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Chair

Mr. Rob Anders

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● (1530)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Good afternoon, ladies and gentlemen. I'm glad everybody is in happy spirits.

Pursuant to Standing Order 108(2), we are yet again into a study of the veterans health care review and veterans independence program. Today we have a full roster of witnesses. That's very exciting.

With the Public Health Agency of Canada we have John Cox, the acting director for the division of aging and seniors. Then we have Claude Rocan, director general for the centre for health promotion. With the Canadian Institutes of Health Research we have Linda Mealing, assistant director of partnerships, institute of aging. With the Department of Health we have Nancy Milroy-Swainson, director, chronic and continuing care division, health policy branch.

Thank you very much for coming today to appear before us. We generally give twenty minutes to the witnesses.

We have Mr. Rocan for ten minutes, I understand.

Mr. Claude Rocan (Director General, Centre for Health Promotion, Public Health Agency of Canada): It will probably be closer to ten to fifteen minutes.

The Chair: Perfect. Go to twenty minutes if you really want. That's fine.

We will open it to questions in a predetermined order for the members of the committee. Then as they ask questions you may want to refer some of those answers. I'm guessing that's why your other friends are here today.

Mr. Claude Rocan, the floor is yours.

Mr. Claude Rocan: Thanks very much.

I'll be making this presentation on behalf of the health portfolio, as you've mentioned. Thank you for inviting us to speak to you today about healthy aging for Canadians, and how the results of our work relate to this committee's review of veterans health care.

You've asked us to focus on the issues from a general seniors population perspective that you can consider in your deliberations on the recommendations of the Gerontological Advisory Council and the report *Keeping the Promise*. You specifically want us to help you consider the recommendation for increased health promotion and innovative service delivery that would help to better meet the health needs of Canada's military service veterans today and into the future.

[*Translation*]

My focus today is on the public health role in healthy aging—what it is, how it can be achieved, its benefits to older Canadians, their families and to Canadians in general. I will highlight trends and research that support a health promotion approach to meeting seniors' health needs including veterans, and provide some examples of the many and varied initiatives and research undertaken by the Public Health Agency of Canada and our partners in the federal health portfolio.

Our work clearly confirms the importance of intensifying population-based approaches to promoting healthy aging.

[*English*]

Let me start by telling you about our role. The federal health portfolio, which includes Health Canada, the Public Health Agency of Canada, Canadian Institutes of Health Research, and other organizations, works to help the people of Canada maintain and improve their health. The mission of the Public Health Agency of Canada is to promote and protect the health of Canadians through leadership, partnership, innovation, and action in public health. We work to promote health and prevent disease and injury, and on emergency preparedness and response. Our work also includes laboratory testing and regulation that support action during infectious disease outbreaks and emergencies.

The public health role related to seniors is guided by a focus on healthy aging; that is, a lifelong process of optimizing opportunities for improving and preserving health and physical, social, and mental wellness; independence; quality of life; and enhancing successful life-course transitions.

The broad definition is consistent with and adapted from the World Health Organization's definition of active aging. It also reflects our knowledge that a number of factors interact to influence our physical, mental, social, and spiritual well-being—such factors as income, education, health services, personal health practices, and coping skills to name a few.

● (1535)

[*Translation*]

This approach encourages us to focus our efforts upstream—that is, before people become ill or injured. At the same time, we need to support those living with chronic disease and disability and help prevent further illness among this vulnerable group which can include veterans.

Let's also set the stage with some facts about seniors, their health and healthy aging. It won't surprise you to hear that as individuals and as a population, Canadians are aging. While today, people aged 65 and over make up some 13% of the Canadian population, by 2041, they will account for 25% of the total population, and they will number some nine million people.

[*English*]

The good news is that older Canadians are living longer and with fewer disabilities than the generations before them.

Almost three quarters of seniors living at home in 2003 rate their overall health as good, very good, or excellent. Nearly one half of seniors say they are physically active. A third report getting a flu shot within the last year—that's as of 2005. Seniors are active in social and economic life in their communities. They are working longer, and when they retire from paid employment they continue to play a vital role in a wide range of community activities—on boards, in schools, and by providing vital support to families and other seniors. Clearly, seniors are taking action to look after their health and well-being.

However, there's more to this picture. We also know that a large majority of seniors—that's 85% of those aged 65 to 79—have at least one chronic disease or condition, such as asthma, arthritis, rheumatism, high blood pressure, emphysema, chronic obstructive pulmonary disease, diabetes, heart disease, cancer, schizophrenia, mood or anxiety disorder, or obesity.

More than one in four have four or more chronic diseases. Prevalence is higher among our most vulnerable seniors—for example, economically disadvantaged groups. Some 15% of Canadians aged 65 and over have been diagnosed with diabetes. In 2007, an estimated 70,000 new cancer cases occurred among Canadians aged 70 years or older.

Disability rates increase with age, from 31% among younger seniors—that's the 65-to-74-years group—to 53% for older Canadians. For these people, everyday activities are limited because of a health condition or problem.

Seniors, especially those over 85, are much more likely to have Alzheimer's disease or related dementia; one in three older seniors is affected. By 2031, we can expect the number of Canadians with dementia to triple from its 1991 level.

[*Translation*]

Clearly, chronic diseases account for an enormous burden—to individuals, their families and other informal caregivers, to the health care system and to the Canadian economy.

Chronic diseases are responsible for 67% of total direct costs in health care and 60% of total indirect costs ($52 billion) as a result of early death, loss of productivity and foregone income.

Promoting health is therefore something that definitely makes sense. The federal government works closely with provinces and territories to find ways to collaborate in the area of seniors' health.

[*English*]

Our work as co-lead of Canada's working group on healthy aging and seniors' wellness—that's a working group of the federal-provincial-territorial ministers responsible for seniors—resulted in a report called *Healthy Aging in Canada: A New Vision, a Vital Investment*. This 2006 report brings together our knowledge about seniors' health; research, including what we know and don't know about what contributes to the health and well-being of seniors and what public health interventions play a role; as well as a recommended framework for action.

This and other research tells us that, for example, there is a clear need for and there are clear benefits associated with helping people maintain optimal health and quality of life at every stage of life.

Relative to all other population groups, healthy lifestyle changes have the greatest impact on health status for seniors. For example, later-life introduction of regular physical activity can extend years of life and years of independent living and can improve the quality of life of older people.

Health promotion efforts are important to disease prevention. Up to 70% of cancers, 90% of type 2 diabetes cases, and 50% to 70% of strokes are preventable.

Seniors living at home generally want to avoid entering a long-term care facility. Moreover, home care can be a cost-effective alternative to long-term facility care, and long-term care in the home can reduce or avoid the need for costly acute-care hospitalization.

● (1540)

[*Translation*]

So by providing the right supports and services at the right time in the right setting, we can better promote and support the health of Canadians as they age, while reducing the burden on the already overwhelmed system.

[*English*]

Let's turn to some of our recent and current work, starting with building the evidence base.

A key aspect of public health is the continual monitoring of trends and emerging issues. We work with partners to collect and analyze data on chronic disease and other health issues, making it available to researchers and decision-makers. Here are some highlights:

Our chronic disease infobase profiles the epidemiology of major non-communicable diseases in Canada, including most current cancers and cardiovascular and respiratory diseases, by province and territory and by regional health unit.

The Canadian integrated public health surveillance service brings together the strategic alliance of public health and information technology professionals, working collaboratively to build an integrated suite of computer and database tools specifically for use by Canadian public health professionals.

The Public Health Agency of Canada and Health Canada have been working with Statistics Canada to develop the Canadian community health survey on healthy aging. This survey will deal with the topic of aging and factors that affect healthy aging such as general health and well-being, use of health care services, social support networks, and work-and-retirement transitions. Data collection will take place for a year, beginning in the summer of 2008.

[*Translation*]

The Canadian Institutes of Health Research is investing in age-related research to create knowledge in the field of aging and advance the knowledge into action to improve the quality of life and health of older Canadians. In 2006-07 this investment totalled over $85 million. The lead CIHR Institutes in this area are the Institute of Aging and the Institute of Health Services and Research Policy.

We must find new and better ways of chronic care management. While prevention of disease is critical, we must also address the needs of Canadians, including seniors, with chronic disease and to prevent further illness, injury and disability.

[*English*]

One of our current and important initiatives in this area is the Canadian diabetes strategy's national project with the Active Living Coalition for Older Adults, aimed at supporting older adults in leading a healthy-activity lifestyle. Ultimately, our work will result in a comprehensive action plan to address diabetes among older adults.

The Canadian best practices portal for health promotion and chronic disease prevention contains relevant and accessible best practices information to enhance decision-making for practitioners, policy-makers, and researchers. The portal currently provides access to 16 interventions to help seniors prevent and address chronic disease and promote health, related to nutrition, physical activity, smoking cessation, and other issues.

The Public Health Agency of Canada also works with a national network of experts to address the public health needs of the population of seniors with cancer and better meet their needs, in particular to understand the scope and nature of support needed and the issues related to concurrent conditions in mental health as well as education and awareness.

Related to improving the mental health of seniors, it is estimated that one in five seniors suffers from a mental health disorder, including depression, cognitive impairment and/or dementia, anxiety disorder, addictions, psychosis, bipolar disorders, and schizophrenia. The number of seniors diagnosed with Alzheimer's disease is expected to almost double from 435,000 in 2006 to 750,000 in 2031. Poor mental health can contribute to a decline in physical health and serious stress on family and friends, and can lead to excessive use of the health care system, including longer hospital stays.

The Public Health Agency of Canada has funded the Canadian Coalition on Seniors Mental Health to develop the first-ever national guidelines on seniors' mental health. These will make an important contribution to the assessment, diagnosis, and treatment of mental health problems among seniors.

● (1545)

[*Translation*]

The agency has also funded the development of a policy guide for home care staff to help them better meet the mental health needs of seniors. We are working with the Canadian Institutes on Health Research—the Institute of Aging—to support research on cognitive development.

[*English*]

Preventing falls is another very significant issue in the area of seniors and aging. Falls are the most common cause of injury among seniors, and they are preventable. Seniors fall at enormous cost. One in three seniors falls each year. Falls account for 85% of all injury-related hospitalizations, at a cost to the health care system of over $1 billion a year. Injuries from falls and fear of falling are barriers to social inclusion of seniors.

Included in our work on this issue was a collaborative venture between Health Canada and Veterans Affairs Canada to fund community-based health promotion projects to help identify effective falls-prevention strategies for veterans and seniors. The work and its results are in active use. For example, Community Links, a not-for-profit organization in Nova Scotia, developed an initiative called “Preventing Falls Together”, which was launched in 2004 and has become an integral part of Nova Scotia's injury prevention strategy.

[*Translation*]

Building on our State of Falls report, the Public Health Agency of Canada will hold a workshop in February to gather advice from falls prevention practitioners, surveillance experts and researchers from across Canada to lay the ground work for coordinated use of data sources and enhanced capacity to track the prevalence, incidence and outcome of seniors' falls in Canada.

[*English*]

With regard to emergency preparedness, people aged 60 and over have the highest death rates of any age group during disasters. Some recent catastrophic events in Canada and elsewhere highlight the vulnerability of this group and the need for planning and cooperation to support seniors during such emergencies as SARS and weather-related and other potential disasters.

The Public Health Agency of Canada, through its division of aging and seniors as well as through its Centre For Emergency Preparedness and Response, continues to provide national and international leadership by addressing seniors' needs and their contributions in the event of a large-scale emergency.

We have worked with partners at home and internationally, with governments and NGOs, with the media, academics, the private sector, and seniors to address emergency planning for seniors.

[*Translation*]

Canada has been invited to address the issue at the UN Commission for Social Development in February. In March we will host an international workshop focused on strengthening networks, identifying best practices and effective messages about emergency preparedness for seniors.

[*English*]

Finally, I would like to highlight our important national and international work on age-friendly cities. We know that the collective challenges in shaping communities that meet the needs of an aging population are immense. In order to create sustainable responses and capitalize on Canada's opportunities to address the complexities we face, all sectors of society and levels of government must be engaged.

As you have heard from others, seniors are vital contributors to the development of innovative and effective solutions. They live the challenges; they know what works and what doesn't; and they have expertise to inform approaches and decisions.

At the same time, the business community, municipal officials, the academic and voluntary organizations are all interested and valuable participants. Over the past two years, at both the international and domestic level, the Public Health Agency of Canada has collaborated in developing innovative models for promoting age-friendly communities.

In an age-friendly community, policies, services, and structures related to the physical and social environment are designed to support and enable older people to age actively, that is, to live in security, enjoy good health, and continue to participate fully in society. Public and commercial settings and services are made accessible to accommodate varying levels of ability.

● (1550)

[*Translation*]

Age-friendly service providers, public officials, community leaders, faith and business leaders alike all recognize the greater diversity among older persons, value and promote their inclusion and contribution in all areas of community life, respect their decisions and lifestyle choices, and anticipate and respond flexibly to aging-related needs and preferences.

[*English*]

Working guides for cities and small communities have been created and are attracting very enthusiastic reaction and interest in Canada and internationally. Manitoba and British Columbia have started using the age-friendly communities model, and other jurisdictions—Quebec, Nova Scotia, and Newfoundland and Labrador—are examining how they can use it.

The Chair: We want to make sure translation has that right.

You can proceed.

Mr. Claude Rocan: The federal-provincial-territorial ministers responsible for seniors recently endorsed the model and encouraged the Public Health Agency to provide leadership in expanding its application across the country. We are now actively pursuing this charge, building on the broad and keen interest that already exists.

We believe that the age-friendly communities model can help seniors and all of the stakeholders in Canada's aging population to determine and initiate needed action that is responsive to and respectful of local needs and jurisdictional priorities.

In closing, I would say that evidence clearly demonstrates that older adults can live longer, healthier lives by staying socially connected, increasing their levels of physical activity, eating in a healthy way, taking steps to minimize their risks for falls, and refraining from smoking.

[*Translation*]

Canadian and international research shows that providing supporting and age-friendly environments and opportunities—the policies, services, programs and surroundings—to enable healthy aging enhances the independence and quality of life of older people.

[*English*]

I focused my comments today on a public health approach for addressing the health of older Canadians. Because our work addresses the health of all Canadians, it's highly relevant to your considerations concerning Canada's current and future veterans, including younger men and, increasingly, women.

The Chair: Thank you. You were bang on twenty minutes. That's quite impressive.

I have some questions of my own, but I imagine committee members will get to them. At least I hope so.

First we will go to the Liberal Party of Canada. Mr. Russell, for seven minutes.

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

I appreciated your testimony and presentation.

Your presentation dealt generally with aging throughout the Canadian population. Has there been work focused on veterans, and were there any differences found in the research that came out of those studies?

Our brief from the researcher mentions a 2002 study focusing on the mental health of Canadian soldiers. Some say as many as 25% of our veterans, mainly those who have recently been in difficult situations, are suffering from post-traumatic stress disorder. I'm wondering if any work has been conducted in that field and if any effort is being put into that problem. What partnerships does the Public Health Agency of Canada have with Veterans Affairs, and what ongoing or past work have you done that could help inform our committee's work?

● (1555)

Mr. Claude Rocan: With regard to the first part of your question, our work is indeed based on a population health approach. We look broadly at the health of Canadians and at aging.

In reference to the last part of your question, we have partnerships with Veterans Affairs. For example, we worked closely with Veterans Affairs on a study of falls. Together, we tested a number of national pilot projects, shared the results, and disseminated them. There is a federal interdepartmental committee on aging, chaired by the Department of Human Resources and Social Development. We participate on that committee, as does Veterans Affairs Canada. It is an opportunity for us to share information and to learn about public concerns. If we have knowledge that can be useful to them, we are glad to have the opportunity to share it.

I am going to ask my colleague John Cox to speak to the study on mental health.

Mr. John Cox (Acting Director, Division of Ageing and Seniors, Public Health Agency of Canada): I'll confess I'm not familiar with the particular study to which you referred. I would need to find out more about it, unless other colleagues here are familiar with it. In general, however, we have done a range of work on mental health issues affecting the seniors population, and we have provided work through voluntary sector partners. We contributed to the development of a lens on the mental health of seniors and persons with dementia.

There's a wide range of concern being expressed, and we need to address how we can make distinctions between some of the views commonly ascribed to aging, which are in fact issues of mental health. Situations arise in which someone is seen as just getting older, but being older is not a proper diagnosis for depression or other psychiatric disabilities, which impinge on older people and their families.

We are continuing to do work of this nature as we move forward.

Mr. Todd Russell: To follow up on that, Ms. Mealing, you're with the Canadian Institutes of Health Research. Is there any work being done on mental health, particularly post-traumatic stress disorder?

Dr. Linda Mealing (Assistant Director, Partnerships, Institute of Aging, Canadian Institutes of Health Research): Yes. There are 13 institutes at CIHR, one of which is the Institute of Neurosciences, Mental Health and Addiction. They are currently in discussions with Veterans Affairs Canada on partnerships dealing with post-traumatic stress.

We have funded exciting work in the past out of McGill University that showed how certain drugs can erase the fear associated with the memory of post-traumatic stress, though not necessarily the memory. You remember, but you don't have the emotional reaction to it. There is that kind of work going on, which is quite exciting.

Other researchers are looking at delirium and depression in veterans care program settings. Because the physiology of a senior person is different from that of a younger person, sometimes drugs for depression don't work well, so people are studying this.

Does that answer your question?

● (1600)

Mr. Todd Russell: Yes, thank you.

I want to turn to a specific issue, and maybe it is an apparent contradiction. On page 5 you say that almost three-quarters of seniors living at home rate their overall health as good, very good, or excellent. On the next page, on page 6, it says a large majority of seniors, 85%, have at least one chronic disease, and 25% have at least four. How do those two statements come together? They seem to be contradictory. You have four kinds of diseases, but you still say your health is good, very good, or excellent.

It's a state of mind, I guess. Is it a comment on the management of the chronic diseases? Are people managing them better?

Mr. Claude Rocan: Again, I think it is a question of state of mind. The responses are subjective, so it's how people feel about their condition. What it speaks to is a fairly positive disposition, which I think is encouraging. It's certainly something to build on.

Mr. Todd Russell: Thank you.

The Chair: Now over to Monsieur Perron, with the Bloc Québécois, for seven minutes.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Ladies and gentlemen, thank you for coming and testifying. I don't know how to ask my question. Mr. Rocan, your presentation was fantastic. It was good, very good, very very good, but it seemed a little too good.

In society, there are no doubt more problems related to seniors, of whom I am one since I'm more than 64 years of age, to which we don't have any solutions. What do we do with post-traumatic stress syndrome cases. How are we Canadians and Quebeckers equipped to care for these people suffering from post-traumatic stress syndrome, that is to say those who have suffered psychological injury in war?

I would also like you to give us some possible solutions to the following problems. You say that home care is a miracle for seniors. I believe in that: seniors should be kept in their family environment as long as possible. Are we equipped with co-generational housing? Do we have the necessary medical staff? What about family caregivers? Let's take the example of my son, if he decides to take care of me one day. I hope he'll have the heart to do it, and I believe that will be the case, but will he have the necessary skills to take care of his old father and mother?

Those are questions that concern me at 64 years of age. You say things are going so well, that research has been done, but we're not considering the existing problems with existing solutions or the problems that we may have. How can we get solutions to all the problems that seniors have today?

Mr. Claude Rocan: That's a very interesting question; thank you for it.

In fact, I wanted to describe what we're doing in the field and to talk about the challenges we're facing, but I definitely didn't want to give the impression that the challenges are minor. There are definitely some very important questions that have to be answered, and I think we're preparing to attack them.

I believe we've already talked a little about post-traumatic stress syndrome. We're doing research in that area. Do we have any potential solutions? I don't know exactly. Linda may want to talk about that a little more. That's a good question.

I talked about mental health in my speech; that's definitely a very important question for seniors. I also talked about the percentage of people suffering from Alzheimer's disease. These are definitely major challenges.

Mr. Gilles-A. Perron: Allow me to speak. I would have preferred you to focus on one or two subjects, and for us to deal with them. For example, let's take the problem of falls. You say that's the main problem for seniors. Why didn't we focus on that? Why didn't we talk about the existing problems, and say how we could solve them and what the solutions were? You're painting a nice picture of the situation, and I'm “buying” the picture. It's true that research is being done.

I went to Sainte-Anne-de-Bellevue. They're doing fantastic research there on post-traumatic stress syndrome. The Americans are also doing fantastic research on post-traumatic stress syndrome. We have tools, but we're short of psychologists. Where do we go? How can we ask the provinces and universities to train psychologists? Because we know that the problem is a personnel shortage. I believe the number or medical employees virtually everywhere in Canada will decline instead of increase. There is a shortage of professionals in all provinces of Canada.

So I would have expected you to say how we can go about asking the provinces to improve and develop staff so that we can have the necessary tools to take care of future seniors like me. Perhaps I'm speaking a little selfishly, but I'm a little old man, I know!

● (1605)

Mr. Claude Rocan: I could ask Ms. Milroy-Swainson to talk about medical and professional staff.

Mrs. Nancy Milroy-Swainson (Director, Chronic and Continuing Care Division. Helath Policy Branch, Department of Health): You're right, this is a very big challenge, but one that's present around the world. We share our experience and our ideas with other countries, at certain conferences, in the context of other partnerships. In Canada, we have the Health Human Resources Action Plan. This is a plan established by the provincial, territorial and federal governments. We're working together to develop a common plan. How are we going to go about it? We're going to start by improving the training of a number of types of health professionals as regards their ability to care for a lot of problems, particularly chronic diseases. In that regard, we're working closely with the provinces, territories and also our partners—like the Canadian Medical Association—to develop certain training projects for physicians, psychologists and nurses. We're working on this problem. You're right, it's a real challenge, and we see that we have to address it.

Mr. Gilles-A. Perron: I'd like to talk to you about something else. I know that the University of Sherbrooke has a research chair specializing in aging which is apparently recognized worldwide. Is the research done there being transmitted around the world? Is it being kept in isolation? A lot of research is being done, but one would say it dies somewhere. We politicians and citizens don't know what the results are or where we're headed. For example, people talk about therapeutic cloning to cure Alzheimer's disease and diabetes. Where do we stand on that? Is that a solution to the problem or not? People are concerned because they're in the dark.

Mr. Claude Rocan: I'll react quickly by saying that this role is very important for the Public Health Agency of Canada. Our mandate is to develop knowledge and to transmit it. That's why we do a lot of work in cooperation with our partners, the provinces and territorial governments, and with other non-governmental partners. We find that the transmission of the knowledge and information that we have is very important in such a complex field. The Canadian Institutes of Health Research are concerned with developing knowledge and conducting the necessary research.

● (1610)

Dr. Linda Mealing: I can add something, if you wish.

We're definitely developing knowledge at the Canadian Institutes of Health Research, but our mandate is also to ensure that that knowledge is applied. We're now offering new fellowships to give researchers the opportunity to develop techniques for more effectively transferring knowledge to the public and to practitioners and decision-makers. Every target is different, and there are different cultures and policies. We're also trying to study the transfer process. The transfer of knowledge application is supposedly a science. That's not my field, but we're studying that.

Last year, for example, we established a program for a network on Alzheimer's disease and dementias. In that network, we require that researchers form a network with non-researchers, that is with individuals who work at the Alzheimer Society of Canada, to ensure that the knowledge we already have is applied to patients by caregivers and physicians. At the same time, practitioners and decision-makers have to be taught to go get the knowledge that will help them make decisions.

Practitioners also have to be educated so that they get into the habit of looking for knowledge. That works both ways. In addition, this network must give young researchers skills so that they can work with non-researchers. Traditionally, researchers have worked in their labs, whereas practitioners and politicians have worked in their offices. While they are young, we want them to be able to start acquiring work experience with individuals who practise a profession outside their field and discipline. That's an example.

That will start in March and will last five years. It's a pilot project. This is the first time the Natural Sciences and Engineering Research Council of Canada has done this on this scale.

Mr. Gilles-A. Perron: Thank you.

[*English*]

The Chair: Thank you.

Now on to Mr. Stoffer with the New Democratic Party, for five minutes.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you very much, Mr. Chairman, and thank you all very much for your presentation.

Sir, on page 5 of your presentation you put “The good news is...”, and I looked at the fourth paragraph and it says “Seniors are active in their communities and they're working longer”. Now, some seniors like to work longer; some seniors have no choice but to work in their senior years because their pensions don't necessarily qualify for them to maintain a decent life to be with their grandkids or their neighbours. I don't know if that's such good news. So I would caution you on that one, because some seniors I see working at McDonald's or Tim Hortons are there because they have no other choice to put bread on their tables. So I don't necessarily call that good news in that regard, but I thank you for that.

I see in this pamphlet you have that CLSA will be doing a questionnaire with 50,000 men and women aged 45 to 85 in the near future. I see some of these reports that come out and they can be somewhat wordy, somewhat difficult to answer. If you're a person who's elderly, who doesn't have a decent formal education through school—and many veterans left school in order to fight and they never got back—will these forms put it in a manner that is not dumbed down but is clearly understandable for them so they know exactly what they're ticking off when they fill out those forms?

Dr. Linda Mealing: I understand those surveys have been piloted.

During the development of the protocol for the study over the last two years they were validating certain tools, making sure the questions were understandable, especially when it came to consent and proxy consent and things like that.

So definitely, the target audience is taken into consideration in developing these questions. I think they've also been working with the CCHS, which has had experience with that at Stats Canada, to make sure the questions are understandable.

● (1615)

Mr. Peter Stoffer: The other concern is regarding first nations and working with that specific group. Are they targeted in the overall picture? Are they specifically looked at? A lot of them live on reserves. A lot of them may have suffered from residential school abuse, or other concerns of that nature. You mentioned diabetes in the native community. Diabetes is running rampant now. Have you incorporated them into the entire picture?

Also, we have many immigrants coming into the country now. Are there differences within populations, say those who are Caucasian, Asian, African, in terms of their diet and culture and mental well-being? What is the information showing in terms of Alzheimer's, their falling, dementia, etc.? Have you broken it down specifically, or have you had the resources to do that?

Thank you.

Mr. Claude Rocan: In terms of first nations, we involve the first nations and Inuit health part of Health Canada. They're very involved in these issues. You mentioned diabetes. There's an aboriginal diabetes strategy that focuses on the needs of that population. It's their role to focus specifically on that population, whereas the work we do is more geared toward the population of Canada as a whole.

With regard to immigrants, I'm going to ask John to speak to that.

Mr. John Cox: I would say there are two issues in play. One is actually identifying the sub-populations you're talking about. Immigrants are no less diverse than the population of seniors as a whole. We could be talking about recent immigrants or immigrants who have been established for some time but may not have adapted fully to either the English or French-language cultures in which they live. So there are specific challenges.

In my experience, the whole issue of seniors from external backgrounds is becoming much more of a factor in discussions. They are more of a factor in terms of service providers looking at how they deliver services in a way that a community such as the South Asian community of Vancouver might take advantage of what is known. At the same time, they want to learn from those communities what their first choices are and where they would go for help. Those may be different access points than we would normally see in a traditional non-immigrant community, if I can put it that way.

I think there's distinct attention being paid to them. We've worked through a variety of projects, for example, in looking at groups of older Canadians from a variety of different cultural and ethnic backgrounds to see what they can share with each other and what needs to be adopted. That carries over with a lot of our current work with international partners on a variety of issue areas, to see what we can pick up as well as what we can share.

I would say that the topic and the concern are well recognized, but the challenge remains and we have to keep at it.

Mr. Peter Stoffer: Thank you.

Mrs. Nancy Milroy-Swainson: I would like to add one thing. In addition to work we do within the portfolio with integrating concerns for first nations or multicultural requirements, we are also mindful of the need to include a first nations perspective.

For example, the Mental Health Commission of Canada is not formally a part of government, but there is a need to integrate mental health and first nations issues. It's similar to the cancer corporation. Both of those organizations are dealing with concerns of critical importance to seniors, and government is interested in making sure there's an aboriginal lens brought to bear on that work as well.

● (1620)

The Chair: Thank you.

Now we go over to the Conservative Party. Mrs. Hinton, for seven minutes.

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

I'm going to begin with some observations, if you don't mind. When you sit and listen to a number of other members speak, things start up in your mind and you might want to mention some of them.

I was very pleased, by the way, to hear you say that the departments within government are actually speaking to each other. I think that's a bonus right there, that intergovernmental conversations are taking place. I think it's wonderful.

I'm also very pleased, and I'm sure you must be very well aware of this, that for the first time in Canadian history this government has put a minister in place strictly for seniors. That's the Honourable Marjory LeBreton. I'm sure she would be delighted with all of the comments that have come out here. This is wonderful information.

I share the concern that my colleague Mr. Perron expressed earlier with regard to the number of doctors. We've had this conversation come up a few times, both personally and at committee. Speaking from personal experience I can tell you without hesitation that it takes a minimum of ten years to produce a doctor. I speak from experience, because I happen to be the parent of a doctor. If they specialize, it will take even longer.

So we have a little catch-up to happen here before we actually have enough physicians for our own country. But it is a worldwide problem. I was pleased to hear you say that as well. I didn't want to think that was my own opinion, that we have this problem worldwide.

In terms of aging, I have to tell you, you shocked me with the content of what you said. I'll go back to page 6, where it says that a large majority of seniors—85% of those aged 65 to 79—have at least one chronic disease or condition such as asthma, arthritis, rheumatism, high blood pressure, emphysema, chronic obstructive pulmonary disease, diabetes, heart disease, cancer, schizophrenia, mood or anxiety disorder, and obesity.

On page 9 you said that health promotion efforts are important to disease prevention and that up to 70% of cancers, 90% of type 2 diabetes cases, and 50% to 70% of strokes are preventable.

First you scared me on page 6, and then you gave me hope on page 9.

I'm going to give you an opportunity to elaborate. There could very well be many seniors listening to this broadcast. So could you tell us, in short form, what you think can actually happen to prevent these diseases? If you can prevent 70% of the cancers, 90% of type 2 diabetes, and 50% to 70% of the strokes, I think that's worth talking about.

Mr. Claude Rocan: Thanks for the opportunity.

There are some common risk factors that apply to a full range of chronic diseases, most of which have been mentioned here. They relate to physical activity, healthy eating, and smoking cessation, and of course healthy weight, which is related very often to physical activity and healthy eating.

Those are huge issues, and we certainly work very hard on those issues generally, as well as having a lens specifically in terms of the senior population. We do have a physical activity guide for older adults. In fact, we have four guides—for children, adolescents, adults, and older adults. There is very useful evidence-based information in those guides to help people make decisions about becoming physically active.

With regard to healthy eating, of course there's *Canada's Food Guide*, which has just been released in revised form. I think it was last year. Again, there is some specific information there for seniors, including advice in terms of taking vitamin D, which is very important to the senior population. There is also an aboriginal food guide that has been developed for aboriginal people. Of course, in terms of smoking cessation, there is very robust programming within the health portfolio to give people advice on how to stop smoking.

Those areas in and of themselves can make a huge difference in people's health status. We do work quite diligently in the area of health promotion to try to get those messages across and to work on the environmental factors that will make it easier for people to make the healthier choices as they relate to their own health.

● (1625)

Mrs. Betty Hinton: Thank you very much.

We heard from the last witnesses on Tuesday about falls by seniors, which you touched on again today. One of the conclusions I drew from the last witnesses was that it was really important to have the physicians we have in this country treating patients on a daily basis, and to make them aware of some of the options they have.

You were talking about education once again, or that's my take on what you just said. I was hoping there was some magic bullet you were going to tell me about, but you were talking about educating people to eat better and about the benefits of exercise. That's basically where you're going—which would also prevent a lot of falls.

Mr. Claude Rocan: Yes, but I think it goes beyond that as well.

I think it's education. I think it's knowledge about best practices: what sorts of interventions have been tried that have proven to be successful; learning from the experiences of other countries and jurisdictions; looking for partnerships to try to transmit that information at the community level; looking for ways of playing a catalyzing role, so that specific interventions can be conducted at the community level.

So I think there are a range of interventions, as well the more environmental types of activities I mentioned, for affecting how people live so they can make healthier choices more easily.

Mrs. Betty Hinton: I have another observation.

Having served as a school trustee for three terms in another life, I think we need to start a lot earlier with seniors on this exercise and healthy eating issue, because if we did that when children were in school and put the emphasis there then, we probably wouldn't be dealing with these problems later in life. One of the observations I made as a school trustee is that we encourage physical education in our school system—we build multi-million-dollar gymnasiums, and then we bus the children to school. It defeats the whole purpose. If children are in the position to be able to walk to school, there's free exercise right there. I guess it's just a matter of our thinking.

If I have any time left over, I will pass it to my colleague, Mr. Shipley.

The Chair: You're 33 seconds over your time, actually.

Mrs. Betty Hinton: Oh, never mind.

Sorry, Bev.

The Chair: Mr. Shipley will have ample opportunity.

Are there any responses by the witnesses?

Mr. Claude Rocan: I just want to mention briefly that I agree with your point entirely. In fact, we are engaged in what we call a joint consortium on school health, dealing with the whole range of health behaviours in schools, including the issue of physical activity.

Of course, from a federal government perspective, we don't have responsibility for what goes on in the schools, but we certainly participate in that forum, and use it as an opportunity to provide some information and some of the research results we have, and just try to play a helpful role in trying to encourage that sort of thinking, so we can make some connections.

I'll just mention briefly one example that I find very exciting, called the walking school bus idea, where seniors help children walk to school. The children are provided with an escort to the school, which deals with the safety and security issue, and it also deals with the physical activity needs of both the senior citizens and the children. So it has benefits from a number of different perspectives.

There are ideas like that, which some communities have tried, and we think it's very important to evaluate the impact of those interventions and, once we have a better handle on how they work, to share that knowledge and information with others who might be interested in trying something like that in their communities.

Mrs. Betty Hinton: A wonderful common-sense idea—really great.

The Chair: Yes, it sounds really good.

I had a comment I wanted to make, but I won't, because it would be inappropriate.

Some hon. members: Oh, oh!

The Chair: It was about a side conversation I had with Mr. St-Denis, but I'll just leave it at that.

Now over to the Liberal Party, and Mr. Valley, for five minutes.

Mr. Roger Valley (Kenora, Lib.): Ah, you're making up.

Thank you very much for coming. I apologize profusely. You've made the effort to get here, and I was a little late. I apologize. Generally, it's constituents who keep us that way, but I wanted to apologize.

I always learn from these presentations and I'm always writing notes and trying to figure out what words to use. Healthy aging and active aging are all important things for understanding how we're going to help everyone enjoy later life.

You go on, Claude, to say: “This approach encourages us to focus our efforts 'upstream'.”

On Tuesday we had a presenter here talking about falls and how important falls are. Later in your document you mention that. And we hear from veterans all the time—and I mentioned this to you today—that part of their problem is they're very hard of hearing: for one reason, because they're elderly; the second reason, we believe, is that simply every veteran we see has pretty well the same issue as a result of their service. They believe a lot of it is involved in their service.

I'll make a comment, and maybe some of you could give your opinion. If we're talking about going “upstream” or about keeping people healthy and active, and if we don't want them to fall, we should be much more prepared to listen to veterans when they need hearing assistance. That alone keeps them from falling, I believe; all of this has been more or less documented.

Is that what you mean by “upstream”: doing something to prevent anything that can happen in the future?

● (1630)

Mr. Claude Rocan: Yes, and it's trying to work, as I mentioned, on the environmental conditions that people live in so that they can avoid crises later on. The preventive agenda is core to the work we do in the public health area. So it's exactly along those lines.

Mr. Roger Valley: It seems we spend an awful lot of effort. When we have senior citizens who are veterans sitting in front of us who we know need hearing assistance, they can't get it for a couple of reasons. One reason is that the department doesn't always put enough value into their statements that it was involved with their service; another, that they simply can't afford it. So they end up facing issues such as a fall, which only makes it worse.

You also mention a couple of things about involvement and working guidelines for cities and small communities. You mention quite a few provinces, some that are active and some that are becoming more active. In the world....

The reason I ask this question is that I see later on in the document you talk about presenting to the UN. I think it's probably next month, is it, in February?

Mr. Claude Rocan: Yes, it's in February; in fact, next week.

Mr. Roger Valley: Where does Canada sit in the world? Are we leaders in some of this work? Is that why we're presenting to the UN? Can you place us in the world? You mentioned some provinces that are ahead, but place Canada in the world and tell us how we're fitting in.

Mr. Claude Rocan: Thank you for that opportunity.

Yes, in fact, we are very highly regarded in the world for the work we've done. The work related to age-friendly cities is something on which we've worked very closely with the World Health Organization.

It's been really pioneering work. Through it, we've developed a guide that is being used around the world. There are now, I think, 33 cities involved in that particular initiative. It's largely due to Canada's leadership, I think I can say, that this initiative has taken place. I think we've done a very significant job. We received an award from Help the Aged in the U.K. for the work we've done in this area.

The other area I would mention is the area of seniors in emergency situations. Again we've been the leader in that area. We hosted a workshop in Winnipeg last year, the results of which will be discussed and presented to the United Nations next week on February 8. We'll be following that up with a second workshop in March that will bring together a number of experts from around the world.

I think very fairly we can say that Canada has been the leader in the world in this area.

Mr. Roger Valley: I was fortunate enough to travel to Chile some time ago, where I recognized the value the world was putting on Canada's contributions.

You mentioned the workshop coming up in March. Can you give us a flavour of some of the countries around the world that are, I guess, coming out of respect for the work Canada is doing?

● (1635)

Mr. Claude Rocan: I'll ask John to speak to that, if you don't mind.

Mr. John Cox: Thank you.

We expect about 130 participants. It's a combined Canadian and international experience. Some of the countries will include Japan, Australia, Lebanon, and South America. I think we sent an invitation to people from Peru, for example, who have been very active with seniors on the ground in preparing for disasters or emergency situations. Probably 20 different countries or states will send experts or representatives to this meeting in Halifax in March.

Mr. Roger Valley: Thank you very much.

[*Translation*]

The Chair: I now give Mr. Gaudet the floor. You have five minutes.

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

Good afternoon, everyone. My mother is 98 years old, and I hope I'll live at home as long as she has, and she's still living at home. I wonder what Health Canada is doing for her. It's my sister who takes care of her. My mother is in perfect health, and she goes out every Sunday and even two or three times a week. What does Health Canada do to help people keep seniors at home? The help we've had so far comes from the CLSC nurse, who comes and washes her once or twice a week. The rest of the time, she goes out with us every week. Last Sunday, I went and had lunch with her. She's in great shape.

We would like her to die at home. My father died at home 25 years ago. We were 11 children at the time. Only 10 are left now, and we take of our mother.

What does Health Canada do to help people stay at home with their children?

Mr. Claude Rocan: I must say your mother is very lucky.

Health care is a provincial jurisdiction, and we don't interfere in it directly. Perhaps Nancy can talk about some of our initiatives.

As I mentioned in my presentation, we're mainly concerned with knowledge development. We're trying to share our knowledge. We're working with the other provincial and territorial governments in Canada. We're trying to work strategically with those governments and with non-profit organizations, research institutes and universities, to gain a clearer understanding of what it is to age in good health and a better understanding of the practices that can contribute to that.

Mr. Roger Gaudet: I understand your viewpoint. However, I don't want to talk to you about provincial jurisdictions because that's not the point of my question. Earlier Ms. Hinton talked about physicians. There's a shortage of physicians. There's a shortage not only in Quebec, but in Ontario as well. Quebec physicians are leaving for Ontario, Alberta and elsewhere.

Couldn't Health Canada tell the government to give the provinces more money for education? That would make it possible to have more physicians. People don't study medicine because it's very costly. Canada could give more money to the provinces and the universities. Perhaps that would be a solution.

If you hold meetings with all the departments in the world, you will only find problems. I was mayor for 13 years and we always had the same problems. We held meetings. Today, thanks to computers, we can find solutions that would be suited to all Canadians. Let's stop holding meetings to find out the problems because we know them. We need solutions.

Even if you went to the UN, you wouldn't solve the problems. Let's take the example of Cuba. A number of Canadians and Quebeckers go to Cuba for operations. How is it that they can be operated on in Cuba? There are doctors on every street corner. In Canada, a supposedly rich and democratic country, we can't get doctors. There's a problem.

Canada currently generates surpluses of $11 to $12 billion a year. A portion of that money should be given to the universities and provinces to help people. If we don't have physicians, we can't help people. Without physicians, no one will be able to solve life's problems.

Those were my comments. Now I'd like to hear yours.

• (1640)

Mrs. Nancy Milroy-Swainson: As I've already said, it's really a problem everywhere in the country and in the world. The government is working with the provinces and territories and granting them money to increase the number of physicians and other health professionals, particularly nurses and psychologists, to name only a few. However, there are other ways to improve access to health services. For example, to assist the provinces and territories, we're working in the primary care field to create teams. The goal is for professionals to be able to work together and meet the needs of people, particularly those coping with chronic diseases, those who need home care or palliative care.

The fact that people work in teams means better access to somewhat specialized services. We're working closely with the provinces and territories and with other partners to create an environment and tools to work in teams. For example, we give money to Canada Health Infoway, an organization that is working to establish a common electronic health record across the country. This tool is to enable professionals to work together and individuals to obtain information on their own health so that they can take care of it.

Canada Health Infoway is also working to create Telehealth programs. The objective is to improve the quality and accessibility of home care, for example, in the case of individuals suffering from heart problems or chronic diseases. The number of professionals is not the only important factor; there is also the way in which these professionals are organized and the way they are supported so that they can meet people's needs. We're working together with our partners to improve those conditions.

Mr. Roger Gaudet: Thank you.

[*English*]

The Chair: Thank you.

Now we're going over to Mr. Shipley, who I know would have loved to have picked up on the tail end of Mrs. Hinton, but he now has his own five minutes.

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

Thank you to the folks coming in today.

Ms. Mealing, I was just taking a peak in the book here, the Canadian Institutes of Health Research's aging biennial report. If you go to page 8 there's some disturbing news in the report. One of the things is helping seniors stay on their medications safely...new emerging teams. It talks about in 2006 we spent $25 billion on medications, the second largest share of health care expenditures. That says that if you're between the ages of 60 and 79, you have an average of 39 prescriptions per year, and that goes up to 74 as you reach ages 80 and over. If we aren't actually concerned about those numbers, we should be concerned about them.

Mr. Rocan, in your comments on page 9 you talk about health promotion. It seems to me that we're running in two directions in terms of health promotion. Is there a direct relationship to the amount of medication we give people in terms of how we measure promotion of health? We talk about health, up to 70%...90% for diabetes, 50% of strokes are preventable. Are you talking about more preventable because of the drugs that we give them, or more preventable because we encourage them to actually do healthy activities?

Mr. Claude Rocan: I would say it's more the latter. We are working very hard to encourage people to undertake healthy activities in a number of ways, as I've expressed, in a number of different levels. The area of health promotion is extremely broad. It does deal with individual behaviours, but it also deals in a broader sense in policies that governments take that can have an impact on health. What we try to do is to have a broader impact on public policy on a number of different levels. Yes, ultimately what we are trying to do is to have an impact on human behaviour and to encourage healthier human behaviour so that people can avoid problems, including problems that require medications and so forth.

Linda, did you want to add a comment?

• (1645)

Dr. Linda Mealing: I think that's the research also—that you have 39 prescriptions—but I think it's eight different medications when you're over 65. I think that's perhaps a culture of the physician who has very limited time, because sometimes physiotherapy or some other kind of therapy could reduce the need for medication. It's also the behaviour of the patient wanting medication and perhaps seeing more than one doctor.

Mr. Bev Shipley: I don't think the patient should be the one who determines whether they get medication or not. Do you?

Dr. Linda Mealing: No, you're right.

Mr. Bev Shipley: Do your agencies actually try to promote good health rather than medicated health?

Dr. Linda Mealing: Yes, definitely.

Mr. Bev Shipley: Do you think you are very successful ?

Mr. Claude Rocan: That's a very interesting question. I think that leads to the challenging issue of evaluation in the area of health promotion. We are definitely working very hard in that area. We put a number of resources into it. I think methodologies related to evaluation continue to evolve. Some are challenging in the sense that we need longitudinal studies to track the impact that we're having. I think that we can certainly show the results of shorter-term interventions and indicate the impact that we're having in that way. But it's hard to develop those causal links between our interventions and the actual change in health outcomes. We continue to try to do that, but it's challenging.

Mr. Bev Shipley: This is not a hit. I'm just concerned, because when you go on to page 14, we talk about prevention of falls. In terms of medications that we have, I don't know if the medications sometimes get the credit for the accidents they cause, because people have mixed medications. We've all heard of times when we as parents, or as siblings of parents, say “no more”, pull back, and some miraculous thing happens to the health of those we're caring about because they've got all these medications that over time have just been building, and they create incoordinations.

I encourage you, as we look at the falls, and this is what we're trying to do.... This is about veterans also. I don't know if these are your studies, but does there seem to be more of a concern for veterans—because of their background of being in the armed forces—that they will tend to have higher medication than others, and are they as susceptible to the health promotion factors you talked about? Are they more accepting of that than other Canadians?

Mr. John Cox: I think part of the question that you're asking is what is the difference between a veterans population as it's known and identified and the general population. I think we obviously suffer to the extent that finding data and having enough data about older persons generally, and the specific sub-populations—whether it's veterans or some of the other sub-groups that we've mentioned in conversation today—is quite a challenge as well. I guess the short answer would be I don't think there is a great deal of information that sets out those comparisons.

I think perhaps David Pedlar of the Department of Veterans Affairs would have the best handle on some of those things from his position as a researcher and gerontologist, in terms of what he's been able to identify with veterans populations.

Did you have something, Linda?

● (1650)

Dr. Linda Mealing: I know that Dr. David Pedlar, your director of research at Veterans Affairs, has been meeting with the Canadian longitudinal study on aging researchers to decide how best to include a military cohort in this long-term study, because of your population health research strategy. There is no clear data, but they are trying to figure out a way to do it efficiently.

Mr. Bev Shipley: Thank you.

Mrs. Nancy Milroy-Swainson: This isn't specifically related to veterans, but with regard to the complications associated with medications, there are two things that Health Canada is certainly trying to do. One is working with pharmacists and providers on optimal prescribing. So there is work to try to ensure that only those who need medication get medication, and those who get medication get the right medication.

Secondly, jurisdictions across the country—with the support of Infoway—are introducing electronic systems to track and contain pharmaceutical information. Through that mechanism—by having all of one person's medications on one record accessible to any pharmacist or physician they go to—that certainly helps avoid unexpected complications. It can flag where there are interactions between drugs that will potentially cause confusion or instability. It certainly is recognized as a problem, and there are tools that can help partly address it.

The Chair: Thank you very much.

Now over to the Liberal Party of Canada. Mr. St. Denis, for five minutes.

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

Thank you very much to the witnesses for being here and helping us out.

I picked up a number of excellent points raised today, but you reference age-friendly communities. As a short preamble, in my northern Ontario riding I have the small city of Elliot Lake, which having once been the world's uranium capital has not a single uranium mine left. The clean-up has been very well done by the mining companies under the Canadian Nuclear Safety Commission's fine jurisdiction. The number of early retirees, younger middle-aged seniors, if I could describe them that way, and even older seniors who have moved to Elliot Lake is incredible, in the thousands. For a lot of these retirees it was basically an economic thing as well as environmental—clean air, access to fishing and the outdoors, and so on. Among these thousands are many retired military. The local legion is one of the biggest legions anywhere. It think it has 800 or 900 members in a town with a population of 12,000.

Could you talk a bit more about age-friendly communities? Is it simply just to set up nice things you can do for seniors, or is it a really proactive modelling of what can be done to encourage seniors to move to rural Canada where we believe the quality of life is higher? With the baby boom generation—I and many of us here I think are part of that—there's a huge number of us approaching those years when we will need seniors' accommodation.

Mr. Claude Rocan: Age-friendly communities is something that in fact was built on to the age-friendly cities initiative that we did internationally. Drawing from the experience of that, this was something that was applied to the Canadian context and it was done through the federal-provincial-territorial forum focused on seniors issues. Through that forum a guide was developed for age-friendly communities. There are I think ten communities that are participating.

Is it ten?

Mr. John Cox: There were ten initially.

Mr. Claude Rocan: It is about looking for common indicators of an age-friendly community, some practical advice in terms of what makes an age-friendly community, and a way of advocating for certain changes and improvements to be made in a community's core characteristics to encourage it to be age-friendly. So it was built on that basis. It certainly is something that can be expanded. There was a tool that was developed, which is essentially a guide that can be used by any community in Canada. In fact it's been gifted to the World Health Organization as well for them to use in other circumstances. It's a very practical tool that communities can use to essentially assess where they are in terms of categories that would make them age-friendly communities and to make some improvements, where appropriate.

I'll ask John to expand on that a little as well, because he's been very closely associated with that project.

● (1655)

Mr. John Cox: The age-friendly communities initiative, which was focused, as Claude has indicated, both internationally and domestically, is now in the roll-out process with interested jurisdictions. It basically provides a mechanism whereby seniors in communities together with other components of the community—the business sector, the non-government sector, the municipality, the municipal government, and so on—can look at those things that seniors themselves find helpful to their enjoyment of their community, wherever it is, or that may be a problem. It could be a lack of proper street repair, or it could be an environmental thing. We've talked a lot about falls and some of the things that contribute to that. It can be a whole range of things, but it's what those individual older community members think would be important to them.

Beyond that, it is an opportunity for them to have established in that process of dialogue possible areas that they can target to move on. Those things can be as simple as getting a bench between bus stops on a hill in Saanich, B.C., or it could be something more extensive that would require coordination between provincial and municipal governments with respect to snow plowing. The province might go through the middle of town and fill the sidewalks essentially with banks of snow. The roads are clear but the older persons or persons with disabilities or moms with carriages can't get across the street because it's just lying there.

Mr. Brent St. Denis: Before I run out of time, how can we get more information on that? Is there a website?

Mr. John Cox: I'd be happy to provide the information to you.

Mr. Brent St. Denis: I will give you my card afterwards.

Mr. John Cox: Absolutely.

The Chair: Now we're on to Mr. Sweet, for the Conservative Party, for five minutes.

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

I might as well stick with the line of questioning Mr. St. Denis was on.

The question of success will be a good point to really check. Do you monitor the take-up of this by municipalities? Do you monitor which municipalities have actually taken up this information or are using it? Do you monitor that?

Mr. John Cox: As I mentioned, there were ten communities across the country who were involved, basically, in the focus testing. Both the Province of British Columbia and the Province of Manitoba have been very impressed with the promise they saw in this. British Columbia is committed, as I understand, to try to get all 168 communities to look at and begin to take advantage of this with a variety of partners. While we don't have that count now, as they've just begun, we will certainly know about that take-up over the next couple of years.

In Manitoba, that government's intention, as I understand, is to move it out in waves of ten communities, based on their interests—and they're providing support for that action.

Mr. David Sweet: I think all of the members on this committee here would like to get that information, so we could be champions of it in our respective communities.

One of the questions that was asked before, and on which we've had a lot of discussion, was about the fact we are moving into a very serious situation from a lack of psychiatrists and psychologists for seniors, and particularly for veterans, because of the added need for professionals in PTSD.

Is there anything we can do that we are not doing right now as a federal government with Health Canada to make sure we have candidates in the queue, so that somewhere down the line in the next ten years we can start to see some of this problem being alleviated? I can think of some things offhand, but I'm certain you've been immersed in these issues all the time and that you must have some action in mind, even to the point of getting some guidance counsellors in high school to encourage young people.

Are we doing anything like that?

● (1700)

Mrs. Nancy Milroy-Swainson: I can't speak to the details of that, but I am awarethat the issue of people's readiness to enter the health professions has been under considerable discussion, not only within the health domain but certainly also within education. In particular, within Health Canada our effort has focused on educational readiness among first nations communities. So there are efforts to support not only first nations Canadians moving right into nursing or psychology or psychiatry, but also to create, if you will, some stepladder programming where once they get to a certain level readiness in the health profession with some experience, they then move to another level of education.

So from the first nations side of things, there has certainly been consideration of that. I can't speak to the details of efforts in the broader sector, but I know it is an issue.

Mr. David Sweet: You had mentioned the Canadian health human resources plan. The native community is in there, but there's not—

Mrs. Nancy Milroy-Swainson: I would have to look at the plan itself to see how they've characterized it. The aboriginal plan is generally reflected inthe pan-Canadian health human resources plan, but it's more specifically reflected in the work of the first nations and Inuit health branch.

Mr. David Sweet: Okay. Thank you.

I wanted to ask you about social engagement. Again, one of the consistent points we hear from all of the witnesses is that the likelihood of a senior staying fit and of course then also being less susceptible to disease and to falling, etc., depends on whether they have good personal networks. Within the higher public policy plans we're giving to the provinces, do we have some specific strategies to try to catch these people earlier? Because I believe that once you're 75 years old and don't have these social networks, you usually don't end up being a social butterfly—excuse the expression—who does this spontaneously. Is there any action or initiative we're taking on that?

Mr. Claude Rocan: I will make a comment first.

You're absolutely right. I think that is a hugely important issue, and it relates a bit to the point that was raised a bit earlier about being part of the workforce. I guess that's what we were trying to get at in the presentation. It's not so much the question of working. It's the question of being engaged in society, and whatever form that engagement takes I think is hugely important. We have done some work in the area of what's come to be called “social capital”, and that's essentially the whole social network of support that people have, being part of the community, family members, part of the voluntary sector, organizations, whatever the case might be.

We certainly have taken some steps to try to encourage an understanding of the importance of social engagement for seniors.

Correct me if I'm wrong, John, but I don't think we have specific strategies at the federal level. Certainly this is a point that's discussed with our provincial and territorial counterparts so that again we can share some ideas. If we have some knowledge of best practices, then that's an opportunity to do that. So we operate it that way.

Mr. David Sweet: I'm probably running out of time, so I just want to try to squeeze in one more question here. On page 13, you have a policy guide that you developed. How current is that policy guide right now for home care?

Mr. John Cox: I would have to go back and check, but I would think it would be within the last three years.

Mr. David Sweet: Thank you.

The Chair: Now we have who I think is our last questioner—Mr. Stoffer, with the NDP—and then after that we still have some committee business to deal with, just so that everybody is aware.

Mr. Stoffer.

● (1705)

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

A few years ago I was at the aboriginal affairs committee and we had a group of elders there, and through the whole presentation the people never once said the word “senior”. They always said the word “elders”. When I asked afterwards why, they said because “elders”, in their view, is a sign of respect; “seniors”, in their view, means an older person.

So I will just throw this out. Have you ever thought of changing the word “seniors” programs to “elder” programs? I was in Resolute Bay just recently. And this goes to Madam Hinton's point that we should be starting these physical education things much sooner than when they're seniors. Elders there are invited into the schools and they are an integral part of the education system. It keeps them fresh, it keeps them with kids, and it teaches them interaction, as you said, to be active in the community. I don't know if you've ever looked at that in terms of recommendations for federal to provincial to municipal...and for other community groups to interact elders with the school systems in order to promote that continuity of wellness in that regard.

That's the statement.

I want to say that Mr. Shipley raised a good point about the amount of drugs people take. I couldn't help but notice that Pfizer is one of the sponsors here in this group, and I just want to play devil's advocate here. Pfizer is one of the world's largest drug manufacturers in the world. Wouldn't that be seen, if you wanted to be critical at all, as possibly just a hint of a perception of conflict in that regard?

I'm glad to see Pfizer using their money to help research for seniors, and I don't want to say stop them from doing it, but couldn't there be a perception of conflict in that regard? I say that with the most positive of views, by the way.

Dr. Linda Mealing: Definitely. At CIHR we have a lot of programs in partnership with pharmaceutical companies. They bring in a lot of dollars, and through CIHR all the dollars are unconditional. They are actually co-funding that whole network about getting research in Alzheimer's disease into action. It's not just about whether this drug works well but also about non-pharmaceutical therapies that are being tested in that network. We conducted regional senior workshops across the country with just seniors and seniors organizations, and they sponsored supporting the cost of that because we paid the way for all the seniors. So yes, it can be perceived as conflict, but we have ways internally to manage.

Mr. Peter Stoffer: Thank you very much.

The Chair: I ask the committee to bear with me for a second. I did say Mr. Stoffer would be our last questioner; however, Mr. Cannan has not had a chance yet, and Mr. Valley wanted 30 seconds to make some statements.

Mr. Cannan.

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

I know we're running out of time, so I'll be very quick.

I appreciate Mr. Stoffer's comments, and you alluded to non-pharmaceutical therapy. They used some placebo experimentation as well, so individuals sometimes think they're on the medication and they're not necessarily. So that's really good, because I'm an advocate of more natural health care in that respect.

I want you to verify, where you said one in three seniors falls every year, and falls account for 85% of all injury-related hospitalizations, how current is that statistic? Do you have any information to show, because you've gone on to some fall prevention programs, that you've been able to reduce that figure?

Mr. John Cox: I think the most recent data available was from the late 1990s, probably 1999. I think it was research conducted through SMARTRISK, an organization that's focused quite heavily on falls. Certainly in terms of programming, while we don't deliver the programs, we've been quite active both in collaboration with Veterans Affairs in the past, and in other fashions, both to test community-based approaches that then can be picked up, and many have, as well as trying to strengthen work around gathering the data that's necessary to approve programs. That work is going on now. We did the initial research to determine the extent of falls programming in Canada and released a report in 2005. The World Health Organization asked for our cooperation in replicating that on a more international scale, and that was done in the last year or so. So we are very much continuing to pay attention to that area, to try to promote it.

● (1710)

Mr. Ron Cannan: There wasn't any breakdown as far as just seniors are concerned? It wouldn't have been specific in terms of vets versus non-vets?

Mr. John Cox: There would probably be information available with respect to the particular program that we ran with Veterans Affairs, but it wouldn't necessarily be generalizable to the full population of veterans and seniors across the country.

Mr. Ron Cannan: In the next paragraph, on page 14, it says, “Among our work on this issue was a collaborative venture between Health Canada and Veterans Affairs Canada”. Is that ongoing?

Mr. John Cox: No. It was a four-year program to test ways of getting both veterans within communities and seniors working together and engaging with other partners within their communities to test out ways that they could either endorse or support prevention activities, or intervene where there had been an initial fall and hopefully reduce the probability of successive falls. From there, I think there was at least one reference in here to a program in Nova Scotia, for example, that has carried on. I think there are a number of others like that. Falls programming is something that provinces in particular have picked up on.

Mr. Ron Cannan: So when did this end?

Mr. John Cox: I believe it was from 2000 to 2004.

Mr. Ron Cannan: I come from the central Okanagan, in British Columbia, Kelowna—Lake Country. We have a high demographic of seniors, and our interior health program authority has excellent falls prevention education.

Also, my colleague Ms. Hinton talked about schools, and we do have the healthy school bus.

So it's a great program, from partnership with the municipality, working with the seniors, both from an environmental perspective and the perspective of exercise.

Thank you for your dedication and work and for your presentations this afternoon.

Mr. John Cox: Thank you.

The Chair: There's one quick thing I want to find out.

With all this talk about falls, I'm assuming that minimizing ice, minimizing multiple storeys and stairs, and minimizing troublesome tub enclosures are probably the big ones. Is there anything we're missing?

Mrs. Nancy Milroy-Swainson: Carpeting, surfaces.

Dr. Linda Mealing: Stairs.

The Chair: So is carpeting good or bad?

Mrs. Nancy Milroy-Swainson: Loose carpeting is bad, or carpeting that doesn't grip. So it's a question of making the environment stable.

The Chair: All right.

Mr. John Cox: Lighting is another issue.

Dr. Linda Mealing: Élisabeth Bruyère actually has a floor that, if you drop an egg on it, the egg won't break. So if a person falls on that floor, they won't break their hip.

The Chair: Where is it that has this?

Dr. Linda Mealing: The Élisabeth Bruyère Health Centre, down by the market. They're testing it.

The Chair: That is fascinating.

Now I'd like to go over to Mr. Valley for a quick round.

Mr. Roger Valley: I probably missed it, and I apologize, but we talked about age-friendly communities, healthy aging, and active aging. I'm going to add a word, when I speak to my own municipalities, about exercise-friendly communities, because especially in first nations, something as simple as road dust treatment can keep the people outside working and walking. They won't do it otherwise. So I'm going to add the word “exercise”. I just thought I'd add that in.

Thank you very much.

Mr. David Sweet: Mr. Chairman, I don't have a question. I just wanted to ask if we could have Mr. Rocan table a report that was done, “Healthy Aging in Canada: A New Vision, A Vital Investment”. I just wonder if we could get a copy for each member, particularly the recommended framework for action. That plays right into our work here.

The Chair: All right. Mr. Rocan is amenable to that.

With that, then, I'd like to thank our witnesses. Thank you very much. Every time we bring somebody before us, we learn something. That was very much the case today. So thank you very much.

We do have a couple of items of committee business. Some members may choose to come up and say hello and goodbye and thank you and this sort of thing, but I'll just kind of roll on, if you don't mind, with some of the business.

All right, committee members, just to let you know, we have a new travel budget request.

Mr. Peter Stoffer: Mr. Chair, while we're waiting, Mr. Sweet and I were today at the public accounts committee, and we heard from a brigadier general and a major general some very interesting information on what the defence department is doing about PTSD and mental health concerns. If possible, I think it would be very helpful for this committee if the clerk asked the clerk of the public accounts committee for the presentations given by the Auditor General and the two generals. We don't necessarily need the Hansard of what all the MPs said, but the presentations would be very helpful to this committee in its study of what Mr. Perron was talking about earlier with respect to PTSD. Their statistical information, what they're trying to do, and how it can be moved forward was very interesting. It was very interesting this morning.

● (1715)

The Chair: Okay, we've made a note of that, and we'll proceed from there.

To go to the travel budget request here, this is with regard to the trip to Shearwater, Nova Scotia; Goose Bay, Newfoundland and Labrador; Comox, British Columbia; and Cold Lake, Alberta. There are two committee members who say they will not be able to travel with the committee. Ms. Hinton has a travel restriction, and Mr. Sweet has some conflicting appointments and schedule issues.

We have amended it, or changed it, so that there will be ten committee members travelling, which brings the budget down slightly. I know that some people on the government side have had a chance to talk with government members of the liaison committee, and hopefully members of the opposition will do likewise.

The budget we have now to travel to those four different locations is $118,434. That's about it. If there are no questions, I'll proceed with that to the liaison committee on Tuesday. Hopefully we'll get a positive response.

Go ahead, Mr. Valley.

Mr. Roger Valley: I just have a question.

As much as we like Ottawa, and I realize that it's important to be here, can we only get to Goose Bay on Friday? Is that why we can't go there on Wednesday, instead of actually staying here in Ottawa?

The Chair: I'll let the clerk answer that. He may have a better idea—

Mr. Roger Valley: We see our colleagues every day. We don't need to see them on Wednesday.

The Clerk of the Committee (Mr. Alexandre Roger): It's up to the committee to decide.

The Chair: I remember that he approached me about that issue, and I indicated to him that I thought most members would probably want to be in their caucuses on Wednesday, except for Mr. Valley and Mr. Stoffer. We'll have to notify their whips.

Mr. Bev Shipley: I didn't realize that. We have a question on the 10th, so we would have to fly out sometime on Sunday. Would we be back here on Wednesday?

The Clerk: We would be back on Tuesday. I sent out the itinerary yesterday.

Mr. Bev Shipley: It would be Tuesday night. Okay. I haven't been in my office since this morning.

Mr. Roger Valley: I just throw out to the floor, to all members who would prefer to do this in four straight days, that we would want it that way. If there is no acceptance, that's fine. But with this agenda, I wouldn't be returning home until late Saturday night. I don't mind that, but I prefer to go on Monday, Tuesday, Wednesday, and Thursday.

The Chair: Okay, we can take a straw vote on it.

Mr. St. Denis.

Mr. Brent St. Denis: I totally agree. On a personal note, there is one of our members, the member whose riding includes Goose Bay, whose sister is getting married on the Thursday. If this were agreeable and the logistics could be done, I would vote for Goose Bay on Wednesday so that our colleague could be with us in his riding.

The wedding is Thursday, isn't that right?

Mr. Ron Cannan: Why doesn't he invite us to the wedding?

Mr. Brent St. Denis: We are invited.

That's the only proviso. The member could be with us in his riding in Goose Bay if we did it Wednesday and came back to Shearwater. This means Shearwater would be the same day, which is good.

The Chair: I'm going to somewhat defer to the clerk, who has been making all the arrangements for this.

Do you have a sense of how this would all work, given the scenario proposed here?

The Clerk: If we go to Goose Bay on Wednesday, I'll just have to ask CFB Goose Bay if they can accommodate us on that day. I don't have an answer right now, but I could get back to the committee.

The Chair: I want to do a bit of a straw poll on this. The option, as I see it, is a five-day engagement with a stop in Ottawa on Wednesday, or potentially....

Do you think it can be done in a four-day engagement?

The Clerk: I'll try. I'll talk to CFB Goose Bay.

The Chair: Let's do a straw poll. I think the two options are for five days, with a stop in Ottawa on Wednesday, or four days, condensed as best we can.

Would those in favour of a five-day scenario, with a stop in Ottawa on Wednesday, please so indicate?

I see two.

All those with a preferred option of a condensed four-day scenario, if possible, please signify.

I see five.

I think there's a general will there. If the clerk can accommodate it, he is so instructed—if it's possible.

We had a gentleman who was supposed to appear before us but who had health difficulties, coughing up bodily fluids such as blood, etc. The idea here is that the brief submitted by Lorne McCartney on behalf of ANAVETS, who could not appear at our meeting of December 13 because of an illness, be included in the evidence of that committee meeting.

• (1720)

Mrs. Betty Hinton: I don't have a problem; it's just that it's hard to include something in evidence when you haven't had an opportunity to question the person who was supposed to be presenting it.

The Chair: If you don't want to have it as evidence for that, then maybe we could just circulate his brief to the committee.

The Clerk: That's already done.

Mr. Roger Valley: This is one who wants to credit...?

The Chair: I'm not sure, exactly. Maybe the clerk can speak to why we're doing this.

The Clerk: He wanted to appear before the committee and wasn't able to, but he submitted a brief. That's the brief he was supposed to present and read at the committee. I circulated it. He was wondering if it could just be inserted into the evidence of the committee as read.

It is a practice that's been done before. There's a way to do it, and the proper way to do it is to adopt this motion. Then I deal with the publications directorate, which means that the evidence that is published on the web will have this included in it.

If the committee wishes, though, we could ask him to return to our committee.

The Chair: For the sake of a man who was coughing up his own blood, I'm going to read that yet again:

> That the brief submitted by Lorne McCartney on behalf of ANAVETS, who could not appear at our meeting of December 13 because of an illness, be included in the evidence of that committee meeting.

An hon. member: Agreed.

Mr. David Sweet: If that's a motion you're proposing that we deal with, could we say “after committee members have inspected it”?

The Chair: I think it's already been circulated, has it not?

The Clerk: Yes, it has.

Mr. David Sweet: It has been circulated?

The Clerk: Yes. I can send it again; I don't have a problem with that.

Mr. Brent St. Denis: It could be great or ridiculous, but it would be his testimony. It wouldn't matter whether we read it or not.

The Chair: I think we're splitting hairs, Mr. Sweet.

(Motion agreed to)

The Chair: Thank you very much.

The meeting is adjourned.

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