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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 want to address the issue of our changed venue. We were originally scheduled to be in room 112 North in the Centre Block, but I understand there was some sort of situation going on with a filibuster in procedure and House affairs. That's how we wound up here. At any rate, there was some fancy footwork, and I imagine we'll have a few more members straggling in as a result of that. We shall see.

I am going to introduce our witnesses, and they'll have a chance to present. After that, I wish to inform the committee of a victory of sorts at the Liaison Committee.

For our continuing study of the veterans health care review and the veterans independence program, our witnesses today are from the Canadian National Institute for the Blind—Catherine Moore, national director of consumer and government relations, and Bernard Nunan, a researcher-writer at the CNIB national office here in Ottawa.

I presume the clerk has told you that you have 20 minutes. You can split that up as you see fit. One can take 20, both can take 10—again, as you see fit. We're generally pretty accommodating and flexible for witnesses. After the presentation we'll move to a far more rigid formula for members asking questions.

With that, the floor is yours.

Ms. Catherine Moore (National Director, Consumer and Government Relations, Canadian National Institute for the Blind): Great. Thank you, Mr. Anders.

I would like to start by asking all of you to indulge me for just a moment and tell me who you are. I am visually impaired and can't read any of your name tags, so I'm not sure who's who or where you are.

Perhaps you would start, Mr. Stoffer, since I've met you before.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): I'm Peter Stoffer.

[*Translation*]

Mr. Roger Gaudet (Montcalm, BQ): My name is Roger Gaudet.

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): My name is Gilles Perron.

[*English*]

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

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

The Chair: I'll have the clerk introduce himself as well.

[*Translation*]

The Clerk of the Committee (Mr. Alexandre Roger): My name is Alexandre Roger and I am the clerk of the committee.

[*English*]

The Chair: Rob Anders.

Mr. Michel Rossignol (Committee Researcher): Michel Rossignol.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Betty Hinton.

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

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

A voice: How sweet it is.

● (1535)

Mrs. Betty Hinton: Ron Cannan is another member. He has just been held up for whatever reason.

Ms. Catherine Moore: Thank you very much for indulging me. It's much easier having some idea of who's who, where you're sitting, and that sort of thing. It helps a lot.

Again I would like to thank you for the opportunity to speak to the committee today. I hope to leave you with some recommendations, which I suspect you are already considering, and a sense of the long-term relationship that CNIB and the veterans of Canada have had.

The CNIB was founded in 1919, in particular to address the issue of war-blinded veterans coming home from World War I. Our original founder and executive director was Colonel Edwin Baker, who had been wounded by a sniper's bullet in France. He went through rehabilitation services in England at St Dunstan's and returned to Canada—he and many other young men—hale and hearty other than the fact that he could no longer see.

What was facing all of these folks in 1919 was going out on the street selling pencils, or being hidden in someone's basement. Blind people couldn't do anything. So it was institutionalization, homelessness, or something, but there was no good alternative. So the CNIB was founded partly to address that issue.

During the twenties and thirties in particular, the CNIB worked with Veterans Affairs Canada—the Department of Veterans at that point—to ensure that there were benefits in place for veterans.

Colonel Baker, as was described in his biography, made 30 trips to and from Ottawa, going to parliamentary committees to argue for an increase in war-blinded veterans' pensions. He was successful in 1926 at bringing it from $9 a month to $11 a month. In those days that was obviously an accomplishment.

In the 1930s, these young men were in their thirties and were also faced with the Depression. The CNIB helped to create employment across the country, as some of you will remember, by having kiosks, cigarette stands, and cafeterias. They created a plan that provided employment for people who were blind, including veterans. So that's where we started.

Today the CNIB is a much larger organization. We have 1,100 employees and 54 offices across the country. Although we still deal with veterans, we also deal with the larger population of Canadians with vision loss. We work on strategies to inform people of ways to prevent vision loss in old age by quitting smoking, eating green leafy vegetables—nobody ever wants to hear that, but it helps—etc. We also work with about 1,800 veterans across the country. Only 30 are left who were blinded in combat. The rest are people who have had age-related vision loss.

The CNIB provides a variety of services to help people maintain their independence or mitigate the emotional and social effects of vision loss. At this point our resources don't allow us to be long-term case managers of veterans who enter our system because they have vision loss. We struggle with even being able to inform them of all the benefits available. Persons with mild vision loss might enter our system and then develop a more severe vision loss later, but we don't know that, because they figure there's nothing to be done. This group is typically in their late seventies and eighties. They are frail, elderly people and often have other issues. That's the gap I will talk about later.

What do we do? Let me show you something to give you a practical example. We provide things like peer counselling and reassurance to people that they may have lost their sight but it's not going to be forever. We work with people and offer things like low-vision aids.

This is a rather large magnifier. It generally has batteries attached, a light, and that sort of thing. It looks a bit cumbersome, but it's a stronger magnifier than you're going to find at Wal-Mart or stores like that—this is five times. I'll pass this around.

● (1540)

So what's the big deal? Well, the big deal is that, by using this, somebody may be able to read his or her income tax form and fill it out. It may not be the most popular activity in the world, but it's essential. It's about independence, even if it's income tax. But it's also about reading price tags, reading the instructions on a pill bottle, and that sort of thing.

So along with that low-vision product, we provide the information and the support around common questions that people ask. Why are my eyes like this? What happened? Did I do something wrong? What can I expect?

We want to emphasize that Veterans Affairs Canada's health services for people with vision loss is a model for the rest of the world. I'm not just saying this to butter you up; it's true. Blind veterans of the United States and the European veterans associations have all looked to Canada in their development of vision health services for veterans. Nothing is perfect, but we're doing pretty darned well right now. I want to congratulate all of you sitting around this table who are monitoring, discussing, and reviewing what we can do better, because that's to our credit. We want to emphasize that although there are some gaps, generally speaking we have a pretty comprehensive program.

Our recommendations mainly have to do with how benefits are distributed, how health services are accessed by veterans. Therein lies the crux of the difficulty. Let me start by saying with absolutely no reflection on this committee—and I assure you I mean this sincerely—that the slowness of review of benefit grids or the ability to add products or new services to what is currently available, that review process, and the red tape that surrounds it, can sometimes can be very daunting and frustrating for all persons involved. I am not speaking in the larger political context, but rather of the process at Veterans Affairs, and I understand that this slowness can occur despite the best intentions of some of the most hardworking, competent, and dedicated bureaucrats.

So our first recommendation is the streamlining of the review of benefit grids. It's not good to make elderly people wait six, eight, or ten months for a new product or a change in a regulation that allows for more than one magnifier in a lifetime. These things are being resolved. We work very closely with program and policy folks at Veterans Affairs. Again, there's no lack of will, but there is some streamlining that could take place. We hope that this streamlining will result from your review and ongoing work.

With respect to our second recommendation, CNIB wholeheartedly endorses the report presented a year ago—to this committee, I believe—by the Gerontological Advisory Council, Veterans Affairs Canada.It was entitled “Keeping the Promise: The Future of Health Benefits for Canada's War Veterans”. This report says it far better than I'm going to be able to do today. It contains recommendations that would really improve the delivery of services for veterans, not only veterans with vision loss but all of them. Our second recommendation is to highlight one of the recommendations from that report, and that is to have case managers assigned to high-needs veterans. We would call somebody with vision loss a high-needs veteran.

So why? Why does this have to occur? In our case, for somebody with vision loss, there's a variety of obstacles: reading information, reading the manuals, reading just what the benefit grid allows. That sort of thing becomes a challenge. The other thing that becomes a challenge is the current set-up, in which a third party, Blue Cross, has a conflicting role in the awarding of benefits.

● (1545)

Blue Cross is the ultimate arbitrator of whether someone is eligible for a benefit, but they are also the body that is the appeal or the dispute resolution mechanism. So they have two roles. They're gatekeeping, which is essential because we need accountability. We are talking about taxpayers' dollars. Blue Cross is gatekeeping on the one hand and, on the other hand, resolving disputes, where perhaps someone believes they're eligible for something else and Blue Cross is going to arbitrate whether they are or they aren't. Blue Cross is a third party, audit type of mechanism that doesn't know the individual, that doesn't know the individual's situation, that doesn't know the nuances of the situation in the way of a case manager—even it were a Blue Cross case manager.

It doesn't matter who does it: Veterans Affairs, CNIB could do it for our clients, or Blue Cross could do it themselves. The recommendation is for a case manager who is able to assess the situation at the beginning and to be available as the situation might change. An example of a change is the person with vision loss. There may not be a problem with the veteran but with their spouse, who has been doing the reading or doing the driving and who may develop Alzheimer's. So that becomes a secondary issue. If a case manager is involved, they will know that in a situation like there is a benefit that already exists for additional help with housekeeping, etc.

It's very difficult to have someone in their late eighties trying to do that type of dispute resolution by themselves. Again, CNIB helps at this point, when we can, but we are not always able to, and we're not phoning people and proactively going out to try to help them.

So that is our second recommendation.

Our third recommendation is to again endorse what the report has already said from the Gerontological Advisory Council. All veterans who have served in the armed forces should be eligible for health services based on their health needs rather than their status. It becomes complicated whether someone served in this theatre, etc. As you all know, I'm not going to tell you what you already know about eligibility requirements and levels of service availability right now depending on types of service. It would enormously simplify some of the red tape if we just went to a veteran who has served in the armed forces, perhaps served in a theatre of war or perhaps not, but that would be a discussion for another day, and that person then becomes eligible for the available benefits.

Those are the three recommendations we have: streamline the red tape around determining new benefits, adding to a benefit grid or taking something off, which is also possible; second, a case management system, monitored or administered either by Veterans Affairs Canada themselves—in our case, CNIB with our clients—or by Blue Cross, it doesn't matter who, as long as there is some process in place; and last, that we eliminate the levels of eligibility for services.

Bernard, do you have anything to add?

Mr. Bernard Nunan (Researcher, Writer, National Office, Ottawa, CNIB (Canadian National Institute for the Blind)): Cathy has said it quite well.

The only thing that came to mind was when Cathy was talking about the need for intervenors. From 1995 to 2002, I was working for one of you. I was working for an MP, and we'd go to the riding and we would meet with constituents. I can remember three or four times when we met with constituents who were veterans. In one or two cases it was the VIP service that they should have been eligible for and they weren't able to access it. One of them needed his trees trimmed and his lawn cut. What you guys were able to do is a bit the same, analogous to what the CNIB does. We have someone, Krysia Pazdzior, for instance, in Ottawa who works with veterans. There are fewer and fewer veterans, but through SAPA, through the Sir Arthur Pearson organization that CNIB set up, she was working with many veterans. It is just that personal touch that you as an MP can offer to a veteran. That's what an intervenor, whether it's CNIB or through another agency, can offer.

Veterans Affairs does a great job, as Cathy said. Europe and the Americans look to Veterans Affairs Canada as a model.

That personal touch, knowing the person.... Some elderly are afraid to ask for something or they don't know what to ask for, and many of them don't know that they can call their MP or that they can call the CNIB. I just want to say that this level of personal touch for an individual who has served his country is much needed.

Thank you.

● (1550)

The Chair: Thank you very much.

I will advise our witnesses that we've just had three more members join the committee.

Just so those new members know, all the other members introduced themselves at the beginning of the session, so that Ms. Moore could hear their voices.

We've had Mr. Valley, Ms. Guarnieri, and Mr. Cannan join us. Maybe all of you could introduce yourselves briefly to her.

Mr. Roger Valley (Kenora, Lib.): Hello, I'm sorry I'm late. I'm Roger Valley, the member of Parliament for the Kenora riding.

Hon. Albina Guarnieri (Mississauga East—Cooksville, Lib.): I'm Albina Guarnieri. I'm sorry, but I went to the other committee room in anticipation of your visit.

Mr. Ron Cannan (Kelowna—Lake Country, CPC): I'm Ron Cannan, Kelowna—Lake Country. I apologize, as I was with Albina, but she led me here! So it's good to be here.

Some hon. members: Oh, oh!

Hon. Albina Guarnieri: We did find our way eventually.

The Chair: There you go.

With that, we'll go to our usual rotation. First, the Liberal Party of Canada and Mr. St. Denis, for seven minutes.

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

Thank you, Ms. Moore, and Mr. Nunan, for being here.

First, let me say that no doubt all of us within our ridings have the CNIB present in one form or other, whether it's an office...or if not an office, certainly many volunteers, if we are in a rural area. I know somebody close to my own organization was a local chapter president for a long time. So kudos to you and your organization for the work you do on behalf of your constituents.

Over the course of this study we've heard from a number of witnesses, and the thought came to mind as I listened to you that veterans have a range of illnesses, disabilities, and medical requirements that they present to Veterans Affairs as they apply for assistance. For example, those with operational stress injury, as it was once called, or post-traumatic stress disorder have had the hardest time convincing the powers that be that their mental injuries came as a result of military engagement somewhere in the world.

Can you speak about the veterans in your constituency? Is their access to veterans services dependent on whether they can trace their vision impairment directly to service, or are there issues in terms of whether or not you have a precondition or predisposition to a certain condition, so that you don't qualify? Talk a little bit, if you can, about access, including the questions put to vision-impaired veterans as they attempt to get help. Or is the help unconditional, such that you're vision impaired and we're going to help you?

Ms. Catherine Moore: To start with the end of your question, it is unconditional. From CNIB, our mandate is to work with anyone with vision loss.

Mr. Brent St. Denis: I'm sorry if I misled you, but I'm thinking about access to Veterans Affairs.

Ms. Catherine Moore: As we access Veterans Affairs, no, I can say there is not a requirement by Veterans Affairs for the person to prove the blindness was a result of a war injury. So there is not that requirement. For example, if someone was hale, with 20/20 vision, when they returned from World War II, but as a result of age-related blindness they now have vision loss, they are eligible for some services through Veterans Affairs—with the obvious provisos that the province pays first, and those sorts of things, which I'm sure I don't have to go into here.

However, the issue becomes the level of service the person has done and what conflict the loss occurred in, etc., which speaks to their eligibility for levels of services through Veterans Affairs. That is the issue. So it's not that the blindness needs to be traced back to a war injury. In this sense, it's a little bit more straightforward than it is with post-traumatic stress, but there are still levels of eligibility for services based on years of service, combat wounds, and exposure, etc.

● (1555)

Mr. Brent St. Denis: Thank you.

Back to the question of accessing Veterans Affairs programs in general, impaired vision means that the materials we'd normally be able to read would not be available to an impaired veteran. Maybe I should know this, but does the department provide vision assistance in some form, either audio presentations of programs, and so on? In other words, while I can read a brochure, can somebody else who can't read it for reasons of impairment—even dyslexia or illiteracy—hear something instead? Are there alternatives to the written word for information from the department?

Ms. Catherine Moore: No, generally not. That's not to say that if it were repeatedly requested, it would.... And I'm not being facetious here. That tends to be a chicken and egg thing in the sense that quite often the veteran doesn't know they're entitled. All departments have a commitment through Treasury Board policy to provide materials in alternative formats upon request, but the reality is that generally information, letters, etc., will come in regular print and will often be inaccessible to somebody with vision loss.

Mr. Brent St. Denis: Would you know—or maybe Bernard, as a researcher, you might know, but if you don't, that's fine—the number or percentage of veterans we're talking about with vision impairment? I don't mean minor vision, correctable, but impairment that is serious enough that it is a life-altering situation. Do either of you have any idea of the percentage of veterans facing that?

Ms. Catherine Moore: I can give you two figures. The one we know statistically is that one out of eight persons over the age of 75 will experience significant vision loss. At this point, CNIB is directly involved with 1,800 veterans who have a severe visual impairment.

My point is that the numbers don't line up. There are more people out there who probably could benefit from CNIB services. Right now it's not a high number—it's 1,800.

Mr. Brent St. Denis: I'll conclude with this. One tries to imagine the life of a vision-impaired or blind person. Those for whom it was an early-life experience, either at birth or in early childhood, would have had a period of youth through which they could adapt to the impairment or vision loss. If it happens later in life, either as you get very old or as a result of an injury at work or in the service, and you're adapting as an adult.... Are the needs in the final years different for those who have become blind later in life versus those who have been blind since their earliest years?

I know with language, if you learn a language early, you learn it, but if you try to learn it late.... We all know how difficult that is.

If my premise is true, does it mean that we have to respond with programs a little differently?

Ms. Catherine Moore: Yes, even if we just do the cut-off date at working age versus retirement age, let's say over 65 or 70. For someone with vision loss prior to that, it's about returning to work and retraining. It's about communication skills, in the context of learning Braille, learning adaptive equipment, computer equipment—voice-activated computers and that kind of stuff. Those are the requirements for someone younger.

I'm happy to report that Veterans Affairs Canada is in the process, and it's my understanding they have approved, in a proactive manner.... If someone returns now from Afghanistan with—God forbid—vision loss, we have determined what would be a reasonable rehabilitation...I'm hesitant to say "package", because it sounds so cold, but a process that would help us, CNIB, and Veterans Affairs enable a person to go back to work.

For someone over 65, clearly the requirements are different. There are social requirements and independence requirements, such as being able to stay at home and cut the grass when you don't see very well. And maybe we'd love to not be able to shovel the sidewalk, given the snow we've had in Ottawa lately, but those are the home care things. It's also about being able to manage your medication, being able to see it, and being able to manage your correspondence and finances—being able to do it yourself as much as possible, rather than have someone else do it for you.

The real challenge for someone over 65 is maintaining their independence, their integrity, and their dignity, rather than, "We'll do everything for grandma or grandpa". Of course, the last thing grandma or grandpa wants is to have somebody do it for them.

● (1600)

Mr. Brent St. Denis: Thank you.

The Chair: Thank you.

We now go over to the

[*Translation*]

Bloc Québécois with Mr. Perron, who has seven minutes.

Mr. Gilles-A. Perron: Good afternoon madam, good afternoon, sir. So that you can put a name to a voice, once again my name is Gilles Perron.

It would seem—

[*English*]

It's okay? You have the translation?

[*Translation*]

Can you hear the interpretation, madam?

[*English*]

Ms. Catherine Moore: Yes.

[*Translation*]

Mr. Gilles-A. Perron: It would seem nowadays the trend is to keep the elderly or sick at home as long as possible, and this seems beneficial for them. However, when it comes to people with either a partial or total visual impairment surely natural caregivers would require training and new techniques and technologies.

Are we ready to move in that direction? Is it happening? Is there a way of improving the system?

[*English*]

Ms. Catherine Moore: Absolutely. We are experiencing the same shortages in terms of rehabilitation people that other health care professions are experiencing. It's not as chronic as the shortage of doctors, but the availability of trained home care workers and of community workers is an issue. We could do better in terms of training people. We could do better in terms of training courses available through universities and community colleges, and we could do better in terms of on-the-job apprenticeships and training in situations.

That's a very good point.

[*Translation*]

Mr. Gilles-A. Perron: I don't know what the situation is elsewhere in Canada, but in Quebec, guide dogs are very much in demand. Do you have any guide dogs? Are they available? Is the cost borne by the Department of Veterans Affairs? MIRA Foundation dogs aren't free, they cost about $10,000 each. Are any such arrangements made for veterans or the blind?

Ms. Catherine Moore: The best guide dog school is in Montreal, sir.

Mr. Gilles-A. Perron: You are referring to the MIRA Foundation in Saint-Hyacinthe.

Ms. Catherine Moore: Exactly.

I'm sorry, but my French isn't up to par. Since you don't have much time and I speak slowly in French, I'll speak in English.

[*English*]

Guide dog schools and the availability of guide dogs in an innovative school like MIRA are available to veterans at an advanced age. There is no cost, but one of the issues is that many guide dog schools in the rest of Canada feel that after a certain age it's not appropriate to have a guide dog. So there is some educating there, about a senior who is perhaps not very active having access to a guide dog should they choose to have one.

[*Translation*]

Mr. Gilles-A. Perron: How much time do I have left, Mr. Chairman?

The Chair: You have two minutes left.

Mr. Gilles-A. Perron: Just enough.

I feel like I almost need to apologize for my ignorance, this afternoon. I never even considered whether there were services for blind veterans. I'm a little tongue-tied. In your presentation, you mentioned that there are about 30 blind veterans among your clientele. Are we talking about a category of people who are wounded to a lesser degree when they come back from war or from the theatre of operations? What sort of a distinction can you make between a normal war wound, and the type of wound which causes blindness?

● (1605)

[*English*]

Ms. Catherine Moore: We don't distinguish. People come to CNIB because they are experiencing vision loss to the extent that it is interfering with their life. For us, there is not a worry about eligibility, because people sort themselves out. Nobody wants to be blind. Nobody wants to admit that they're blind. For us, when they arrive or if we have a referral, it is because they have already had a significant vision loss. So for us, there is no category.

We have a range of services and the person expresses to us the problems they are experiencing. It may be that they're socially isolated. They may express that they would like to read again, and in that case we would provide an audio library service, for example.

For us, there is a worry about being able to meet the demand, but there is no worry about someone coming with not enough vision loss to be eligible. We work with whoever identifies themselves as having a vision loss.

[*Translation*]

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

[*English*]

The Chair: You have a minute left, if you wish.

[*Translation*]

Mr. Gilles-A. Perron: Roger, there's one minute left.

Mr. Roger Gaudet: My name is Roger Gaudet, and I am the member for Montcalm and the deputy critic for Veterans Affairs.

One of the three principles you referred to would have the effect of rationalizing the process. Could you explain what you mean by that?

[*English*]

Ms. Catherine Moore: What I mean is that at this point there is a review, which obviously you've all been involved in, that has been going on for the last three years. The difficulty is that within Veterans Affairs at this point, to my knowledge, there is not a mechanism for an ongoing consultation with the community organizations that are also directly tied to veterans.

For example, what would happen is that we would determine a gap in service. A good example—which has been resolved, and I want to be clear that this has been resolved—is that at one point there was a regulation that there would be one magnifier per lifetime. Someone would enter the Veterans Affairs vision health services with a certain level of vision and would be prescribed by an optometrist this type of magnifier. Two years later, they would have much more severe vision loss because of the deterioration. One magnifier per lifetime—too bad.

It took nearly a year to have that changed. It was changed, but there was no mechanism to expedite what was really a very simple change or addition to a benefit grid.

That is my example. There isn't a mechanism of ongoing consultation.

The Chair: Thank you.

[*Translation*]

Mr. Roger Gaudet: Thank you and I'll come back to you in a moment.

[*English*]

The Chair: Absolutely.

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

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

I am Peter Stoffer. Thank you, madam, for the work you do on behalf of all kinds of people throughout the country. My own father, before he passed away, was losing his sight fairly quickly because of the combination of diabetes and other things. He was more worried about that than anything else.

You mentioned war veterans who have not necessarily become blind during their active service but later on in life may be entitled to some benefits, and that's correct. But what about veterans who served in peacetime operations, say from the sixties and seventies, and are now in their late sixties or early seventies and are becoming visually impaired and can't make a connection to any injury during their service, because this happened long after their service?

Are you aware of any benefits that Veterans Affairs has for them?

● (1610)

Ms. Catherine Moore: No, I'm not aware of that.

Mr. Peter Stoffer: Also, a lot of the spouses of Second World War and Korean veterans are visually impaired. Besides your work with them, does DVA also do any work with the spouses, that you're aware of?

Ms. Catherine Moore: It's my understanding that there remain spousal benefits, but again, not across the board and not consistently.

Mr. Peter Stoffer: Are there any recommendations you could make?

Ms. Catherine Moore: Yes, that they be across the board and that they be consistent. I would roll your two questions together. I would recommend that if it's armed service, whether it was in peacetime or wartime, the person be considered a veteran, and that their spouses continue with their benefits should they have health issues that require those benefits.

Mr. Peter Stoffer: You're probably aware that some benefits for veterans are dependent on their income. Some veterans or some service personnel may do quite well in their private lives, and when they call up looking for assistance, if their income is a little higher, they may not be eligible for some of those benefits.

Are you aware of any of those when it comes to vision impairment?

Ms. Catherine Moore: I'm not so much aware of that as I am aware of a tug of war that sometimes delays the delivery of service, between a provincial jurisdiction or a Veterans Affairs jurisdiction. It's more in those cases. I'm not aware of income affecting vision loss services.

Mr. Peter Stoffer: Thank you very much.

The Chair: Thank you, Mr. Stoffer.

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

Mrs. Betty Hinton: Thank you.

Welcome, Catherine. I've been listening to what you've had to say, and you've educated a number of us, I'm pretty sure. So I'd like to start off by saying, thank goodness for Colonel Edwin Baker. I don't know what a lot of visually impaired people or blind people would have done without that kind of man taking on this kind of cause, so those are positive things.

I became aware of how many visually impaired people were within my riding shortly after becoming a member of Parliament. It's actually very surprising. It's something that, when you're not visually impaired, you don't often think about, but you become very aware of it when you are a member of Parliament. The young man who made me aware of that is a young piper from the Kamloops Pipe Band, a very talented young man, and I gave him a business card because he had an issue, and of course he couldn't read it. So today when I gave you a business card, those business cards are in Braille and have been for the last eight years, and that's as a result of this young piper. So I think you do more to educate people than you may realize, and I just wanted to acknowledge that here today.

I don't think there's anybody in the room who hates red tape more than I do, so you've got an ally in me. I think that red tape should be eliminated. I agree with you wholeheartedly that streamlining a benefit grid would be a wonderful way to do it. But you also said that you didn't see a mechanism in place yet, so I'll try to help you by making you aware of the new ombudsman position that was put in place just recently. I think you'll find an ally in that new ombudsman, so you may want to refer some of your clients to him if they're having serious difficulties.

You were talking about having 1,800 veterans as your clients, but only 30 of them were blinded in combat. I was very pleased to hear that as a government we don't differentiate between the two and we just support people, and that you're doing exactly the same thing.

Specifically, is there something you might be able to make this committee aware of in terms of what we could do under the VIP program, which is what we're studying now, to make life easier for visually impaired or blind veterans?

Ms. Catherine Moore: I guess you're giving me an opportunity to repeat myself. A case management system would make their lives easier because it would give people a voice. I don't want to sound agist and talk about the poor frail things in the corner, because I think that's very disrespectful. But the fact is that when you're 80 years old and you're looking at some hearing loss, and you're looking at vision loss, and you're looking at some mobility loss and you don't have your licence, etc., there's a big thing that this human being is already coping with every day. To have to go to bat for services for themselves from Veterans Affairs is sometimes more than you can expect from someone.

So a case management system where there would be...and it's an ombudsman's role in a way. I don't believe there's anybody within Veterans Affairs, or even necessarily within Blue Cross, who wants to withhold a service from a veteran who's entitled to it. It's the not knowing or the misunderstanding or the miscommunication, and that case management system could take the onus off the individual to have to somehow manoeuvre the system themselves.

● (1615)

Mrs. Betty Hinton: You're right, I did give you an opportunity to repeat what you've said. But I've learned through this committee, and as a member of Parliament, that sometimes you have to keep repeating the same message over and over until it gets heard. So if there's any other message that you would like to deliver to this committee and to the public at large, please feel free to do that now.

Ms. Catherine Moore: I would like to make a plea to the committee, in any way that you're able to do it, to free up some of the bureaucrats, particularly at the front line. I realize that crossing political-public service lines is difficult, but I would urge you to free up the people from the front lines who know what should be happening to enable them to make those kinds of decisions, and move forward. That would, again, lift an enormous weight off some of them.

Mrs. Betty Hinton: You've mentioned something earlier, and we've had other witnesses on other aspects of this VIP program make comments on this as well.

We have an epidemic in this country that has just happened in the last decade or two, and a lot of it is because of overeating, but there are other causes, obviously, for diabetes. How many in your caseload do you believe, of those 1,800 people, are the result of diabetes? Can you put any number on that?

Ms. Catherine Moore: The good news and the bad news is, not many of our current caseload of veterans, but that's what will quadruple that number. Type 2 diabetes is hitting people in their fifties now, and a quarter of those people have some type of retinopathy already. Of that group, a quarter will develop vision loss as a result of diabetes. Those are the statistics. That's it.

So unmanaged type 2 diabetes, which many people don't take as seriously as they could because it's often the misguided belief that it's not as bad as having to take insulin, is what's coming to that group, but it's not here yet. Prevention tactics could be put in place to mitigate those effects.

Mrs. Betty Hinton: Wonderful. That's not good news, but it's always better to be prepared than to face a dilemma and not have any background on it and not know what's coming.

As a country, I'm not sure we realize the devastation that will come from diseases such as diabetes, which are in most cases preventable, or at least you could start early to try to prevent that kind of damage. But what would be the leading cause? I know you told us that in the future you believe it's going to be diabetes, but what's the leading cause now? Is it accidents?

Ms. Catherine Moore: No, the leading cause is age-related macular degeneration. The macula is the centre of the eye, a very rich area in terms of blood vessels and oxygen flow. That's the area of your eye that allows you to do fine work: read, sew, write, that sort of thing. Your risk for AMD, as we call it for short, age-related macular degeneration, can be reduced by following the same health regime we advise people to follow to reduce the risk of diabetes, etc., because it is another vascular illness, essentially.

You can't prevent it. Family history and genetics are risk factors. Fair skin is a risk factor. Blue eyes are a risk factor, etc. But unhealthy eating, smoking, all of those things, will increase your chances. Smoking in particular will increase your chances of getting age-related macular degeneration by 30%. So at this point we're into public health for prevention.

● (1620)

Mrs. Betty Hinton: You've not only helped this committee today with the VIP, and what we can do to improve things for veterans; I think you've done a pretty good job of educating all of us, as well as the public.

Thank you very much for coming today.

Ms. Catherine Moore: Thank you.

The Chair: Thank you very much.

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

Mr. Roger Valley: Thank you, Ms. Moore, for coming in today and for bringing your three recommendations. Having sat through quite a number of meetings, sometimes I wonder exactly what we've been asked, but you've been quite clear on that, so thank you for that.

You've touched on the big difficulty: a lot of people don't realize the services that are available. That's one of the problems we have as MPs. You mentioned we can provide service for these individuals.

We do not know where the veterans are. There are ways we try to find out—members of the Legion, attending events, trying to build our own files—but we have no way of knowing exactly who the veterans are. It's through word of mouth and other veterans and other organizations that work with them and are willing to share with us.

I assume because of the privacy laws in Canada, we're not allowed to have a list of the people living in our ridings. I'm not even sure that the military, when they leave active military service, provide them with.... I'm sure they provide them with a list of services that are still available to them, but they probably don't go as far as to say their member of Parliament can help them in a lot of ways. It's a constant sticking point for us.

It's a problem in my riding—over 30% of the province of Ontario and only a very few people live there, a lot of separate, isolated communities—trying to reach out and trying to find out who's a veteran and who needs service and who's going to come in. You mentioned that a lot of people lead independent lives. They don't necessarily want to come and ask for help. They're living with a condition or a vision problem that something could be done about.

What would you say to that? As MPs, we know a lot of stuff that the general public doesn't know right now, yet we cannot find out who's a veteran in our riding. Does that not seem a bit strange? It seems a bit strange to me.

Ms. Catherine Moore: It does and it doesn't. So what could you do about that? From our point of view, I think in your householder, in the material you are sending out, try to ensure the print is a bit larger than you might be used to. You may be doing this already, but you are distributing information as an MP in those ways. Mention Veterans Affairs. Advertise your services, so to speak, that it is possible. Do you think you are eligible? Are you a veteran? Try to use good clear and legible print with no background. We can send any or all of you information on just how to make your householder in particular a bit more accessible, not the content but the format. That's one way.

And the other way is your website, if you have one. Now, that might sound a bit counterintuitive, because we're talking about older people, but the caregivers for some of the elderly veterans are their children, and those children are going to websites and that sort of thing.

Mr. Roger Valley: Maybe I didn't explain it.

Probably most of the 308 parliamentarians are using a lot of those tools. We use websites, we use the larger print in our material. It's still not going to help us to get a list of people.

The government knows—I shouldn't say the government—the military knows where their people are. They would have an address for them. We have to be able to reach these individuals to provide service to them, and it's difficult and frustrating. We build our files as quickly as we can, but as you've pointed out, 1,800 vision-impaired veterans are a clear indication that we're not reaching these people, considering the number in the general population with vision problems.

So we struggle with how to figure out how to get to them. People who have large military bases in their community may have more of a network, but in a far-flung riding like mine, it's very, very hard to build these files. And everything you've said is exactly true in my riding. These people don't know what's available, so we struggle to figure out how we're going to do that.

I think you mentioned we have 30 veterans who were blinded in combat. Is that recent combat or is that combat from the other crises?

● (1625)

Ms. Catherine Moore: They're World War II veterans, World War II and one person from the Korean War.

Mr. Roger Valley: So we don't have any stats for any casualities like that from this current conflict?

Ms. Catherine Moore: We could be wrong, but I think we would know if someone has returned from Afghanistan with vision loss. So to date that has not happened, or it has not happened in a way that either the military or we know.

Mr. Roger Valley: Thank you for all your hard work. If there's any way you can make a recommendation, MPs should know who their veterans are and who served their country in their riding, because we have a tough time reaching them, and it's a challenge. We've asked this question of many groups, and it's a privacy law, but these people are not living the life they could if they had the services available to them that we could help them get.

Thank you very much.

Ms. Catherine Moore: I think Service Canada might be able to answer that as Service Canada expands its mandate. They have a very good communications program right now, but we're not there yet.

The Chair: Thank you.

I just want to make a quick point. Not everybody who appears before the committee knows the intricacies of householders and all these types of things. You have some knowledge, which is quite impressive. Most people appearing wouldn't know what that term was or the common usage around here.

Now over to the Bloc Québécois and Mr. Gaudet, for five minutes.

[*Translation*]

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

I have learned a lot this afternoon. I probably won't die today. In fact, it turns out that you live longer when you learn something new every day.

Over the last fiscal year, you had $64 million in revenue. Of this amount, 47% came from the private sector, and 28% from government. From what level of government did this 28% come from?

[*English*]

Ms. Catherine Moore: Twenty-eight percent of our revenue comes from government; 8% of that is federal, and that's generally money in our research projects; 20% of it is provincial. So the majority of our income comes from private charitable donations.

[*Translation*]

Mr. Roger Gaudet: What was the Department of Veterans Affairs contribution to the CNIB for services rendered to the 1,800 blind veterans?

[*English*]

Ms. Catherine Moore: We are fortunate that in Veterans Affairs we are allowed to bill on a fee-for-service for a certain amount of hours and service delivery. We have just negotiated a new contract with Veterans Affairs, which brings us, I think, into line with what we're doing. In a sense, we are fortunate to be reimbursed to work with veterans.

[*Translation*]

Mr. Roger Gaudet: Could you now talk about doing away with the various administrative layers? Could you explain that to me again? I didn't grasp everything you said. What did you mean when you said "do away with the system's administrative layers"?

[*English*]

Ms. Catherine Moore: There are levels of eligibility for a veteran, depending on their service in the military. Some veterans are eligible for a more comprehensive menu of services than other veterans, depending on whether they served during World War II, whether they served in combat versus in peacetime.

A person could be a veteran, for example, of peacekeeping and not be eligible for health care services as a veteran, even though they are a veteran the same as someone who served in the Korean War, for example, who has lost their vision later in life, not as a result of the Korean War. Simply they are a veteran of the war, so therefore they're eligible for services, but another person who did peacekeeping is not.

It's the levels of eligibility that are at issue.

● (1630)

[*Translation*]

Mr. Roger Gaudet: Thank you very much. If you ever need our help, we'll always be here to listen. Thank you for coming here today.

The Chair: Thank you.

[*English*]

Now we're on to the Conservative Party of Canada.

Mr. Shipley, for five minutes.

Mr. Bev Shipley: Thank you for coming, Mrs. Moore. I think you've been an inspiration to all of us as we've listened to your frank discussion, quite honestly. I think you will find that's what we appreciate very much, and not only that, but the knowledge you've given us in terms of the working relationship you've built through CNIB and VAC. Those things don't just happen. So through history, obviously, that has been fostered and has grown. So I commend both organizations for making that happen.

As we're trying to work through this VIP so we can get the job done, one of the things we have found in all the discussion is that there's always the issue around independence.

Having macular degeneration in our family, I have experienced some of the actual physical attributes that come with that. There always seems to be that issue of the independence, not wanting to acknowledge—I don't need the services, I don't need the equipment.

Whether it's through the blindness or in discussion with the veterans on post-traumatic stress disorder, we have an acknowledgement that they don't want to acknowledge that they have certain diseases. It's how we can communicate. That is the issue. That is one of the large issues. If somebody had the magic bullet to make the communication gap go away, we would be much more successful in all of our organizations.

So anything you have to help us—in general terms, not just for you—in terms of how we're going to communicate with veterans, up to the modern-day ones, we would very much appreciate that.

One of the things you talked about is the case management. Then you emphasized the fact that with the gap between when they come in at an early age and then later, there is not any tracking of individuals who come in with some sort of medical concern, even though it is small. So if they go back 20 years there are no records. Is that what you're saying?

Ms. Catherine Moore: It's a shorter time period. Well, macular degeneration, as you know, is a deteriorating eye condition. So what happens is that the person may see us initially with some mild vision loss—maybe mild from our point of view, but not from theirs—and then, a couple of years later, there may have been quite a bit of deterioration, to the point where they're perhaps not seeing much at all.

It's that failure, sometimes, of the benefit grid to acknowledge that the same person at one point might have this and at the next point might have something different. So we'll get questions like, why do they need this now when they just got such and such?

Again, these are innocent...not innocent; they're not deliberately disrespectful questions, but they're auditing-type questions. Why does this person now need this? They just had such and such two years ago. Well, because it's different now. Again, that's where the case management system would fit in.

But in reply to your original question—and again, we don't have time to wax philosophical here—the issue that veterans themselves are struggling with, and the military struggles with, is that you have two separate ethos going on at the same time. As a military person, you're expected to be strong and tough and suck it up and get out there and do the job. Do it as part of a team, etc. It's very counterintuitive for someone to require assistance.

So to overcome that—and the dilemma is very clear in the issues of post-traumatic stress, but it falls into blindness also—is to remove the stigma of needing help. That's the communications approach that needs to be, I think, engineered. Veterans Affairs perhaps would be able, through its communications department, to deliver that kind of message: it's all right to need help. It doesn't make you less tough, strong, etc.; it simply makes you strong enough to admit you can't do it all by yourself.

● (1635)

Mr. Bev Shipley: I would suggest maybe, from what we are hearing from witnesses coming forward in other venues, that there may be more recognition of that from the new vets than from the traditional ones. Because it was always, just suck it up, get over it, that's the way life will be, whereas I think now a societal issue is that I can do that as long as I know that if some issue comes along and I need some help, help is there.

I think you will hear from all of us that if the opportunity comes, we would support the needs-based in terms of any type of care over what's there now, basically, of a status.

I'll just leave it at that. Thank you, again, very much for coming out.

Ms. Catherine Moore: Thank you.

The Chair: Thank you.

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

Mr. Todd Russell: Thank you, Mr. Chair.

Good afternoon to Ms. Moore and Mr. Nunan. It's good to have you here.

I was just reflecting that I believe one of the first organizations I helped raise money for when I went to university—because we didn't have much of it in my little town of 50 people on the coast of Labrador, and some people had never heard of many of these organizations—was the CNIB. It's just one of those nice occasions that I sort of reflect on when I see somebody like you here, and the amount of money that gets raised through direct fundraising.

I just wanted to go back to your statistic again that the CNIB has about 1,800 veteran clients. You said this is somewhat low, or you figure this is a low number.

Ms. Catherine Moore: Statistically speaking, I would say yes, it is low, but I can't really tell you any more than that. I have the same sense as the other gentleman that, indeed, we're missing a group, but how we get to that group is the question.

Mr. Todd Russell: Take the 1,800 compared to the overall figures in terms of veterans and the number of people within Canadian society generally who are accessing services for impairments or blindness. How does that compare? I'm trying to see if there's a gap and how big the gap is, even statistically.

Ms. Catherine Moore: Statistically, we don't know. I can give you some figures, but I want to caution everyone that we don't know the details of this.

According to Statistics Canada's post-censal data in the participation and activity limitation survey, or PALS, 800,000 people in 2006 identified themselves as having a severe visual impairment. That's 800,000 people over the age of 15.

Now, if we take CNIB's statistics on the number of people we have, 65% of our clients are over the age of 70. Again, this is quick and dirty, but because vision loss, as we know, is age related, maybe 50% of the 800,000 are over 65 or over 75, which means we're talking about 400,000 people. Or we'll say it's that amount just in the interests of discussion.

Right now 108,000 people are registered with CNIB. I don't believe in panicking or just throwing figures around, so we don't know if there are 300,000, or 400,000, or even 700,000 more people out there who need to be getting CNIB services. I suspect that's not the case. But as we all know, as everyone in this room is mentioning, there is a gap between the people who are getting services and the people who could benefit from them but are not getting services.

So is that number big? I don't know—but it could be.

Mr. Todd Russell: Yes, I can understand that it's very difficult to get a handle on it.

I want to raise another issue. We had some witnesses appear before us regarding falls and falls prevention amongst the veterans. One of my colleagues talked about hearing impairment or injuries dealing with the balance system, which is affected by the inner ear. Is there any correlation between falls and blindness or seeing impairment? Or has any work been done on that?

● (1640)

Ms. Catherine Moore: Yes, there has been work done on that in the U.S. We have material that we will leave with you that includes indications from the Framingham study, a longitudinal study on health outcomes for people. I think there were 4,000 or 5,000 people in the study over a long period of time. The shocking figure from the study was that over 2004-05, the cost to the U.S. health system for falls and injuries related to vision loss was $2.2 billion.

Again, we don't have the research to say that if we teach people how to use a white cane, if we teach people how to keep their balance even though they no longer have a horizon as a frame of reference, we can prevent all the injuries and falls of somebody with vision loss, because generally we're also talking about somebody who has such other issues as mobility, arthritis, and that sort of thing. However, we can be pretty certain and confident, I think, that if those people were receiving orientation and mobility training—that is, how to move without sight, how to move with a white cane, how to orientate yourself in space without visual references—we could reduce a fair proportion of those falls that are vision related.

Mr. Todd Russell: Thank you very much.

The Chair: Now we're back to the Conservative Party of Canada, with Mr. Sweet, for five minutes.

Mr. David Sweet: Before you start my time, Mr. Chairman, I'd like to ask Mr. Nunan if he had something to add on that last question.

Mr. Bernard Nunan: Yes. Cathy was referring to the Framingham study, and I just wanted to point out that you do have it in your folders.

Mr. David Sweet: Thank you.

Ms. Moore, thanks for coming.

Since you mentioned the folder, Mr. Shipley mentioned communications, and Mr. Russell mentioned fundraising, I'll mention that I remember standing on Princess Street, back when I was 10 or 11 years old, helping out a Lions Club member with White Cane Week. It was quite big in those days.

Is getting the message out becoming more challenging for CNIB in terms of awareness? I don't see anywhere near the heightened public awareness—what the white cane means, how people can, with dignity, help people who are using the white cane, etc.

Ms. Catherine Moore: I think CNIB, like all organizations, is struggling a bit in a very loud, competitive world to get its message out. The cold hard fact is that nobody really wants to hear about going blind. Having said that, CNIB has taken a different approach to its communications and public education. We have gone through a rebranding process, which I think sounds funny, because your brand is not what you're about; what you do is what you're about.

We are trying a couple of things, and mitigating the stigma of vision loss is one of them. We say to people, you can still come to CNIB if you have some vision—most people with whom we work do have some—and there is no shame involved.

We are also trying to move into the research around things like whether our training reduces falls and the prevention of blindness. We are also partnering with other groups—ophthalmology, optometry, other research councils, the Foundation Fighting Blindness—because there are ways to avoid blindness. And there are medications coming on the market and that sort of thing. There's retinal research that is leading toward, if not a cure, at least ways to reduce the effects of vision loss.

Mr. David Sweet: You led right into my next question, which is on age-related macular degeneration. I understand that in the United States there are shots that not only arrest it but actually regenerate the retina. Is that correct? Do you know where we are as far as approving that drug is concerned?

Ms. Catherine Moore: There is a medication available now, which has been approved by Health Canada—it's called Lucentis—but it has not yet passed through the common drug review. This is a particular medication that arrests a very particular type of AMD—wet AMD. A much smaller number of people actually have wet AMD. I can tell you that Veterans Affairs has Lucentis on its formulary, and it will pay for it.

Mr. David Sweet: Lucentis is in a pill form, but there are shots available now in the U.S. Are you familiar with those?

● (1645)

Ms. Catherine Moore: I'm not as familiar with the shots, but the shots are a variation on Lucentis. It's a complicated thing. There is another medication. Those shots involve that type of medication that has not been clinically tested to be used with eyes. That's the difference.

Mr. David Sweet: In your package you mentioned that it's a cruel irony that cataracts are looked after in this country but not AMD—that if, on the other hand, the same person develops chronic vision loss as a result of a common eye disease, they have to go to CNIB for services. Is this the case across Canada, in every province? Health care is delivered by the province. Are there any exceptions?

Ms. Catherine Moore: Yes, Quebec is a great exception. Quebec provides a different model of service delivery in which the provincial government takes a much greater fiscal responsibility in providing vision loss services and vision care. *C'est bon, Québec.*

Mr. David Sweet: When it comes to Veterans Affairs Canada, do they get the same level of treatment, whether it's cataracts or AMD?

Ms. Catherine Moore: Yes. You can be proud that Veterans Affairs does provide reimbursement to CNIB, fee for services for CNIB, and for other areas in terms of vision loss services. Quebec and Veterans Affairs are the two models that we hope will eventually be adopted by provincial government health systems.

Mr. David Sweet: Thank you very much.

I have one last quick question on the White Cane Week and the promotion, etc. Do the public schools still have awareness for young people on White Cane Week in their curriculum?

Ms. Catherine Moore: CNIB is no longer involved in White Cane Week. It's another organization called the Canadian Council of the Blind. I believe they are still doing some information provision to the grade schools.

I know what you're talking about. Years ago I worked in Halifax, and we used to have the kids come in every year during White Cane Week. We took them on a tour, to show them how to use a white cane and that sort of thing. One time we had emergency vehicles arrive twice because one of the little persons discovered that 9-1-1 worked on the pay phone during the tour. That's a little aside.

Mr. David Sweet: I still remember how big it was.

Ms. Catherine Moore: Exactly.

Mr. David Sweet: When they're young it gets imprinted—that behaviour toward people who have sight impairment. They treat them with dignity as well. It lasts a lifetime.

Ms. Catherine Moore: Yes, I believe that.

Mr. David Sweet: Thank you very much.

The Chair: Thank you very much.

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

Mr. Peter Stoffer: If I may digress for one second on a personal note, I notice my own vision going for distance so I wear glasses when I drive at night, or if I want to see something at a far distance. Some folks have been recommending laser treatment. I haven't asked anyone this yet. Is it a good idea to get that, or just stay with glasses?

Ms. Catherine Moore: Well, we at CNIB have a policy to never make medical pronouncements one way or the other. However, if it ain't broke, why are you fixing it?

Mr. Peter Stoffer: Well, I can't see as well as I used to.

Ms. Catherine Moore: You're okay with the glasses, yes?

Mr. Peter Stoffer: Yes.

Ms. Catherine Moore: Okay.

Mr. Peter Stoffer: All right.

Some hon. members: Oh, oh!

Mr. Peter Stoffer: That's all I have to say. Thank you.

Ms. Catherine Moore: Exactly. You're much more dashing with glasses on, no doubt.

Mr. Peter Stoffer: Thank you, madame.

The Chair: We'll go to the Conservative Party of Canada again, and Mr. Cannan, for five minutes.

Mr. Ron Cannan: Thank you, Mr. Chair.

Thanks, Mr. Nunan and Ms. Moore, for the presentation and the opportunity to hear more about the CNIB.

I come from the Okanagan Valley, Kelowna Lake country. In the interior of British Columbia we have a very active CNIB. They have a few staff members but many volunteers. I have many constituents who take advantage of the services you generously offer. Some of them are veterans, and others are of different ages.

I recognize that it's White Cane Week this week, and in the next hour I'm meeting with four of the reigning Canadian national blind curling champions who are here in Ottawa. It's the national blind curling championship this week. They're the third-time champions and are looking forward to a fourth time, so they appreciate all the support as well.

I've been approached by some visually impaired individuals about the election process with Elections Canada. Have you had any recent dialogue with them? The 2006 election was my first, and I had a few people complain about the process. They like to keep their independence and they're not allowed to because of the ballot structure.

● (1650)

Ms. Catherine Moore: We work with Elections Canada. In the 1920s, one of the things Edwin Baker did, as the founder of CNIB, was change the election law to allow a veteran to go into a polling booth and vote with the aid of someone. Obviously a secret ballot is the foundation of democracy. We changed that in 1920, because before that, if you were blind you couldn't vote.

We're now in 2008 and we need to change it back so it becomes possible to vote independently. We're working with Elections Canada, and we'd love to have the support of Veterans Affairs and you folks, to make it possible. We think we have everything in place for the actual day, and I can go into details later if you like.

Candidates meetings remain an issue—knowing where they are, being able to read candidates' materials, candidates having the financial capacity to produce things in an alternate format, that type of access, just knowing where the meeting is—all those sorts of little details. I have to tell you that the blind and visually impaired community is the most engaged political community you could ever hope to meet. They are on the bit about all kinds of things.

I will share something we did in the last federal election. We advised everyone who wanted to talk to all of the candidates in their particular ridings—no matter which party, because we're non-partisan, and Bernard developed the phone numbers—to phone the candidates' offices and say, “When you're going door-to-door on my street, come and talk to me because I want to talk to you.” We were able to get you into the living rooms of blind folks to talk to them. It was really a good thing.

They're engaged and want to vote, so your question is very apt. I'm sorry, I could take all day on that one.

Mr. Ron Cannan: I thank you for that very articulate and passionate explanation and plea, and we will continue to work with Veterans Affairs and Elections Canada, if we can, to help make that a reality.

I know how passionate some of the visually impaired are in my community. I spent nine years in local government. I've tried the simulator, walked through the streets trying to visualize—no pun intended—the fact that you're walking around and trying to take on their life and understand the challenges they face, the curb cuts and the snow and the conflict between the different wheelchair accessibilities.

If you have a veteran in a wheelchair and one who is visually impaired, they have different needs. That's something else that, in working with communities across the country, we have to address as well.

Talking about passionate individuals with a passion for politics, one of my most dedicated volunteers is a visually impaired individual. We've had many good debates.

One other area is that some of the veterans would like to go to a place, sort of a relaxing area, almost like a community centre. That's one of the challenges. Some of the CNIBs don't have the ability to set up a separate recreation centre, almost like a lounge, where you could go and interact. Have you been able to establish those in any of the major urban centres?

Ms. Catherine Moore: The Canadian Council of the Blind—the folks you're meeting with afterwards—have chapters and recreation areas and that sort of thing. I think they are better equipped to provide that type of gathering and peer support. I think peer support is a bad word for just sitting around and talking to your friends. We can get very technical about it, but that's what people need. We're human beings. Everyone needs social interaction. The CCB does a good job and wants to do a better job at that.

Mr. Ron Cannan: Thank you very much for the great work that you're doing, both of you. We'll continue to do all we can to help make your life as enjoyable as possible, and a productive contribution to society.

● (1655)

The Chair: Thank you very much.

At this stage, unless there are any other committee members who are—

Mr. David Sweet: Yes, I have one more question.

Since it's come up a number of times, I wonder if you could articulate for us the difference in the mandates of the CCB and the CNIB, so we have some clarity on that.

Ms. Catherine Moore: Yes. I have to tell you that tomorrow night I'm at the CCB curling for White Cane Week event as a stand-up comic, so wish me luck. So there's plenty of interchange, back and forth.

Mr. David Sweet: Do you want to try some of your stuff on us?

Ms. Catherine Moore: No, no. I think that would be cruel. I'm hoping they drink a lot before I get there.

The CNIB is a rehabilitation agency. Rehabilitation by its nature, if you do it right, should not be for the rest of somebody's life; it should be short term. Now, short term could be a year, and it doesn't matter if the person comes back 50 times, but there should be a clear statement of what we are going to do, what your goal is, and we work with you to enable you to meet that goal. We do rehabilitation. We provide services.

The CCB is a grassroots membership organization whose mandate is to provide leisure and recreation and a social gathering and to advocate on behalf of people who are blind. The CCB's membership is made up of people who are blind.

In CNIB, we have a membership and a governance structure, but not necessarily everyone is blind.

So the simple differentiation is that we provide a service, and the CCB provides more of a long-term social, club, or community adherence.

Mr. David Sweet: That's probably the only place where you cross mandates, as I would think that both CCB and CNIB do a certain degree of advocacy.

Ms. Catherine Moore: Absolutely. CCB was at the table with us with Elections Canada, and it was enormously helpful.

Mr. David Sweet: Thank you.

Thank you, Mr. Chair.

The Chair: All right, then, at this stage I'd like to thank our witnesses for their appearance today. I give you credit in the sense that it's kind of like writing an essay. You made sure you told us what you were going to tell us, you told us, and then you told us what you had told us. That's important, because sometimes there's not that focus with regard to presentations. So I appreciate it.

If you don't mind, if committee members wish to say their goodbyes and thank yous, we still have a few items of business to proceed to. So if the committee doesn't mind, I'm just going to move into that, and you're free to just kind of pack up or do as you wish.

First, I'll inform the committee members that we had a victory at the Liaison Committee. With regard to our travel to the four different bases, that is a go. We've had approval for the 10 members, plus research, plus clerk, plus support staff, plus interpreters. So that's all good.

Another thing that may be slightly saddening, maybe for Mr. Russell particularly, is that we did look into the idea of being able to alter the time somewhat with regard to the visitation at Goose Bay. I understand that there's a family matter in your neck of the woods. It would have meant taking a charter flight directly from Cold Lake to Goose Bay, which we understand is longer than a transatlantic flight to Europe, not that I'm opposed to that. But that would have meant leaving Cold Lake that evening, not arriving in Goose Bay until 5 a.m., and then going straight from arriving there on a red-eye to basically getting on the tour. Anyhow, we gave that some consideration but decided that probably the stopover was a better way to do that. We apologize, but we looked at it—

Mr. Todd Russell: That's all you can do.

The Chair: —and that's what it came to.

Now, just for edification or knowledge, I signed the per diem form with regard to that travel.

The last thing is with regard to that travel. I believe some committee members brought forward the idea that maybe we'd leave slightly early on one of the days, and that way members can get back for connecting flights to their ridings on Friday.

Mr. St. Denis, do you wish to speak?

Mr. Brent St. Denis: Yes.

For some of us who live in non-metropolitan areas—Mr. Valley, who's up in Kenora, whose car is in Winnipeg, and me in northern Ontario, and maybe some others—for the sake of about an hour and a half, two hours maximum, on Friday afternoon, could we simply leave a little bit earlier on the charter from Goose Bay? I've chatted with my friend here, who feels that we can get the job done there by two o'clock. I'll let him speak for himself, but he thought that might be possible.

I have a family baptism on Saturday morning, not my own child but my sister-in-law's, and I'd have to leave, for example, on the1:50 commercial flight. Roger is in the same boat. Otherwise we don't get home until Saturday. So for the sake of about an hour and a half, if we could tweak, compress, work over lunch, or start as early as Todd can get there from his wedding up the coast, maybe we could get away at around two o'clock or 2:30. We'll have to confirm the times exactly with the company. If it's three hours, with the time zone difference, that's great, because it's like 2:30 to 5:30. There's a seven o'clock flight to Toronto. We're going to arrive at the Shell or Esso Avitat, and we have to get from there over to the main terminal, so we might want to land sometime between 5:30 and six o'clock so we can get cabs over to the main terminal and have enough time. Friday night might be a busy time for security and what not, with Friday night business travel.

If Todd is still okay with that, I'm sure we can get everything done.

I'm not sure how far the base is from the airport.

● (1700)

Mr. Todd Russell: We land at the base.

Mr. Brent St. Denis: Then if we could get out of the room at two o'clock for a 2:30 takeoff, for maybe a 5:30 landing....

The Chair: Okay, just so committee members understand, we're arriving at Goose Bay, I believe, on Thursday evening. Then we'll have the chance to see around the base and talk about the issues and interact and whatever on Thursday and Friday morning and afternoon. So the proposal is to just leave a little bit earlier on Friday, in mid-afternoon instead of in late afternoon.

Go ahead, Mr. Cannan.

Mr. Ron Cannan: I concur. It might even make more sense—because I have to fly out of Toronto too—to land in Toronto.

Mr. Brent St. Denis: You'll get to Toronto probably faster landing in Ottawa. We have all the staff and everything to drop off. This is not a jet, I understand. This is a twin engine, one pilot, kind of "strap your bags to the underbelly"—

Mr. Todd Russell: Every seat is an aisle seat and a window seat.

Mr. Brent St. Denis: Is it a Dash 8?

The reason I raise the speed thing is that I charter in my riding. I have a big riding, and once in a while I charter and I use a medevac plane. This thing goes over 300 miles an hour. It's a twin prop and a turbo prop. It flies. It really makes a difference when you charter to know what kind of plane they're using, because they could use a really slow putt-putt and charge you the same price as a fast one.

There was one trip where we used a jet and, I'll tell you, we got from Ottawa to St. John's in an hour and 15 minutes.

You have to balance costs, time, people's weekend committed to work, and what not.

The Chair: Fair enough.

I don't sense that there's any fight on that issue around the table. I think everybody is fairly amenable with being able to make connections and what not on late Friday. I think the clerk and the people who will be coordinating that understand.

With that, I think we've covered everything. The meeting is adjourned.

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