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Chair

Mr. Rob Anders

Standing Committee on Veterans Affairs

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● (1530)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good afternoon, ladies and gentlemen.

I'd like to welcome everybody back from our Christmas and holiday break. Happy new year to you all.

We are continuing, pursuant to Standing Order 108(2), the study of the veterans health care review and the veterans independence program.

Today we have two witnesses with us. We have Clara Fitzgerald, from the Canadian Centre for Activity and Aging, and we also have Mark Speechley, from the University of Western Ontario, Department of Epidemiology and Biostatistics, Faculty of Medicine and Dentistry.

Just for our witnesses' benefit, the way this generally works.... I don't know if you've been told that it's twenty minutes or ten minutes.

Good, you heard twenty minutes. That's what is usually standard. So you can split that as ten minutes apiece, or one of you can hog nineteen minutes and the other one will get one minute, as you see fit. Then after that, the committee members will take turns asking questions based on a strictly delineated, previously agreed to roster of the parties.

The floor is yours.

Mr. Mark Speechley (Professor, Department of Epidemiology and Biostatistics, Faculty of Medicine and Dentistry, University of Western Ontario): Thank you for inviting us here today.

I'd like to thank Veterans Affairs Canada for funding for the research we did into Canadian veterans. We did what we think is the largest study of falling among veterans of Canada.

I've summarized the results of our work in the brief I submitted. I won't take your time by re-reading it, but I'd like to point out three key points.

We found that falling is more frequent among Canada's veterans than in the general population of older adults. We know that Canada's veterans report poorer self-rated health than the general population, and we found that although it's a small number, 3.8% of the sample reported not having enough funds left over at the end of the month to meet their obligations. We found when we did analyses on that variable that those people also had an increased risk of falling.

I point out those, which might seem to be negative comments, but I want to start on the positive, because I know Veterans Affairs Canada has an excellent reputation for its compassionate care of veterans. I've read the *Keeping the Promise* document, and I want to compliment the agencies responsible for that document.

I will just go through what I think are some positive features of the *Keeping the Promise* document and then conclude with what I think are some things that have to be kept in mind as you go forward in revising this excellent program.

The positive features of the *Keeping the Promise* document are the single point of access and the coordination of services, particularly the coordination with provincial health care. In Ontario we have the CCAC, and I think that's essential.

Another positive feature is that these people will be working closely with primary care, which is absolutely essential. The team-based care and the case manager model is another positive benefit. The comprehensive assessment of older adults is evidence-based and appropriate.

I note with great approval the mention of physical activity and fall prevention. Fitness classes are specifically mentioned, and Clara will be talking about that, because that's her area of expertise.

Also, I was very happy to see evaluation and research mentioned in the document.

As you move forward revising this excellent program, I have some evaluation questions that I would encourage you to keep in mind. It's important that you are sure that the funds follow the veteran or older adult on a needs basis. It's one thing to have people eligible for a service, but if they don't need the service, the money may not be used to maximum benefit. I think we really have to be able to be sure that the funds are being used where they are most needed.

An evaluation question I have is, to what extent are VIS funds truly integrated with provincial funds? When I did my fall prevention study, I had doctors calling me. The evidence suggests that doctors should call back their patient to evaluate, say, the number of medications they're receiving. I had physicians tell me that they didn't think OHIP, in Ontario, would pay to call back a veteran to check on things based on what their questionnaire told us they should check.

That's a real concern to me, because that raises the question of funding. We know we have the evidence that we can prevent falls, but the question, as always, is who's paying, and are the funds travelling with the client the way they should be?

I think we have to ask, how does the early intervention specialist ensure that the veteran has a primary care provider? In Ontario, we know many people do not have a family doctor, so that's one question that I would raise. It's excellent that it's here in the document, but I would question how we will know that this good step is actually being done.

I see in the document that the veteran is encouraged to have a comprehensive health assessment. This is what we did in the second phase our project, which we haven't published yet but it's in preparation. We randomized people into two groups. One group got a comprehensive geriatric evaluation and an evidence-based set of recommendations for what should be done to prevent falls. We found no difference between that group and the group who just got a letter to their family doctor.

● (1535)

It's on that basis—not just my study, but others I've read in the literature—that we say comprehensive assessment and recommendations alone are not enough. It's a necessary but not sufficient step to prevent falls.

When I read your document, I see that the veteran will be encouraged to have a comprehensive health assessment. I would ask, how many do? Is simple encouragement sufficient to get the assessment done? I would ask what assessment is used, because there are several assessments that can be used.

If we do move towards a standardized assessment, I would encourage you to consider the minimum data set, which has been studied. It's an international suite of assessments that allow comparability, so we can compare Ontario, British Columbia, Quebec, etc., and the United States and other jurisdictions. It's a wonderful initiative.

Again, I've got a note here: Who pays? Who pays when these things all happen?

I've drawn a line across my page here and I'm just going to conclude with things that occur after the standardized assessment of an older adult.

It's most important that the veteran has regular contact with the care manager to see that the results of the assessment are put into action. I emphasize that an assessment and a recommendation, if that's all you do, I can almost guarantee you won't prevent falls or any of the other negative things we want to prevent.

I think once the assessment is done and the recommendations are made, and the case manager ensures the veteran is getting these things, then we have to ask, are the interventions evidence-based? There are many things that are done out there that are evidence-based and some that are not. So that's something I would put in your evaluation program.

The actions should not only be evidence-based, but they should be continuous, and you have to have regular follow-up. The assessment should be repeated. It's not just a one-time deal. It has to be repeated for two reasons. First of all, new problems can arise in older people quite quickly. And second, if the assessment is repeated, then you use it as an indicator of success of the program. If you don't do it, you really don't know if you're having any success at the individual level.

Similarly, with the referral to specialists, some evaluation questions I would have are how long does this take; are the appointments kept; is the referral appropriate; and are the actions taken appropriate and based on evidence?

In conclusion, to emphasize the positive, we know we can reduce falls by 25%. We know we'd better start doing a better job of it now, because we have a looming epidemic of falls as the population continues to age. We can use existing knowledge to create a uniform national fall prevention program, which, if funded and sustained, will have benefits for individual veterans, families, and society at large.

Thank you very much.

The Chair: Thank you.

That allows just under twelve minutes to Ms. Fitzgerald, if she wishes.

Mrs. Clara Fitzgerald (Program Director, Canadian Centre for Activity and Aging): Thank you for recognizing the Canadian Centre for Activity and Aging as a national leader in the area of physical activity and aging. For those of you who are not familiar with the Canadian Centre for Activity and Aging, we are a national centre located in London, Ontario, at the University of Western Ontario. Our mandate is to conduct research in the area of physical activity and aging, and then to develop model programs and leadership training programs that support the research we've learned in order to help older people maintain as much of their functional ability as possible. The work we do is geared to both very well older adults living in the community and frail older adults living in a variety of different care facilities.

I think it's important for us to let you know that this is a wonderful opportunity for us to have a discussion with the members of this committee and to talk about the value of physical activity programming as an intervention to help many of the ill effects of aging that many of the veterans and older adults experience as they get older and have various levels of functional decline.

Like Mark, I took note of *Keeping the Promise* and the guide to access Veteran Affairs Canada health benefits and the VIP program. What I thought was quite interesting—I learned as I read—was that the VIP program in place and many of the services provided to the veterans are based on their veterans status as compared to their actual level of need. So I think there has to be better integration based on the service delivery model, on what the actual veteran needs, not so much based on their age and/or status but on their functional needs. I'm sure many of you can think of a variety of different older people who are younger than others and yet not as functionally capable.

I've noted in the documents as well the importance of physical activity and the need for increased and improved community-based programming. That was emphasized actually in both documents, and I thought that was encouraging.

When we were coming to Ottawa, I was trying to think of specific community-based interventions that assist veterans to maintain their functional mobility in the variety of communities I've worked in throughout the country. I couldn't really come up with many of these type of programs. I think that's a direction that the document indicates the group wants to move forward in, and yet we have to realize that many of these older people want to age in place. We need to ensure that programs and services are delivered to them within the communities they live in. The wonderful thing as well is that the work you're doing helps not only veterans but older adults in general.

Much of the work we do beyond the research phase of it is not funded. It ends up that many older people who are able to financially pay for programs and services that are evidence-based can attend those programs and services if they're up and running in their various communities. There are a couple of challenges here. In some communities, the funds don't exist to get these evidence-based programs in place. The other challenge is that some of the veterans might not qualify for the VIP funding or may not have the funds to offset these costs.

I can share with you an example of a veteran I know through our centre, where we have over 420 older people who access our programs and services. This veteran had been taking part in a chronic obstructive lung disease program for about ten years. The program was physician governed and monitored, and was run out of a hospital in London, Ontario. The hospital felt that this program could be run within a community model setting, and looked to the Canadian Centre for Activity and Aging, based on the expertise we had in delivering evidence-based programs, to implement this program.

● (1540)

Having said that, there are direct costs associated with taking part in a variety of functional mobility programs to first of all try to prevent functional decline; secondly, if a fall has happened or something else, to try to help these people recover—the rehabilitation phase of functional mobility programming; and thirdly, if rehab has taken place, to help these people maintain their functional gains in the long term, so that they can benefit from the purposeful activities that those programs have helped them be able to take part in.

This person was not aware of the level of funding that might be available through the VIP to access the service, and we were not in a position to be able to offer this service to this individual at no cost. Discussions began in early August, and to make a long story short, the person finally received funding through the VIP in middle to late December. I feel that timeframe is too long, and the older person didn't know how to navigate the system in order to benefit from these health promotion initiatives, even though they're indicated in the document. I wonder how aware these veterans are of these health promotion initiatives as compared to perhaps rehab initiatives after an incident such as a fall has happened. So it's really looking at how we can help prevent further functional decline in the long term.

I'm sure my brief has been circulated along with Mark's. I just want to address a couple of recommendations based on some of the points I've mentioned.

There's a lot of information and a lot of research that has been done to explain the benefits of physical activity for older people. If you're not aware of that information, when you had the Health Canada representatives speak to your standing committee, they would have highlighted *Canada's Physical Activity Guide to Healthy Active Living for Older Adults*. It's a great document. It summarizes briefly the importance of physical activity programming for older adults.

At this point, I think the emphasis really should be on taking a look at the vast amount of information out there, the research that has been published—and a lot of it being Canadian research—and looking at how we can translate that information into effective and accountable functional mobility programs for older adults and veterans, and to ensure that these programs are evidence-based and outcome-based.

What I mean by outcome-based is we don't feel it's good enough just to set up physical activity programs throughout the country for a variety of veterans and older people in general. It's essential that these programs are outcome-based, and we know what it is we're trying to measure and what risk factors they present, so that appropriate programs can be put in place to prevent furthering those risk factors.

There are a few key words: evidence-based programming, outcome-based programming, programming in place in a variety of communities throughout our country, and ensuring that many of these programs can be delivered within the home care infrastructure—so really supporting aging at home.

It's essential to develop cost-effective physical activity model programs for veterans and older adults based on research and led by competent leaders to ensure that funding and support for these programs in various communities is provided where older adults reside and ensure that physical activity programs, as I mentioned, are outcome-based, community-based, and foster aging at home.

As well, to help our older adults and veterans living in a variety of different care facilities throughout our country, it's important to note that these types of programs should also be in place in those types of facilities. Regardless of your age, it's always possible to maintain your functional mobility. We know that when we start losing functional gains, they're not necessarily due exclusively to aging, but inactivity plays a huge role.

● (1545)

The second recommendation is that if implemented as part of the routine primary care of veterans and older adults, the evidence demonstrates that physical activity has the potential to prevent functional decline and keep more people living at home longer with an improved quality of life. There are several cost savings later on, which we can talk about further.

Third is to provide assistance to veterans to navigate the health care pathway, so they're informed of the services available to them. From the experiences I've had with three veterans in particular, they didn't know what they didn't know. They didn't know these services were available to them, because they were health promotion services, as compared to rehab services. So it's important to make accessible evidence-based health promotion programs through the veterans independence program, and not solely rehab programs or programs based on veteran status but also based on their functional needs.

In closing, I think the key here is to look at the programs that already exist. Many of us have done research to develop these programs and to help them be implemented in a variety of communities so we can start the piloting of these programs to have an actual impact on the functional lives of these veterans and to help them become engaged in living independently as long as possible.

Thank you.

● (1550)

The Chair: Thank you.

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

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

Thank you to our guests for coming today to share some of your work. I'm sure if you've been following some of the work of the committee, you know we all have a great desire to improve things for our veterans, and we thank you for your information.

My first question is to either of you. You mentioned a study and where you were. Can you tell me how far out the study reached? In particular, was there involvement from the small towns, rural areas?

Mr. Mark Speechley: The first study was in the whole southwest region. We captured 1,300 veterans from ten counties of the southwest Ontario region. The intervention study could not be that widely distributed, because we had to have the comprehensive assessment and we only had so many people who could do the assessment. Some were done, though, as far away as Bruce County and down to Windsor.

It was a challenge finding people to do the assessments, because there was no funding in the project for that. It was funded by the system, which might be part of the reason it was not as successful as it might have been.

Mr. Roger Valley: I probably should have clarified where my comments were leading. We're talking a little bit farther out. I'm from Kenora riding, which is about 30% of the province, more than 30% of the province, but it's a long way from there.

Realizing you have touched some rural communities, I was going to ask a question about remote sites. A lot of people don't realize how many remote sites we have, but we have over 90 that are accessed by air alone, which do have veterans. That's always a challenge. We know the challenges of serving veterans in the large cities, in the counties, but when you move out to those other areas....

That leads to my next question. Your recommendation—I think Mark made it—talked about a lot of good work done out there,and I think Clara mentioned it also. You mentioned there's some good work done by Canadians, but I assume there's been a lot of work done around the world. I'm wondering if you could just briefly touch on some of that and where it would be done. Is it the United States, is it Australia, is it Britain?

Mr. Mark Speechley: I think Australia and New Zealand are leading the world in this particular area right now.

Mr. Roger Valley: By your comment and the first of your major recommendations, you're suggesting we have a lot to learn from the work that's already been done.

Mr. Mark Speechley: We don't have to reinvent the wheel, absolutely. We can take a lot of the stuff off the shelf and apply it in Canada. I know there are remote areas in Australia. I'm not sure how they solved the problem there, but that's something they might have some experience in.

Mr. Roger Valley: I would like to think that at some point somebody started to work on some of the smaller places. How do you choose?

Mrs. Clara Fitzgerald: If I can add to Mark's comments regarding the rural areas, some of the work that we've done, in particular the home support exercise program, is delivered by personal support workers in the homes of older people to help older people maintain their functional gains where they live. In these rural communities, these personal support workers are organized via the home care infrastructure. They provide services to these people at home through that home support exercise program. Although that work and that research was not done specifically with veterans, it was done with a variety of older people living in remote communities who were not able to access community-based programs and services that those living in larger cities were able to access.

We were able to demonstrate with that study that even using these health service providers who are providing care to these clients at home, we were able to improve strength, balance, flexibility, and cardio-respiratory fitness. We know that functional declines are associated with decreases in those physical components. So I think a lot of the effort in those rural communities is really to look at aging-at-home studies and implement some of the work that we've done and others have done and look at models that can replicate as much as possible the same model, but within the home care setting. It is not physically possible to bring these people, just due to the....

● (1555)

Mr. Roger Valley: Nor would I want them to be moved. I would hope they get the service there.

You mentioned the focus of the study is falls, and how they happen. When we are visited by veterans, as constituents, one thing is fairly consistent, especially in an older veteran: it's a hearing issue. We're always fighting for pensions based on hearing; we're working on those aspects.

Is that a large part of why the veterans have more falls than the rest of the population? Is it because of their hearing?

Mr. Mark Speechley: That's a good question, and I'm probably not enough of an expert in that area to speak. I know that the inner ear is one of the three main parts of the balance system. I had never thought that maybe military service, which we know can cause hearing loss, might also affect balance.

Excellent question. I wish I had an answer. I don't want to speak beyond my expertise.

Mr. Roger Valley: Because I think that consistently throughout you'll see that's one of the key points that they always have.

I suspect I'm getting close, I'm getting glared at, but I just want to highlight something.

Clara, you made a point your last—

The Chair: There's no glare. There's a minute and 30 seconds left. You can go ahead.

Mr. Roger Valley: So I can talk for a minute and 29, because he won't cut you off.

Just lastly, then, on your last point, Clara, you just read it, "Provide assistance to navigate the healthcare pathway". Over and over and over again, for the people who are coming before us, this is a huge problem. I would make the point, because you're only talking about an aging population—well, we're all aging, I guess. You're talking about a population that's Second World War, Korean War, and everything else, but just for your own information, we're getting it from the younger vets. We're getting it from the people who are still actively in the service, who are not able to carry out their duties but are still in the forces. Trying to get through the health care system is a huge problem. I'm very happy to see this here in one of your recommendations, and you can expand on it; he won't cut you off.

Mr. Mark Speechley: Well, again, I made the point that I was very happy to see this VIS is using that single point of access, and then you've got these people who are working together with the veterans to help them navigate the system. But then we also have the same thing in Ontario called the community care access centres. So then the first question I had was how is this single-point-of-access program going to work with Ontario's single-point-of-access program? Now we've got two single-point-of-access programs. If they're all working together, then it's a step in the right direction.

Mrs. Clara Fitzgerald: I would agree with Mark. I think that the IS program should potentially work in collaboration with the CCACs so that there is not a duplication of services to older people, in general. I think there are opportunities there to learn from the work that the community care access centres in Ontario have developed. Again, it is a single point of entry. And their single point of entry is based on the functional needs of the client, not based on the status of the person. So the veteran's status wouldn't come into play.

I think as well—and I can only speak on behalf of the health care pathway—that the older adults need to become aware of various health promotion initiatives to prevent various areas of decline, in the area of functional decline, because sometimes people don't think about accessing services until something has happened, until they've fallen, they've fractured something, and now they need rehabilitation.

But the question is, after rehabilitation, what happens? What's in place for the residents—the veterans? I do a lot of work with long-term care facilities, and that's why I said "residents" there. What's in place for the residents to help them maintain their functional gains post-rehabilitation? What health promotion programs could potentially be in place? And then also, following rehabilitation, what follow-through programs are in place to help them maintain their functional gains post-rehabilitation? It's critical to think about, because most of the funds are invested in rehabilitation after a fall has happened, etc., to help the person regain as much of their functional potential as possible. But then what are we doing to help these people maintain these functional gains long term? I'm suggesting that efforts, programming, need to be put in place at those two ends more so than in the middle because programs in the middle are better understood because they're directed by the hospital care system, whereas these two at the outer end are community based, and oftentimes the veterans are not aware of what those programming services are for them. In many cases, they're not in place.

● (1600)

The Chair: Thank you very much.

And now it's on to Monsieur Perron with the Bloc Québécois, for seven minutes.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Welcome Ms. Fitzgerald and Mr. Speechley.

Your presentation was quite interesting. However, it only dealt with the southwestern part of Ontario. Do experts in different provinces or different regions communicate with one another? Can you give me a general outline? Do your studies reflect the situation in other provinces?

[*English*]

Mrs. Clara Fitzgerald: If the question is are these types of programs and services in place in various parts of Canada as compared to southwestern Ontario, the answer is no. I can't speak to the study. Mark can speak to the study. When we look at the types of programs and services that I was recommending should be in place to help with the functional mobility of veterans and older people in general, for these types of programs and services, although they may exist in various pockets, the level of funding, the level of evidence to support these model programs is not consistently coordinated.

At the Canadian Centre for Activity and Aging, we are a national leadership training centre as well. So we certify people to become leaders of these types of programs nationally.

I was just mentioning to Mark on the flight over that we've never been contacted once at the Canadian Centre for Activity and Aging by Veterans Affairs Canada to ask us where these types of programs exist, where certified personnel to lead functional mobility programs exist in Canada. And we can give you a snapshot of where those programs are in place, but there is definitely a cost to those programs because they're not offered at no cost.

Mr. Mark Speechley: To answer your question, if our program weren't successful for southwestern Ontario veterans, there's no reason to believe it would be successful for veterans elsewhere in the country. But I'm not sure that was your question.

[*Translation*]

Mr. Gilles-A. Perron: Did your study produce the same results as studies that were done elsewhere in Canada?

[*English*]

Mr. Mark Speechley: There was a study done in Calgary. It did not reduce falling in one group relative to the other. There have been many unsuccessful fall prevention studies, some in Canada and many from elsewhere. But there have been successful ones too, and those are the ones that.... We're trying to decide how much we have to do to prevent falls, and my major point is that assessment and recommendation is not enough.

[*Translation*]

Mr. Gilles-A. Perron: Since I have some time left, I would like to make a final comment before turning the floor over to Jean-Yves.

There is a sentence in your brief that I find rather puzzling: “Canada's veterans report poorer self-rated health than the general population of older Canadians”.

I have a hard time believing and understanding that. It seems to me that our veterans are just as fit as the general population in the same age bracket.

● (1605)

[*English*]

Mr. Mark Speechley: Apparently not. We ask people—

[*Translation*]

Mr. Gilles-A. Perron: That is what they are saying?

Mr. Jean-Yves Roy (Haute-Gaspésie—La Mitis—Matane—Matapédia, , BQ): But is it the truth?

[*English*]

Mr. Mark Speechley: “Compared to other people your own age, would you say your health is excellent, very good, good, fair, or poor?” When we ask people that, veterans have poorer health than Canadians over 75.

Mrs. Clara Fitzgerald: Their perceived health is poorer.

Mr. Mark Speechley: It's their perceived health.

[*Translation*]

Mr. Jean-Yves Roy: I have a similar question. You say that: “Falling is more frequent in Canada's veterans (40%) than in other samples of older adults [...] ”.1,913 veterans took part in the survey. How many of these 1,913 veterans are men?

[*English*]

Mr. Mark Speechley: Of the 1,913 veterans, 96% were men.

[*Translation*]

Mr. Jean-Yves Roy: Very well. If, among the general population, you were to take 1,913 men, 90% of whom are 81 years of age, the number of falls would be the same. Among the general population, there are more women among the 81-year-old segment. And, at this time, the men are the ones who have the greater number of falls. Therefore, you cannot say that falling is more common among veterans than among men who are, on average, 81 years old.

That's the part of your study that I don't understand.

[*English*]

The Chair: The witness is allowed a response, but just to let our Bloc colleagues know, they are now over five minutes, so it will be the last of the questions until the next round.

Excuse me, the rounds are seven minutes. Keep going. It's fine.

Mr. Mark Speechley: Thank you for your question.

We can't compare exactly, because the veterans are 81, or mostly between 79 and 83, because they were 17 to 21 during the war. I can't make an exact comparison, but the numbers were quite a bit different compared to the national population health survey. It's on that basis that I made my statement, but I will check my numbers, and if you like, I will follow up with you.

[*Translation*]

Mr. Jean-Yves Roy: You can't state that falling occurs more often among men whose average age is 81. The rates are about the same, because men tend to fall more often than women. I don't know why, but there are more 81-year-old women than men among the general population, since women outlive men. That is a fact. Therefore, you cannot say that falling is more common among veterans. That is what I am having a hard time understanding.

The same goes for your statement that there is a higher risk factor for older veterans than for older adults. If you take a group of men with an average age of 81 years, they will all have the same risk factors and will all be subject to the same proportion of falls.

[*English*]

The Chair: All right.

That exhausts seven minutes for the Bloc Québécois. I apologize, but there were seven minutes, 22 seconds devoted to that, so I apologize for cutting in.

Now we're over to Mr. Stoffer with the New Democratic Party.

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

I thank both of you for your presentations today.

Was the survey you mentioned a written or oral survey?

Mr. Mark Speechley: It was a written questionnaire and was mailed.

Mr. Peter Stoffer: Would it be possible to get a copy of that survey in the future?

Mr. Mark Speechley: Absolutely.

Mr. Peter Stoffer: Also, you mentioned 1,913 veterans and 1,398 spouses and caregivers. Did you get that list from DVA?

Mr. Mark Speechley: It was from client lists of Veterans Affairs Canada.

Mr. Peter Stoffer: Those were their client lists. So you didn't survey any veterans who were not DVA clients?

Mr. Mark Speechley: I'm afraid not. We couldn't.

● (1610)

Mr. Peter Stoffer: That's most unfortunate, because your figure that 3.8% of the sample said they didn't have enough money to meet their ends refers to clients of DVA. The veterans who are not clients of DVA, I put it to you, are having much greater difficulty in terms of the financial aspects. It would have been nice to have a survey on how they do.

Secondly, did you survey any spouses of veterans who had passed away?

Mr. Mark Speechley: No, the veteran had to be alive.

Mr. Peter Stoffer: In all honesty, would you say it's an incomplete survey?

Mr. Mark Speechley: Well, it's a selected sample.

Mr. Peter Stoffer: I love that word.

Also, did you do a survey at all...? I know that one of the main principles or guiding lights of the veterans independence program is to allow veterans and their spouses to stay in their homes longer.

When I talk to doctors, I find that the falls occur when the veteran or his spouse has moved out of their house and into different surroundings and they are not familiar with the bedroom, the bathroom, the hallways, and sometimes they're not mentally adjusted properly to accept those new surroundings; thus things like falls happen. Did you do any correlation between falls at home or falls somewhere else, such as in a mall, or somewhere else, or falls in a new setting where they had been moved?

Mr. Mark Speechley: I wish I had. I had to keep the questionnaire short to get the response rate at 70%, so I just asked for the number of falls. We didn't make distinctions between where they were.

Mr. Peter Stoffer: Okay.

I have one other point for you.

A lot of this, of course, has to do with what facilities are available in the provinces or territories. As my colleague Mr. Valley indicated, the rural parts of Canada have great difficulty in accessing services or assistance, or even in picking up the phone and not getting an answering machine when calling in that regard.

Has any of this work translated to the provinces and territories, where they could be encouraged to work with the federal government, who pays? My own personal view with regard to veterans is that it should be the federal government that pays for it, but there are always those challenges of who delivers the service. Veterans Affairs may pay, but somebody else delivers the service, and therein sometimes the baton doesn't get passed properly.

What analysis or recommendations can you give to this committee to see that this dialogue and communication is increased from he who pays to she who delivers so that the process can be smoother for veterans?

Mr. Mark Speechley: To use the example of the physician who called me and said he wasn't going to call the veteran back in for a reassessment because OHIP wouldn't pay, if Veterans Affairs would pay, then OHIP could bill Veterans Affairs. It's a simple example.

Mr. Peter Stoffer: Thank you.

The Chair: Thank you, Mr. Stoffer.

Now on to Mrs. Hinton with the Conservative Party, for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Thank you very much.

It never ceases to amaze me that no matter how many years you sit on this committee you learn something new almost every meeting. I never realized, for example, that there was any kind of activity happening at a university that was specifically studying falls. That's news to me.

Those were very interesting comments that you've been making, and I've been busy trying to read all of your paperwork while I've been listening. There are a couple of things I'm going to put in front of you for some feedback.

It always becomes a question of who pays. Health care is a shared responsibility. Basically it's the province that provides it, and the federal level of government sends funding to the provinces. You're going to get a little differentiation, I suppose, from province to province, but there's probably a way for more than one level to work together.

I was also thinking about the delivery part of it. You were wondering how our veterans are going to find out about this. I think it's a bigger discussion than simply veterans; I think it should also include all elderly people.

There are a number of different ways we could do this integration of the province, the community, the federal level, and the physicians across the country. If a patient is in a physician's office and the physician tells them about some of these facilities or exercise programs that are available to them to prevent the fall, I think that would also be beneficial.

Something we always overlook—and we shouldn't, because they do a tremendous job in this country—is the veterans organizations. They may be the best educational source we could have for notifying veterans of these different programs that are in place.

In terms of the programs that are in place, again we have this wide variety. You can have things such as the Y, which I know works with seniors, whether they're veterans or not; seniors centres, where many veterans live; recreational departments in cities and communities; and groups that get together on their own.

As an example of a group of seniors getting together on their own, my community, the city of Kamloops, has a seniors group that goes to the larger malls in the city prior to their opening in the morning. As a group of seniors, they walk the whole mall with no one in their way and go up and down the stairs. They have a very good social part to this as well as the physical activity part of it.

There all kinds of different ways. My husband, who is not yet a senior—he would shoot me if I said he was—goes to something called a boot camp. I personally thought he was crazy when he and my daughter started going to this together, but the difference in his well-being and the way he feels since going to this boot camp has been tremendous. It's a group of exercises done in a group setting. He is the oldest member of his group, but he's benefiting from this tremendously.

I was also listening when Mr. Valley was concerned about outlying areas. If you don't live in a city you don't have access to a Y, perhaps, and maybe don't have access to a large mall that you could use at no charge. I'm sure in some parts of Canada this is still the way it is.

But do you recall ever seeing one of the mobile van units that used to go around as libraries to smaller communities that didn't have the facility of a library? That might be something worth exploring as well: having a mobile unit that has these physical trainers, if you will, go into remote communities and produce these kinds of programs. In that event, maybe the veterans organizations in those communities could take over, once they had learned to do it.

I was listening, and these are just thoughts coming out of my head. I will leave the balance of the time for you to answer, and if there is any time left over I will pass it to my colleague, Mr. Shipley.

● (1615)

Mr. Mark Speechley: Thank you very much.

I forgot to mention the Royal Canadian Legion, which was absolutely essential in this project. The funding came from VAC and Health Canada, but the Royal Canadian Legion was our partner. They were extremely supportive. I should have mentioned it. Thank you for the opportunity to acknowledge them for their support.

I agree with you one hundred percent. There are all kinds of fall prevention and physical activity opportunities out there. But as Clara and I were talking about on the plane, for the younger older adults, who are basically no different from any of us, except they're a little older, the malls are fantastic, and they don't need supervision.

We're concerned about the frailer adults. I think there are well-meaning people in senior centres and church basements where exercise classes are offered, but if the person doesn't have proper training, one can actually do more damage than good. A person can get into trouble pretty quickly with cardiac problems or falls. The Centre for Activity and Aging is actually known for training physical activity instructors.

In terms of the remote areas, I don't have a solution. It's a big challenge, and I sympathize with you.

There is the home support exercise program, which can be done in your chair in Kenora as well as it can be done in your chair in downtown Toronto. Getting the videotape to Kenora isn't a problem. Having a person fly in to give the instruction isn't a problem, but someone has to pay for that plane ride.

I don't know the answer to getting supervised exercise classes to remote areas. We wrote a grant to try to do that with a mobile unit and it wasn't funded.

Mrs. Betty Hinton: I've changed my mind. Mr. Shipley is used to that, so he's going to let me have the rest of my time.

There were other things I read as I was listening to you. You were talking about muscle strengthening, which is obviously a benefit to anyone, no matter what age you are. You were talking about balance training. I would agree with my colleague that a lot of veterans suffer from balance problems because of injuries they've had during their service. If you have an inner ear problem, or you have a tendency to develop inner ear problems, you're going to have a balance problem.

The other thing that really wasn't mentioned—and this comes from my background prior to being an MP—is the medication. A lot of seniors are taking more than one medication for more than one problem, and that is true for veterans as well. Sometimes the integration of two medications can cause problems that might make a person lose their balance, or fall.

This goes back to what I was saying earlier. If we're going to have a solution to the problems of veterans or seniors falling, it's going to take cooperation from a number of bodies. It will not work unless one of those bodies happens to be the Canadian Medical Association. Physicians are in the best position to give advice to their patients who are seniors, whether or not they're veterans. That advice is usually heeded by seniors. If their daughter who happens to be an exercise guru were to tell them to do something, they may not heed that as quickly as if it came from a physician.

I think we have to have the province and the federal level onside with this. We have to have the physicians onside with it. We have to have a lot of people onside with it. We might even be able to find willing partners in insurance companies.

Thank you.

● (1620)

Mrs. Clara Fitzgerald: I think what your question and comments speak to very eloquently is that a one-size-fits-all protocol for veterans is not a model that will work effectively for everybody.

To identify the risk factors that are reducing independence for these veterans, whether they're living in community-based care facilities in various communities throughout our country or they are older people who are primarily homebound, I think it's important to address the risk factors that potentially contribute to their dependency and create appropriate programs they could benefit from. If the falling is happening because of a hearing issue, then maybe that hearing issue needs to be addressed. That's not to say that the physical activity intervention won't still benefit that veteran; it certainly will. But we have to take a look at the primary causes that are causing dependency and chronic disease in veterans.

Mr. Mark Speechley: If I could, I'll speak very quickly to the medication problem. I agree that it is a major problem. We identified it as one of our risk factors. We notified family doctors that their patients were on eight medications and asked if they could please review them. In many cases, the doctors reviewed them, and the patients were still on eight medications.

In Dr. Campbell's work in Australia, he did a clinical trial in which he actually reduced psychotropic medication—tranquilizers and barbiturates. He had a huge reduction over one year, and that was a successful trial. Unfortunately, at the end of one year, they were right back where they started. It's a really tough thing.

The Chair: Thank you very much.

Now we're on to what's known as the five-minute round, so everybody gets five minutes. There is no seven-minute business.

Now we're over to the Liberal Party. We'll have Mr. St. Denis for five minutes.

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

Thank you, Ms. Fitzgerald and Mr. Speechley, for your help today.

First, if I could ask Ms. Fitzgerald, you made reference to an example of a veteran who came to see you. It had something to do with there being no cost. I don't need to know anything confidential, but what were the services you were able to provide? I'm not sure that you mentioned that.

Mrs. Clara Fitzgerald: The service he was seeking was to take part in a chronic obstructive lung disease exercise program. The veteran had chronic obstructive pulmonary disease. The program was not led by a physiotherapist. The program was led by a kinesiologist and other allied health professionals. The programs funded and recognized by the VIP are ones that are led by physiotherapists or are medically supervised. We had to make the case that the program being delivered was evidence-based. We were fortunate, being a national centre that does its own research and that benefits from the research others do, that we were able to make the case.

The question would be whether a similar veteran in another community who was trying to access a similar program would be declined because it was a health promotion initiative and not necessarily a rehab initiative led by a physiotherapist.

● (1625)

Mr. Brent St. Denis: Thank you for that clarification.

I'll continue. Presumably, other sorts of—I'm not calling that non-traditional—non-central remedies, including non-traditional medicines, like acupuncture, would have a difficult time being covered under VIP. For the record, that may be something we want to pursue.

I'd like to talk about the gateway concept. Based on the evidence I've heard, if I could fix one thing only, it would be access by the veteran and being carried through the system—the continuity. It almost seems like you have to assign an expediter, a helper, an ombudsman—

Mrs. Clara Fitzgerald: A health navigator.

Mr. Brent St. Denis: Yes, you need a travelling companion for every veteran to walk him through the system. Not only are there the general limitations of age, but you may have added to that literacy issues, and the list goes on.

In fact, this example you gave is part of that. There's discontinuity for everybody else. In the example you gave, you were able to help that veteran.

I'm just wondering if either or both of you could talk a little bit about the continuity issue. We could have the best programs in the world and the most devoted and dedicated program officers and officials and professional care personnel, but if we can't get them from A to B to C efficiently and on a timely basis, we miss the benefit. I'm wondering if you could talk about that a little bit, if you have thoughts on it.

Mr. Mark Speechley: That was my reading of what the VIS program was designed to do, and that's why I was so positive when I saw that. I would just like to see it evaluated. It's easy to say we want to have continuity of care, but if you get caseloads that are too large, or if you don't have a rapport between the case manager and the veteran, then these things aren't going to work.

Mrs. Clara Fitzgerald: As well, you can make the recommendation, but then if the person is not following through on the service, you can't evaluate that service as not being appropriate; it's that they never took part in the program. They didn't take the medicine or whatever the case might be.

Something to consider, which I just thought about as you were asking your question, is perhaps something like a travelling journal. The person is in the know on their health status, and as they navigate the system, the journal is on the journey with the veteran. That way we're better able to track the programs and services that have actually been attended by the veteran. That is something perhaps to consider—something that travels with the person—because it is impossible for all of the various health care providers to be in the know on what's going on with this person, and when you're reinventing the wheel, it's very difficult to do. If there were something like a travelling journal that follows a person, that might be—

Mr. Mark Speechley: We did that with hip fracture patients, and it worked great.

Mr. Brent St. Denis: Yes—a bureaucracy positioning system, which could literally say where Mr. Smith is this week in the system.

The Chair: There you have it.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Mr. Chairman, as a point of information, Mr. Speechley has referred to VIS, and I just want to make sure there isn't a program I don't know about. Is it a different program, or are we referring to VIP? I just want to clarify that.

The Chair: It's an intriguing question. I was wondering about that myself earlier on.

Mr. Speechley, do you wish to speak to that?

Mrs. Clara Fitzgerald: It's the veterans integrated services, and it is in the *Keeping the Promise* document on page 30, where it indicates that there is a single point of entry of questioning by the veteran and that there are various coordinators, intervention specialists, based on the needs of the veteran, and that the single point of entry is supposed to facilitate a more integrated delivery of services. As we know through the community care access centres that have been established in Ontario, the case managers are the people in the CCACs who are sort of the gatekeepers of the services a person is entitled to.

This integrated model looks very promising, but at the same time could be challenging, as Dr. Speechley was indicating, if it's not evaluated to see how really they are navigating the system.

So regarding VIS and VIP, we are talking about two things. We're not just getting the letters mixed up.

● (1630)

The Chair: Thank you. That clarifies it.

On to the Bloc Québécois, Mr. Roy, for five minutes.

[*Translation*]

Mr. Jean-Yves Roy: Okay.

I have no other questions.

[*English*]

The Chair: Fair enough, that's fine, unless Mr. Perron would like to speak. No? Okay.

Now on to the Conservative Party, Mr. Shipley, for five minutes.

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

Thank you, Ms. Fitzgerald and Mr. Speechley, for coming out. In fact, I'm from your area just north of London. I can tell you that through the University of Western Ontario, Dr. Ted Hewitt does an exemplary job, I believe, of getting funds and doing the research that is so necessary and needed, not only for this but, likely as part of what he has gone out to get funding on, for many things that affect the livelihood of individuals and businesses, research that takes us out into the future. I just want to say welcome from one of the home guys who are not too far away from you.

Mr. Speechley, you mentioned a number of times the international falls prevention programs you're looking at and doing your research on. If I had time, I'd have some questions about the cost and the effectiveness of this particular survey.

You talk about the ones in places like Australia and New Zealand, where they've actually had falls prevention programs in place though a network, as I understand it. Can you tell me about the success of these programs and how they would relate to something that we could consider in Canada? They don't have a lot of winter in Australia and New Zealand. Set aside some things. I always get concerned about duplication in surveys just to keep things going, but is there something we can learn from them? What have you found in those programs that would be beneficial for us as a benchmark?

Mr. Mark Speechley: Thank you.

The Chair: Before our witness begins, we have a few side conversations on both sides of the table, and it is probably somewhat distracting for our witnesses and others concerned, so if we can maybe just....

Thanks.

Mr. Mark Speechley: I anticipated your question.

I tried to find some evidence that their national fall prevention programs were effective, and I guess they have been too recently introduced to provide evidence. Now that you mention 1999, if there was going to be an effect, we might start to see it. I looked for publications to that effect, and I couldn't find any.

At the national level, we don't have evidence that they work, but we know from several specific studies that we can modify risk factors and reduce falling in the study groups. I think we have to extrapolate from these studies to the national level, but I'm afraid I don't have evidence.

Mr. Bev Shipley: Ms. Fitzgerald, in one of your comments you talked about the document *Keeping the Promise*. You talked about the VIS, the VIP program, and how that may be a concern: integrating those two programs and the services that may come from them. Is that just a logistical issue?

Mrs. Clara Fitzgerald: It's not so much a concern, it's that the the veterans integrated services explanation in the document is similar to what we're aware of in Ontario for older adults in general through the community care access centres. I think what's important to note is that it makes it look simple on paper, yet we know from various older adults and veterans we've spoken with that navigating the health care system is not simple, and often they are not aware of which programs are available to them.

At the same time, I think what I was trying to say was that the VIS program should be evaluated to measure if it actually helped with the uptake of a variety of services that were available to veterans and measured which services were being used more than others. You can take a look at the services being used compared to the services veterans are potentially not using, but we know from the research that they are appropriate in improving independence. If you did an analysis of how many veterans are accessing community-based functional mobility programs, I would guess the number would be very low, yet we know these programs and services are very important in helping them maintain their independence. Is it that they don't know about these programs, or is it that they know and they're not taking part in them?

● (1635)

Mr. Bev Shipley: I think you have hit on two things that are true.

For example, we just did a study on post-traumatic stress and a number of health issues, and we found two elements. One is that we can't get the message out, or we're having trouble getting the message out, but I think the message is getting out better than it was. Then you have the other element where they know about it, but it's not them; they don't need it.

There's a third part. We heard from a witness from New Zealand or Australia that sometimes when they provide them free they won't take them. It's a sentiment that our veterans have—that they've always given, they won't take for nothing. So when you add a small fee to it there was a much bigger acceptance by those individuals to participate in the program.

In terms of our communications, I'm looking for help. How is the Canadian Centre for Activity and Aging funded? The reason I'm asking is I'm trying to see where you can fit in. You made the comment that you'd never been asked by Veterans Affairs, so I don't know how you got here. I think somebody from this one invited you. You have been invited and you will be learning because aging affects veterans and others. Where would you fit in to help us make that communication and fill in that gap between the VIS and VIP issues? For example, how do you see where you could fit in to help our veterans as a group of aging people?

Mrs. Clara Fitzgerald: Thanks for the question. There's lots to think about.

To answer your first question, about how we are funded, the Canadian Centre for Activity and Aging, although we're a national centre, receives no core funding from any federal, provincial, or local government, nor do we receive, even though we are a research centre within the University of Western Ontario, any funding directly from the University of Western Ontario. So all of our funding is based on a variety of different research grants from a basic and applied perspective, and we generate revenue from a variety of different programs and services that we then deliver to train others to become leaders for older adults.

That's not to say, though, that a centre like ours should not be funded because we are a national centre, and the viability of a centre like ours rests on pins and needles from year to year, and our mandate is directed by the funds we receive. So some of the questions that were asked earlier were broader. If the research was extended beyond southwestern Ontario in different communities, it would be great to extend some of the research beyond certain communities, but we can only do what we're funded to do.

So that's to answer your funding question.

The second question was what is the role that the Canadian Centre for Activity and Aging might play. First of all, I think it's also important to note that the staff who run the veterans integrated services and the VIP program need to be aware of organizations such as ours that are doing extensive research in this area so that they can direct veterans to a variety of programs and services that they might not even be aware exist, and that these programs are evidence-based. A centre like ours can certainly help to get the message out to older people, because older people are the best people to get the message out to older people. So via those networks and the various communities we worked with nationally, ensuring that older people are getting the message out to other older people I think is really essential in not only hearing the message but doing something about it.

Someone said to me, when they met me, “It's a young Canadian Centre for Activity and Aging”, meaning I don't really look like I'm 65. But at the same time, the message is sometimes that if I was older and maybe sharing the message, the uptake of the message would be better received. So I think getting that message out through national publications for clinicians, practitioners, physicians, and then also ensuring that the information is translated at a level that older adults can share it with other older people is essential.

● (1640)

Mr. Bev Shipley: You should have a way of getting it out through Tim Hortons.

I think my time is likely up.

The Chair: Yes, it is, sir. That being said, we have an interesting scenario with regard to the questioning.

So now, if Mr. Sweet wishes, he can have some time if he likes.

Mr. David Sweet: Thank you very much.

You were talking about comprehensive assessments for the aged. You were suggesting that it would be on a regular basis and there would be follow-ups to see how a person would be progressing or if there would be degradation in their physical capability or balance, whatever. In the broader world, outside of veterans, how common is it for a GP to send a senior for a comprehensive assessment?

Mr. Mark Speechley: Not at all. Well, no, not not at all, but it's not routine. So I'm thinking about on a person's 70th birthday, in the way that when a woman reaches 40 she's supposed to have a mammogram, and when a woman is sexually active she's supposed to have a PAP smear, about that kind of thinking applied to people on their 70th birthday. They would receive a comprehensive evaluation and it would go in their file and it would be repeated perhaps in five years or when they fall. That sort of thinking, to my knowledge, is not done in primary care anywhere in Canada.

Mr. David Sweet: You mentioned about recommendations. After a comprehensive assessment, then, there would be recommendations about how to sustain or develop a better degree of balance and mobility. You said it would have to be evidence-based. What would be the non-evidence-based argument? You must have come across that or you wouldn't say it. What are non-evidence-based recommendations?

Mr. Mark Speechley: They would be traditional medical practices that haven't been demonstrated to work. Fortunately, the number of those is getting smaller every year.

Mr. David Sweet: That leads me to my next question. In some sense there must be some dichotomy in the fact that there's a lot of research out there but that it still has a long way to go. I notice in one place you say that “optimal exercises to preserve balance and reduce the risk of falls are not yet known”, and yet you have mentioned quite often that any increase in physical activities can reduce the chance of falls. I don't want to disparage the fact that even getting in shape makes you feel better—you can tell that from your husband—but there really is a lot more work to be done on what enhances someone's capability to be in better balance and reduce the risk of falls. Is that correct?

Mr. Mark Speechley: The point I was trying to make, and my apologies if I didn't make it clearly, is that we have some falls prevention research programs that clearly show a reduction in falls and we have some that show no reduction in falls. What we're trying to do now is figure out the minimum—the intensity, the regularity, and even the types of interventions that have to be done. We don't know where that point is. But it seems to me there's a bend in the line, rather than just a linear gradient, which you'd expect to find.

● (1645)

Mr. David Sweet: And this is where you'd suggest there's a big gap in funding and that it could really help the research?

Mr. Mark Speechley: As a researcher, yes, I would say more research is needed.

Mr. David Sweet: You've been talking a lot about the veterans' integrative services. Have you had any communication with the gerontological group that made that recommendation? If I hear you correctly, you're generally okay with that model recommendation. The one thing I heard you repeatedly say is that you'd want some evidentiary practice, some capability of making sure it was executed properly and that there were measurable results.

Is that the only thing, or is there some other? Have you talked to them, and is there anything else you'd criticize the model for?

Mr. Mark Speechley: I know Norah Keating. I wasn't part of this document. I know some of the people who are involved in this. I'm just concerned that if all we do is assess and recommend, and that's it, it won't work. We have to assess, recommend, and then follow up—have rapport, assess again. It's not cheap, and it's going to cost money to save money. But it will save money, if we do it right. I guess the key point is that stopping at recommendations is not enough.

Mr. David Sweet: I agree with you. In health promotion, we have a long way to go not only with veterans and seniors but in every dimension of our culture.

Thank you very much for your information and for clarifying the things I had some concerns about. Good work.

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

Mr. Peter Stoffer: Once again, thank you both very much.

You had indicated that DVA has never contacted you. Your brief says, “With funding from the Falls Prevention Program of Veterans Affairs Canada...”. Did your organizations go to DVA to fund this research, or did they come to you?

Mr. Mark Speechley: It was your predecessor, so maybe you could answer that.

Mrs. Clara Fitzgerald: The point I was making was that the Canadian Centre for Activity and Aging, for as long as I've been affiliated with it, which is 15 years, has not had a request or a question from Veterans Affairs Canada asking us where there are programs in place that veterans can attend to maintain and/or enhance their functional mobility. That was the point I was making.

As far as the funding is concerned, perhaps you want to speak to that, Mark.

Mr. Mark Speechley: Clara's predecessor was Nancy Ecclestone, who had contacts with Health Canada. She was aware of the falls prevention initiative and came back to London and told me about it.

I'm not sure that answers your question, though.

Mr. Peter Stoffer: The federal government through two departments funded this research. Those are for veterans who are currently under DVA; they're clients of DVA. Is there any consideration down the road of doing a study of veterans who are not part of DVA?

Mr. Mark Speechley: That was your earlier question.

Mr. Peter Stoffer: Yes.

Mr. Mark Speechley: The only way we could get address lists was through Veterans Affairs.

Mr. Peter Stoffer: The Royal Canadian Legion will give you a tremendous amount too. They have a lot of lists of veterans who aren't DVA clients, and they would be able to help you.

Also, Clara in her paper here talks about the various physical things—imbalance, tai chi, physical exercise—and, sir, the same in yours, but I don't see anything regarding mental health. Or maybe I didn't read it properly.

You said that 40% of veterans tend to fall more frequently than other adults. From my understanding—I can't speak for the committee—the older veterans who I speak to, especially some of the ones who are very frail, seem to reflect a lot on what their wartime experience was and those kinds of things. An awful lot of them are also suffering from maybe dementia, a touch of Alzheimer's, and those things. I don't know how many of those folks would have filled out a survey, but I know that for folks who have dementia or Alzheimer's, filling out a survey is quite challenging no matter how simple you make it.

In your study, did you have an opportunity to study the mental health of these individuals? A lot of times, that could lead to physical problems, which could then lead to falls. So did you have a chance to do that, and if not, would you be planning to do one in the future?

Mr. Mark Speechley: Thank you for the question.

On the front page of my questionnaire, I said that I had exclusion criteria. If there were major cognitive issues for a person—they'd had a stroke or something like that—then they were not to fill out the questionnaire themselves. All fall studies, unfortunately, have to exclude people with major cognitive impairment, because they just can't participate. It's an oversight that we can't find a solution to.

We did ask people to rate their memory compared with other people their own age. People who reported that their memory had changed over the past five years were more likely to fall. So it is a risk factor for falling.

● (1650)

Mr. Peter Stoffer: That kind of reminds me of a joke. Three old veterans were sitting on a park bench when this beautiful woman walks by. The first one says, "I'd like to give that lady a hug." The second veteran says, "I'd like to give her a hug and a kiss." And the third veteran says, "Now what was that other thing we used to do?"

That works in the Legion hall. He was talking about memory loss.

Voices: Oh!

The Chair: Mrs. Fitzgerald.

Mrs. Clara Fitzgerald: I would just comment that the mandate of the Canadian Centre for Activity and Aging is to investigate the interrelationship between physical activity and aging. Most of the work, certainly with various programs, if a study is done, also looks at the mental health benefits.

I can say clearly, from the various older people who benefit from our programs and services, that the people who stick to the program long term are people who have made a variety of friendships and social relationships with other older people who have similar interests, similar challenges.

So the social component is very important, but I was speaking today specifically on the functional benefits of physical activity for veterans.

The Chair: It's very kind of you to respond to Mr. Stoffer's question.

Now over to the Conservative Party of Canada, to Mr. Cannan.

Mr. Ron Cannan (Kelowna—Lake Country, CPC): Thank you, Mr. Chair. That's a hard act to follow.

Thank you to both of you for presenting. I had the chance to review your information. Like my colleague Ms. Hinton, I come from British Columbia. UBC has done some excellent research with gerontology and studying fall prevention. We have five different health authorities, and as you say, one size doesn't fit all veterans. That's the same within the whole country, because there are geographic and demographic differences.

In my riding I have the largest percentage of seniors 65 and older of any census metropolitan area in Canada, so I'm very familiar with the whole issue of trying to reduce hip replacements and knee replacements, not only from aging, osteoporosis, but slips and falls. I've found that we have had pretty good success within our health authority.

From your experience, do you find there's been some good dialogue between Veterans Affairs and Health Canada in working on educational programs, or do you see an area for improvement there?

Mr. Mark Speechley: If I could just answer briefly, when the fall prevention initiative was under way it was clear that the two agencies were communicating very clearly and it was a great partnership. My understanding was that the Department of Veterans Affairs approached Health Canada because Health Canada had more experience in actual health research, but when the program ended, as far as I know, so did the collaboration. That's my impression. I wish it had continued.

Mr. Ron Cannan: Let's see if we can figure out where it broke away and see if we can bring the parties together again, because definitely from your information you've shown there is proof that the prevention education works.

In your studies, have you been able to come across, as my colleague Mr. Sweet alluded to, health prevention, whether it's in diabetes or with aging, and in this case, with veterans, that there are dollars invested in prevention that will actually save down the road in health care? Have you been able to quantify that in any research?

Mr. Mark Speechley: It's very difficult to do, because it's difficult to show that something was prevented. It's easy to show that something happened. To my knowledge, that's sort of the third rail of primary prevention research, to show that if I spend $10, I can save $100; and even if we can come up with that number, how long is it going to take to save the $100?

● (1655)

Mr. Ron Cannan: I can understand. That's a challenge we all face. You have only so many dollars and you want to make sure you get the largest impact with those investments.

The last one has to do with exercise. We all have a responsibility to look after our own self at whatever age we are, and we want to make exercise fun. I commend the video-gaming companies and the Christmas rush for the Wii. Some veterans and seniors in my community have purchased them. You go to the senior centres and now they're suffering from different injuries from playing too much bowling, and fighting over who's going to play tennis.

Do you have any ideas on how we can make exercise more fun and challenge people? Some people are limited as far as their mobility is concerned because of incidents they've had serving, as a veteran, as a member of the Canadian Forces. A lot of times it's stimulating the heart and keeping the mind active, because some of their limbs may have less mobility. From your studies, have you come up with some interesting ways you can maybe pass along as well?

Mrs. Clara Fitzgerald: Sure. I'd be pleased to let you know that the Canadian Centre for Activity and Aging has been doing extensive work with Vancouver Coastal Health and the other health authorities in British Columbia to translate some of the knowledge from various studies we've done, primarily in care facilities, to help to maintain and restore the functional abilities of frail older people living in care facilities in British Columbia.

Instead of those regional health authorities reinventing the wheel, they looked at who was doing research, brought in the people who've done the research, applied it, and trained the staff. So you'd be happy to know they're not reinventing the wheel; they're actually looking at where the research is and putting it into place. I commend Vancouver Coastal Health for that direction.

As far as your question goes, how can you make physical activity more fun, I would add, how can you make it more enjoyable so that people actually stick to the program? All of us in this room, whether we're older people or not, know what the health benefits of physical activity are. We might even know where to go, what to do, and so on, but sticking to the program, the adherence, is the tough part.

Certainly incorporating a spoonful of sugar, a recreational component to make it somewhat enjoyable for the older person, is essential to keep them coming, but what's critical is that they become aware of what the functional gains of the program are for them specifically, and that over time the program does not become a recreational diversion, especially if the outcome of the program is intended to help the person maintain or restore their functional gains.

That's where many programs nationally fall short. They start off as evidence-based programs, and then they're reduced to recreational fun: let's everybody sit in a circle and have a good time. So that messaging to older people has to be clear. I think that recreational component is critical but shouldn't be the be-all and end-all of the physical activity intervention.

Mr. Ron Cannan: Thank you very much for your passion and interest. It's going to help us all in the end.

The Chair: I think I've exhausted the list of those people who want to ask questions.

I want to thank our witnesses. You've been a spoonful of sugar to us. Thank you very much for your testimony today. We're of course incorporating all this into the things that will come out with regard to health care for our veterans, so I appreciate it.

Just as you wrap up and what have you, there's some other committee business I want to deal with for members of the committee.

I know there was an exchange between Mr. Cannan and our guests with regard to health issues. On Thursday we're going to have Health Canada come in, so we'll continue that discussion.

There are some other people our clerk is looking to get in. One is Maggie Gibson, who is standing in for Howard Bergman, from the National Initiative for the Care of the Elderly, or NICE, as it's called.

There's also Terry Wickens, national president of the Korea Veterans Association of Canada; and Dr. Gloria Gutman, from the Department of Gerontology, Simon Fraser University. You were on our list, and now you have appeared.

There are some other people who wish to appear: Cathy Moore, national director, consumer and government relations, Canadian National Institute for the Blind; Bernard Nunan, researcher-writer for the Canadian National Institute for the Blind; and the Aboriginal Veterans Association of Canada.

We have those down.

As well, I have a quick update with regard to the trips on this matter. We're looking to do Comox, Cold Lake, Shearwater, and Goose Bay just before the break, the week of February 11; Valcartier on February 28; and Petawawa on March 6—just to bring the committee fully up to speed.

That's that.

● (1700)

Mr. Brent St. Denis: Are we going to discuss the trip?

The Chair: I was intending to adjourn, but if you wish, we can discuss it.

Mr. Brent St. Denis: Remember the issue we had at the budget committee. Was there any place dropped form the original list?

The Chair: No.

Mr. Brent St. Denis: What was the issue? Just remind me.

The Chair: Just to apprise committee members, I think I may have to be careful in terms of how I discuss this, because I'm not sure that the goings on of the liaison committee are....

An hon. member: In general terms.

The Chair: In general terms.

The suggestion was that we travel to all of the places mentioned, but that we travel at half strength, in a sense. I think there are some committee members who, because of conflicting committee assignments and what not, in terms of times.... We probably wouldn't be able to have a full component anyhow. It's a question, really, of the difference between a not-full component and half a component. Well, I'm not sure how big that is.

Mr. Brent St. Denis: What was the breakdown with the number of members?

The Chair: The clerk may remember better than I. Was it six?

The Clerk of the Committee (Mr. Alexandre Roger): Six west and six east.

Mr. Brent St. Denis: How do you break down the six? Is it six plus the chair, or six with the chair?

The Chair: Six with the chair. So that's five.

Mr. Brent St. Denis: Five other members. How do you do that?

The Chair: I'll let the clerk explain that.

Mr. Brent St. Denis: Could we have a quick discussion so that we can get some answers?

The Chair: I'm asking the clerk, because he has a better grasp of it than I do.

The Clerk: It's six including the chair. Basically, the chair goes on only one side. Because there are twelve members of the committee, we split it right down the line in the middle. So six members will go on one side, and a different set of six members will go on the other side.

Mr. Brent St. Denis: So it's not a party breakdown. You have twelve people, and you pick the half you can go on.

The Chair: That's right.

From what I understand, talking to some of my colleagues, at least on the Conservative side, I don't believe that everybody can travel. That being said, I think it's a little more accommodating than what you may initially think.

There is a plan, of course, to go back to the liaison committee. I certainly am supportive of the committee travelling as a whole. I would please ask you to talk to the members of your respective parties so that they clearly understand, when it comes before liaison, what we all wish.

Mr. Brent St. Denis: May I make a comment on that, Mr. Chair?

The Chair: Yes, of course.

Mr. Brent St. Denis: Peter, can you hear? This is mostly for your benefit.

You may recall you reported as you did, and then in the dying days of the session before Christmas I spoke to our whip, who spoke to the Bloc and the Conservatives, and we were going to have a unanimous motion in the House to revert to the original budget.

We need Peter to get his whip onside.

The Chair: Mr. Stoffer.

Mr. Peter Stoffer: I'll authorize it right now. I'll speak to Yvon.

The Chair: All the other parties were in agreement on this negotiation, and the NDP—

Mr. Peter Stoffer: Ours said no?

The Chair: It is true, sir.

Mr. Brent St. Denis: Your whip said no, Peter. We had it all set.

Mr. Peter Stoffer: I will talk to him.

The Chair: All right. In the full light of time, I'm sure all will be made available.

Mr. Valley, did you have something you wanted to say?

Mr. Roger Valley: We need to know as soon as possible. I know it's difficult, but I can't just snap my fingers and leave my riding. The odds of my getting a flight out anywhere.... I can drive somewhere. It's very difficult if I don't work six to eight weeks ahead.

The Chair: Believe you me, I tried both through negotiations through the party whips and through the liaison committee, and I will try again through the liaison committee. I ask all of you to flex your muscles with your respective people and we'll do the best we can.

Monsieur Perron.

[*Translation*]

Mr. Gilles-A. Perron: Just before the Christmas break, I asked about the working conditions for civilians in Afghanistan and for their suggestions. I did not ask for a report or a study, but Michel took the initiative of preparing one. He came up with a terrific report, which I had the time to read while the rest of you were arguing with one another.

Thank you very much, Michel, you did a great job. Take a look at it. It's very well done.

● (1705)

[*English*]

The Chair: Yes, understood. Well, congratulations to Michel for his work.

Mr. Russell.

Mr. Todd Russell (Labrador, Lib.): Thank you, Mr. Chair.

I appreciate the work you and the clerk are doing on this matter. When can we have some firm dates and places?

The Chair: These are firm dates. The only thing that's going to wiggle at this point is how many people go, and that will depend on the decision of the liaison committee.

So once again, I do stress to members, please talk to your people on the liaison committee for the respective parties.

Mr. Todd Russell: What are the dates?

The Chair: Once again, Comox, Cold Lake, Shearwater, and Goose Bay would be the week of February 11, before the break week, so it would be a week of travelling. Call it the first full working week in February.

And then we visit Valcartier on February 28, later that month. That's a day trip. That's pretty easy.

And a visit to Petawawa will be on March 6, just into the beginning of the next month. That's a day trip as well.

Mr. Stoffer.

Mr. Peter Stoffer: Just to bootleg, when we're in Petawawa, do you remember the story last year of the children who were having difficulties? There was an agreement between the federal government and the provincial government to provide psychological assistance to those children. While we are there, is it possible to get just a quick update of how that program is going? Would that be possible?

The Chair: Well, Mr. Stoffer, you can talk to the clerk about it. I don't know what arrangements have been made with regard to the base. Certainly you can ask with regard to that when we're there. Maybe you would want to talk with the clerk about that.

Mr. Peter Stoffer: Fair enough.

The Chair: Mr. St. Denis.

Mr. Brent St. Denis: I'm sorry, I had missed.... Goose Bay was with Comox, Shearwater, Cold Lake?

The Chair: Yes, sir. That's right. It's part of our big package.

Mr. Brent St. Denis: The longer trip is all the further—

The Chair: That is correct.

Everybody understands the marching orders, then, are to please talk to your whips, talk to the people from your various parties on the liaison committee, and then hopefully we can all travel together.

The meeting is adjourned.

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