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Mr. David Sweet

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● (1530)

[*English*]

The Chair (Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC)): Order, please. We'll call this meeting to order.

We're continuing our study of Veterans Affairs services offered by members of the Commonwealth and the G8.

We have esteemed witnesses with us today. We have Carlos Lourenso, the director of continuing care programs; Colleen Soltermann, acting director of disability and treatment benefits—did I get those names correct?—and Adam Luckhurst, associate director general, program management.

Adam reminded me that he addressed our committee in the 39th Parliament on the services of the Australian veterans affairs organization.

Is there just one person, or do all three of you have opening statements?

Mr. Adam Luckhurst (Associate Director General, Program Management, Department of Veterans Affairs): I'll provide a brief opening comment, then I'll hand it over to Carlos and Colleen to run you through the presentation.

The Chair: Okay, very good. So all three of you will be participating in the opening.

Okay, then, I will let you go ahead at your discretion, Mr. Luckhurst, and then afterwards, of course, we'll continue with questions on a rotation basis, the way we normally do.

Mr. Adam Luckhurst: Thank you very much, Mr. Chair.

Thanks very much for inviting us to here today. I think we'll be able to provide you with some excellent and detailed information, particularly about our long-term care and VIP and health benefits programs. But I guess within the theme of our presentation today, it's really about how we're working towards establishing a better continuum of care for those we provide services to.

Colleen and Carlos, in their areas of responsibility, are managing the programs that really are about this continuum of care. Obviously, we're very strongly focused on the care and needs of our veterans, particularly as they age and particularly as they become less able to look after themselves or receive the support they need from their family members and caregivers.

There are a few points I'd like to make before we hear from Colleen and Carlos.

First, our client demographics are certainly changing very rapidly and are going to mean that over the next five to 10 years we'll have, unfortunately, many fewer World War II veterans to care for. We're obviously closely monitoring the need for an uptake of services and are planning now how we'll manage this change into the future.

Second, and I think really importantly—and I guess I'm commenting more on long-term care—certainly across the range of programs we provide we've made quality of care a priority. And I think through the presentation you'll see that the work we're doing here is really about how to ensure that the care provided in the facilities is able to best meet the needs our veterans have.

Over time, we also want to specialize the care available in our contract beds to really make sure that we provide extra services above and beyond what is available in the community.

Finally, overall, we have a comprehensive range of programs in place to provide our veterans with the best possible care when and where they need it. Whether in their homes or their communities, in communities or in community-based facilities, more and more veterans want to remain in their homes and communities for as long as possible. And I guess what our programs are about is working with them to make that happen. We want to be able to give veterans more choices in the sites of care that best meet their particular needs.

As I said earlier, we hope to be able to share considerable information with you on these programs today. We recognize that you're discussing other programs at various times, and also in Charlottetown, so we'll try not to cut across those areas at all.

Now, if I could, I'll hand it over to Carlos first, who'll describe, in particular, the long-term care and VIP programs.

Go ahead, Carlos.

● (1535)

Mr. Carlos Lourenso (Director, Continuing Care Programs, Department of Veterans Affairs): Good afternoon.

I'd like to thank you for the opportunity to come here to speak to you about two very special programs we have for our war service veterans and other veterans across the department. Over the years we've been very privileged to be able to provide an array of services to Canada's war veterans.

The material you have before you has been provided in advance, so I won't be going over the details of the slides. You can ask me any questions afterwards, but I'll speak to the themes and highlights of those slides so we can get through them.

I'd like to begin with slide 3 and some key underpinnings of VAC's approach to what we call a continuum of care. VAC has been in the business of providing home care and long-term care for more than a quarter of a century now. We know that clients prefer to stay in their own homes in their own communities as long as possible. For many veterans, home care is the preferred and most cost-effective option we can provide them. It promotes client independence, and we try to offer a continuum of supports that promote choice and independence, while at the same time trying to be cost-effective.

Our services have evolved over a number of years. The VIP and long-term care programs have evolved significantly over the last quarter of a century. One of the things we try to pay most attention to in both programs is quality of care.

When we speak to a continuum of care, there are many definitions, but what we essentially refer to is an integrated and seamless system of services for veterans. Our approach is needs based, designed to foster a continuity of care using a variety of resources and providers we have and that exist in people's communities. It's designed to serve clients along their life courses from a needs-based approach, recognizing that people and circumstances change as they move through those life courses. It includes a variety of things such as health care benefits; medical services; supports to encourage and support independent living; and then intermediate, chronic, and residential care settings.

I'll take a few minutes to speak to you about the veterans independence program. Some of you may know about this program; others may not. The goal of the veterans independence program is to help people stay as healthy as possible, try to prevent functional decline, and remain independent in their own homes. It's available to eligible veterans, primary caregivers, and certain survivors of veterans who were never in receipt of VIP. It enables people to be independent and self-sufficient. It tries to improve their long-term health care by having services that are implemented as early as possible, improve quality of life for recipients and their families, and reduce the skyrocketing costs of institutionalization.

These outcomes are achieved through various benefits we have in the VIP. Some of the bigger ones are listed in your next two slides. Slide 8 really touches on the largest pieces of the VIP. The total expenditures for the program are $303 million. About 60% of that is focused on the housekeeping area. Nursing home care occupies about $54 million. Grounds maintenance is about $46 million. Then there are the smaller components of nutrition and personal care.

On the next slide we talk about the type of evaluation that has occurred with the VIP over the years. As far as we know and understand from our provincial partners, it is the longest-standing program with a national capacity in Canada. It provides clients requiring different types of care with the services that will delay their need for institutionalization.

● (1540)

We know it has been rated at a very high level by recipients, and as far as substitution of care, it reduces health care costs significantly. We also know—and you can see some of the numbers there—that the average cost of providing VIP for somebody in their house is about $2,800 a year. VAC's contribution to a VAC contract bed is on average annually $56,000 a year, and we contribute to the cost of care for veterans in community facilities about $13,000 a year.

We also know through various programs we have, such as the OSV/VIP, which is the overseas veterans at-home program, that when some veterans—and we've had a couple thousand of these—are offered services at home, many who were assessed as requiring long-term care and nursing home care are able to stay at home. In fact, they can stay at home for a long period of time and not require that institutional care. So we're very pleased with some of the results we've had with this program.

On the next slide, we introduce something called the continuing care research project. This was a large-scale study undertaken between VAC and the Government of Ontario. It was endorsed by the Canadian Seniors Partnership, and it recently released some major findings. Some of these are summarized on page 11: “Under appropriate circumstances, long-term home care is often a cost-effective alternative to long-term facility care. With this study, there is now a substantial weight of research evidence that home care is a lower cost alternative to long-term facility care”—even for people at similar care levels—“even when the cost of informal caregiver time is considered.” In other words, it was factored in that if you paid for the informal caregiver time,plus the other services that were being received at home, the home care services were still a much more cost-effective alternative and a much preferred alternative to facility-based care.

We also note through this study that “Home support services are an integral part of long-term home care. Veterans Affairs Canada has data to suggest that its Veterans Independence Program is beneficial to Veterans, caregivers, and...taxpayers.” And we have “a growing body of evidence about the substantial economic contribution made by informal caregivers” across the country.

There is a tremendous amount of potential now to develop new knowledge from VAC's experience and through this research. The study has garnered a significant amount of interest in provincial forums, at the federal health care partnership level, and with other providers. Certainly, if this committee is interested in a more complete or comprehensive review of that study, it can be provided to you.

I'll take you to page 13 now and demonstrate some of the types of feedback we've been receiving from VIP.

VIP has been called the gold standard for home care in Canada by a variety of experts. It's been called the perfect model of independent senior care. It has been featured in *Healthcare Quarterly*, a Canadian publication geared to health care managers and administration. The feature in that particular magazine was entitled “Increasing Value for Money in the Canadian Healthcare System”.

VIP has been a key topic discussed at a number of different conferences and symposia focused on aging and seniors, including the Canadian Research Network for Care in the Community.

As you may know, the Special Senate Committee on Aging commends Veterans Affairs Canada on its success and cost-effectiveness in creating a program for veterans that is considered the gold standard across the country. In fact, the committee has identified VIP as a possible model for a national home care program.

We continue on an ongoing basis to meet with our partners in the provinces and in other jurisdictions to talk about the VIP program, its success, its challenges, how the program has evolved over the years, and the changes we're looking at making to ensure that it remains completely relevant to the clients it's trying to serve.

● (1545)

On slide 14, just to very quickly give you a sense in the graph of the VIP forecast, the top line represents the uptake of VIP since inception in 1981 and how it peaked once again with the introduction of the survivors becoming eligible for VIP, the expansion of VIP services to survivors in 2001. In 2002, you can start to see the increase there. It also shows you the clear demographic pattern that's existing, and that the need for VIP over the next decade will subside, will decrease. We see some uptake from the CF veterans, but certainly not enough to compensate for the decline in other populations.

I'll move on to the next slide to provide you with an overview of our long-term care program. It has a very long history. Long-term care in Veterans Affairs Canada started after the First World War. It was a program intended to support veterans coming back from war who had acute and rehabilitative needs. Veterans Affairs operated its own system of hospitals. In fact, in the mid-1940s, Veterans Affairs had 44 hospitals and facilities that we were operating across the country for veterans. Of course, the Veterans Affairs system predated universal health care in Canada, and there was a need to create a variety of different services as veterans evolved in terms of their needs. As they aged, the institutions began to change in terms of their focus from providing acute and rehabilitative care to more chronic and long-term care.

The facilities, with the exception for one—Ste. Anne's Hospital in Montreal—were transferred to the provinces beginning in the 1960s as a result of something called the Glassco commission and a cabinet decision to transfer those facilities to the provinces, which took on the jurisdiction and responsibility for health care across the country.

We continue to evolve in the long-term care program. There are changes being made to try to be relevant and adapt to the changing needs of veterans as we move through the system. Their current program includes just over 10,000 clients, with just over 3,000 clients in what we call our contract beds, and 7,000 clients in community beds, which are also known as provincial beds.

The long-term care program supports three different types of beds: contract beds, which are beds either in community facilities or in large veterans facilities with which Veterans Affairs has a contractual arrangement to provide care for veterans in those beds; departmental beds, which refer to the 420-odd beds we have at Ste. Anne's Hospital; and then the majority of clients reside in community beds, which are provincial beds that are available to them as citizens of their province, and Veterans Affairs helps them with their cost of care.

We operate within the provincial systems across the board, and we try to ensure there's fairness and consistency with respect to the amount that a veteran will pay in a bed, regardless of where they live. If a veteran lives in a province that does not insure long-term care, they will pay the same rate as a veteran who lives in a province that does insure long-term care. In the Atlantic provinces, in Nova Scotia and Prince Edward Island, Veterans Affairs will pay more because the cost to the resident is more. The veteran will pay $856 in British Columbia. We will pay less, and the province picks up more, and the veteran will pay $856.

On page 17 you can see that today we have just over 100,000 VIP clients, with 96,000 in the community and 7,000 in long-term care. We have just over 3,500 long-term care clients who are not VIP clients. That means those clients are in contract beds. The forecast for just under a decade from now sees that 103,000 drop to just over half, to 65,000, and the long-term care number to about the same, about 50% of today's number.

The next slide gives you a sense of the long-term care forecast. We believe we have peaked in terms of the long-term care admissions for veterans—which are around 10,500 or so—and that we're now on the downside of the slope. Those numbers should decrease slightly over the next few years, and in about three to four years they should decrease quite dramatically.

● (1550)

The next slide is slide 19.

We operate our long-term care program in a complex system of provinces, health authorities, health boards, and so on. The program continues to evolve in order to try to meet veterans' needs across all these various jurisdictions.

Client choice is a key factor for our long-term care program. Veterans have been voting with their feet. Over the last decade, we've seen an increase of 80% in terms of community bed uptake, and although our contract beds have been available to veterans, we've actually seen a decrease while the overall numbers have continued to increase.

Implementing quality assurance in our long-term care program is our number one priority. We understand that our veterans live in a variety of facilities, most of them facilities that we neither own nor operate, and over which we have no jurisdiction. Finding ways to ensure that veterans are okay, that we meet the commitment we made to these people many years ago, is the number one priority in this program. We examine how best to recognize and support them in their choices in where they want to live, whether they want to continue to live at home, in an alternative setting in their community, or in long-term care.

We have a contingent of contract beds, as you know. We're beginning to experience vacancies across those contract beds, and we're beginning to make plans to ensure that the contract beds of the future remain there for the veterans who need them. Many of them are specialized. We want to be able to use those assets to provide the specialized type of care that veterans may not be able to receive in their community in a timely manner.

Contract beds serve as a tremendous asset to us. If a veteran doesn't need a contract bed as a traditional long-term care bed, they may in fact need specialized care that we might be able to provide through that bed. We work with provinces and health authorities to ensure that if veterans do not need the contract beds we have to pay for, those beds may be available for use in the community. We continue to ensure that we have the highest standard possible for our departmental beds in our Ste. Anne's facility.

When we speak of war service veterans, we are keenly aware that we have a responsibility to ensure that Canada's deep commitment to these very special people is met and that we provide them with the programs, services, and support that we insisted we would provide to them in the years to come.

This is very important for those of us who, as I have, have worked with veterans for a long time in long-term care. I visited them in their homes when I first started with Veterans Affairs. These are very special people. Time is the enemy for them. There is only a certain amount of time, and we need to make sure these folks have services and programs across the board, whether in community facilities or in contract facilities; that we're engaged in a variety of activities with other providers to ensure that their needs are fully met; and that they can exercise their independence and their choice.

We try to manage the VIP and long-term care as a continuum for the benefit of veterans. We have brought these programs together under one operational unit to ensure that when we look at changes in the VIP, they mesh and merge with the long-term care program so that we eliminate any gaps that may exist between those two programs and we strengthen the continuity between them. We need to ensure that the evolving provincial programs we see every day are captured in this continuum of support.

Every day something changes across the provinces, across the health authorities, and it's our responsibility to ensure that within the limits of our authorities, we find ways to support veterans through all these different and evolving types of care. We must eliminate gaps and overlaps between the programs so that they can be supported through one or the other and not fall in between them. Within our current authorities we will advance, and are advancing, policy solutions that allow for options to be found to solve both some of the problems we ourselves are facing and some of the problems across the provinces in which veterans live.

● (1555)

I want to talk a little bit about quality of care.

Quality assurance is key to us. We know that most of our veterans live in provincial beds—those who are in long-term care—in systems that are strained, in circumstances that are sometimes volatile. We lack jurisdictional authority. We work with our partners to help make improvements; however, at the end of the day, what we can do is ensure that our individual veterans in long-term care, those who have moved to a place that will likely be the last place they live in their lives, are okay.

We've undertaken some very aggressive initiatives to ensure that this happens. We, in partnership with the Royal Canadian Legion, are visiting and undertaking satisfaction questionnaires with up to 4,000 veterans a year across all sorts of different facilities.

We have recently begun a process under which we will send out a registered nurse to visit up to 4,000 veterans a year to ensure that their needs are being met, regardless of whether they live in a licensed, regulated community facility or not. We know that things can slip by and that nothing can replace the presence of a health professional who is able to undertake a comprehensive assessment and identify unmet needs so that we can take appropriate action.

We undertake facility reviews on a variety of facilities, whether they're veterans' facilities or not, and in most cases they're not. We're also pursuing, in partnership with Accreditation Canada, an expanded accreditation program that will see accreditation exist not only for the larger facilities but also for the smaller ones in rural communities and in smaller communities where we know veterans live.

We will continue to monitor provincial compliance measures. Provinces, to varying degrees, undertake different kinds of processes aimed at ensuring that their facilities are meeting the long-term care standards of that province. We have a process in place where we monitor the various compliance measures, we identify when facilities have not met various standards, and then we undertake action in that regard, undertaking a facility review and other action as deemed appropriate.

With respect to the veterans independence program, we undertake monthly file reviews at the field level, at our district offices. We do annual follow-ups on clients. We do audits and evaluations of registered providers who are providing services to veterans, and we undertake quality assurance reviews on a targeted basis.

I'll now give you a break from me and pass you over to my colleague Colleen Soltermann, who'll talk to you about our treatment benefits program.

The Chair: Before you go ahead, Madam Soltermann, we typically are pretty amenable to going over time here, but we're at 26 minutes now and generally it takes around 20 minutes. How much longer will your presentation take?

Mrs. Colleen Soltermann (Acting Director, Disability and Treatment Benefits, Department of Veterans Affairs): There are three slides left, and I'll speak to them relatively quickly.

The Chair: Thank you.

Mrs. Colleen Soltermann: Thank you, Mr. Chair.

I'm just here to give you a brief overview of our health care benefits program, more commonly known as the treatment program. Basically, our veterans who are receiving VIP and long-term care support do have access to our health care benefits or treatment program. It's designed to enhance the quality of life of VAC clients by providing them with health care benefits and services—which I'll speak to on the next slide—in order to respond to their assessed health needs. It's a critical component of our approach to a comprehensive suite of programs and supports, and it's key in ensuring that our veterans are well taken care of in long-term care and the VIP program as well.

There are 14 programs of choice, as you can see on the next slide. That's how we administer them. I won't speak to each and every one of them, but these are examples of the types of benefits available. For example, we provide aids to daily living, which can be canes and bathroom aids. We provide medical services, such as injections. Prescription drugs is also a program that supports veterans significantly. As well, we provide prosthetics and orthotics, which can include footwear and braces and artificial limbs, as needed. The last one on my list is vision care. We provide glasses so veterans can see better.

The last slide I'll speak to deals with how we link with some of the other programs that VAC has, in particular the new veterans charter. I know that you've heard from my colleagues on the new veterans charter and the programs available under it, which provide significant support, one of them being the disability awards. The other aspect of disability benefits is, of course, disability pensions. We also have a mental health framework, and I understand you'll be travelling to Charlottetown in the near future to hear from our colleagues on mental health. Also, the other program is case management.

We also work closely with the Federal Healthcare Partnership. It has a continuing care partnership working group through which we work with various departments. We work closely with provincial home care and long-term care programs in the community, as Carlos was explaining, and municipal and non-governmental programs. We also work very closely in the research area, whether it be with other departments, other countries, or on our own research with universities in the field, to ensure that we respond to veterans' needs.

That would be it from me.

● (1600)

The Chair: Very good. Thank you very much.

I mentioned in the opening—and I think it's good to reiterate this, particularly because we're going to be going to the report stage soon —that Mr. Luckhurst's presence here is an example of some of the work that Veterans Affairs Canada does. In fact, one of VAC's employees is in Australia right now. So this is an example of collaboration in learning best practices between the different veterans affairs organizations in the countries.

So I would just verify that this is going on presently, and that you're not going back until September, I understand. Mr. Luckhurst likes our winters, and that's all I'm going to say.

Now, for seven minutes, Madam Sgro.

Hon. Judy Sgro (York West, Lib.): Thank you very much.

And an extra special welcome to you. I do hope you find the experience positive. We're very happy to have you here with us today.

All of the information has been very interesting and has provided lots of room for lots of questions. The first one I wanted to ask about is the issue of extending the VIP program to spouses. Where are we with that particular scenario? It has been committed to and talked a lot about. Where are we as we speak, today, May 9, on that issue of extending it to spouses?

Mr. Carlos Lourenso: Currently, as you may know, the program for spouses and survivors has expanded over the years. At one point in time, spouses were eligible to receive the VIP services for 30 days; then in 1990 that was expanded to one year; and then in 2005, the program was expanded so that spouses or survivors could receive a lifetime continuation of the program.

In budget 2008, it was announced that in fact a further expansion would be forthcoming and that spouses and survivors could receive the program not just if their deceased spouse had been receiving it, but also if that spouse had been eligible for the program. So had the deceased veteran been in receipt of a disability pension or in receipt of WVA or an income program, then the spouse or survivor would be entitled to receive services under the VIP for their lifetime. We're implementing that, and we've had quite a significant uptake of that in the last while.

That's where it stands right now.

Hon. Judy Sgro: But not everybody is receiving it who has requested it.

● (1605)

Mr. Carlos Lourenso: The spouses who are receiving it are those whose deceased veteran would have been able to receive the program. Those are the authorities we have in place that we've implemented.

Hon. Judy Sgro: As of today.

Mr. Carlos Lourenso: As of today.

Hon. Judy Sgro: Hopefully, we'll see that change. I do think the VIP program is a wonderful program, without question, but I suspect my colleagues will follow up on that. I've got some other questions for you here.

On the issue of providing home care, how many hours of home care do you provide per veteran? Your costs are quite low. You're talking about $2,800. The average annual cost of the VIP program was $2,800—this is VAC's contribution—compared to $56,000 had the individual been in a contract bed.

Mr. Carlos Lourenso: Currently that's not reflective of the maximum; that's reflective of an average that people receive based on an assessment of needs.

Hon. Judy Sgro: Your maximum is $8,885.

Mr. Carlos Lourenso: Close to $9,000, that's correct.

Hon. Judy Sgro: All right. When you go in to provide the home care services that the veteran needs, one, where do you obtain the workers, the home care workers? But second, they must be maxed out at 20 hours a week or 10 hours a week or whatever. What are the limitations?

Mr. Carlos Lourenso: It really depends on the individual circumstances. There is no limit in terms of the number of hours. There is a tier in terms of the limit, in terms of how many dollars can be contributed towards that client for that particular service, but no actual limit in terms for the number of hours. So in some cases you can get a greater number of hours at a lesser per-hour cost or charge and in other circumstances less, depending on the type of services you receive.

Hon. Judy Sgro: To a maximum of $8,885 a year.

Mr. Carlos Lourenso: I believe that's the number right now.

Hon. Judy Sgro: Yes.

The whole program sounds wonderful and you deliver it fabulously, Mr. Lourenso. You've got the compassion in your voice that I think we all like to see, and the caring is clearly there, but it sounds like one thing. If the average expenditure on the VIP program for all of those fabulous services is about $2,000 and rarely reaches the maximum, it's hard for me to imagine, just given the home care pressures I hear a lot about from the community at large, not necessarily just veterans, that they're getting very much home care on this.

Mr. Carlos Lourenso: Perhaps I can speak a little bit from my own experience in going out and undertaking assessments. That's a number of years ago now, and they seem to be getting greater and greater all the time.

All services that are allocated to veterans in terms of home care or groundskeeping, personal care, are allocated based on a health need. Many times people, in order to remain at home, actually need fewer services than we think they do. They need services with key activities of daily living and key functions within their house in order to remain independent, but people don't give up their independence. They want to continue doing those things that they can do. So although we have a maximum of $9,000, the reality is that, across the country, the average amount of VIP allocated is much less than that.

If they needed more, they would receive more. There is no limit around the $2,800. The limit is, obviously, almost three times that amount. But it really demonstrates that with some supports in critical areas, people are able to remain independent in their homes for a long period of time.

Hon. Judy Sgro: I don't want to belabour the issue right now, but $8,000 doesn't pay for a lot of home care. I would suggest that they've got a spouse or a family member who's doing one heck of a lot of work and the $2,000 or $2,800 is paying for a limited amount of minimum services required.

But i want to move on to a couple of other areas there.

There's the issue that the eligibility criteria for access to departmental health programs seem to be much more reactive than proactive. What are you doing to try to change that?

Mrs. Colleen Soltermann: With respect to the treatment benefits program?

● (1610)

Hon. Judy Sgro: For all of the programs.

Mrs. Colleen Soltermann: For all the programs. We have criteria that are in place to support veterans with the VIP and the long-term care, and the treatment benefits that we provide support that care in their homes or in the long-term care facility. If they are eligible for the VIP and the long-term care, the treatment benefits come along with it. Our war service veterans, for example, can have access to the treatment that they require to address any health need to the extent that the province doesn't provide that care.

So for the most part, our war veterans, once they're participating in the VIP and the long-term care, can have access to the treatment they need in order to support their health needs while they're at home or in long-term care.

The Chair: Madam Soltermann, I'm sorry, and Madam Sgro, it's over eight minutes, actually.

[*Translation*]

The Chair: Mr. André, you have seven minutes.

Mr. Guy André (Berthier—Maskinongé, BQ): Hello everyone.

That is a good question, Ms. Sgro. I am going to continue in the same vein by asking other questions.

You offer home support services to veterans. I understand that priority is given to home care rather than care in institutions. It is less expensive. You offer several services: inhalation therapy, nursing care, housekeeping, assistance with bathing, etc.

In Quebec, in each region, there are CLSCs, local community service centres, where professionals such as inhalation therapists, nurses and social workers are employed. They offer a range of services. In Quebec, there are social economy cooperatives that offer housekeeping services and assistance with bathing to the public. There is a great deal of pressure exerted on the system, because the aging population needs these services.

How do you link these services? When you assess people who need home support services, for example, do you use the same grid to evaluate the number of service hours required as that used by the institutional network for the population as a whole?

Waiting lists are a problem that the health care system is often confronted with. When someone asks for assistance with bathing or home care, his or her name is placed on a waiting list, and it may take some time before the request is evaluated. Are the waiting lists longer or shorter than those for the existing institutional network? Is the program of service and resource allocation more or less generous? Do you evaluate customer satisfaction with regard to the services offered? Often, the existing network provides for only one bath for someone who might need three per week. Services are being cut, and the same is true for housekeeping services.

Is your budget adequate enough to allow you to offer these services to the clientele? It is a big question, but now the floor is yours.

[*English*]

Mr. Carlos Lourenso: Thank you for your question. It is a big question.

Perhaps I could begin by saying—and this might help to clarify part of the question from the previous member—that the VIP program is intended to top up provincial programs that are available for veterans and anyone else who is eligible. People access the programs locally, as anybody would, through an assessment by their local health authority or, in Quebec, through the CLSCs. After that assessment, they are allocated a certain number of hours or services by the CLSC or by the health authority where they live. After they are allocated those services, we will still take an assessment from Veterans Affairs and see if there are other services or benefits they weren't eligible for or that had hit a limit in the province, and we will augment the services they receive to ensure that the full scope of their needs are being met.

With respect to the question within your overall comments, if someone is on a wait-list for services from the CLSC or a health authority in another jurisdiction, they do not wait for our services. We will apply the VIP services to people while they're waiting for the provincial services. They will not go without. We don't have a wait-list for VIP. If you're eligible for VIP, you, like any other citizen in the province, will access your provincial home care services. When you do that, we will also assess you from a Veterans Affairs perspective and provide you with the additional services you may need, if you need them. If you're on a wait-list and there is an absence of services, we will apply our services at that point.

● (1615)

[*Translation*]

Mr. Guy André: You state that the services offered to veterans are the same as those normally offered to the general public, except that some of them could be offered through the Department of Veterans Affairs.

I will give you a concrete example. Let us say that I am incapacitated and living in my home. I need three baths per week, but after having completed an assessment and in order to take into account the service cuts, the CLSC provides me with only two. So I tell them that I need three. Do I go to Veterans Affairs to have access to my third bath? Does Veterans Affairs pay the CLSC or the cooperative so that I can have my third bath? Do you use the same assessment criteria for the hours and services?

[*English*]

Mr. Carlos Lourenso: In that situation, someone accesses the services they need from their local provider. So let's take your example. Two baths is their limit. We will send out our counsellor or a registered nurse to undertake an assessment of you. They agree that you need a third bath in that week, and we will implement the VIP program and offer you the support you need in order to access that additional service. And that additional service can come from a provider of your choice. And we will work with you together; our counsellors on the front end will work with you to determine where you want to receive that extra service. Is it from the same provider of the CLSC? It could be, or it could be from another provider. We don't pay them, we pay you.

One of the beautiful things about the VIP is that it allows people to do self-managed care. They manage their own care as much as possible. So we would say to them that we will give them what they need to get their third bath a week and we will help them decide where they want to get it. When they get it, if they want to pay for it or receive a bill, we will work out whichever method is better for them, and they become the manager, or the boss, of their own affairs.

The Chair: *Merci beaucoup, monsieur André.*

Mr. Stoffer, you have five minutes.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chairman, and thank you, ladies and gentlemen, for coming today.

You're absolutely correct, sir, that those who receive the VIP program are ecstatic about it, but I'm concerned about the ones who apply and are turned down.

As you know, in 2005 the government-in-waiting promised that all widows of World War II and Korean War veterans would immediately receive the VIP service. So my first question for you is this. Are all widows or widowers of World War II and Korean War veterans receiving VIP?

Mr. Carlos Lourenso: We....

● (1620)

Mr. Peter Stoffer: It's a yes or no answer, sir.

Mr. Carlos Lourenso: Could you repeat the question again?

Mr. Peter Stoffer: Are all widows and widowers of World War II and Korean War veterans receiving VIP services?

Mr. Carlos Lourenso: I don't think so.

Mr. Peter Stoffer: Thank you.

I have a gentleman in Halifax named Captain Earle Wagner, whose wife passed away last year. He applied for VIP but was told that he was too wealthy and too healthy to receive it. He lost his primary caregiver, his wife. He was told by DVA that because his wife had passed away they would provide him with the care, but that he would no longer be eligible for VIP service because of his income and his stability.

I have a widow in St. John's, Newfoundland, whose husband passed away. He was one of those World War II guys who never thought about applying for DVA or government services, because people just didn't do that. They didn't ask government for help. He passed away. She was told that she has to have a disability tax credit or have a low income in order to qualify for VIP, and she doesn't have either. She was told by the 1-866 number that if she could get a doctor to give her a disability form that she could use to claim a tax credit on her T4, then she would be eligible to apply for VIP.

Why would you good people, with all your good intentions, make an 82-year-old widow go through that process? All she wants is to be able to stay in her own home. I have dozens and dozens of examples of this nature—people who are turned down by VIP even though their husbands or spouses served in World War II or in Korea. It's frustrating for a member of Parliament to tell them no.

So I'm asking you, as an MP, even though most of these people aren't even my riding, what we can do to improve this situation so that these people can receive the VIP service. I don't think the government did this intentionally, but they have developed a two-tier widow and a two-tier veteran. Yet when they landed on Juno Beach, there was no two-tier system in place. When they landed in Korea, there was no two-tier system. They served their country. We owe them. I don't think we should be putting them through this rigmarole.

My last question has to do with payments that some have to make. If you get long-term service done, you pay $45 or whatever. You pay the contractor, and then you send the receipt to the insurance company and you get it back within 30 days. Some elderly veterans are forgetting to submit all the proper forms. In order to assist them, why doesn't the contractor just charge the government directly and bypass having the veteran do it?

Mr. Carlos Lourenso: I'll start with the spousal survivor question.

Government has made certain decisions, and government has decided where it wants to be on that question, the scope of the authorities. Our role is to implement those authorities to the best of our ability. We share the same passion to ensure that we can do that, and we implement those authorities the best we can. That's what we've done in the survivor situation.

Mrs. Colleen Soltermann: With respect to the payment aspect of your question, what we've been able to do with our contractor, Medavie Blue Cross, is to have providers register with the provider. The person who's accessing the benefit, say the veterans independence program, won't be paying out of his own pocket if he's using a registered provider. Rather, the provider would be reimbursed by our contracted administrator. We've been able to work with Medavie to ensure that clients won't be out of pocket when they're using registered providers.

The Chair: Mr. Kerr.

Mr. Greg Kerr (West Nova, CPC): I'd like to say thank you for joining us today and for providing us with a lot of information.

I want to make sure we're absolutely clear on this point—all veterans, if there were no veteran program, would be eligible for any other programs provided by their jurisdiction, by provinces, such as home care and the like. I think we should start with that: they are automatically eligible citizens of their particular jurisdiction. This is a top-up program, as I understand it. So what they're getting is over and above what other citizens within that jurisdiction would receive.

Could you comment on that first, just to make sure I'm reading it correctly? Is this a correct interpretation?

● (1625)

Mr. Carlos Lourenso: That's essentially correct. The VIP is used as a top-up program. We expect that provinces and health authorities would offer to veterans whatever services are available to any other citizen of the province or that health authority.

We do run into situations sometimes, in tight times, when provinces or sometimes health boards find that a particular person presents as a veteran, where they will deflect to Veterans Affairs first. Certainly the client would never be punished or penalized in any way for that.

But generally speaking, you are correct, sir.

Mr. Greg Kerr: I think you heard the last questioner say that he's happy with the program. It's those who aren't covered by it or who aren't eligible. We'll get into that, because you very delicately handled that. It's more our responsibility as government, more so than on the delivery side.

On this, though, a terrific amount of review goes on within the VIP, with all the support programs. As you said, it's constantly changing, and you're dealing with a lot of organizations in that regard. Where do you see the greatest pressure coming from as a growth item? The aging is working against them. You said that time is working against them. Where do you see the greatest pressure coming for new program services through the whole of VAC—the VIP, particularly, but through the whole program? Where do you see that pressure coming from?

Mr. Carlos Lourenso: From the analysis we've undertaken and the research, I think the pressure comes in the new services that are evolving from the provinces. At a certain point in time we had very little, and then home care emerged. We had nursing homes and old folks homes with different types of titles. What we see now is this emerging piece in the middle—things that you've heard of, like retirement living, supportive housing, assisted living—and all of these different care modalities that are being developed by provinces and in other jurisdictional authorities.

Our challenge is to try to ensure that within the authorities we have at this given day, we're able to renew our policies so that veterans can continue to access the services that best meet their needs. If someone is well enough and chooses to stay at home, then we should be able to support them at home. If they can't stay at home anymore but they don't really need a nursing home, then our challenge is to be able to support them in that place that exists in the middle, in that supported living environment. The greatest challenge for us now is to find ways to be able to consistently apply a supportive policy framework for veterans across that continuum, seeing that this evolution of these middle programs differs across all of the different provinces.

Mr. Greg Kerr: Good. Thank you very much.

I have a bit of time left here, and my colleagues will have some wonderful questions in a moment, but I really do want to home in on the contract versus the community beds and get a better understanding of exactly what a contract bed is and why it's losing favour, I guess, or becoming less desired, or whatever way it was that you put it. Can you tell us a bit more about where a contract bed would be, what it would be, and why it is not as much in favour today?

Mr. Carlos Lourenso: There are different types of contract beds. And it depends on the agreement we had with the province or the facility at the time the beds were transferred to the province.

In a place like your area, Soldiers Memorial Hospital is a facility that has 25 contract beds in it. Those contract beds are for veterans only; civilians can't get into those beds. We pay the full cost of those beds. The programming is essentially the same as the programs in the provinces.

As for other contract beds, if you go to B.C., the deal with B.C. was that when we transferred the facilities to them, they took the facilities. We have a number of beds that we have priority access to, contractually, and we don't pay any extra for those beds. So the province contributes to them, as they would for any other bed. The resident contributes. We ensure that the resident pays a standard $856 and we don't pay any more.

In some places in Atlantic Canada, the agreement was that we pay the full operating cost—Soldiers Memorial, Camp Hill, Taigh Na Mara, places like that which you might be familiar with. It's the same situation with some other big ones in Ontario—Sunnybrook, Perley Rideau here in Ottawa, and the Parkwood Hospital in London. Those are the big ones that we pay, and veterans have a priority access to those facilities. In some of them we offer specialized programming based on the needs of the veteran profile in that area.

● (1630)

Mr. Greg Kerr: So for a veteran, it could be more costly for them individually to go into some of those contract homes.

Mr. Carlos Lourenso: No. The cost is always the same.

Mr. Greg Kerr: So why are they losing favour with the veterans?

Mr. Carlos Lourenso: Generally speaking, most contract beds are located in large urban-centred facilities. People want to move to smaller facilities that are scattered across the country in their communities.

The Chair: Thank you, Mr. Kerr.

Thank you, Mr. Lourenso.

We'll go to the Liberal Party, and Madam Foote, for five minutes.

Ms. Judy Foote (Random—Burin—St. George's, Lib.): Thank you for being here, for your presentation, and for your eagerness to take questions from those of us around the table.

I was listening with interest to you talk about your program that enables veterans to have renovations made to their homes as the need arises. At what point is the decision made that you will no longer make renovations so the veteran can stay in his or her home? Some of the things you referenced were changes to a washroom, or maybe a ramp into a home. At what point does it become too costly? For instance, would you put a bedroom downstairs? Is there a point where you would no longer make renovations and move that veteran into a long-term care facility?

Mr. Carlos Lourenso: I can speak to that from one perspective, and Colleen can speak from another.

On what we can and cannot do, we have different levels of approval for costs. Essentially, for us, the limit on what you can do to somebody's house is based on their health, safety, and security. We can build a ramp, and we have built a new bathroom on a main floor. There are a number of modifications—some of them quite significant—we have made to people's homes to allow them to live there for a subsequent number of years. From a cost-effective perspective, if you look at spending *x* number of dollars to create a bathroom on somebody's main floor and then look at the cost of institutionalization, it becomes a pretty good option.

We have different levels of approval, financially speaking. At a certain point it doesn't become cost-effective anymore, or you're trying to keep somebody at home and fundamentally jeopardizing their safety and security. They're not able to be at home anymore.

Would you like the details on the levels?

Ms. Judy Foote: Is that decision left to the veteran when it comes to their safety and the level of care they receive, or is it made by the Department of Veterans Affairs?

Mr. Carlos Lourenso: It's made by our health professionals. A core assessment is undertaken, usually through a registered nurse, and then there are branching assessments. In a case like that we would have physiotherapists, occupational therapists, registered nurses—any specialist required—fully assess the situation to ensure that an appropriate modification would assist the person to remain in their own home safely and securely for a period of time. In the VIP, we make the decisions in the end, but they are made in very close consultation with veterans, their families, and those most concerned about them.

● (1635)

Ms. Judy Foote: In a situation where a veteran wants to remain in his or her home, the spouse is still living, and it's been determined that it's in the veteran's best interest to stay in the home, what happens if the spouse becomes disabled? If it's determined that it's in the veteran's best interest from a psychological perspective to have him continue to live in the home, will you make renovations to accommodate the spouse?

Mr. Carlos Lourenso: We don't have the authority to provide benefits to the spouse. We have the authority to ensure that the veteran is able to remain secure and safe in the home, so services can be provided. If his spouse had been providing services to him in order to achieve those outcomes, we would be able to implement services that would substitute for those she had been providing. But we couldn't make renovations specific to her physical incapacity.

Ms. Judy Foote: For a veteran to access the VIP program, is it necessary for the veteran to be seen by a medical doctor?

Mr. Carlos Lourenso: No.

Ms. Judy Foote: Just explain to me how it works, then.

Mr. Carlos Lourenso: A veteran would make an application, a contact, to us. The process would involve, initially, a screening of sorts to determine service—they served in whatever capacity they served—and eligibility, and some other key factors. But essentially, the decision about VIP is, first of all, that they have the right service, either through their service disability pension, their income status, or their frailty level. There are a variety of different ways to get VIP. Then the decisions about VIP are made based on our assessments. Area counsellor assessments, which are essentially done by our social workers, and our nursing assessments are the main core assessments used to decide what services will be put in place. Sometimes there will be a medical doctor, if that's required.

The Chair: Thank you, Mr. Lourenso.

Thank you, Madam Foote.

Now we'll go on to Mr. McColeman for five minutes.

Mr. Phil McColeman (Brant, CPC): Thank you so much for your passion for your work, which is very obvious to all of us.

In 2008 our government expanded services, as was mentioned. How many of the survivors are now eligible for services? Do you have actual numbers of people who benefited as a result of that expansion?

Mr. Carlos Lourenso: I can tell you how many applications have been approved. It's 2,252 as of a week ago.

Mr. Phil McColeman: Okay, and do you have any sense of the number who are eligible?

Mr. Carlos Lourenso: We had potential uptake projections of around 12,000. We're sitting at that number now. We have close to 300 applications pending. We've also commenced a fairly aggressive outreach program to find where survivors are to see if we can increase those numbers. We don't really know where it will land in the end.

Mr. Phil McColeman: I'd just like some clarification, just to expand to the next step. Mr. Stoffer brings up the ideological argument that everybody should be covered, no matter the income level or whatever. He mentioned that you assess people individually and that there is an income test. Is that correct?

Mr. Carlos Lourenso: Do you mean survivors?

Mr. Phil McColeman: I mean survivors.

Mr. Carlos Lourenso: In order for survivors to be eligible, they need to meet certain income or needs requirements—disability requirements or income requirements.

● (1640)

Mr. Phil McColeman: I want to give you a couple of examples.

If you've done really well, and you're wealthy, and you choose to live in a million-dollar house, and you choose to participate in the program because you're a widow or widower of a veteran, are you eligible? Can you get the funding?

Mr. Carlos Lourenso: You're wealthy and you live in a million-dollar house.

Mr. Phil McColeman: Yes.

Mr. Carlos Lourenso: Likely not.

Mr. Phil McColeman: Okay, so what you're saying is that there is an income test.

Mr. Carlos Lourenso: There is a test based on income, yes.

Mr. Phil McColeman: Actually, I have that situation in my riding. I'm not suggesting one way or the other, except for the fact that in my experience working with mentally disabled children and their families, what happens when the people who really don't need it because of their income level receive it is that people on the other end of the scale are diminished. You're not able to serve better the people who really need it, who don't have the income.

I wanted to make that point. It is philosophical. It is ideological. But I think we can't lose sight of the fact that there are veterans I know who have done incredibly well and wouldn't think to ask for additional benefits. They're responsible for their own situations, and they really don't need it. To me, that's a good thing, because that allows us to put in more resources for the people who truly need it.

I'm wondering if you have any reaction to that from where you've seen it on the ground. Do you have any comments regarding what I've just said, because you've seen it on the ground?

Mr. Adam Luckhurst: No, other than that I think there are always people in very different circumstances. It's hard to be able to systematically address all the needs all the people have all the time. In any government program—and I guess I can talk more from the Australian than the Canadian perspective—you have to draw some boundaries around different programs at some point. And sometimes the boundaries among the different programs work well and sometimes not as well as you'd like.

There are, on occasion, times when people do better than others and times when people need care. From my experience in VAC, I haven't seen a huge number of people saying large numbers of people are missing out. There may well be individual circumstances where we work with people to deal with some of the problems they raise, and I think it's fair to say VAC does very well in trying to ensure that people get in the gate, through benefit of the doubt provisions and those sorts of things.

But I don't think there's any screamingly urgent area we need to address, from our perspective, that has come to our attention. There are always areas where people would like things to be expanded, though.

The Chair: Thank you, Mr. Luckhurst.

Thank you, Mr. McColeman. That does it for your time. Unfortunately, you're over five minutes.

Next will be Monsieur Gaudet from the Bloc Québécois.

[*Translation*]

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

Mr. McColeman's question got my attention.

You replied that if the widow was a millionaire, she would not be entitled to services. I would like you to tell me why, because it does not make sense. If her husband was a veteran who served his country, why would she not be entitled to these services? I don't understand the concept.

I am not saying that she should be entitled to all services, but she should certainly be entitled to some of them, such as having her lawn mowed and housekeeping services. If the Prime Minister is rich, will he have his pension taken away from him? I have a problem with that. I think that everyone should be treated equally, unless I have misunderstood how the veterans affairs system works.

Your presentation is entitled “Continuum of Care: Programs and Progress”, but I don't see any progress here. If you say that she is not entitled to services, then that is not progress, it is a step backwards.

[*English*]

Mr. Carlos Lourenso: The essence of the question was if the person were wealthy and the authorities that we have to apply to the program have with them conditions around income and around functional ability or disability, and the program is applied in respect of those authorities.

● (1645)

[*Translation*]

Mr. Roger Gaudet: You're not sure of the decision that you would make in such a case. I'm not saying that this person should receive services seven days a week, but that she is entitled to the same services that her husband received when he was alive. That's what I'm asking for. I'm not asking for additional services. Is she entitled to the same services that her husband received when he was alive, even if he was a millionaire? He was rich too, if she is now.

[*English*]

Mr. Carlos Lourenso: Certainly, once again, the VIP serves as a top-up program. Like any other citizen of her province, she would be able to apply to a home care program that applied in her province. After that, with respect to benefits from Veterans Affairs, we have in front of us a program that government has decided has certain authorities, certain benefits, certain limitations, and we would apply those. In the case of this program for survivors, there are limitations with respect to income level and with respect to disability or functional ability.

[*Translation*]

Mr. Roger Gaudet: If I'm not mistaken, there are some 100,000 veterans in Canada. In 2018, there will be 60,000 still alive. They will be the veterans of modern times. Have you planned for a certain number of spaces in hospitals specializing in the treatment of post-traumatic stress disorder?

Last year, the committee went to Petawawa to visit with soldiers. Some of them were in very bad shape. What is being done for them? If DND looks after them until they retire, there will be no problem. However, if they leave the army, in my opinion, they will be considered veterans. What will you do for them? Do you have specific places set aside for them in hospitals?

[*English*]

Mr. Adam Luckhurst: There are a number of ways you can answer that question, I think.

One of the foremost issues is, what is the most appropriate care that should be provided to a younger person? I think there is always an issue around our traditional long-term care beds and how appropriate they are for a younger person. If you look at the case of, for instance, Ste. Anne's, one of the pieces of work they've been doing is moving into a national centre for OSIs, as well as providing the traditional long-term care facility that they do so very well there. So they are also looking at how best to treat the particular needs of the younger veterans as well. They're looking at the particular sorts of care that will best meet the needs of those younger people. So it's not the hard infrastructure of beds and those sorts of things, but it's around the different sorts of counselling and the access to the right levels of professionals with the particular skills that they need to treat occupational stress injuries. It's also about having space for group programs and ensuring that the families can access the programs and those sorts of things.

In my mind, it's not just a question that we had beds before and do we need beds again; it's really about what the key care areas are where people require support to help them get better. It's really about what the best service is and the best service delivery model for that.

The Chair: Thank you, Mr. Luckhurst.

Merci beaucoup, monsieur Godin.

Now on to Madam Tilly O'Neill-Gordon, for five minutes.

Mrs. Tilly O'Neill-Gordon (Miramichi, CPC): Thank you, Mr. Chairman.

I want to thank you for your fine presentations here this afternoon. I'm sure the veterans that you deal with, as well as all of us sitting here today, realize how devoted you are to this program and how much care and thought you put into it. For that, you deserve words of congratulations for your work and your presentations to all of us here this afternoon.

We all realize how very important the veterans are to us, how much they've done for us, and how much we should be willing to open up and help them. I feel it's our job as MPs to make sure we represent our veterans well.

When we look at slide number 12, we see that an individual who was ranked with the care level of six or higher is less than the one with a care level of five. I was just wondering why that is. At what care level is it necessary, or even more cost-effective, to put that individual into a nursing home—even though they're eligible for VIP benefits—and have them get the support there?

● (1650)

Mr. Carlos Lourenso: That graph speaks to some of the findings of the research initiative that I can't really speak to. I don't want to leave you with any misleading statements. Certainly that's something we could get you an answer for and get back to you on. We'd be pleased to do that. As well, if you want any other information on the continuing care research project, it was quite extensive. There are some pretty significant impacts. We could always arrange that in whatever format, but we will get the answer to that question for you.

Mrs. Tilly O'Neill-Gordon: As well, as we were going around, we realized how important the topic of veterans and survivors has been to all of us and continues to be. I'm wondering if you can give us an idea of how many have taken advantage of the services offered under the VIP program, or have you already answered that?

Mr. Carlos Lourenso: Right now we have 2,252 survivors who have been approved. Another 270 or so are pending.

Mrs. Tilly O'Neill-Gordon: Thank you.

The Chair: You have two minutes left, if another colleague wants to take it.

Mr. Clarke.

Mr. Rob Clarke (Desnethé—Missinippi—Churchill River, CPC): Thank you, Mr. Chair.

I want to thank the witnesses for coming.

An interesting point was brought up here. I'm just wondering about the VIP mandate to address the topping up for veterans who need financial assistance for home care and meals. Am I correct there?

Mr. Carlos Lourenso: That's correct. It does have those elements. It can help with meals. It tops up whatever services they may be receiving from their provincial providers.

Mr. Rob Clarke: A good portion of the veterans right now who are participating in the program are receiving assistance in one form or another from home care, such as cleaning, food services, medical care if required. Is that correct?

Mr. Carlos Lourenso: Correct.

Mr. Rob Clarke: How much time do I have?

The Chair: You have another 58 seconds, and then your round is right after that.

Mr. Rob Clarke: With the mandate of the VIP being on an on-decision basis, is it a living, breathing document that changes from case to case?

Mr. Carlos Lourenso: The VIP is rooted in legislation. It has a number of standardized components: benefits, services, limits, different authorities that are applied consistently across the various jurisdictions nationally.

Mr. Rob Clarke: So the VIP mandate is set there to help people in need of it the most, right?

Mr. Carlos Lourenso: It is there to help those who have been deemed eligible by government through legislation.

The Chair: You still have over four minutes, sir.

Hon. Judy Sgro: Is that his second five?

The Chair: No, he took two minutes from Madam O'Neill-Gordon, and his round is next. We're watching it closely.

Hon. Judy Sgro: I thought you were giving him an extra five minutes.

The Chair: Do you have another question?

● (1655)

Mr. Rob Clarke: Regarding program expenditures, the slide stated that in 2007-08, $46,211 went towards grounds maintenance, $170,307 went towards housekeeping, and a mere $19,868 went for personal care. Can it then be assumed that many veterans are well enough to stay in their homes, but the manual duties of household upkeep keep them from their independence?

Mrs. Colleen Soltermann: Housekeeping and grounds maintenance are very successful in keeping veterans at home, and it often takes the burden off the caregiver by providing those benefits so that they're able to actually provide the personal care themselves. In that way it's quite successful in providing the overall support that a veteran would need in order to stay in their home. It is quite successful. Housekeeping and grounds maintenance are two key elements in making sure the yard gets shovelled in the winter and the house is maintained, and laundry is done.

It supports significantly, yes.

Mr. Adam Luckhurst: I guess the other part is that it has flexibility, so it really links back to what individual needs a veteran may have. So based on what services they get elsewhere, based on what they're capable of doing themselves, what the spouse or caregiver is able to do, or what their children are able to do, the package of services is worked through from there.

Mr. Rob Clarke: Thank you.

I'll share my time with Mr. Kerr.

Mr. Greg Kerr: On slide 21 you're talking about quality review, quality assurance. I think it's an important area that we haven't talked about too much.

Say you're doing an aggressive review and analysis, and you do it both with staff and with professional nursing staff. You mentioned you also are in contact with the Legion, etc. Can you give us a sense of how that actually happens? I was curious, because you say "provincial compliance". How would you get the provinces to comply, since they're so independent in health care and that kind of delivery? How does that process work?

Mr. Carlos Lourenso: Different provinces have different methods to monitor the adherence to provincial standards at various facilities. In Ontario, for example, through the Ministry of Health and Long-Term Care, they send out teams of five or six people who go into a facility unannounced and assess all sorts of different elements of that facility, everything from personal care to hygiene, to infectious disease control, to finances, and they assess the facility against provincial standards. The results of that assessment in Ontario, for example, are posted publicly on their website. They list the facilities, the standards that they've met, and the standards they have not met.

What we do is have people who are dedicated in each of our regions. Part of their work involves going in and looking at the various compliance reports—and they vary across the country—with respect to facilities where veterans live. If they identify that X facility has in fact become non-compliant to three key standards, then we would be notified and would have some of our staff go out and undertake a review of sorts with that facility, to ascertain the impacts on veterans.

Mr. Greg Kerr: And it works?

Mr. Carlos Lourenso: It works great. But even better, what works in terms of the first part of your question is the initiative around going out and assessing individual clients.

Many times when people move into nursing homes at the end of their lives, not a lot of people come to visit them. Sometimes they can go months and months and, perhaps, always without anybody coming to see them. When we have interested people like the volunteers from the Royal Canadian Legion, when we have our own staff go out and visit them, ask them questions, ask them how they feel about where they live, undertake an assessment, identify unmet needs, that's a big deal for those folks. It's not only that it's the right thing to do in terms of their health, it's simply the right thing to do in terms of them personally, because that may be the only contact they have.

● (1700)

The Chair: Thank you, Mr. Lourenso.

Thank you, Mr. Kerr.

The next round is actually for the NDP. Mr. Stoffer's not here, so we'll go right to Mr. Andrews for five minutes.

Mr. Scott Andrews (Avalon, Lib.): I'm trying to get my head around a couple of the issues here. I'm looking at your slide showing how much money you spend in the different areas. You have 103,000 clients on VIP, with 96,000 in the community and 7,000 in long-term care.

On this chart of how much money you're spending, is the nursing home the long-term care portion of that for those 7,000 clients?

Mr. Carlos Lourenso: Yes, it is. For that 7,000, it is.

Mr. Scott Andrews: Okay, good, so that money is right in the long-term care for the 7,000.

I want to get back to what my colleague Madam Sgro was talking about earlier with respect to home care. On this slide here, is the home care there the personal care?

Mr. Carlos Lourenso: Home care is kind of a generic term that refers to all of the services somebody would get in their home. When you talk about home care, we're actually splitting it out here into separate elements that constitute home care. So when somebody's getting home care, a portion could be housekeeping, a portion could be groundskeeping or assistance with their yards, a portion could be personal care or access to nutrition.

Mr. Scott Andrews: So you don't specifically knock out home care; you lump it in with housekeeping and all that as well.

Mr. Carlos Lourenso: It's a generic term that's used across the industry, so home care refers to a program in different provinces. Within that program, there are different elements of services. Our home care program has housekeeping, groundskeeping, personal care, access to nutrition, and so forth.

Mr. Scott Andrews: Okay. So you have 96,000 clients under this home care, let's say, and they can have up to $8,000 worth—

Mr. Carlos Lourenso: It goes to $9,000.

Mr. Scott Andrews: Out of that 96,000, what's the average they're getting in home care?

Mr. Carlos Lourenso: In terms of the overall services in their home. I think it is $2,800.

Mr. Scott Andrews: That's what you said: $2,800. How many are actually getting on the upper end of the $8,000? If you're averaging it out, are you just averaging out how much money you're spending? I'm kind of curious, because you say that you can go to $8,000, but how many cases are actually getting that much home care?

Mr. Carlos Lourenso: I'd have to get that information for you. I don't have that here, but it is an average nationally.

Mr. Scott Andrews: Okay. We'd like to have that. We're just trying to get a better understanding.

Looking at your long-term care, in your slides here you're telling us that your expenditures and/or your clients are going down in regard to your long-term care?

Mr. Carlos Lourenso: We're saying that our client totals are going down. The numbers of clients are decreasing.

Mr. Scott Andrews: Okay. Would you be forecasting to spend more money on long-term care clients in the future if your client base is getting older? I'm missing something here.

Mr. Carlos Lourenso: Based on our current forecast, we expect that our long-term care clients have already peaked in terms of the maximum uptake and that we're sliding down the other side of that peak. We wouldn't expect that long-term care would cost us more in the future than it costs now, based on our current projections.

Mr. Scott Andrews: Okay.

Judy, do you have anything?

Hon. Judy Sgro: The Gerontological Advisory Council issued a report in 2006 that recommended significant changes in the way care is provided to elderly veterans. Has there been any increase in terms of home care provided in light of the recommendations by the advisory council? After that report was announced, were there any changes made in 2007-08?

● (1705)

Mr. Adam Luckhurst: I think it's fair to say that the report from the Gerontological Advisory Council was quite broad in its scope and talked about a whole range of elements, not just the veterans independence program. Obviously, we looked at that report and considered the full range of issues that it raised for us, particularly in light of the highly credentialled membership of that advisory group. I think it's fair to say—and maybe Carlos could comment about individual impacts on VIP—that within the existing authorities we have, we've already moved to look at a number of different changes, I guess, that were reflected in that report.

For instance, Carlos talked about how we brought together long-term care and VIP in a management perspective. That's all about bringing that continuum of care much more to the forefront ,so that we get the better flow-through of services and programs to veterans who need that sort of support.

We've talked a little about case management. I guess part of what the report was saying around the way we case-manage is about making sure that we look much more broadly at the full range of services that are available so we can best meet a client's needs. There has been a huge amount of work done within the department in regard to looking at its case management processes so that we can much better get the flow-through from client needs through a process of looking at the full range of service delivery options out there, options that VAC is responsible for, that the provinces are responsible for, and that community organizations have responsibility for, so we can better get a package of services that meets the needs of the client, the veteran, at the end of the day.

Is there anything you wanted to add about the VIP, Carlos?

I think it's more a flavour of how we're moving forward overall, about bridging the gaps between the different programs, which can either add to or take away from the impact, depending on the way you change some of the interfaces.

The Chair: Thank you, Mr. Luckhurst.

Hon. Judy Sgro: Have we received this report of the Gerontological Advisory Council? I don't recall seeing it.

The Chair: We received it in the 39th Parliament. For any member who would like a copy, we can have the clerk dispatch one to you post-haste.

Hon. Judy Sgro: Are there 500 pages or what?

The Chair: No. I don't remember it being that large.

Hon. Judy Sgro: It's not too big?

The Chair: It's about 60 pages.

Hon. Judy Sgro: All right. I certainly would like to receive it.

The Chair: There's a fine executive summary at the front, as I remember.

An hon. member: Good. That always comes in handy.

The Chair: We still don't have Mr. Stoffer here, so now it's back to the Conservative Party and Mr. Shory for five minutes.

Mr. Devinder Shory (Calgary Northeast, CPC): Thank you, Mr. Chair.

It's an interesting committee and this is a very interesting program. This is my first time on this committee, and this seems like a great program for our veterans.

You spoke about outreach programs in the program itself. Is that correct?

Mr. Carlos Lourenso: When I spoke about outreach, I think what I said pertained to the outreach that we're undertaking in connection with the extension of the VIP for survivors. We're exploring and implementing some outreach avenues to make sure we have done due diligence in finding survivors who may be eligible for the program but who have not yet applied.

Mr. Devinder Shory: You are saying that basically the program allows you some budget or allows some initiatives to be taken to find the survivors and to provide the benefits.

Mr. Carlos Lourenso: We would do that as part of our normal operations. We do outreach quite consistently across the spectrum. It's something that we've done in communities, with community partners, from a case management perspective and from the perspective of trying to link with other provincial providers as well. It's certainly a big part of our work every day.

Mr. Devinder Shory: For that initiative, do you have any budgetary limits, any budget allocations?

Mr. Carlos Lourenso: No, and we're certainly not close to the projected expenditures for that program.

Mr. Devinder Shory: What is your experience with the effectiveness of this outreach approach? Is it successful to an extent?

● (1710)

Mr. Carlos Lourenso: Do you mean the one connected to the survivors?

Mr. Devinder Shory: Correct.

Mr. Carlos Lourenso: I can't comment on that. It's fairly new, and I don't know if there are any results on it. We could find out and get back to you, if that's of interest to you.

Mr. Devinder Shory: Okay.

The question of whether the veterans are receptive to the whole program itself came to my mind. Do they appreciate the program? Are they satisfied with the program, or do they have a lot of complaints?

Mr. Carlos Lourenso: Do you mean the VIP program?

Mr. Devinder Shory: That's correct.

Mr. Carlos Lourenso: When I was a social worker travelling around northern Ontario delivering the VIP program about 20 years ago, I was the envy of every colleague who came out of my school because I was essentially delivering something incredible.

Veterans are ecstatic about the DVA guy or gal showing up, sitting down with them, running through the various benefits that they're eligible to receive, mutually formulating an agreement with them on what they can do and what we can do, and putting those services in place. The satisfaction rating of that program has been one of the highest among all the programs that we know. It's been an incredibly successful program.

Mr. Devinder Shory: It's normal with age for anybody to become a little rough and tough and perhaps to not even follow the requirements one needs to follow. How important is the health of the veteran in keeping the veteran at home or in the community? In some circumstances, for example, veterans get stuck on the idea that they want to stay home, even though their health doesn't allow it.

How do you deal with those circumstances?

Mr. Carlos Lourenso: Each of those situations is always very individual, but we have very good people in the field as social workers, nurses, and other health professionals. Our approach has always been to work very closely with clients to identify both their strengths and the areas where they need help.

Certainly it has always been our orientation to allow folks to choose as much as possible where and how they would like to live. We certainly lean on the side of allowing a veteran to have as much autonomy as possible. At a certain point, if there are concerns around their own safety and security, we would sit down with them and their families and try to work out a solution that's amenable to them.

There are a variety of solutions now. Sometimes I think people don't realize that you don't need to move from your house into a traditional nursing home. There are all sorts of options in between that we might be able to help with. I think when we do that, the situation calms itself down accordingly.

Mr. Devinder Shory: Can I have a minute?

The Chair: Mr. Stoffer has returned now.

Does Mr. André, the member from the Bloc, have one more question?

[*Translation*]

Mr. Guy André: Thank you for your explanations.

Currently, there is a great deal of pressure on the health-care system and on service delivery, there is much talk about efficiency and effectiveness in delivering services to the population. Money is hard to come by, and certain governments tend to want to privatize services.

The annual cost of the department's long-term care program is $340 million. What is the cost of administering these services?

Have you done an analysis of the way you deliver these services, to determine whether you are being as efficient, effective and economic as possible, not in terms of customer service but rather in administrative and management terms?

I am wondering whether the program would be more efficient if the budget was transferred to the provinces and to Quebec, for example, to departments that are already set up to deliver these services.

● (1715)

[*English*]

Mr. Carlos Lourenso: Thank you.

First of all, I don't know offhand what the answer is for the administrative costs associated with the program, but we can get that information for you, if you wish.

As for how services are provided, let me explain a little bit how the system works, and that may help you to understand.

When somebody needs long-term care in their province, in their particular health authority, they normally or in almost all cases apply —even the veterans—through the local placement agency. In Quebec, it's the CLSC. So they go there, and they're assessed to be at a certain level of need, and then they're in or they're out. If they're in, they're admitted, or they're put on a waiting list for a particular facility they have chosen.

In most cases and provinces, people are able to choose one, two, or three priorities, and they go into one of those. When they're in that facility, for the vast majority of veterans, they're in a community facility in a community bed. Veterans Affairs' role is to assist them with their cost of care; we have no other role. The facility is owned and operated by its respective jurisdiction. Our role is to ensure that the amount of funds the veteran must contribute is consistent across the country.

With respect to the type of care and the efficiency of that care, once again, we don't assess the efficiency of a system that is essentially provided for, in paying the bulk of that system.

[*Translation*]

Mr. Guy André: That's what the provincial health departments do. They administer funds and distribute services in the various establishments.

[*English*]

Mr. Carlos Lourenso: But in some situations, we do have a role in evaluating the services provided. I talked about the quality assurance measures we take and how we watch and monitor what goes on in provinces and facilities where veterans live. Perhaps more importantly, in some of the contract bed facilities that we have—Maison Paul-Triquet and CHUL in Quebec—we sometimes do have specialized programming and other types of programming in those facilities, and we undertake regular analysis of those types of programs to ensure they meet the outcomes that we've set forth. Even in a facility like Ste. Anne's, all sorts of specialization occurs there. It is very well regulated and evaluated to ensure that we're achieving the types of results we want to achieve.

So we can do that very comprehensively in the contract bed facilities and the community facilities outside our jurisdiction. We monitor the care there, but we don't comment on their efficiency of operations.

The Chair: Thank you very much, Mr. Lourenso, once more.

The actual rotation list goes back to the Conservative Party right now. Are there any more questions from the Conservative Party?

Mr. Greg Kerr: No, I think we're fine.

The Chair: Okay, then I think diplomacy would say, with the time we have, one question from Mr. Stoffer and one question from the Liberal Party would be all we could do. We've got about three or four minutes of business.

So ask one question, please, Mr. Stoffer.

Mr. Peter Stoffer: Well, actually, I have to excuse myself to go to defend Newfoundland's interest on the seal harvest in the House. So in fairness to the witnesses, I don't have any more questions, except I say thank you very much for coming and keep up the good work with those who get the VIP. Let's hope more of them can get it.

Thank you.

● (1720)

The Chair: Thank you, Mr. Stoffer.

Madam Sgro, you can ask one quick question.

Hon. Judy Sgro: I just wanted to clarify a couple of things.

Thank you so much. I don't want to talk because it's taking my time, but we really appreciate your coming and trying to make it so that we all understand the same facts.

On the VIP program, when it comes to the spouses getting the program, the commitment was made that everybody would receive the program. But that's not correct, because it's really income tested. If you have the $1 million house and $5 million in the bank and you ask for the VIP program, frankly, you're not going to get it. Am I correct?

Mr. Carlos Lourenso: The program has an income element and a disability element to it.

Hon. Judy Sgro: So when we continue to get letters from people who are not receiving the program and have gone through due process, I assume what they're not coming back to us and saying is that it's under the income-tested area—because that's not something, I believe, that's been talked a lot about. That's why they're not receiving it.

Mr. Carlos Lourenso: It could be. It would vary for a number of reasons.

Hon. Judy Sgro: On the VIP program, I would suggest that home care in most provinces is okay. Are most people who receive the VIP program taking advantage of the snow shovelling, the grass cutting, and the other things our traditional home care programs don't provide?

Mr. Carlos Lourenso: I can't speak offhand to the number of people, but certainly there are many VIP recipients who would receive a groundskeeping element that they would normally not get from their provincial home care programs, as you have suggested.

Hon. Judy Sgro: So they're eligible for some of both, to a maximum of $8,000 a year?

Mr. Carlos Lourenso: Close to $9,000, that's right.

Hon. Judy Sgro: It's $8,883, which can be used for either home care or the grounds maintenance services and so on, right?

Mr. Carlos Lourenso: Any combination thereof.

Hon. Judy Sgro: Or any combination.

I know you don't have the information, but could you let the committee know how many people actually get the top amount? I know you're averaging it out, but I'd be interested to know how many people actually get the $8,000 and how many use that service for groundskeeping versus the home care side. It really tells us a bit of the difference between the two, because I think, from what I hear, a lot of people are willing to settle for the home care side from the province, but it's that extra help with things like snow shovelling and grass cutting that helps keep them in their homes. I'd be interested to know where the split is on that one, if you could send that information to the committee.

Mr. Carlos Lourenso: Absolutely.

Hon. Judy Sgro: All right, I'll leave it at that, then.

Thank you very much.

The Chair: Thank you, Madam Sgro.

I have one question just because of the way of the questions, and I may have missed it, but just to give you the opportunity to answer this. If I'm correct, the VIP program and, of course, every program is means-tested by need—not just income, but need. And one of the things I want to clarify is that when you do the assessment, part of that assessment is whether the person has the physical capability to look after their grounds. Am I right or wrong that that's part of the means test?

Mr. Carlos Lourenso: That's right. Do they have the capacity? Do they have the resources? That assessment would take into account all their capacities and strengths and then all the deficits that would exist as well.

The Chair: So if they have the physical capability to shovel their snow or cut their grass, then that is not something that would be covered, versus someone who does not have the physical capability and it would be covered?

Mr. Carlos Lourenso: It's a little deeper than that. If they have the physical capability and the general ability and wherewithal to do it, we don't go and assess somebody as having the capacity to do it when they're sitting there saying that, for a variety of other reasons, they can't. But we certainly don't impose that on them either. Sometimes people want to go out and do most of their snow shovelling, but they want help on the heavy days, and we make allowances for that. It's really driven by how they want to manage their own affairs.

The Chair: This the key thing I wanted. I didn't hear as succinctly, in past meetings, that it was needs-based, and that was really the measure. I appreciate it.

Thank you very much for your time. You've answered a barrage of questions from pretty well every avenue. We appreciate your efforts, and of course your day-to-day efforts to serve our veterans. Thank you very much.

Some hon. members: Hear, hear!

The Chair: There's one piece of business. I don't think it requires that we go in camera. It's simply an advisory from the chair.

Our next meeting is going to entail directing the researcher on the elements you would like see in the upcoming report on the study we've done. That may necessitate a little bit of study and homework on your part over the next 48 hours. You'll want to make sure you're familiar with the evidence from the previous Parliament as well, because that will be included in this report. And of course, everybody will probably have some highlights from their rounds of questioning that they'll want to make sure are in the report as well.

So this Wednesday, the primary reason for the meeting will be to direct our researcher on some of the outcomes we want to see in the first draft.

Yes, Monsieur Gaudet.

● (1725)

[*Translation*]

Mr. Roger Gaudet: Mr. Chair, when will we be receiving the report?

[*English*]

The Chair: This Wednesday we'll simply be giving some very specific instructions to our researcher, Michel. Then he will be drafting it.

[*Translation*]

Mr. Roger Gaudet: Okay. He'll have one week to do it.

[*English*]

The Chair: That will take at least a week, I would think. There's a lot of evidence, which I'm certain he's already been working through but is going to have to finalize.

Hon. Judy Sgro: Mr. Chair, will our researcher be giving us the beginning of a draft report to go through, to see what we think is missing? That's usually the way we do it, isn't it?

The Chair: No. The point this Wednesday will be simply to direct the researcher on what we want to make sure is in the draft report.

Hon. Judy Sgro: Okay.

[*Translation*]

The Chair: Mr. André.

Mr. Guy André: Usually, we receive a draft report. Then, we make comments and add things. I think it might be better to proceed as the committee usually does, instead of going over all the notes and making suggestions. I would rather receive a copy of the draft report, so that we can consider it and then make suggestions. I have a problem with the suggested procedure.

Sunday May 24 poses a problem for Mr. Gaudet and myself, because we have political commitments. I would like to discuss this at the next meeting, because we don't have enough time to do so today. As concerns the report, I think it would be easier to proceed as I have just described rather than as you have suggested.

[*English*]

The Chair: Thank you.

Are there any other speakers on this topic? Madam Sgro.

Hon. Judy Sgro: Usually the practice has been that we're given the draft report, and then we discuss it and see what we think is missing and want added. I think it's a much faster way of doing it, rather than having the researcher just ask us what we want in it. I don't want to waste the time of a meeting. It's usually done that way: we get a draft report and then see what's not in it that we think should be in it.

The Chair: I understand there are two traditions. That has been my past experience as well. But I understand that there are other traditions of directing the researcher. I'm certain the researcher can do this.

If there's no other dialogue, and if everybody is unanimous on that feeling, then we probably will not have a meeting this Wednesday, because it's going to be too difficult to get witnesses for it. Then we'll be coming back....

Let me get an answer from Michel.

Will we be able to have a draft the following week?

● (1730)

Mr. Michel Rossignol (Analyst, Political and Social Affairs Division, Library of Parliament): There's the break week.

The Chair: Our next meeting will be the first Wednesday back after that. Do we have that—

The Clerk of the Committee (Mrs. Catherine Millar): On the Wednesday we have, hopefully, the ombudsman, then the departmental officials in response to the ombudsman. So the draft report won't be until probably June 8.

Mr. David Sweet: All right. Michel will have a lot of time to get the draft ready.

Yes, Mr. Stoffer.

Mr. Peter Stoffer: Here's one thing, Mr. Chairman, that could be done, if everyone agrees to keep it confidential. If we each get a private copy of the draft, then in our own ways we do the homework and submit, through you to Michel, what changes we'd like to see, or additions or deletions. That way, most of the argument could be ironed out by the time it gets to us. But we'd have to agree to keep it so that nobody else sees it.

The Chair: There are two things. First, I have no problem with getting the draft to you prior to the meeting, under the understanding that every members knows that it's confidential. But I think any addition or subtraction from a report should always be done in open debate in the committee. There's just no way to do it electronically, fairly.

I don't have any issue about that. Does anybody have an issue about distributing it, if Michel has it ready before the meeting?

Hon. Judy Sgro: That's providing it's confidential.

The Chair: It's up to the members to do that.

Mr. Gaudet, and then Mr. Kerr.

[*Translation*]

Mr. Roger Gaudet: Have you finished discussing the report? I don't want to mix up the topics. Settle the question of the report first, and then I'll ask my question.

[*English*]

The Chair: No, on this point I think Mr. Kerr wanted to speak.

Mr. Kerr.

Mr. Greg Kerr: Obviously we try to deal by consensus, but in no way would I want us to be discussing the report unless the whole committee is here together. That's not meant in any disrespect. So I think whenever we get it, we set time, even if it means a special meeting to deal with the report, because we owe it to the report to do that.

So I would say that we get it confidentially and then set a meeting to discuss the report here.

The Chair: Okay. Is everybody agreed on that?

Some hon. members: Agreed.

The Chair: Monsieur Gaudet, you'll need to make it quick. We're already out past our time.

[*Translation*]

Mr. Roger Gaudet: I have a question, Mr. Chair.

On May 24, I have been asked to act as honorary chair of a Uniatox walkathon for people suffering from drug addiction. The walk begins at 10 a.m. and ends at 5 p.m., so I won't be able to make it to Ottawa in time to take the plane to Charlottetown.

I thought we were leaving Tuesday afternoon and coming back Wednesday evening. There are six Conservative members and six opposition members, so whether there are votes or not, that doesn't change anything. I don't understand why you decided to leave Sunday evening. Personally, my activities always wrap up on Sunday evening.

[*English*]

The Chair: Monsieur Gaudet, I assure you it wasn't my decision. We did it in open committee. But maybe it's worthwhile to ask how many people will be going to P.E.I. Is the meeting you're having, Monsieur Gaudet, on the actual Monday of the P.E.I. trip, or is it on the Sunday?

[*Translation*]

Mr. Roger Gaudet: Both.

I had switched my Monday schedule for Friday because I had an activity in my riding on Monday evening. But now you are telling me that the trip will be on May 24 and 25. I am all mixed up.

[*English*]

The Chair: Monsieur Gaudet, I think the only thing I can do on this, if the committee is willing to suspend the trip again, is suspend it. But I think, other than that, we'll have to—

[*Translation*]

Mr. Roger Gaudet: I am not asking that the trip be suspended, but next time, I will make sure not to miss any meetings. I do not understand why you decided to leave Sunday evening, it is beyond me. There are six on one side and six on the other. Everyone is going and there is no problem.

[*English*]

The Chair: I'm going to recognize the speakers in a moment.

Monsieur André, the key thing is right now you're trying to give regrets with respect. We want to treat you with respect too and say we understand that.

Now we'll go to Madam Sgro.

Hon. Judy Sgro: If we know we're supposed to be in Charlottetown for nine o'clock on Monday morning.... I'm using my own points and am just flying directly to Charlottetown for Monday morning at nine o'clock. I'm not going to be going down with a group, because I have a conflict. Maybe Monsieur Gaudet could do the same thing.

I'm going to fly back with the charter flight, but we can get there on our own time, at least on Sunday. It was the committee that decided that Wednesdays were too difficult and that Monday was a far better day for us to try to make this very important trip.

● (1735)

The Chair: Mr. Kerr.

Mr. Greg Kerr: I just want to confirm that it was this committee that changed the time twice to accommodate the committee members, and therefore we agreed to go down on Sunday and have our meetings on Monday. I would really not want to see us do anything to upset the staff. And I don't mean that upsetting is the most important thing, but they have accommodated us twice already on changes, and this committee has said let's go down Sunday and have the meeting on Monday. I really think we've just got to go ahead and do this.

The Chair: Okay.

It was Mr. André. This will have to be the last interjection, and then we're going to—

Mr. Guy André: Is the charter leaving from Ottawa?

[*Translation*]

Is the flight leaving from Ottawa and returning to Ottawa. That is a problem.

[*English*]

The Chair: Okay, the meeting is adjourned.

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