House of Commons
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 015 • 2nd SESSION • 39th PARLIAMENT

EVIDENCE

Tuesday, March 4, 2008

Chair

Mr. Rob Anders

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● (1530)

[*English*]

The Chair (Mr. Rob Anders (Calgary West, CPC)): Welcome to yet another meeting of our glorious veterans affairs committee.

I would like to welcome our witness for this afternoon. From Simon Fraser University, we have Gloria Gutman, co-leader of the British Columbia Network for Aging Research, and former director and professor emeritus, Gerontology Research Centre and Department of Gerontology.

You're probably aware that this is pursuant to our study of the veterans health care review and the veterans independence program.

The way it generally works is that our witnesses receive either ten or twenty minutes. In this case, the clerk says it will be ten minutes. I'm sure that if you were to extend beyond that, we would not treat you harshly. Then we go to a predetermined order of questioning. The first round is generally seven minutes, and after that it's five minutes back and forth.

With that, I offer the floor to our witness and guest.

Thank you.

Mrs. Gloria Gutman (Co-Leader of B.C. Network for Aging Research, Former Director and Professor Emeritus, Gerontology Research Centre and Department of Gerontology, Simon Fraser University): I'm pleased to be here.

I would like to begin by saying that I have long been a fan of the veterans independence program. In one of my capacities, which is that of immediate past president of the International Association of Gerontology and Geriatrics, on numerous occasions and in numerous countries I have spoken with considerable pride about our continuing care activities in this country, drawing particular attention to the VIP program, which has played a leadership role over the years.

I'm here wearing a number of hats, but in respect of my research, I'm probably best known as an environmental gerontologist. My speciality has been in seniors housing, shelter and care for persons with dementia, and in the built-environment side of things, extending as well to WHO projects on cities that are age-friendly.

Today I'd like to speak a bit about some recent research of mine on how to make hospitals more age-friendly. This is particularly important. We need to remember that the bulk of veterans are able to stay in their communities because when they are ill or have an accident they are able to go to a hospital and get the care they need. To a lesser extent, this also applies to those who look after these veterans, the older wives, daughters, and so on.

What many people don't know is that, unfortunately, sizable numbers of older people who go into hospital because of congestive heart failure, a heart attack, or a fall lose functional status and independence while they're in the hospital. The resultant condition can be far more severe than the one they were admitted for. One reason for this has to do with iatrogenic illnesses—in particular illnesses that come about because of some treatment or procedure. Often it's a medication interaction or medication misprescription. But there are also other causes. Some of them lie in outdated beliefs and stereotypes about what you can and cannot repair in older people, what treatments and procedures they can successfully survive and thrive on.

What we're learning more and more is that age per se is not a good predictor of who should qualify to be a recipient of a heart transplant or a bypass surgery. If you think back 10, 20, 30 years, many of the procedures that today are commonplace—knee replacement, hip replacement, triple and quadruple bypass surgery—were thought to be far beyond what any older person could survive. They were considered too risky for older people. We now know that in fact many of these procedures can be successfully performed and can provide a better quality of life to older people. There are still some people in the medical field, some nurses and doctors, who are not as aware as they should be of the resilience of older people. So we need to increase our supply of geriatricians, geriatric nurses, all of the allied health professionals that work with older people.

● (1535)

Some of the blame for the deconditioning that happens when older people go into hospital resides with the seniors themselves. They think they need to remain in bed, whereas in fact the opposite is true. The sooner they can get back on their feet and start to resume the activities of daily living, the greater the possibility that they can go home and continue to live independently.

It's also important to recognize that the physical environments of hospitals can act either as barriers or as facilitators for older people. We did some studies in British Columbia in acute care hospitals, and we looked at the design of the hospitals. We talked to staff, and they told us what they thought were the problems. Then we brought in groups of older people who were all over the age of 75 and still living at home. They weren't sick, but they were older people somewhat on the frail side.

We exposed the older people to two different rooms. One was a traditional hospital room. The second one had started out the same as the first but we adapted it, and we found that it did make a difference in terms of their ability to understand and remember post-discharge instructions and in terms of their being safely mobile as they moved about the room. They got out of the bed, walked towards the washroom, sat themselves down on the toilet, got up from the toilet, went over to the sink, and pretended to wash their hands, brush their teeth, and comb their hair—all of the things that many of us take for granted and that people who go into hospital need to resume doing as soon as they possibly can.

The design alterations we made were all done in stages. The first thing was to drop the ceiling and to add some acoustical tiles to act as sound barriers. The second thing was to put in a rubberized flooring. The third thing was to make it possible for the patient to control the lighting. Many times when an older person—or anybody, for that matter—goes into hospital and they're in a bed, to reach the light, which is way behind the bed, they have to have considerable manual dexterity to grasp and pull the string. We realized that this was beyond what people could do, and that they were falling out of bed and breaking their hips for reasons like that. But if you go into a Home Hardware, you can buy—off the shelf, for a very minimal cost—a remote control that allows you to turn lights on and off.

We also found that by making it possible for the older persons themselves to control the bed going up and down, it was much easier for them to get out of the bed and to do so without tripping and without injury.

Another kind of simple adaptation we did was to put an automatic light, a movement-activated light, in the bathroom. When the door opened and they entered the bathroom with a walker, they didn't have to take their hands off the walker in order to turn on the light.

So there are a lot of simple solutions that can be done to make hospitals much safer and to make it easier for older people to be able to be independent during the period while they are convalescing, which has a great impact on what will happen when they go home. These are small illustrations.

The study was done in a community hospital, but I draw it to your attention because I know that many veterans who become frail end up in veterans hospitals. I would bet your hospitals are no better than the community hospitals in terms of the physical design. And these things can be done. These are adaptations that need to be done.

● (1540)

A set of studies we have not yet done, but which needs to be done, has to do with making hospitals safer for people with dementia. The good news is that more and more people are living to be old. The bad news is that over the age of 85, the probability of having a dementing illness goes up considerably. But those people, if they get physically ill, still need to go into hospital and need to be safe.

Many of these same kinds of adaptations can be done to the homes of older people for relatively minimal cost. When you think what it costs if a person falls and has a serious injury from that fall, the adaptation is well worth the kinds of costs that might be involved. Canada Mortgage and Housing Corporation, through the various programs it has had over the years, has made it possible for some of these kinds of adaptations to be funded. Those programs need to be expanded, continued, and improved and enhanced, both for veterans and for other people.

In terms of seniors housing, we talk about the six As. Again, I know that in the veterans program many units have gone up. They tend to meet the first A, which is affordable. We think about accessibility, tend to think about it as wheelchair accessible, but with normal aging what many more people experience is sensory fading, so you need to be concerned about lighting and sound and those kinds of things. They need to be attractive. They need to be acceptable, to be the kinds of homes people want to go into. And people need to be able to age in place, which is the catchword these days, meaning that people can stay in a familiar environment for an extended period of time.

One of the things that makes that happen is the availability of some alternatives, so that if they cannot manage in the family home or in conventional housing without some help, they can move into an assisted living facility. As there is further change, those who do require it should be able to get into a care facility.

In many parts of the country, care facilities are now restricted to only those who are very, very fragile, so there is a gap between independent living and assisted living, and then the care facility over here. What happens to those people in the middle? We need to be sensitive to those kinds of challenges. Those are the primary things.

The other issue, which has to do with design, is making it possible for people to be very much a part of the community in which they live. This means being able to get out of their home and to navigate to get to the store, to get to the bank, to get to the doctor, and to be independent for as long as possible, which has implications in terms of how you design your streets—the traffic signals, traffic patterns, and so on.

The World Health Organization, in conjunction with the Public Health Agency of Canada, has just finished a project that was done in 33 cities around the world. That now has a rural and remote component in Canada, where they're looking at how to improve communities to make them more friendly and to keep our senior citizens functioning. These apply to veterans; they apply to other seniors.

I guess the unique feature for veterans is the experiences they have had in the past and how those translate in terms of current changes in behaviour. We know that some seniors are at risk because of their previous experience; some seem to have greater resilience because of their previous experience.

● (1545)

Certainly the message that comes through loud and clear is the heterogeneity, both of your veterans community and your general community. There is not a one-size-fits-all. Gerontologists are very much talking about options, alternatives, and a range of different kinds of living, working, and recreational spaces for our senior population.

Those were the main issues I wanted to bring to the table.

The Chair: Fair enough. Thank you very much.

To let you know, according to my time clock, you went thirteen minutes, and I didn't start the clock until you were two minutes in. We let you have a good run at that.

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

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

I can guarantee he won't be near as kind to me.

Thank you very much for your presentation today. I come from northern Ontario—Kenora riding. A lot of my questions are going to be around the professionals we use to help protect the older generation.

I was amazed at what I learned from your comments just on my own home. I'm the oldest guy in it, but I'm not quite as old as some of my colleagues. You just cleared up a problem in my own home. I have a mother-in-law who's older than 75, and her older brother. The biggest complaint she has when she visits is that she's not in familiar surroundings and she could easily fall. I could alleviate that through the comments you made about remote control. I had never thought of that; I thought it was just my mother-in-law complaining. It's amazing how we can do something in our own homes.

I want to ask a lot of questions about age-friendly cities. We have just started hearing these kinds of comments, so I'll be looking into that.

You said we need more geriatric nurses—I think that was the term you used.

Mrs. Gloria Gutman: Yes.

Mr. Roger Valley: Do they come from the existing nurses who decide to specialize, or do they become trained to deal with older people right from the first part of their career?

Mrs. Gloria Gutman: They do generic training in regular nursing and then some specialization.

We would argue that in today's population we need to have every nurse who is trained in a module on geriatrics. After all, who are in hospitals? It's basically the older population. Many of the younger people are now being treated as outpatients.

Mr. Roger Valley: That's true. So you're not saying a specific geriatric nurse qualification, but everyone who is there....

Mrs. Gloria Gutman: It's a specialization.

Mr. Roger Valley: Do they do it right out of university? I have mentioned before that my daughter is a psychiatric nurse, but she came out of university like that. She wasn't a nurse first and then specialized.

● (1550)

Mrs. Gloria Gutman: There are training programs that give them the credential to call themselves geriatric nurses.

Mr. Roger Valley: Okay.

We just finished touring some military bases, and we heard about the services being provided, or that are trying to be provided, for the serving men and women in the forces. We know there's a break when they leave the forces and become veterans. They're not receiving any kind of transition, and it makes it difficult for them.

The thing we heard about the people who are serving is that there are not enough professionals in any of the fields. How do we deal with that?

As I mentioned, I'm from one of the areas in Canada with not much population, large distances between communities, and very few services for the general public, let alone the aging public. How do we try to get more professionals into this field?

Mrs. Gloria Gutman: It's interesting. When the question is asked why they don't have a problem in Britain recruiting into geriatrics, it's because the geriatricians are paid at the same rate as surgeons or urologists or psychiatrists. In this country there appear to be some differences. First of all, it often takes more time to work with the older patient. You have to talk a little slower; you have to give them a little more time. There is not the same incentive. They don't make as much money. The surgeons can perform a lot of surgery and get higher fees than the individuals who specialize in geriatrics.

We also need to make it clear to the young doctors that this a very challenging field. We need to put in some incentives—scholarships, prizes, reasons for them to be attracted to the field and to see the potential.

Mr. Roger Valley: Thank you.

You classified yourself as an environmental gerontologist. Are there many people in your field who provide advice?

I know I'll be cut off shortly, but again to that, you just mentioned Britain. Where does Canada stand in the world, then? What's our approach toward geriatrics? Are we doing well? Do we have a long way to go to get to where Britain is?

Mrs. Gloria Gutman: We have been blessed in this country by a number of Brits who came over here and who have played leadership roles. The people who have come into the field have been excellent, both the imports and the local people who have been attracted to the field. We've been lucky that the geriatricians are very good, as good as you'll find anywhere; there just aren't enough of them. We have tended to use them as resources to deal with the more difficult problems, because there never will be enough. Again, you have to insert into the generic training of virtually all the specialties and subspecialities the idea that they're going to see more and more older people, and that they should think about prevention in particular.

Mr. Roger Valley: Prevention will go along with being an environmental gerontologist. That's what you do. That's how you explained yourself. Do you get resistance when you're trying to explain what we need to do inside our home environments to actually make a difference"? Is enough attention put on that? You just said there probably isn't.

Mrs. Gloria Gutman: Well, there are not a lot of us. The Simon Fraser University Gerontology Research Centre is one of those places in the country that does specialize in this area, but there are people around the world who belong to several of the subgroups dealing with issues of housing for seniors and environmental gerontology. Yes, we are consulted—not as much as we would like, but we are consulted.

Mr. Roger Valley: Thank you.

Mrs. Gloria Gutman: Part of my role in life seems to be that I get the developers who come across from south of the border. You can see the saliva dripping. They think that there's all this older population and that they're going to bring their products from the U. S.A. and they're going to work in Canada. What they don't realize is that we have a very different health care system, in the sense that many of our people will stay at home for as long as they possibly can. They will access home care; they will take advantage of the services available; and they will, if somebody tells them where they can access some funding, in fact make adaptations.

● (1555)

Mr. Roger Valley: Thank you.

The Chair: All right. Now we'll go over to the Bloc Québécois and Monsieur Perron. *Vous avez sept minutes.*

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good afternoon and welcome, Madam. I thank you for coming today.

In answer to the last part of my friend Roger's question, you said that the tendency that is emerging today is to keep older persons at home as long as possible. Even though these older people need care, we try to care for them at home.

I believe that the problem is whether we have the qualified personnel necessary to keep these people at home. Are there family members present and are they qualified to take care of these older people in their home? Generally, family members are taking up the task. You talked about the adaptations that must be made to the house, which I greatly appreciated, but I would like you to tell us more particularly about how we can make older people comfortable at home, before they reach the point where they must be hospitalized. You talked mostly about the situation at home. I would like to hear your views on this subject.

[*English*]

Mrs. Gloria Gutman: Many people are able to stay at home if they can get some.... It's what we used to call homemaker services, but they now call them home support workers, who can come in and do some of the housekeeping, make some meals, and assist them with bathing, assist them if they need to go to an appointment.

What has happened in a number of our provinces, my own included, is that we had many of these services that were available at relatively low cost for those—it was means-tested—who could not afford to pay for it themselves, but many of those have been cut back. That's the prevention side of things.

If you want to keep people staying in their own homes, then those kinds of services need to be available. That was one of the areas in which the veterans independence program played a leadership role—making some of those kinds of home support services available.

There are often arguments about whether we can afford, with our aging population, to provide some of these preventive services. I would argue that we cannot afford not to provide prevention, because if people are needing those kinds of services and they can't get them, then they will end up occupying much more expensive services at a premature time in their lives.

As far as family being able to provide support is concerned, the vast majority of families who are doing these services, particularly for your veterans, are their spouses, who are not much younger than they are, and sometimes more frail.

● (1600)

[*Translation*]

Mr. Gilles-A. Perron: There is another element to be considered: distances can be long in Canada. The more I know about the subject at hand, the more I realize that the majority of services are designed for major centres. In a small village such as my home village of Évain, in Abitibi, which is in Northern Quebec, there are no services. Services are provided informally and we do our best to cope.

How can we solve this problem? I do not believe that an older person should be uprooted from his or her small community and be moved to a major centre in Ottawa, in Toronto or in Montreal. How could we better adapt our services to the needs of older people?

[*English*]

Mrs. Gloria Gutman: Well, some of the ways that are being explored are in terms of application of new technologies. You know, many old people watch television. There's a lot of health information that you can give over television. There are systems being developed that allow a physician or a medical person who is remote from that older person to be able to do diagnosis.

There are various kinds of technologies you can use to do cardiovascular readings, check for diabetes. There are all kinds of things that are possible that companies like Intel, in their demonstrations, tell us can be adapted and used by older persons.

The problem is they are not mass producing many of those technologies at a price that is affordable for the average person. If you can put a man on the moon and you can monitor all of his functions, it should be relatively simple to be able to do some of that in our rural and remote communities. But we have not put our attention to it to the extent that we should.

[*Translation*]

Mr. Gilles-A. Perron: Is it because of the cost that we are not paying attention to it?

[*English*]

Mrs. Gloria Gutman: Some of it is just a matter of attitude, not recognizing the potential size of the market, and the belief, again....

You know, I spoke earlier about people not understanding, seniors included, the possibilities of rehabilitation or habilitation. Similarly, there are opportunities for technology because of the fact that you have a potentially huge market worldwide—not just in Canada—of people who are living outside of major centres. Instead of making another iPod for the kids, they should be thinking about how we make that iPod work for an older population, some of whom are not quite so techno-savvy.

[*Translation*]

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

[*English*]

The Chair: Merci.

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

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

Thank you, Madam, for your presentation.

We have the Canadian Medical Association in town today doing their lobbying efforts. One of the things they did with MPs was check our pulse, our blood pressure, our glucose, and all that, and I found out today that as a 52-year-old, I have the body of a 51-year-old. Amazing. It's simply amazing.

My question for you is about dealing, generally, with a generation that doesn't like to ask for help. How do we get them around the asking and actually say, you know, you can do this?

Second, of course, in terms of veterans and their past experiences, is that some of them may be suffering not from dementia or Alzheimer's but from psychological nightmares or concerns of that nature. It concerns not just them but their caregivers as well. What advice do you give to the committee in order to assist them in dealing not only with their own human frailties but with their psychological frailties as well?

● (1605)

Mrs. Gloria Gutman: One of the things that has been found to work in a variety of contexts is having peers give the lessons. So it's one veteran talking to another, one older person talking to another, and using our older people as resources. At any point in time you will have about 5% of seniors who are sufficiently disabled that they require institutional care. Another 10% are living at home with major restrictions on what they can do. That leaves 85% who are able to do most of what they want to do most of the time and who have things they can offer other people.

If you read the reports on volunteers, you know that per capita, those seniors who volunteer give more hours than many of the younger people. Many seniors do volunteer, but I think we have an untapped resource in terms of using peer groups and peer leadership to deal with some of the problems of aging.

Mr. Peter Stoffer: In my own riding and across the country there are people who are functionally illiterate. They don't understand prescriptions. They don't understand what a doctor writes up. In some cases, inadvertently, not on purpose, the person who is speaking to them speaks above their heads at a level they just tune out. They don't want to feel stupid. They just basically say they didn't hear a word that person said, because they didn't understand.

What advice would you give practitioners and professionals, not to dumb down the message, but to make the message as straightforward as possible so that they clearly understand what's available?

Mrs. Gloria Gutman: That again is something that needs to be in the generic training. We need to get into the very basic medical curriculum that you should understand who your patients are.

We also need to use some of the other health professionals. Medication is a huge issue, but there are many pharmacists in various communities, and there have been demonstration projects showing that the pharmacists are able to answer the front-line questions. They take the time. They're willing to answer the questions. So we need to take greater advantage of the allied health professions and not just rely on the physician. To many older people the doctor is the last word, but still, they will listen to another professional.

Mr. Peter Stoffer: The last question for you is the cultural aspect. As you know, the face of Canada is changing. In about 20 or 30 years, many of our seniors will be of Asian descent, Middle Eastern descent, African descent, and first nations people, of course. That is changing, and obviously there will have to be a change in the approach of some of the practitioners because of cultural differences. Do you see them preparing for that?

Mrs. Gloria Gutman: Certainly if you take a determinants-of-health approach, then you have to recognize culture is a very big issue. Culture and gender are the two cross-cutting variables within the World Health Organization's active-aging model. In virtually every situation you need to take those two into consideration.

In our own document produced by Health Canada, the document that has to do with policy directions, it says very clearly as well that we need to look at and take a determinants-of-health approach. The face of the country is changing, and presumably the face of the health care professions is also going to change, so that's a positive note.

● (1610)

Mr. Peter Stoffer: Thank you.

The Chair: Thank you very much.

Now over to the Conservative Party of Canada and Mrs. Hinton for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Good afternoon, Mrs. Gutman, and thank you very much for coming today.

You've talked about a few things today that I would love to hear a little bit more about, but I have some observations, if you will bear with me. It's obvious to me that you're interested in all aging Canadians, as I believe everyone at this table is, but this committee's mandate is to speak about veterans and their health issues and their aging. It's part of what we're dealing with in this committee. I'll get to a point later where you might be able to speak specifically to veterans.

You mentioned something I found very interesting. You used the phrase “physical design of hospitals”. I think most of us would be guilty of the same problem, that we don't really think about the physical design of a hospital because with any luck at all we stay out of them. If you end up having to go to a hospital, you're usually feeling pretty rotten anyway, and you're now at that age where some difficult things are happening, as you described the acoustics in the bathroom and changing the flooring, etc. Those are all very interesting things to me.

Do you advise provincial governments as well? Are you part and parcel of that? That would be one question, because obviously hospitals are under the mandate of provincial governments. Do you give advice to hospitals?

Secondly, I'm reading that the mission of the B.C. Network for Aging Research is to “increase the overall capacity for aging research and leverage funding by bringing together individuals and organizations with an interest in aging research”. What kinds of groups and organizations do you work with? Do you believe the collaboration of these groups allows the research to be more complete?

If there's more time, I have a couple more questions.

Mrs. Gloria Gutman: To answer your first question, the research I did was commissioned by the Fraser Health Authority. To their credit, they have been looking into the issue of age-friendly physical design of hospitals for some time, and they came to the gerontology centre at the university. I did a review of the literature for them, because they wanted to know if they were missing something, and then designed the study to answer some of the gaps that were identified.

So yes, we certainly are consulted by groups or agencies like the Fraser Health Authority, which deal with a sizable population. We try to transfer the knowledge so the information is available to other people and other jurisdictions.

Mrs. Betty Hinton: You're a member of the International Association of Gerontology and Geriatrics' executive committee. You're a very impressive lady, by the way, with all the things you're involved in, and I offer you my congratulations for what you do for seniors.

How do you feel the services offered to Canadian veterans compare with those that are offered in other parts of the world? What changes would you implement if you had the authority to do so?

Mrs. Gloria Gutman: Let me answer your previous question first, which was the one about the groups that the B.C. Network for Aging Research brings together. What we try to do is bring together health authorities with academics, the provincial government, and the private sector, as well as with consumers. We find that the seniors need to be involved in the research, both in drawing attention to what questions need to be answered to improve their quality of life, and also in the area of technology or environmental gerontology, where we most definitely want to user-test the products.

The users need to be consulted right from the beginning, through the prototype and through to the next stage, the development of the product, because there are closets full of assisted devices that people have bought. They use them once or twice and they find them too darned difficult, so they sit unused.

In the study we did for Fraser Health we tried out some grab bars that were available from a commercial outfit—they sit on either side of the toilet to enable people to steady themselves so that they can get on and off safely—and found that they were just too difficult to manipulate, except by the tallest and strongest of our sample of people.

● (1615)

Mrs. Betty Hinton: It defeats the purpose, doesn't it?

Mrs. Gloria Gutman: So you have to try them out.

Mrs. Betty Hinton: The last question I asked you is how you feel the services offered to Canadian veterans comparate with other services around the world. How do you feel it's going, and what would you recommend as a change if you had the authority to do so?

Mrs. Gloria Gutman: Relatively speaking, I think the services that have been offered have been exemplary. That's why I prefaced my remarks at the beginning by saying that the VIP program, particularly on the home care side, has offered some very good opportunities in support of seniors.

There was a recent article in the Canadian Association of Gerontology's journal, “They Suffered With Us and Should be Compensated: Entitling Caregivers of Canada's Veterans”. I think the gerontological community would agree that the support of those caregivers is an area that could be strengthened and expanded.

Mrs. Betty Hinton: We've managed to add 24,000 veterans and their caregivers to the program in the last two years. It's something I'm very proud of, but I will give you my assurance that this is not the end and that there will be more.

You are making a contribution to this committee making recommendations in a report, so thank you for your time.

Mrs. Gloria Gutman: Also, as we continue to be involved in peacekeeping or in efforts such as Iraq, we're going to have succeeding generations of veterans, and those groups are each going to be different. The people who are coming back from the countries in which we've been sending troops are techno-savvy, for example; that's a very different cat from the veteran of previous wars.

Mrs. Betty Hinton: We're not in Iraq, by the way.

Mrs. Gloria Gutman: So you have to keep being dynamic.

Mrs. Betty Hinton: Canada's not in Iraq; we're in Afghanistan. But you said that you have connections to groups in the United States, so I can certainly understand that little mix-up.

The Chair: My goodness. Thank you very much.

We'll go over to Mr. St. Denis, with the Liberal Party of Canada, for five minutes.

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

Thank you, Dr. Gutman, for being here. It's very interesting.

I was late because I was visiting with a delegation from the Canadian Medical Association. They're doing a lobby day today on the doctor shortage. I'm not sure if my colleagues have met with the delegations as well.

You mentioned the importance of training more geriatricians. One of the interesting points they raised was that many students going through post-secondary incur student debt. According to the figures they provided, the average medical student leaves medical school with $158,000 of debt.

So when you're looking at becoming a family physician or specializing, for the average person, cashflow becomes an issue. When choosing a field, if you have the intellectual capacity and opportunity, you may choose a field in which the income stream would be higher, allowing you to deal more effectively with the debt.

I'm going to guess that maybe geriatricians aren't on the high-income end. You mentioned income. We're humans, and taking care of our families and having a certain lifestyle are important for most people. So their suggestion was that we have to somehow weight the debt load as a sort of national priority, or do something with the cashflow so that medical students are making choices of a sub-profession based on their interests, their special loves, and the needs of the marketplace, as opposed to their own cashflow needs.

I'm wondering if you have any comments on general levels of compensation for geriatricians—because I'm sure there's a shortage—vis-à-vis professionals in other fields of medicine.

● (1620)

Mrs. Gloria Gutman: I would think we should be thinking about offering some incentives and some bonuses to those people who go into geriatrics, because this is a service that we need.

Mr. Brent St. Denis: Okay, fair enough.

In another vein, a witness who appeared a few meetings ago mentioned age-friendly communities. And of course there would necessarily be an important health and medical aspect to age-friendly communities. I don't recall that they mentioned where, but they mentioned there were some pilot communities that, with Health Canada's assistance, had sort of developed some models of age-friendly communities. Do you know anything about those?

Mrs. Gloria Gutman: Yes, I do. That's a World Health Organization project that was done in conjunction with the Public Health Agency of Canada.

A guideline document that talks about how to make your cities more age-friendly has been produced. That came about from talking with seniors in 33 cities around the world. That is available on the WHO website.

Mr. Brent St. Denis: Okay. Thank you. That's very helpful.

It's something about which we were trying to get more information. I happen to represent a large rural riding, but one of our communities, Elliot Lake in particular, has attracted thousands of early—and is there such a thing as a middle-aged retiree, like in their sixties—and some older retirees to northern Ontario because of the modest cost of housing and clean air and so on. It is creating some unique challenges and opportunities for—

Mr. Roger Valley: And it's a Liberal environment.

Mr. Brent St. Denis: Yes, clean air. So thank you for that reference.

I'll conclude with one of the points you made. You talked about the application of senior-friendly technology and the integration of that technology in such a way that you didn't have one device for the lifeline hanging around your neck for when you fall, and another one over here for the lights. You mentioned the things they had developed for the first lunar landing.

It would seem that we have, within our grasp, fairly inexpensive options that we could integrate into one simple clutter-free, trouble-free device for seniors. Am I right in assuming that we need to integrate these things so that they control lights and contain something to answer a door monitor, if, for instance, someone says “Hello, it's your neighbour, Mary Smith”, and so they can lock the doors or unlock the doors, or turn on the computer so you could access, maybe through a video conference, a professional?

There must be ways to make it very simple. I know it would be helpful to me, and I'm not yet a senior.

Mrs. Gloria Gutman: The integration is a little trickier than what meets the eye. I've been asking exactly the same questions as you have for probably the last ten years, since we developed the Dr. Tong Louie living laboratory.

The idea was that yes, there's too much independent technology and not enough where all the information comes in to one place. It is possible to do. There are some software engineers, biomedical engineers who are working on those products, but they still have a ways to go. Again, the idea is that if they can solve that problem and make the device that will do a whole bunch of things at once, all of us are going to want to buy it.

The incentives have to be there. We need to talk to our funding agencies to answer to CIHR, to the Institute on Aging, and suggest to them that they should be maybe having a few special competitions on the technology development side of things for assistive products. Traditionally it has been more difficult to get research funding for that area. There are groups around the world that are working on it, but the funding has been limited.

● (1625)

Mr. Brent St. Denis: Thank you.

The Chair: Thank you very much.

Now over to the Bloc Québécois. Monsieur Gaudet, *vous disposez de cinq minutes*.

[*Translation*]

Mr. Roger Gaudet (Montcalm, BQ): Thank you, Mr. Chair. Your French is improving, which is very good. Congratulations.

Good afternoon, Madam Gutman. My mother is 98 years old and she is living at home with my sister who will be 70. Sometimes, we wonder whether it is my sister who's looking after my mother or my mother who's looking after my sister. We are a large family: we were 12 children, 10 of which are still alive. We greatly value our family and we greatly care about it.

What I find elsewhere is that there seems to be a lack of caregivers. We do not want older people to be institutionalized in long-term care homes. However, it seems to me that we do not have enough personnel for home care. I would like to know your opinion about that. Why are governments saying that they do not have enough money? For me, that is one issue.

[*English*]

Mrs. Gloria Gutman: It's a problem around the world that has been caused by the drop in the birth rates. Around the world young people are having far fewer children than they used to have. So there is a much smaller supply of family to provide for older people. If anything, that says to us that there needs to be investment, there needs to be development of the home support industry. If we don't have a daughter, a son, or grandchildren to look after us, then we hope there will be a supply of paid labour to look after us.

Much of the home care around the world is being provided by immigrants. In the Pacific Rim countries Filipino nurses have played a major role in support of older people. We certainly want to make sure that people who are coming into the country and who are engaging in this kind of work have the right kind of training and the right kind of personality. In general, we have been blessed by some very good immigrant workers who have come in and taken on the role.

We need to think about the quality of home care. We began to look at the quality of hospital care, but there has been less attention paid to the quality of home care. Some research has been done in that area on how to monitor home care and how to ensure there is a sufficient amount of supervision. Training is one thing; the second is the degree of supervision and oversight. Whether the government is paying for the service for those who cannot afford it or the individual is purchasing it in the marketplace, we still need to make sure there is sufficient oversight and regulation that the service is provided at a proper level of quality.

[*Translation*]

Mr. Roger Gaudet: I agree with what you are saying. However, when you say that there are not enough children, I agree with you, but the son or daughter who has only one living parent, the mother or the father... Admittedly, some do not have any children.

It seems to me that our governments, both provincial and federal and even municipal, are not giving any help to families, be it some social benefits, tax credits, or municipal taxes exemptions.

Whether it is in hospitals or in long-term care centres, there is no love for the people. The attendant comes in in the morning and he has only 10 minutes to wash a client before moving to the next one. There is no love such as there would be if they were living in a house where people take the required time to care for them. It seems to me that our governments should perhaps give more help.

● (1630)

[*English*]

Mrs. Gloria Gutman: We need to make sure policies are in place to encourage those family members who are capable, who are loving, and who are wanting to give service to be able to do so and not at such a high cost that they resent doing it.

For example, there are people who would like to stay home and look after their parents, but if they don't work in the marketplace... you know, they need two incomes for the family to survive. So we have to make it possible for family members to be able to be paid, and there are some programs that will in fact enable that. It has to be family that is somewhat removed—it can't be your daughter or your son—but it may be possible to employ a nephew or some other family member. Particularly in rural communities where there aren't outside workers, we maybe need to think about those kinds of things.

You want to be able to put safeguards in place so you don't have people who are taking on the job to exploit an older person, but rather, where they do have the skills and they are the only ones around to support them, to make it possible for them to do so without ending up in the poor house.

[*Translation*]

Mr. Roger Gaudet: Thank you very much, Madam.

Thank you Mr. Chair.

[*English*]

The Chair: Thank you.

Now over to Mr. Shipley for five minutes .

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Thank you, Ms. Gutman, for coming. It's actually been very interesting.

You made a comment earlier about individuals who often are institutionalized, whether that's into hospital or the homes where they actually rely totally on other services, and lose their independence not necessarily because they want to, but it just happens. I think because of that, clearly, we've tried to and want to put things in place for independence, hence the VIP.

One of the things you talk about, and we have had a big issue with, obviously, is getting professionals. We've tried to do a lot in our budget, and in fact we've increased post-secondary education by 40% to try to entice people to get further education past secondary school. In saying that, when we look for professional services and home care services, quite honestly there is another element to it, that likely those services are rather non-professional but essential. I wonder if I could get your thoughts on it, because we hear a lot about what the government needs to do. Could I get some thoughts about what we can do to have people help people?

There are organizations—and I was at one last night, actually, called NeighbourLink—where there is an outreach to community by the young and the old to help people. I'm wondering if you have suggestions or thoughts on how we could expand those types of services, rather than always just forking government dollars out to hire people, when we actually have a growing demographic of aged people who are retired but healthy, who actually want to be doing something.

● (1635)

Mrs. Gloria Gutman: For those seniors who do want to engage in helping other seniors, there are a number of vehicles. There are seniors centres and some programs that are run through seniors centres. There are some service and demonstration programs that have been done around the country, intergenerational programs and so on. I would agree with you that yes, we could and should expand on some of those programs to take advantage of those seniors who are able and willing.

Part of the problem is the stereotyping, that we tend to think about seniors as being old and frail. But there are lots who are not old and frail. I think the change in our policies about mandatory retirement may help to change some of the attitudes, to recognize that seniors can and do wish to contribute and to continue to do so.

Some people want to continue working in the paid labour force. There are others who are happy to be in voluntary roles. You have to get the right fit and get people matched up in the right program.

It's interesting that right now in British Columbia, where we have the Olympics coming, VANOC has partnered with the ministry that deals with seniors and has been doing the active ageing program to talk about how we can get seniors to be volunteers for the Olympic movement. The first question that we asked: Which seniors? Of course, those who have been athletic all their lives are going to be the ones who will most likely be chosen to fill these positions. But are there spinoff benefits that we can get from associating things like the Olympics, which are high-profile and very positive kinds of images, to feed back into the community so that other people will get on the bandwagon and use that as a vehicle for expanding the areas in which people volunteer?

Mr. Bev Shipley: I will go on to a different topic, if I still have time.

You were talking about safe and familiar environments. I know my colleague has brought this up in terms of the design of buildings and what have you, because there are certain provincial codes. There's a limited number who go into hospital; there are more who actually go into retirement homes, seniors homes, where they're still active, before they hit a nursing home.

Do you have much input or are you asked about things designed—going beyond provincial codes—that would encourage activity, encourage those to have access to equipment that is good for them to be using?

Mrs. Gloria Gutman: We do get asked about that. It tends to be the for-profit developer who is the one who asks those questions, mainly because on the non-profit side, while they would like to do some of these things, the first thing that gets cut when it's budget time is anything that is above the basic building code, unfortunately.

The other question that you always want to ask is whether this design option or this equipment has actually been tested with real people. There are all kinds of high-end assisted living facilities in the States that have these fancy equipment rooms and all kinds of products—exercise machines and so on—that the kids think are great, but that the old people don't really use. You want to make sure you're investing in the kinds of equipment or products that will be used and will meet the needs of older people.

Mr. Bev Shipley: I think I'm about out of time.

Thank you.

The Chair: We have a space here that you can come back to.

Now we have Mr. Valley, from the Liberal Party, for five minutes.

● (1640)

Mr. Roger Valley: Thank you.

I have one quick question. I want to thank Ms. Hinton for the advice on my mother-in-law. I just want to make sure everyone knows that I want my mother-in-law safe and healthy so she spends most of her time at her own home.

You mentioned the institute for the aging, research funding. Does Veterans Affairs fund studies on aging veterans to see if their needs are different? We know that some of the problems veterans have come from their hearing loss. So they have special circumstances. I'm wondering if Veterans Affairs does any funding for those institutes.

Mrs. Gloria Gutman: I think it has partnered with the institutes on some projects. This is another area you might want to explore a bit further. I can't give you dollar values or tell you about specific funding programs, but certainly that's a vehicle. You want to find out the special needs and see whether they are being met.

Mr. Roger Valley: I know we've heard of some involvement. Maybe we'll ask the researchers to let us know what studies Veterans Affairs has been involved in.

That's all I have. Thank you.

The Chair: Mr. Sweet.

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

Thank you for coming today and giving us some really good information.

I wanted to go back and clarify a couple of things you mentioned. You mentioned about iatrogenic illnesses and the fact that these are from physician interventions. Did I hear you right that most of the complications are iatrogenic, that most occur after they're hospitalized?

Mrs. Gloria Gutman: A high proportion of the deconditioning that occurs happens because of iatrogenic problems, yes. A Harvard malpractice study showed that the number of mistakes made were disproportional in the older population.

Mr. David Sweet: Is there a high level of awareness of this in the medical community, and is it being addressed? We have an aging population. If most of the complications occur from physician intervention, then we're going to create numerous problems. Are there actions on the go right now?

Mrs. Gloria Gutman: Some of it is a matter of figuring that older people don't warrant the concern they'd give to others. Some of it comes from not paying enough attention to the fact that you can rehabilitate these older individuals. They're not necessarily a writeoff just because they hit a particular age. Yes, I think we need to draw more attention to those kinds of things.

Mr. David Sweet: That's good, because all of us are careening towards that kind of age, and at some point we'll all hit it. The Canadian Medical Association ought to be interested in this issue. I know McMaster University does a lot of educating in the riding that I represent.

Do you think there's a new push on to keep doctors aware that this needs to be a high priority for them?

Mrs. Gloria Gutman: I don't think there's as much emphasis as there needs to be. The geriatrition side, or certainly the Canadian Geriatrics Society, will make the point as loudly as they can. But I don't know that the Canadian Medical Association as a full association is reading the demographics as they should.

Mr. David Sweet: We've had previous witnesses talk about cities designed to be age-friendly. Do you think that municipalities are really applying age-friendly principles to future design? Do you have any data on this?

● (1645)

Mrs. Gloria Gutman: Well, it's interesting. This is one project that has captured quite a lot of fancy. The key question is whether they will, in fact, act on it. We've spent the last three years engaged in this age-friendly cities project and getting the design guidelines; what we don't know is the follow-through, because the research has not taken place. The development of the project only went to phase one, which was to get the guidelines in place; we need now to make sure they are implemented.

Mr. David Sweet: You talked about deconditioning. Do seniors decondition much faster than their counterparts who are 20 to 30 years younger?

Mrs. Gloria Gutman: Yes, they do decondition faster. One interesting article asked what astronauts, seniors, and people with AIDS have in common. The answer is that all three groups tend to spend time immobilized, and it's that immobilization that.... If you have them in space, where they're not able to exercise and to use their muscles in the normal way, even the young, healthy astronauts start to decondition very fast. There have been several studies in which volunteers spent several days in bed; the deconditioning does happen, but it is faster for the older population.

Mr. David Sweet: Thank you very much.

Thank you, Mr. Chair.

The Chair: Thank you. That was fascinating.

Now, because of rotation issues and various things, it's going to be Mr. Cannan up for five minutes for the Conservative Party.

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

I've had the opportunity to hear you speak a few times. I'm from Kelowna; I represent Kelowna—Lake Country. I know that a gentleman by the name of Warren Neufeld brought you to the Okanagan many years ago. He was way before many people's understanding of the whole gerontology issue and before the study of aging came into play. I appreciate your hard work in the studies in this area.

There was one specific area you mentioned in dealing with our veterans when they're in the care homes: the training that staff receive. Most or many of the staff are care aides, and it's sometimes a six-month to a one-year program. A post-secondary institution such as SFU or UBC doesn't do that much short-term teaching; it's more the colleges and institutes.

I just wondered what studies you have been able to pass along to the colleges. Have you seen those programs being implemented into the training of the care aides so that they are able to pass that expertise on to the veterans when they're tending to them?

Mrs. Gloria Gutman: Several of the colleges over the years have had programs. Malaspina had a program, and the college in New Westminster; I've forgotten the name of it. They were pioneers in the development of training programs for the care aides. There have been some of those.

At my own university, Simon Fraser, we have a post-baccalaureate diploma that can be done in one year if a person goes full-time, or over five years if they're doing it part-time. We've had a number of individuals who have taken advantage of that to get the extra credential in gerontology, but those are degree programs for people who come in with one degree already.

We also have a very well-subscribed master's program and shortly we'll have an operational PhD program, but largely the training of care aides has been at the community college level. Some of the graduates of our program are people who are training the care aides; we have felt it very important to train the trainers at the university level.

Mr. Ron Cannan: Another area that's very important is occupational therapy. Have you been working with occupational therapists as well?

Mrs. Gloria Gutman: Yes. Graduates with our post-baccalaureate diploma or our master's degree literally go through all of the helping professions, so we have OTs, PTs, nurses, social workers, pharmacists—many of the allied health professions.

● (1650)

Mr. Ron Cannan: At Simon Fraser University, specifically with the gerontology study, have you had much interaction with the Department of Veterans Affairs?

Mrs. Gloria Gutman: We have not had a lot of involvement with them in the past. It has been more on an individual level. I've been consulted on a few of the projects with Veterans Affairs, but we have not worked specifically with them on the development of their training programs. We could.

Mr. Ron Cannan: Lastly, specifically you mentioned a lot of improvements that are required in some of the care homes where our veterans are staying, and services are provided by the provinces. So have you been working with provinces across the country, or just with the B.C. government?

Mrs. Gloria Gutman: My people have worked primarily with the B.C. government, although some of our people have had contracts with the U.S. It's a contract basis. We're very willing and able to work with other groups, and we do try to make sure that there is some knowledge translation from every project we do.

Mr. Ron Cannan: Great.

Obviously, each province delivers the health care service, according to our Constitution, and can look to the advice that you can provide to each province and territory to ensure that we have the services that our veterans require in those care homes. So thank you very much for your leadership.

Mrs. Gloria Gutman: There are a lot of things that are generic. Yes, we have delivery systems that vary by province, but still, many of those services are generic and apply across the board and are translatable from one province to another.

Mr. Ron Cannan: Thank you very much. Keep up the good work.

The Chair: Thank you.

Mr. Shipley had indicated earlier—

Mr. Bev Shipley: No, I'm fine.

The Chair: In that case, folks, I think we've generally wrapped up questions for our witness today.

I want to thank you very much for your presentation. I know you've given us a lot to think about. I've made a number of notes here. As Mr. Valley pointed out, it affects us as well in terms of how we design our homes and what have you. So it's very interesting stuff.

I just want to notify the committee, as I go forward with some future business or other business, that Mr. Stoffer has decided to bring his motion forward at the next meeting of the committee. So we're not dealing with that today.

Did everybody receive their handout?

We're probably best to deal with that at the next meeting anyhow. That way, Mr. Stoffer has a chance to present his motion.

Anyhow, that's that, and we'll see you next time, folks.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

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