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Chair

Mr. Rob Anders

Standing Committee on Veterans Affairs

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● (1100)

[*English*]

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

While we're assembling and to give you a background on how this is going to work, I'll tell you that we're going to have a teleconference this morning with Darragh Mogan and Ken Miller.

I'll apprise everybody of how it's going to work. Witnesses generally have twenty minutes to use as they see fit to introduce themselves. You can split it as ten minutes apiece, or five and fifteen, or you can just have one person speak; it's whatever you want to do. Then we open it up to questions from members of the committee.

We are obviously in our study of the veterans independence program. Without further ado, I think I'll turn the floor over to our witnesses: Darragh Mogan, director general of the program and service policy division, and Ken Miller, director of the program policy directorate.

Good morning, gentlemen.

Mr. Darragh Mogan (Director General, Program and Service Policy Division, Department of Veterans Affairs): Good morning. Thank you very much for allowing us the time and for indulging our being on the end of the phone rather than there with you. Unfortunately, I'm unable to travel today.

I wanted to give a little focus to the opening—

The Chair: If you don't mind, I'm going to interrupt for a second, because the people who are doing the transcripts and the blues for the committee need to know which of you is speaking right now.

Mr. Darragh Mogan: I'm sorry; I'm Darragh Mogan.

The Chair: Thank you.

Mr. Darragh Mogan: When Brian Ferguson and I were appearing at the committee last May, we talked about the veterans health services review and the veterans independence program. What we didn't get to in the discussion of the continuum of care was the very important role long-term care now plays in that continuum and will certainly play in the future. Some 11,000 veterans receive long-term care under the auspices of Veterans Affairs. So with the indulgence of the chair and the committee again, my comments will focus on the long-term care aspect of that continuum and so will my opening remarks.

My first part of the opening remarks is to say I'm pleased to be here today—but actually I'm not there, and I apologize for that—in my capacity as director general of program and service policy.

Let me start by saying that Veterans Affairs has a long history of providing long-term care services and benefits to veterans. In 1919 Veterans Affairs began providing care, treatment, and rehabilitation for soldiers acutely injured during the First World War. Activity peaked at the end of the Second World War in 1946, when the department owned and operated 46 hospitals.

However, the environment soon began to change. By the 1950s, universal health care was becoming a reality, particularly in the late fifties. The foundation of the social safety net that has defined modern-day Canada was emerging. As First World War veterans aged, their long-term care became a priority. At the same time, in the early 1960s the provincial responsibility for heath care came to the forefront. In 1963 a cabinet decision, the Glassco commission decision, obliged VAC to transfer its hospitals to the provinces, which it did over the years, with the exception of Ste. Anne's Hospital in Montreal, the department's only remaining federal institution.

However, as part of the various transfer agreements outlining the transfer of these facilities, a fixed number of long-term care beds would remain available to the department on a contractual basis. These were called priority access or contract beds. Veterans have access to these beds in a network of facilities across the country. Today, VAC has close to 4,000 contract beds in 172 facilities at an average bed cost of $55,000 per year. Approximately 60 per cent of these contract beds are in 14 large transferred hospitals in urban areas. The average length of stay in a contract bed for a veteran is 2.6 years. Those eligible for contract beds include veteran pensioners, overseas service veterans, income-qualified veterans, and certain allied veterans.

To respond to the evolving needs, eligibility for long-term care benefits grew to allow veterans to access long-term care beds in community facilities. Today the department supports approximately 7,300 veterans in over 1,900 community facilities in addition to the veterans we support in our contract bed facilities. VAC pays for the uninsured cost of care, which in some provinces is the full cost of care, if long-term care is not an insured service. In other provinces the VAC portion is minimal, but the financial support from Veterans Affairs ensures that the cost of care to veterans is the same no matter where they stay.

The average stay in community care is 1.2 years, less than half that of a contract bed. The main reason for this—I speculate here—is that our largest group of veterans who are eligible for the priority access or contract beds are only eligible for this most expensive care option and tend to go there earlier and stay longer because of the absence of choice for them. I will speak more about this a little later.

● (1105)

Those eligible for a community bed include veteran pensioners, overseas service veterans waiting for contract beds, income-qualified veterans, lower-income Canada Service veterans, and certain allied veterans, as well as Canadian Forces veterans, reservists, and civilian pensioners, but only for the care of service-related disabilities.

Over the years, veterans have shown a marked preference for remaining at home as long as possible. Veterans Affairs' first national home care program—we like to think that it is very innovative, and I believe that it is—was introduced in 1981 to assist veterans in remaining in their own homes for as long as possible or in accessing community facilities closer to where they live. This highly successful veterans independence program provides services such as housekeeping, grounds maintenance, personal care, and nutrition services to help veterans remain independent in their own homes and communities. At the moment, approximately 73,000 veterans and 25,000 of their primary caregivers receive benefits from this program.

As a result of the increasing need among aging war service veterans for residential care, and faced with long wait-lists for access to some facilities in major centres, the department introduced two approaches to respond to this specific need. In 1999, using the VIP model, the overseas service veteran at home pilot project was introduced to allow eligible overseas veterans to access these services at home while they were waiting for contract beds to become available. Eight hundred and seventy veterans access this program. In 2000, we also enabled overseas service veterans to access care in community beds while they waited for contract beds to become available. Twenty-four hundred veterans now use this program.

Throughout its evolution, VAC has been committed to the quality of its long-term care program, which costs about $340 million annually. In response to a Senate report in 1999 called *Raising the Bar: Creating a New Standard in Veterans Health Care*, the residential care strategy was developed. In response to the needs of aging veterans and their families, the strategy emphasized specialized care for those with dementia. It includes VAC's ten national outcome standards of care, which were developed through significant consultation with external health professionals, gerontological experts, and provincial ministries of health.

Standards were developed for such areas as safety and security, food quality, personal care, and access to clinical services, among others. They were endorsed by the Veterans Affairs' Gerontological Advisory Council, the same council that provided the report forming the basis of the veterans' health services review. The Gerontological Advisory Council was represented by some of Canada's most distinguished experts on aging and seniors' and veterans' issues, and it included representatives from the six major veterans organizations. Our national outcome standards are the foundation upon which we have built our quality assurance in long-term care.

To help ensure quality care for veterans in these facilities, Veterans Affairs undertakes the following measures. It surveys veterans' satisfaction with contract or community beds through the completion of a client satisfaction questionnaire, often with the help of VAC or Royal Canadian Legion representatives or with input from the family when the condition veterans suffer from does not allow a direct contribution. Departmental staff follow up with the facility management on any identified issues, and if they are not dealt with in a timely manner, a facility review is completed.

During 2005-06, close to 3,300 veterans completed the survey with what we consider to be a remarkable 96% overall satisfaction rate, nationally.

Veterans Affairs has professional health care staff complete facility questionnaires to assess an institution's ability to provide for the care and needs of veteran residents. Again, any identified issues are followed up immediately.

Veterans Affairs has partnered with the Canadian Council on Health Services Accreditation and has seen the successful accreditation of most of its 4,000 contract beds.

● (1110)

As most veterans receive long- term care provincially, VAC remains committed to quality care by improving its oversight in residential care and strengthening the services provided by the department.

● (1115)

Mr. Ken Miller (Director, Program Policy Directorate, Department of Veterans Affairs): It's Ken Miller. I'm just going to take over from Mr. Mogan at this point, with the committee's agreement.

So what does the future hold? You've heard now how over the past 90 years our programs have incrementally evolved to meet clients' changing needs. But the expansion of eligibility has resulted in numerous categories of veterans, each qualifying for long-term care based on different eligibility criteria and gaining access to different benefits, some of which are based on health need and others granted automatically. The result is that we're 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. It may also provide certain veterans who are fully functioning in their community with more benefits than needed.

We're also seeing a 20 percent vacancy in contract beds and an 81 percent increase in utilization of community beds since 1996. Many times community facilities are preferred over contract beds as they're closer to the veteran's home, closer to their family and community, and they provide the option for a spouse to live there as well when that's an appropriate level of care that's needed.

Veterans are demanding more choice in care options, and unfortunately the current criteria often limit the choice and the fit for the veteran. In spite of the changes made over the years to try to better respond to the long-term care needs of veterans and their primary care givers, the reality is that further action is required if we are to make a difference in how these veterans live out their remaining years.

We realize that the time to act is now. The average age of our frail elderly war veterans is 84 years old, with almost 2,000 passing away each month. We want our veterans to age as well as possible and to receive the most appropriate benefits and services at the right time and at the right place. What is needed is a long-term care program that offers choice in care settings, including greater access to the veterans independence program services and also to community-based assisted living options. Overall, we envision a program that is flexible, providing support and assistance across the full spectrum of need, in which the level and intensity of service could be increased depending on the need.

Ultimately, Veterans Affairs wants to meet the individual needs of veterans who have faithfully served our country. To that end, we will continue to work with provinces and long-term care facilities to respond to changing needs of veterans. Also, we will work with veterans organizations and stakeholders to maintain the principles of choice, quality, and accountability. Finally, we will move forward with the veterans health services review, which could address many of these issues.

With that, Mr. Chair, I'll turn back to my colleague Mr. Mogan to conclude our comments.

Mr. Darragh Mogan: In effect, committee members and Chair, that does conclude our comments. I think we're ready to take questions that members may have.

The Chair: All right. Thank you very much.

We have a rotation, and just so you know, it goes from party to party. We start off with the Liberals, with Mr. Valley for seven minutes.

Mr. Roger Valley (Kenora, Lib.): Thank you, Mr. Mogan and Mr. Miller. Thank you for participating today. Even though you were unable to travel here, we'll be able to get the information and answer some of the questions we need answered.

My first question is whether you can just run through something again. I know you explained it briefly. The contract beds are in the hospitals that have been handed over in 14 large urban centres. That is in contrast to the community beds. Can you explain how the community beds are situated generally across Canada and the difference between the two? We understand one's in the urban centres, and the community beds are where?

Mr. Darragh Mogan: It's Darragh Mogan here, responding to the question. The community beds are in about 1,900 facilities across Canada. They're really where the veterans choose to go, and where they're licensed by the province for the most part. That's the kind of choice I think Ken Miller was talking about that veterans prefer. So they're located wherever it is there is a vacancy and the veteran wants to go and the provincial admission criteria are met.

Mr. Roger Valley: I'll explain again. I represent Kenora riding. It has very small communities. Can you tell me that there would be community beds? We saw maps with the distribution of the beds right across Canada. I do not remember a lot of choice in my riding or in northern Ontario. I believe we're serviced by one of the large hospitals out of Winnipeg—

Mr. Darragh Mogan: Yes, that's Deer Lodge.

Mr. Roger Valley: I don't know that we have any other access. Thunder Bay may, but the next access for a large facility is, I believe, over in Sudbury. So you're saying we would have contract beds in even the smallest of communities?

Mr. Darragh Mogan: No. What I'm saying, Mr. Valley, is we have about 4,000 contract beds and the inconvenience of those is that they're not located necessarily where the veterans are located all the time. So it would mean that someone from Kenora would have to go to Winnipeg, and there's a real down side to that in terms of one of the determinates of health, and that's social integration. You can't lose your family contact when you have to drive 250 or 300 miles to see somebody.

So what we also use is a supplement. That's where the majority of veterans are. About 7,400 of them are community beds, some of which would be in Kenora. Some of them would be in Dryden, if they're there. Some would be in Fort Frances, perhaps. So that's the way of overcoming the disadvantage for veterans, say, in Kenora with having to go to Deer Lodge.

● (1120)

Mr. Roger Valley: You mentioned a figure of $55,000 as the average cost per year for some of the beds, and I don't mean to split hairs here, but some of these hospitals are extremely small. This would be enough to make sure that there was a bed available in a small community if a veteran desired it there. It does cover the cost of it, then?

Mr. Darragh Mogan: The $55,000 we're referring to is our average cost for our contract beds, not the beds they use in Kenora or Dryden or Sioux Lookout, perhaps, but our costs, on average, for the Deer Lodge site beds—the 4,000. The community care beds are partially financed by the provinces and we just provide a top-up to whatever charges are made to the veteran patient so it's the same cost outcome for the person in a bed in Kenora as it would be for the person in Deer Lodge.

Mr. Roger Valley: Thank you, and thank you for your knowledge of my riding. Not many people know where the riding is, let alone can name some of those small towns that you name.

Mr. Darragh Mogan: Well, there you go.

Mr. Roger Valley: In 2006 the Gerontological Advisory Council, which we've heard a lot of, and we've asked and had here as witnesses, mentioned that out of the some 200,000 war veterans, only 40% receive health care benefits.

Mr. Darragh Mogan: That's correct.

Mr. Roger Valley: I was wondering before you explained some of the things you already explained this morning whether that was because a lot of them are in the outlying areas. Clearly on some of the programs you're initiating, some of the ones that have been in place, and some of the ones you're revising, could we expect that number to rise because you're reaching out to the different areas?

Mr. Darragh Mogan: Certainly as part of the veterans health services review that Mr. Ferguson and I discussed with you last May, the object of that would be to see if we could respond to the 60% of veterans who don't have an eligibility for any care from us, or if they do, they only have eligibility for the most expensive care, and that's that $55,000-a-year bed care. So yes, I think the object of the exercise would be a bit more responsive than we are to the 60% of veterans who are not now eligible.

Mr. Roger Valley: Thank you. We look forward to a report some day that can show that number climbing with all your outreach.

You mentioned the outreach with some of your surveys, and 33,000 veterans completed surveys. If I'm looking at it correctly here, 96% had a high satisfaction rate. You mentioned some of the ways you do outreach through the Canadian Legion, through VAC, in rural Canada. Are those the only methods you have? I'm just wondering how else we can reach.... Because as members of Parliament, we're not allowed lists that tell us the veterans who live in our riding. I think it would be a good tool for me to use to make sure the services are provided for those veterans, but we're not allowed to have that. We do work through the legions. I'm a long-time legion member myself. We do everything we can to try to find our veterans, but it's very hard for us to do.

Do you have any suggestions on how we would contact these veterans? There's outreach by either politicians or by anyone else in the outlying rural areas.

Mr. Darragh Mogan: It's a good question, and it's a challenge for anyone, particularly elected members, to reach the people they want to reach; I understand that, especially with a large riding like yours. Really, general knowledge and general information that you're interested in veterans and interested in helping is the only way in which privacy law will permit you to function in that area. We have the same restrictions on us. If the individual knows that they're being supported by us and has accepted that we can use that information to outreach them, that's fine. But it's really only a general kind of outreach. Through legion branches, the legion branch service officers know an awful lot of people in their area. And if the individual veterans, or particularly their families, can be in touch with you as a member of Parliament, or any member of Parliament, to help them out, then they can give you the authority to contact us, and that's great. That's perfect.

From our own experience, when we talk about the number of people suffering from any illness who go into these institutions, it's really very important to have that kind of outreach that you can get through legion branches and through your own constituency work.

Mr. Roger Valley: I'll use some more of your words: “Veterans are demanding more choice in care options. Unfortunately current criteria often limit choice.” Just before that, you stated, “The result is that we are faced with complex eligibility rules.”

With all the changes and revisions and new programs, are we able to actually reduce some of the red tape at some point? The nature of the complex rules discourages people. Are we able to work with some of that and actually remove some of it?

● (1125)

Mr. Darragh Mogan: I think it's fair to represent the work of the health services review, done in response to the report of the Gerontological Advisory Council, as aiming to reduce to as few as we can the barriers to good health care that come from complex eligibility rules, apart from administrative costs. So I think there's a fair appetite for making real progress on that.

Mr. Roger Valley: Thank you, and I'll pass off the questions to my colleagues.

The Chair: Thank you, Mr. Valley. You took 7 minutes and 52 seconds, which was pretty good.

Mr. Perron, for the Bloc, for seven minutes.

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): I hope I'm going to get my 52 seconds also.

[*Translation*]

Good morning, Mr. Mogan and Mr. Miller.

I have a lot of questions as a result of your presentation. For example, you say you have agreements with 14 major hospitals. Can we have the names of those major hospitals?

My second concern is that you say you have agreements with virtually every province because the provinces don't have the same systems. In Quebec, long-term care comes under a provincial program that covers virtually all of them. Are the costs incurred by our veterans who have access to this care entirely paid by Quebec? I'd like you to give me a snapshot of the Canadian system and provincial systems, and I'd like to know the percentage you pay in each of the provinces to occupy the beds.

A trivial question also comes to my mind. Are there still a lot of veterans overseas? I wonder how many of them have stayed there and have access to services.

Lastly, I'd like you to give me more details on what is my biggest concern. I'm talking about your eligibility rules, which virtually none of the veterans or their friends and family know. I'm also talking about the complexities that these people have to face in registering for the program.

Those are the questions I had to ask you.

Mr. Darragh Mogan: Thank you for your questions.

I can't name the 14 hospitals at this time; I don't exactly remember them. I can send you the list after the committee meeting.

Mr. Gilles-A. Perron: I will wait for that list.

[*English*]

Mr. Darragh Mogan: We have agreements with some provinces, but not all. In some cases, agreement is...[*Technical difficulty—Editor*]. Where we do have agreements with provinces, these focus primarily on the management of these long-term care contracts.

[*Translation*]

Mr. Gilles-A. Perron: Pardon me for interrupting you, but we have technical problems. It's hard to hear you and your voice is being cut off. I understood absolutely nothing of what you just said.

[*English*]

Mr. Darragh Mogan: Okay. Is this better?

In regard to agreements with provinces, there are some agreements with provinces but they are only used to normalize the relationship between the provinces and the federal government for the management of these contract beds. For instance, we have them in Ontario and in Manitoba. We don't have many contract beds in the province of Quebec, so there's no federal-provincial agreement there, but there are agreements with the facility. For instance, in Quebec City there are agreements with the facility there on the day-to-day operation of it, the admission criteria, who pays for what, and the relationship between admission of a veteran to one of these facilities and the civilian eligibility. Across the country, the care of veterans is very much a cooperative federal-provincial enterprise and we rarely, if ever, have any difficulties in that area, which is a very good thing.

Where Veterans Affairs is asking a province to provide a service, we pay for the service. Where it's for the care of a pension disability, someone who has a war injury, we pay 100 percent of the cost, no matter what province it occurs in.

● (1130)

[*Translation*]

Mr. Perron noted that there were problems with eligibility and the rules governing eligibility. He was no doubt right.

[*English*]

Monsieur Perron was commenting on the complex eligibility rules, and from a public service point of view, we couldn't agree with you more. One of the goals of the health services review, which Mr. Ferguson and I spoke of last May, was to attempt to reduce if possible, and we think it is possible, these rules that have been built up over 60 years of adding eligibility each time there was a political interest in doing that, without reconciling all the different criteria that a veteran might have to meet. We feel it's more important to focus our administrative resources on our abilities in caring for veterans rather than managing rules, and I think there would be general agreement at the political level with that goal.

Monsieur Perron, I hope I've addressed some of the questions you raised.

[*Translation*]

The Chair: Mr. Perron, go ahead, please.

Mr. Gilles-A. Perron: It is true that we must address the problem of the complex nature of the laws.

I have a final question to ask you. What is being done with our young veterans, those who come back from war with psychological injuries? For example, at Sainte-Anne-de-Bellevue, after we fought for it, seven beds are now available for them, instead of five beds that there had been for a long time.

[*English*]

Mr. Darragh Mogan: I understand, Monsieur Perron, your question very well. From the time of the passage of the new veterans charter in April 2006, our commitment to care for and support younger veterans became more manifest. It is a top priority, between the Department of National Defence and ourselves, to ensure that individuals who are suffering from service-related disabilities, especially coming out of combat zones, but even otherwise, are cared for as a first-rate priority using community facilities and using any of the other capacity that we have developed with National Defence, such as the network of mental health clinics through our OSISS clinics and national defence OTSSC clinics.

You're quite right, having eligibility rules standing in the way of the care of these young people is unacceptable.

[*Translation*]

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

[*English*]

The Chair: Yes, sorry about that, but Mr. Perron had seven minutes and 46 seconds. So he's seven seconds under.

Mr. Gilles-A. Perron: You owe me.

The Chair: Now, normally we would pass on to one of the other members, but they're not here today, so we're going to go to Mrs. Hinton of the Conservative Party for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Thank you, Mr. Chairman.

Welcome, Mr. Mogan and Mr. Miller. It's always a pleasure to talk to you.

I don't have a lot of questions. I'm going to pass to my colleagues, but I do have a couple of comments I'd like to make.

I was extremely happy to see that the contract beds are actually allowing veterans to stay and have their spouses nearby. That's something that's very important to quality of life.

Regarding another thing that Mr. Valley said earlier, and maybe I can help him in this period of goodwill here, I get my message out to my veterans through two mechanisms. One is the ten percenter and one is the householder. I've had a number of veterans who really didn't have any idea they were eligible for some of the things they're eligible for. Perhaps that's one of the reasons why we've added 12,000 brand-new veterans to the role.

Thank you very much for appearing today, and I'm going to pass to Mr. Shipley.

● (1135)

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

Thank you, Mr. Mogan and Mr. Miller, for coming today.

I think all of us understand the significance of a VIP program and the extension of that as much as we can to our veterans. I want to follow up, and I suspect we're going to have a number of discussions around similar issues. One thing we talked about was the gerontological report—the GAC report. It's wanting to bring together health benefits, VIP, and residential care issues under one VIS program. I think we agree with that.

One of the comments under the weaknesses talked about the complex eligibility. We've already had some discussions about that. I want to get some comments on how you would set it up so we get away from the regulatory issues and get down to what we all want to see, which is that the service and benefits get to the veterans. It seems that if we are struggling in terms of effectiveness with one program, putting three under one without a sincere change of direction by our department will not make things easier. I wonder whether you have some comments.

Mr. Darragh Mogan: You've effectively summarized the nub of the problem that the veterans health services review is attempting to address. If complex eligibility rules for one program affect three different program areas and you integrate them into one veterans integrated service like the Gerontological Advisory Council recommends, then one could argue that you have three times the challenges.

Our purpose with the veterans health services review is to attempt to simplify the gates into the programs so we don't have two or three different eligibility gates and sets of rules that someone must adhere to before they can get help from us. In the best of all possible worlds, if a veteran had a need we'd respond to it. That is the goal of the veterans health services review. We hope to be able to make recommendations to the government that achieve that. It's certainly the goal of the Gerontological Advisory Committee's report, *Keeping the Promise*.

So, Mr. Shipley, your observations seem to be right on the money.

Mr. Bev Shipley: Just to follow up, you mentioned the attempt to simplify. If that's an attempt to simplify under a new program that is integrated, I'm wondering why that attempt to simplify hasn't been there for the single programs.

Mr. Darragh Mogan: That's a very good question. The programs do intersect. The long-term care program does intersect with the VIP program. If we simplify the rules in one, it would be quite unfair not to do it for the other, because they are in effect meant to run as a continuum. One of the reasons they can't run as a continuum is that there's this gap in the middle between home and long-term care, and that's assisted living. That's certainly one gap we want to fill.

Others might have different opinions, but I think the department and the Gerontological Advisory Committee felt that this was the right time to fix all the eligibility rules, if we could, and not to fix or have better rules for VIP but then the same complex rules for long-term care.

Mr. Bev Shipley: You mentioned that the average veteran's age is somewhere around 84 years old. We always have a concern that when something comes up they don't have someone to help them through some of these complex periods in which they're trying to make applications. Do you see where the new ombudsman will come in? Is that a role in which they may be able to help some of the veterans, even under the new regulated service if that attempt to simplify does come in?

● (1140)

Mr. Darragh Mogan: I would see a really positive advantage to having the ombudsman involved, both pre- and post-change. So I would have to answer, yes, it would be another voice advocating for those veterans who might not feel they're as well supported as they could be—and that's perfectly fine.

Mr. Bev Shipley: Am I still okay?

The Chair: You have 31 seconds.

Mr. Bev Shipley: Okay.

You talked about treatment. I'm just wondering, is there a difference between the contract rooms and those in our communities in terms of standard of treatment? You're seeing a 20% vacancy in the contract beds, and yet you're seeing an increase in the utilization of community beds. We understand that people want to stay in their communities, but we also recognize that many of these communities will have the contract beds in them also, even if they are the larger centres.

Mr. Darragh Mogan: I'll try to respond briefly to that.

We have found that if you give veterans a choice, they'll choose to be as close to home as possible. That to some extent will explain the vacancy rate in the 14 larger contract facilities, because they're located in communities where about 50% of the veterans live.

To me, that explains it. It's not that the care isn't good in these contract facilities—we pride ourselves on it being excellent—but it's just not convenient for a man and a woman when the man is 85 and the woman can't drive any more. Even in Toronto it's not convenient for someone who lives in northwest Etobicoke to go to Sunnybrook.

Mr. Bev Shipley: Thank you.

The Chair: Thank you, Mr. Shipley.

We now have the second round of the rotation, which goes to the Liberal Party.

Mr. Boshcoff, for five minutes.

Mr. Ken Boshcoff (Thunder Bay—Rainy River, Lib.): Thank you, Mr. Chairman.

This is Ken Boshcoff, Thunder Bay—Rainy River, and I'll ask my questions. Perhaps you can write them down and then respond back. They shouldn't take very long.

One, when we talk about contract beds, these are both chronic and long-term, I'm assuming, at an average of 2.6 years. Is this usually the final domicile for most of these veterans?

Two, would communities in northwestern Ontario, such as Fort Frances, Atikokan, Rainy River, and Emo, be eligible for provincial travel grants out of province to, say, Winnipeg, or does the VAC do this as part of their social integration of funding formula?

Three, we talked about a 20% vacancy growing in contract beds, and we're averaging 2,000 deaths a month. Does this budget transfer to the 81% increase in community beds? Would the number of veterans returning from Afghanistan and the Middle East and other theatres have a portion of this for both physical and mental treatment? Are there adequate dollars to address their new needs?

Four, we hear of many cases that make the news about people who are short weeks or months of eligibility. In view of the average age being 84, will there be any relaxation of these rules to accommodate some of these people who are short by days, weeks, or months?

Five, with regard to the uninsured costs, you identify that many provinces and territories may pay fully and others not. What is the spectrum—100% payment to zero, if that is the range?

Finally, I'd like a quick response on the timeframe for the veterans health services review. I thought that would be done already. When can we expect some finality on this?

Thank you.

Mr. Darragh Mogan: I'll try, with my colleague Mr. Miller, to answer the questions, but there were a number of them there. I just want to make sure I get to all of them.

You asked about...[*Technical difficulty—Editor*]

The Chair: Once again, we're having some difficulty here. The transmission is coming through in a staccato manner. As a result, the translators are having difficulty. Mr. Gaudet has brought that to our attention.

I don't know; just try your best on your end, sir, with your microphone. I'm sorry.

● (1145)

Mr. Darragh Mogan: Maybe I'll just speak more slowly.

In terms of the final domicile and the 2.6 years, yes, for the most part that is their final domicile. Veterans Affairs Canada does not provide travel grants for individuals to travel to facilities—for instance, to Deer Lodge. That's something we could certainly look at, but we don't do that now.

In some ways it might be preferable, if you can get comparable care, to invest the money in providing care in the community where the individual lives rather than travelling a long way off.

Mr. Ken Miller: To add to that, we do and can provide for the cost of travel when the veteran actually has to travel a distance to get the appropriate level of care. If it isn't available in their community at the community facility or an institution that is close to them, then we will take them whatever distance is required to have them go to the right facility.

You asked a question as well about vacancy in contract beds. I think the focus of your question was basically about the flexibility we had in terms of moving budgetary amounts between funding community beds or funding contract beds, and also covering funding requirements for the beds for Canadian Forces veterans. You used the example of what veterans returning from Afghanistan may have. There is a fair bit of flexibility around that in terms of our budget and how we use it to provide for the treatment costs in those various care settings.

You had a question as well concerning eligibility, and you made reference to clients falling somewhat short of timeframe. The only case in point that comes to mind around that is in the case of Canada-service-only veterans who were individuals who served during the time period of the Second World War but never left Canada. There is a regulatory requirement that they would have served for 365 days in order to become eligible. We do from time to time see individuals who have served various lesser periods who don't have eligibility. That is something that potentially could change in the future, if there were a will to explore that.

Your fifth question was around uninsured costs and what the range is. There is a considerable range across the country. It typically tends to be higher cost to Veterans Affairs in the east, and lower cost in the west. However, from a veteran's point of view, it's a wash, because veterans who are receiving care pay what we call an accommodation and meals rate. That is calculated on the same basis for clients regardless of where they live. It's a little over the $800 a month range, and that covers the cost of accommodation and meals, obviously things they would pay for if they were living in their own private accommodation rather than in a facility. The way it works is, regardless of the level of provincial insurance that provides for the beds, from a veteran's perspective it equalizes at the end of the day.

The last question was around timeframe in relation to the veterans health services review. Mr. Mogan will respond to that.

Mr. Darragh Mogan: The question is probably more properly directed to the minister, because it is more of a political question.

I can say that the department and the Gerontological Advisory Council are seized with the same urgency that's behind this question, and we would like to be in a position—I think our minister has said this fall—to bring some proposals forward. I'd like to think we'll meet that timetable, but really, beyond that, maybe Ms. Hinton can comment. Beyond that, I really don't feel I can say more.

The Chair: All right.

I want to let you know, Mr. Boshcoff, you got appreciably more time than five minutes. I'll put it that way.

Mr. Ken Boshcoff: With all respect, Mr. Chair, that's why I tried to condense my questions.

● (1150)

The Chair: I understand, and you've worked very effectively that way.

Now we'll go to Monsieur Gaudet with the Bloc Québécois, for five minutes.

[*Translation*]

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

Last weekend, on Remembrance Day, I met a veteran who fought in World War II. That man was 87 years old. He only received his veteran's pension two years ago.

Earlier you said that Mr. Valley had a large riding. My riding isn't as large. You say that the Royal Canadian Legion knows its people, but I'm not sure of that. The Legion isn't a little social club. Veterans who go to the Legion... I've only been in two legions, because there are two in my riding. However, there are five or six veterans at most. I'd like to hear your opinion on the subject.

[*English*]

Mr. Darragh Mogan: It's Darragh Mogan here, Mr. Gaudet.

If I understand your question, it is whether the Royal Canadian Legion receives money to help veterans. The answer is no, they don't. They are an independent veterans organization and have been since 1924. What they do for Veterans Affairs, on an out-of-pocket basis only, is help us with surveys of the almost 11,000 veterans we have in long-term care. It's only their out-of-pocket costs that are covered for that, and they are a great help in that regard. Beyond that—it's a voluntary organization—there's no financial contribution by the government.

[*Translation*]

Mr. Roger Gaudet: So the real veterans, those who really need help, aren't receiving it. I thought the Canadian Legion received a certain amount of money for administrative purposes in order to provide real support to veterans. From what you're telling me, it's aid to the Department of Veterans' Affairs, that's all. We're talking about surveys, among other things. It's not a matter of providing services to veterans.

[*English*]

Mr. Darragh Mogan: Monsieur Gaudet, I don't think.... My answer could be maybe misunderstood. The facts are they provide a service bureau for veterans and help them, as part of the dues that members pay—the 425,000 members there are. They are an advocacy group. They would not accept money from Veterans Affairs for that reason.

Where we do have a financial arrangement with them is only for out-of-pocket costs in doing facility patient satisfaction surveys for us. There's no exchange of money with the Royal Canadian Legion, nor would they want there to be one that would involve compromising their independence as an advocacy group.

[*Translation*]

Mr. Roger Gaudet: Are our young veterans, whether they're returning from Afghanistan or elsewhere, covered by your veterans services policy? What are you doing for them when they return to Canada?

[*English*]

Mr. Darragh Mogan: Yes, Monsieur Gaudet, they are part of our commitment to service. We'll provide them with all the benefits that are available under the new veterans charter that was passed by all-party agreement in April of 2006. They're fully eligible for that.

We have a responsibility, once National Defence has looked after the initial injury, to care for them when they become veterans, and to care for their families, to provide them with a job placement program, a comprehensive rehabilitation program, and case management counselling to ensure that their transition to civilian life is at least as smooth and successful as that of their war veteran forebears at the end of the Second World War and Korea.

[*Translation*]

Mr. Roger Gaudet: Physicians from the Royal 22nd Regiment whom we met told us that, in the case of guys returning to Canada suffering from post-traumatic stress disorder, it was psychological, not physical, rehabilitation that was causing problems.

We have to ask ourselves whether we have enough psychiatrists and psychologists to help these young people. A young man, 21 years old, committed suicide in Quebec about two weeks ago. The government quickly invested $1.5 million. I believe that will have very little effect. Physical rehabilitation is all well and good, but you also have to think of psychological rehabilitation.

● (1155)

[*English*]

Mr. Darragh Mogan: Monsieur Gaudet, we couldn't agree with you more. Part of the rehabilitation program that was approved as the new veterans charter was for psychological rehabilitation. Up to the time I checked most recently, the majority of individuals who are coming into the rehabilitation program are coming in for psychological reasons. It's very important to have that kind of capacity, because you don't want to have someone enter a vocational rehabilitation program and, as they say in English, set themselves up for failure when they're not psychologically ready to take that on.

Secondly, we have an extensive network of clinics, between National Defence and ourselves, and we have more that I could brief you on. We could provide you with an independent briefing—maybe we should—on our mental health strategy to provide a fuller answer to the member's question.

[*Translation*]

Mr. Roger Gaudet: Thank you very much.

[*English*]

The Chair: Thank you.

Now back to the Conservative Party with Mr. Sweet, for five minutes.

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

Thank you for your presentation earlier.

Mr. Miller, or maybe Mr. Mogan actually, answered a question that was asked by Mr. Boshcoff, and I want to clarify something.

You mentioned that the review was a political decision, but then you said you still had work to do that you were going to deliver within a timeframe of the fall. That's what our concern is, the work that needs to be done for the minister to make that decision. You said that you are on track. Is that correct?

Mr. Darragh Mogan: Yes.

I believe the minister has made a public commitment to try to bring this to government in the fall. I believe we are on track to do that, sir.

Mr. David Sweet: Okay.

I want to ask you, because of the convoluted eligibility rules that you mentioned in your presentation, is there any case in which there's a bed being used where the VIP would suffice, but because of these rules the person doesn't qualify for the VIP?

Mr. Darragh Mogan: Yes, unfortunately there are.

They would be people who have eligibility for our expensive contract beds but who do not have eligibility for the veterans independence program.

Mr. David Sweet: So in fact once we get all the background work done there are some cases where it would be more beneficial to the veteran and save the government money as well.

Mr. Darragh Mogan: Yes, sir.

Mr. David Sweet: Also, when we had the Gerontological Advisory Council in—and I'm sorry, the time is now a blur to me—there was a campaign that they said was going on or was going to be started about active phone calling to veterans to make sure that veterans who did qualify understood the benefits they were qualified for and got them. Is that procedure still going on?

Mr. Darragh Mogan: We do have a capacity here called proactive screening. What that phone unit does is telephone veterans who we feel are at relatively higher risk of health incidents. We'll follow up on them rather than waiting for the veteran to tell us that something is wrong. That proactive screening unit is really a godsend to us in terms of our ability to reach out, and we use it quite regularly.

We could also use it to do surveys of veterans with particular needs that we might not otherwise be able to respond to.

Mr. David Sweet: I don't expect you to have that by memory, but do you have any data that you could forward to the committee regarding just how effective those outbound calls are, how many veterans are actually being added to the rolls because of those?

Mr. Darragh Mogan: I don't know that we're necessarily adding veterans to the rolls. They would be people who are on the rolls now.

One of the things that we're doing, to get back to Mr. Gaudet's question, is contacting younger veterans who have gone through our transition interview process when they became veterans to follow up with them, especially the most severely disabled ones, to see how they're doing rather than waiting for them to call us.

We can provide you with data on the activity of the proactive screening unit. I think we actually have once before, but we'll be pleased to do that again.

● (1200)

Mr. David Sweet: Thank you very much.

The Chair: All right.

We're now going to move over to Mr. Valley from the Liberal Party for five minutes, and then Mr. Cannan for five minutes as well.

Mr. Roger Valley: Thank you.

Mr. Mogan, you mentioned a couple of times that you spoke to us in May. I went back to my notes, and there's a big note—I'm not sure if it's to you or to myself, so I'll have to ask you again. If I asked this question in May, you'll have to forgive me.

We talked about the health care review that you're doing and we're doing, and how much involvement there is with the veterans themselves. Are the general public of Canada or the veterans aware that this is going on?

You mentioned something, and again, I'll use your words. It's kind of profound, but changes have been made whenever there is a political will for it. That's unfortunate, but that's probably the reality we live in.

How much are the public of Canada or the veterans aware that we're doing a health care review? We have many people who give us comments if they are neighbours of a veteran and they see a veteran suffering. The veteran himself may not comment, but maybe the neighbour would.

Have we ever done any general advertisements? Have we done any outreach anywhere in Canada, such as your newspapers, letting them know this is going on? You may have responded positively in May. I don't remember. As I said, this might be a note to myself.

Do you have any thoughts?

Mr. Darragh Mogan: The smart way for me to answer is to say it is a note to yourself, but it's not. You're quite correct.

The government had a choice to make on this one, and the choice we made was to ask the Gerontological Advisory Council—and they worked nearly for a year on this—to solicit views from the best and brightest in this country and internationally on what would make the most sense, given the complex eligibility rules we had, the fact that we aren't able to help 60% of war veterans, the fact that there are Canadian Forces veterans out there who need help when they're younger and older, and the fact there are primary caregivers who need help. We asked them to have a look at what we do and to give us advice.

The six major veterans organizations are on the Gerontological Advisory Council, but that isn't necessarily to restrict their advocacy; it is to ensure that they have the advantage of the best and brightest in this country on the questions that we asked. Their report is in the public domain. It's on our website. We submitted it to you, we'll submit it to anybody who wants to see it, and we solicit comments on that. We're getting quite a few.

I think the veterans community knows that we're doing it. We've had a process of talking to provinces about the policy basis for this—not to share views, because with a large cohort of baby boomers coming through, the lessons we've now learned about proper care of the elderly will pay dividends later on. Although we didn't seek a broad consultation mandate on this, in effect we've had all the benefits of a broad consultation mandate without the time necessary to get a specific mandate in that area. I'm quite confident we got pretty broad-based input, Mr. Valley, into our deliberations.

What we are waiting for, and with enthusiasm, is a report from the standing committee.

Mr. Roger Valley: Thank you.

There is a timeline on the VIP benefits that are extended to the widows of veterans; I believe it was sometime in the 1980s. What about extending the VIP to all the veterans' widows? This is something that has been campaigned on; it's something that's been said should be done. We know there is a large price tag for this, but at what level do you stop providing support for the widows? Is it following the timeline that was mentioned in the past?

Mr. Darragh Mogan: I'm constrained from answering. I understand your question, but that's probably a question that's better addressed to the minister, sir. I think there is a very broad awareness in the public service that supports Veterans Affairs, and from the Gerontological Advisory Council, of the very important role that voluntary primary caregivers play in the health of veterans. We're aware of that, and that awareness will have some effect on policy decisions down the way.

Mr. Roger Valley: In some of the input from some of the people you mentioned, especially the gerontological society, did they touch on that? I remember reading their report. I don't have it here in front of me. Did they comment on extending VIP to all veterans' widows?

● (1205)

Mr. Darragh Mogan: Yes, they did. One of the individuals who is on there is probably one of the foremost researchers on family caregiving in the country, if not North America. That's Professor Norah Keating from the Centre of Human Ecology at the University of Alberta. She's a very gentle and kind individual and she made her views on this subject very well known.

Mr. Roger Valley: Can you give us a snapshot of what she said?

Mr. Darragh Mogan: I don't know whether Norah appeared before your committee or not.

Mr. Roger Valley: Yes, she did appear. I saw her name in my book here.

Mr. Darragh Mogan: We'll see if we can get an extract from her and send it to you, sir. How's that?

Mr. Roger Valley: All right. Thank you very much.

The Chair: Thank you very much, Mr. Valley.

Now we'll go back over to the Conservative Party and Mr. Cannan, for five minutes.

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

Good afternoon, gentlemen.

My name is Ron Cannan. I'm the member of Parliament for Kelowna—Lake Country in beautiful British Columbia. It's in the Okanagan Valley.

Just for your information, we have an aging population. We have the highest demographic in the census of metropolitan areas of people 65 and over—it's almost 16% of the population—and a good portion of those, of course, are veterans. We all want the best for our veterans and I'm looking forward to this holistic overhaul of the veterans health services review when it's completed.

Just following up on my colleague Mr. Sweet's questioning, I'm dealing with some of my constituents who wanted the veterans independence program so they could stay in their own homes, but they are not eligible; but, as you indicated, they would be eligible to go into the long-term care program, which is costing Veterans Affairs about $340 million a year. Do you have any idea how many individuals would be eligible to go on the VIP program and not for this long-term care program, and the potential cost savings for the government?

Mr. Darragh Mogan: I can't really speculate on that, but if we were to ask any ten veterans who are now eligible for long-term care in our own contract beds in larger centres where they would like to go, seven of the ten would say they'd like to stay in their own communities.

Mr. Ron Cannan: How long has this discrepancy been in existence?

Mr. Darragh Mogan: With our ability to provide care in the community through community beds, we're certainly becoming increasingly aware of it, as are the veterans organizations. I don't know where this actually began.

Mr. Ron Cannan: So it's been a decade or two. The VIP program began in the early eighties, correct?

Mr. Darragh Mogan: That's right. For those people who are eligible only for the larger contract beds, at Shaughnessy, for instance, we've run a couple of pilot projects to provide them with alternative care in their communities while they're on the wait list. All of them prefer that, as far as I know. Some of them are able to stay at home, and they are not eligible for VIP at home. When asked if they wanted to go into a contract bed while we were giving them this care in the pilot project, they said, “No, we prefer to stay at home if we can”.

That's been going on for the last four or five years. It's really proof, as if any more proof was really needed, that if you give individuals choice they'll take the choice that sometimes costs less but makes a lot more sense for keeping them close to their families and their communities.

Mr. Ron Cannan: So it's fair to say that all veterans and widows are not treated equally with the existing program in place.

Mr. Darragh Mogan: That's correct.

Mr. Ron Cannan: Do you think our direction from this review will be more to a needs-based model?

Mr. Darragh Mogan: That's exactly what we propose—to go to a needs-based model. That would be the policy foundation of the change from a largely entitlement and complex eligibility foundation to a needs-based foundation. Ideally, if you have the need and any eligibility, you can be responded to in the same way.

Mr. Ron Cannan: So we should try to simplify the complex rules that are in place right now and base it on needs and not eligibility or where you served, as you indicated.

Mr. Darragh Mogan: That's the hope.

Mr. Ron Cannan: You mentioned there are about 2,000 veterans passing away each month out of 220,000 across Canada.

Mr. Darragh Mogan: That's the number of war service veterans, yes.

Mr. Ron Cannan: How many who are eligible are waiting to go into long-term care beds?

Mr. Darragh Mogan: It's regional in some senses. In some places we have longer wait lists, but on the whole we don't have a wait list for contract beds. We don't have a lot of trouble placing veterans in community beds, where the majority, some 7,000, are now placed.

● (1210)

Mr. Ron Cannan: You mentioned that you have a 20% vacancy rate.

Mr. Darragh Mogan: The 20% vacancy rate isn't everywhere. There is a bit of a challenge in Ottawa, as some of you will know, and there's a challenge in New Brunswick that we're looking at.

Mr. Ron Cannan: We're dealing with an aging population dying with dignity. Is there a hospice house for veterans to deal with the palliative care approach?

Mr. Darragh Mogan: Palliative care can be provided in our contract beds.

Mr. Ron Cannan: A lot of the regions now have specific hospice houses.

Mr. Darragh Mogan: We don't have specific hospice settings for veterans, but we can provide that kind of support for individuals who go into palliative care under the veterans independence program. We also provide palliative care support in the home, which is quite unusual in the Canadian health care system.

Mr. Ron Cannan: That's excellent. I think that will be welcomed by my constituents and all veterans. You mentioned that in the nineties some minor duct-tape reviews took place, and it's just appalling that this has gone on so long. I'm looking forward to the overhaul the minister and this committee are doing at the moment. The sooner it comes the better.

Thank you, Mr. Chair.

The Chair: I think we've exhausted our questioners list. We have a motion and some other business to get to. So thank you very much to our two witnesses this morning, Mr. Mogan and Mr. Miller. Thanks for your time.

We're going to suspend now and go in camera for a motion and a vote.

Mr. Darragh Mogan: Thank you very much, on behalf of Ken Miller and myself.

The Chair: Thank you so much, gentlemen.

[*Proceedings continue in camera*]

● (1210)

(Pause)

● (1250)

[*Public proceedings resume*]

The Chair: Order.

Mr. Shipley just said he was going to bring a notice of motion, so I'm going to let him do that.

Mr. Bev Shipley: Are we out of in camera?

The Chair: Yes, we're out of in camera.

Mr. Bev Shipley: I have a notice of motion. I'll have the clerk have it sent out today, but this is the verbal. It would be very much like the one Mr. Valley had—that we arrange a study tour to visit the bases within Canada where our armed forces are deployed and returned to. So we can have that opportunity to have a discussion, to arrange a study tour of operations. That would be the basis of it, that we would do our Canadian bases.

The Chair: All right, so I'm assuming therefore probably Tuesday we would deal with that.

Mr. Bev Shipley: Thursday.

The Chair: That's right. It is Tuesday. My, how the week flies. Fair enough. So we have a heads-up about that.

Now we're into our veterans independence program health care review. On a tangential point for a second, if I may, because there have been some issues raised in the House of Commons with regard to extension of benefits to widows, etc., I was expecting we'd get more questions on that, frankly, and was surprised we didn't. Maybe you didn't feel those were the appropriate witnesses to ask.

Hon. Albina Guarnieri (Mississauga East—Cooksville, Lib.): We can always oblige.

The Chair: I was surprised. That was what I was expecting. That being the case, here are some other people we can have on the subject. We'll start at the top here. Someone from ANAVETS—we don't know who the someone is, but the person is soon to be determined. We don't have a date on that in terms of their availability.

The Clerk of the Committee (Mr. Alexandre Roger): No, not that one.

The Chair: Then there's Ron Griffis, national president, Canadian Association for Veterans of United Nations on Peacekeeping, December 13, which is still a while away, but fair enough. Then we have Jean McMillan and Brian Forbes, assistant director, administration, National Service Bureau, The War Amputations of Canada. There's no date for that. We don't know. And there's Don Ethell, Gulf War Veterans Association of Canada, who once again is available as of the 13th.

Okay, and then some other witnesses are proposed by Veterans Affairs.

Mrs. Hinton.

Mrs. Betty Hinton: I have a couple that you might want to consider.

● (1255)

The Chair: Is it okay if we add those at the end of the list?

Mrs. Betty Hinton: Sure, whatever you like.

The Chair: Dr. Hollander, GAC member—I always love those acronyms—health services research, evaluation, and administration expert, December 4. That's a little sooner.

Dr. Pedlar, director of research, December 4. Dr. Mary Alpeter—it doesn't have a date on that either. And you did try to reach Jean-Guy Soulière? He said no. There you go. Let's just pretend he's not even on that list. Scratch him right off.

Mrs. Hinton.

Mrs. Betty Hinton: There's often discussion on the makeup of the Veterans Review and Appeal Board, and we might want to have Victor Marchand appear; the other person might be Dale Sharkey, who's the executive director of VRAB. I understand that for privacy reasons we can't invite new members of the board, but we probably could invite these two people to have discussions on the changes and the direction VRAB is taking.

The Chair: All right. I don't know whose hand was up first. I'll let you gentlemen be the determinators.

Mr. Roger Valley: I defer to Mr. Sweet.

The Chair: Mr. Sweet.

Mr. David Sweet: We have pinpointed in our investigation of PTSD one crucial element, and that is, there are not enough psychologists, psychiatrists, and counsellors in Veterans Affairs in order to be able to service veterans. It's only going to get worse; it's not going to get better, and we've identified that.

Are there any witnesses the clerk may be able to find who would give us an idea about possible strategies we could recommend, for example, with respect to folks in colleges, for counsellors, or in universities, for psychologists and psychiatrists? We could recommend some strategy by hearing witnesses and hearing their proposals and some expertise that's outside of the boundaries of the.... I don't know how long it takes once a candidate is in these academic institutions before they're capable of taking part. I'm not aware of how long it takes to produce the expertise for a counsellor.

One of the things I don't believe we have on record as far as treating veterans with PTSD is exactly where the biggest vacuums are. Can we fill most of the void with counsellors, or do we actually need a vast array of highly trained psychiatrists for this? I think that's an invaluable thing we could do for VAC and get on record here.

The Chair: Thank you, Mr. Sweet. I think that's an interesting idea.

Mr. Valley.

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

I thank my colleagues for the good ideas.

We probably can come up with a couple more names we would like to submit to you, or bring up at the next meeting. It's good we're reaching out as far as we can. If we cast the net wide, we might catch somebody of great interest. Thanks to my colleagues, and we will get back to you with some names we'd like to submit.

The Chair: Yes, to the clerk; he's the full-time guy on this.

Mrs. Hinton.

Mrs. Betty Hinton: This is not about witnesses, although I'm getting a feeling throughout the room, and it's certainly something I feel very strongly about. I'd like to run it past the committee to see if anybody would also like to consider it.

We did have a bit of a session on post-traumatic stress syndrome. I know that everyone of us in this room is very interested in what we learned and what we heard. I'd like to see the review we have already undertaken completed as soon as possible so we can move forward and make improvements to the veterans independence program through the health care review.

I'm wondering if there's an appetite in this room, in light of some of the things that have happened and in light of some of the things that have been said today, to look into the aspect of suicide. My understanding, from the few questions I've asked today, is that we don't track them as a country. Canada has never tracked how many suicides happen as a result of military deployment, etc. I know it is tracked in the United States, and the numbers are frightening.

I would like to know if there is a will in this room to go down that road after we finish the health care review so we can move our current traditional veterans ahead. Get this done and out of the way, and then have a good hard look at what's happening with our modern-day veterans and the kinds of things they're facing.

● (1300)

The Chair: Sounds like a worthwhile endeavour.

Monsieur Perron.

[*Translation*]

Mr. Gilles-A. Perron: To respond to Betty Hinton, I'm going to point out that there are no files on people who commit suicide. I know of 20 cases. I have a list of some 40 individuals for Quebec, the last being Major Michel Desjardins. He committed suicide in late September or early October. That 50-year-old man was under treatment at Sainte-Anne Hospital, in Sainte-Anne-de-Bellevue. Yes there's a large number of them, and it's more than frightening.

Going back to what was said at the outset about including people in the list. In response to the concern expressed by David Sweet, I would say it's possible to contact the Association des psychologues du Québec. It represents a large number of psychologists. Perhaps those people would know more about the question. I'm sure its representatives would come and testify.

Are we going to discuss problems relating to veterans? If so, Jennifer Migneaut, who has become a prominent specialist on veterans forms, could come and tell us about the problems that entails. She got involved in the field about two or three years ago, when her husband wanted to file an application.

She said it was complicated and infeasible. We could invite her to come and explain to us in what way completing an application form for veterans assistance is complicated. If you're interested in that, I have her contact information.

[*English*]

The Chair: There have been a lot of great suggestions to add to the list. At this stage we're over our time and we're losing committee members like flies. I'm going to suggest we wrap it up and resume on Thursday.

[*Translation*]

Mr. Roger Gaudet: When we come back in January, will we be starting over from scratch?

[*English*]

The Chair: I wouldn't think so. There's no prorogation intended as far as I know.

[*Translation*]

Mr. Roger Gaudet: I want to know if we're going to continue, regardless of whether there's a potential prorogation.

[*English*]

The Chair: I don't anticipate a throne speech for January.

The meeting is adjourned.

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