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Chair

The Honourable Shawn Murphy

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● (1105)

[*English*]

The Chair (Hon. Shawn Murphy (Charlottetown, Lib.)): I'd like to call the meeting to order. I want to extend a warm welcome to everyone. *Bienvenue à tous*.

Today, colleagues, we're here to deal with chapter 4, "Military Health Care—National Defence", as set out in the October 2007 report of the Auditor General of Canada.

I'm very pleased that we have with us Sheila Fraser, the Auditor General of Canada. She's accompanied by Hugh McRoberts, assistant auditor general, and Wendy Loschiuk, principal.

We also have, from the Department of National Defence, Major General Walter Semianiw, the chief of military personnel; and Brigadier General Hilary Jaeger, commander of Canadian Forces health services group, director general health services, and Canadian Forces surgeon general.

On behalf of the committee, I want to extend a warm welcome to all.

I'll turn it over to you, Mrs. Fraser. I understand you have a few opening comments.

Ms. Sheila Fraser (Auditor General of Canada, Office of the Auditor General of Canada): Thank you, Mr. Chair.

We thank you for this opportunity to present the results of chapter 4 of our October 2007 report, "Military Health Care—National Defence". As you mentioned, I am accompanied by Hugh McRoberts, assistant auditor general, and Wendy Loschiuk, principal responsible for our audits of the Department of National Defence.

At the time of our audit, National Defence and the Canadian Forces were providing medical and dental care to over 63,500 Canadian Forces personnel on 37 military installations across Canada and abroad. Members of the Canadian Forces are excluded from the Canada Health Act. The provision of their health care falls under the National Defence Act. If a military member needs medical services, it is the responsibility of National Defence to ensure that the services are provided. National Defence spent about $500 million on medical and dental care for its members last year, and costs have been rising.

In this audit we looked at how National Defence ensures that its military personnel in Canada receive quality health care. We did not look at medical care outside of Canada on deployments such as Afghanistan, nor did we do an assessment of medical treatment or practices.

We found that National Defence needs better information to manage its health care system and to help monitor whether it is delivering quality medical care to military personnel that is appropriate to needs. We also found that National Defence needs more information to better assess the performance and cost of the military health care system.

In this regard, our audit identified three main issues: first, the lack of health care information to monitor and measure performance; secondly, the need to better demonstrate the link between service delivery and the rising cost of military health care; and finally, the need for better governance and oversight.

[*Translation*]

First, I think it is important to note that military members themselves, when surveyed by the Department, said that overall they were satisfied that the military health care system responded to their needs. National Defence has been improving access to medical care and the continuity of care for its military personnel as part of its ongoing Rx2000 reforms.

On the issue of health care information, the Canadian Forces Spectrum of Care policy states that it is committed to providing Canadian Forces members with health care comparable to that which other Canadians receive. But we found that National Defence was unable to demonstrate how it assured itself that the care it was providing met its standards and expectations of quality health care practices.

We found that, with the exception of mental health standards, 35% of the Department's policies on standards of care were out of date. These policies are used to define the current and accepted practices that medical professionals are to follow when providing patient care, and they can help to ensure that members get appropriate care wherever they are posted.

We were concerned about the lack of information needed to ensure that only licensed and certified military medical professionals were treating patients. The Department has informed us that it is working on documenting the status of its health care professionals and developing a policy on mandatory maintenance of a provincial licence. Your committee may wish to ask the Department for an update on progress.

Furthermore, the military health care system expects its medical professionals to maintain their skills, and to support this, the Department has instituted the Maintenance of Clinical Skills program. Maintenance of skills is a requirement for the delivery of quality health care. Again, however, we found that the Department does not have the information it needs to monitor the success of this program—that is, to determine whether military medical staff are using the program to get exposure to a full scope of practice outside the military clinics. Because of this lack of information, we conducted a survey and found that few military medical professionals were completing the program. Your committee may wish to ask the Department about its progress on developing a tracking tool to monitor the maintenance of clinical skills,

[*English*]

The second main issue that we identified was the rising cost of the military health care system. Here we also found that National Defence lacks information to determine whether levels of service for its medical clinics are appropriate according to needs and to analyze whether the costs are reasonable.

For example, we found that in comparison with average provincial per-patient costs, National Defence costs are higher. The department has not developed a performance measurement system that would clearly measure what its health care system is achieving and at what cost. The department does have some indicators, but often information must be pulled together as needed, and it is still difficult to get an overall picture of the health of Canadian Forces members.

National Defence is working on an information system, and the committee may wish to be kept up to date on progress.

Third, we found that ten years after the department had identified a need to provide oversight of its health care system, there is still no mechanism that brings together all stakeholders to provide guidance and a basis for accountability. There is a need to bring together senior management responsible for providing health care, representatives for the military members using the services, and the senior military leaders who need to have healthy personnel to meet operational requirements.

Mr. Chair, National Defence has agreed with our recommendations and has developed an action plan to address the concerns raised in this report. I am pleased to see that the department has defined the outcomes it is working towards in the action plan and has set target completion dates. The committee may wish to have the department report on its progress and the results it is achieving.

This concludes my opening statement. We would be pleased, Mr. Chair, to answer any questions the committee members may have.

Thank you.

● (1110)

The Chair: Thank you very much, Mrs. Fraser.

And I'm now going to ask Major General Semianiw for his opening comments, but before I do that, am I pronouncing your name close to correct?

Major General Walter Semianiw (Chief of Military Personnel, Department of National Defence): Yes, you are, Mr. Chair.

[*Translation*]

Mr. Chairman, members of the committee, Madam Auditor General of Canada, ladies and gentlemen, I am Major-General Walter Semianiw, Chief, Military Personnel. I am accompanied by Brigadier-General Hilary Jaeger, the Surgeon General of the Canadian Forces.

In my capacity of Chief, Military Personnel— I am an infantry officer, not a doctor—I am responsible for the CF health care system, while Brigadier-General Jaeger is, in addition to being the Surgeon General, also the Director General, Health Services, and the Commander of the CF Health Services Group.

[*English*]

It's indeed a pleasure and a privilege that we're both here today to appear before you in order to address the Auditor General's report on military health care.

More importantly, we're here today to outline those activities we are currently undertaking to improve health care for our sailors, soldiers, airmen, and airwomen at home and abroad that address the recommendations in this report.

Firstly, as already noted by the Auditor General, the department fully accepts the recommendations outlined in this report. Our view is that the report is a fair and balanced assessment of the state of a military health care system in transition.

As a number of you are aware, Rx2000 and the Canadian Forces health information system programs represent very significant reforms that began in the year 2000. Granted, work remains to be done to fully implement these programs and to continually improve care. Nevertheless, we are fully confident that many of the initiatives already under way as part of those two programs will serve us well in addressing not only the Auditor General's recommendation but more importantly the building of a modern patient-focused military medical system.

Next I would like to acknowledge the comments of the Auditor General where she noted that previous concerns about accessibility and continuity of care have been addressed by Canadian Forces health care reform, that a high percentage of Canadian Forces personnel are satisfied with the health care they receive, and that the new model for health care is considered a best-practice approach.

Indeed, many of the changes undertaken by the Canadian Forces health services reform, such as collaborative practice and electronic health care records, were advocated in the 2002 Kirby report entitled “The Health of Canadians: The Federal Role” and the 2002 Romanow report entitled “Building on Values: The Future of Health Care in Canada”, and they continue to be supported by the Health Council of Canada.

As you are all well aware, the report itself makes eight recommendations centred on four key themes. Allow me to make a few comments relating each of these themes to the provision of high-quality health care to the men and women in uniform.

The first area of concern is that of cost. All Canadians certainly understand that health care is expensive. Providing a very comprehensive range of services for a relatively small population across national and international boundaries and subsequently meeting the CF needs and expectations as well as those of its personnel when illness and injuries occur costs more than providing a less comprehensive range of services to a more static and more centralized population. A health care system such as the Canadian Forces is therefore more expensive.

The Canadian Forces health services group runs a public health care system that has an education organization that delivers essential professional development. The Canadian Forces health services group also provides unique occupational and environmental health care that must be prepared to operate effectively under hostile conditions in any climate and terrain in the world, and it experiences frequent extraction of its health care providers for associated training and tasking requirements. But the Canadian Forces believe that it is not just a cost but also an investment that is worthwhile not only in meeting our obligations to the Canadian Forces personnel, the men and women in uniform for this nation, but as a means of fostering operational capability.

As noted by the Auditor General in a 1990 review of the health services, willingness to fight is influenced by members' general state of health and by their confidence in the health system's ability to provide prompt evacuation and treatment of casualties.

I was pleased to note that Madame Fraser recognizes these unique military health system requirements and acknowledges that drawing a direct comparison with the cost of running a civilian health care system is indeed difficult. While the Canadian Forces health services currently capture significant cost data, full implementation of the Canadian Forces health information system will help to refine further analysis of the relative impact of different cost drivers.

The next area of discussion is performance measurement. A number of Office of the Auditor General recommendations revolve around choosing performance indicators, setting standards of care, and measuring activities against these standards and indicators.

A recently instituted Canadian Forces health services performance measurement advisory group has begun to develop a performance measurement framework to define applicable performance indicators into set benchmark standards and reporting requirements. The list of indicators chosen will be in keeping with the pan-Canadian primary health care and population health indicators that were recently developed in consultation with the Canadian Institute for Health Information.

● (1115)

It's worth noting that Canadian Forces health services will be among the organizations taking a lead in institutionalizing these practices in a multidisciplinary primary care setting.

The third concern that needs to be addressed is the accreditation of health care providers. As part of the Rx2000 reforms, it was decided to reinstitute external accreditation of CF health services. As part of this process, a Canadian Forces national credentialing cell was recreated in mid-2007. To date the cell has achieved license verification for 100% of physicians and dentists, 96.7% of pharmacists, and 79.9% of nurses. A new Canadian Forces credentialing policy is set for release in February 2008.

Let me now turn to governance of the Canadian Forces health care system. It's not the sole purview of the providers of health care and services to determine which medical and dental services, treatments, and items should be provided at public expense to entitled personnel. After a review of the terms of reference for the spectrum of care review committee, which makes health care entitlement determinations, I sought and received approval to raise the level of oversight of this committee to the leadership of the Canadian Forces.

Having the Armed Forces Council, the leadership of the Canadian Forces—the Chief of Defence Staff, the Vice-Chief of Defence Staff, the Chief of the Air Staff, the Chief of the Maritime Staff, and the Chief of the Land Staff—make decisions about Canadian Forces personnel health care entitlements will help Canadian Forces health services ensure that costs incurred are indeed related to patient requirements and operational needs.

Mr. Chairman, members of the committee, Auditor General, ladies and gentlemen, this completes our introductory remarks.

Thank you.

The Chair: Thank you very much, Major General Semianiw.

We're now going to go to the first round. I believe that we have time for an eight-minute first round.

Mr. Wrzesnewskyj, you have eight minutes.

Mr. Borys Wrzesnewskyj (Etobicoke Centre, Lib.): Thank you, Mr. Chair, and I'd like to thank the witnesses for coming before us today.

My questions are for the witnesses from the Canadian Forces.

As we know, Afghanistan is an extremely stressful environment. Many returning soldiers have had the difficult experience of seeing their brothers in arms or sisters in arms suffer the loss of limb or life, or the horrific experience of seeing civilians caught in crossfire.

What percentage of soldiers who return...? First of all, I assume that all soldiers, upon their return, are screened to assess their state of mental health. If that is in fact correct, that all soldiers returning have an assessment done of their mental health, what percentage return with mental health issues such as post-traumatic stress?

● (1120)

Brigadier General Hilary Jaeger (Commander, Canadian Forces Health Services Group, Director General, Health Services, and Canadian Forces Surgeon General, Department of National Defence): Thanks for that question.

In fact we are watching the mission in Afghanistan and its effect on the overall health of our soldiers, particularly the mental health of our personnel, very closely.

We have a well-developed process in place to assist them while in theatre. A psychiatrist, a social worker, and a mental health nurse are deployed with the task force at all times to provide service in theatre and to stay abreast of the general state of morale and mental health of the troops deployed.

The soldiers go through a process known as third location decompression. That's a bit of jargon. All it means is that they're given some time to rest and recuperate in a place that is neither the theatre of operations nor their home base. So it's a third place, and it's currently in Cyprus.

While there they undergo a period of four to five days of rest and what we term psycho-education. These are briefings on what to expect with the transition from Afghanistan to home life. What is the normal set of experiences during that transition, and what are the warning signs that things may not be progressing normally? They're also given instructions on the many ways to access both health care and non-clinical support services through the operational stress injury social support program. All our soldiers clearly understand that help is available and know where to get it.

The most elaborate follow-up is done four to six months afterwards. That's because we want some time for the differing emotions related to return to settle down. There's euphoria. There's perhaps some disappointment. There are a whole lot of conflicting things.

The data collection is still ongoing. Of course every rotation is a little bit different, but the data we have so far from these four- to six-month detailed screening follow-ups suggest that about 27% of people coming back have some difficulties. The vast majority, about 16%, have hazardous drinking behaviour. So more than half of that 27%—16% of the total deployed—show hazardous drinking behaviour. But an important number of people are struggling with more serious mental health issues, depression and post-traumatic stress disorder being the two most notable.

Mr. Borys Wrzesnewskyj: Thank you.

MGen Walter Semianiw: Mr. Chairman, maybe I could just kind of build on it and give it a finer point.

In 2005 I commanded Canadian military operations in Afghanistan for six months. Prior to deployment, there was screening of my soldiers, sailors, airmen, airwomen, and myself. We had the mental health care providers with us to watch, and a place where people could go and talk if issues came up, to see what was happening. At the same time, prior to leaving we did screening. Then they go through the third location decompression. Then once we're back home, we do it again.

Having gone through all of that, there are three stops or checks now in that process to ensure that we try to capture as many individuals as possible and help them through the process.

The Chair: I would just make a comment before going back to Mr. Wrzesnewskyj.

We're dealing with a very important issue, and I appreciate the attendance of everyone here. I should have mentioned this in my opening remarks, but I'd ask all questioners to keep your questions succinct and relevant to the report, and I'd ask all witnesses to be very brief and relevant in your answers, so that we can cover as much material as is necessary.

Mr. Wrzesnewskyj.

Mr. Borys Wrzesnewskyj: Thank you, Chair.

So 100% of all soldiers get screened, and it appears that 27% have some form of mental health issue, including issues of substance abuse, and 16% of those have issues of substance abuse.

What is the concrete number, as opposed to a percentage? How many thousands? If we take all those rotations, how many soldiers who have served in Afghanistan are facing mental health issues? Do we have a number, or can you extrapolate a number for us?

● (1125)

BGen Hilary Jaeger: If I were to give you a number, it would be an extrapolation based on multiplying percentages times the number of people, and that's not where I'm at. To link it to the Auditor General's report, I do not have a data collection system with which I can look across the Canadian Forces and ask, “How many active patients do we have right now with post-traumatic stress disorder?” I can't say that.

Mr. Borys Wrzesnewskyj: If 27% suffer and we have rotations, potentially there are thousands of soldiers out there. We saw that 85%, when they were questioned, were quite happy with the medical services they received. However, 75% of soldiers did not feel that they received adequate support or help with mental health issues.

What is being done to address, potentially, thousands of soldiers out there who are suffering in silence, or agonizing? That's not acceptable, that 75% number, that three out of four suffering soldiers are not getting the help they deserve.

BGen Hilary Jaeger: Thanks for the opportunity to clarify. That 75% number comes from a survey we commissioned Statistics Canada to do on our behalf in 2002, which was before we implemented the changes under the Rx2000 reform. I would expect that were we to repeat that survey—which we have plans to do in the future, but that's probably not going to happen for a couple of years—that number would be vastly improved.

Mr. Borys Wrzesnewskyj: You touched on something else: soldiers with issues of substance abuse. Major General Walter Semianiw had mentioned that you pre-screen as well. As regards people with substance abuse problems, he said 16% of returning soldiers have these sorts of problems. What percentage have these problems going into Afghanistan?

BGen Hilary Jaeger: I'd like to clarify, concerning the 16%, the hazardous drinking behaviour, that has not necessarily reached the threshold of substance abuse nor of alcoholism or other drug dependency. Those who work in the public health field will recognize hazardous drinking behaviour as any regular consumption of more than two drinks per day on average for males, and more than one drink per day on average for females. It's a fairly low threshold as a possible warning sign.

Mr. Borys Wrzesnewskyj: I see. So what percentage would be at that higher threshold, that perhaps it's not just alcohol but there's other substance abuse? And if they're screened ahead of time, are they removed from combat missions?

BGen Hilary Jaeger: We do not routinely ask the alcohol screening questions in that kind of context, pre-deployment. We do have a program for safety-sensitive drug testing, which is not part of my purview; it's not a health services function. All people going into theatre are screened for other drugs of abuse.

MGen Walter Semianiw: To respond further to the question, the Canadian Forces, the department, has put a new program in place composed of three parts. It has been announced in Canadian Forces and actually been made public.

The first is that we conduct safety sensitive testing of soldiers, sailors, airmen, and airwomen going into a theatre of operations. This is not just Afghanistan but into a theatre of operations. Clearly, if it is found that there are issues, they are removed. It has been done. We have removed individuals. The leadership has removed them—not doctors, but the leadership—for failing to meet the bar that we require individuals to meet in order to be safe and to be able to do what they need to do in combat.

Secondly, we've just begun blind testing across the Canadian Forces, randomly going across the Canadian Forces to draw some data.

Where we are moving in the future, in one year we'll be...to do testing as we see fit across the Canadian Forces, to additionally build on the policy and to address the issue that you raise.

The Chair: Thank you, Mr. Wrzesnewskyj.

Monsieur Laforest.

[*Translation*]

Mr. Jean-Yves Laforest (Saint-Maurice—Champlain, BQ): Thank you, Mr. Chairman.

Good day to all of you and thank you for joining us. My question is for the CF representatives. The audit conducted by Ms. Fraser's office looked into how many military personnel were under the care of a mental health professional. According to the report, DND was unable to provide an answer to that question.

You stated that you did not have a data base. I am very surprised to hear that and very disappointed that an organization as large and important as the Canadian Forces has not yet compiled a data base so that it can, at the very least, give members of the public and parliamentarians an accurate picture of mental health problems in the military. In that respect, I totally concur with Mr. Wrzesnewskyj's question. As I see it, we should be able to get a much more accurate picture of the number of CF members who are receiving treatment.

CF members are on assignment in Afghanistan on an important mission. How many forces members exhibit mental health problems when they return home and what kind of treatment do they receive? What kind of care do they receive to help them overcome their problems? Given your response to the AG and your statement today to the effect that you do not have a data base, are you not in fact saying that you do not want to disclose the real numbers? I think it is important for us to have that information.

● (1130)

BGen Hilary Jaeger: Thank you, sir, for your question.

I too am anxious to have a system in place that could provide me with that kind of information. Mental health is not the only issue involved. But it is an important question, since the mental health of CF members affects the general population in Canada.

We made a decision in 1995, as part of a re-engineering initiative too find ways of doing more with less. Do you remember that? The Canadian Forces were caught up in this movement, along with the health care system. As a major, I attended a meeting where we discussed which particular initiatives could be abandoned. The decision was made to stop collecting data. We have complete data on a person's medical history, but we do not have a system in place to generate information for management. This information is available on paper, but cannot be computer generated.

Mr. Jean-Yves Laforest: If I were to ask you how many CF members exhibit mental health problems when they return from Afghanistan and how many commit suicide, you would not be able to give me an answer. Is that what you're telling me?

BGen Hilary Jaeger: We have figures on the number of active CF members who have committed suicide.

Mr. Jean-Yves Laforest: And what are these figures?

BGen Hilary Jaeger: Over the past eight years, the number of suicides in the Canadian Forces has remained relatively constant. The number varies between 10 and 13. However, I do not have statistics on the number of retired CF members who have committed suicide.

Mr. Jean-Yves Laforest: So then, you know that between 10 and 13 returning CF members take their own life every year. In light of this fact, can you not design a specific program? There seems to be a pattern here. What is being done right now to avoid these tragedies? Have you developed a specific program to deal with this problem?

MGen Walter Semianiw: If I could interject for a moment, I think you're asking two questions. Firstly, are there programs in place at this point in time to help CF members? The answer is definitely yes. Secondly, is data on CF members readily available? That is a somewhat more difficult question to answer, but yes, that data can be found. As Brigadier General Jaeger said, all of this information is currently on paper. However, the situation may improve in a year or two, with IM/IT.

Mr. Jean-Yves Laforest: The audit found that 75% of CF members who sought treatment for mental health problems were dissatisfied with the care they received. As for the suicide rate, members of the media looking into this problem wonder how such a thing is possible. According to sources close to CF members, the soldiers did not receive the help they needed to prevent these tragedies. The feeling is that they are not given the proper care or seen by the right people.

● (1135)

BGen Hilary Jaeger: I would like to clarify a few things for you. I will do my best to explain the finding of a 75% dissatisfaction rate among CF members. This figure comes from a survey conducted in 2002. In actual fact, 25% of the people who were interviewed said they were completely satisfied with the mental health care services received. Others—I cannot recall the exact percentage—maintained that they were somewhat satisfied. Still others were unaware that they needed mental health services. They exhibited symptoms, but did not realize that they had a problem that needed to be addressed. Still others—and again, I do not recall the exact percentage—who had received care said they were dissatisfied with the services. To say that 75% of the people were dissatisfied is not totally accurate. It is also extremely important to mention that this survey was conducted before we put in place our current system for delivering mental health care services.

Mr. Jean-Yves Laforest: According to a press report dated October 31 last, in 2006, 20% of CF medical personnel were practising without a licence. Has this situation changed at all? Do medical professionals have the necessary qualifications to help people deal with mental health issues?

BGen Hilary Jaeger: Thank you for that very important question. Since the release of the AG's report, we have made the most progress in terms of carrying out this particular recommendation. The problem is this: at the time of the audit, we were unaware of the problem, since there was no system in place to verify licences. Upon conducting an internal audit, we determined that 100% of our physicians and dentists hold valid, current licences. This is true as well of 96% of our pharmacists and 80% of our nurses. As for the remaining 20%, we simply have not verified their status yet. We still have a bit of work to do in this area.

Mr. Jean-Yves Laforest: Thank you very much.

[*English*]

The Chair: Merci, Monsieur Laforest.

Mr. Sweet, eight minutes.

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

My first question is for the Auditor General. I just want to clarify something.

On page 7, paragraph 4.10, you had mentioned that the specific parameters of the terms of reference for your audit were around health care delivered to “Regular Force members in Canada”. Is that correct?

Ms. Sheila Fraser: That is correct.

Mr. David Sweet: The major-general mentioned in his opening remarks that operating a health care system with personnel all over the world, across national and international boundaries, affects the cost.

With your terms of reference, should there have been any reason why foreign deployments would affect the cost of health delivery in Canada?

Ms. Sheila Fraser: We didn't specifically look at that issue. We did raise a number of factors that affect health care costs in the military's health care system: the need to have health care available immediately to members, and a number of other factors as well, the major one being the availability of services. So there is an indication in the report, as mentioned, that we can't do a direct comparison with the health care costs in the public system, and one would expect it to be more expensive. The issue is, what is a reasonable cost? We would have expected National Defence to have determined some kind of benchmark and to be tracking the costs and to ask if they are reasonable or not.

Mr. David Sweet: Major General, are you working towards a process where you can benchmark?

I agree with you that it should be more expensive, and of course we want the absolute best quality for the people who serve and put themselves in harm's way. But it seems to me that given that you have some of the most healthy personnel in the nation, there would be some offset from that.

Could you tell me if you have a benchmark process you're going to go through?

● (1140)

MGen Walter Semianiw: Mr. Chair, I'll speak first to give you some information, then turn it over to General Jaeger, to give you a vantage point from a soldier, an infanteer, a soldier who has been on many operations, as I have. But I speak from that vantage point.

I touched on it briefly. Right now the medical system is moving very quickly; it has already expended a lot of money to put in what is called the Canadian Forces health information system. In short, we're already into phase three. We're putting additional money into it, and it will be able to give us

[*Translation*]

the data, as I was saying earlier,

[*English*]

the facts that we need much more easily than we have had.

If I were to pose the question today—and General Jaeger and I speak about this—at any one point in time, across the Canadian Forces, how many people are in this state of sickness or need this type of support, we can get that information. I think it's something that has to be understood. We can get that information. But we feel, as did the Auditor General, that it takes too long, because you need that type of information, as the Auditor General said, to make informed decisions.

So when this project closes out, we'll be able to answer or address that specific issue and have that information quickly in a number of broad areas and be able to answer the questions posed, which are sound, tough, and I think great questions, such as how many individuals in the Canadian Forces today are suffering from mental health challenges. Tell us that; we need to know that. We're the first to tell you that until this project or program comes into full swing and is fully implemented in the next couple of years, we won't be able to do that quickly, but we think we should be able to.

The Chair: Mr. Sweet, before you go on, I believe the Auditor General has a comment.

Ms. Sheila Fraser: Mr. Chair, I just wanted to make one point of clarification. I was informed that the foreign medical costs are part of the support to deployed operations account. They're not in the medical costs here per se.

Mr. David Sweet: Okay, thank you. That was my concern, but I guess it's all dependent upon the collection of data.

One thing that is troubling around costs, which I think deserves a separate specific answer, is on page 16, where, under the contracting of physicians, the figures juxtaposed there for contracted physicians' costs look like they're out of control. Can you explain why there's such a disparity in the costs between the civilian positions and those contracted privately?

BGen Hilary Jaeger: The shortest answer I can give you to that question, sir, is that the costs you see are the costs we pay our third-party contractor, Calian Technology. They are not necessarily the costs they pay the service provider. There is a profit margin. They're a private company; they exist to make profits for their shareholders, so there is a margin between what they charge us and what they pay the provider. But the provider rates do vary, because we seek to entice providers into some parts of Canada where physicians are not easy to attract.

Mr. David Sweet: So maybe some brinkmanship and negotiating might be at hand for this, as far as getting costing....

BGen Hilary Jaeger: We try to hold the line as much as we can, but my bottom line is if I need a service provider somewhere to provide essential medical care to the members of the Canadian Forces, then if it's going to cost a little bit more, that's far preferable to not having the service provided or to having the member obliged to move somewhere else for the care.

Mr. David Sweet: Okay.

Page 22, paragraph 4.57 points to another big concern, because it almost looks as though there is a cultural issue developing. In paragraphs 4.55, 4.56, and 4.57, there is a discussion about the maintenance of the clinical skills program, and there is a statement here by the physicians, I guess, who were spoken to in the audit. They didn't take advantage of the program because they believed they could not spare the time. In other words, they refused to go away from their own duties in order to be more excellent caregivers later. Is that still going on?

BGen Hilary Jaeger: I believe the situation is improving with our uniformed physicians in particular. You have to understand I may not have been able to clearly explain to the Auditor General's staff the components and the differences between the maintenance and clinical skills program, which is military-driven with military requirements to keep the skills required to support deployed operations and the licensing bodies' and credentialing bodies' requirements for continuing medical education, which is a separate ongoing educational requirement.

Because we have had over the past several years—

● (1145)

Mr. David Sweet: I would just like to clarify something. I'm not talking about the licensing issue. I'm talking about this maintenance of clinical skills program in and of itself.

BGen Hilary Jaeger: Right. Yes.

The maintenance and clinical skills program is something we actually first came up with in the late 1990s when we realized that just working in your office didn't cut it to get you ready to go to Afghanistan and see the kinds of patients we're seeing there. We thought we needed to take military providers out of that kind of garrison-based very routine setting and challenge them more clinically. That's also a cost driver, by the way, because the goal is that roughly 20% of a unit's foreign physicians' time is spent doing that, so that makes them less available to provide direct patient care.

During the time since we conceived the program—and now on average we are about 35% short of military physicians across the board, so we don't have enough uniformed bodies to really make the program work the way it was intended to—we have focused on identifying those people who are coming to deployment in the next year or so and pulling out all the stops we can to make sure that they get brought up to speed in time for their deployment. That has resulted in relatively less effort for those who stay behind.

We are making headway with our uniformed medical officer recruiting. We expect to be up to full strength within about a year and a half, and after that I hope we can do much better at meeting the targets of the maintenance and clinical skills program.

Mr. David Sweet: On page 21, it says that “eight out of ten physician assistants who tried but did not pass the certification exam were providing direct patient care”. Is that still going on, and are they being compelled to comply now?

BGen Hilary Jaeger: The timing was a bit unfortunate. We had another rewrite of the certification exam very shortly after the report went to press, and I can't tell you that eight out of ten aren't practising, but I can tell you that anybody who is practising who has not passed the credentialing exam is practising under direct supervision. They are not independently ordering medications or tests.

The Chair: Thank you, Mr. Sweet.

Thank you, Brigadier General Jaeger.

Mr. Christopherson.

Mr. David Christopherson (Hamilton Centre, NDP): Thank you, Chair. I appreciate that.

I am pleased to have here my colleague, the member for Sackville—Eastern Shore, the hard-working veteran affairs critic. He is going to provide the lead for us on this file, so I'm going to turn it over to Peter.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chairman, and thank you, committee members, for the opportunity. And to the Auditor General, thank you, and to our distinguished guests, thank you very much for your service to your country as well.

I have the privilege and honour of representing the Shearwater air base. Twenty percent of my riding is either currently serving or retired military personnel along with their families, and I couldn't help but notice that in the brief you presented to us, sir, you didn't mention the word “families” in the first paragraph.

I don't know if you recall, but last year in *The Globe and Mail* there was an article of a soldier sitting in the background, and his kid was in the front, and the caption was "Dad, if you die in Afghanistan, I'll never forgive you as long as I live. Now go serve your country."

There was an ombudsman report from André Marin, the former defence ombudsman, slamming both the Ontario and federal governments for ignoring the needs of children who have lost parents in Afghanistan. And I couldn't help but notice at exhibit 4.3 on page 14 of the Auditor General's report that although there's a moral obligation for the Government of Canada to provide treatment to family members or their loved ones who suffer from PTSD and other concerns, there's no legal requirement. It goes on to say that they're unable to extend member care to include family support because of resource shortages.

As everyone knows, when you're serving overseas for your country, or serving anywhere in the world, your thoughts are always back home with your family, and if the families aren't getting the care they need, then I don't think the soldier can perform up to speed as we would ask them to do.

Is the defence department improving family services, not just through MFRCs but through resource allocations and things?

My other question is about reservists. When reservists come back, they don't go to a base. They either go to universities or back to their jobs. And we found on the veterans affairs committee that the Government of Canada has a hard time tracking where the reservists are, to see how their mental or physical states are.

My question is for the Auditor General. Did you also include reservists' information when you were doing your data report?

And to the military, what are you doing to include reservists, to ensure that they're well cared for?

● (1150)

MGen Walter Semianiw: I'll begin first on the question about reserves, and then I'll move back to the family.

Firstly, we in the Canadian Forces would agree with everything you've said. Clearly with everything we've seen, we've known, we've practised, and that's in our culture, a strong family is the bedrock of operational effectiveness. I agree with you there.

On the reserve piece first, when we look at reservists, we have to understand there are different types of reservists. There are those who are doing it part-time, 30 days a year, called class A reservists, and those who actually help fill in full-time in the regular force and those who go on operations.

As you're probably all aware, the number of reservists going on the next deployment is almost 500, and it will continue to be that, so it's an issue that had to be addressed. As such, the department and the Canadian Forces have addressed this in the last year and will be addressing this in the next two months in four areas.

First, if I'm a reservist part-time, and I'm out there and I get injured getting ready and keeping fit on my own, who is going to look after me? Right now, when we take a look at the policy, it's not in place, but I know that we have a piece of policy that will hopefully be implemented in the next 30 days, which will state that if you are a class A or part-time reservist, and you get injured staying fit—and it's one component of the whole issue—you will be covered for pension purposes and with Veterans Affairs. That's the first piece.

The second question was, if I'm a reservist and I'm training for operations and something happens to me, who's going to look after me? This all comes back to the family. In September we put out a policy that stated that if you are a reservist and you are training back in Canada for an operation, you are covered for pension purposes and by Veterans Affairs if you are injured.

Next, two months ago we put out a new policy that states that if you are a reservist coming back from operations anywhere around the world, and you are injured and you're sick, you will stay on class C, that's full-time service, to receive the full suite of benefits that a regular force soldier would, until not only the medical system but your leadership says you're ready to transit back to be part-time, be it 30 days or a year.

Finally, we are looking at the last piece, and that is the transition interview piece. This is connected to the Department of Veterans Affairs, so I'll speak about it briefly. You could address the question to them. This is to ensure that the part-time reservists—and that's the challenge, reservists who are working with us full-time on class B or class C—we do look after. You have a leadership chain. You have a structure. They're with us. They're close to us. But in the reserves, as you know, they're across the country.

What will happen is a class A reservist who has trained for operations and who has been in operations will receive a Veterans Affairs transition interview before they leave the military, and that will ensure that they get connected, Mr. Stoffer, to Veterans Affairs before they leave.

We think that with those four pieces there, those policy pieces, we're finally starting to address it.

Structurally, General Jaeger is about to put into place nurses into the reserve field ambulances across the country to help manage, to help coordinate, to help assist our reservists out there to work through this environment with Veterans Affairs and others so they get the best care and patient care that they can.

So that's the reserve case.

Mr. Peter Stoffer: Thank you.

Ms. Sheila Fraser: Mr. Chair, we did not include services provided to reserve force members within the scope of this audit.

Mr. Peter Stoffer: One gentleman and his wife in my riding went to an OSISS centre. They were told they could only get ten treatments and that's it.

Most psychologists indicate that treatment for an injury between the ears could last a lifetime. Why would there only be ten treatments, and not continuous treatment until they could be deemed mentally capable again?

MGen Walter Semianiw: It's not an issue that they are only going to get ten treatments. It's that we can give ten treatments and then the health care system of the province would continue that support.

There is a continuum of care. But you're right: all the soldiers, sailors, airmen, and airwomen I talk to want to stick with the mental health care provider they began with. That's what they're probably saying to you. It's something we have to look at.

On the family piece, if I may address that now, you're right, the bedrock of operational effectiveness, in large part, is the family. When a soldier is away on any mission, anywhere around the world, we want him to focus on that mission. The way to do that is to ensure he knows his family is being looked after while he is away.

We address that. A number of years ago the Canadian Forces and the department established the military family resource centres across the country to begin to address that need. We are very shortly going to establish a director of family services for the Canadian Forces. It will take place in about three months. That individual, on both policy and service, will start to bring in more coherence.

There's a lot more. I'd be more than happy to come back and talk to you on this at any point.

● (1155)

The Chair: Thank you, Mr. Stoffer.

Mr. Holland, please.

Mr. Mark Holland (Ajax—Pickering, Lib.): Thank you, Mr. Chair, and thank you to the witnesses for appearing today.

I want to come back to something that I think is the dominating issue here, which is mental health care services. I am going to summarize the concerns I have and ask some specific questions, because I really don't think we have some answers to this point.

We know from the questions and the report of the Auditor General that we don't have firm numbers on how many of those serving in our armed forces are receiving care for mental health disorders. Brigadier General Jaeger said that you may have the data in a couple of years' time. That concerns me, and I want to come back to that in a second.

We also know we can't meet the demand. When soldiers come back from theatres of operation to Canada, we simply can't meet all the demands for mental health care services.

If we flip the number you gave us before, instead of saying 75% are dissatisfied, we know that in 2002 only 25% were satisfied. That was some time ago. You say there are changes. There hasn't yet been a survey to assess the current status. The only answer to that was “maybe in a couple of years' time”.

We have a critical decision to make as to whether we will extend the mission in Afghanistan. The government wants to do that. Yet we were told that we have no firm grasp on the status of mental health care for our armed services in a theatre that is putting our soldiers in a very difficult and mentally stressful situation. This has generated a lot of questions for Canadians.

Let me come back to this. Instead of saying that maybe in a couple of years' time you'll have that data, specifically what are you doing to ensure that we will get that data, and what date will we have it by?

I am starting with the simplest question. How many of our armed forces are actually receiving care for mental health disorders today?

MGen Walter Semianiw: I`d like to first come back to the issue of time. And I think I made the comment, not General Jaeger.

I want to clarify something for the committee, because I think it's getting lost in some of the discussion. If you want the data, I'll give you the data, but it's going to take about a week and a half. It's not that I can't get you the data; I can. Getting the data quicker is the issue, and that's what the Canadian Forces health information system will get back in the future.

Mr. Mark Holland: Could I ask a question of the Auditor General?

The Chair: Are you finished, sir?

Mr. Mark Holland: If I could, Chair, I want to go to the Auditor General.

Why would we say that we don't have the information in the report if it could be produced in a week and a half?

Ms. Sheila Fraser: Chair, I'd just like to clarify.

What we are talking about in the report is ongoing monitoring and the systems that would be able to provide that information quickly, and that there be continual monitoring of this, be it for mental health or any other injury, to see tendencies, trends. The kind of information that can be obtained now is by going through files on an ad hoc basis, a one-time request. To do it every month means you'd have to spend a week every month to get this information. Our main concern is that there is no information system supporting this program.

Certainly at the time of our audit—and DND officials might want to clarify if anything has changed—we note in 4.29 that there was a health information system that was begun in 2000. The targeted completion is 2011. There was a large component of that.... The funding was cut in 2006, so it's delayed even further. We do express concern in the report that this seems to us to be taking a very long time and that there's a certain amount of uncertainty about actually getting the kind of information you would expect to be able to manage this health care system.

● (1200)

Mr. Mark Holland: The question, then, to the major-general would be, okay, when? When are we going to be to the point where we can get that information in a timely fashion and can use it in a meaningful way?

BGen Hilary Jaeger: Thanks.

It's not that we have absolutely no information now. I can tell you that we know that six months after a mounting base gets people back, their mental health clinic experiences a doubling over baseline of their mental health workload. From base to base we can track that.

When will the automated system be in place so that we don't have to rely on that base-by-base, case-by-case reporting? Well, that depends on Treasury Board approval of increased third phase funding for the Canadian Forces health information system. We are supposed to, if all goes well, begin implementation in May of this year. It will be substantively complete by 2010, and we'll have the dotting of the i's and the crossing of the t's on the project done by 2011.

Mr. Mark Holland: Okay. Well, certainly we'll be looking to ensure that the government is supporting the troops on that end and that the money is in fact put in place.

I want to come to my point about the survey and the fact that we keep talking about the data being so old. We don't have a handle on people's current feelings about the quality of health care that they're receiving. There was a comment made, I can't remember by which of you, that maybe that was something you'd do in the future.

I think this is obviously a very big concern. We do have a difficult decision to make. I think Parliament would want to have that kind of information before making a decision on extending the mission.

When are you planning to get a current and accurate read on the quality of health care that our Canadian Forces personnel are receiving so that we can have that information available?

BGen Hilary Jaeger: Each clinic at the moment, as part of their routine activity, does conduct customer satisfaction surveys, for lack of a better term. What we don't do is roll those out nationally. And we don't impose on clinics a strict schedule for doing those surveys, nor do we mandate, necessarily, that they focus particularly on the mental health part of their clinic, or, frankly, on the general practice part of their clinic.

Mr. Mark Holland: But you can understand the concern here. As the questioning proceeds, you keep saying, "Well, this data's old. We're sure it's better, but we have no empirical evidence of that." So what we're left with is that the only way we have national numbers is by going back to 2002.

So the question is when are we going to have rolled-out national numbers so that we can actually have a current snapshot of what we're dealing with?

BGen Hilary Jaeger: Depending on the wishes of my superiors, I can put in place a focused satisfaction survey that will get useful information back within six months, but it will be a self-reported, paper-based satisfaction survey on a random sampling of people going through a clinic.

That can be done.

Mr. Mark Holland: Can you undertake to ask your superiors and come back to the committee to say if that could be undertaken? Again, I'd feel much better about getting a firm date and a commitment that it's going to happen, instead of saying, you know, maybe you're going to have this data at some time. It's very hard for the committee to debate this issue when we don't have current information.

MGen Walter Semianiw: That's a fair question. That's something we're going to do, and I commit to that.

Right now our focus is on getting what we've got right and getting it better. For example, next week, February 5 and 6, we have 450 soldiers, sailors, airmen, airwomen, all different ranks, coming here to Ottawa. We're conducting a lessons-learned symposium on care of the injured in the Canadian Forces—what have we done the last year and a half, two years, what do we need to do better to listen to them, aside from doing a survey, to identify those areas in which we need perhaps improved policy, process, machinery. That's happening next week for two days, a very internal kind of activity. And from that we'll develop and take away an action plan.

Mr. Mark Holland: Thank you.

The Chair: Thank you, Mr. Holland.

Mr. Poilievre, you have up to eight minutes.

Mr. Pierre Poilievre (Nepean—Carleton, CPC): I was dismayed to learn from Mr. Holland's intervention, as well, that we don't have accurate or up-to-date numbers on patient satisfaction within the forces. I was dismayed to learn that, until I turned to point 4.17, in which that data is included in the report. It says here, "According to a patient satisfaction review conducted by National Defence in 2006, more than 85% of those who responded reported that they were satisfied with the health care they received." That's on page 9.

> In 2004, a Canadian Forces health and lifestyle survey found that 83% of members felt their health concerns were addressed at the time of their appointment, and 76% stated they received results of tests and procedures within an appropriate timeframe. More than 80% of members felt that the clinic's hours met their needs.

There's some up-to-date data that might be useful to members of the opposition as they consider the Afghan mission and the position they might like to take in the future.

I have a question around the costs and the administration of military health care. I see here that point 4.36 says that regular-force military physicians range in salary from $207,000 to $231,000—perfectly reasonable. What strikes me as potentially unreasonable is that on the previous page it indicates that 40% of physicians in the military are doing administrative work. That does seem to be an enormous amount of cost for an administrative worker. Having a licence to practise medicine seems like a heck of a lot of qualification necessary for a position in the administration of the system rather than in the direct delivery of health care.

Can you comment on why this is?

● (1205)

BGen Hilary Jaeger: I can start off, and then perhaps other people might want to offer other comments.

I'm one of those 40% of physicians who are considered to be in administrative positions. Most of those 40% are in fact less administrative than my position. You could call them medical supervision, medical policy development, public health related positions. I have an entire directorate devoted to public health.

Similar to a medical officer of health in a city, these people do not see patients on a day-to-day basis. They are busy worrying about issues of public health policy and program implementation.

Mr. Pierre Poilievre: Sorry, that does seem to be an extraordinarily high number, though: 40% of your physicians are doing bureaucratic work. I understand there's some role for bureaucracy in administering any program, but 40% of physicians are working as bureaucrats. How can you explain a number that is so large?

BGen Hilary Jaeger: With one exception in my organization, we don't employ physicians in jobs that non-physicians could do. I have one person who's acting as a commander who could be somebody else.

It looks worse from the military point of view. Remember, our baseline is 35% short to begin with. Most of those administrative positions, or medico-administrative positions, are the more senior positions for which we cannot hire a contractor. The contractors are concentrated in the service delivery part of the organization. The supervisory, policy development, and direction positions are almost exclusively uniformed providers.

Mr. Pierre Poilievre: Again, allow me to doubt that there's any necessity to have 40% of your physicians in a role of that nature. You've listed policy development and program implementation. All of these things are good, but they're all code for bureaucracy. It would be the priority of the Canadian taxpayer to see that trained physicians who make over $200,000 a year would be on the front lines of providing the gold standard health care to our soldiers instead of working in bureaucratic positions. Perhaps our resources would be better used if that kind of transition were carried out.

MGen Walter Semianiw: If I could just clarify, clearly, General Jaeger's not a bureaucrat. General Jaeger's a leader. Take a look at what many of them have to provide: when I was in Afghanistan with my medical company, my medical officer's time was spent providing leadership, and command-and-control coordination. I agree. Time would have been maybe even, some would say, spent out doing some medical work, being a doctor. But that is fundamental to the success of operations and having a chain of command and a leadership and, more importantly, in having doctors sitting here next to me who are qualified to speak. That, I would submit, is part of the price of doing business in a military; it's part of the price of providing leadership and getting it right in what we've got to do and—

● (1210)

Mr. Pierre Poilievre: That's all fair, and “bureaucrat” is not a negative term. There is a need for bureaucracy. But I'm just questioning. That 40% number does seem quite high, but I do take your answer on that.

I see here that $108 million has so far been budgeted for this information system. That's one-fifth of the annual health care budget for the military.

In 4.29 it says that there's still a lack of funding. Why is it that these information systems, whether it's here or with the gun registry or elsewhere, seem to cost so much money?

MGen Walter Semianiw: I'll start off and then turn it over to General Jaeger.

The first thing I would tell you is that I don't think the province of Ontario—I could be wrong—shares its medical information with other provinces and, more importantly, that there's a medical system and an information system in place to do that. That's what we're talking about here. We're talking about a health information system that will be able to go across the country, around the world, and talk to each other. That brings that additional burden, challenge to getting it right.

BGen Hilary Jaeger: I share your frustration with information technology, by the way. I've yet to see it come in on time and on budget.

But that being said, what makes the health information system a unique challenge is that it's not only doing it across provincial boundaries, it's doing it in two official languages and respecting all of the privacy concerns that go with dealing with health data in an electronic manner. It makes it a very expensive proposition.

Mr. Pierre Poilievre: Right. The goal, though, is to have up-to-date information all the time, so the left hand knows what the right hand is doing.

But once again to ease the concerns of those who believe they can't decide where they stand on the mission in Afghanistan, over the issue of information we do have some up-to-date information here, as I've cited, on the satisfaction of Canadian soldiers with the health care they're being provided. Some of the more specific data that was sought earlier can be provided to them in about ten days. The goal now is to shorten those timeframes so that information can be provided the same day.

Right now it's not that the data doesn't exist or that it can't be made available. I just don't want that to be used as a pretext for not taking a position on a military mission, because that data is available right now.

BGen Hilary Jaeger: You're absolutely correct. The data is there. It's not really rolled up into the form of useful information or knowledge. Most of the time you have to go to some length to turn data points into usable information at the moment.

The Chair: Thank you very much, Mr. Poilievre.

Thank you, Brigadier General Jaeger.

Colleagues, we're now going to go to the second round. It's going to be tight, but we'll try to stick to the five minutes, and I'm going to have to cut you off at five minutes. So keep your questions short and the answers brief and to the point.

Mr. Hubbard, you have five minutes.

Hon. Charles Hubbard (Miramichi, Lib.): We'll watch our watch. Thanks, Mr. Chair.

First of all, I'd like to concur with Mr. Poilievre that in terms of 65,000 or 70,000 people, and it costing $108 million or whatever in terms of providing assistance, there must be some regional health authority somewhere that you can draw on. If we look at the Canadian costs of health, if every little regional health authority needed $100 million to provide its data, that certainly would seem to be a tremendous amount of money.

I'd like to first of all be able to recognize that.... You know, I read the audit report in terms of qualifications, in terms of accreditation, in terms of upgrading, and it was rather shocking. I'm glad to hear that the major-general has information for us today to indicate that there has been significant improvement. I'm not sure in terms of pharmacists—there still is a little spread there—but for doctors and nurses and that, it seems you're making considerable improvements.

Now, if we go back to when I was in the service, we had an old system known as PULHEMS. It dealt with people who entered and who were assessed in terms of their medical proficiencies. The "M" was for mental health.

Today we have a lot of soldiers, sailors, and air people leaving the forces, and if we were to look at them today, would there be any indication of a serious concern with a change in M—for example, people coming in assessed as M-1, using the old system, going out as an M-4 or an M-5, and needing medical attention in the civil society? Do you have any information or any data on that?

● (1215)

BGen Hilary Jaeger: You were trained in the British system, because PULHEMS—or it may have been in the Canadian army at the time—is still in use in the British army.

We do not codify our people according to that same approach. We do not split out mental health from any other aspect of health.

Hon. Charles Hubbard: I probably am dating myself—

BGen Hilary Jaeger: You know, codification....

Hon. Charles Hubbard: —but I'd be very dismayed, Mr. Chair, if there weren't a similar system to assess people's mental health today.

BGen Hilary Jaeger: There is a system that assesses people in terms of vision, colour vision, hearing—a geographic factor that says where they can go and how far away from medical support they can be, an occupational factor in terms of what they do, and an air factor for suitability for operational jobs in the air force. But there is no separate coding for mental health over other health factors.

Hon. Charles Hubbard: So really, you're saying to our committee today that there has been no method of addressing this. Because sooner or later we're talking about veterans, and when those veterans go to look for benefits, they must have certain medical evidence to indicate what they encountered, the problems they had when serving, and whether or not, by someone's assessment, they have good mental health when they leave or whether their mental health deteriorated during the time they were in service.

There must be some evidence within your organization today to indicate that people have had mental problems, that they've seen psychologists, that they've seen psychiatrists, that they've seen social workers, and that when they're trying to go back into civil life and they have a history that was created by the military...because you know, as I said before, that when they entered they were classified as M-1, under that old British system, and left as an M-4.

BGen Hilary Jaeger: Every encounter with the health services system is documented on an individual's medical record. When you leave the service, you have a release medical exam that specifically does seek to compare and contrast your state when you started with your state when you left. And that would include mental health issues. The only difference is that there is no number code that describes that.

When you talk about transition concerns, sir, we do have challenges with transition. We've worked a lot with Veterans Affairs Canada toward making our mental health clinics interoperable, because it can be very difficult to effect a good hand-off between somebody who is a serving member of the Canadian Forces one day and is a veteran the next day. There's not always the same level of services available to both halves in the same city. So we keep working to move that forward.

MGen Walter Semianiw: If I can expand a little bit, something you need to be aware of, as I touched on earlier just as a side piece, is called the transition interview. The critical question is how you connect the soldier, sailor, airmen, and airwomen as they leave the force and do this transition that General Jaeger talks about in an efficient and effective way. It's called the transition interview.

What happens now, usually six months prior you meet someone from Veterans Affairs who does an interview with you. They go through what you need, what's happening, what challenges you have, and that information they will get from us on the military side for those soldiers, sailors, airmen, and airwomen who transit to Veterans Affairs, where they would be called clients. The information is passed from one department to another and there are a lot of linkages between the two to ensure there is a transition.

Second, to ensure the policies are the same—and that's the challenge, that there's no gap between the two—we have been working on harmonizing the two. The policies on the military side you'll see for mental health, the M-1 and M-4 challenge, you'll get the same support on the medical side. That's why it was decided a number of years ago to establish operational stress injury clinics in Veterans Affairs. They mirror very much the same set-up that we have in the military. So there is something very similar as part of Veterans Affairs that our soldiers, sailors, airmen, and airwomen actually transit to if they have a mental health challenge.

The Chair: Thank you, Mr. Hubbard.

Mr. Fitzpatrick, you have five minutes.

Mr. Brian Fitzpatrick (Prince Albert, CPC): Thank you, Major General and General Jaeger.

References have been made to bureaucrats. We see a lot of bureaucrats on this committee, but neither of you sound like bureaucrats. Your answers seem to be quite different from what we normally get here, so I want to commend you for the information you're giving us.

● (1220)

MGen Walter Semianiw: You don't pay me to be a bureaucrat, right?

Mr. Brian Fitzpatrick: I would like to deal with performance measurements. There seems to be a lot of emphasis on getting performance measurements in place. It's my observation that the provincial systems we have in Canada have a long way to go to get uniform performance measurements in place across the country, and it's a work in progress.

Many of the provinces seem to be very reluctant to get with it and to provide that sort of data. They probably have a whole host of reasons why they would be taking those positions, but it seems to me, if I'm hearing you folks correctly, you do have the data. Maybe you're a little bit behind in having this produced on as frequent a basis as people might want, but you do have access to the data to know what kind of service the men and women who serve in the military are receiving. Am I correct in that assumption?

MGen Walter Semianiw: Yes.

Mr. Brian Fitzpatrick: Okay. Thank you very much.

I want to deal with wait times, which I think are crucial to any health care delivery, especially in your operations. If somebody in the military saw a general physician in the armed services and required the treatment of a specialist, how long do you think it would take—if you can give us some sort of guidance—before that service person would actually gain access to the specialist and start receiving the required treatment?

BGen Hilary Jaeger: The answer of course varies a little bit by geography and by the specific specialty you're looking for, and of course in urgent situations, in emergency situations, waiting time isn't an issue.

We tend to do a little better than the civilian sector, largely because where we have enough volume we have Calian contracted physicians for that specialty who come to that base on a schedule, perhaps every Friday or every other Monday, and you get seen in that kind of delay.

We are looking at a month or less for most specialties, very few go out longer than that.

Mr. Brian Fitzpatrick: That's very interesting, because the only organization that I know, for the last ten or so years, that has tried to track waiting times in this country has been the Fraser Institute people. They issue their list for provinces every year.

In my home province of Saskatchewan, the average wait time that I saw last time, from the time you see a general physician to receiving your first treatment, is something like 27 weeks, which is close to seven months, which I find appalling and unsatisfactory. If my car broke down and the mechanic told me to bring it back in seven months, I'd be a little bit dismayed. But you're saying you feel that your wait time average might be in the realm of a month. That's far better than what we have in the Saskatchewan system.

Speaking of mental health as well, even though it's not an area for the federal government, I've encountered many people in my riding who have people in their families who have serious mental health problems. It's more a provincial area, but I have tried to look at this problem a bit, and I find that in the provincial system in Saskatchewan, there is a real major shortage of mental health services for people who have mental health problems. If somebody has a mental health problem in their family, I'm sure if we surveyed them we wouldn't like the kindsof responses we'd get back on that sort of thing.

Some people have tried to conjure up that there's some really systematic, major problem in the way we're dealing with mental health in the military. You mentioned one psychiatrist for 2,000 people over in Afghanistan. I think there might be one or two for my entire riding, and that's 73,000 people. How do you think your mental health services do stack up, compared to the provincial systems?

● (1225)

The Chair: Thank you very much.

BGen Hilary Jaeger: I'd refer the committee to Senator Kirby's recent report when he was chair of the Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last,* which made the splash about mental health.

Compared to the services available to the average Canadian, I believe we do very well, but you raise a challenge that in fact comes into play with us every day as we try to fully implement our mental health reform.

We have resources to hire people. We have the authority to spend the money. The money is waiting there. Where are the health care providers?

It's a very, very competitive market out there, and there are not a lot of health care providers. When we do find the right people, they tend to like working with us a lot, and they tend to become very loyal and very dedicated to what they do. But it is a hard job to find them, and it is a harder job to entice them to work in some of our more peripheral areas.

MGen Walter Semianiw: And to be fair, it's not just a national issue, it's an international issue. Internationally, the number of mental health care providers are in short supply around the world. So we're competing with not only the internal-to-Canada challenge, but also the international challenge.

Again, to reaffirm what General Jaeger said, it's not an issue of us not having enough money to do it; it's an issue of finding people who are qualified to do it and then hoping they want to go where we want them to go, which becomes, for me and for her in uniform, an unlimited liability issue to serve this nation.

The Chair: Thank you very much.

Monsieur Lussier.

[*Translation*]

Mr. Marcel Lussier (Brossard—La Prairie, BQ): Thank you, Mr. Chairman.

Ms. Fraser, mention was made of a survey conducted in 2002. Many things have happened in Afghanistan since 2002.

Do you think the sampling used for the survey was representative of our CF members? Are we talking about a regional survey? Have you commented at all about this?

Ms. Sheila Fraser: Mr. Chairman, as we noted in the report, this survey was carried out by Statistics Canada. Judging from our experience with Statistics Canada, I would have to say that these surveys were carefully conducted and that their findings are very good. However, as we also indicated in the report, the specific focus of the survey was mental health services. On the heels of this survey, medical services launched a series of initiatives to improve services in this area. These initiatives are listed in the report.

Mr. Marcel Lussier: So then, steps were taken to begin compiling data on satisfaction levels.

Brigadier General Jaeger, are their plans in the works to provide mental health services to returning soldiers in February 2009?

BGen Hilary Jaeger: We will follow the same procedure that we have followed for other rotations, namely third-location decompression in Cyprus. At that point in time, members are informed of all the services available to them. Mandatory screening which occurs four to six months after the soldiers are rotated out and which is designed to identify CF members at risk is very important to us. That is why all CF members—it is never exactly 100%, but that is our goal—who have been deployed are required to undergo a detailed screening.

I am well-acquainted with the Chief Medical Officer at CFB Valcartier. She is well aware of the importance of monitoring these individuals closely and she takes the appropriate action.

MGen Walter Semianiw: The Veterans Affairs' team is already on the base, and that is very important for this program.

● (1230)

Mr. Marcel Lussier: My colleague Mr. Holland raised one very specific issue. We need some statistics, since parliamentarians will be making some decisions in the coming months.

I would like to make a formal request. Firstly, is it possible to single out from the figures presented to us, the medical costs associated with the mission to Afghanistan? Right now, the figures are all rolled into the same budget.

Secondly, do you have any statistics for us on the number of military members who have been injured to date to Afghanistan? The newspapers report the number of fatalities. Could you tell us how many soldiers have been injured and are currently being treated by medical personnel? Overall, how many cases of mental illness have been diagnosed every year since our mission to Afghanistan began?

It is critical for us to have these figures. Could you get them to us? We are not interested in surveys on the satisfaction of CF members, even though these are important in terms of doing overall evaluations. We would like some statistics on the number of casualties in Afghanistan. This type of request is in line with the notion of transparency that the Prime Minister has promised. Therefore, it is important that you provide us with these figures.

MGen Walter Semianiw: We can do that for you.

Mr. Marcel Lussier: When?

BGen Hilary Jaeger: It will take us two or three months.

The Chair: Thank you very much, Mr. Lussier.

Mr. Jean-Yves Laforest: Mr. Lussier has just made a specific request and we've been told that this information will be forwarded to us. That means the public accounts committee should be getting some figures. At least that I what I understood.

Thank you very much.

[*English*]

The Chair: Let's firm this up. The information will be tabled with the clerk of the Standing Committee on Public Accounts. What timeframe are we talking about?

MGen Walter Semianiw: It is three months, to be specific,

[*Translation*]

and the information will relate to the situation in Afghanistan.

[*English*]

The Chair: It will be within three months, and that will be tabled with the clerk in both official languages.

MGen Walter Semianiw: Yes, it will be in both official languages.

[*Translation*]

It will be tabled in both official languages.

[*English*]

The Chair: We'll go to Mr. Epp for five minutes.

Mr. Ken Epp (Edmonton—Sherwood Park, CPC): Thank you, Mr. Chair.

I want to build a picture here. For many years I was the head of the math section at NAIT, where I worked as an instructor. I was the chief guy. I had an assistant, and then we had about 20 guys who were in the classroom. In that particular instance you would say that there were two administrators, even though both of us taught part-time, and we had 20 other guys who were actually full-time in the classroom.

When I see 40% of the military physicians not providing patient care, if I relate that to my situation, it would mean we would have had in our department eight administrators and 12 teaching in the classroom. That seems terribly disproportionate to me. I would like you to explain this.

If you were to ask me how many of our people were involved in administration, it would be 100%, because every instructor has to report marks, and so on. There was a certain amount of administration involved in the work, but as for administrators per se, really, I was the only one.

The question, when it was asked, was how many of you are involved in administration. I think every medical doctor is. There are forms to fill out and so on. But when I read that they are not providing patient care, that 40% are in administration, surely there is an error there. I would like an answer to that, first from the Office of the Auditor General.

Ms. Sheila Fraser: Mr. Chair, I'd like to ask Ms. Loschiuk to respond to that.

Ms. Wendy Loschiuk (Principal, Office of the Auditor General of Canada): Thank you very much for the question, Mr. Chair.

We went in to do some work to find out where all the doctors were and what they were doing, and we were able to get information from the department on what the different positions were, who the general duty medical officers were, and others, and where they were being posted. We are looking at military personnel here; we're not talking about civilian personnel.

It was a fairly easy thing to do, I think, to find out how many people they had, how many people they had practising in the clinics and doing direct patient care, and how many they had doing other work.

The question of the 40% was then calculated. The important message that came out for us was why is it 40%? Is that reasonable to expect, given the situation of the Canadian Forces, given how the Canadian Forces is organized and given what people are expected to do? As General Jaeger has pointed out, there are some positions that do require doctors; there is no question about it. But do all of them require doctors? We believed that as part of the administration, as part of looking at their Rx2000 and going through and reorganizing themselves, this was a cost driver the department should look at.

● (1235)

Mr. Ken Epp: Okay. Could I have a response from Brigadier General Jaeger?

BGen Hilary Jaeger: I'll make a couple of observations.

I have a fairly long period of service in this organization, and I'd say that the process of scrubbing down the positions to remove as many physicians as possible from doing jobs that non-physicians could do was a major thrust between 1995 and the beginning of Rx2000. As an example, the commanding officer of a field medical unit, a "field ambulance", as we call it—which has nothing to do with a vehicle with four wheels, but is just an historic term—always used to be a physician. I held that position some years ago. Now it's held by a health services operations officer, a health care administration officer with training. So there has already been a process to take physicians away from doing jobs that can be done by other people.

When you look at the number of positions that require medical training across the headquarters—and it's interesting you have the educational background you mentioned—part of what drives that 40% figure is that it's not like running a hospital or a big clinic. It's also like running a ministry of health at the same time. A little bit of Health Canada is in there for regulatory purposes. There is a research and development component in there. There is a medical education component in there. There is the public health system I spoke of, and the Public Health Agency of Canada is full of physicians, but none of them sees patients. So all of those things contribute to that ratio of brain power of people who don't actually speak to people one-on-one in an office.

Mr. Ken Epp: Thank you, Mr. Chair. I think my time is 20 seconds from being up.

The Chair: Thank you very much, Mr. Epp.

Mr. Stoffer, for five minutes.

Mr. Peter Stoffer: Thank you once again.

First, because we operate in NATO environment in many circles in the world, do we do any comparisons between our medical experiences within DND compared with how, say, Holland or Britain do it? That way you're not reinventing the wheel; you can take the best practices from others and combine them. Are those discussions taking place, and do you do studies to compare where savings can be met and where best practices can follow?

BGen Hilary Jaeger: The short answer is yes.

There are two major fora for that. NATO has a committee on the use of medical services. All of the surgeons general of the NATO nations and the partnership for peace nations meet twice a year. They have an elaborate substructure of expert panels and working groups, which they can direct to examine specific issues to ensure commonality of approach. There is also cooperative research done at the NATO level via a smaller, more cohesive group. An analogue to that would be Australia, Britain, Canada, and the United States, the ABCA countries, which actually include New Zealand, although they don't get their initials on the title. So a group of very similar nations address how to approach medicine, and interoperability there has worked very well. Of course, our biggest one-on-one exchange is with the United States.

It may interest the committee to know that in fact the facility that is Canadian-led in Kandahar also has contributions from the Netherlands, Denmark, Australia, New Zealand, the United States, and the United Kingdom, all working together to make that one facility work.

Mr. Peter Stoffer: Thank you.

It has been noted and been said, and it's also in the Auditor General's report, that when you sign up you have the unlimited liability, which basically means that I can have a good night's sleep because of the uniform you wear. So I've always thought that we in government or in opposition have what I call the ultimate responsibility, although you never see that written anywhere, to care for you right to your headstone, including that of your family. And in many cases you'll hear the slogan "support the troops", but when you stand in a crowd and say don't forget to support them when the uniform comes off, you get a blank stare that says, what's he talking about?

Some of the biggest problems I have on the veterans committee are about watching the baton being passed from DND to DVA. It drops a lot. It takes months sometimes for medical files to go from National Defence to DVA for people to apply for pension and compensation benefits. And in fact I hope you never have to fill out the forms for PTSD, because that alone can give you PTSD, in our testimony.

Having said that, and I know my Conservative colleagues are always worried about 40% of doctors filling out forms and things, and they should always talk to their defence minister to fix that up. I don't think necessarily it would be you. But don't you think that in your experiences and in terms of some of the advice that you can give to General Hillier down the road and to the bureaucrats and to the government and to opposition that when it comes to signing up for the unlimited liability we have the ultimate responsibility and that costs should not be a concern? We shouldn't be nickel and diming our troops and their families when it comes down at the end.

I know you have challenges in terms of the number of personnel, but when somebody calls up looking for help we shouldn't put them through the wringer. The only thing we should ask them is if you've served, how can we help you? It would be utopia for me to see that happen.

What would it take to make that happen, besides more money?

● (1240)

MGen Walter Semianiw: Aside from the money piece, to come back to the discussion in front of us, I would agree with you. First, if we look at the soldiers who have fallen, is there a price the nation can put on any soldier who fell? I would submit you cannot.

Mr. Peter Stoffer: Right.

MGen Walter Semianiw: That then segues for me into a very critical question of can you then perhaps sit back and say that a health care system that's providing health care to those in uniform who have an unlimited liability contract with not only society but this nation somehow should be constrained by dollars and cents? My short answer is no. However, I also agree it needs to be done efficiently and effectively—

Mr. Peter Stoffer: Yes.

MGen Walter Semianiw: —because there is a responsibility that we need to do that.

I could sit here and tell you that we have, over the last number of years, moved very quickly to establish a stronger link between us and the Department of Veterans Affairs, but to segue it back into an issue here it would be can the two departments have information management systems that could talk to each other. Fair question. That is something we're moving towards. Our officials are now working together to ensure that we can pass that information, because right now it's in paper form and it needs to get downloaded. And remember, this has been going on for 30 years; it's not just since the last three years, it's been going on for many years. But officials are now meeting, with full support from the department and the government, to be able to bring that piece together so that information can be patched seamlessly between the two organizations so that there is, as was mentioned here, a seamless transition.

So we are moving towards what you would call utopia or nirvana.

Mr. Peter Stoffer: I have a point of clarification, Mr. Chairman.

Is it not true, sir, that a mission doesn't end until the last person who serves that mission dies?

MGen Walter Semianiw: Whose policy is that? The Department of Veterans Affairs?

Mr. Peter Stoffer: No. Jack Ford, an 89-year-old veteran, told me that. He said the mission doesn't end until the last person who serves that mission passes away.

MGen Walter Semianiw: I would submit to you that I don't think a mission ever ends. It will never end in the history of a nation. If you take a look at it from the point of view of honouring our veterans, we continue to honour them every day. If you look at how we portray that information, we still recognize them.

World War I hasn't ended. It won't end when the last great vet passes away. We'll continue to celebrate. We'll continue to honour the sacrifices they have made. So I look at it a little bit differently. I don't think a mission ends when the last veteran has died.

However, the nation views it from a pension and benefits point of view. And clearly from our point of view a mission continues, I would say, in the name of its nation forever, in perpetuity. It helps build this nation, as we do in uniform.

The Chair: Thank you, Mr. Stoffer.

Mr. Wrzesnewskyj, five minutes.

Mr. Borys Wrzesnewskyj (Etobicoke Centre, Lib.): Major General, previously you had stated that it would take you about a week and a half to produce the numbers, the number of soldiers undergoing mental health care at this point in time. Can you commit to providing that to our committee within the next two weeks?

MGen Walter Semianiw: I would say yes, but you have to know how simple and how challenging it is. As General Jaeger alluded to, much of this, if not all of it, is decentralized.

● (1245)

Mr. Borys Wrzesnewskyj: I understand. It's in files.

MGen Walter Semianiw: Just to be clear, if we were to bring a base wing surgeon in who has a geographic catch basin, he'd probably give you a pretty clear assessment of the state of that area. So it's rolling it up together, and we could do that. But again, I come back to this committee, why we're here. Once we have that information system in place, we'll be able to do it quicker.

The short answer is yes, we can.

Mr. Borys Wrzesnewskyj: Thank you.

BGen Hilary Jaeger: In a week or ten days, we'll get you the active number of mental health patients across the country. That will not necessarily tell you which ones are related to service in Afghanistan or which ones just have mental health issues.

Mr. Borys Wrzesnewskyj: Thank you.

I have a tremendous sense of unease. In fact I'm somewhat disturbed that we have over a quarter of our soldiers returning from the mission in Kandahar, and they're identified as having mental health issues. We have no idea how many of those soldiers are receiving the type of care they require. These people could be in very dark places. We also know that a significant number of them have been flagged for substance abuse or potential substance abuse with addictive substances. Suicide was mentioned, and we know that they have access to weaponry.

What's most disturbing about this isn't just not having the figures, but that the armed forces have known, since 2002, the last time they checked on this.... Six years have passed, and for the last six years they've known that 75% did not feel that they were getting the type of mental health care they required.

The initial answer was, well, we'll get those numbers in two years. It's taken this committee to request to get at some of those numbers, and the numbers could have been accessible. The armed forces, if they truly were concerned about this issue, would have had those numbers.

I have a question to the brigadier-general. Back in October, when this report came out, Mr. Day was quite concerned, and rightfully so. He said that by 2009, meaning by the end of 2008, $100 million would be poured—he said this in October, in the same timeframe that the mini-budget was being presented—into issues of mental health, and 200 mental health care professionals would be hired by the end of this year.

How many millions have poured into your department, Brigadier General, since that statement three months ago? And how many of those 200 have been hired or are in process—the actual numbers?

MGen Walter Semianiw: If I can kick off here before General Jaeger comes back, on the first comment you made, first, if you had the information but you didn't have the programs, what would that achieve? I would come back and tell you—which I think is the tougher question—what has this department and the Canadian Forces put into place to ensure that its soldiers, sailors, airmen, airwomen who have mental health challenges actually are getting the support they need?

If you want to—I don't have time—I could sit this afternoon for a couple of hours and tell you what's been done since 2002 to make sure they get the support they need. I would submit to you that's the issue at hand. Rolling up information from bases and wings, I'll give that to you any day you want. My issue is, are they getting the support they need?

We have put clinics in across the country. We have put policies in place. We are hiring more individuals- General Jaeger will answer that question in a minute. A lot has been done in the last six years, not just in mental health but in OSI, in PTSD, establishing peer support networks. To be fair, a lot has been done by the Canadian Forces because it knows this is a challenge, it knows it needs to do this to do the right thing.

So I would come back and say a lot has been done. I'd be more than happy to lay it all out for you. We'll get you the figures. The lack of figures has not stopped us from doing the right thing to get them the support they need. There always will be cases; you can bring them from your constituency, one or two here who need different and better support. Part of the challenge is in the number of mental health practitioners and finding people to bring them into the organization. Getting them to want to go to Petawawa to live there is also a challenge.

Again, I come back, we've done a hell of a lot to do this and get this better. We've got a hell of a way to go, but we're on the way to getting it right.

Mr. Borys Wrzesnewskyj: Major General, as a senior army officer you must realize that you have to have accurate information when facing an enemy out in the field. This is an enemy within that can cause lives to be lost among our armed forces. I'm stunned to hear that it's not critical to gather the information, to have proper assessment of how to go after that particular enemy that could be taking the lives of our soldiers.

I guess we still we haven't had the answer about the commitment of the $100 million—

● (1250)

MGen Walter Semianiw: If I may, I come back to the comment and the point that was made here that we have the information, but it's at what level? Right now, at our bases and wings, our medical teams know what the challenges are. When they need additional staff, they get hold of her. We ensure that they get hired. For me to tell you that I can't, at the tip of my fingers, give you that information is one part. The critical information that we need to have is at the right place, decentralized, to be able to get the resources that we need to support them.

The Chair: Thank you very much, Mr. Wrzesnewskyj.

Mr. Borys Wrzesnewskyj: On a point of order, the second part of my question was not answered.

In October the Minister of National Defence had said $100 million would be poured into mental health issues, and 200 professionals would be hired. Has the department seen any of that $100 million, and have any people been hired?

The Chair: Very briefly, Major General, if you want to respond to that specific question.

BGen Hilary Jaeger: The $100-million figure does not ring any bells with me. I don't recall the statement first-hand, so it puts me at a bit of a disadvantage.

Mr. Borys Wrzesnewskyj: It was made in the House of Commons on October 30, 2007.

BGen Hilary Jaeger: The mental health program under Rx2000 represents $90 million of incremental resources over baseline from its inception in 2005-06 to its completion next year, in 2009. That does involve the 200 additional mental health providers. We are about halfway done that hiring process.

The Chair: Thank you very much.

Mr. Lake, you have five minutes.

Mr. Lake is the last questioner, and I have a few myself.

Mr. Mike Lake (Edmonton—Mill Woods—Beaumont, CPC): Thank you, Mr. Chair.

I'm almost inclined to have a discussion, of course, about the impact on physical and mental health of the proposed opposition policy of sending our soldiers into Kandahar for reconstruction and training without allowing them to defend themselves when attacked by the Taliban. But we won't have that discussion, obviously, in this short timeframe.

Actually, there are a few things you talked about today that raise some questions about the numbers. You talked a little bit about the suicide rate. I think you said it has been the same for some time, 10 to 13 per year. That's over how many years?

BGen Hilary Jaeger: I would have to double check if you want the exact answer, but that is dating back to at least 1999. That includes the mission since it's been in operation in Afghanistan.

Mr. Mike Lake: So there hasn't been a marked increase in that time period.

BGen Hilary Jaeger: No. It has stayed reasonably consistent, recognizing that suicide rates are difficult to track because they represent rare events. You have to track them over large populations to get reliable data.

Mr. Mike Lake: It's concerning, nonetheless. Ten to 13 suicides per year is still—

BGen Hilary Jaeger: Any suicide is concerning, but if you look at comparators to an age- and sex-matched Canadian population, our suicide rate is actually slightly lower—

Mr. Mike Lake: That's what I was going to ask, actually.

BGen Hilary Jaeger: —which is particularly remarkable, because our rate of depression, which is the most recognized risk factor for suicide, is actually 80% higher. So we have more depression but less suicide.

Mr. Mike Lake: I do want to quickly move on, if I could, because I was interested in hearing you talk about this director of family services office. I sense that you might want to talk about it a little bit more.

I had the opportunity this past weekend to go to the War Museum. They have a slide show there on the men and women who have lost their lives in Afghanistan, and it honours them. There are pictures of them and their families. I was struck by how many of them have young families, with three and four kids in them.

As a parent myself, I'm really concerned not only for whether the families are being taken care of here, not just the families who have lost a parent but the families whose parent is off for six months at a time, but also for the peace of mind. It's tough enough for us to leave for four days, let alone going halfway around the world to face what they're facing there. That peace of mind would be so important for all the things we're talking about right now, the mental stability and things like that.

I think you said it's due to be in place in three months. Can you talk a little bit more about this office and what its role will be?

MGen Walter Semianiw: To give it some historical perspective, the Canadian Forces, as stated, established these military family resource centres across the country. They do sterling work in assisting families who have loved ones overseas on any operation. I know the discussion gets focused on Afghanistan, but it is anywhere we send our men and women in uniform. They support that.

Our view, as mentioned here, is that we think we can strengthen this, and it needs to be strengthened. We have a number of policies we are going to put in place very shortly. I talked about the structural piece, but that was to have an individual within our headquarters who would be responsible and accountable—I think there is an issue of responsibility and accountability—to whom we could turn and who would put the policies in place for a strategic framework across the country, to ensure there is a consistent application across the country for our families.

We see an increase in the resources we will put in that area, no ands, ifs, or buts. I can't give you the figures in three days, a week, or two months. Intuitively, I can tell you it is going to cost more. We have the money set aside to be able to do what we need to do, to build on the military family resource centre success and to make it stronger and connect it nationally across the country, to ensure that we probably do more.

What do I mean by that? Here are some of the things we're looking at. It already happens in theatre that families do talk to loved ones by telephone; they get so many minutes a week. Perhaps we can move to video teleconferencing. Other militaries do that. Could we put that in place? Some of that is already actually being done on a case-by-case basis. Back home there are a lot of activities, as all of you see in your constituencies, that the MFRCs do in their work with the families, such as activities on the weekend, to keep the families together.

Again, the challenge has come back to the issue of what role we have to play in supporting the family, especially with mental health. It has been raised here. It is the issue we are going to speak to the department about, of what we can do to make this better on the mental health side. A mental health solution for a soldier is a family solution; it is not just about the soldier. We're putting the director in place—there will be an announcement—and a lot more, to bring it all together to strengthen that piece for our soldiers, sailors, airmen, and airwomen.

● (1255)

Mr. Mike Lake: I just want to follow up on Borys' line of questioning there.

I thought you made a good point. The treatment and help for people is the most important piece, and we can't forget that. But, for myself, I want to have some confidence that steps are being taken to address these deficiencies in terms of the information that you're gathering, so that you can do an even better job of delivering that treatment in the future.

So I will close with that. Please give us some reassurance that you are taking steps in that.

MGen Walter Semianiw: We are taking steps. We could sit here for hours and lay everything out that we're doing. It's not the aim of this committee, but I'd be more than happy for you to come and receive a briefing on what we're doing. I think you'd be very pleased to see this, as we're moving it ahead. Some of it has been done intuitively, because we know we need to do it to get the right thing done. Again, what the Auditor General raised will only help make it stronger. I would agree with you.

The Chair: Thank you very much, Mr. Lake.

I have a couple of questions before I ask for concluding remarks.

First of all, in her opening comments the Auditor General stated that National Defence had agreed with the recommendations and has developed an action plan to address the concerns raised in this report. Can you file with the committee a copy of this action plan?

MGen Walter Semianiw: Yes. We brought it with us, and we'd be more than happy, Mr. Chair.

The Chair: If you could do that, we'd appreciate it very much.

To close, I have a general question to Brigadier Generall Jaeger, as the surgeon general for the Canadian armed forces.

I think we've had a very good discussion this afternoon. There have been a number of concerns raised in the auditor's report, and there were a number of concerns raised this afternoon.

One of the concerns relates to the lack of data and empirical evidence on health issues in the Canadian Forces. Speaking as a member of Parliament who deals with some of these families on a day-to-day basis, and in speaking with other members of Parliament and reading some of the reports in the media, there is a certain level of disappointment out there.

I know you're always going to get certain cases. In my district we have the head office of the Department of Veterans Affairs, so I'm aware of those situations too. My view is that they do tremendous work. There are always going to be certain issues.

But dealing specifically with the defence issues, there is a certain level of disappointment, from more than a small number of families. I can appreciate the horrendous challenges you face as the surgeon general. You're dealing with issues. We have ramped up our combat mission in the last five or six years. You're dealing with a cohort in society that's more demanding, less deferential. I don't say that in a derogatory sense. I am comparing them perhaps to the World War I and World War II veterans. You're also dealing with a health care professional environment that's brutal. You're competing with every province and country in the world. You're trying to get people to work for you, and if you are successful, then you try to deploy them to Gagetown or Petawawa, which may not meet their personal lifestyle or desires. I can appreciate the problems you're faced with.

My general question to you, as surgeon general for the forces, is whether you think you have the resources to do the job. Looking one to three years down the road, do you think you're going to be able to accomplish what everyone here and everyone across Canada wants your department to do?

● (1300)

BGen Hilary Jaeger: Thanks for that question, Mr. Chairman. It's a deceptively complex question, which was phrased relatively elegantly.

With regard to the answer, I see in my leadership and in the commitment of the Canadian Forces and the Department of National Defence probably more willingness to commit the necessary resources to do what needs to be done than I've seen throughout the rest of my career. That does not mean that right now I have everything I could possibly want to provide outstanding service. I think I have everything I need to provide a very solid baseline of service.

Now, should some things change in the future, for example should the definition of who is entitled to care change—and right now, families and part-time reservists are not defined as being entitled to care—then I will not have the resources I need to provide the adequate level of support. Changes in those definitions would be huge drivers of requirements for service delivery.

Can I be more efficient in some areas? The answer is yes. But I need management data to tell me where I can make those efficiencies. Those efficiencies that I can make will never bring me down to the average provincial level of expenditure for health care. I have over 1,200 of my people in what we call the “field force”. They don't see patients. Their job is to be ready to go on missions overseas. So I have some fairly substantial drags on my efficiency.

MGen Walter Semianiw: Aside from the Auditor General's report—and we have to do better—I would add that the leadership of the Canadian Forces and the department did tell Brigadier General Jaeger in the month of October that she is directed to spend whatever money she needs to get it right for soldiers, sailors, airmen, and airwomen. She was very happy to hear that.

It is agreed that we need to do it better, as the Auditor General said, to ensure that we have the performance measurement pieces in place. But clearly, money should not be an issue that prevents our soldiers, sailors, airmen, and airwomen from getting the support they need for what they've done for this nation. That's what she has been told to move ahead and do.

Mr. Pierre Poilievre: I have a point of clarification, Mr. Chair.

There was one statistic that I did not get, and perhaps I didn't hear it right. Did you say that according to your statistics the suicide rate among soldiers is actually lower than the general population for equivalent age groups?

BGen Hilary Jaeger: If you control the statistics for age and sex distribution, people in the general population at highest risk for suicide are males between the ages of 19 and 24. So if you control for that sort of fraction, we are slightly below the average Canadian rate.

Mr. Pierre Poilievre: Very interesting.

The Chair: On behalf of everyone on the committee, I want to thank you for your appearance today, Major General Semianiw, and Brigadier General Jaeger.

Ms. Fraser, do you have any closing comments?

Ms. Sheila Fraser: Thank you, Mr. Chair.

I'd like to thank the committee for their interest in this audit. I think it is testimony to the importance of this program and the medical services that are provided to the Canadian Forces. We do hope this audit will help to improve the management of that program and we are pleased with the response from the department, the development of the action plan. We will certainly be monitoring this going forward. I would hope this committee will as well.

Thank you.

The Chair: Thank you very much, Ms. Fraser.

Major General Semianiw, do you have any closing comments?

MGen Walter Semianiw: Just to reiterate the comments up front. Again, we fully embrace and support the recommendations of the Auditor General, not just with what's been done, but in the future working with her team to continue to move ahead. The action plan we've put in place to start addressing in a real way some of the issues I think is a testament to where we need to go.

As this committee knows, it does come back to dollars and cents. Clearly, we're going to do better. We've got to do better when it comes to performance measurement, when it comes to accounting. We're committed to doing that. At the end of the day, I would say, and I've said this many times, clearly, what we need to do for men and women in uniform is to do the right thing, and that is to provide the best health care they need, both physical and mental, to continue to serve this nation the way they have.

● (1305)

The Chair: Mr. Stoffer, you have a brief comment you want to raise.

Mr. Peter Stoffer: Yes.

Mr. Chairman, on a lighter note, I thought we'd let everybody know this, that we have a reunion here. When the brigadier general was the lieutenant colonel of the 2 Field Ambulance, she was serving with the second in charge, Andrew, who's our researcher, both under the brigadier general at the time, Rick Hillier. So there you have it.

The Chair: We've gone full circle here.

Mr. Peter Stoffer: Well done. Thank you.

The Chair: Okay.

I want to, on behalf of everyone on the committee, thank everyone for their appearance today.

Our next meeting, members, will be Tuesday morning, 11 o'clock, and we'll be dealing with the Canadian Border Service Agency.

The meeting is adjourned.

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