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Chair

Mr. Rob Anders

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● (1110)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): All right, I've pounded the gavel already. According to some of the background noise we heard on our earphones here, obviously our guests are available and getting familiar. That's good.

Welcome to yet another committee of veterans affairs. I apologize to everybody for the lateness in assembling today, but another committee was previously using the room, and they went a little bit long, and then there was a matter of setting up extra tables here and reconnecting the sound system.

We are studying the veterans health care review and veterans independence program.

We apologize to Monsieur Perron, because he likes to have guests appear live, but unfortunately these individuals were snowed in. They have graciously been able to join us. Our guests today are Marcus Hollander with the Gerontological Advisory Council, and David Pedlar, director of research for the research information directorate with the Department of Veterans Affairs.

Without further ado, the way it works is that I generally allow 20 minutes. It can be 10 minutes apiece or however you wish. I'm assuming you've been offered 20 minutes. That's the standard operating procedure. After that, the committee members, in a prearranged order, have the ability to ask questions.

So I turn the floor over to our guests.

Mr. David Pedlar (Director of Research, Research Information Directorate, Department of Veterans Affairs): Thank you very much.

This is David Pedlar speaking from Charlottetown.

First, I want to extend my apologies for not being able to participate in person. I did make two efforts to get to Ottawa yesterday, and I failed on both counts due to flight cancellations, so I hope the committee will accept my apology.

Marcus and I are delighted to be here today to talk to you about what the evidence tells us about best practices in the organization of care delivery systems for the elderly, and the department's veterans independence program in the context of those practices.

I will be going into more detail later in this presentation, but as you have heard in previous presentations from the department, the veterans independence program, commonly referred to as VIP, provides services such as housekeeping and grounds maintenance, which are provided to eligible clients to help maintain their independence in their own homes and communities.

In addition, I will discuss an important research study being undertaken in partnership with the Ontario Seniors' Secretariat, which is nearing completion and is designed to contribute to our ongoing efforts to improve care for older veterans while also sharing lessons learned in veteran care with Canadians.

Currently Veterans Affairs is engaged in the veterans health services review—which you, of course, are aware of—the department's most comprehensive review of health care in over 60 years. The research we'll talk about today will be in support of that review.

In terms of the subject expertise before you today, I have a broad background in research for care of the elderly, as well as expertise in some topics in veterans and military health for our younger clientele as well. My recent expertise in the area of the veterans independence program is largely in the context of the research study that we'll be discussing with you today.

Dr. Hollander is a nationally and internationally recognized expert in care delivery systems for the elderly. He is also the scientific lead on a study of the veterans independence program that we will be discussing this morning.

We'll be doing a joint presentation, so I will now ask Dr. Hollander if he would be so kind as to start our presentation from here.

Mr. Marcus Hollander (Member, Gerontological Advisory Council): Thank you very much. I'm certainly pleased to be here. Again, I give our apologies as well.

I want to talk a little bit about the broader context of care delivery for the elderly, and then we can talk about the veterans independence program and how that fits into some of the parameters.

How care delivery systems are organized and structured can have a significant impact on how efficient and cost-effective they are in practice. The importance of integrated models of care delivery are now generally recognized, and many people in the continuing care industry support the need for preventive home care and home support for people needing care over the longer term.

An extensive program of research on the cost-effectiveness of home care, the national evaluation of the cost-effectiveness of home care, presented a number of policy recommendations regarding how home care services could be structured. The synthesis report of the project notes that if home care is to make more readily the types of substitutions required to achieve greater effectiveness, it needs to be part of a broader, integrated system of home care and residential care, often referred to as continuing care.

By having administrative and fiscal control over such a large integrated system of care, senior executives and policy-makers can take steps to ensure that appropriate and cost-effective substitution of home care services for acute care and residential care can in fact take place. Simply enhancing expenditures on home care per se may have a limited effect unless steps are taken to ensure that appropriate substitutions can be made of home care services for acute and/or residential care,

The history of home care and continuing care services is one of amalgamation of professional and supportive services. However, in our current national policy, the focus seems to be on shorter-term professional home care. Nevertheless, a recognition of the importance of preventive and supportive care is reflected in recent recommendations in Ontario and British Columbia to enhance home support services to allow people to remain in their homes.

There is some evidence about the extent to which long-term preventive home support services can reduce admissions to hospitals and long-term care facilities. A British Columbia study indicated that long-term home care can prevent or reduce the rate of admissions to hospitals and long-term care facilities. People who only received housekeeping services and were cut from service in two health regions were compared with people who were not cut from services in two similar regions in the mid-1990s. In the year before the cuts, the average annual cost per client for those cut from the service was a little over $5,000 compared with about $4,500 for the comparison group. These costs included hospital services, physician services, and drugs, as well as long-term and home care services.

In the third year after the cuts, the comparative costs were $11,900 and $7,800, respectively, for a net difference of some $3,500. Thus, on average, the people who were cut from care cost the health care system some $3,500 more in the third year after the cuts than people who were not cut from the service. Total costs over the three-year period after the cuts were $28,000 and $20,500, respectively, for those cut from care compared with those not cut from care. Most of the differences in the costs were accounted for by increased costs for acute care and long-term care services.

With regard to home support services providing a community-based alternative to residential care, a study of the cost-effectiveness of long-term home care found that over time and for all levels of care needs, home care on average was significantly less costly to government than care in a long-term care facility. It was also found that the savings from substituting home care services for residential services were not theoretical, but that actual savings were achieved in British Columbia from the mid-1980s to the mid-1990s by holding down future bed construction of long-term care facilities and by making investments in home care. Over a 10-year period, due to a policy of substituting home care for residential care, some 21 persons per 1,000 people aged 65 and over were shifted from residential care to home care.

● (1115)

What does not seem to be fully appreciated in the current policy discussion is a seeming paradox of service provision. While elderly persons with functional limitations have health conditions and need medically necessary care, the appropriate responses to their health care needs are, in large part, supportive services. Taking the time to give a bath to a senior who needs care, preparing a meal and feeding that individual, and ensuring a safe and sanitary environment in the home does not have to be done by a nurse. For people who are too frail to shop, cook, or take baths on their own due to their medical condition, this type of personal support allows them to maintain their independence for as long as possible, and may actually save the health care system money by avoiding repeated hospital admissions and premature entry into long-term care facilities.

A major strength of the veterans independence program—which David will discuss—is that the preventive care and home support services have remained a key focus of the VIP program over time, to the benefit of veterans and their families.

● (1120)

Mr. David Pedlar: Thank you, Marcus.

I'll continue and talk about the veterans independence program and the research study.

The veterans independence program, or VIP, which you're familiar with, serves just over 100,000 clients across Canada. About 6,400 of these receive nursing home care. It's our flagship program for seniors. It was designed to function as an integrated and coordinated continuum of care, including home care and institutional care components. There continues to be considerable interest in VIP as a care model among other groups such as the Royal Canadian Legion and also in jurisdictions across Canada and elsewhere.

VIP, first known as the aging veterans program, was started in 1981 as an alternative care model for aging WWII veterans. The program design was developed in the late 1970s to address the enormous challenge of planning for the care needs of over half a million WWII veterans who would be reaching old age in the 1980s. The new model would provide an alternative to the building of thousands of new long-term care beds, while also satisfying the preference of veterans to remain in the community with their families as long as possible.

The program was built on the cutting-edge notions of independence and care in the community. It has evolved and undergone a number of modifications, but there are several core principles I want to go over briefly.

One is comprehensiveness. The program is comprehensive in scope, with a wide range of services to promote choice and address a wide range of types and intensity of care need. I think you are familiar with the components: services for personal care, home-making, access to nutrition services, grounds maintenance, health and diagnostic services, home adaptation, nursing home care, transportation, as well as access to a broad range of treatment benefits.

The concept of early intervention has also been a hallmark of this program. The VIP is what we call a preventative and maintenance home care model. It provides a lower level of service intensity during the early stages of a client's functional decline in order to promote well-being and independence and more successful adaptation in the longer term. In this way, services can be adjusted over time to compensate for changes in health circumstances as health needs increase with frailty or disability.

Home support services are another key part of the program, including basic housekeeping and grounds maintenance. These have been essential features of the VIP design. As Dr. Hollander has stated, home support is a critically important type of support that is based on the idea that a modest input of non-professional services like homemaking and grounds maintenance can play a pivotal role in supporting well-being, living at home, and functioning in the community as long as possible. It also plays an important role by supporting and leveraging the inputs of care provided by family caregivers, who are a cornerstone of veteran care.

Self-managed care is also an enduring theme of the VIP program design. In most jurisdictions VIP clients have the flexibility to choose their own provider of services for home-making, personal care, and grounds maintenance services, unless they want or need help making these decisions. This aspect of the program promotes independence and choice, as users often want to play an active role in decision-making about service choices.

Finally, case management is the fifth key point. It is also a central feature of the program. This is an approach that organizes client contact, needs assessment, planning for care, follow-up, and management of care transition. The human resource input to support this is called the client service delivery team, located in district offices. The team, led by a counsellor/case manager, works closely with a client service assistant, nurses, and medical advisers to problem solve, work on complex care plans, and approve certain service and equipment requests.

I'm going to talk a little about the overseas veteran pilot, which has also helped us confirm the effectiveness of the VIP program design as an alternative to costly institutional care.

In 1999 Veterans Affairs implemented the overseas service veterans at home pilot project in three sites that were identified as having significant wait times for admission to a contract bed. OSVs, which I think you are familiar with now, are a group of VAC clients who were not eligible for VAC programs except for our most expensive program, a contract care bed. The pilot sites were Camp Hill in Halifax, the Perley in Ottawa, and The Lodge at Broadmead in Victoria.

Under the pilot, veterans who had historically only been eligible for this most expensive option, a contract bed, if assessed as requiring long-term care and if a bed was not available, could receive interim benefits from the VIP program—in other words, home care benefits—while they were on wait list.

The pilot was successful, and after an internal assessment it was revealed that for the majority of participants, should a bed become available, their preference was to remain at home with the added home supports. Interestingly, housekeeping services were the most used element of the program. Families reported that the home care option played a key role in maintaining their independence and helping them continue in their role as caregivers.

● (1125)

Upon completion of the assessment of the pilot, it was extended nationally in November 2001, and formalizing legislation was passed in 2003.

In a nutshell, though, the pilot is kind of a dramatic illustration of how care substitution can work. If more desirable care options are available, it's possible to deliver care for less cost. As this project was not comprehensively evaluated at the time, it is part of the focus of an important research study, which I'll now briefly talk about, that's called the continuing care research project, to make informed decisions on continuing care policy at Veterans Affairs, as well as to make a contribution to national policy-making on continuum of care issues.

Veterans Affairs implemented a large-scale research study in partnership with the Ontario Seniors' Secretariat. The overall purpose of the study is to develop new knowledge to contribute to future policy and planning with respect to continuing care for veterans and to contribute to the broader policy debate regarding the provision of health services to the elderly.

The research project has two overlapping studies. Taken together, both studies feature a measurement strategy that includes a sophisticated economic analysis of financial costs and care outcomes for veterans independence program clients across three care contacts. That's in-home care and residential care, and also supportive housing. This will include measurement and costing of care contributions from VAC, but also from other sources, including informal primary caregivers. Level of care need is also carefully measured to ensure apple-to-apple comparisons of costs and outcomes.

The first study addresses the need for further study of the OSV pilot that I have just described. It is intended to provide a rigorous and independent evaluation of the OSV initiative. Information has been collected through hundreds of interviews at the sites of the original pilot: Halifax, Ottawa, and Victoria. Here the focus is on comparison of home care and institutional care, consistent with the pilot. Analysis of this information is now under way.

The second study is a broader and larger cost-effectiveness study of home care, supportive housing, and residential care. It's being undertaken in the Toronto area, in which three groups of veterans will be compared: clients in long-term home care, clients in supportive housing, and residential care clients. Over 1,000 interviews are completed, and analyses are well under way.

This study will address some key questions about the VIP and the continuum of care, including a rigorous review of the OSV pilot, including the overall strengths of the VIP model and our continuum of care and approach. We'll be able to look at levels of satisfaction with the program among veterans and family members. We'll be looking at the cost-effectiveness and efficiency of the continuum of care, and whether there are opportunities to improve effectiveness or encourage more care substitutions. Finally, we'll be understanding more about the contributions of family caregivers, who play an important role in veteran care.

Data collection for these studies is complete and analyses are under way by Dr. Hollander and his group. Final results of these studies are expected to be available in the spring of 2008. We'll be receiving feedback on these studies from a national advisory committee. It includes representation from three provinces as well as a number of groups with an interest in continuing care in Canada.

We would be able to describe today some of the preliminary findings, if members want to explore that in more depth.

Overall, the purpose of this kind of work is to learn more about how to organize care delivery systems and how to use resources effectively, because using resources effectively would be a key issue in the context of the veterans health services review.

To conclude, we believe the VIP has been a very effective program. Two key features of the program's design are emphasis on prevention and maintenance and on its recognition of the importance of basic home support services.

We look forward to the results of the research study we have discussed, to better understand the program and how it can be improved in the context of the veterans health services review.

I thank the chairman for the time we had available to us to present this morning. Thank you.

● (1130)

The Chair: Thank you very much.

To give you witnesses a sense of where we're going with this, and I'm sure you already largely understand it, I think pretty much everybody around the table is generally in favour of expanding the program. It's a question of to what extent, where the lines are drawn, and what we recommend, in a sense.

With that, I'm now going to the prearranged rotation for questions, first with the Liberal Party of Canada.

Mr. Valley for seven minutes.

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

Thank you for joining us today. We appreciate the fact that weather kept you away from us, but we're glad to have the opportunity to talk to you.

You listed a number of things, and the main thrust of my questions will be about different areas of the country. I first want to go to the... and I'll use your words here. I think you said it's five key principles that have survived the test of time.You list them here and you mentioned them in your comments.

Briefly—we have heard this since it was touched on over and over again through your presentation—can you list the services VIP would provide? There's probably a half dozen to a dozen of them. Can you run through them quickly for us again?

Mr. David Pedlar: That would be my pleasure.

One area is personal care services. That would be services required in the performance of activity of daily living, such as eating, dressing, washing, grooming, toileting, and ambulation. Another is grounds maintenance. That's to assist with grass cutting, snow removal, and so on and so forth. Another area is housekeeping. These would be services for routine domestic tasks, such as laundry, vacuuming, cleaning floors, dusting, etc. Another would be access to nutrition. This would cover either going to sites to eat or delivery of food to the home, so that's wheels to meals or meals on wheels. Another is transportation costs. That's transportation to participate in social activities, to do banking, shopping, visiting, and so on and so forth. Another is called ambulatory care. That's to assist with health and social services outside the home, such as adult day care and respite care. Another area is called health and support services. These are health assessments, diagnostic services and personal care. Those are largely provided by a health professional. Home adaptations are also possible under the program to facilitate access to the home. I think there's a maximum dollar per residence for those kinds of services. Finally, of course, there's nursing home care, which is also part of the continuum.

Those are the main services that are available under the veterans independence program. Housekeeping would be the most used element of the program at the moment.

Mr. Roger Valley: Thank you. I did catch in your comments earlier that housekeeping is the most...I'm not sure “popular” is the right word, but the one that's accessed the most.

On the ones that touch directly on health care services, these aren't provided by the department, then. They're provided by provincial workers, contract workers, obviously, if it's a professional service being applied.

Mr. David Pedlar: Yes. Different aspects of the program would have different approaches to accessing. For example, as I mentioned earlier, one of the models that are part of the program, one of the key principles I mentioned, is self-managed care, and that means, for many of the services we provide, that the veteran can play a key role in choosing providers in his or her community to provide the services. In many cases, we have a third-party payer who can actually handle the administration of the payment of the costs around the program.

Generally speaking, though, we don't have a team of housekeepers and health professionals who actually go out and provide the programs. The expertise or the support is found in members' communities. I know we have lists of providers, care lists and provider lists, in different communities to help veterans find providers who can provide support for them.

Mr. Roger Valley: Thanks. That will get right to the point I want to bring up.

I'm looking at page 9 of your document. You talk a bit about the success in how you're providing the services in the urban areas. Is there any evidence on how successful we are out in the rural areas?

I notice that your study, too, is going to be in that very rural area of Toronto. So I'm trying to figure out how we make sure we're receiving some level of service that's equivalent to what happens in the big urban centres.

Then I have a second part to that question. Even lumping urban and rural together, you then get to remote areas—and I serve the riding of Kenora, which has a lot of remote sites.

Are there any studies or evidence on how successful we are in the rural areas and then, after that, in the remote areas, which would be very difficult?

● (1135)

Mr. Marcus Hollander: We actually did a study a few years ago with the Royal Canadian Legion and the University of Alberta that looked at issues facing rural seniors. This study focused not necessarily on our clients but on a group of veterans as a whole. The research study involved surveys, analysis of Statistics Canada information, and also some community case studies.

We do know that there are often problems with availability of services in rural versus urban areas. We also know that there are regional differences in the availability of services. So these are challenges we struggle with, and we don't always have simple answers in terms of how to address them.

One thing we do know, though, is that in terms of how we case manage clients—that would be how our counsellors work directly with clients in these kinds of environments—we have to be aware of high-risk groups, groups that we might have to pay more attention to. Those would be people without social support—in other words, people who have less of a social support network to help them. Those would often be people who are alone or isolated or who have more health challenges. We know that there are certain key things that can help us when we work with clients in those areas. We have to pay more attention to certain kinds of risk factors for clients who live in those areas in terms of how we deliver our program and how we case manage.

In terms of strategies for success in rural areas, we know that living in a rural area may require more planning ahead for services in order to access them. More effort may be required in seeking services. Therefore, the self-manage aspect of our program, which gives a client considerable flexibility in who they choose to provide services, could also be of assistance.

Also, as you would know, being able to drive and have transportation can also be critical and is often more important than it is for clients in urban areas, especially if public transportation is not available. Therefore, paying special attention to what we can do in transportation, whether it's social transportation to assist with banking or other social needs or whether it's medical transportation, can be especially critical in these areas.

We also know that connections to other people and social support can play a really important role for people who live in rural areas. So making sure that veterans can connect with social groups or Royal Canadian Legions or other opportunities that can help them connect with other people and build support systems can also be of great assistance.

This is an ongoing challenge for us.

I hope I've provided some helpful information to address your question.

Mr. Roger Valley: Thank you.

The Chair: Thank you very much.

Now we're over to the Bloc Québécois. Monsieur Perron, you have for seven minutes.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good morning, Mr. Chairman. Pardon me for not being very clear-headed this morning. I got up at 5:00 a.m. to get here. The road between St-Eustache and Ottawa wasn't pretty at all.

Gentlemen, I would like you to tell me about home care. I don't know whether you have conducted a study or whether you've gone to see how that works in Quebec. It seems you omitted Quebec from your presentation.

For the past 12 to 15 years in Quebec, local governments have decided to favour home care. That has been and is a not very successful operation. One fact is noteworthy. I don't know whether it's because of family solidarity, but it works better in rural and isolated communities than in the major centres. The major centres have problems.

In Quebec, the government helps by subsidizing residences housing a number of generations. For example, we could transform my house, either build another one, or build part of a house near mine, and my parents would live there with me. The government would assist me financially in modifying my house, as it provides financial assistance for modifying apartments, by adding ramps, for example, to assist seniors.

Personally, I've noticed—and this also appears to be the case in Quebec—that home care works well when both elderly partners are alive. When one of the two dies, the other goes first to the home of a son, then to the home of a daughter, then to that of another son, then to the home of another daughter. That causes all kinds of problems.

Care must be taken with regard to home care. Of course, your report talks about thousands of dollars saved, but what are the economic consequences for the person who receives this care at home? That isn't a question; it's simply a comment.

Since I find it very hard to speak into thin air, I'll stop my presentation here.

● (1140)

[*English*]

Mr. Marcus Hollander: My first response is, in terms of the study we're undertaking, that what you point out is correct. We're not undertaking the study in Quebec. But I want to emphasize that we have not forgotten Quebec.

If you look at the broader work that we're doing in the context of the health care review and if you look, for example, at the “Keeping the Promise” document and the work I've done myself over the last decade or so; in fact, the “Keeping the Promise” document relies heavily, in a lot of the service innovations that it talks about, both in the areas of screening and in some of the concepts around the single-entry model, on current cutting-edge practices in Quebec.

In many ways, in terms of the “Keeping the Promise” document and other work we're doing, we looked at Quebec as a model in many areas of our program designed for elderly people. So Quebec has not been forgotten. It actually plays a very important role in terms of the thinking we've undertaken around the veterans health services review.

I wasn't exactly clear on a specific question to address, outside of my general comment. I don't think I have anything more to add to that. However, if you could reformulate a question, I would be delighted to reply to it.

[*Translation*]

Mr. Gilles-A. Perron: No, I've finished, my friend.

[*English*]

Mr. Marcus Hollander: Thank you.

If I could just add something to what David was saying, in the research we're doing and in the work nationally and in this study and other studies, the issue of family members, particularly the spouse, who may remain either after the person dies or certainly if the person goes into a long-term care facility, is an important aspect and one that needs to be addressed perhaps more actively.

What happens to spouses and the contribution that the spouses actually make to the care of individuals was something we did look at. Certainly the contribution of the spouses came up in terms of the work we're doing and the policy options or suggestions Veterans Affairs might consider to further support families and spouses, particularly in circumstances in which the person in care may go to a long-term care facility.

● (1145)

Mr. David Pedlar: If the time hasn't run out, I should just mention that we do provide considerable support to informal caregivers now. One of the best forms of support, though, is home support, like housekeeping. This is a major support for families. It reduces the burden on family members who might otherwise have to provide that care, and it allows them to continue their efforts.

We also provide various types of respite care to give caregivers a break. We extended VIP services to primary caregivers, or to a group of primary caregivers, as you're well aware. We can also pay for family members to provide care under certain circumstances, such as when they live outside the veteran's home, and occasionally when they live with the veteran, although criteria can be tighter for that kind of support.

Finally, caregiving is a major part of the study we're undertaking right now. We're actually going so far as to cost the contribution of caregiving. It will give us, as well, a more nuanced understanding of what caregivers' needs are. There's also a second study under way. It's a smaller-scale study, but we're looking at caregivers of younger disabled CF members. So caregiving and support to families is a major focus and a major concern of research and of the department.

The Chair: Fair enough. Just so the witnesses know, rarely does witness time run out. We extend a great deal of discretion to you. How much time the members each have is a question of respect for the rules and respect for each other in terms of our original agreement. So you often have greater latitude than the member asking the questions.

Now we're on to the New Democratic Party and Mr. Stoffer, for five minutes.

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

Thank you, gentlemen, for appearing before us today via telephone.

This is my first question for you. How many veterans and their spouses and/or widows or widowers do we have in this country?

Mr. David Pedlar: I actually don't have that number right at my fingertips. I'm sorry about that. I can provide that to you. There are different ways of slicing and dicing that one. I would want to make sure I had it correct.

Mr. Peter Stoffer: Okay. Then how many World War II and Korean veterans and the spouses and/or widows and widowers of that class of veterans would be around?

Mr. David Pedlar: I know that there are around 220,000 veterans of World War II and Korea. I think there are something like 260,000 survivors. But if we are getting down to numbers, my preference would be to confirm numbers and reply back to the committee.

Mr. Peter Stoffer: Okay. To receive the VIP program, one of the questions DVA asks individuals is about their income. Is that correct?

Mr. David Pedlar: Not necessarily. I think you've probably heard from other members that eligibility for our programs is sometimes complex, so there are different—

Mr. Peter Stoffer: But sir, generally if a person is financially well off, they won't receive VIP, will they?

Mr. David Pedlar: No. Certainly they can receive VIP if their need is related to their pension condition or if—

Mr. Peter Stoffer: It's related to their pension condition, which was my next question. If they're not on a pension, do they receive VIP services?

Mr. David Pedlar: Yes, they can receive VIP. There are basically two broad gateways. Well, there are actually three ways. One is related to service eligibility. You know, you have to have the right kind of service to access the program. A second would be generally through a pension, which means that you could have a disability pension, a medical disability pension, from the department. The third avenue is through income, and those conditions can work in different ways in different circumstances due to the complexity of our eligibility. I think other witnesses have probably addressed, and the "Keeping the Promise" document addresses, concerns about the complexity of eligibility.

Mr. Peter Stoffer: Yes, and you had mentioned "Keeping the Promise".

Now, my next statement, although not for you...I'll be asking the minister this when he appears. But as you know, in the last campaign, there was a written promise to extend VIP services to all World War II and Korean veterans and their spouses immediately upon forming a government. I want to ask you a simple question: can that be done immediately? There was no mention of a health care review or an Ontario coalition review. The promise was "immediately", and an awful lot of people hung on those words.

Obviously there has to be a hold-up somehow, otherwise this government would have honoured that commitment. But it hasn't so far, so I wanted to know if that could be done immediately. Because you've specifically stated the VIP program saves money, and so if it saves money, if you extended it to other people, then obviously it would save even more money, if you stretch out that argument.

That's my frustration. I just spoke to a lady this morning in Musquodoboit Harbour whose house was flooded out. She's the widow of a veteran who died a few years ago, but because he didn't apply for VIP services, she doesn't qualify for any benefits whatsoever. That is a pure frustration a lot of my colleagues have in the House, when you have to turn around and say no to them.

I understand you're doing a review, but I always thought that a veteran was a veteran was a veteran. You shouldn't have complexities when it comes to answering a phone call. If they call up and require services and they have served their country, I fail to understand why it's so difficult to get this through.

● (1150)

Mr. David Pedlar: My reply to that would be that a decision of that nature would be best directed to the Minister of Veterans Affairs.

Mr. Peter Stoffer: That's understandable.

How many veterans and/or their spouses die on a daily basis in this country? I've heard figures of around 120 to 130. That includes, roughly, 70 to 80 veterans and/or their spouses. Is that an accurate figure?

Mr. David Pedlar: The figure I've heard quoted for veterans is approximately 2,000 a month of our war service veterans. I'm not clear on what the number would be for our survivors, but both those questions can be easily answered.

Mr. Peter Stoffer: Okay. So when will we see the end of the review, sir?

Mr. David Pedlar: My role is in the area of health research, and the health research I do contributes to the review. But as far as timelines go, that is another question that would have to be directed to the Minister of Veterans Affairs.

Mr. Peter Stoffer: Thank you very much.

Mr. David Pedlar: It's my pleasure. Thank you.

The Chair: Thank you very much.

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

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

Thank you both, Mr. Hollander and Dr. Pedlar, for coming again, as we had that pleasure before.

I want to follow up on my colleague's question about rural services. I also have a rural area, very much more rural—not quite as remote, though, as my colleague's. You indicated that you have already done one study. I'm wondering when you did it.

Mr. David Pedlar: It was a couple of years ago. I think the final report came in maybe 18 months or two years ago.

Mr. Bev Shipley: Okay. Were there recommendations in that?

Mr. David Pedlar: There would have been suggestions. I can make that report available to you, if you're interested.

Mr. Bev Shipley: I think that would be good. I'd ask to have that, and have it tabled.

Mr. David Pedlar: May I ask if someone will be noting that so I'll know to follow up?

Mr. Bev Shipley: Our clerk is taking diligent notes here.

Mr. David Pedlar: Thank you. It would be our pleasure.

And if you ever wanted someone to present on that study, Norah Keating, who's a member of the Gerontological Advisory Council, was the lead on that study, which is now also becoming a book, I think, and I guess she would be delighted to come and speak on that.

Mr. Bev Shipley: Thank you. That was just a follow-up, because I think there's always a distinction between rural and urban and, as my colleague said, remote areas, which are different.

Can I go now to Dr. Hollander? You split this, but when we talked about the nurses—and this was on page 4—you said you don't need to be a nurse to carry out most of the services that are supplied. Obviously we understand the outdoor functions, but when you get to the indoor, outside of the cooking and that sort of stuff, where there's health care, bathing, and that sort of stuff, how do you select the requirements someone has to have?

Mr. Marcus Hollander: Typically—and I believe this is certainly true in Veterans Affairs and in provincial continuing care systems—there is usually a process by which someone who needs care would come to the attention of the health care system; that is, they themselves might call, or a physician or a family member might call. There would be a short screening to ask what the nature of the problem was, and if it appeared that the person did have a health care need, there typically would be a comprehensive assessment of the individual and also probably of the level of availability of family to support, and so on. That comprehensive assessment done by the assessor would provide a pretty good overview of the needs, circumstances, and environment of the individual. Based on that review and on discussions with the client and the family member, a care plan would be developed that would be matched to the kinds of needs that had been identified, so essentially it would be within the care plan that the determination would be made regarding appropriate types of services.

Certainly if professional services and nursing services and so on are required—and they are very important services—they would be part of the care plan, and those services would be provided. What we find is that often they also need these kinds of supportive services, and these services would also be part of the care plan.

Through this process one would determine what the needs are and develop a care plan. Then essentially the services would be authorized in some appropriate manner, whether by providing the services directly through the health staff in the health region or by purchasing them through third-party providers, and so on.

● (1155)

Mr. Bev Shipley: I'm going to run out of time, and I do have one more question before the chair gives me the signal. I appreciate the comments.

I want to go to the research you talked about, the veterans at home pilot project. I think I'm understanding the whole pilot project correctly. If I'm reading it correctly, you said that the project was expanded in 2001, and that legislation came forward in 2003 but it hasn't been evaluated. There were more studies done, it would appear, and we are now going to complete a study that is going to come forward in 2008.

Are we talking about the same thing?

Mr. Marcus Hollander: Yes, we're talking about the same thing.

Mr. Bev Shipley: It was not evaluated following the legislation in 2003, so we have a study that started in 2001 and this is now 2007. In 2003 there was not an evaluation done. Do you know why not?

Mr. David Pedlar: Actually, a small-scale evaluation was done during the first two phases, but it wasn't as thorough an evaluation as we thought was necessary.

Part of the interest in doing a more sophisticated study came in part from the Gerontological Advisory Council, because they felt that not only was it important for Veterans Affairs, but it was also very helpful information that might have a greater impact outside Veterans Affairs in the broader health care community.

Mr. Bev Shipley: My concern is that we have something that has been going on for.... You're not going to get anything now for five years, from 2003 to 2008. I'm wondering why. Is there a good reason?

Mr. David Pedlar: We've collected different levels of evidence over time. Currently, though, the evidence is being used in the context of the health care review.

The OSV program is part of the bigger picture of the health care review. The kind of evidence that we're generating would be to enter different kinds of questions, such as whether the VIP program should be more comprehensive than it is now. Through this kind of study you can help answer that question. Another question would be whether there are greater opportunities for care substitution between home care and institutional care. These are the kinds of questions we can answer, nuance questions, through a study like this, so this kind of study is actually very important for our current priority, which is the veterans services health care review.

There are different levels of evidence in terms of the quality of studies. The better the evidence, the more impact the studies can have. This study will have very good evidence, so it can have a very strong impact at Veterans Affairs and potentially in other health care jurisdictions as well.

● (1200)

Mr. Bev Shipley: Thank you very much.

The Chair: Thank you, Mr. Shipley.

Now we are on to the Liberal Party of Canada for the second rotation, where each person will have five minutes.

Mr. St. Denis, for five minutes.

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

I was quite intrigued when both of you mentioned the study that indicated a saving in the third year of $3,000, if I wrote this down correctly, in favour of those who had home care versus those who went without it, indicating what I think we all anecdotally realized, that it is less expensive and a happier situation when we can help seniors stay in their homes as long as they physically can.

Did I write that number down correctly? The advantage is to the taxpayer in that study, to put it crassly, or to society, by keeping our seniors at home?

Mr. Marcus Hollander: That is correct, and I think the difference was about $3,500 in the third year after the start of the study. There was really a natural experiment in British Columbia, where there was a policy of no longer providing housekeeping services to people who were at the lower level of care. A few of the health units, as we called them at the time, took that very seriously and reduced their rosters. Others did not, and so we had a natural experiment where we could look at two health regions where the cuts were made and not made.

When we broke down the data in that study, we found that on average, if you looked at the two groupings, the major increasing costs related to admissions to long-term care facilities—on a proportional basis, more people were admitted to a facility, thus increasing the costs—and the use of hospital services. So the people who no longer got those services basically found they might run into some problems, for whatever reasons, because of the lack of those services. The result was that they went to hospital more often and were more likely to be institutionalized in a long-term care facility.

Mr. Brent St. Denis: Before I continue, I have a small related question. What would be the average number of hours of home care provided in the study?

Mr. Marcus Hollander: It would have been very modest. I can't remember the exact number of hours, but typically for a low-level care needs person, they might get something in the order of four to six hours a month. That is, somebody may come in, perhaps twice a month, to provide some basic care and home maintenance. So relatively, it was very low-cost provision of health care.

Mr. Brent St. Denis: So again, to use your words, a very modest investment in home care leveraged a tremendous advantage in terms of the cost of institutionalizing someone and, of course, in terms of related visits to the hospital and emergency wards, because they didn't want to have somebody helping them at home.

Mr. Marcus Hollander: Right.

Mr. Brent St. Denis: I think most of us would have guessed that was the case, but it's good now to have the studies confirming what we might have guessed was the case.

Is it because the dollars in question here were federal that the person was institutionalized or getting help at home? The funding envelope was the same in both cases. This, I imagine, led to the possibility of an experiment like this, because where we are unable to do these things, sadly, is where there are different jurisdictions involved. Get outside the veterans community to the population in general and we're then dealing with provincial dollars and federal dollars comingled, and it's harder to make that case.

Were there any provincial impediments to the experiment?

● (1205)

Mr. Marcus Hollander: First of all, it was basically a study that was done in British Columbia, so it would have related to the British Columbia continuing care system at that time. These would have been dollars within the provincial ministry of health. Obviously, with federal transfers, some of that money would be federal as well.

Really what the province did was make a determination that it wanted to invest funds in the people who needed higher levels of care and make that kind of a transfer. That was the policy choice.

Fortunately, the University of British Columbia has been working actively for a number of years with the Ministry of Health in British Columbia, and they have a very good database of administrative data, all confidential, and so on, but nevertheless, that was the data set that we were able to use, and it has data on home care services, residential, drugs, physicians, and hospitals. One can, on an anonymous basis, look at what the consequences are if there are certain changes in policy, and we were able to do that.

Mr. Brent St. Denis: Thank you.

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

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

[*Translation*]

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

I have some simple questions to ask you, gentlemen. Have the studies that have been done been conducted in order to find problems or to find solutions to those problems?

[*English*]

Mr. Marcus Hollander: I think typically what would happen is that one would do studies on issues of relevance for future decision-making. They would be an input into policy formulation, so you may not be fully aware of a particular circumstance. If you do good targeted research, you can get relevant information about that, and depending on what that is, it may point out certain policy choices.

With regard to the kind of research we've done and are doing in this project, we are looking at levels of satisfaction as well as cost. This is not simply a cost study; we are also looking at contributions made by caregivers and the satisfaction with services.

What we find is that for people with similar levels of care need, home care is typically—not always, but on average—a lower-cost alternative. So in fact people usually prefer to remain at home. What this evidence would say is that if people prefer to remain at home, if they can get an equivalent level of care to meet their needs that they're satisfied with, then that might be an option for policy-makers to consider in terms of making greater investments in home care rather than in residential care.

That said, one must continue to recognize the importance of residential care for people who need that kind of service. So typically one would hope that the kind of data that is collected would in fact lead to improvements and solutions.

Mr. David Pedlar: I agree with Marcus' comments. In a nutshell, the goals of the study were really twofold. One was to take a really sophisticated look at the veterans independence program, one that hadn't been taken to date, in order to assist us with formulating our policy, especially in the context of the veterans health services review, which is a very serious undertaking.

Secondly, there has been ongoing interest in the veterans independence program in other jurisdictions in Canada, and outside Canada as well. If you want to transfer information about best practices, the best way to do it is in a high-quality research study, which this is.

[*Translation*]

Mr. Roger Gaudet: Thank you. I'll come back to that later, if I have the time.

My second question concerns home care. Is your first priority health or maintenance? I know this is very important. It's all well and good to say that it's less costly, but our veterans have given us our freedom. Health care is as important as having a beautiful lawn and all kinds of things outside the house. I think that what's important is on the inside, and that's the veteran and his family.

So I'd like to know what you mean by "health care". I'm not telling you that maintenance isn't important. It shouldn't look bad. But health care is very important, for me at least.

● (1210)

[*English*]

Mr. David Pedlar: I talked earlier about the concept of comprehensiveness. That means you need a range of options to address the wide range of needs that veterans present with. Where veterans require higher-intensity care that could involve health care and more professional care, we want to make sure that's available to them. Where they may require non-professional supports, we want to ensure that those are available as well.

I think the discussion around housekeeping was more from a national policy perspective. While Veterans Affairs provides housekeeping and considers all the components of its program important, there has been a trend away from housekeeping services and towards professional care services.

Veterans Affairs' and the veterans independence program experience is that comprehensiveness really matters, and that housekeeping really matters as well, as do other components of the continuum of care, such as ones that would involve more professional health care providers. It's all important, and it's important that a program is capable of addressing a wide range of needs.

The Chair: Thank you very much.

Now we'll go to the Conservative Party of Canada, and Mr. Sweet, for five minutes.

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

Thank you, Dr. Pedlar and Dr. Hollander, for your good work.

It's my understanding that in the past year 12,000 new clients have been initiated into the veterans independence program. First, could you tell me if that's correct? Second, how did that come about? Was that through the phone solicitation that we heard had happened? What gate did they come through?

Mr. David Pedlar: Unfortunately I don't have the direct answer to that question. I can get it for you. I don't work on the data in day-to-day program delivery.

I know a large number of clients came on, over the last few years, with the extension of services to primary caregivers, but I'm not exactly sure what the breakdown of new clients would be. That information is available, though.

Mr. David Sweet: You had mentioned in your opening remarks that there are 100,000 across Canada on VIP right now. If you extended the VIP to all the people who could use that, who need that, what would the caseload be?

Mr. David Pedlar: Again, I don't have that kind of detailed information. However, caseload is complicated. It wouldn't simply be the number of cases divided by the number of case managers. It would be based on the number of clients who we think require different levels of intensity of service. The kinds of clients who would require the most intensive service would be ones who have high health care needs.

One of the factors in the veterans independence program is that we have a wide breadth and depth of need. So we have a considerable number of clients who have relatively lower care needs and therefore require less intensity in terms of how their caseload is managed, and we would have clients who were more in the middle, and then we would have clients who have high levels of health care needs.

Mr. David Sweet: That's fine. I knew there'd be different levels of intensity, but we don't have the data anyway.

Mr. David Pedlar: I don't have the direct answer to your question.

Mr. David Sweet: That's fine.

You say that in 2008 there are going to be some findings of this study. Mr. Shipley asked you a bunch of questions, and I have to admit that I might be a tad confused. In regard to this particular study that's going to be delivering its findings in the spring of 2008, when did it begin?

Mr. David Pedlar: The data collection started a year and half ago.

Marcus, is that correct?

Mr. Marcus Hollander: Yes. I think it started in 2006.

Mr. David Pedlar: The data collection started in 2006.

● (1215)

Mr. David Sweet: The other question I have is, in all the studies that have been done, has it ever been studied, looked at, or proposed, having a doctor involved and the cost of actual house calls? In other words, would there be a cost saving if, rather than the veteran having to get the physical capability to get to a doctor's office or a hospital, there were house calls to monitor the veteran's health?

Mr. David Pedlar: I don't have a direct answer to that question either. There are different ways that we use medical professionals. Medical professionals may be involved in pension medical exams, which is one way we may work with physicians. Another would be that we do have medical advisers involved in our care delivery teams who work with the veterans independence program at our district offices. So we actually do have physicians involved in medical care and in medical care decision-making; however, it's primarily the counsellor and other health professionals who visit the home.

I actually don't have a direct answer to the question. I don't know if Marcus has any experience with models that do direct doctor visits.

Mr. Marcus Hollander: No.

I think it's an important area and it's one that would in fact be good to study. I think that to do that more broadly you would want to be looking at making some connections between the primary care system and the continuing care system, really to see what options there might be for physicians to be encouraged to make these kinds of house calls or to work perhaps within the home care organization.

What has happened in some home care organizations across the country is that they have contracted with physicians. I believe in one case in Toronto it was with the person responsible for family medicine in the hospital. There is a recognition that there needs to be better linkages with physicians. So if you have a home care organization that has a physician, they can link with the physicians in the hospitals to facilitate discharge, and they can link with community physicians as well, in terms of issues related to care.

So the role of physicians is very important in this, but I'm not aware of a number of circumstances where there is an actual program of home visits. I believe there are some physicians who are doing it, but I think it's limited at this point in time.

But it is an important topic, and—

Mr. David Sweet: I just have one more question here.

I'm glad you thought it was advantageous to study.

The Chair: Thank you very much.

Bless your heart, Mr. Sweet. Six minutes and nine seconds.

Now we're over to Mr. Valley with the Liberal Party, for five minutes.

Mr. Roger Valley: Thank you.

I want to return, just a bit, to a question I didn't get an answer to, about urban, rural, and remote.

You mentioned in part of your answer back to me that there are different ways of identifying high-risk people. I'm concerned that maybe people who are out in the rural areas should start off rated at a higher risk. In your comments to me earlier, you mentioned that there are timelines and care has to be planned more ahead of time.

We're used to that when we live in the rural areas. We understand what it means to travel for services and everything else, but I would almost make the point that in rural areas they should be at a higher level, and the remote areas definitely should be at a risk because they have very few or no services, with almost no travel options. I'm talking about fly-in locations at the extreme level.

Going back to the two studies you mentioned, have we missed something with not putting more of a focus on studying how we serve in the rural areas?

Mr. David Pedlar: I agree that we should continue to focus on this issue. It's a challenge, and I think you've made a good point by underlining it as something we should continue to focus on. I appreciate that focus.

In terms of how risk is defined, I think that's more or less what I was saying. It's not so much to say that anyone in a rural area is at higher risk, but it could be said that for people in rural areas who have certain risk factors, like people who live alone or who have higher levels of health care challenges, at the equivalent level of need they could be at higher risk because of problems that might be related to their access to supportive services.

So I agree generally with the direction of your comments.

● (1220)

Mr. Roger Valley: So as a committee, when there are two studies ongoing and we're waiting for a report, and we don't want to delay that in any way, how do we involve those people and get a study that will show some of the dramatic differences? I think they're there.

Mr. David Pedlar: One thing that had been briefly discussed earlier was that we do have an expert who is a member of our Gerontological Advisory Council, Norah Keating, who has done a study that we financed and worked on with the University of Alberta and the Royal Canadian Legion. The committee may want to hear about that study in more detail, and we'd be delighted to share that information with you so that you can look at the results of this work and discuss how it could better inform veteran care. We'd like to get your perspective on it as well.

Mr. Roger Valley: Thank you. I think she has already testified before us. Maybe there could be a return visit.

I'm going to give you both an option. You're talking to politicians. If you could wrap it up in a couple of sentences each, tell us what needs to be fixed. You've outlined many things. You have a couple of studies going on and they're going to be provided. But what could we do right now that would make life better for these veterans?

You mentioned that we're losing quite a few, and their families, due to age and everything else. Tell us in a couple of sentences what you would do right now to change it, without all these studies in your way and with legislation, which takes time and action by government, which drags itself out. What would you do if you could flip a switch right now and make a change for these people we're trying to serve?

Mr. David Pedlar: I'll answer that question with a few points.

I think the “Keeping the Promise” document gave us a good template, and while it can't be done immediately, some of the key points included making a single integrated health care program. That can't be done overnight, but it can be done probably in a relatively quick period of time if the decisions are made to support that.

Simplification of eligibility is another point. It has been a long-standing barrier to veterans accessing our program.

Another area would be making sure that we have our assessment tools in place to measure care needs and care levels that are as well developed as possible. We do have good tools in place, but we could strengthen those tools over time.

Make the continuum of care more comprehensive. That's also consistent with the “Keeping the Promise” document. There are probably points on the continuum of care where we need to have more options and the flexibility to use those options, such as areas of assisted living.

In the kinds of studies I think Dr. Hollander is working on, he'll probably be able to tell us more about whether there are things we can do right now in terms of opportunities to do more substitution of care. Within our current care model, that would mean asking if there are any additional opportunities to substitute care, and that would mean keeping people home longer if that's where they want to be. I think these studies may help to identify some opportunities in that area as well.

Finally, informal care is an ongoing area, and there are ways we can support informal care. I think our study will help to inform that question as well.

Mr. Roger Valley: Thank you very much.

The Chair: All right. Mr. Sweet didn't finish his last round of questions, and it is time to go back to the Conservative Party.

Mr. Sweet, for five minutes.

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

Doctors, I'm just going to follow up with one more question, then my colleague Ron Cannan will have some questions for you.

I'm glad you thought there might be some merit in including doctors for house calls, particularly in the kind of study that you have in metro Toronto, where you'd have a high density of veterans. But I can also see where Mr. Valley is concerned about the rule of having veterans saved of all the travel they would need to undertake to get to the medical care that only a doctor could provide.

But my final question was just this. You had mentioned in your opening remarks that you have some preliminary findings from the study you're working on, and you most kindly said that if we asked you, you would give them to us. Could you give us some of those preliminary findings from that report, which is going to be due in its entirety in the spring of 2008?

● (1225)

Mr. David Pedlar: Maybe I'll ask Marcus if he would be kind enough just to give a very high level of what some of the themes are in the preliminary or early findings, to help to support the work of the committee.

Mr. Marcus Hollander: I am happy to do that.

Here are some of the key findings, which are similar to what we found in other studies.

If you standardize the care need and you have a classification system that allows you to group people into similar categories of needs so that you can make apples-to-apples comparisons, it does seem to be less costly to provide care in the home. What that means in terms of possible implications for consideration by Veterans Affairs Canada is that it would be appropriate to look at whether there are any current policies that may limit the amount of resources available, and to explore whether Veterans Affairs would like to consider caring for people more actively within the community than they are currently.

Certainly the data seem to indicate that it would be less costly to care for people with similar levels of care if they were able to remain in the community, so there is an opportunity, I think, for the kind of substitution David has talked about. When doing so, one has to be somewhat careful, because just because it costs less doesn't meant it can apply to everyone. This would need to be done as part of an appropriate assessment process and so on, but the opportunity seems to be there.

The other thing is not a direct finding, but an indirect finding, as with other studies. It is that the opportunities for making those kinds of substitutions.... First of all, the data say that one can make those substitutions. Typically those substitutions are better done within an integrated program whereby you really match a program of services and procedures to the needs of the person so that it is supportive of the kind of direction that the “Keeping the Promise” document has indicated.

We've also found that the spouses make really quite a significant contribution to the care of individuals. Most of the people in the study are veterans and are men, and the spouses make a significant contribution, so if there's something that can be done to further enhance what may be done with spouses, that's something that could be considered. Certainly we now have some documentation about the contribution made by these individuals.

The other thing is that one of the key characteristics to be able to do good research, analysis, and planning is a good standardized assessment tool that has been validated, and a client classification system that's consistent across all types of care. We did use those kinds of tools in our study; we would think that consideration of that point would be very helpful. If you don't have those tools, you're not able to make the kinds of apples-to-apples comparisons that we've talked about.

The other thing that was found had to do with the kinds of services that Veterans Affairs pays for. They have a couple of programs, and there's a bit of a mixture of the kind of thing you'd usually see in a home care or continuing care program and some kinds of services that may be in an extended health benefits program. We simply point that out to see whether any consideration to perhaps recognizing those distinctions would be appropriate.

Those would be the main findings to date that we could comment on.

The Chair: Thank you very much.

Mr. Sweet's intention was to allow Mr. Cannan some time, but we're at five minutes and 24 seconds, so we're going to go over to Mr. Stoffer with the NDP. It's the Conservative Party's spot after that, so then Mr. Cannan will have an opportunity.

Now we're over to Mr. Stoffer and the New Democratic Party for five minutes.

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

Gentlemen, I appreciated your response to my colleague David Sweet's question.

We heard that 12,000 new clients have gotten on the VIP service, although we've never had documentation on that. You've indicated that you're not the data person, but if you could get the information for us, we'd appreciate it. Since the government came into power, how many people have actually gotten onto VIP who are new clients; and at the same time, can you tell us how many have gotten off, who've either passed away or just no longer qualify for the service?

Sir, I just heard you say, in conclusion there, that you now have some evidence of what the spouse has done for the veteran. You have some documented evidence. I believe that's what you said. I find that rather incredible, because I don't see why you need to have a study or evidence to know what a spouse does for a veteran. All you have to do is talk to them, go to a military family resource centre. The answer is quite simple. Without them, government wouldn't be able to do their job and a lot of these men wouldn't have been able to survive the horrors of what they went through during World War II, Korea, Bosnia, and now Afghanistan, and everything else. They play a very, very critical role in the care of our veterans.

To say you have documentation now that provides evidence of it is really quite incredible, to be completely frank with you. But if we go on your numbers that over 2,000 veterans die every month, and I figure at least half their widows or spouses die, then you're looking at 3,000 people a month. Since this government formed the government in February 2006, and by the time your report comes out in April, that means 78,000 veterans or their spouses will have died since the “Keeping the Promise” document.

And then, once that document hits the government, there has to be a study by the various department officials and the cabinet. If we get into an election, it's delayed even further—mind you, that's not your business—and the reality is that many thousands more will have passed on prior to receiving any kind of benefit from these studies. My frustration is that many people call up on a regular basis asking for the simplistic answer of groundskeeping and housekeeping services—not health care services but groundskeeping and home care services. That's really what they're after, and they're being denied left, right, and centre.

So could you tell me, why would groundskeeping and general maintenance of their house inside be considered under a health care review?

● (1230)

Mr. David Pedlar: We define health care broadly to include various aspects of a client's well-being. Health care is defined generally, consistent with good models of care for the elderly. It focuses more broadly on a person's capacity to function in a home and in the community, and not narrowly on what might have been considered, traditionally, medical-type health care concerns. So health is defined broadly, as it should be, for older persons.

As to the issue around studies and deadlines, and one thing or another, I can assure you that the preliminary findings and earlier information that has been collected on the study is being used for planning purposes within the veterans health services review as it's available. We don't have to wait until spring 2008 to make the research findings useful. We make them useful immediately. That's partly done by making sure there's a close working relationship between the team in Veterans Affairs that's working on the veterans health services review and the research team led by Dr. Hollander. There has been ongoing direct interaction between the two, so that findings from one can be used as soon as they're available, even if they're preliminary.

So we're not waiting for anything. We're using what we have as we move along, and we're making good use of it.

Mr. Peter Stoffer: Thank you.

When you give Mr. Sweet his answer regarding how many have gotten on and my question of how many have left the program, could you also give us a statistic, if you're able to find it, on how many people actually call up for VIP services and are denied.

I'll just give you one quick example of a woman, Chris Beattie of Halifax. Her husband died. He was a veteran. He actually applied for VIP before he died. He was accepted into the program, but he had, as she says, the audacity to die before the program was actually delivered to him, and thus she was denied any access to VIP services.

This is the type of frustration, sir, that we experience on a day-to-day basis. So I just wanted to give you that as an example.

Thank you.

● (1235)

Mr. David Pedlar: We appreciate that feedback.

The Chair: Thank you very much.

I almost wanted to respond to Mr. Stoffer's question. I appreciate the fact that he's asking questions that he asks in the House, which is good. I was hoping he would do that.

I'm just offering my thought on this. For some of these people in my community who are 80-some years old, shovelling the walk or doing these various things in icy conditions can definitely be a health hazard if they slip and break a hip or something like that. As well, there's the strain on their heart and various things.

We will now go to Mr. Cannan of the Conservative Party, for five minutes.

Mr. Ron Cannan (Kelowna—Lake Country, CPC): Thank you, Mr. Chair, and my thanks to the gentlemen for being with us this afternoon.

Most of the questions have been asked. I also agree with the whole issue of health care as quality of life. We have to incorporate that element.

I represent the constituency of Kelowna—Lake Country, in the interior of the Okanagan in British Columbia. To those who have been familiar with Victoria and UBC and studying gerontology and the whole philosophy of aging in place, we have the highest demographic of those 65 and older. That's about 16% of my population in Kelowna, and Victoria, of course, has the highest number of individuals over the age of 80. So we have some excellent research based out of B.C.

I know Minister Abbott, our health minister, and Premier Campbell have been using this philosophy of home care and assisted living versus institutionalization or hospitalization, both from an economic and also a quality of life point of view. I think we have a model there, and we have the research. And like my colleagues at the table, I have many constituents who have come forward looking for improvements to a program that we know is broken and needs to be fixed.

I would just ask you this, then, from a summation of all the discussions that we've had with prior witnesses. If this committee completed and put a bow around the witnesses' information that we've gathered to date and submitted a report before our Christmas break, would that help you to expedite this legislation coming forward in the new year?

Mr. David Pedlar: I can't really speak to legislative timetables, but I can tell you that information from your committee, of course, would be very helpful in terms of the work the health care review is undertaking, as well as the research study that we're undertaking.

As health policy is formulated, of course, we use various sources of information, and they all make an important contribution. For example, research and the study that we're undertaking would be one important piece of information, but another critical one would be the kind of advice that this committee would give.

I know this committee had the pleasure and the opportunity to speak to, really, a wide range of experts in recent months, as I did have an opportunity to read the proceedings of some of your past meetings. So I'm sure a report from your committee would be welcomed and could play an important role in the process.

Mr. Ron Cannan: Excellent. We talked about this briefly at the last committee meeting, and if we can get a consensus after the conference call is over, hopefully we can get that report completed. As a member of Parliament on the government side, I'll do my best to get the legislation enacted as soon as possible.

Thank you, Mr. Chair, and my thanks to the witnesses.

The Chair: Thank you.

I don't have anybody else on the speaking list.

Mr. Brent St. Denis: I have a short intervention, Mr. Chair.

The Chair: Mr. Brent St. Denis, for the Liberal Party.

Mr. Brent St. Denis: I wanted to ask this, gentlemen. Going back to the fascinating study comparing a group that didn't get VIP and was eventually institutionalized, or put into homes, I guess, more appropriately, to a group that had home care and was able to avoid being put into a home, in the measurement that we've been given today—and the measurement most easy to make is a financial one—is any measurement of the quality of life possible? Some day I'll face that music, or my family will on my behalf, I suppose. From talking to many seniors, I would imagine they are happier when they can stay home, if they don't have to go to a nursing home.

Is there any way to measure the quality of life benefit of being able to stay at home and what that means in terms of longevity, to measure the indirect benefit to your health that comes with just being in your familiar surroundings with a spouse if your spouse is still alive, or with your family and your community? Is there any measurement of that quality of life?

● (1240)

Mr. David Pedlar: The answer to that is yes, but I think I'll hand it over to Marcus to explain to you exactly how we're measuring those kinds of questions in the study.

Mr. Marcus Hollander: There are quality of life scales that we've used in the past. There are strengths and weaknesses to each of them. But certainly if we look at the outcomes in studies, some of the things one typically looks at are the satisfaction people have with services—both the clients and the caregivers—and the quality of life of the individual.

What one typically finds is that both satisfaction and qualify of life are comparable, and sometimes better, for people living in the community. It varies a bit from study to study and whether you're looking at one or the other of those factors, but generally that seems to be the pattern of findings.

The other part of your question really relates to something that would be done more in a longitudinal study, where you would look at people over time and perhaps look at time to institutionalization and so on when you do comparisons. There has been limited research in that area, as far as I'm aware, at this point in time. But it's certainly an important area.

Longitudinal studies are a bit more difficult, particularly if you're using the outcome measures that we're talking about, because you want to do that over time. Their levels of satisfaction may change over time, and so on.

These are not studies that are easy to do, but certainly it's an important point that you make, and certainly one would want to see satisfaction and outcome included as outcomes. If you're doing cost-effectiveness, you need to look at both the outcomes and the cost.

Mr. David Pedlar: If I could add to Marcus's comment, on the second question around the health impacts, while a more complex strategy is required in order to really measure that effectively, you can ask people about it in a cross-sectional study, in the kind of study we're doing. Although it's not as strong a measure, it's also helpful to get that kind of information just by asking people hypothetically about what some of the effects are of being able to stay at home longer.

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

Thank you to the witnesses.

The Chair: Thank you.

Once again I have exhausted the questioners list. At this stage we're not wrapped up, though, because there are a couple of things I think some members wish to raise.

I'd like to thank our two witnesses, Mr. Hollander and Mr. Pedlar. Thank you very much. After we let you gentlemen go, we will be discussing the issue of the report, and hopefully that does help you. So thank you very much for appearing today.

And I apologize to the committee members and everybody else with regard to the snowing-in factor, but you were accommodating to be able to do this via teleconference.

Mr. David Pedlar: Thank you. It was my pleasure.

Mr. Marcus Hollander: Thank you very much.

The Chair: Thank you.

Some hon. members: Hear, hear!

The Chair: For our committee members, I wanted to mention that I talked to Michel. He says that Tuesday next week is probably not likely, but maybe Thursday, just before we go to break. We may be able to have something to talk to and debate, or what not, with regard to a report on the issue. It's short timing, really, given that we're not going to have that much time before the break, but we'll do the best we can.

And I think Mr. Shipley's leaning over to talk—

● (1245)

Mr. Bev Shipley: No, Mr. Chairman, you've just summarized. I think it is likely. We've heard a lot of discussion today about studies and not getting the length of time, and I think everyone here wants to move ahead. So if our researcher can put together at least that draft report for us to have and discuss before the break, that would be wonderful, and much appreciated also by our vets.

The Chair: Thank you.

Is there any other discussion on the subject? No? Okay.

This meeting is adjourned.

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