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Chair

Mr. David Sweet

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● (1105)

[*English*]

The Chair (Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC)): Meeting number 11 is now in session.

Good morning, Mr. Marshall. We'll move to you in a second.

I understand there was a member—I believe it was Mr. Oliphant—who asked if we could handle some business. Is that correct, Mr. Oliphant?

Mr. Robert Oliphant (Don Valley West, Lib.): Yes, but could we do it at the end? Judy is not here, and I know that she was the one—

The Chair: Yes, we could. It's always risky to hold it until the end. On that note also, we have witnesses who might be late for the second half. So we'll keep it for the end. But let's try to be crisp on it, because it's going to jam the business portion of it.

Do I have consensus on that? Shall I keep the business for the end?

Some hon. members: Agreed.

The Chair: Welcome, Mr. Marshall. You were in front of the committee twice in the 39th Parliament?

Dr. Victor Marshall (Chair, Gerontological Advisory Council): Yes.

The Chair: That's what I thought. Welcome back.

Dr. Victor Marshall: Thank you.

The Chair: We appreciate your expertise from the Gerontological Advisory Council. Do you have some opening remarks?

Dr. Victor Marshall: I do, Mr. Chairman.

The Chair: Are your remarks less than 10 minutes, Mr. Marshall?

Dr. Victor Marshall: They're probably right on 10 minutes—I tried.

The Chair: Okay, that's fine, then.

Please begin. When you've finished, we'll go with our regular routine rotation.

Dr. Victor Marshall: Thank you, Mr. Chairperson and the standing committee, for giving me this opportunity to come before you once again.

As you know, I have served as the chair of the Gerontological Advisory Council since its inception in the fall of 1997. I'm sure you've all read and digested GAC's report, *Keeping the Promise*, which we released in 2006. I appeared before this committee in April 2007 to discuss it.

Over the past 13 years, I've also attended meetings of other VAC advisory groups, and I was a member of the new Veterans Charter advisory group as well, which of course released its report in October 2009, *Honouring Our Commitment*.

I know that you're primarily interested in the new Veterans Charter, as it continues to be a living and therefore changing and changeable charter. While *Keeping the Promise* focused on the concerns of DVA for the traditional veterans of World War I—there were four alive at that time, and of course none now—and World War II and Korea, in that report we suggested that the basic principles advocated for the traditional veterans should really be applicable to all veterans.

The Gerontological Advisory Council works largely through consensus and only rarely votes on motions. However, GAC, at its last meeting, formally and unanimously endorsed the report of the new Veterans Charter advisory group. As you know, that report also endorsed the basic principles in *Keeping the Promise*. So there's a real synergy between these two reports. That's really the theme I have for you today.

I want to speak to some of these general principles of, if you will, consistency or agreement across those reports, and then take some questions from you.

Any recommendation that the Gerontological Advisory Council made had to pass three tests, basically. It had to meet the needs of the veterans groups, as they see it, to be acceptable to them. It had to be realistic in terms of the clinical and health care experience of the providers. And it had to pass the scientific criteria so important to the academic members of the council, who are really interested in evidence-based practice. These same principles, which I can translate as realism, pragmatism, and scientific validity, also governed the new Veterans Charter advisory group in its deliberations. I really don't think you can do better as a way to formulate policy advice.

I think the most useful thing I can do is to highlight the congruence between these two reports. The basis of this congruence is that both reports place the veteran in a life course context. The life course context is widely accepted by social scientists and employed by the policy research initiative of the Canadian government. It maintains that in order to understand people in the later years, you really have to understand what they have been through all of their lives, and also in relation to the way they encountered history. For example, research shows that psychological damage occasioned by operational stress injuries does not necessarily emerge immediately, but may only have effects later in life, sometimes much later in life. For that matter, the same can be said for musculoskeletal injuries. That makes it difficult, if not impossible, to link the veteran's needs to a specific service-related incident that may have occurred years or even decades earlier.

Another principle enunciated in *Keeping the Promise* and further developed in *Honouring Our Commitment* is the emphasis on the social determinants of health. That concept is very Canadian, in fact. It dates back to the famous Lalonde report and also to what is colloquially referred to as the Epp report—after the then minister, Jake Epp—*Achieving Health For All*. These are charter documents in the field. Their approach has been adopted by the World Health Organization and very much influences thinking among the National Institutes of Health in the United States, CDC, and the Canadian Institutes for Health Research in Canada.

Social epidemiologists maintain that social determinants of health other than medical care, which is one of the social determinants, account for more variation in health status than does health care itself. The emphasis on policies to address not only medical care but also other social determinants of health, such as economic conditions, I take to be a major strength of the *Honouring Our Commitment* recommendations.

● (1110)

The big example for me in that report is in terms of economic well-being and the importance of taking a life course perspective, as reflected in recommendation 2.2: “Ensure disabled veterans receive a fair, equitable income consistent with a normal military career.” It's a good thing to index disability benefits to the cost of living. However, if the base salary remains that of a private, these benefits will not fairly reflect what the individual would have been able to realize had they been able to stay in active service and live out a normal military career with its attendant promotions.

I know there are concerns about the issue of lump sum payments. This is a complex area, and I am not an economist; I am merely a sociologist. But my major area of research in aging, in fact, has been in the sociology of the life course and the changing transition from work to retirement. My reading of the literature on people's anticipations and planning for retirement suggest that lump sum payments may have disadvantages from the perspective of the veteran.

I recently summarized for my aging class at the University of North Carolina at Chapel Hill—where I am a professor—the data related to income security in later years. There are four basic points. Most people think they're saving more than they are. People think they have more pension coverage than they do. Most people don't know—this is in the U.S.—that the social security retirement age is rising from 65 to 67, and people expect to work longer than they actually end up working.

This is all evidence-based knowledge in the U.S., and I assume it applies to Canada. The new Veterans Charter would do well then to provide predictable economic support that does not change drastically when one reaches the conventional retirement age of 65 or the normative actual retirement age of about 63 or 64 in Canada.

Some people who receive lump sum benefits as compensation for pain and suffering are likely to spend them rather than use them wisely over the remainder of their life course. Lump sum benefits may be less costly to the department, but they can be very costly to the economic and social well-being of our veterans.

The recommendations in *Honouring Our Commitment*, I think, present a reasonable set of proposals in this area. An ecological perspective is another plank in the platforms of both reports—advocated in the Gerontological Advisory Council as well—which places the veteran in the context of his or her family and community and urges the provision of care programs close to home.

Keeping the Promise promoted the principle of family based services, and this approach is reflected in the new Veterans Charter advisory group recommendations regarding the family. In fact, it's the very first recommendation in that report, to strengthen family support services in five different areas.

A program based on needs rather than on complex service-based eligibility requirements was central to recommendations in *Keeping the Promise*. We maintain that it is neither feasible nor necessary to relate a current health condition in the later years to a specific war or conflict-related event. Moving to needs-based criteria with careful screening of needs could save a lot of administrative dollars and reduce the complexity and the time of the appeals process that many veterans go through.

To address veterans' needs—I know Muriel Westmorland has emphasized this to you—rehabilitation has to be stepped up greatly as a Veterans Affairs Canada service component. While doing so is costly, I'd like to suggest to you that it's also an investment, because active rehabilitation early in life is going to enhance the veteran's ability to remain in the workforce, to attain economic security, and to remain healthy longer.

Putting all this together, we in the Gerontological Advisory Council saw the need for a new way to organize comprehensive, integrated health and social services. We continue to think this has a wider applicability through the new Veterans Charter evolution to address as well the needs of the Canadian Forces veterans. All members of the Gerontological Advisory Council think *Keeping the Promise* articulates a clear set of principles for the reform of health and social services for all of Canada's veterans.

We are all delighted that the May 2008 report of this committee called *Keeping the Promise* is a bold new approach to health programs and services, and your first and second recommendations were that the DVA redesign its programs for both classes of veterans, as recommended by the department's Gerontological Advisory Council in *Keeping the Promise*.

● (1115)

I will tell you frankly that neither I nor other members of the Gerontological Advisory Council, which I chair, are particularly happy that the legislative authorities to act on this advice are not in place. My impression is that the Department of Veterans Affairs values the policy advice in *Keeping the Promise* greatly, and at its request we have been giving the department advice as to how to move as far as we can in the direction we've advocated, sticking within existing legislative authorities.

So here's where the advice of the new Veterans Charter advisory group I think is useful, because it rests on the same general set of principles. We think the recommendations in *Honouring our Commitment* meet those three tests that I mentioned earlier: they meet the needs of veterans; they are realistic in terms of providers; and they are consistent with research-based evidence about the health and social service delivery and economic support mechanisms that are needed.

My message to you, then, is a ringing endorsement of that report, and I hope you'll recommend the necessary changes to legislative authority.

Thank you.

The Chair: Thank you, Mr. Marshall.

This is just a reminder that we have a second set of witnesses, so we will have barely enough time—probably not enough—for two full rounds. Please share your time with your colleagues appropriately.

Also, maybe just because of the last meeting, let's try to stay focused on what's under the charter so that we have enough material for our analysts to finish the report.

Now we'll move on to Mr. Oliphant for seven minutes.

Mr. Robert Oliphant: Thank you, Mr. Marshall, and thank you for coming back repeatedly to this committee. You may end up being an example of gerontological forbearance, in the end, if we don't get moving on this.

I am still a relatively new committee member. Just so I get it in my head, in 2005, the study was commissioned and a group was put together. Your report came out in the fall of 2006, so we're at almost four years. Your principal recommendation was the integration of programs that related to health care for what we call traditional veterans.

Dr. Victor Marshall: That's correct. We also had recommendations for jacked-up health promotion—

Mr. Robert Oliphant: Health promotion and—

Dr. Victor Marshall: —and integrated services, under our determinants of health framework.

Mr. Robert Oliphant: I've read the report. I think it's excellent.

Has your group continued meeting in these last four years?

Dr. Victor Marshall: Oh, yes, it has, but we have almost certainly had our last meeting, because there is a move afoot to come up with an integrated advisory council, which will bring together a number of the people who are on the Gerontological Advisory Council now and then the people from the new Veterans Charter advisory group and representatives from the mental health advisory committee, although that will remain a separate committee.

So we'll continue—and maybe I'm speaking out of turn—but this is not finalized. This is what we are actively discussing now. And then I would actually remain on and chair a committee focusing on the traditional veterans within this broader event.

We held our last meeting last fall, but we're still doing a bit of committee work.

Mr. Robert Oliphant: Okay.

In these four years, has anything changed in Veterans Affairs as a result of your study? Your principal recommendation has not been accepted by the government.

Dr. Victor Marshall: That's correct. And I've written the minister—not the current minister—twice expressing our unhappiness.

Mr. Robert Oliphant: Okay. We're now into this sort of strange world of our new veterans now becoming senior citizens. The reality is that even in these five years there's been a shift, so that many Cold War veterans, peacekeepers, and other veterans are now close to being or are senior citizens, and some of them are actually quite aged persons.

Are your findings still hopeful or valid for new veterans under the charter? Is there some work that can be done to bridge that gap?

Dr. Victor Marshall: Just to preface my remarks on this, I would like to say that I think our report had a significant impact within the VAC bureaucracy, if you will, in helping to move the culture in the direction of our recommendations. We think the bureaucrats in Veterans Affairs—the ones we deal with at, least—seem very supportive of all of this.

● (1120)

Mr. Robert Oliphant: Where's the block, then?

Dr. Victor Marshall: It's legislative authority. These things cost money. For example, to provide an integrated service delivery system, if you followed our recommendations, will involve shuffling quite a bit of money and would require legislative authority to do that. So we've been giving them advice, and they've basically said, “We don't have the legislative authority. We like what you recommend, so work with us to try to tell us how close we can get.” You know, push the envelope, if you will, within existing legislative authorities.

On your point about the age issue, you're absolutely right. In fact, I checked with David Pedlar, because this is a moving target. Of course, Canadian Forces veterans are also getting older. Their average age, according to what David Pedlar told me two days ago, is 56—that's of the clients. At 56, they're not youngsters. You're an older worker in this country, Stats Canada will tell you, if you're 45 years of age.

Mr. Robert Oliphant: That's right. I feel it in the mornings.

Dr. Victor Marshall: Well, I'm 66 now and I feel it all day long.

Mr. Robert Oliphant: One thing you said to me twigged something. You talked about how our gerontological care does need to reflect the life and work experience—I don't want to put words in your mouth—of those we are caring for, that we need to be specific about the kind of care we provide in old age, depending on what people went through in younger years.

I'm opening up the thing. Are there long-term care needs that you think those who have served in the Canadian Forces will have that are maybe not unique but specific to their class of work, their commitment, their service, that need to be then planned for as we help them approach their late age?

Dr. Victor Marshall: The literature on PTSD—most of the literature is American, although there's some great Canadian stuff coming out now—has noted there's quite a difference, say, between the effects of operational stress injuries, as we like to call them, depending on which war people served in. In World War II...most of the literature on PTSD specifically is from the Vietnam experience. Some of the severity there is attributed to the nature of the fighting. You didn't know where the enemy was. If any of you have read Paul Fussell's book about World War I, the lines were clear. Good guys were here and the bad guys were on the other side of the line. In Vietnam, they were everywhere.

So different wars have different battle conditions. They also have different reception conditions. When someone, say, becomes disabled and has to leave the service and return to civilian life, the climate is very different. The Americans, after Vietnam, entered a hostile climate, or at least they perceived it that way.

Mr. Robert Oliphant: Ours may be indifferent to Afghanistan veterans.

Dr. Victor Marshall: I think it's different. I think the receiving climate in Canada and the U.S. is very positive for veterans.

Mr. Robert Oliphant: This points out to me that there's still a federal role for long-term care. It seems to me that Veterans Affairs seems to think it's going to save a lot of money on long-term care when World War II and Korean War veterans are finished with that need, but in fact we may need facilities, we may need programs and plans, specifically for our veterans in their late years, and long-term care.

Dr. Victor Marshall: I think that is true, and partly because there are probably a lot more head injuries and things like that.

Mr. Robert Oliphant: My concern, very specifically, is that we have transferred federal facilities to the provinces. The government is planning on transferring our last one, which I would like to see as a model of excellence for the rest of the country for our contract facilities. It would seem to me that these new veterans need that care, are going to need something that's not the same as what I'm going to need. Mine is a stressful job, but it's not like the military.

The Chair: Thank you, Mr. Oliphant.

Dr. Victor Marshall: I should say this. I sort of feel ambiguous, because I have tried to represent the Gerontological Advisory Council, but my opinion on Ste. Anne's...you're talking about Ste. Anne's, I think? The council has not expressed a view on that. My personal opinion is that I would be sorry to see it go. Of course, I grew up in Calgary. The Colonel Belcher Hospital, which Don Ethell loved so much, was part of my childhood.

The Chair: Thank you, Mr. Marshall. We always give flexibility to the witnesses, but I have to time the members. You can always continue with your answer.

By the way, 66 years old; the years have been good to you.

We're now on to Monsieur André *pour sept minutes*.

● (1125)

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good morning, Mr. Marshall. I am happy to...

Since I'm speaking French, I'll give you time to adjust your earphone.

[*English*]

Dr. Victor Marshall: I can hear you—I think.

[*Translation*]

Mr. Guy André: I did a little research...

[*English*]

Dr. Victor Marshall: Sorry, I'm on the wrong channel now. I'm picking up in French.

Mr. Guy André: Has the time been stopped, Mr. Sweet?

The Chair: You should be hearing someone say that this is the English channel right now.

[*Translation*]

Begin, sir.

Mr. Guy André: I wanted to point it out, because sometimes I have some speaking time taken away.

So I did a little research on the Gerontological Advisory Council. In 2006, you submitted a report recommending that a more integrated approach to gerontology services for aging veterans be developed. That discussion paper was submitted to the Department of Veterans Affairs. Since 2006 when the paper was submitted, which contained several recommendations for improving services, have there been improvements, do you have the ear of the Department of Veterans Affairs in this regard?

[*English*]

Dr. Victor Marshall: Yes, we have the ear of the department. Again, I don't think that's the issue. From all the feedback I get from our interactions, right up to, say, Brian Ferguson, which is as high as I go—occasionally we get a visitor who is higher than Brian—and Darragh Mogan and that crowd, they all seem very sympathetic, and I mean 100% sympathetic, to what we are doing. Again, there's only so far you can go without budgetary adjustments, which require legislative authorities. That is my understanding of it.

[*Translation*]

Mr. Guy André: So you're saying that the recommendations have been more or less taken into account.

[*English*]

Dr. Victor Marshall: By the department itself, yes, they are very much so.

[*Translation*]

Mr. Guy André: After the numerous consultations this committee has held, I have the impression there is a problem with access to services for veterans who live in remote rural regions. That is the big difficulty, as I see it.

When you talk about an integrated approach, you are certainly talking about an interdisciplinary approach for all services. I have the impression that it is always easier in the big cities than in rural communities, where some veterans do in fact live. The entire problem of home support is more difficult there.

Would you have recommendations to make to the committee to ensure greater access to gerontology services or home support for veterans in rural communities in remote areas?

[*English*]

Dr. Victor Marshall: You're absolutely right. It is a huge issue. I think that problem is part of the reason there is an interest in expanding home care services rather than nursing home care.

Thirteen years ago, when we established the council, the veterans organizations' representatives on the council were, as the academics would put it, wedded to the bed. They had legislative authority for so many contract beds, so many nursing beds, and so many hospital beds. The council was reluctant in the first year or two to actually see the department move to expand home care service because they were afraid the money would be shifted away from these valued beds.

The gerontological experts on the committee were successful—I know we were—in getting across the idea that, actually, while there will always be some people who will need nursing home care, people like to stay in their own homes as much as possible. Even for demented people with Alzheimer's disease, for example, there are as many of them being nicely taken care of at home as there are...

It doesn't necessarily mean institutionalization in a nursing home. Others on our committee are much more expert on long-term care. In fact, we had Canada's leading experts on long-term care on the Gerontological Advisory Council. François Béland is one and Dr. Shapiro, from Manitoba, is another.

I think it's easier to sort of organize and contract for home delivered long-term care services in the rural areas than the alternative, which is to bring people to larger centres, to nursing homes. We no longer have a situation of every little town having its own nursing home. So if you want to keep people closer to home, community-based services will help, in part, to solve that problem.

● (1130)

[*Translation*]

Mr. Guy André: I still have time, don't I, given that my friend the chair cut me off earlier.

As I said, the situation is different in the city. In terms of home support services for veterans in more remote rural areas, do you think that cooperation, collaboration with public health institutions in the regions is being maximized? Could arrangements not be made to work more with partners in the public health network, to sign more agreements to deliver these services to veterans in rural communities? What more could be done?

[*English*]

Dr. Victor Marshall: I would recommend that, but I have to say I'm a little handicapped because I've been living in the United States for 13 years, where it would be harder to do than I anticipate it would be to do in Canada. I know there are huge provincial differences in nursing home care, as I understand, across Canada as well. So I don't really have the detailed knowledge to say. It's just my hunch that it could be done.

Also, the Legion, for example, has played a very important role with respect to the monitoring of nursing homes, working in collaboration with Veterans Affairs Canada. They have played a very important role. And a program like that might be expandable to do the monitoring because it's the quality control that is the issue, isn't it? It's one of the big issues, at least, if you're doing something spread out over a large area.

The Chair: Thank you, Mr. Marshall.

Thank you, Monsieur André.

Now we will move on to Mr. Stoffer for five minutes.

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

And, sir, thank you very much for coming today.

We have, from Suzanne Tining, the deputy minister, copies of the four reports that your group has done over the years. What we don't have is a written response to those recommendations.

I'm just a bit confused here. We had Mr. Allard, of the Legion, who is part of your organization, indicate to us when he was here that there has been no written response to the recommendations. The witness after him, the following day, said that you don't get one, that you talk to them, you discuss your recommendations, but there is no written response to your recommendations.

When we do a report from this committee, we send it to the minister. Within a certain allotted time they give us a written response to our recommendations and to our basic analysis of what we've heard. I'm wondering, you've been here since the beginning, have you ever insisted on, or has your group ever asked for, a written response to your recommendations? You've said that, like Darragh Mogan, they're very receptive to your recommendations. But we really don't know that unless they put it in writing to say what they think of your analysis and your recommendations.

So have you ever asked for written recommendations to your reports? If not, why not? I'm just a bit confused as to why you wouldn't insist on or you wouldn't receive a written response to your very worthwhile recommendations.

Dr. Victor Marshall: We have not ever requested it. And I don't remember—it's been 13 years—anyone on the council ever suggesting that we get a written response to specific recommendations we made.

I have, in a sense, requested a response from the minister, but all I get is the "we do a lot for veterans" kind of reply. This is, again, not from the current minister, who is newly appointed, but I've had letters like that.

So why haven't we done it? We have felt that the relationship is good, ongoing, and more like a dialogue we have with these people.

When we have our council meetings there are always other members of the department there as well, besides Darragh and Ken Miller. And Brian Ferguson is there when he can be as well. So I think we've just felt that it's more like an ongoing dialogue. We give this advice, it appears in fairly detailed minutes, but we have not really felt the need to do that because we've trusted—and maybe it's misguided, although I don't think so—that they are doing their best to follow our advice and that they like our advice. They certainly tell us that orally, and in the minutes of virtually every meeting we have there is an expression from Brian Ferguson, the senior ADM, and from Darragh Mogan. That's in the minutes of the meeting, saying how valuable they find our advice.

● (1135)

Mr. Peter Stoffer: Now, sir, your organization does this on behalf of veterans and their families. When I say veterans, I assume you're also including RCMP—

Dr. Victor Marshall: Yes.

Mr. Peter Stoffer: Although I don't see that in here. So I assume you're including RCMP veterans in that same dialogue.

Dr. Victor Marshall: We were established just for the traditional veterans, and the RCMP wasn't in that picture. But we adopted this mantra—and I don't know whether it was the Royal Canadian Legion that started it or whatever—but a veteran is a veteran is a veteran, and the Mounties would come in there as well.

In later years, with the activity going on with the new Veterans Charter advisory group meetings and so forth, and a lot of cross-membership and representation, we do talk about these issues. We've always had reports since that exercise has been going on. Muriel Westmorland would come and report, and of course Don Ethell was sitting on both committees, so we were very well apprised.

Mr. Peter Stoffer: Okay.

You do this on behalf of veterans, so you speak with veterans, you speak with their families, you do the consultations, you make a recommendation, and you send it off to the department. I assume veterans receive copies of your reports. I'll just take page 16 of your 14th December SNAG of 2007, just out of the blue—

Dr. Victor Marshall: SNAG, you say?

Mr. Peter Stoffer: Yes.

The Chair: Just a moment, Mr. Stoffer.

I think everybody needs to remember that the special needs advisory group, the new Veterans Charter advisory group, and the Gerontological Advisory Council are three different organizations. Mr. Marshall is representing the Gerontological Advisory Council.

Mr. Peter Stoffer: Understandable, but my premise, sir, is that they do this work on behalf of veterans. They speak to veterans.

Veterans would probably get copies of your report. But how does a veteran know that the government has responded to these recommendations? All they get is what you've said, but they don't have anything corresponding to what the department has said. For example, Veterans needs to provide support to the caregiver who may also be the spouse, who in many instances could be raising young children. That means if there's a disabled veteran under the new Veterans Charter and his wife is providing the support for him, your recommendation is that VAC should provide support to her.

How do we know the government has responded to this? The veteran doesn't know what the government's official answer is to your question. That's my problem, and I'm trying to close the loop here, and I say it with great respect. You do this great work on behalf of veterans, but the veteran doesn't know what the government's response is to your recommendations.

The Chair: Hang on just for a moment, Mr. Marshall. I gave some latitude at the time because of my other intervention, but you are over time.

Mr. Peter Stoffer: Sorry. That's right.

The Chair: Just for the record, again, SNAG is not Mr. Marshall's report—

Mr. Peter Stoffer: Understandable. I just grabbed the first one out of this material here.

The Chair: He can comment on it.

Dr. Victor Marshall: That was SNAG, but in fact we've said the same thing in the Gerontological Advisory Council as well. So the thought certainly applies, and there actually have been some legislative changes in that area with extending the...oh, I forget the name now, there are so many acronyms. When the veteran dies and if they're on VIP, for example, that benefit used to end after one year. We strongly advised, urged, that it be extended, and it has been extended, not as far as we would have liked, but there have been some results.

Mr. Peter Stoffer: Thank you, sir.

The Chair: Thank you, Mr. Marshall. I was just trying to keep the testimony straight.

Mr. Peter Stoffer: Yes, understandable. Thank you.

The Chair: Now on to Mr. Storseth for seven minutes.

● (1140)

Mr. Brian Storseth (Westlock—St. Paul, CPC): Thank you very much, Mr. Chair.

I'm not used to Mr. Stoffer and the chair being so confrontational with each other.

Mr. Marshall, thank you for coming forward. Before I get into my rounds of questioning, at the end you were talking with Mr. Stoffer about some of the legislative changes that have come about that have come from recommendations from your organization or other organizations you represent.

What are some of the other legislative changes you've seen in the last few years?

Dr. Victor Marshall: The expansion in eligibility for the VIP for home delivered services. It was a long story. The department offered home care in two jurisdictions as an alternative to people on very long waiting lists. Perley was one of them, and I forget the other one. Then when it came time, they said they would go on the home care program. Six or eight months later they'd be told they could get this nursing home bed now; it was waiting for them. They thanked them and said they were doing just fine.

That exercise was expanded within legislative authorities, and then finally the legislative authorities were changed to enhance that, which is good. It takes the pressure off the waiting lists for nursing home beds.

Mr. Brian Storseth: Absolutely.

That's an example of some of the legislative changes that you've seen made.

Dr. Victor Marshall: I have to say, we never know how much was due to us or whether it would have happened anyway. We'd like to think we have had something to do with it.

Mr. Brian Storseth: I do appreciate your comments about the Epp report, a very good report that was done by the former member for Provencher.

I want to start out my questioning by saying that I agree with you that we do have a responsibility to the men and women of the Canadian Forces and the RCMP, who put on their uniforms and serve our country day in and day out. That responsibility has to continue after they've been injured on the job one way or another. As you said, though, operational stress issues come up years later, oftentimes after the member has left the forces and doesn't even realize they have it.

One of the things I've seen and encountered in my riding several times is members who leave the forces, who are employed in another field, and they start having family problems. They come to realize they have PTSD or other forms of operational stress disorder. It's at that point in time that they really run into the wall, if I can say so. I'm sure you've experienced many of these cases as well. It seems to me that they no longer fit within DND, or the family no longer fits within the military family resource centre and all the other outlets that were there for them.

I was reading some of your recommendations. Could you put on the record some of the recommendations your committee made to make this process a better process?

Dr. Victor Marshall: Are you talking about the new Veterans Charter advisory committee?

Mr. Brian Storseth: Yes.

Dr. Victor Marshall: Yes, good.

I anticipated that question a bit, but you'd better tweak me one more time. I'm sorry.

Mr. Brian Storseth: No problem.

For example, I have a gentleman in my riding who spent 20 years in the Canadian armed forces. He spent about 10 years outside of the forces in private business. He was diagnosed with PTSD, but he no longer goes through DND or Veterans Affairs. At the end of the day, it's dealt with through an insurance company that has its own profit/loss margin it's looking to protect, and its own doctors, who do a fairly good job of protecting that. It creates red tape after red tape for these men and women, as well as their families, because their families oftentimes no longer have the resources they would have when one of them was in the military.

Dr. Victor Marshall: Maybe it's not given much prominence, but in *Honouring Our Commitment*, the new Veterans charter advisory group makes the point that there does not seem to be the authority to keep track of veterans. Why shouldn't it be a permanent account, so to speak, that's there? Even if someone has just been discharged, there should be a way to monitor who's out there and some ease in getting back into the system. That would facilitate things.

Mr. Brian Storseth: I would even go a step forward and say that if a military doctor afterwards diagnoses the individual with PTSD, then it is our responsibility to look after him. The onus should not be on him to prove to 15 more sets of doctors that he actually has that condition. That's what I'm looking for.

Also, the definition of family in some of your recommendations is very ambiguous—within the charter. How would you envision expanding that definition?

● (1145)

Dr. Victor Marshall: The definition of family has been debated by the Gerontological Advisory Council and the new Veterans Charter advisory group. It is true that both reports are a little ambiguous about the family. It's maybe one of those things that's dangerous to define. I'm thinking of the U.S. context, where there is the “don't ask, don't tell” policy. The situation is very inflammatory in some circles, for example. Canadians are much more at ease about things like that.

The family, though, clearly includes spouses, whether in a formal legal arrangement or consistent partners. In our *Honouring Our Commitment* report, it includes children, but it may also include parents, for example.

Mr. Brian Storseth: Exactly.

I believe in-laws are included as well, right?

Dr. Victor Marshall: Yes, and in-laws as well.

Mr. Brian Storseth: My last—

Dr. Victor Marshall: But to go back to the point just prior to that, there is this idea of needs-based rather than eligibility-based criteria. If you are a veteran and if you've ever worn the uniform and put your life at risk and you have issues or problems you need help with, you should be able to get it. You shouldn't have to go through a complex... Say you're 86 years old and you are having terrible problems with your back from riding a tank in Sicily in 1943. You shouldn't have to do that. If you're a veteran, you should be taken care of.

Mr. Brian Storseth: Even these guys who are 56 years old, quite frankly—

Dr. Victor Marshall: Sure.

Mr. Brian Storseth: The other part I want to give you a chance to answer is on the expectations. I don't think a lot of people realize—

The Chair: You'll have to be very brief, Mr. Storseth.

Mr. Brian Storseth: —the next Chief of the Defence Staff is probably a private right now in the Canadian Forces. We have that general upward mobility throughout our Canadian Forces. There is an expectation that if you spend 20 years in the army, you're going to move along, but it seems there is a gap in the charter, so that these guys get frozen in at the level at which they get in.

Dr. Victor Marshall: They get frozen in, say, as a private.

Mr. Brian Storseth: Yes. Could you expand on the importance of that a little?

Dr. Victor Marshall: I have two books on life course sociology. One is called *Restructuring Work and the Life Course*, in fact. This is the life course principle in action here. The committee has recommended—also, you should start at the level of a corporal, because a private is not a lot.

It seems to me that if someone was willing to serve their country and in the course of doing so developed an injury, that person should just be taken care of. They shouldn't have to pay any financial benefit. These various programs in their complexity may pay 75%, but it's taxable now, so it piles up.

There is this principle in the life course called cumulative advantage and disadvantage. It's called the Matthew effect, from the Bible. To those who have much, much is given; for those who have little, little is given. It really suggests that's what happens, and there's evidence of it. Over the life course, it's as though the rich get richer and the poor get poorer. If you could intervene earlier, you could stop this fall into greater poverty.

The Chair: I'm sorry, we are way over time right now. We have time for half a round of questioning for the Liberal Party, the Conservative Party, and the Bloc. You each have five minutes. Then hopefully our witnesses will arrive; they landed a little while ago and are making their way here.

We will go to the Liberal Party for five minutes. Go ahead, Madam Crombie.

Mrs. Bonnie Crombie (Mississauga—Streetsville, Lib.): Thank you, Mr. Marshall, for joining us here today.

The Gerontological Advisory Council was set up in 2005 at the government's request and has a mandate to advise, yet your advice isn't being heeded.

Tell me, who else is a member of the advisory council?

Dr. Victor Marshall: We were actually set up 13 years ago. It was actually while I was still in Canada, in 1997. We've been in business 13 years.

Who else is on the council? Over the years we've had many people, but let's see if I can get them straight. They're in the report here. She went off a few years ago, but we've had Evelyn Shapiro from the University of Manitoba, who I would say counted at the time as the leading long-term care expert in Canada. The second one was François Béland, from the University of Montreal. He's still on the council. He's now the leading one, since Evelyn retired at the age of 80 or something like that. We've had Neena Chappell, who was the director of the centre on gerontology at the University of Victoria. She was on the council for a number of years. Norah Keating has testified before this committee. She is a gerontologist and an expert on families and the burden placed on the family through caregiving for people who have PTSD.

● (1150)

Mrs. Bonnie Crombie: Mr. Marshall, would you characterize these individuals as leading authorities on gerontology?

Dr. Victor Marshall: I'll tell you something with all respect and all lack of humility: they are the best gerontologists in the country.

Anne Martin-Matthews is on the council now. She's the scientific director for the Canadian Institute of Aging, which is one of the CIHR institutes, and she's as good as they get.

Mrs. Bonnie Crombie: It begs the question. Why have your recommendations fallen on deaf ears?

Dr. Victor Marshall: As I say, they really have not fallen on deaf ears within the Department of Veterans Affairs Canada, so to say why they have fallen on deaf ears is at a political level, and I don't know if I should go there.

Mrs. Bonnie Crombie: You met with the civil service. You've met with the deputy minister and other civil servants and gotten positive feedback. Have you ever met with the minister?

Dr. Victor Marshall: I haven't met with him one on one, but I've met him in the context of attending meetings.

Mrs. Bonnie Crombie: Has he ever given you any indication of his agreement with your principles and recommendations?

Dr. Victor Marshall: Actually, I would say no. As I mentioned, when you write the letter, the response you get back basically says that the department is doing a lot for veterans; it's doing all these nice things for veterans. It never explicitly says, "We endorse this report." We've never been told that the department endorses *Keeping the Promise*.

Mrs. Bonnie Crombie: So a council was struck, a report was written, and the recommendations won't be followed. They won't act on your recommendations.

Dr. Victor Marshall: I am hoping that maybe you folks can help some people to do so. The current vehicle, the new Veterans Charter advisory recommendations, really incorporates most of the same principles, the same basic principles, right?

Mrs. Bonnie Crombie: Yes.

Dr. Victor Marshall: Also, there has to be some kind of evolution. At one point, of course, all the traditional World War II and Korea veterans will be dead, and then there will be no problem with two systems. There will be no problem achieving that a veteran is a veteran is a veteran, that kind of thing.

Mrs. Bonnie Crombie: If you had to prioritize, which of your recommendations would be most critical in the short term to have implemented?

Dr. Victor Marshall: Maybe because I was on the economic committee of the new Veterans Charter advisory group, I think the recommendations about the economic injustices would be one.

The second critical one—and I know the Department of Veterans Affairs and the Department of National Defence are working on this—is what I would call the hand-off, the transition from DND to having Veterans Affairs Canada be responsible. It's in the report—there are all the delays, progress is being made, and Veterans Affairs is getting involved more while people are still serving. But those delays are costly. From a rehab point of view, it really slows it down. As Dr. Loisel explained to you, it's really costly if people don't get rehab in a timely fashion.

The Chair: Thank you, Mr. Marshall.

I'm sorry, Madam Crombie. I know it seems like the time flies when you're there.

Mr. Mayes for five minutes.

Mr. Colin Mayes (Okanagan—Shuswap, CPC): Thank you, Mr. Chair.

I'd like to thank our witness for the work he has done over the last 13 years: nine for the former government and four for this government.

You talked a little bit about social determinants of health. I think that's a really important issue regarding veterans' recovery and mental well-being. It deals with family, community, and employment. In terms of a lot of these recommendations, it's easy to recommend something, but to include also how to implement those recommendations is really important.

There has been some discussion at committee about the possibility of employment opportunities for veterans, with DND or the federal public service, and that goes a little bit around to what you've talked about as far as economics are concerned. I don't think the mental well-being of a veteran is enhanced just by increasing pensions and giving more money. I think there has to be more to it than that.

Could you just develop on that statement?

● (1155)

Dr. Victor Marshall: I agree with you completely.

One thing in my additional notes here that I thought I would try to get in is that education really is the key.

I've done some work... We're refining that work with a graduate student of mine who's going to do a dissertation out of it, and David Pedlar, the director of research, is going to be on our committee. But we've done some research with the Canadian Forces survey, which is fairly old now, but clearly shows that educational attainment really makes a difference when people are discharged with a disability. It's a huge difference. There are predictable levels. Those with less high school do a lot worse than people with some high school even. Having a degree makes a huge difference as well. It's a qualitative difference. There's a statistically significant difference in financial outcomes later in life.

I have a student in my class, a Caroliner—I just gave him an A on his term paper as a matter of fact—and he's here because he's paid for by the G.I. Bill in the United States. We used to send World War II veterans to college. Educational benefits can make a huge difference. It is a social determinant of health.

We have to remember—and this is referred to in the report—people who are transitioning from the military, which is a particular kind of work, are now going into other occupations in a different field. Having an educational foundation to be able to do that can be very, very important.

First of all—and this is a DND thing, not a VAC thing—I think there should be a lot more attention to helping serving soldiers and members of the forces upgrade their education while they're in the service, and in a sense make the forces an educational... No one should leave the Canadian Forces without at least the equivalent of a high school education—no one.

The university support would be an investment that is well worth it. Look at how educational benefits helped transform this country as well as the United States after the Second World War.

These were not even explicitly on the table. That's me talking. I think that would be a really good thing.

The other thing, in the broader sense, about the social determinants of health, and this may be where the recommendations in *Keeping the Promise* for a kind of jacked-up integrated case management system come into play, is you need a system that's comprehensive enough that you can handle the health aspects of the disability but also the social aspects in terms of economics and the family. They all intertwine.

We know that operational stress injuries, for example, lead to a lot of marriage failures, and we can understand why with the things people are going through. There are other things—increasing the use of the Canadian Forces bases. Family benefits programs and their accessibility by veterans are great. They're also in several parts of the country, which helps as well.

But I think case management is a really important function. That also means training people for broadly based case management, which integrates not just the health aspects but the family and economic aspects as well.

The Chair: Thank you, Mr. Marshall.

Mr. Mayes, thank you.

Now on to Monsieur André. *Cinq minutes, monsieur.*

[*Translation*]

Mr. Guy André: The Gerontological Advisory Council reports directly to the Department of Veterans Affairs. Is your research funded entirely by Veterans Affairs Canada?

● (1200)

[*English*]

Dr. Victor Marshall: The council?

[*Translation*]

Mr. Guy André: Yes.

[*English*]

Dr. Victor Marshall: Yes, it's fully funded. We're basically volunteers, but it costs money to bring us to meetings.

[*Translation*]

Mr. Guy André: Fine.

Your mandate come from Veterans Affairs Canada. I assume that the people in the department have concerns and do studies. They give you research assignments, so you will produce a paper.

[*English*]

Dr. Victor Marshall: No, actually we have a mandate to give advice. Technically it's to give advice when we are asked for advice, and sometimes we tell them what to ask, or we give it anyway. But we do not have a research budget.

Now it may be, in an indirect way—and I'm sure it is—that some of the advice we give leads to some research being funded. Certainly when we were first formed, the academics like myself would discuss an issue, a problem, and the first thing we'd say is we'd better do some research on that. The veterans organization members would say "we're dying", so we learned to draw on what we knew already. You had the top gerontologists in the country, so we knew what was going on, but we didn't have time to do new research. But we did advocate strongly, and we are told we had a huge impact on the department jacking up its own research operations under David Pedlar's leadership.

[*Translation*]

Mr. Guy André: But you told the committee that your recommendations are often not taken into account. Research is done, there's a problem, a report or research paper is produced, it's put on a shelf. That's kind of how the institution operates, as I have known for some time.

Doesn't it get a bit frustrating, when you spend time writing a research report, to see that the recommendations are not taken into consideration? That is my first question.

As well, you are consultants for the Department of Veterans Affairs on certain issues. I imagine you get the department's consent for the subjects you address in your research. As a result, the department should be somewhat open to studying your recommendations. It seems not, though. So I wonder about this.

I have one last question. In fact, I think of the services in question here as being similar to the services provided for seniors in general among the public. Apart from the question of the organization of services for seniors, how is your gerontology research different? How can it be used for the benefit of other seniors in the general public? How is the Gerontological Advisory Council different from equivalent bodies elsewhere in Quebec or Canada or in other areas of gerontology research? How is your research different and what is unique about it?

[*English*]

Dr. Victor Marshall: On the first one, is it frustrating, yes, it is. But you know, I tell graduate students when they're starting their careers, "Don't try to solve all the world's problems in one study. It's a long-range process. Bring your little pebble, throw it on the pile, and maybe you'll eventually get a small hill going." We're not revolutionaries here.

I think everyone on the council—the academics, at least—feels it's just a privilege to be able to do something, to make some kind of contribution for our country and for these veterans. So it is discouraging. But again—and I've said this before—it's not that the department is unreceptive to our advice. The department is receptive to our advice. It just seems to have trouble getting things done. That's my interpretation of it.

Is there a consensus on research themes? Well, we have a report at every council meeting. I'm talking now about the Gerontological Advisory Council. We have had a report at every meeting on the research activities that are going on, so we are well briefed. David Pedlar is there, and we react to what he's doing.

I think the department is really going in the right direction under David's leadership, in the sense that there's a heavy emphasis on operational stress injuries. This goes back to... You asked about Ste. Anne's, that big centre now for operational stress injury research, which is really important.

There's a place now, in the new Canadian longitudinal study of health and aging, for a veterans unit, a component in there so that they can learn more. That's where it's done, because there's not a huge budget for veteran-specific research. But if you can sort of buy into various ongoing research projects, bigger nationwide projects like that, identify the veterans and get data that way, it's a... And he's been very strategic in building alliances like that, working with various Canadian institutes for aging and health. The one on rehabilitation, for example, is really important in that area.

So compared to 13 years ago, there's a huge difference now in terms of the available research data. They're still working at building up more what you might call administrative data that could be used, that you could get from records, and so forth. The council has spent a lot of time reviewing and critiquing the tools that are used to measure health status, for example, so they get better data like that. So I think a lot of progress has been made in this area.

● (1205)

The Chair: Thank you, Mr. Marshall.

We're way over, Mr. André.

And I see our other witnesses have arrived.

I want to thank the members. Thank you very much, Mr. Marshall.

Dr. Victor Marshall: You're very welcome.

The Chair: As was said multiple times, we appreciate your work on behalf of veterans.

Yes, Mr. Stoffer?

Mr. Peter Stoffer: I have a quick point of order. I want to congratulate the honourable witness for saying that the rich get richer and the poor get poorer. Sign him up.

Voices: Oh, oh!

The Chair: That's an independent comment from a member.

On behalf of the committee, I want to thank you for your good work for veterans.

Dr. Victor Marshall: Thank you. Is it all right if I stay to hear more?

The Chair: Absolutely, you can stay.

Dr. Victor Marshall: Thank you all for bearing with me in my testimony.

The Chair: We'll suspend for about two minutes until we have a transition of witnesses.

● _____ (Pause) _____ ●

The Chair: Go ahead, Mr. Oliphant.

Mr. Robert Oliphant: The business that Judy Sgro wanted me to bring up is the issue of ensuring that Sean Bruyea is scheduled for a witness time.

A second thing, which I want to bring up, is that we had a witness scheduled for last week named, I believe, Harold Leduc. He was cancelled; he was on the schedule and then came off the schedule. I just wonder whether he's able to come back or whether there is someone who could take his role. I believe he was part of the group on the establishment of the new Veterans Charter.

I'm looking at my note here.

The Chair: Okay.

Mr. Robert Oliphant: Yes, it is Harold Leduc and he was to be here on Tuesday of either last week or the week before.

The Chair: I will have to get back to you on that. George is not our regular clerk and doesn't have the schedule with him. I know that Sean Bruyea has been rescheduled. I believe it's toward the third week of May—actually, right after we come back. He's scheduled with another witness, one hour for each of them. I'll check about Mr. Leduc.

● (1210)

Mr. Robert Oliphant: Leduc sits on the review and appeals board, but he was from the Canadian Peacekeeping Veterans Association, the CPVA, which was one of the six veterans organizations that supported the charter.

I wonder whether we have any one of those organizers. That's my question.

The Chair: Okay. I'll have to look into it, because it sounds as though he decided not to come. We will have to determine what the case is and then try to find an equivalent witness, if he doesn't want to show.

Mr. Kerr had some business, and then Mr. André.

[*Translation*]

Mr. Guy André: Since you opened the door, we'll continue until 1:00, and we will finish with the witnesses.

I wanted to talk about a witness, Francine Matteau. I have proposed to the clerk several times that we invite her. I think it is very important for Ms. Matteau to be able to testify urgently. We have met with various people involved, various actors, officials from various associations, but Ms. Matteau is engaged in an important battle relating to the lump sum and services to veterans. She is directly involved and affected by the program. I think it is a good idea for us to meet with the associations, but it is also worthwhile to meet with people who are directly affected by the situation. That is why I am strongly urging that Ms. Matteau be invited to testify.

[*English*]

The Chair: Is there some consensus on that witness?

Mr. Kerr.

Mr. Greg Kerr (West Nova, CPC): I want to ask you or the clerk a question for clarification. Is this within the time parameter you've given us? Basically we've agreed we're wrapping up on May 13. Does that fit within the schedule to get these done?

The Chair: Again, because we don't have our regular clerk here, I'd have to get back to the committee regarding that.

Mr. Greg Kerr: I think we want to talk about whether it's going to mean an extra meeting or not and how it would fit in. I just want to be sure about it.

[*Translation*]

The Chair: Mr. André.

Mr. Guy André: I would have liked the clerk to be here because I have discussed it with him. Obviously we have to set priorities. I wanted to say that it is always very worthwhile to hear someone who is engaged in a group effort, as Ms. Matteau is at present, and who is directly affected by situation but is not part of an association. I think that is the unique aspect of Ms. Matteau's case.

I would like us to go ahead and meet with her. Should I make a motion? I would like her to be invited.

[*English*]

The Chair: Well, you can certainly do that, Mr. André. I just had a conversation with our great analyst, who has a photographic memory, and although we don't have the documents here, he remembers the schedule. We have very little margin, if you want to get the study done and tabled before we leave for the summer recess.

We can look at that. If you'll allow one meeting so that I can come back and report to the committee how we might be able to fit her in, that would be great.

I think there probably is consensus in that regard, that we could check the schedule. Right now I can't give you a definitive answer until I see the schedule, but the analyst tells me that there's not much margin at all, so we'd probably have to put her in with another witness if we were going to do it at all.

[*Translation*]

Mr. Robert Vincent (Shefford, BQ): Mr. Chair?

The Chair: Yes.

Mr. Robert Vincent: Every meeting for several weeks you have called us to order and pointed out that we are examining the new Veterans Charter. So it would be worthwhile to ask questions about the charter. However, as you know, the witnesses, in their testimony, prompt us to talk about what they want. Our questions are asked based on their testimony. If their testimony is not about the Veterans Charter, our questions also will not be about the charter. Ms. Matteau, on the other hand, will definitely talk about it in her testimony, because she is directly affected since her son received the lump sum and not the pension. She will be able to talk to us about the harm caused by the fact that it is a lump sum instead of a pension. She and her son are in that situation right now. It would not be necessary to be calling us to order all the time. We would actually be talking about the new Veterans Charter, there would be a specific case. That is why it's important.

● (1215)

[*English*]

The Chair: Mr. Kerr.

Mr. Greg Kerr: Mr. Chair, I think you're right. You come back and tell us how much time there is and how it might be divided. We can't bump another witness to add a witness; we'd have to work it in with the ones who are on the list. I think that's all we're asking: how we accommodate this within the number of hours we have left to work with it. I think if you can come back and tell us exactly what the breakdown is, we can deal with it at the next meeting.

[*Translation*]

Mr. Robert Vincent: I'm going to ask you another question. I know that there are committee members travelling to the Netherlands from the 1st to the 10th. Will the committee still be meeting while those members are away?

[*English*]

Mr. Greg Kerr: Good luck to those going to the Netherlands.

Oh, I'm sorry. I assume any committee members who are going would be represented by another member from their party. We're carrying on business next week as usual, and I assume you'd have replacements sitting in place. We're not slowing down; we only have a couple of weeks left to get this done.

The Chair: Just for the record, we're not meeting next Tuesday, but we are meeting next Thursday.

Is there any other business?

[*Translation*]

Mr. Robert Vincent: You'll get back to us next week to tell us where we could incorporate Ms. Matteau in the present schedule.

[*English*]

The Chair: I'll come back with some recommendations. I'm always at the behest of the committee.

That concludes our business.

Welcome, Mr. Maguire and Ms. MacKinnon. I apologize that we got into some business when you weren't here, but we're glad that you have made it now.

I'd like to introduce our witnesses to the committee. From the Royal United Services Institute of Nova Scotia, we have Heather MacKinnon, who I understand is a lieutenant-colonel, retired.

Dr. Heather MacKinnon (Medical Doctor, Royal United Services Institute of Nova Scotia): It's lieutenant-commander.

The Chair: I apologize, ma'am.

We also have William Maguire. You can tell from the medals on his chest the amount of service he's given to our country.

Do you both have opening remarks?

Okay. We're going to have limited time today, unfortunately, but I'll allow your opening remarks, and then we'll try to figure out what time we have left for our rotation for questions.

Ms. MacKinnon, you can go ahead, and then I'll go to Mr. Maguire.

Dr. Heather MacKinnon: Do you have a copy of my address? If not, I have copies.

The Chair: Did you submit it in advance?

Dr. Heather MacKinnon: Yes.

The Chair: Are the copies you have in both official languages?

Dr. Heather MacKinnon: No.

The Chair: We'll have to go with your oral testimony only.

Dr. Heather MacKinnon: All right.

The Chair: Monsieur Vincent.

[*Translation*]

Mr. Robert Vincent: Ms. MacKinnon, when did you send your document to the clerk?

[*English*]

Dr. Heather MacKinnon: It has been about 10 days.

Mr. Robert Vincent: Thank you.

Dr. Heather MacKinnon: I did call to confirm.

[*Translation*]

Mr. Guy André: Mr. Chair, we raise the question because the other witnesses sent documents that were not translated within the time specified. We checked. There is a logistics problem. We are seeing it again today.

[*English*]

The Chair: Our regular clerk is not here. I cannot establish the question about what the issue is.

[*Translation*]

Yes, I understand.

[*English*]

Dr. Heather MacKinnon: I did bring copies of that. I've also submitted an article from *ON TRACK* magazine, which is in English and French, so you will have that. My résumé is in English and French, so that's prepared for you.

The Chair: Just make sure the clerk gets anything you have that's in both official languages. He'll have to inspect it before it's distributed to the committee members.

Dr. Heather MacKinnon: Okay.

The Chair: You can go ahead now, Ms. MacKinnon.

Dr. Heather MacKinnon: I'll go ahead with my notes. I'm going to read this.

Mr. Chair, members of the Standing Committee on Veterans Affairs, thank you for allowing me this opportunity to speak today on behalf of our veterans.

I would like to start by telling you a little about myself. I am a former medical officer who has served in both the regular and reserve forces. I have participated in numerous military operations, both at home and overseas. I have a unique general practice in Halifax, composed of former military and RCMP members and their spouses. I formed this practice, as I have discovered there is a definite need for a medical transitional service for both regular and reserve forces personnel who have left or who are leaving the Canadian Forces.

I am also an active member of the Royal United Services Institute of Nova Scotia, or RUSI, which I am representing here today. For those of you who may not be familiar with RUSI, I would like to take a moment to explain to you who we are and what our organization does. The Royal United Services Institute of Nova Scotia serves as a discussion and education forum on Canadian defence and security issues. Our membership includes serving and retired officers and members of the Canadian Forces, the RCMP, other security agencies, business, industry, community leaders, and other interested individuals who carry out a number of activities that support the implementation of effective foreign defence and security policies. In addition, we encourage the development and maintenance of Canada's military and security forces, and we feel strongly about the requirement for a comprehensive benefits package that many of our veterans require in order to sustain a reasonable standard of living.

In order to gain better understanding of the benefits available under the new Veterans Charter, RUSI Nova Scotia established a committee, of which I am a member, to determine if deficiencies exist, and, if so, to offer our assistance to help resolve shortfalls within the charter in a fair and equitable manner. To date, the committee has met with senior members of the Legion, Veterans Affairs Canada, the veterans affairs committee ombudsman, Nova Scotia Capital Health, provincial and federal politicians, veterans, and serving members of the military.

We have concluded that there are many positive aspects to the programs available through the new Veterans Charter. However, the current VAC plan to downsize and eventually close existing long-term medical care facilities as the World War II and Korean War veterans decline in numbers raises grave concern, not only for the veterans and their families, but we believe for all citizens of this magnificent country.

Modern—that is, post-Korean War—veterans do not have access to the specialized long-term health care facilities currently run by Veterans Affairs Canada. These facilities are all specialized, ranging from Camp Hill veterans hospital in Halifax, Ste. Anne's Hospital in Sainte-Anne-de-Bellevue, Quebec, Sunnybrook Hospital in Toronto, to the smaller nursing homes around the country that have a few beds under contract to VAC. Modern veterans in need of long-term health care must compete with the general public for beds in nursing homes or hospitals. Waiting lists are long for placement in these facilities. The facility may be located a great distance from the veteran's home and family. The facility is most likely not equipped to offer the expertise to deal with veterans' special needs, such as post-traumatic stress disorder treatment, severe head and body trauma, and amputee rehabilitation.

I have permission from the family to discuss one such veteran with you. This gentleman is Major (Retired) Philip Paterson. Major Paterson is also a patient I have been looking after for several years. I knew him when I was serving with the Canadian Forces. Our committee visited him at home this past November. He was diagnosed several years ago with PTSD, post-traumatic stress disorder, and more recently dementia. Although he's still living at home at this time, his deteriorating condition is such that it is placing an unacceptable level of stress and financial hardship on his family.

Major Paterson attended the Royal Military College at the same time as our committee chairman. Despite his dementia, it was clear during the conversation that he recalled, with fond memories, many of the same people and events that transpired some 40-plus years ago, but was totally at a loss to remember things his wife had said only a few minutes earlier. His condition had deteriorated to the point where he urgently needed to be placed in a permanent facility.

● (1220)

Despite numerous attempts to have him admitted to Camp Hill veterans hospital in Halifax, however, he was officially denied access by Veterans Affairs. He was admitted to a long-term care facility in Bridgetown, Nova Scotia, a three-hour drive from his family. The need for specialized programs and to be with other veterans provides one of the few remaining opportunities to foster any form of quality of life for our veterans.

Please don't take these comments as blasting Veterans Affairs Canada. There is much to like about the new charter. There is a much stronger focus on reintegrating the injured veteran into the workforce and society in general. There are existing training opportunities, some hiring priority in the federal civil service, and psychological services such as the operational stress injury centres located in several provinces.

Veterans Affairs does not supply medical treatment to veterans. This is done through the provincial health care systems. DND and VAC have collaborated to set up the joint personnel support unit at various bases to help Canadian Forces members who are being medically released to transition to civilian life. These centres do not supply medical transitional services for these patients. This type of service has yet to be established. As you know, that is what I do as a private general practitioner. I would like to see medical transitional services that are designed to deal with the regular and reserve forces set up across the country.

Mr. Chair and members of the committee, our modern-day veterans have served this nation under the most dangerous and miserable conditions imaginable. Their dedication and sacrifice have helped form one of the cornerstones of Canadian foreign policy and have earned Canada the utmost respect and envy around the world. The ability to provide the specialized medical care that so many of our veterans currently need, or will require, is not a gift, but a debt they are owed by this country. The measure of an institution such as Veterans Affairs cannot be determined by fiscal management alone, but rather by compassion and quality of the service they provide.

I am absolutely convinced that any short-term budgetary gains realized through a reduction to essential veterans services will be minor when compared to the long-term cost to our veterans, their families, and society at large.

Mr. Chair and members of the Standing Committee on Veterans Affairs, please help to ensure our veterans receive the treatment and respect they have earned. Do not allow the erosion of specialized treatment or the elimination of the long-term care facilities they so desperately require.

I would like to express my sincere thanks to you for having taken the time to listen to me today. If you have any questions, I'd be happy to answer them.

● (1225)

The Chair: Thank you, Madam MacKinnon.

We'll go on to questions after Mr. Maguire gives his opening remarks.

Mr. William Maguire (As an Individual): First of all, before I start off, I'm going to tell you I'm not an educated man in regard to what you people have gone through. I am a soldier. I have been a soldier since the age of 15. And I will talk like a soldier. I'm not here to make friends. I'm not here to get a job, a high-paying job, or any other thing. What I'm trying to do is bring to light what's going on with the new charter, having worked with many veterans under the OSISS program, if you please.

Mr. Chair and fellow members of the Standing Committee on Veterans Affairs, it is a great honour to sit with such noble individuals. Thank you for your time to let me speak to you today on issues that are very concerning to my fellow veterans, and I speak for the fellow veterans. Having served in all three branches of the military over a span of 37 years, there's not much as an individual that I have not covered. This includes tours with NATO and the United Nations organizations. My schooling was completed carried out on a battlefield. My instructors were hardened men who had served in the Second World War and Korean conflicts. So one might say that you grew up very fast or you were forced to the wayside.

My first encounter with death through battle was at the age of 18 in Cyprus, 1967-68, and my last throw of the hat in the battlefield was under the conditions in Somalia in 1992-93.

If given the chance, I would like to bring issues to the table in regard to the new charter and how it has failed the veteran. Other issues that should be covered are how Veterans Affairs treats its veterans, patronizing by persons of authority who have no experience with military or no understanding of the afflictions suffered daily by veterans. These same persons always seem to come to light when serious conditions arise regarding the veterans and their health. The final decision has to be made by them whether or not the veteran is entitled to his/her claim.

It must be remembered that the majority of these patrons have no medical or psychological background whatsoever. It has gotten to the point where the system is overriding the recommendations of medical professionals. This is not only a sham but a disgraceful and demeaning act to the medical system. Some very highly qualified medical professionals have actually been picked out and harassed by Veterans Affairs and deemed not competent to give medical advice to Veterans Affairs in regard to veterans' claims.

Where does a veteran stand? He or she is left to their own demise. More and more I see that Veterans Affairs is being run like a business and not as an agency to help our veterans who have served for years without the right to appeal or complain. Now that the veterans need help, they seem to be dropped to the wayside, and it is getting worse.

William (Bill) Maguire, P.O. Box 5, Eastern Passage, Nova Scotia.

I've brought 20 copies of this, plus 20 copies of my time served in the forces. And I apologize, sir, it's not in French.

I am open to questions.

● (1230)

The Chair: Thank you, Mr. Maguire.

No worry, you can leave a copy of that with us. We'll have it translated and redistributed to the committee members.

Mr. William Maguire: The member has already come forward. I'm taking the copy from you, sir.

The Chair: We'll move on to questions now. We have time for one round, so please share your time accordingly among the parties.

It's on to Mr. Oliphant.

Mr. Robert Oliphant: Could I ask for a three-minute warning? I'm going to share my time with Mrs. Crombie.

The Chair: Will do.

Mr. Robert Oliphant: She'll talk to Mr. Maguire and I'll talk to Dr. MacKinnon.

Thank you, Dr. MacKinnon.

You've clarified something in my head and I wanted to just double-check it with you. I've been working on this issue for a number of months now.

I'm going to ask if the chair could ask my colleagues to please pay attention. I had difficulty hearing Dr. MacKinnon because my colleagues were speaking. I didn't raise a point of order, but I felt it was very rude that they were talking through her testimony. It's not as rude that they're talking through my question, but I'm finding it difficult.

The Chair: Mr. Oliphant, I have stopped the time.

Maybe I'll just add to that. I have spoken to committee members a number of times. We always have a lot of business to do, and sometimes we have to lean back and talk to staff, etc. Please be mindful when doing that.

I know you've flown all the way here today. You barely got here in time, and now you're going to be flying back. So we owe a debt of gratitude to you, not only for coming, but also for your service to Canada.

Go ahead, Mr. Oliphant.

Mr. Robert Oliphant: Thank you.

Many of the arguments are based on a medical model of transition from DND and active service to Veterans Affairs, ongoing commitment to our veterans, and then long-term care, which is almost a third phase. I'm sort of seeing it now in three phases. There's the transition, which includes some new Veterans Charter and rehabilitative stuff; support for everything from catastrophic injuries to lesser injuries, but maybe complex injuries; and then long-term care may be affected. Our previous witness said that long-term care needs may be different for veterans because of their service. Whether they are amputees or have other injuries, different care may be involved later in life.

What I heard you say—and it was clearer than it has ever been before—is that most of the arguments have been based on the service they gave, and that we owe them. You did say there's a debt, not just a gift. But you also said that specialized care is necessary.

So there are two things: the debt we owe for the service that men and women have given to our country is a covenant, not just a contract, and they have specialized needs that are different from the regular population. In the balance of those two in this new model, tell me a little about the specialized care you see as necessary.

● (1235)

Dr. Heather MacKinnon: We can break that down into two parts. When people are released from the forces for medical reasons—or even other—they're usually put out without any medical follow-up. The door is closed and they're out. So it doesn't matter what has happened; once your release date is over, you're out. There is no transition set up for these people, so they go to whoever will take them. I just happen to be one doctor in particular. Because I'm a veteran, I take veterans in my practice, and it has become renowned.

I have been speaking about medical transitional services. We need to train more doctors to deal with these people with their special injuries. They might have post-traumatic stress disorder or they may be amputees. A lot of them have chronic pain from injuries. You have to understand that you don't even need to have been in a war to be broken in the military, because there are years of training. It's like being in a triathlon for your whole career. You're in it all the time for 20 years, because you're always training and hurting yourself.

Bill is a good example. He's a patient of mine, but he's also very broken from his varied career. He was in the army in Cyprus; he was with the airborne. He's had a lot of things bat him around. We even crossed paths in Somalia because we were on the same ship together. Bill is a good statement for all the things that can happen. But what I'm trying to say is there is no service set up for this for people leaving the forces.

One of the articles I did bring, which is in two languages, is an article I submitted to *ON TRACK* magazine. We'll pass it around later. It goes into more detail on this.

You can be a reserve force member who was a class C or class B when you were over in Afghanistan. Then you come back and go back to just being a class A, meeting on Tuesday nights. You may have some sort of injury. You're back in the provincial health care system and there's no follow-up. There's nobody checking up on these kids. Nobody knows what they're doing. I'm starting to pick up a few of these, but I'm not really getting a lot of them because they're lost.

Mr. Robert Oliphant: Thank you.

Your testimony, both of you, was not only on what can happen, but that the service never ends. Thanks.

Mr. William Maguire: That's a good way of putting it, sir.

The Chair: Madam Crombie, I have to stop the time.

Because we've had some administrative issues, Madam MacKinnon, if you have any documents with you, please don't hand them out. Give them to the clerk and we'll make sure they're dealt with appropriately. Thank you very much.

You have two and a half minutes, Madam Crombie.

Mrs. Bonnie Crombie: Oh, I get two and a half minutes. I'm so delighted. Thank you.

Mr. Maguire, I want to question you, if I could. First let me thank you for being here today and for the service you have given to our great country.

You talked a little bit about how the new Veterans Charter has failed—has failed you and has failed veterans. I wonder if you could give us a few specifics about where exactly it has failed.

I'm going to put all my questions out in case you talk out the clock, so that you can refer to all of them. That was the first one.

Second, I was shocked and mortified to hear that you've been patronized, or you feel that veterans have been patronized in the way you've described. I wonder if you have any concrete examples. Is there anything we can do, as a committee, to address this grievance? It just mortifies me that this would happen to our veterans.

Finally, you mentioned that Veterans Affairs Canada has been performing as a business, without considering policy that would act in the interests of our veterans. Are there any specific issues you can address as well that we can assist with?

Mr. William Maguire: You asked how the new Veterans Charter has failed. One of the big things that upsets a lot of us modern veterans is that anyone who applied for a claim after April 1, 2006, was deemed to be under the new Veterans Charter. The new Veterans Charter eliminated all pensions. You were given a lump sum for your injuries and basically told to go on your way and leave them alone. You had your $50,000 or $70,000, or whatever it is, so now leave them alone.

They have said that they are trying to keep the quality of life of the veteran at a high level, percentage-wise. In other words, keep us at home as long as possible and keep us out of the system. This is done through rehabilitation programs, spousal allowances, and things like this.

Again, the new Veterans Charter has failed. I am over 100% disabled. My wife has had to quit work to look after me. Yet there is no compensation out there for her. When I asked why, I was told that she is my wife and she is expected to look after me. I thought that was very demeaning. Between us, we've lost over $3,000 a month. I've gained $300 through the Canada Pension Plan.

Every time we ask for funds—not just me, but other veterans I have worked for—we are given the same story. We're not entitled. We don't meet the requirements. And it goes on and on, especially if you come under the new Veterans Charter. It seems that they want nothing to do with us.

Now, the men who were under the old charter, prior to April 1, 2006, are pensioned, and their indexed cost of living index goes up 6% every year. Six percent is a lot of money when you're making $2,000 or $3,000 a month under pension plans. We're not given anything. We're getting nothing.

Then they say that if you're 100% disabled, you have no need to ask for anything, because they are here for us. Well, that is “bullarkey”. I need pills now, and I have to get Heather to sign for the prescription, and I'm told that I'm not covered. I'm a diabetic and I need stockings. I'm not covered. It goes on and on.

Your second question was...?

● (1240)

Mrs. Bonnie Crombie: It was about being patronized.

Mr. William Maguire: We know there's patronization going on. A blind man would see the patronization going on. The people filling the slots in high authority positions within the VA are coming from patronization.

You get a man who was a news reporter or an actor or a big-time lawyer filling in these positions of authority, making final decisions on my quality of life. They don't understand the military. They don't understand the afflictions we're going through, and I think personally they don't give a goddamn what goes on with the veterans, because we can't get hold of them. We can't touch them. If you ask who authorized something, they're not allowed to tell you. Then they say they trust their veterans.

If you go into any VAC, first of all, you have to go through more security than you do at the airport, just to get in the door. Then the receptionist sits behind a bullet-proof glass. You need passes to get from one area to the other area. Then you're escorted. This all builds on us. We're in a position now where a veteran who suffers from PTSD doesn't trust anybody, and then you put him into an environment like that and say, "Oh, you can trust me." Who the hell are you? "Well, this one here said he's going to help me." Well, how are you going to help me?

What is your third question?

Mrs. Bonnie Crombie: I think you perhaps touched on it as well. I probably have to cede my time, but it had to do with how things are run as a business rather than with consideration for the veterans.

Mr. William Maguire: I am not going to say any names. There's an old saying in the army that if you start giving out names, you start doing pack drill, and I'm getting too old to do pack drill.

I'll give you an example. A case manager is married to a veteran. The case manager takes her job very seriously. She comes home and tells the veteran—which is her right, even though she's not supposed to do it because everything is confidential—"Today I walked into the coffee shop at Veterans Affairs and there they were, all laughing about who they could screw today, who was getting this claim and who was getting that claim."

There were two similar cases. Everything was the same. The case manager was going to pass them both up the food chain. A finger comes over a shoulder and says, "Pass that one, deny that one." How? They're both the same. "You've put in too many claims this month." Then we find out, through the grapevine again—now this is all second- and third-hand information I'm getting here, but I do know the names of some of the people, and I will not divulge those names. I promised them I would not ever give out their names, because if I did, they'd lose their jobs. If a supervisor doesn't spend all his moneys that are awarded to that area, then he is given a bonus. Is that a business?

● (1245)

The Chair: Thank you, Mr. Maguire. I just need to make sure we have some questioning time for the other parties.

Monsieur André, go ahead, please. We'll have to probably bring it down to five minutes, Mr. André.

[*Translation*]

Mr. Guy André: You gave the Liberals nearly 10 minutes, Mr. Chair. I think we can take our time.

Ms. MacKinnon, I am delighted to meet you. I would like to congratulate you, and also Mr. Maguire, on your important military mission.

In terms of medical services, you talked about long-term care for aging veterans and what I call front-line services. Those services are provided for veterans returning from Afghanistan, in particular, who need services. There is an entire reorganization going on in terms of hospitals. The federal government has divested itself of some hospitals and long-term care. Given that seniors always prefer to stay close to their families, the department can't provide long-term care for all veterans. However, specialized services have been developed, for example to treat post-traumatic stress syndrome. It is important that these services be continued.

Ms. MacKinnon, I would first like you to tell me what specialized medical services have to be provided by Veterans Affairs Canada because they are particular cases unique to the military or they need time for rehabilitation or reintegration afterward. I would like to know which services are not offered at present and which are provided but could be delivered in health care institutions other than Veterans Affairs Canada hospitals.

Dr. Heather MacKinnon: Right.

Mr. Guy André: Did you understand my question?

[*English*]

Dr. Heather MacKinnon: *Oui*.

First of all, Veterans Affairs Canada does not treat people medically. You must look at Veterans Affairs Canada as—

[*Translation*]

Mr. Guy André: I wanted to talk about the Canadian Forces.

[*English*]

Dr. Heather MacKinnon: —an insurance company. All Veterans Affairs Canada can do for patients is to get doctors like me to treat them. We're not paid by Veterans Affairs Canada; we're paid by the provincial government to treat them. So Veterans Affairs Canada does not pay any doctors to treat any patients.

But what they can do is support me when I say a patient needs physical therapy, occupational therapy, or message therapy. Veterans Affairs will pay for so many episodes, 20 sessions a year or something like that, but that's all they do. They will pay for somebody, a nurse or a worker—usually an occupational therapist—to come out and assess a patient in the house and recommend some changes, maybe in the patient's house, to make life more comfortable. But Veterans Affairs doesn't treat them.

The real problem here is that there is really no medical interaction with Veterans Affairs Canada. They are a business; they supply business things. Think about any insurance company that you deal with. They deal the same way that an insurance does with their clients. It's run the same way.

The medical care is something that has to be not contracted outside, because you don't contract a doctor to treat patients; you find a doctor. You find a doctor through the regular provincial heath care systems to treat these patients. Some doctors are better than others at finding help for their patients.

As far as the long-term care facilities go—because I think it is just terribly serious—there is no long-term care any more for veterans. All they can do is pay for some of the support services that veterans would get in their home or something, but they don't offer long-term care facilities any more for our modern veterans.

Thank you.

● (1250)

[*Translation*]

Mr. Guy André: You said that after the age of 65, you were no longer covered by your drug plan for certain drugs. Did I understand correctly?

[*English*]

Mr. William Maguire: I don't understand the question. Say that again.

[*Translation*]

Mr. Guy André: You said that some drugs were not covered by your insurance.

[*English*]

Mr. William Maguire: Yes.

[*Translation*]

Mr. Guy André: I'm asking you the question because I don't have the answer. When you were...

[*English*]

Mr. William Maguire: Okay, I'm going to give you the answer. I, for one, need drugs, a lot of drugs—

[*Translation*]

Mr. Guy André: That's what you said.

[*English*]

Mr. William Maguire: —and sometimes the provincial health care will not cover those drugs. DVA does not cover these drugs.

[*Translation*]

Mr. Guy André: Right.

[*English*]

Mr. William Maguire: So DVA tells me to go to the doctors' offices in town to ask if they have any free samples.

[*Translation*]

Mr. Guy André: Right.

[*English*]

Mr. William Maguire: And I was lucky.

[*Translation*]

Mr. Guy André: Would those drugs be covered by your insurance if you were in the military?

[*English*]

Mr. William Maguire: Yes.

[*Translation*]

Mr. Guy André: Would it be possible for you, as is the case in the public service or in other jobs, to continue to pay into the insurance plan when you retire or as an injured veteran, to be able to get the drugs?

[*English*]

Dr. Heather MacKinnon: Do you want me to answer that?

Mr. William Maguire: Go ahead and take that.

Dr. Heather MacKinnon: Okay. If a member of the Canadian Forces retires after so many years, when he reaches a Canadian Forces pension, then his medication is covered by the same plan that you would have, the public service health care plan. However, if he doesn't reach that time, if, say, he is wounded in Afghanistan, he is only pensioned for the disability related to his wounds, he's only given medication that's paid for—

The Chair: That's the time now, Mr. André.

[*Translation*]

Mr. Guy André: It can't be continued without the insurance plan. So that needs to be fixed.

[*English*]

Mr. William Maguire: Everything that comes after that is not covered.

The Chair: Mr. Rafferty for five minutes.

Mr. John Rafferty (Thunder Bay—Rainy River, NDP): Thank you very much, and thank you both for being here today. Thank you, of course, for your service to our country.

This—

Mr. William Maguire: You don't have to thank me, sir. It was an honour.

Mr. John Rafferty: I have a question for Dr. MacKinnon, but Mr. Maguire also, if you'd like to answer...

I've been distressed about a number of things that have been said here today, but let me ask about the high-care needs. When you talk about beds being contracted, and sometimes being three, four, or many more hours away from your family, is there an answer to that? Is there a solution that you would put forward? And what would that solution be?

Mr. William Maguire: Open up more veterans hospitals.

Dr. Heather MacKinnon: Keep them as they are. The veterans hospitals are already running. What a veterans hospital is now—take Camp Hill veterans hospital in Halifax—is a building that is actually owned by the province, but VAC pays for the care of the veterans in the hospital. They also own 10 beds in another hospital in another town. They own 10 beds in another one, and this is all across Canada. Every province has a set-up where Veterans Affairs have contracted so many beds.

They get special care. They get veterans care. There are veterans wings where things are... They get the special care for the amputees, for the head traumas, for the PTSD, for the other veterans problems. They also get to be with their own people, other veterans. Socially, it's a wonderful and rewarding situation for them. This is gone.

● (1255)

Mr. John Rafferty: In rural Canada, even if those beds are contracted, they may still be some distance away from rural communities. I don't want to put words in your mouth, but would one of the solutions possibly be that the beds are contracted where they need to be contracted?

Dr. Heather MacKinnon: Absolutely.

Mr. John Rafferty: Not necessarily at veterans hospitals, but contracted close to home.

Dr. Heather MacKinnon: Close to home.

Mr. William Maguire: Correct me if I'm wrong, but do they not go on a waiting list, like Pat? Then as one comes closer to his home, they will move him to that position?

Dr. Heather MacKinnon: Well, yes.

Bill is talking about Major Paterson. He's in the regular social system in Nova Scotia right now. He's been denied by the veterans hospital because he is not a post-Korean War veteran. He does not have the right to a veterans long-term care facility. So he is now like any other person who has an illness that puts them into a long-term care facility. Usually, you see elderly people in these long-term care facilities, like our parents and so on. He is with all the rest of them, and he is on a waiting list, yes. The first place that came up was three hours away. He will stay there until they find another facility for him, but he may not get another facility near his home. He may be dead before that happens. It could take years. Actually, now that he's placed in a home, he goes back down to the bottom of the list. That's the provincial system. But since he's a veteran and he responds well to anything related to the military, even though he has dementia, we feel he deserves to be in a veterans bed somewhere in the province, preferably close to his home.

Mr. John Rafferty: When you put that argument forward, what's the reaction of VAC?

Dr. Heather MacKinnon: He's been denied. We submitted the application, his wife submitted the application, and it has been denied.

Mr. William Maguire: We've used some pretty powerful people, not to put pressure on them but to try to enlighten them about the conditions, and he was still denied.

Mr. John Rafferty: Okay. Thank you very much.

The Chair: Thank you, Mr. Rafferty.

I would just seek some unanimous consent that we'll go a few minutes over time to allow the government party to have their time.

Some hon. members: Agreed.

The Chair: I have Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you. I'll share my time with Mr. McColeman.

Thank you again to our guests for attending today.

Mr. Maguire, some of the veterans you've discussed this with... One of the themes we've had out of our study is the lump sum benefit that is paid for pain and suffering. I'm wondering what your thoughts are on that, and what are the thoughts on the lump sum payout from some of the people you have discussed this with and represent?

Mr. William Maguire: Do you want the truth or do you want a lie?

Mr. Ben Lobb: You're here, so you might as well tell us the truth.

Mr. William Maguire: Shitcan it.

Mr. Ben Lobb: Okay. What would you like to see...?

Mr. William Maguire: Pensions. Go back to pensions.

Mr. Ben Lobb: Okay.

Mr. William Maguire: That way, you're going to increase the quality of life for the veteran. He can depend on that monthly pension coming in. You give a man suffering from PTSD... Normally there's an addiction with PTSD: drugs, alcohol, gambling, sex. Some have two, some have three, some have all four.

You give a man under these conditions $150,000 or $200,000 and he's going to be a happy man for six months. Then what do you do? The onus can go on the veteran and you can say that he should have put it into a bank and made interest on it. But these guys aren't aware of what's going on. To them, it's “Holy Jeez, I've got $100,000 or $200,000 and I'm going to enjoy it.”

Mr. Ben Lobb: I'd just like to ask one more question, and then I'll turn it over to Mr. McColeman.

Are you saying you'd like to see the earnings loss benefit program in place—

● (1300)

Mr. William Maguire: For the younger—

Mr. Ben Lobb: —and run in tandem with that? Do you want to see them...?

Mr. William Maguire: Yes. Why not? You get a young man who's 40 years old who is completely disabled—

Dr. Heather MacKinnon: He's 22 years old.

Mr. William Maguire: Yes, 22 years old. He can't work. He cannot contribute to the Canada Pension Plan. Why not?

Mr. Ben Lobb: Fair enough.

Mr. Phil McColeman (Brant, CPC): Thank you. I too want to underscore just how much we appreciate your being here, and what you have done in terms of your service to our country. Over the last while, we've doubled the number of operational stress injury clinics across the country. In your view, has that money been well spent or not?

Dr. Heather MacKinnon: It's been money well spent. I live in Nova Scotia, and 80% to 90% of my patients are veterans or former military. The nearest OSI clinic is in Fredericton, New Brunswick, so in my time I have only managed to get one patient there. I have another one who came to see me, and through Veterans Affairs we have worked to get him there. He lives in Cape Breton, but we managed to get him to the OSI clinic. In my time, I've had two go up to that.

There is the OTSSC. That is the occupational stress injury clinic within the military itself, and that's where they treat military members. They're excellent centres, but they have to release them. When people are released from the forces, they leave these centres. It was hoped that the OSI clinics would fill in for that, but there just aren't enough of them.

People have to travel great distances, and I can tell you that most of my patients are so stressed at the thought of travelling to New Brunswick...I've had one cancel because he couldn't deal with the drive. It was only a five-hour drive, but he couldn't handle it. When they are there, they are there for such a short time; it's usually overnight. It's so intense that they decompensate. The doctor I was dealing with over one of my patients—we had a nice little rapport—is gone now. There's not even follow-up for them. It's a one-time event.

It's probably better if you're close.

Mr. William Maguire: I think the OSI clinics should be put in place around every major base in Canada—not on the base per se, but off the base, because a lot of these gentlemen, and the women also, cannot open up on a base level if they're still serving. Even members that are out have a very hard time going back into a military institution, going through a gate into a base area. They just lose it; “I'm not going in there, that's it.” I've had to deal with that time and time again through the OSI peer helper training program that I was on.

Dr. Heather MacKinnon: We need more OSI clinics.

Mr. William Maguire: Yes. And we need more psychologists who are trained with PTSD.

Dr. Heather MacKinnon: Psychiatrists as well.

Mr. William Maguire: Psychiatrists, psychologists—they're not out there.

I think Mr. Sweet mentioned something about a list for how we find our doctors. I asked that question thirty years ago. I asked if there was a list of doctors where I could go to say that this man needs help for this condition. I was told to tell him to go to a phone book. I said, that's some help, that is. You have a man who suffers from PTSD who is even scared to answer his phone and you tell him to go to a phone book.

Mr. Phil McColeman: Thank you, Ms. MacKinnon and Mr. Maguire.

I want to thank you again on behalf of the committee for your service, Madam MacKinnon, not only in the military for our country, but also now for your service in helping veterans who continue to help our country.

Mr. Maguire, I would like to say—and I think the rest of the members will resonate with this—that you gave us the crown of the nobility in your opening remarks. I'd suggest to you, sir, that nobility might be measured by the degree in which you're willing to sacrifice your life for your comrades, and you certainly exceed us in that regard. Thank you very much for your service, sir.

Mr. William Maguire: Thank you again, sir. It was an honour.

Some hon. members: Hear, hear!

The Chair: The meeting is adjourned.

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