. We are taking a careful look at the appropriateness of disability pensions and low-income as the only gateways to access our health care program. For example, eligibility could be based on a combination of military service and need - in simple terms, a veteran is a veteran is a veteran.

I'd like you to tell me—

Mr. Christian Ouellet (Brome—Missisquoi, BQ): Selection parameters?

Mr. Roger Gaudet: Selection parameters and other things of that kind.

[*English*]

Mr. Brian Ferguson: Yes. There was a problem with the younger veterans as well when we were looking at the changes that led to the new Veterans Charter, that the disability pension became the gateway to getting into related health services that are required relative to the injuries that may have been sustained in service to Canada.

Rather than having to come forward to the department and proving that you had been injured in some way, and linking that back 50 years to whatever happened to you at that time, the concept would be that if you're an older, frail veteran who needs support, we would find a way to place you on a continuum of need. In other words, if your needs were low, services would be provided in accordance with those needs. But if they were higher, you would get them based on the higher need that you now face. That's the basic concept that has been recommended by the Gerontological Advisory Council, and we're giving it a serious look.

The other aspect is that rather than constraining our decision-makers on the front line with complex eligibility rules, that would be the simple rule. They would need to have the judgment to be able to figure out what the right kinds of services are, but it would be a major breakthrough in terms of transforming the way we do our business.

[*Translation*]

Mr. Roger Gaudet: Thank you, sir.

[*English*]

The Chair: All right.

On to Mr. Stoffer of the NDP for five minutes.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you very, very much for coming here today.

I wanted to correct one thing, though. In your second paragraph, you say:

> In the early to mid 1900s, Veterans returning from World War One, World War Two and the Korean War were greeted with a suite of benefits and services to help them successfully reintegrate into civilian society.

That was true for many veterans, but it wasn't true for aboriginal veterans. Many of them were left out. In fact, they went back to their units or reserves or wherever and really didn't get very much at all. So I would simply caution you on that, because if I were an aboriginal veteran who read it, I think I'd be a little perplexed by that.

You said something as well that I couldn't agree with more: “a Veteran is a Veteran is a Veteran”. I'd like to only add one thing to that and say: “a widow is a widow is a widow”.

I have repeated this many times. I have a letter that was written on June 28, 2005. It is signed by Stephen Harper, the Prime Minister of the country, and it says:

> A Conservative government would immediately extend the Veterans Independence Program services to all widows of all Second World War and Korean War veterans regardless of when the Veteran passed away or how long they had been receiving the benefit prior to passing away.

I have another letter written by, at that time, the opposition critic, saying “until the Conservative Party forms government I am unable to change the regulations to extend V.I.P. benefits to all Veterans' widows”.

The Conservatives are now government—it's been that way for over 15 months—so my question quite clearly is, have you been given instruction to extend immediately the VIP program to all widows of veterans, regardless of time of death or if they applied?

● (0930)

Mr. Brian Ferguson: May I answer your first statement about aboriginal veterans?

Mr. Peter Stoffer: Yes.

Mr. Brian Ferguson: There has been testimony I think in front of this committee by the department a number of times explaining the benefits that were given to aboriginal veterans. I would simply refer to that testimony that has been given, simply to put it on the record.

With respect to the second issue, what I can tell you is that upon the minister assuming his responsibilities, one of his early acts was to request that we launch a veterans health services review, and that element you have identified there would be included in the considerations.

Basically, he also requested that we not take an incremental approach similar to what had been done in the past, but rather to take a comprehensive approach so that the total result of this review would be a package that met the broad suite and spectrum of needs of a number of areas of concern, including that one.

That was done, and that's what we've been operating under as the direction since we started, and we're working ahead, as I indicated.

Mr. Peter Stoffer: The difficulty I have is that you indicate that this program, the VIP, actually saves money. So if a person served in World War II and in Korea—that's proven, he's a veteran—and if he has a widow, he passes on and he has a widow, what's the difficulty in extending the VIP to her right away? I don't understand what the difficulty is. If she's a widow and she's in her home and somebody passes away, I don't see what the difficulty is in extending the program. You have a two-tier system right now: some widows get it, some don't.

As you know, by the time we get this review in the fall, it will probably be next year before we see anything, and by that time, a fair number of these widows will have passed away. They're very frustrated, and so are we, because a letter from the Prime Minister, when he was in opposition, said they would do it immediately. To them, immediately means right now—not after a review, not after careful consideration, but right now.

I know this is a question more for the minister, but I can't tell you how frustrated I am that they're being delayed because of a review. A review was done in 1998—a health care review—and we're doing another one. These widows are getting older. They're getting frail. This system saves the government money. I don't understand why....

My question for you, though, on another aspect of health needs, is on hearing loss. I'm getting an awful lot of veterans in the Halifax area who have been turned down for hearing aids and/or a pension because they couldn't prove that the hearing loss was related to their service on board the ship or on battlefields. When they came home, they didn't go get a hearing test; they just went back to wherever they lived. Now, years later, of course, they have tinnitus or hearing problems.

Dr. David Lyon has said very clearly that there is a relationship between exposure to loud noise at that time and what's happening 60 years later. But they're repeatedly being turned down, over and over again.

I'm just wondering, how can we move that issue forward to help these guys?

Mr. Darragh Mogan: Maybe, Mr. Stoffer, I'll try to give a little addition to the answer Brian gave to your first question. This is a very important one. I can't presume to make any political statements, and I wouldn't.

There are veterans who served Canada who are not eligible at the moment for the health services they need as much or perhaps even more than spouses. So it's not that one trades off against the other. We have a very complex eligibility system. After 60 years of adding patchworks, it's very difficult for people to navigate through it, even our own staff. What we don't want to do, even though there is an imperative to move quickly on this, is, in a rush, make some serious mistakes that we'll be back here having to be accountable for later on.

I don't detect any change in the commitment. I do sense that a comprehensive review of health services that will get away all the barriers to good health outcomes, including those for widows, is, in terms of veterans, at the top of the government's list of things they really want to do.

I guess all I can do, from a public service point of view, is say that it does take time. I can't account for every second of time that's lapsed between the time it was written and now. But what I can say is that I don't see a diminution in any commitment there. I do see the desire to make a comprehensive approach so that we don't add yet another patchwork eligibility issue.

Hearing loss is one of the major presenting conditions for pension eligibility. The benefit of the doubt is there. If someone doesn't have clearcut evidence that their service was a causative factor in their loss of hearing, if they're in a trade, a hard C trade or whatever, that's likely to produce hearing loss, benefit of the doubt means they will get their disability award or their disability pension.

If there are problems on an individual basis, we'll look at them for sure. I don't know that there's sort of a system-wide problem. Maybe you could provide more information and we'll respond to it.

● (0935)

The Chair: Now we'll go on to Mrs. Hinton for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Thank you. I may not use all my time. I may share it with Mr. Shipley.

There are a couple of things I want to clarify. I believe I heard you say this earlier. You're waiting for recommendations from this committee in order to complete your report to the minister. Is that correct?

Mr. Brian Ferguson: I said that we would welcome input from the committee, Mrs. Hinton, and that we're striving to get the report done as quickly as possible. Everybody is recognizing a sense of urgency around pulling it all together, and we're doing our very best to try to pull a complex subject area together.

We would welcome input from the committee. The form of input, obviously, would be something the committee would be better able to determine, I think.

Mrs. Betty Hinton: It should be sooner rather than later.

Mr. Brian Ferguson: It should be sooner rather than later, exactly.

Mrs. Betty Hinton: This may sound like a question that has nothing to do with anything. How long did it take to produce the Veterans Charter?

Mr. Brian Ferguson: Do you mean the new Veterans Charter? I think it took quite a number of years, actually. There was work going on for several years before the intense work of developing a policy framework and the legislative package came together. Once that intense work began, it probably took about two years. I would say, all told, just off the top of my head, that it was probably about a five-year effort overall.

Mrs. Betty Hinton: Okay. So a five-year effort for the Veterans Charter. This is by no means saying anything negative about it—I think the Veterans Charter overall is a pretty good charter—but I think you'd be the first to admit that we noticed that there are holes that need to be corrected. So if I heard you correctly, you are saying you want to avoid that, and I recognize that the minister wants to avoid that, the ad hoc part of it. We want to be comprehensive, so I'm in favour of that.

If you could personally change one aspect of the system as it is now, what would it be?

Mr. Brian Ferguson: I think I've already mentioned it, and that is to move to a needs-based approach, where we can actually eliminate all of the complex eligibility rules that say you have to have a disability pension to qualify for this benefit, or you have to have a low income to qualify for that benefit. If we could get rid of that and have a system that enabled people to actually just have their needs met, that would be the single biggest change, as well as to be able to couple that with giving the authority to front-line staff to make that determination, obviously within appropriate control frameworks and accountability regimes. But certainly that would be it, in my view.

Mrs. Betty Hinton: Well, we're on the same page.

In your mind, having had the experience of going through the Veterans Charter, what do you think it will cost in terms of funds to accommodate exactly what you've just talked about? Are we talking about $200 million? Are we talking about $500 million? Are we talking about $1 billion? Do you have an educated guess on that?

Mr. Brian Ferguson: I'll answer first.

There's a range of costs, depending on which option you take. The options are in general terms now, but I would say they range from a very low cost to...overall, because if you do a needs-based approach, you can actually assign a benefit that isn't as expensive as maybe an entitlement benefit because you're giving what they actually need, not what they might have been entitled to under the old system. On the other hand, you will get more people in the club, which would increase the cost at that end.

So I would hesitate to give you a cost figure at the moment because I think it would be misleading. But I can tell you that the costs would range from I think a very little, incremental cost, if any, to a significant cost. But it would be less than if you don't change the system. We've already identified that if we don't change the system, the options for government at large are going to be more expensive to accommodate needs.

I know that doesn't give you numbers, but I think it's the reality of where—

● (0940)

Mrs. Betty Hinton: You'll have my full support in terms of making the changes, because it has been apparent for years that change has to be made. Mr. Stoffer mentioned his impatience. I share the impatience, but I recognize that to do it right, it takes a little time. So I'm pleased to see the direction.

The other question I was going to ask...oh, I'm sorry, I may have interrupted Mr. Mogan.

Mr. Darragh Mogan: I was going to add only one amplification, and that is if we looked at the entitlement cost alone, the way it's structured now, it has very complex eligibility rules and a whole bunch of footnotes at the bottom. If we were to implement that for all the survivors—which Mr. Stoffer has raised—who are entitled now, the bill for government is really high, and the satisfaction level about responding to need in a hurry would not be that great. It would take us a long time to get that through government, if we ever did. So I think that's certainly the context to consider, the alternatives that we would be putting forward in the fall to the minister.

Mrs. Betty Hinton: You've been a part of the department for many years and you've served this country very well. When you say "very high", you make me nervous. Are you talking $1 billion?

Mr. Darragh Mogan: I'll take that back. The entitlement costs would be considerably higher. I don't know how to qualify it without stepping outside the bounds that I'm contained by here. But it would be considerably higher than responding in a needs-based way, and it would be a slower system, with all the Byzantine rules we now have.

Mrs. Betty Hinton: We don't want it to be slower—

Mr. Darragh Mogan: No, we don't, I don't think.

Mrs. Betty Hinton: —we want it to be faster.

I'll pass the remainder of my time to Mr. Shipley.

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

We did have an interesting discussion with witnesses the other day, with Mr. Marshall of the GAC. I think when we look at that, we can be assured that this committee wants to work with you to bring this study to fruition for the veterans. That's what we're here for.

In terms of acting and timing, we've actually done a number of things, right from the bill of rights to the ombudsman who is coming in place, and we're now looking at the health care and the extension of the services that we really want to look at.

In terms of the VAC, you say you take their advice because you believe they are the experts and they're brought together. I appreciate that, and I think most of us around this table would share that view after their presentation the other day. How will that be compiled? We're going to have to make some priorities, obviously, at the end of the day. Are you compiling, then, the programs they have, and will you come with options?

Mr. Brian Ferguson: When we develop our analysis, we'll look at the available options in terms of addressing the needs that have been identified. They're helping us identify the needs and gaps in service, and the *Keeping the Promise* document does a really good job of that.

We're focused with them now on the needs assessment toolkit, because without that you have nothing to work with. You can say you're going to have a needs-based approach and you can say it's going to be disconnected from complex eligibility rules, but until you have something the staff can work with that is tried and true, you don't have a system that's capable of being implemented. So the primary focus of their latest work with us has been to help us design an approach that would work as a needs-based approach.

We're using a model from Quebec called *Le système de mesure de l'autonomie fonctionnelle*, which the council widely recommends be adapted by us to use.

I don't know whether that's helpful or not, sir.

Mr. Bev Shipley: I'll get it in another round.

The Chair: Unfortunately, Mr. Shipley was only given a minute by Mrs. Hinton, so he'll be able to follow some of the questions subsequently.

Now over to Mr. St. Denis for five minutes.

● (0945)

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

Thank you, gentlemen, for being here today.

Just a point of information for colleagues, who are probably aware that our committee meeting, as are all committee meetings, is broadcast on the web. After that meeting, I had a call from a brother of one of the nine soldiers who died on August 9, 1974, and he was appreciative of the work of the committee that day. So in cyberspace we are being heard.

On the notion of the overall review, ad hoc changes versus comprehensive changes, I think we appreciate that there's a time and a place for both. Ad hoc changes will sometimes provide for the patch that's needed to deal with an immediate concern, but every so often you have to step back and look at a comprehensive review. We appreciate the work of the department in that regard, and I hope what we do will be helpful. But it is a concern that, based on the five-year figure used for the charter, we might be facing more or less five years for this.

When did the clocks start on the department's review?

Mr. Brian Ferguson: Previously, I think we had been doing some preliminary work in this area for about a year prior to the minister's coming into the department.

Mr. Brent St. Denis: Roughly sometime in 2005.

Mr. Brian Ferguson: Yes, but it wasn't this review; it was an analysis of current programs. Three programs constitute the whole package: VIP, the house program, and long-term care. I would say the start date was shortly after the minister arrived, and he asked us to launch a comprehensive review.

Mr. Brent St. Denis: Just for the record, if it does take five years —and I hope it won't—that's 2011. The concerns of Mr. Stoffer and my colleague, Rodger Cuzner, who is Joyce Carter's MP.... As Mr. Stoffer said, it might be more urgent to get on with the commitment made by the government to the widows of—

Mr. Brian Ferguson: May I comment on that, sir, so as not to leave you with the impression that that's the timeline we're working under. We're working on a very compressed timeline. The report we're delivering in the fall places us on a completely different part of where we were in the previous.... For the one that took us five years, we didn't have the report for about four years.

Mr. Brent St. Denis: Oh, okay.

Mr. Brian Ferguson: So we're in the latter stages of this one, even though we're moving faster. Through the previous review, we've gained a heck of a lot of information we can reuse, one being that when you move from an entitlement-based system to a needs-based system, it enhances the service. The new Veterans Charter is working, and we've gained a lot of knowledge from that that we're applying here, so we're saving a lot of time in that regard. It doesn't take us away from doing a comprehensive—

Mr. Brent St. Denis: I appreciate that clarification and to know that the report is due this fall. Thank you.

In your presentation, you refer to the traditional veteran—we only have a couple of World War I veterans left—World War II, Korea, and so on. If I use the term "modern veteran", the person who's leaving the military now, they are still your clients. Through this review, is there a consideration of the different paradigm within which the traditional veteran spent his or her time in the military versus modern military engagement and the needs of the modern-day veteran? I wonder if you could touch on how the review might deal with those two considerably different subsets within the veteran community.

Mr. Brian Ferguson: Darragh, do you want to respond?

Mr. Darragh Mogan: It's a very good question. Brian put forth the principle that a veteran is a veteran is a veteran. We didn't mean it only to a war veteran is a war veteran is a war veteran, because there are individuals, especially since 1990, who have had pretty harrowing service for this country.

The principles of a needs-based versus entitlement-based approach, according to the Gerontological Advisory Council and anyone we've consulted with, fit both groups. The new Veterans Charter was meant to provide services and benefits for immediate support for transition to civilian life of much younger veterans, and the health review is meant to finish that process off, as was done for the war veterans, by providing a needs-based approach when they need it.

Their average age is not 28 or 29; it's actually 56. There are 600,000 Canadian Forces veterans out there. There are 150,000 who are over age 65 and about 7,000 or 8,000 over age 85. So although the need is not great there, it's certainly there. The Canadian Forces veterans organizations, the three of them, which have been working with us on this, endorse—at least they do up to now—the findings of the Gerontological Advisory Council's report, *Keeping the Promise*, and they expect that the principle of a veteran is a veteran is a veteran will be addressed in the context of the review.

That's a long-winded answer, but yes, we're very much seized with the idea that this, to the extent we can do it, is a needs-based system that won't create new categories of veteran eligibility.

● (0950)

The Chair: Thank you very much.

We're over time now, so we'll go to Monsieur Ouellet for five minutes.

[*Translation*]

Mr. Christian Ouellet: Thank you, Mr. Chairman.

Thank you for being here today. Your contribution is important.

Coming back to a subject that was addressed by my colleagues, you say this in your presentation: It is often difficult to relate current health problems to a specific event or situation that occurred during military service 50 or more years ago.

How do you determine whether it's really a veteran's need or a normal need of an aging person? Is the choice made in standard fashion across Canada, or is it made based on the judgment of the persons responsible? Could that differ depending on whether you're in British Columbia, Halifax or Ontario?

[*English*]

Mr. Brian Ferguson: You've actually put your finger on one of the great difficulties of the current system, which is to be able to relate the current malady or illness back 50 years to the causal effect, a cause that determined that illness, which is why in the end we have a system that's based on collecting information that would make a connection between the disability and it being caused by service.

We go back into the archives and pull out all the relevant information, and our adjudicators will make an assessment based on that information as to whether there's anything on the record that might have indicated that the individual was injured or suffered some difficulty during military service that could be related back to the current illness.

That information is coupled with the medical reports that we pay for that are sought on behalf of the veteran to determine whether the medical doctor looking at the evidence would say that the condition could have been caused by that event that occurred 50 years ago.

Taking those two factors into consideration, our adjudicators will then determine whether they're eligible for the benefit. If they're eligible, there's a step taken to determine what is the degree of payment that would be made, and that degree of payment is determined through the level of disability that the individual has suffered.

That's the way the system works. It's very paper-heavy. It requires a lot of analysis and pulling information from files. We turn the system around as fast as we can. We average less than six months to get those types of decisions made, but they are difficult to make, quite frankly, given the lack of information. So we end up with individuals who can't pinpoint the particular evidence that they need to justify that, which is why this needs-based approach would do away with that.

The needs-based approach would say, okay, an aging veteran who has served in service would not have to relate that particular request for a disability benefit, which they could still apply for under a changed system, but would not have to achieve success in order to get other treatment benefits—the VIP program and other benefits that would be required.

[*Translation*]

Mr. Christian Ouellet: If a veteran finds that your judgment is not fair, can he appeal it, and is there a form of assistance for appealing from that judgment?

[*English*]

Mr. Brian Ferguson: We have a number of systems in place. One of them is to provide free legal service to anyone who wishes to make an appeal against a departmental decision. That free legal service is available to assist veterans in taking their appeals to the Veterans Review and Appeal Board. The board is an independent body from the department and in its role can make decisions based on the legal support the veteran receives.

● (0955)

[*Translation*]

Mr. Christian Ouellet: Since you have a fixed budget, wouldn't you do well to try to direct certain aging veterans with health problems to the public services of the provinces rather than take care of them? You say that it's very complex and that there is office work, but a judgment has been rendered. Would the Department of Veterans Affairs do well to direct some of them to the provincial systems?

[*English*]

Mr. Brian Ferguson: No. I would say there's no incentive to do that. In fact, all our benefit payments are statutory, so the department is held harmless, in a financial sense. In other words, we have a fixed budget for our operations in terms of our staff and IT systems and things like that, but the payments to veterans are statutory. If someone has an entitlement, that person gets paid regardless. You can see from the statutory payments over the last several years that there have been quite large increases.

[*Translation*]

Mr. Christian Ouellet: Do you make cash transfers to a province that provides long-term care for veterans? Is that statutory as well, as you say?

[*English*]

The Chair: The responders can take as long as they like, but the questioners have a time limit.

Mr. Brian Ferguson: Is that question still a part of the—

The Chair: You can choose to do with it whatever you wish.

Mr. Brian Ferguson: I just want to clarify that. Provinces provide their citizens with certain health benefits. If they provide them to veterans, as citizens, that's an expense the provinces incur. But if the services the provinces provide are not in accordance with what the veteran has a right to under the Pension Act and other legislation, we will pay for additional services. We will pay the province for the top-up. There are variations of that across Canada, but the Veterans Affairs top-up makes sure that it's a consistent service.

Mr. Darragh Mogan: I'll add a supplementary comment that I think is important. For as long as I can remember—and that's a while, I'm afraid—there has never been a dispute, or there very rarely is, between the provinces and the federal government on veterans. Brian mentioned that Veterans Affairs will top up to the level that is enshrined in veterans legislation.

More importantly, using the community system is very important for good health outcomes for veterans and their dependants. Whereas we're a paying partner with provinces, we don't want to take somebody unless there's no care available in the community. We don't want to take a veteran out of the community and isolate that veteran from family and friends. This happens occasionally when the care isn't there. That would not be something we would want to be in the position of doing. It also creates federal-provincial friction, which I don't think anyone in this room, or any public servant or politician, would encourage.

The Chair: Now we're going to move on to Mr. Shipley, who sadly only had a minute of the previous time.

Mr. Bev Shipley: Thank you, Mr. Chairman.

To follow up a little, I'm glad to hear that, in terms of cooperation with the provinces, that act of the federal government does top up and meet those needs.

At the end of my last question, Mr. Ferguson, you were talking about the needs assessment. Actually that was sort of my next question, and I'm glad you stepped into it.

One of the things you'd mentioned earlier—and we see it quite honestly time and time again—is that the applications become so complex that not only do the applicants not understand them, but neither do the staff people. The elevation of frustration tends to get pretty high when we cannot get consistent answers back from an applicant. You talk to different people and you get different answers.

I'm hoping that part of our discussion and your review, when you look at the needs assessment criteria...that they are clear and understandable, and not just to the applicant. Obviously now we'll have an ombudsman who will be there in part to help, but there always needs to be a consistent and understandable message coming from the staff. I guess that's not so much a question as it is a comment of mine, but you can make a comment on it. We see it in many departments from time to time.

● (1000)

Mr. Brian Ferguson: That's a very valid comment on something we constantly have to guard against. I can say that for the new Veterans Charter, the approach we took was to invest hugely in the training of our staff. That was one critical element.

The other element we tried, which really worked well, is a self-assessment tool that we put up on the Internet. We had thousands and thousands of downloads of that tool by presumably interested potential applicants, to do their own screening on their own assessment, based on what they understood to be the program benefits and requirements.

I would hope that we would be able to do that to some extent even with our traditional veterans. People will say they're not computer literate, but some of them are. Another thing is that a lot of their families use the tool to help them. I agree completely with your comment that we need to make sure this is as simple as possible for the client.

Mr. Bev Shipley: We've had witnesses, when we were talking about post-traumatic stress and about an ombudsman, and we started to look at the expansion and at the extension of health care services. As you've been going through the review, has the investigation also looked at the availability of the professional services that are going to be requested?

Mr. Brian Ferguson: Certainly that is an aspect of it, particularly with reference to post-traumatic stress disorder. A continuing concern that we have jointly with our colleagues in DND is the need to increase our capacity in that regard across the country. We've taken active steps. We've created a network of operational stress-injury clinics that operate there, which you've probably heard about. We've taken steps to create a common list of service providers among the Department of National Defence, RCMP, and us. We've introduced the concept that clinical care managers be assigned to more complex cases. I'm making that reference to indicate that we have responded in that area.

I'm not so certain in this area whether we're facing the same issue, but I think it's safe to say we will be addressing it.

Mr. Darragh Mogan: I think with larger numbers, and larger numbers in rural areas—you've heard that comment already—it's safe to assume we're going to have a little challenge with suppliers, especially as the basic home care isn't adequate and you have to move it up a bit, and you want to have the kind of medical and clinical assessment that guides public servants in what they might be offering. I think it will be a challenge down the way.

Mr. Bev Shipley: Again, governments have made, and likely will continue from time to time to make, some commitments that can't be carried through.

An hon. member: No, don't say it.

Mr. Bev Shipley: On this side they haven't. If one of those commitments is to provide it, but actually that service is not available, then we need to.... And that's all part of what I'm saying about prioritizing. It's good to say we're going to do all these things, but we need to make sure we can do them if we say we're going to do them.

Mr. Brian Ferguson: I understand.

Mr. Bev Shipley: I likely have a minute here just to finish off.

I'll just go back to some earlier questions about your review and the timing of it, and the input you want to have from this committee, which we very much appreciate. If you were to put a time on when you would want our input to be in front of you, if you're going to wrap this thing up in the fall—and we know how there's some time in the preparation of that—when should we be wrapping up ours so that you have that input for your study?

Mr. Brian Ferguson: In an ideal world, and this isn't a facetious comment, it would be yesterday. But in reality, sir, I think the sooner you can get it to us...if you could get input to us in the next few months, that would be exceedingly helpful to us.

● (1005)

Mr. Bev Shipley: I don't like to leave it as a few months, because if you want it.... We want it this fall, so I'm hoping that as a group we'll quickly bring in the witnesses who are needed and get the job done.

Mr. Brian Ferguson: Even if you wanted to give us something on an interim basis, it would at least give us a sense of your direction so that we could actually utilize it sooner rather than later.

Mr. Bev Shipley: Thank you.

The Chair: Thank you, gentlemen.

Now on to Mr. Valley for five minutes.

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

One of the things you mentioned was about some of the health care barriers that are in place and how we have to constantly search them out to try to make sure the veterans don't fall through the cracks.

We had testimony—or whatever you want to call it—on April 24, and some of us were surprised, and maybe shouldn't have been, to hear that some of our currently serving members in the Canadian Forces are receiving pensions while they're still serving. Do they receive them from Veterans Affairs?

Mr. Brian Ferguson: Yes, and that was a system that ended, actually, when the new Veterans Charter came into being on April 1, 2006. They're still eligible for a disability award, but the pension system that existed prior to that no longer exists for anybody applying for a disability benefit.

So they still are eligible for disability benefits, but they're not in the form of a pension. For example, if someone loses a hand and remains in the Canadian Forces in some capacity, they would be compensated for that under the new Veterans Charter, the same as anybody else would for losing a limb.

Mr. Roger Valley: So the pension aspect ended with the introduction of the new charter?

Mr. Brian Ferguson: That's correct.

Mr. Roger Valley: I don't know that some of our witnesses are aware of that, because they identified that as one of the key problems with some of the health promotion techniques they were trying to use to help these individuals get over some of their health situations.

Mr. Brian Ferguson: Now, it ended for new applications, but the people who had already gotten into the previous system were grandfathered. So there would be continuing pension benefits going to anybody who actually had received a pension prior to that date.

Mr. Roger Valley: Yes, but I think the message we got, and I could be wrong, is that this was an ongoing problem, so I don't know that they're aware of that.

Mr. Brian Ferguson: No. It was that individuals in the CF were getting pensions while serving. As of April 1, they get a disability award.

Mr. Darragh Mogan: If I might ask, just for clarification, was the issue that they were getting a disability pension or a disability award while they were serving? In other words, some might say they're almost getting a salary increment while they're serving and somebody else who is serving isn't. We've heard that.

Mr. Roger Valley: It was the opinion of one of the individuals—and again, I'm careful not to put words in somebody's mouth—that this was a disincentive to getting better, for some of the issues they suffered under, because they were receiving a pension while still serving. One of the individuals felt that was a big barrier to helping the physicians treat the patients.

Mr. Brian Ferguson: In fact, I think we identified that as a barrier in the *diagnostique* leading up to the change that we implemented with the new Veterans Charter, which—

Mr. Roger Valley: Well, I'm glad to hear that, because we were concerned when we heard that, that this was something we had done through legislation to create a problem that is going to hurt our veterans in the future.

Mr. Brian Ferguson: In this case, we've actually eliminated that system.

Mr. Roger Valley: Good.

I don't have any more questions at this time, Mr. Chair. I won't allow you to cut me off; I'll cut myself off.

The Chair: Okay. Normally, I would ask Mr. St. Denis if he wants two minutes, but he's otherwise occupied.

We will move on to Mr. Sweet, then, for five minutes.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Thank you, Mr. Chairman.

I have a couple of things, quickly. Are the inbound calls from veterans to the client service personnel taped or monitored at any time for quality control?

Mr. Brian Ferguson: To my knowledge, no, but I'll double-check and get back to you on that, sir.

Mr. David Sweet: Okay.

Mr. Brian Ferguson: To my knowledge, at this table, I don't believe so. I certainly have never received any direction to do so.

Mr. David Sweet: Sometimes given the responses I hear that some veterans get, it would be good to know this is being checked to make sure that the people actually understand how to relate to veterans.

On that note, by the way, I do like your point that “a Veteran is a Veteran is a Veteran”. I wonder, when we say traditional veterans and modern-day veterans, whether we sometimes inadvertently create a class structure. I'm careful, though, to say that I know it's not intentional. Anyway, I like that terminology of yours much more.

I seldom would ever speak for the whole committee, but I think everybody was impressed by the Gerontological Advisory Council report, when we had the opportunity to question the council about it. I just have to say that the more of that report you actually incorporate into your services, the more pleased we'll be than ever.

I also want to say that all of us get lots of calls. I have two military bases in my riding and I certainly like to get the calls, but the calls not only have our staff busy, they're also heart-wrenching in most cases. I just wanted to say to you very directly, but empathetically as well, because I understand the amount of work you have to do, that if your work right now—and I'm certain it is—is going to mean less administration and that we're going to have a program that's sustainable and one that's going to meet the needs out there and be timely, then I'm all for it, but just make sure you don't waste even a day ensuring we can deliver that and encapsulate as many of the needs of our veterans, of every degree, we can.

I was quite concerned when we heard from the advisory council that some provinces are actually now refusing basic care to veterans and are asking Veterans Affairs.... That was what they said at the time when we questioned them. I don't know if you looked at the blues on that.

Is that the case?

● (1010)

Mr. Brian Ferguson: To my knowledge, no, but certainly what I explained earlier is my understanding of how we work.

I don't know whether, Darragh, you want to add anything to that, but as Darragh said, we have really good cooperation with our provincial colleagues. The fact that we've got 50 client service teams on the ground means they interact with their counterparts in the provinces continually.

Mr. David Sweet: Is it Mr. Marshall? Who is it?

Mr. Brian Ferguson: Yes.

Mr. David Sweet: He said there are three provinces now who are asking Veterans Affairs to pay for basic care for veterans.

Mr. Darragh Mogan: Maybe I'll comment.

I won't presume on the intentions of Dr. Marshall. Outside the Canada Health Act, in long-term care—which is not insured under the Canada Health Act, as such—there is variation in what provinces offer. Some offer more, some offer less, some offer different things. The goal of Veterans Affairs is to even that out, where we have to, especially in the area outside the Canada Health Act.

I don't know of any circumstance where veterans, just because they're veterans, are being disentitled or disenfranchised for anything that's offered by a province under the Canada Health Act. That I can say, categorically.

I do know that where Dr. Marshall and the Gerontological Advisory Council have advised creating a veterans integrated services program, there are going to be some provinces that offer a lot more than others, which has as much to do with the available provincial wealth I think as anything else.

But I don't think, from my experience, there is a province in this country that targets veterans for disentitlement. I really don't think that's so, and I don't think that's what Dr. Marshall meant.

Mr. David Sweet: This is a two-part question. Are there countries who have exemplarily high satisfaction ratios for their veterans care, and are we looking to those countries in this review so that we can benchmark against them and make this part of the resulting product?

Mr. Brian Ferguson: There are two aspects to a response. One is that we are well connected to a number of countries and we work continuously with them. In fact, the U.S., the U.K., New Zealand, Australia, and Canada have formed what is called the Senior International Forum. It's been operating for a number of years. We share information on best practices with each other on a continuing basis. In fact, I would say without hesitation that we cherry-picked from those countries many of the ideas that are in the new Veterans Charter. We will continue to work with them to look at ideas for improvement of our health services as part of the health services review.

We have instituted our own monitoring systems as well, though. As Darragh mentioned earlier, in our long-term care facilities, we monitor using a standard tool that is designed around 10 outcome areas that we insist be met for our veterans in these institutions. Our results are well up in the 90% range in terms of satisfaction at the moment.

We also run periodically through a common measurement tool, an independent assessment of the client satisfaction with us. We use that to try to improve where we see areas of deficits or whatever needs to be improved upon.

But I'll go back to your original question. Yes, we are looking with these countries. To pick one country that provides an exemplary service I think would be difficult, but everybody has strengths and weaknesses in different areas. We're trying to, again, use the same approach here.

Darragh, is there anything you'd like to add?

● (1015)

Mr. Darragh Mogan: If we want to characterize it, New Zealand, for instance, provides a very good case management service—that's what they do—and we've modelled our case management service along theirs. Our veterans independence program came in in 1981. The Australians have replicated it. They have a very good rehabilitation system there, as the British do, and we copied that, to the extent we could, in the new Veterans Charter.

Mr. Brian Ferguson: Our job placement program as well?

Mr. Darragh Mogan: Our job placement program is modelled on the British Ministry of Defence, so I think it's fair to say that that Senior International Forum provides us with a pretty good smorgasbord of things to choose from.

The Chair: Thank you very much, gentlemen.

Now on to Mr. Stoffer for five minutes.

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

I will just put a concluding aspect to my VIP crusade, as we say... still working with the widows and the veterans. They can only go by what they're being told, and what they were told by the now Prime Minister is that it would be immediately. The letter doesn't say there would be a review. It doesn't say we'd look at it. It doesn't say we would consciously think about it and we'll get back to you. It says immediately, and that's all I can go on.

If it sounds impatient, then it is, but the fact is these widows are getting older. They don't have much time. We'll lose about 40,000 Second World War and Korean War veterans this year. They'll leave behind...two-thirds of those will be widows, and most of them will not be eligible for VIP, and that is unacceptable in my term.

So I just put that one to rest right now. I know that's not for you, but if you can take it back to whomever and tell them to get their butt in gear on this one, it will be greatly appreciated, because it saves money. It saves money. The longer we wait, the more it costs us. If you do it for anything, do it for fiscal responsibility than for anything else.

My concern is Louise Richards. You probably saw her article in *The Hill Times* this week. I'm just wondering if you have an ability to respond to that, regarding her access to care at the Perley.

Also, we're getting a fair number of calls from across the country. There was one, a Harvey Friesen, which you're probably aware of, with asbestos. He was paid posthumously $100,000 for that. We're getting more and more people coming up, suffering from the effects of asbestosis, from their exposure to the ships and various buildings and plants they worked at during the forties and fifties, and that's coming back to haunt them now.

I'm just wondering what the department is doing in order to ascertain their concerns, to give the benefit of the doubt, to ensure that these aged civilians and veterans are able to be cared for as soon as possible.

Mr. Brian Ferguson: Perhaps I could ask my colleague.

Darragh, do you want to talk about the bed situation and I'll comment on the asbestos?

Mr. Darragh Mogan: Thank you, Brian.

We're aware of Ms. Richard's letter, her response to the minister's letter. I can't comment on the specifics, and you know I won't do that. What I can say is the issue was about the convalescent care beds at the Rideau-Perley centre and about whether veterans could have access to those beds, because they are on the civilian side of the hospital, and whether they could have access on a priority basis. The answer is, they are not part of the 250 priority access beds at the Rideau-Perley, but—and there's a big “but” here—if individuals, through a rehabilitation plan or for care of their war service-related injury, need convalescent care in the Rideau-Perley, in the Hotel Dieu Hospital in Kingston, in Nova Scotia somewhere—wherever they need it—we can pay for that and we will.

The reason we haven't had a reserve of convalescent beds there is because it tends to isolate the location of where this care can be received, and the downside of that is probably greater than the upside. The downside is it's only available to people in certain areas where we have these reserves of beds, and for the others, they have to move and leave their families to go to them. So if you can purchase the equivalent care somewhere in the community nearby for a war-related disability, it makes more policy sense. Our experience is that four out of five veterans would rather stay closer to home than they would to move a long way away.

I think that's probably the kind of policy...but we certainly understand Ms. Richard's concern there, and I don't know that the minister ever made a commitment that those were priority access beds, but they are available. If they need it, we can purchase the care.

● (1020)

Mr. Brian Ferguson: With respect to the asbestos issue, we are doing our best to ensure that generally veterans are aware of their rights to access the Department of Veterans Affairs for services, so that we have as much general outreach as we possibly can give to them within our communications strategy. For example, we have *Salute!* magazine, which goes out, admittedly, to existing veterans, not clients, but through that network there's a lot of interaction at Legion halls and things like that where people who are clients share that information and share the *Salute!* magazine. It gets well distributed across the country. We communicate in the *Maple Leaf* magazine, which is the internal magazine of DND.

So we attempt to make it known that for anybody who has any kind of illness that they think might be related to their military service, Veterans Affairs is there for them to come and see us.

When it comes to a specific illness and linking it back to the causal effect, we have thousands of maladies that could be attributable to military service, depending on what the circumstances were. It would be very difficult for us to go back and try to trace through history to find where people may have served and to highlight for them that they may have served in a particular area. It's a very complex subject, as I've learned in the last while as we've looked at this asbestos issue. But what we're doing is we are attempting to see what we can do in terms of communications on the subject, and we are looking at ways and means of enhancing that—I'll call it—outreach, to let people know that awards are being given for this particular substance and that we are there for them.

I don't know if that helps at all in terms of your questions.

Mr. Peter Stoffer: Again, I go back to just the aspect of the "benefit of the doubt". It's nice to say that, but I'll send you the hearing loss ones and the asbestos ones that I have for you to review. In my own case...and I'll correct myself if I'm wrong, but I don't see the benefit of the doubt being applied. I always see, "There's no link that shows you suffered a hearing loss, so you're denied." That's what I'm seeing on my desk from these hearing concerns. I write them back and they say, "What about the benefit of the doubt?" That's fine, but unless there's a link to prove that their hearing loss was caused by those guns going off on the ships, we can't prove it. So there is my problem.

Mr. Darragh Mogan: We certainly want to see those. Benefit of the doubt works a certain way, and I don't want to pretend to be a lawyer, heaven forbid, but the benefit of the doubt means in the absence of any contradictory evidence, where the other legal proof is balance of probabilities, which is if six say yes and five say no, it's yes, and if six say no and five say yes, it's no. We don't have that, but the benefit of the doubt is not a vague term. It's quite a specific legal term.

The Chair: Thank you.

When Mr. Stoffer looked up before, that was actually when his time ran out, but I wasn't clear enough in terms of communicating it. Now the time is over to the Conservative Party, if there's anybody who wishes to get in five minutes worth of questions.

All right. Over to Monsieur Gaudet for five.

[*Translation*]

Mr. Roger Gaudet: I have a brief question, Mr. Chairman.

To what services are veterans' widows and widowers entitled? What happens after their spouses die?

[*English*]

Mr. Brian Ferguson: Generally, there are two basic types.

One is that the widow or widower is entitled to a continuing pension if his or her spouse had been in receipt of a government pension from Veterans Affairs. A percentage of that pension would continue for the spouse. That's one benefit they receive.

Secondly, if the spouse was receiving the veterans independence program before he or she died, the widow or widower would be entitled to continue with whatever service the veteran was receiving, either groundskeeping or housekeeping, or both.

Those are the two benefits of spouses.

[*Translation*]

Mr. Roger Gaudet: Thank you, sir.

[*English*]

The Chair: Now, finally we go to Monsieur St. Denis.

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

I have a fairly short question. I'd like to follow up with something my colleague, Mr. Valley, was pursuing. It was some evidence we heard from a physician with the military in relation to post-traumatic stress disorder, part of the overall health review.

If I understood correctly, less than 10 years ago, after many complaints by former military and studies by the then defence and veterans affairs committee, it was ultimately decided by the government that something should be done for injuries at work, much as you see in the civilian world with provincial compensation programs. So an attempt was made more or less to mirror that for our military—none of us, I'm sure, would disagree with that notion—and at the same time, by providing military personnel with access to disability benefits while they're still in the service, to encourage them to come forward rather than to hide injuries for fear of being let go. So there were certainly a lot of positive benefits there.

I think the point of the testimony was that with that came a lot of extra demand on the medical resources of the military. Whereas they wouldn't have been concerned about the paperwork and the processing of a disability-type claim on top of the regular medical services to the military, they now had the two. I think the issue, then, was human resources in the medical field to deal with this.

Is your review going to deal, among many other questions, with that particular question?

● (1025)

Mr. Brian Ferguson: In actual fact, we're dealing with it through another mechanism. I don't think it's a fundamental, transformational item for the review, although it's an extremely important issue for us. In other words, we have an ongoing relationship with the Department of National Defence. We meet quarterly with the senior management cadre, on to the chief of military personnel, and under the veterans services side of our house we meet constantly. One of the areas we're continually working on is to try to speed up the process of the paper flow from DND through to Veterans Affairs Canada for disability benefits and for other reasons. That issue is on the radar screen. It's one we're continuing to work with.

We realize that the issue—and we were informed and educated by DND along the same lines some time ago—is that their physicians are there to help their military members deal with problems. That's job one. Job two of providing input to the Veterans Affairs disability award process is one in which they were having difficulty meeting the workload demand.

We have introduced some changes to this to try to improve that system, and we're actually seeing quite significant improvements in turnaround times. We've offered resources to them to help find the people who can actually deal with those awards.

One of the things we're doing is actually accepting the military evidence as being the basis for our disability award program, so as not to create a second requirement. Subject to privacy concerns about whatever the CF member may have relative to that, we're able to use that document.

So there are improvements under way in that area. I see it as something we should be doing anyway, and not something we should be waiting for the veterans health services review to fix for us.

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

The Chair: And finally, Mrs. Hinton had an interjection.

Mrs. Betty Hinton: I have a bit of a question here. You just said that if they were entitled to a continuing pension, it continues. If the veteran was on the veterans independence program, it continues for the spouse.

A problem that I've had for many years, and I've said this repeatedly, is that the veterans of World War II and the Korean War are a different breed. They are extremely independent, very self-sufficient. In many cases, they have refused to have that kind of support. They don't want someone to shovel their driveway. They don't want their windows cleaned. They don't want their lawn mowed. Then one day they're shovelling their driveway and they have a heart attack and die, and now the widow is unable to have the continuing service. That's one thing I would like to see addressed. That is the whole issue here. If they were not on the VIP program prior to dying, the widow is not entitled. I just wanted to make sure that was clear.

You've answered this before, because I've been at committees in areas where you've said this. Who is entitled to the VIP program? They have to be a serving veteran who was in a battle. Is that correct?

Mr. Brian Ferguson: That's not entirely—

Mrs. Betty Hinton: Okay, I didn't think so.

● (1030)

Mr. Brian Ferguson: Darragh is one of the godfathers of the VIP.

Mr. Darragh Mogan: I'll take credit for its successes, thank you.

To be eligible, you need to have one of two. One is if you had service in a war zone—so Korea, overseas service—and have low income. That's one of the gateways that we have to administer. The other one is if you have a war-related or service-related disability and that's prompting a need for long-term care. That's yet another gateway.

For spouses or survivors, there is eligibility now, and that's a continuation of a veteran's benefit. But the veteran had to have the benefit, so the circumstance that you've described, Mrs. Hinton, is not one for which we can now reach out to survivors at this stage. The health review is meant to take that on, to look at what can be done for those survivors, where the veteran, either for the reasons you've cited or other reasons, never came forward when they would have had a benefit had they come forward.

Mrs. Betty Hinton: So you have an 84-year-old veteran right now, today, who is still doing his own shovelling or he's getting his son to help him, and his wife is still living in the home with him.

Because this is broadcast, would you agree with me that the best suggestion we could make is that if you're in that position, you run down right now and apply for the VIP before something happens to you?

Mr. Brian Ferguson: Certainly if they feel they could use the VIP, they should do that. In fact, I was going to make a comment prior to that that one of the things we're doing under the veterans health services review, which we shouldn't forget, that we've mentioned is this health promotion aspect.

What you're saying is absolutely right. People should be more aware of their health risks, particularly seniors. Falls prevention, for example, is something we should be very concerned about.

So I could see your issue being addressed through this health promotion concept, where we say to elderly veterans—and if some of them are listening, that's fantastic—that they should actually be quite concerned about risks like that and they should not put themselves at undue risk. If they think they need help, they should come and see Veterans Affairs.

Mrs. Betty Hinton: Thank you.

The Chair: All right. It looks as though that wraps up our question period. I would like to thank our witnesses for appearing today.

There are some things I would like to make everybody aware of in terms of the wrap-up of today's meeting.

On Thursday, we'll be having the Gerontological Advisory Council appearing as witnesses; on Tuesday, we have Senator Roméo Dallaire; and on Wednesday, we have an informal meeting with PTSD victims, in the evening, based on what we've previously discussed.

As well, I know Mr. St. Denis asked me today about a letter to the minister that we previously discussed and that has been drafted. So at one of these opportunities, that will be presented as well.

Is there a question?

Mr. Bev Shipley: I have just one comment pertaining to the advice of our witnesses today.

If we're looking to put recommendations forward—it doesn't have to be a study, but recommendations—we need to gauge our time and our witnesses around it. This is now May 8, and likely within the month this place will close down. So if we're going to have something in place, I'm just suggesting that we try to monitor ourselves to get the recommendations in so that they will have those as an inclusion.

The Chair: Mr. Stoffer.

Mr. Peter Stoffer: A clarification. He indicated that for a veteran to get VIP he has to be of a certain income. I go back to the statement of “a Veteran is a Veteran is a Veteran”. One thing I would recommend is, regardless of income, they should be treated the same.

Thanks.

● (1035)

The Chair: Mr. Valley, did you have an interjection?

Mr. Roger Valley: It's an unrelated issue.

You and I spoke about this room, and we're attempting to have the House recognize it as the veterans affairs room. I spoke to you about it. If we're successful in doing that we should make a much bigger issue of it. I would like to see us have a reception whenever it happens, whether it's in June or October, and I think we should invite all the veterans groups. We should let them participate in some of the artwork decisions. We should have a reception in one of the larger rooms upstairs and make the veterans realize how special they are, that we're going to have a room named after them in this committee. I wanted to bring that up formally before the committee that, regardless of when it happens—whether it's a month from now or six months from now—we should make the effort to bring the veterans in and make them feel we are actually listening to them.

Some hon. members: Hear, hear!

The Chair: I remember you sharing that previously with me, and I'm glad you brought that up at the committee meeting here. I think it's a grand idea, and maybe we could have a selection of art to potentially look at in one of those rooms, and, as you say, have veterans and some of the committee members, etc., participate in helping to choose what art will decorate these walls.

Mr. St. Denis.

Mr. Brent St. Denis: When you mention art, I assume we mean the Art Bank. Is there a pictorial inventory, or on the website, where we could get—

The Chair: I don't know.

Mr. Brent St. Denis: We don't want to look at 1,000 pieces. If we had a subset of military photos, either from the Art Bank website or from some kind of display, it would be interesting to work together and pick out some samples for them to help us. Maybe then we'd have 30 pieces in here and during the reception they could pick their six or whatever favourites and those would be the six.

The Chair: I think that's a splendid idea. Do I see any interest from the clerk or the researcher?

Mr. Michel Rossignol (Committee Researcher): The War Museum has a collection of war art, and there is some way of looking for it through the Internet. Yes, the war art in room 362 in the East Block was obtained through the war art collection of the War Museum. So there could be some discussion with them as to what is available, because those are copies of original war art. So there could be a similar availability there.

The Chair: Mrs. Hinton has an interjection.

Mrs. Betty Hinton: I think this is a wonderful idea, and I'd love to see that kind of participation.

I simply want to make a note that if the two pieces that are framed that I donated already are not used, I want them back, please.

The Chair: All right.

As well, I'd like to put it out there that it could be paintings, it could be posters, it could be pictures—it could be any of those. And maybe there are other things I haven't thought of.

Mr. David Sweet: There's no end to sources out there, that's for certain.

One thing, Mr. Chairman, since we're on art...has everybody visited the Veterans Affairs site and watched the video clip there honouring our veterans? Has everybody seen that?

The Chair: I don't believe I have.

Mr. David Sweet: The video clip on the Veterans Affairs site is a very moving video clip of basically the service through all the conflicts our veterans have had. If you haven't been to the site, it's very moving. You would like to see it.

The Chair: Thank you.

I think we'll now adjourn, and we'll see each other back on Thursday for the Gerontological Advisory Council.

The meeting is adjourned.

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