HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 008 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Monday, October 17, 2011

Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1535)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon. Could I please call the committee to order?

We're doing something a little different today that is—kind of—a first of its kind. From the Canadian Geriatrics Society, we have with us Dr. Frank Molnar, who will be doing a powerpoint presentation. I know that Dr. Molnar is very aware that this presentation has to be within the parameters of the time I've set out. That is very important.

If you'll bear with us, we thought it might be set up prior to the committee, but they're still trying to work out some technical things. We will just need to have some patience.

We're very pleased that, pursuant to Standing Order 108(2), we're studying chronic diseases related to aging. The committee has acknowledged that our demographic is an aging demographic.

We are so pleased to welcome all of you to this committee today to give us some knowledge and some insight, some very important insight.

We have with us, from the Canadian Medical Association, Dr. Haggie, who is the president. Welcome, Dr. Haggie. I welcome Dr. Ricketts as well.

From the Canadian Chiropractic Association, we have Dr. Eleanor White and Dr. Tucker. Welcome.

From the Canadian Nurses Association, we have with us Ms. Barb Mildon, president-elect, and Mr. Don Wildfong, nurse adviser, policy and leadership.

Of course we have Dr. Frank Molnar here as well.

We're very pleased that you're here.

Dr. Molnar, I am going to leave you till the end to allow for everything to be set up.

We're going to begin with the Canadian Chiropractic Association and Dr. Eleanor White and Dr. John Tucker.

You have a ten-minute presentation. When I turn on the light, you'll know that you have about a minute left to wind down. Please begin.

Dr. Eleanor White (President, Canadian Chiropractic Association): Madam Chair and members of the Standing Committee on Health, Madam Clerk, and colleagues, thank you for inviting us here today to have the opportunity to be with you again.

The issue of chronic disease related to aging is both serious and growing. More than 90% of adults over the age of 65 report suffering from at least one chronic disease. Notably, most risk factors for chronic disease, and particularly those related to aging, are often preventable. The Canadian Chiropractic Association believes that preventative health care for all ages is the key to halting or attenuating the advance of chronic disease and promoting health for all Canadians.

We have two fundamental recommendations. First is to implement progressive public education programs targeting vulnerable populations. That includes promoting active self-care to encourage all Canadians and communities to take responsibility for their own health. Second is to support collaborative approaches among public health organizations, health care providers, governments, and for-profit and non-profit sectors. These measures taken together would have a profound beneficial effect on health care, and would address chronic disease and health funding issues across Canada.

The effects of unhealthy lifestyle choices are most visible in older adults. However, the development of chronic disease begins much earlier, often during youth. Accordingly, the prevention of disease and promotion of health must take a population-based approach covering the full spectrum of ages, ethnicities, and socio-economic demographic sectors. It's never too late or too early to invest in promoting healthy lifestyle choices.

Research is fundamental to addressing the issue of chronic disease related to aging. Research informs treatment and preventative measures, and guides public education initiatives. The Canadian Chiropractic Research Foundation is the chiropractic profession's primary research-funding organization. It also allocates funds and develops opportunities. In partnership with the CIHR, the CCRF has established the chiropractic research chairs and professorships in universities across Canada. Many of these positions devote time and effort to the study of chronic diseases related to aging, and the treatment of age-related conditions. Such research informs practitioners on best practices available and clinical guidelines, and in turn promotes better care for patients.

Public health workers produce a number of valuable resources to help Canadians live better and healthier lives. However, many programs are time-limited and have restricted resources that see them falter after only a few years. The use of health care providers as educators might be one way to substantially change the public health programs and augment them. For example, the CCA has developed a number of educational resources for use by Canadian chiropractors and the public to promote physical activity and prevention of injury. We've listed three. One is in the area of brain injury prevention. The CCA has partnered with ThinkFirst Canada to promote the brain day program among elementary school children in Nunavut. The brain day program educates youth about the importance of injury prevention, in the hope that these approaches will also be translated to the community at large.

Our fit-in-15 program, developed in consultation with the Public Health Agency of Canada, promotes a progressive introduction of physical activity into one's daily routine. The program is based on the concept that fitting in at least 15 minutes of physical activity a day can lead to the development of the habit to exercise and the motivation to increase daily physical activity. Adults who are physically active are shown to significantly decrease their risk of diabetes, heart disease, and some forms of cancer.

Older adults are at risk due to falls. Falling among seniors is one of the leading causes of disability and morbidity. It is estimated that senior fall-related injuries in Canada cost over $2.8 billion per year. In response to this, the CCA has developed a program that we call “Best Foot Forward”. It's a campaign targeted specifically at Canadian seniors. The campaign provides practical strategies on how to prevent falls at home, and how to promote balance and strength on a daily basis. The program has been widely disseminated, used, and shared with our partners. All of the self-help materials are available at no cost on the CCA website.

● (1540)

Our organization believes that specific targeted approaches are needed for subgroups of the population, including veterans, first nations, aboriginal populations, Royal Canadian Mounted Police, and Canadian Forces. These groups should be provided with the full continuum of care, including integrated service delivery, to better prevent occupational chronic conditions and chronic disease.

Partnership and collaboration are key to a prevention and reduction strategy. The task at hand must be embraced by primary contact health care providers, support workers, and the federal, provincial, and territorial governments, as well as non-profit and private sectors so that the promotion of a common consistent message on healthy living strategies will have a more meaningful and significant impact when embraced by all sectors.

Canadian chiropractors can help alleviate the burden of chronic disease among seniors by providing care and co-management to patients. The early detection of dysfunction and immediate treatment of common musculoskeletal complaints have been shown to decrease the probability of chronic pain. Studies have demonstrated that chiropractic care for patients presenting with low back pain decreases the utilization of diagnostic testing, reduces the rate of hospitalization and back surgeries, and lowers overall costs and prescriptions, including NSAIDs and opioids. Qualitative benefits include improved quality of care and quality of life for patients treated within an integrative model.

Many communities, particularly in remote areas across Canada, are requesting greater access to care, patient choice in service delivery, and the implementation of preventive health measures. Canadian chiropractors are part of the solution to these requests.

A progressive transition from an acute care model of health to a preventive model can help seniors maintain good health, resulting in independence and improved quality of life. CCA believes that Canadian chiropractors must play an important role in the promotion of healthy aging and the prevention of chronic disease, including musculoskeletal conditions. The inclusion of all health care providers and patients in this dialogue will deliver more innovative and sustainable solutions. Maintaining independence and quality of life for seniors in Canada is an important goal that impacts both the sustainability of the health care system and the fabric of our society.

The Canadian Chiropractic Association recommends that dealing with the present and growing challenge of chronic diseases related to aging be based on a public health, prevention, and wellness model where there are incentives for stakeholders and individuals to assume a greater degree of responsibility for health care outcomes. We believe that public education combined with strong support for multi-sectoral partnerships and interdisciplinary collaboration will yield the best results.

Thank you to the committee for the opportunity to contribute to the dialogue on chronic diseases and aging.

The Chair: Thank you so very much.

You still have three minutes. Are you doing the whole presentation, Dr. White?

Dr. Eleanor White: Those were our introductory remarks. I'll be glad to answer anything in the question period.

The Chair: Well, we'll do it in due time, when it's time. There are two of you here and you have three minutes left, so I wondered whether there were some more comments you wanted to make.

Dr. Eleanor White: I'm sure John will contribute later.

The Chair: Okay.

Now we'll go to the Canadian Medical Association.

Dr. Haggie, will you be doing the presentation? Okay, thank you. We look forward to it.

Dr. John Haggie (President, Canadian Medical Association): Thank you very much for the invitation, members of the committee.

The Canadian Medical Association wishes to commend the House of Commons Standing Committee on Health for undertaking this study of the issue of chronic diseases related to aging. It is a timely issue, since the first members of the baby boom generation turn 65 this year. It's predicted that by 2031, a quarter of Canada's population will be 65 or older.

Though chronic disease is not exclusive to seniors, its prevalence does rise with age. According to Statistics Canada, about 74% of Canadians over 65 have at least one chronic condition, such as diabetes, high blood pressure, arthritis, or depression, and nearly 25% have three or more. The proportion is higher among people 85 years and over.

What are the causes of chronic disease? There are many. Some of them are rooted in unhealthy behaviour—smoking, poor nutrition, and in particular a lack of physical activity. This latter concerns physicians particularly because of the rising obesity rate in Canada. Obesity increases one's risk of developing chronic diseases later in life.

But there's more to chronic disease than simply unhealthy behaviour. It's also affected by a person's biological and genetic makeup as well as by his or her social environment. Lower income and educational levels, poor housing, and social isolation, which is a greater problem for seniors than for other populations, are each associated with poorer health status.

Now the good news. Chronic disease is not an inevitable consequence of aging. We can delay the onset of chronic disease and perhaps even reduce the risk that it will occur at all. The conditions of patients who do have existing chronic disease can often be controlled through appropriate health care and disease management, so they can continue to lead active and independent lives. Thus, the CMA supports initiatives promoting healthy aging, which the Public Health Agency of Canada defines as the process of optimizing opportunities for physical, mental, and social health as people age.

Healthy lifestyles should be encouraged at any age. For example, the Canadian physical activity guidelines, which the CMA supports, recommend that people 65 or older accumulate at least 2.5 hours per week of aerobic activity such as walking, swimming, or cycling. Experts believe that healthy aging will compress a person's period of illness and disability into a shorter period just prior to death, enabling a longer period of healthy, independent, and fulfilling life.

For those who are already affected with chronic diseases, treatment and management is long term and can be very complex. People with diabetes, for example, need a continuous, ongoing program to monitor their blood sugar levels and maintain them at an appropriate level. People with arthritis or mobility problems may require regular physical therapy. For the patient, chronic disease means long-term management that's much more complicated than simply taking antibiotics for an infection. People with two or more chronic conditions may be consulting a different specialist for each as well as seeking support from nurse counsellors, dieticians, pharmacists, occupational therapists, social workers, or other health professionals.

Often, management requires medication. The majority of Canadians over 65 take at least one prescription drug, and nearly 15% are on five drugs or more, which increases the possibility, for example, that two of these drugs could interact negatively with each other to produce unpleasant and possibly serious side effects.

Long-term complex chronic disease care is in fact the new paradigm in our health care system. About 80% of the care now provided in the United States is for chronic diseases, and there's no reason to believe Canada is greatly different. Hence, it's worth considering what form, ideally, a comprehensive program of chronic disease management should take for patients of any age. The CMA believes it should include the four following elements.

First is access to a primary care provider who has responsibility for the overall care of the patient. For more than 30 million Canadians, that primary care provider is a family physician. Family physicians who have established long-standing professional relationships with their patients can better understand their needs and preferences. They can build a relationship of trust so that patients are comfortable in discussing frankly how they want to treat their condition—for example, whether to take medications for depression or to seek counselling with a therapist. The family physician can also serve as a coordinator of the care delivered by other providers.

● (1545)

This leads to our second recommended element, which is that of collaborative and coordinated care. The CMA believes that given the number of providers who may be involved in the care of chronic diseases, the health care system should encourage the creation of interdisciplinary teams, or at a minimum enable a high level of communication and coordination among and between individual practitioners and providers. We believe that all governments should support interdisciplinary primary care practices, such as the family health networks in Ontario, or the primary care networks in Alberta, which bring a variety of different health professionals and their expertise into one practice setting—a medical home, if you like.

Widespread use of electronic health records can facilitate information sharing and communication among providers. There should be a smooth process for referral, for example, from family physician to specialist, or from family physician to physiotherapist. The CMA is working with other medical stakeholders to create a referral process toolkit that governments, health care organizations, and practitioners can use to support the development of more effective and efficient referral systems.

The patient may also need non-medical support services to help cope with disability related to chronic disease. For example, a person with arthritis who wants to remain at home may need to have grab bars, ramps, or stairs installed there. Ideally, a coordinated system of chronic disease management would also include referral to those who could provide these services.

The third necessary element is support for informal caregivers. These people are the unsung heroes of elder care. An estimated four million Canadians are providing informal, uncompensated, unpaid care to family members or friends. About one quarter of these caregivers are themselves over 65 years of age. Their burden can be a heavy one in terms of time and expense. Stress and isolation are very common among caregivers.

The federal government has taken steps to provide much-needed support to informal caregivers. The most recent federal budget, for example, increased the amount of its caregiver tax credit. We recommend that government build on these actions to provide a solid network of support, financial and otherwise, to informal caregivers.

The fourth and final element is improving access to necessary services. Only physician and hospital services are covered through the Canada Health Act, and many other services are not. All provinces have a pharmacare program for people over 65, but coverage varies widely between provinces, and many—particularly those with lower incomes—find it difficult to pay for their necessary medication. Seniors who do not have post-retirement benefit plans—and these are the majority—also need to pay out of pocket for dental care, physiotherapy, mental health care, and other needed supports.

We recommend that all levels of government explore adjusting the basket of services provided through public funding to make sure that it reflects the needs of the growing number of Canadians burdened by chronic disease. In particular, we recommend that the federal government negotiate a cost-shared program of comprehensive prescription drug coverage with the provincial and territorial governments.

In conclusion, the CMA believes that the committee is wise to consider how we might reduce the impact, on individual patients, the health care system, and society, of chronic disease related to aging. Chronic disease management is a complex problem that warrants close attention, as it is now the dominant form of health care in Canada. We look forward to the committee's deliberations.

Thank you for this opportunity.

● (1550)

The Chair: Dr. Haggie, thank you for your very insightful comments. Indeed, your presentation reflects some of the goals and objectives that we have as a committee, so thank you very much for reiterating that.

We'll now go to the Canadian Nurses Association and Ms. Barb Mildon.

Ms. Barb Mildon (President-elect, Canadian Nurses Association): Good afternoon.

On behalf of Canada's 250,000 registered nurses, thank you for the opportunity to speak to the important issue of chronic disease related to aging. CNA will be sending you a brief on this subject containing key recommendations and supporting evidence, but today I will focus on a few main points.

Canada needs a national strategy on healthy aging that includes chronic disease prevention and management, a strategy anchored in team-based care and enhanced access to primary care and community-based supports, particularly for older Canadians, who are more susceptible to chronic diseases and their related complications.

Chronic diseases are the major cause of death in Canada, and their treatment represents a $90 billion annual cost to our economy, accounting for 67% of all direct health care costs. Given that many of these diseases can be prevented or lessened, investments in this area will save health dollars, improve quality of life, and save lives. CNA therefore urges the federal government to lead a healthy aging strategy that emphasizes chronic disease prevention and management.

A comprehensive pan-Canadian healthy aging strategy should be multi-faceted and include measures to foster health promotion and early detection of disease, keep people in their homes longer, support formal and informal caregivers, address the determinants of health, and facilitate better access to health services, including appropriate end-of-life care.

Multiple chronic diseases, not age, are the main driver of health system use by seniors. Multiple chronic conditions require expensive treatments, complex care management, and represent a considerable burden for individuals and their families. For example, health professionals regularly deal with the compounded effects of obesity, type-2 diabetes, and high blood pressure. What's especially alarming is that this is a cluster of conditions that is increasingly common among younger and younger Canadians. We need to act now to reverse this alarming trend.

An example of success can be found in the Complex Chronic Disease Clinic in Calgary, Alberta, where an interprofessional team has reduced hospital admissions through an integrated approach to care. Registered nurses, nurse practitioners, physicians, and pharmacists are collaborating to address medical, social, lifestyle, and other factors that affect health outcomes. This comprehensive chronic disease management model reduced the total number of hospital admissions by 24% and the total length of hospital stay by 51%.

Of course, the ultimate goal is to reach patients and families and give them the supports and tools they need before multiple chronic conditions develop. Health screening, early detection, and access to the right interventions early on can help patients to better manage initial risk factors and conditions, increasing their chances of preventing and reducing the severity of the occurrence.

As we age, the likelihood of developing chronic conditions increases. For too many of our seniors, however, interventions come too late. For example, when hypertension is undetected or not well managed an individual is at greater risk of establishing a stroke and/or advanced cardiac disease. When a health crisis hits, it often triggers the all-too-common chain of events involving ambulance transfer to an emergency room, hospital admission, prolonged hospital stay, and rehabilitation. This situation illustrates the serious consequences of insufficient community and home care services in Canada. All too often, home care services are time-limited and focused on post-hospital recovery versus ongoing chronic disease management. This gap in service is likely familiar to many in this room.

Thus, CNA's second recommendation is that the federal government support primary care reform with a particular focus on home- and community-based services, emphasizing interprofessional collaborative teams. There is a desperate need to bolster community-based health services such as primary care, ambulatory care, and home care to improve the health of our nation.

Far too many Canadians visit our emergency departments or are hospitalized for health conditions that could and should be managed in the community. There are excellent examples of primary care models that should be more widely implemented. These include community health centres, family health teams, and nurse-practitioner-led interprofessional clinics. These models fully harness the expertise of health professionals so that Canadians have access to the right care at the right time and in the right place, thus helping to reduce barriers to accessing needed services.

● (1555)

Primary care initiatives that ensure earlier and more consistent access to care lead to straightforward, low-cost, easier-to-manage interventions. As registered nurses, we know this territory well. A simple example is community-based or mobile foot care clinics that provide timely support for lifestyle and behaviour changes that result in early detection of serious foot diseases that may lead to the need for amputation for people with diabetes. A foot clinic may not be the most glamourous example, but it represents a tangible, community-oriented service that demonstrates the benefit of addressing minor complications early, before they snowball into personal catastrophes.

We know that prevention diverts health care costs away from far costlier acute care interventions down the road. Optimizing the health and wellness of Canadians requires that care be brought closer to home, to the very heart of our communities.

We need to think and act differently to expand the implementation of new approaches such as mobile health clinics, after-hours services, home visits, and community outreach programs that are publicly funded and not for profit.

In one such approach, teams of mobile emergency nurses responded to non-urgent calls from long-term-care homes. A recent study in Toronto demonstrated that these teams were effective and able to provide the necessary care for 78% of the residents they visited, who would have otherwise been sent to emergency rooms for treatment. The cost of these mobile visits is 21% less than the cost of having those same needs addressed in the emergency room.

Let me once again stress that now is the time for a national strategy on healthy aging. CNA's vision for this strategy is one that enhances timely access to primary care, harnesses the effectiveness of interprofessional collaborative teams, brings care closer to homes and communities, and provides the appropriate range of community-based supports necessary to adequately prevent and manage chronic disease.

Chronic disease is indeed an alarming and growing concern, in every part of our country and around the world. As discussions on the next federal, provincial, and territorial health accord ramp up, we must take the opportunity to confront this pan-Canadian epidemic in a more strategic way. Indeed, registered nurses and other health care providers play an integral role in preventing and managing chronic disease throughout the entire continuum of care. Greater benefits to the health of individuals and enhanced health system sustainability can be realized by a healthy aging strategy that emphasizes chronic disease prevention and management and is enabled by primary care reform.

Thank you, again, for the opportunity to speak with you today.

● (1600)

The Chair: Thank you very much.

My sister is a nurse, and she often sounds just like you: practical, down-to-earth, and with some very insightful ideas. Thank you so much.

Well, Dr. Molnar, we have some technical challenges here. I have seen your chronic diseases overview, and I understand everyone has a copy of it. We are looking forward to your presentation. We will follow along, then.

Thank you so much for the preparation you have put into this.

Dr. Frank Molnar (Secretary-Treasurer, Member of the Executive, Canadian Geriatrics Society): I work in health care, so I am used to technology not working.

The Chair: There you go.

Dr. Frank Molnar: Thank you for inviting me to speak on behalf of the Canadian Geriatrics Society.

When I was putting this together, I had to think long and hard about the focus I should take. I think the most important thing for the society is for us to bring forward the critical diseases that need to be included in any study of aging and any study of chronic disease.

The most important disease, from a geriatric perspective, is one that's often not considered a chronic disease. It's dementia. Dementia in many forms is considered the grandfather or the godfather of chronic disease. It's one that has the largest impact on health care and the largest impact on alternative level of care, and yet it's often marginalized. It's not found in our health care plans. I know that almost none of our regional health authorities in Ontario have included dementia care as part of their plans. It has a huge impact, but it seems to be peripheralized very often.

How common are Alzheimer's and related dementias? I would invite you to look at the *Rising Tide: The Impact of Dementia on Canadian Society* document at the Alzheimer Society of Canada website. It shows that we now have about half a million people in this country with dementia. That really underestimates the impact on Canadian society, because each of those persons with dementia has a caregiver or may have two or three caregivers, all of whom are at risk of anxiety disorders, depression, or caregiver burnout. So in fact if we look at how many people are impacted by dementia, it's probably one million to two million Canadians. The numbers are really huge, and there are about 100,000 new diagnoses every year, or one every five minutes.

It's highly prevalent. It's also very expensive. You can look at the cost breakdown. Right now it's costing us about $15 billion, and that's rising quickly. Once again, I would invite you to look at the *Rising Tide* report to see the methodology of that economic analysis, but the scale of the numbers is probably very correct.

So it's a prevalent disease, and it's an expensive disease. How does that make it any different from heart failure, from COPD, or from diabetes? There are two distinct differences with dementia. One is what we call the dementia domino effect. Many people can go along quite well managing their heart failure, their chronic lung disease, or their diabetes until they develop cognitive issues. Once dementia starts to be weaved into the mix, you start seeing loss of control of their heart failure, their COPD, or their diabetes. It spins out of control very quickly, they end up in hospital, they're stabilized, they're discharged, and they end up back in hospital. They go through a cycle with the health care professionals not really recognizing the underlying foundational problem that has caused destabilization. Many people have referred to having two or three chronic diseases at the same time. Certainly hospitals struggle with that. But once you mix dementia into the equation, hospitals really fall down and they really have great difficulty in managing dementia. That's been my clinical experience over 20 years and the clinical experience of dozens and dozens of geriatricians.

Does the data really support that? We do have a report from CIHI, the Canadian Institute for Health Information, and I've included two key pages from the CIHI report. If you want the full report, I do have some copies in French and English with me.

CIHI says that the main diagnosis driving alternate level of care, or ALC, rates in Canada is dementia. Diagnosed dementia is related to one-third, or 33%, of cases of ALC. I think that's a huge underestimate, because working in the hospital, many—if not most—cases of dementia are unrecognized. So if you really did a study and drilled down and asked how many people who are listed as requiring alternate level of care truly have dementia, I would not be surprised to see 50% or 60%. It's really the driving diagnosis for the destabilization of multiple chronic diseases and for our ALC crisis.

So any study of chronic diseases and aging that goes forward really, in our opinion, has to include dementia as a central component.

What opportunities are there? I'll throw out a few. I've talked to a few colleagues and we've discussed this at the Canadian Geriatrics Society. Certainly down the road we should look at models in other countries where they have dementia networks. We do have dementia networks in Canada; they're voluntary networks. People like me pay to be part of it. We support it with our own money. We should think about making those networks formalized and accountable to the Canadian public so they can organize dementia care and so they can link with other chronic diseases. As I said, it's that interplay between diseases.

Surprisingly, I presented to our department of endocrinology, and none of the diabetes specialists were aware that diabetes is a risk factor for dementia, and one of the first signs of dementia is inability to use your insulin. They didn't realize there was that interplay. And we've heard that before, that the specialties are not communicating, are not integrated. So any study of chronic disease really has to look at that integration of different chronic diseases.

● (1605)

As far as other things we can look at, national dementia strategies have been applied in other countries, and I'd certainly look at those models. Dementia should be included in any study that goes forward. That's message one.

I have a second message, and it has been brought forward already. We really have to take a long, hard look at community care. When you look at the cause of the hospital crises—the bed gridlock, the ALC crisis—the main cause is not what's happening in hospital. Hospitals and long-term-care institutions bear some of the responsibility, but we have a community care system that is not integrated and does not communicate. It is not strong enough to keep people out of the hospital, so it overflows into the acute care system. The acute care system, our most expensive site of care, becomes the default setting for all of these care issues, and it is not set up to deal with multiple chronic conditions or dementia. There are very few specialists in dementia working in the acute care system. If we want to fix the system and study chronic care, we have to look at how the system interacts with chronic disease.

Another issue is long-term care. There are problems in long-term care, but once again they are related to community care. Some studies out there indicate that 20% to 30% of people do not need to be in long-term care. I have some issue with the methodology of those studies. I have formal research training, and some of the methodology can be challenged. But when I talk to directors of long-term care they say that 20% to 25% of people probably don't need to be there any more. They had an illness that required prolonged recovery and they recovered and became better. They'd already sold their house and had nowhere to go, so the nursing home was their new home.

Other people enter long-term care or nursing homes because they cannot afford residences. Essentially, we're punishing low-income seniors by forcing them to go into long-term-care institutions prematurely, instead of finding alternate sites where they can live. In essence, for these people with chronic diseases who require care, we need subsidized residences rather than long-term care or nursing homes.

This does not just penalize low-income seniors; we are all paying the price. They are living in long-term-care beds or nursing home beds that are desperately required by acute care hospitals. This is one of the reasons we have a backup of patient flow going to long-term care, ALC crises, hospital bed gridlock, and emergency departments that are full. We have people in long-term care who do not need to be there. If as a society we gave them proper care, they would be in subsidized residences and we would not have to build as many nursing homes as people say we need. We need to build more, but not as many.

What can we do in the community? This is getting into your expertise, not mine. I'm a simple doctor—even worse, I'm a teaching doctor—but you guys can take it or leave it.

● (1610)

The Chair: We'll take it.

Dr. Frank Molnar: There's an army of senior volunteers out there. Do we have tax credits for volunteers? I don't know. Certainly that's something. Can you find a way to engage that army of senior volunteers to help in the health care system? You're already giving some tax credits to people who are caregiving, but we have to look at how much support we can give to caregivers. Are they still allowed to contribute to CPP while they're doing the caregiving role?

If someone has multiple chronic diseases and a family member is not taking time to care for them, they will end up in hospital. That is almost guaranteed. So as other people have said, you really have to look at caregiver support. We've talked about tax incentives, but that doesn't really help low-income seniors. Think about other incentives that could bring low-income seniors into the volunteer pool.

We've talked about mobility and falls, and those are other huge issues. We really need to look at exercise programs that prevent de-conditioning. There's a lot of literature out there on programs that prevent de-conditioning and falls. Then we have to look at incentives to bring seniors into those programs. We can't just build them; we have to entice people to come in.

The bottom line for us is that the weak link in the health care system is really community care. I agree 100% that we have to look at health promotion and prevention measures. However, we have to recognize that people eventually become ill, and then we need to have a community care system that is strong enough and integrated enough to keep them out of hospital. Right now we don't. We have a bunch of community care silos that compete for money. They do not cooperate or collaborate, and they have no accountability. There is really no connection between community care and acute care. So we have to look at the system itself. If you do research, it will have to look at the entire system design.

Thank you.

The Chair: Thank you, Dr. Molnar. We appreciate so much all your insightful comments.

We'll now go to questions and answers, and we'll have seven minutes per person.

We'll start with Madam Quach.

[*Translation*]

Ms. Anne Minh-Thu Quach (Beauharnois—Salaberry, NDP): Good afternoon. I would like to thank everyone for providing us with very relevant information. I have a number of questions. I will start with my questions for the Canadian Chiropractic Association.

You are saying that we must focus on preventive care to help people be in better shape and healthier. Do you have an estimate of how many more chiropractors would be needed to cater to the aging population and provide more appropriate care?

Can I ask all of my questions?

[*English*]

The Chair: No. Perhaps we'll take that one first.

Who would like to take that question?

Ms. Mildon.

Ms. Barb Mildon: My apologies. I am so sorry. I didn't have my interpretation working properly and didn't understand the question.

The Chair: Could you repeat the question, Ms. Quach, please?

[*Translation*]

Ms. Anne Minh-Thu Quach: My question is for the Canadian Chiropractic Association.

You were talking about preventive measures and about implementing education and care programs. Is there an estimate of how many more chiropractors should be in the system to provide more effective care to people in order to prevent chronic disease?

● (1615)

[*English*]

The Chair: Dr. White, would you like to try that?

Dr. Eleanor White: I'd like to start with an appreciation of the question. You finished your question with how could we prevent chronic disease. I'd like to first make clear that as one of the primary care practices, it would always be a collaborative approach.

We've all spoken to essentially the same topics. The common points have been collaboration; having a medical home, or a health home; integrated services and research; and primary care reform. So taking those points into account and answering your question, I would suggest that we don't perhaps need any further numbers of chiropractors to assist in the job. What we need is better access to the patients and them to us.

We also need to disseminate information in a manner that is much more imaginative. For every practitioner who is successful in his or her office, whether it is medical, psychiatric, chiropractic.... For nurse practitioners, the problem is time management. To educate patients on what they may need to know is no longer always possible to do, need to need. Often you can. Often extra time is set up. But we have to be much more imaginative in how we deliver material.

First, I would think, is that material is consistent, not only within a profession but inter- and intra-professional. Second, the use of social media, of having things on our websites, of having things on Facebook, is very appropriate.

I'd like to suggest another small program that might be of use, particularly to a federal audience. All our patients now come to us with what they have read on the Internet: I have such and such a condition. I have read this. Is it of use? I'm aging. I have a husband with such and such, or a mother. How do I deal with this? So they're researching information.

The federal health minister has brought the importance of clinical guidelines to mind, and so have the provincial premiers. Those guidelines are currently geared toward practitioners finding treatment for chronic disease as one of many things. Perhaps what the federal government could do very well is take those clinical guidelines and turn them on their sides and find an adjudicated, authorized manner of taking the successful approaches to treating a disease and make that accessible to people for self-care.

If you have diabetes and you look online to see what you can do, instead of finding some sort of approach that you wonder about in terms of validity or usefulness or safety, have an authorized report so that when you look at diabetes you would see this is what the following practitioners all do—they have been shown, through the research, to be effective to the following degree, particularly when done in conjunction with so and so's approach.

We know that all our patients are doing a lot of self-care. I think we have a role. If we all do our clinical guidelines properly, and compare them and find common points on the side instead of silos, we could serve in a capacity that way as well as our treatment and education of patients in the office.

The Chair: Thank you, Ms. Quach.

You have a minute and a half for your next question and answer.

[*Translation*]

Ms. Anne Minh-Thu Quach: My next question is also for the representatives from the Canadian Chiropractic Association.

You talked about progressive public education programs. What exactly do you mean by that? Could you give us examples to get a better idea, please?

[*English*]

Dr. Eleanor White: I mentioned three. We have more, but one program that has been very successful has been the falls prevention program. This was developed in conjunction with Canadian Public Health. This is a program on CD and on paper, which is presented by chiropractors to long-term-care facilities, to retirement facilities, or in office, and it is made available through the website to younger, more fit individuals who could take advantage of the material. Again, having that accessibility in a more modern approach is one way to attack it.

Another way is to have in-office groups and speakers. But really, this should be done on a multidisciplinary basis. That is where it is most effective. Again, chiropractors are not accessed through the community care portal, and they could be very well.

● (1620)

The Chair: Thank you, Ms. White.

Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

First of all, I want to thank all the witnesses for being here today for this very important study. One of our earlier witnesses said that the impact in Canada is $190 billion per year. The fact that we are getting this input at this time is very timely.

I would like to talk to the chiropractors, too, seeing as you are here. First, I want to congratulate you. You had a really good write-up in *Consumer Reports* recently on the profession. I have a couple of questions specifically, if you could answer. One, could you provide us with an example of how chiropractic could be involved with both the prevention and treatment of chronic disease? Also, we hear a lot about collaborative care. There are some good examples out there, and I was wondering if you could give us good examples of that and also some of the hurdles you see.

Dr. Eleanor White: If I may draw from personal practice, I will be brief with this. I will give you an example of a 65-year-old woman who came into my office about two years ago with general bone pain. She was also diabetic. She hadn't had a bone density test in almost ten years. We phoned up the physician. She had been lax with her medical care. We got her in, and sure enough we found greatly advanced osteoporosis.

That obviously affects the manner in which one is treated. We got her referred to a good exercise practitioner who could help her develop a safe program and a nutritionist who could help her with a program for bone health.

Down the road, however, she mentioned her granddaughter, who was about 15 at the time and who was having headaches at around eleven most mornings. She brought her granddaughter in, and her granddaughter was moderately obese and was a single child of a single parent. She tended to not eat her breakfast. Of course, by eleven in the morning she was hypoglycemic and would go out and have pop. She drank a lot of pop, maybe five or six cans a day, as an awful lot of kids do. Pop has phosphoric acid, which leaches calcium out of bones. Here you have a child with the red flags in her family of diabetes and osteoporosis. You have a diet low in dairy, high in phosphoric acid, along with lack of activity in the young girl, and she is pre-diabetic and will probably be a candidate for osteoporosis down the road, if not other conditions.

That is a good example of how primary care practitioners—and in particular, chiropractors for musculoskeletal things—will take a look and ask where they can collaborate with other professions and how they can get this person well looked after.

Good access to laboratory and imaging material is essential to all primary care practitioners. That is one hurdle we have. It varies from province to province. These situations allow for education of a patient as well as early intervention and prevention. It allows us to increase activity. It allows for consultation with other practitioners. Again, the message has to be ubiquitous and universal. All practitioners need to be speaking the same way.

You mentioned barriers. Barriers for us are often differences between provincial jurisdictions. Having now worked federally, I see how different it is from province to province for not only coverage of care, but also the access to lab and imaging materials. An easy consultation and referral base with medics in the community is on the whole so much better than it used to be, but still there are some barriers. We've implemented a huge amount of effort into research in the last ten years, and that is helping greatly. But we need more, and we need more interdisciplinary research. Those would be some of the highlights.

Mr. Colin Carrie: Would you be able to provide another example of the prevention and treatment of chronic disease? I know that in my practice, I had a lot of arthritic....

Dr. Eleanor White: We have a lot of arthritic patients. I asked my husband, who was a chiropractor before he developed early dementia, if he had noticed that our practice was getting older, and he said "Have you noticed that we are?" We tend to see people our own age and a few family members.

Arthritic conditions, mobility, and capacity-affecting conditions are the most common things we see, and I think it's the best thing we offer.

Structure and function are interlinked always. If people are not able to move well, they don't sleep well. They don't eat well. They become socially isolated, and they may become depressed. The body-mind connection cannot be overstated. Eventually, you end up with chronic illness.

I work as a CPP medical member. I do hearings once a month. I'm about to go into them in the next three days. We see so many fibromyalgia people who are unable to find answers psychologically or from the rheumatologist. The only thing we can offer to date is some management. Early prevention includes what we can offer physically and the use of and referral to all those specialists to prevent some of the early psychological components of fibromyalgia.

You also mentioned examples of good collaborative centres. The one most commonly known is the family health unit at St. Mike's, which has a chiropractic physiotherapy clinic that's working very successfully. There are models in Calgary. There are excellent models in northern Europe, where chiropractors attend university with the medics and split off in fourth year. They're in the hospitals. They're in the state-run clinics. There is just no barrier. We've a lot of lessons to learn from across the water.

● (1625)

Mr. Colin Carrie: Okay, thank you.

One of the things we see is more remote communities and the challenges they have with services. I notice now that a lot more people are having nurse practitioners and nurses as their primary health practitioners. I am wondering what nurses do to ensure that appropriate services are available for seniors with chronic diseases in small or remote communities in Canada. What are your challenges?

Ms. Barb Mildon: Thank you for the question.

You are certainly right that the number of nurse practitioners is growing across our country, and they are providing primary care services, particularly in remote and rural communities. I would say that the most important thing they do is provide comprehensive assessments and health care plans for individuals.

Where the services are constrained by the lack of other professionals, perhaps, nurse practitioners can draw on other services, such as nurses themselves. Registered nurses can provide an array of services. Generally, in a small clinic, an array of services are available. I would say that there is a considerable amount of ingenuity in our smaller communities. Also, in this era of telehealth, that is probably the greatest use of the ability to reach out to our interprofessional colleagues with the kind of care and guidance that's needed. Telehealth is exploding across the country, and nurse practitioners are certainly the ones on the leading edge.

The Chair: Thank you so much.

We'll now go to Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Madam Chair.

I want to congratulate all of you for the very comprehensive presentations you made.

I think what's important to me is that you didn't talk only about physical health. You brought in mental health, and of course you also brought in the social aspects of chronic diseases and aging, and I think that's really important.

What I hear you all talking about is having a strategy and looking not simply at one disease state but at the whole problem.

Dr. Molnar, you really struck a chord when you talked about the fact that we're backing up beds, not only because we require home care but because people are poor. They're living in residential care facilities because they can't afford to live anywhere else.

I would like to know if you see a strategy, because this is going to be the biggest challenge for us in providing care down the road. It's already starting. Apart from using, as Ms. Mildon said, the integrated, comprehensive primary care model, with all kinds of people working together within the scope of their practice to provide care, how do you see that linking with home care, with community care, and with social services, for instance, so that you can have this broad strategy you're talking about? What form do you see that strategy taking? Do you see that as something we should be looking at in a 2014 accord?

● (1630)

Dr. Frank Molnar: Those are enormous questions, the kinds of questions the president of the CMA should be answering, as he's much more experienced than I am. I can only speak to a portion of that, and you might want to pass the question to John, if that's okay.

Several links are not occurring. Speaking for the specialists, the specialists are not responsive to the family physician. So if family physicians or CCAC case nurses have an issue that needs to be dealt with quickly at the specialist level they cannot get in, they cannot get help. The word I kept writing down as I heard it at the different talks is "accountability": there's no accountability or responsibility on the part of many of the sub-specialties.

We keep waiting lists, we make sure patients flow through, but we have no responsibility to see that particular patient at that particular time. There's a real disconnect between outpatient clinics and in-hospital clinics. There needs to be some way to join these specialists who are in hospital with the specialists who are out of hospital and make sure they are readily accountable to family physicians, CCAC, community care access centres, and that they have rapid access to those areas of expertise.

That's my little piece of the puzzle, but I have to defer on the rest of your question to people who know more about the greater system.

Dr. John Haggie: I'll try to take a bite of that one, because I don't think there's a magic bullet there either. But I think if you look at the elderly poor, which was where I took your question started from, they start poor younger. The causes of poverty are interlinked with growing up in poverty and poor education.

I come from a province where there are areas where 40% of children will graduate from high school. Now, in an age of service base and information, knowledge translation, and all those good things, someone who hasn't completed grade 12 is condemned almost from the get-go. There are better experts out there than I am on how you deal with poverty. Poverty and education and the social determinants of health underpin health. There's a crystal-clear link between poverty and poor health, between low education, low housing standards, and poor health. You can't argue those figures. How you choose to deal with that is outside the realm of physical medicine. But if you do not address it, then it could be argued you're tinkering around the edges of the problem.

Ms. Barb Mildon: If I may just add, what a pleasure it is to hear my colleagues' responses.

One example I would add is we've done it quite well with our community health centres, where it is a fully integrated interprofessional approach, including social workers, who bring their unique expertise to the problems Dr. Haggie has just outlined so well. I believe we need to look more broadly at the fee-for-service model and where it causes barriers, and where a salaried model opens up access and provides some more comprehensive service.

The Chair: You have about four more minutes.

Dr. Molnar is first and then Dr. Haggie.

Dr. Frank Molnar: I would be very careful about a full-salaried model. I know our geriatrics groups have been on full salary for dozens of years, and what you see over time is a loss of incentives to do more clinical work. What the Province of Ontario is now looking at is a blended model where you have a base salary so people are attracted to the field, but then you have to do fee for service to move yourself up. So full salary I think has real drawbacks. Fee for service has perhaps even bigger drawbacks. So a blended model would be preferable.

Dr. John Haggie: I just spent two days in Fraser Valley Health Authority at a meeting on medical makeover. The whole issue of payments boils down to two things: what you want to pay for and how you want to get it. The second thing is there is no perfect system. What you have to do is pick the system that gives you the problems you can live with, not the ones you can't live with. Because there isn't going to be a perfect system, and there isn't the Harry Potter spell that's going to make it all work. You have to pick so that you mix and match, so the deficiencies of one system are covered by the advantages of another. To try to legislate one size fits all, it ain't going to work in Nain or Hopedale or Moose Factory. It might work in downtown Toronto and vice versa. So I think you're going to have to look at geography as well.

First, you have to decide what kinds of services you want and then the best payment model to deliver those, and what can you live with as a problem from it.

● (1635)

The Chair: I'm concerned about that Harry Potter aspect. I'm glad you chaired it.

Your time is pretty well up, but you go right ahead. We'll give you a little more time.

Hon. Hedy Fry: I don't really want to take up somebody else's time, but I want to have one quick follow-up on what you were saying.

I think you talked a bit about accountability. How do you see that being built into such an integrated system? It would seem to me that accountability from the part of the caregiver, or even from the part of the public administrator, which is government, is to look at outcomes. Should accountability not be based on outcomes?

If you talk about, as Ms. Mildon talked about, decreasing hospital admissions by 25%—I don't know if it was you who talked about it—and then the length of stays and bringing them down by 51%, that is a clear accountability measure, isn't it?

The Chair: Very briefly, Dr. Haggie.

Dr. John Haggie: It is. In one sentence, I think the system has to be responsible and accountable to the person who funds it, which is the Canadian patient, the Canadian taxpayer, and there are various ways you could do that. But yes, I agree.

The Chair: Mrs. Block.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair.

Thank you, to all of you, for being here today.

My questions are going to be for Dr. Molnar.

I used to sit on a health board—the largest health region in Saskatchewan. I haven't been there for about three years, but I know that the lion's share of a provincial budget typically is going to health and that the lion's share of the health budget is typically going to acute care.

Back in the day, I recall we had something called a “one-way valve”. We moved into the health district model and then the region. We could take acute care dollars and put them into community services, but we couldn't take from community and put into acute care, and that's probably for obvious reasons.

I want to ask you about the slide in your presentation under “Community Care: The real cause of Hospital ALC crisis and Bed Gridlock”. We've talked about primary care models, encouraging collaborative effort on the part of health care providers. In the last point, it says that hospitals are the most expensive site of care and they've become the default care system. You say that this needs to change. What would you do to change that reality? What has to happen?

Dr. Frank Molnar: Number one, we have to strengthen community care.

My area of expertise is in the realm of dementia. Many people with dementia get sick with minor illnesses—a bladder infection—that just brew and stew until they explode into a septic episode where they end up in hospital for a long stay, for months and months.

What you really need is a community care system that allows people—CCAC nurses, home care workers—to identify symptoms early, allows the patient to get to the family doctor quickly, or that has home visits.

Toronto has been experimenting with home visits. There are many seniors who cannot get to the out-patient clinics; they can get to the emergency department by an ambulance, and that's it. We need a system that gets them to family doctors, or that gets family doctors or nurse practitioners to them very quickly, that deals with the acute problems quickly, and that has immediate access to specialists in areas where they don't feel they can manage. Those specialists should have some ties to the hospital, and they should have the ability to have some elective admissions—this is language we don't like to use in acute care—maybe a one-week admission, to pre-empt or prevent a three-month admission.

We really need to look at systems in other countries, to see how we can get to patients quicker, how we can get help to them quicker, how we get to the specialists, and how we can do controlled, short admissions rather than long ones. That's what I see is missing in the system right now.

Mrs. Kelly Block: Again, we've talked about primary care models, health care providers working together at the local level. What are the different associations you represent doing at a provincial or national level to address the need to change that focus and address community care?

Dr. Frank Molnar: Is that a question for me, or for someone else?

Mrs. Kelly Block: Anybody could answer it.

The Chair: Who would like to answer it?

Dr. Haggie.

Dr. John Haggie: I'll have a crack at that.

My own jurisdiction is Newfoundland. Telehealth, which Bob mentioned, is being pioneered by a unit in Labrador, where they've had challenges delivering health care to rural communities. It has made a big difference. Again, it's a question of multiple strands to answer the problem.

On the concept of looking at funding models, in Alberta, for example, there is a system whereby funding can be attracted for the primary care networks. It goes to non-medical services for groups that agree to provide comprehensive care. That money allows them to provide walk-in clinics, on-site foot care clinics, diabetic counselling, nutritional counselling, and those kinds of things. Groups of doctors amalgamate under this umbrella of a primary care network.

To step back and ask what could be done at the federal level, I would take you back to the two issues of best practice and innovation. There is no comprehensive system for identifying loci of best practices. There are good things in Labrador, there are great things in Saskatchewan, and there's the urology practice in Saskatoon. There are wonderful things in Alberta and perhaps in Ontario, but that information doesn't get shared. There's no centre for best practice. The health council may have thought at one time that would be part of its mandate, and it kind of never went that way.

The other thing is innovation. How do you plant the seed and fund models that are trying something out? If you don't allow new ideas to bubble up and succeed or fail without prejudice, you'll never get any further than you are at the moment. The Canadian Medical Association would like to see the feds look at a centre for innovation. There has been some talk of that and some money suggested in that direction. We say that's a good start, and let's have some more.

So if you want to try to build a firmer foundation you need to have mechanisms to identify and promulgate best practices—areas where there's funding for innovative approaches along team lines, and that kind of thing. In actual fact, that was one of the things that fell out of the 2004 accord right back at the beginning. There was some money set aside for primary care reform, and that kick-started some team approaches in our province for the money that was produced there. So I'd offer that as a possible way ahead.

● (1640)

The Chair: Do you have a brief comment, Ms. White? Go ahead.

Dr. Eleanor White: From a slightly different perspective, where fee for service is an issue with your question, in Ontario there is no provision for lower-income people to access chiropractic care and have it funded, since funding was withdrawn in 1994. That makes it difficult when you're looking after a population stuck at home, perhaps in poverty.

There are experimental clinics in many loci, as Dr. Haggie mentioned, where we're doing a salary-based approach that is covered by local associations, and you have a multi-disciplinary approach. That has had terrific reviews from the seniors and chronic-care patients. We're in the midst of work on a project in Nunavut as well—a multi-disciplinary project for that community. But again, the projects are not interconnected, they have not yet become the norm, and fees are a problem.

The Chair: Thank you very much.

Ms. Mildon.

Ms. Barb Mildon: Thank you very much. I will be brief.

There are just three things I want to mention. First of all, we are certainly partnering with our other associations, and are very pleased with our recent collaboration with the CMA on transforming the health care system. There are documents out on that. Of course, everywhere CNA goes we advocate for an integrated home care and community-based system.

Another example that has recently been given is the PATH program. It stands for "partners advancing transitions in health care", under the auspices of the Change Foundation. It is focusing on engaging and supporting a community coalition of providers, patients, and caregivers to redesign problematic care transitions—in other words, those where complexity is causing the ALC length of stay.

The Chair: Thank you very much. I'm glad you caught that and gave us that insightful information.

We'll now go to the second round, with five minutes for questions and answers, and we'll begin with Dr. Morin.

● (1645)

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much.

I would also like to talk to you as a health professional. We all agree that bad lifestyle choices contribute to a rise in chronic problems for seniors and adults alike. As health professionals, we tell our patients to eat healthier. Yet they continue to eat food that is bad for their health. We tell them to exercise and they do little or none. The same goes for smoking, for cigarettes; they continue to smoke for pleasure or for other reasons. At the end of the day, even though we have the best of intentions as health professionals, our recommendations and advice are not followed. In short, prevention is no easy task.

I would like to open this discussion and ask the representatives from all the associations, including the Canadian Geriatrics Society, what we can do. In addition to our good intentions, what can we do to really change the habits of our patients?

[*English*]

The Chair: Who would like to take that one?

Ms. Mildon.

Ms. Barb Mildon: Thank you very much for the question. I am so sorry that I can't respond in French.

Mr. Dany Morin: Oh, no; it's okay. Please do it in English.

Ms. Barb Mildon: The most important thing is early diagnosis and treatment, first of all. It is having those screening programs in place where we pick up these diseases that are lifestyle-caused, or certainly exacerbated, and begin to recognize them.

Second, I would say that we need programs from the ground up. Our public health nurses in schools, for example, have been pulled back in many communities across Canada. We no longer have the robust program of school health that we may have had once, yet we must begin in infancy. We must begin with young children to teach them lifestyle ways.

Those are the two areas, and then, of course, there are the treatments throughout the life cycle upon which we need to focus.

Dr. John Haggie: Just to take up Barb's point a little bit, I would go back to the issue of education. Somebody once said "You give me the child, and I'll give you the man". Essentially, if you go back to school and can become a health-literate graduate of high school, by which I mean someone who understands enough to navigate the information that's out there, you've probably done as much as you can.

The background to healthy eating is sometimes actually economic. I've worked in areas where it is cheaper to buy two bags of chips and a can of Coke than it is to buy a glass of milk and an apple. When you are on a very limited income—and I come from a province whose average income is lower than the Canadian average, and the population I refer to has a lower average income than that even—that makes a huge difference. You go with what will fill your belly on that day, not necessarily what's going to be good for you over the long term. A hungry kid at school is not going to learn, either, so a school breakfast program might be something you would want to think about.

I'm talking outside my field of expertise. I'm a general surgeon. I'm a disease expert, and I've gone right back to now talking about education and clean water and those kinds of things. That's just my two cents' worth, but I'm off my home patch.

Maura, on the other hand, is right on her home patch.

The Chair: Ms. White, you had your hand up.

Dr. Eleanor White: I don't think I should be the poster child for problems with healthy living. That is a lifelong problem.

People tend to go toward pleasure and away from pain. That is pretty universal behaviour. So until the message either gets through well enough or people have a scare, they tend not to respond as well unless they are trained at an early level.

Perhaps we could look at two models. One is the anti-smoking program, which is finally showing good outcomes in youth, as there's a dropping rate of smoking now. And the other is the dental models. Again, that's based toward pleasure. People want to look good. In the chiropractic world we often say that if people's spines were in the front they'd pay more attention to them. As it is, they don't see them unless they are painful.

Perhaps looking at other successful models might be an approach. The thrust of our practice is always about capacity and how one functions, and people tend to only pay attention when they're in pain.

The Chair: Dr. Ricketts, I believe you had your hand up.

Dr. Maura Ricketts (Director, Office of Public Health, Canadian Medical Association): Yes, thank you for that question.

This is an area where it is appropriate to recognize that you have to understand how complicated it is to change people's behaviour. You can be neither naive nor excessively sophisticated. It is extraordinarily difficult to change behaviour.

The tobacco example is an outstanding one because the first evidence about the risk of tobacco began appearing in the literature around 1955. Yet it has come to now before we actually have the rates of tobacco consumption down to 15%. But we are still going to see lung cancer surpass breast cancer as a cause of cancer deaths for women, because the smoking rates spiked some 10 or 15 years ago.

These are disasters, and when they are that complicated you have to recognize that your whole society has to unify itself in its message to try to end up with change, because it isn't solely the human behaviour that's involved. Our environments facilitate us doing these things.

● (1650)

The Chair: Thank you, Dr. Ricketts.

We'll now go to Mr. Gill.

Mr. Parm Gill (Brampton—Springdale, CPC): Thank you, Madam Chair.

I want to thank all the witnesses for coming and providing us with very valuable information.

My question is for Mr. Molnar. A number of recent studies have suggested that being bilingual can actually ward off dementia. How credible do you think these studies are?

Dr. Frank Molnar: I think there is some partial credibility. There's probably an education effect. Many people who are bilingual may have a different educational level.

But there is also a possible cognitive stimulation level. As people switch back and forth between languages, they're cognitively stimulating themselves and using different parts of the brain and using the parts of the brain that are required to change association. So I think there is some validity to them.

Certainly, being a Canadian, I think it's a good idea to be bilingual, and I recommend it as a health care measure.

Mr. Parm Gill: I have another question. Is there one particular province you feel is doing more than others for older people who may suffer from chronic disease?

Dr. Frank Molnar: I can't point out one province. I don't know if anyone else on the panel can.

Mr. Parm Gill: Is there a role model or maybe a—

Dr. Frank Molnar: No, we're the creatures of our environment. I'm an Ontario doctor, so all I know are the pros and cons of my system. Health care being a provincial mandate, I know my provincial environment.

I don't know if anyone else has anything else to add.

Dr. John Haggie: I can only echo that. I think it's very much a patchwork. There are hot spots where there are local centres that have focused on dementia care, but they are little oases in a desert otherwise.

Mr. Parm Gill: To the Canadian Chiropractic Association, how beneficial is chiropractic treatment for seniors with chronic disease?

The Chair: I believe, Dr. Wildfong, you want to make a comment. And then who would like to take Mr. Gill's question following that? Okay, Ms. White.

First, we'll hear from Dr. Wildfong.

Mr. Don Wildfong (Nurse Advisor, Policy and Leadership, Canadian Nurses Association): I would just point out that I'm not a doctor, just to clarify that.

The Chair: Okay, Mr. Wildfong.

Mr. Don Wildfong: Thank you.

With respect to the healthy aging policies or provincial and territorial treatments of older adults, I think indeed there is variation across the country. And I think we'd do ourselves a great service to look at comparative analyses at an international level as well.

We know, for instance, that in places like Copenhagen—unlike in Canada, where we have public health nurses make home visits for the healthy babies and healthy children program, which is wildly successful—they have public health nurses visit people over the age of 70 in their homes to assess their needs, to help them with health system utilization and navigation, health information, and health-seeking behaviour. I think the international comparison is warranted.

The Chair: Who would like to take Mr. Gill's question?

Dr. Eleanor White: I think he addressed it to the Canadian Chiropractic Association.

Lower back pain is incredibly prevalent in our society and generally starts in middle age, often occupationally, and can continue in a chronic manner. Geriatric lower back pain, or back problems, can have many different types of etiology.

As for effectiveness with respect to treatment from chiropractic spinal manipulative therapy, the way one treats different conditions varies depending upon the general health of the individual. I'd say that the longer the condition is in existence in the individual, the more the treatment becomes one of management, as opposed to curative.

Very often in a senior, if you can extend the independence of an individual or their ability to enjoy their life—and at a younger age to continue with their work—that's success. And chiropractic has an excellent record with back pain and back function.

● (1655)

Mr. Parm Gill: What proportion of the patients would you say are seniors?

Dr. Eleanor White: In a typical practice? Is that what you're referring to?

Mr. Parm Gill: Yes.

Dr. Eleanor White: Again, I'll go back to my comment about the age of the practitioner. In my practice, I would say that over 50% of my patients are over 40. With a young grad, they may see more younger families.

The Chair: Thank you so much, Ms. White.

Thank you, Mr. Gill.

Five-minute rounds come very short, don't they?

We'll now go to Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): I would like to thank all our guests for coming here to refresh our memories and to make things clearer at times. I have two questions.

Just now, we were talking only about patients. My question is for Dr. Haggie and it is about the medical staff.

An aging population also affects the medical profession. Has your organization looked into what the medical workforce will be like in 2036? Over the next few years, should we change the number of training positions in universities and hospitals for health professionals? Do you think we should change recruitment policies for foreign-trained health professionals?

[*English*]

Dr. John Haggie: In my province, 35% of the practitioners currently in practice are within five years of retirement, if you take 65 as a retirement date. However, what is happening is that a significant number of those practitioners are not retiring in the way the generation before them did. They are altering the way they work. They still have a lot to contribute. They have skills that they want to pass on. So they move away from the more acute, physically demanding areas of their specialties into something a little less exciting, from a physical point of view. That's one factor.

The aim of this country should be that it should be self-sufficient in terms of physicians. That then leads to the question of what that means.

We have had a huge increase in the number of medical students in this country. There are still more Canadians studying medicine abroad than there are studying medicine in Canada. That then raises all sorts of issues about repatriation.

There have been a variety of arguments, both legal and otherwise, that say these people who have been trained abroad and who have taken the Canadian exam should be entered into the residency program, for example, at the same rate. That's resolved itself at the moment.

The issue in terms of residency posts is that there are an inadequate number. We probably need 1.2 residency posts for every Canadian graduate, but if you have 3,500 Canadians who have graduated elsewhere, those numbers don't match.

The other problem is that we really don't know what residency spots are entirely appropriate. How many family physicians as a percentage of the global output of medical schools, residency programs, do we actually need, or will we need? If chronic disease is going to be the new paradigm, and it is, do we need to focus more on those specialties and disciplines and residency programs that actually produce that kind of graduate, rather than the acute specialty programs such as general surgery?

In my case, for example, we don't have the data on that. That's come to light lately because residents have done training and then found difficulty getting employed.

That's the background. Then there is question about how you deal with those doctors who have trained overseas and may not actually be Canadians and want to emigrate. I know for a fact that FMRAC, the Federation of Medical Regulatory Authorities of Canada, is actually looking at a streamlined, common licensing process for physicians, whether they trained in this country or they trained abroad.

That might answer some of those issues. Then you've got capacity issues in terms of whether they're coming in for residency spots, again because that's going to be it. Again, it's not a simple answer, unfortunately. It illustrates the complexity of what is an adaptive complex system.

● (1700)

[*Translation*]

Mrs. Djaouida Sellah: My second question is for Mr. Molnar.

The committee has also learned that, if 14% of the population today is 65 and over, in 2036 it will be 25%; that's 10 million people. Right now, what percentage of health care services goes to people age 65 and over? And how does your organization adapt to these changing demographics?

[*English*]

Dr. Frank Molnar: Once again, my CMA president is going to have more data than I will. Acute care is where I live. In acute care, seniors are the main clientele despite the fact that the posters describing our hospital don't have any seniors on them. The Canadian Geriatric Society is a very small society. We have probably 200 geriatricians in this country. We should probably have 500 to 600 geriatricians. We don't have enough physicians trained in care of the elderly—those are family physicians who have an extra year of training.

Overall, if you look at geriatric medicine care of the elderly, the numbers of physicians who have the expertise in dealing with the multiple chronic diseases, who have cross-trained in multiple areas and can deal with cognition, are probably somewhere between 40% and 45% of what we really need. So we're far behind. The earning potential for those groups is lower than their peers', so it's not a competitive speciality. So we're not really getting a lot of residents into these areas. We're falling further and further behind. I would echo the comments that were made before. There's a real mismatch between the training positions that are being offered and what our society needs. The data is not there, but there is a huge mismatch. In geriatric medicine care of the elderly, that gap is growing.

I'm sure Dr. Haggie could talk to the numbers.

The Chair: Thank you, Dr. Molnar.

Did you want to make a comment on that, Dr. Haggie?

Dr. John Haggie: No. I think I would really just echo what has been said. I don't know that there's an awful lot more I can add, quite frankly.

The Chair: Thank you.

Now we'll go to Mr. Brown, please.

Mr. Patrick Brown (Barrie, CPC): Thank you, Madame Chair.

This committee has done a lot of work on neurological disorders over the last few years, and I took an interest in Mr. Molnar's comments about dementia. A common thread has been on tax credits for caregivers. I wanted to tuck into some other areas related to dementia, ways that might alleviate some of the challenges that society and individuals inflicted with this disease live. I wanted to know what your thoughts were on the New Horizons program.

In the community I come from, Barrie, Ontario, one program that I thought was helpful was art for the aging. They had programs like that in seniors homes that would stimulate mental activity for those who were, unfortunately, going through dementia. There were also programs that engaged them in physical activity. I know we don't know a lot about dementia, but I understand that one thing we do know is that a way to delay onset is to increase the level of activity. The New Horizons program has a budget, I think, of $28 million for programs like that in seniors homes. Is this the type of thing you think is a wise investment?

Dr. Frank Molnar: I think the investment in terms of cognitive stimulation, exercise, etc., is useful all the way through one's lifespan. One, there's a lot of evidence now showing that all the stuff we've been talking about—exercise, nutrition—actually prevents dementia. Two, once you have dementia, to be given cognitive stimulation will certainly slow down the dementia. In my clinical practice, we see a lot of people with dementia who are living alone, becoming withdrawn, becoming socially isolated, and we see their dementias accelerate. As soon as they move into a residence that has some cognitive-stimulating program, their cognitive scores and their function actually improve to a degree we don't see with medications. So the cognitive stimulation can actually outperform the medications in many instances.

So absolutely, it's a worthwhile investment.

● (1705)

Mr. Patrick Brown: Okay. You said these can potentially prevent dementia. That's obviously an exciting concept. Do you know what types of techniques are being used in other countries, which Canada should look at? Are there any examples or models where there are more robust programs that would enable preventing this disease or delaying onset?

Dr. Frank Molnar: Like all physicians, I have a whole pile of articles that are sitting in my office. I actually have a whole box of articles on different systems, different approaches to dementia, different systems around the world. So I do have a collection. I haven't gone through them, so I don't know that—

Mr. Patrick Brown: I think members of the committee would be very interested in stuff like that, and if you could send them to the clerk, I'm sure she could distribute them—

Dr. Frank Molnar: Absolutely.

Mr. Patrick Brown: —because I think one of the hopes we have is to have a study on neurological disorders, and stuff like that would be really interesting.

Dr. Frank Molnar: I will be very happy to share it. You have my card, and the box is ready to ship tomorrow. It will be one less thing in my office.

Mr. Patrick Brown: You want to read it too, Colin. I know you do.

The other question I want to ask is—

The Chair: Can I keep in mind that those articles have to be translated? So if you have the time, Doctor—and I'm sure you have lots of time—it would be great if you could pick through them and choose the ones that are your personal favourites and send them and then we'll get them translated so we'll have an overview. Thanks.

Mr. Patrick Brown: One of the things that *Rising Tide* and a lot of the neurological subgroups talked about was the need for a neurological population study. I know this is ongoing. I think we're two years into it, or two and a half years. What do you hope this $15 million study is going to indicate to Canadians and to Parliament? I know this is something that was urged, that was necessary for Health Canada to support. Do you have any thoughts on what we're going to learn from this in terms of dementia?

Dr. Frank Molnar: Is it the CLSA, Canadian Longitudinal Study of Aging, you're referring to?

Mr. Patrick Brown: No, it's the National Population Health Study of Neurological Conditions, which is being done by the neurological charities, I think.

Dr. Frank Molnar: Yes. I'm a bit of a pessimist and skeptic at heart. I think what we're going to find is all the old boring stuff—people who exercise well, who eat well, who follow their health conditions well, who avoid head injuries, have delayed onset of many of these conditions. So I don't think we're going to find any fantastic breakthroughs. We're probably going to see that a lot of people don't have assessment of their cognitive disorders until a much later stage than we expected, so that screening programs are necessary.

So I think it will reinforce a lot of the old information we already know. I'm not anticipating a major breakthrough.

The Chair: Thank you.

Thank you, Mr. Brown.

Ms. Quach.

[*Translation*]

Ms. Anne Minh-Thu Quach: You all touched on integrated care as being the approach the government should take to make primary care more accessible to patients and to prevent chronic diseases. Could you tell me whether you have suggestions for the steps that should be taken first as part of a strategy that promotes prevention and integrated care so that they both become more accessible and universal?

The people from the Canadian Medical Association talked about the public health care system. They also mentioned the importance of following the principles in the Canada Health Act, including the need to improve some services that are not covered under medicare.

So there are a number of parts to the question. First, where should we start in terms of developing a strategy for integrated care? Second, as part of that, how can we continue to rely on the public system for prevention?

● (1710)

[*English*]

Dr. John Haggie: That sounds like one for me.

The Canadian Medical Association went out over the last year and spoke to Canadians about what they wanted from their health care system. We spoke to about 2,400 people face-to-face, and we had another 4,000 comments online. We produced a variety of documents as a result of that, and the last one was *Voices into Action*, which was a kind of narrative of what we'd heard.

The message was very clear from Canadians. They want a system that was free of gaps, free of silos. They don't want this crazy situation, which evolved from the forties and fifties, where we were an acute-based system. We dealt with acute illnesses, and health care was delivered by physicians by and large in institutions. That's how medicare was set up, and that's how it's funded. That's the Canada Health Act.

They suggested this needed to be looked at from several points of view. We distilled down the principles from this, with support from the Canadian Nurses Association and a whole variety of other groups. I think there were 60 other stakeholder groups that signed on with us.

Essentially, they looked at it from the point of view of better value for money, better health care, and a better patient experience. If you actually sit down and say, well, if you've got a chronic illness, what is the system going to look like if you need it, there are lots of good examples scattered around Canada and North America and the globe. The catch is getting that information and measuring it in terms of outcomes.

At the end of the day, it's the outcomes that matter. The difficulty is that we've got a huge outcome gap. We are fifth in spending among OECD countries in terms of percentage of GDP, and if you look at outcomes as they define them, we're 27th or 28th. We've got this huge gap. The question may not be so much about how much we spend as much as how we spend it.

In answer to your question, again, there's no simple answer. But if you start to look at the system from the point of view of a person with chronic disease, it won't take long to find a way of describing a system that doesn't mean 30% of your old people never get to see the doctor because they can't get out of the house—they don't drive, there's no one to get them there—and they wait until they fall over and have to call an ambulance.

You can describe a system because of its faults. What you need to do is say, well, what would happen if there were no faults here? How would you recognize it? That's a very difficult thing to do at a table like this, but if you go to the 85-year-old who can only afford to take her diabetic pills every second day, you can start to see where the holes are, and the holes are sometimes individuals.

The Chair: Mr. Wildfong, I think you wanted to make a comment too.

Mr. Don Wildfong: As a brief comment in support of what Dr. Haggie has just mentioned, we know that the electronic health record is a great answer to some of the many challenges we're facing, both in terms of creating a safer experience for patients and for their experience at each interface across the system. I'm sure we've all heard a lot about this. That's one way that speaks to the integration of information and technology.

I would also say that the past accord has put an emphasis on five wait times—surgical and diagnostic wait times—and we would suggest that those have probably missed the mark and not really addressed the real causes of waiting, the human costs of waiting, which Canadians and their families are dealing with every day.

The Chair: Thank you.

We'll now go to Mr. Williamson.

Mr. John Williamson (New Brunswick Southwest, CPC): Thank you, Madam Chair.

I'm going to follow up a bit, because I'm hearing all kinds of interesting ideas today. Particularly what jumped out is that there's no perfect system. They all have different answers. They all have different problems or challenges.

What I'm trying to sort out is what the paths are for this committee to look at or consider going forward. Collectively you've all touched on different areas that speak to your field, but then you jumped out to talk about education, a lunch program, an arts program for seniors, for example.

At the end of the day, where is the conflict here? You've got 13 jurisdictions delivering health care across the country, all with different challenges from those of the federal government. What's our responsibility, do you think, in terms of setting priorities that lock provinces into areas they might not want to be in, particularly with the comments that the last accord might have missed on a few markers?

If there's no perfect solution, is our approach to encourage provinces to address these and ensure that the funding is stable, and they take up innovation and look around not only Canada, North America, but the world for solutions?

This would probably be a question to the CMA, but I'd be curious to hear from others as well. I'd ask you to keep your answers brief, because we've only got five minutes here.

● (1715)

Dr. John Haggie: I think the federal role in health care, which is kind of the message I took from your question, is that it has several. It's the international voice of Canada on the world health stage. It has a responsibility as far as I would see it, on behalf of our members, to provide an even playing field. So if you live in Iqaluit or you live in Goose Bay or you live in downtown Toronto, it is not unreasonable to expect that you would have a broadly similar access to a broadly similar range of a broadly similar standard of health care.

The delivery challenges are certainly acute in more rural areas, but I think on a practical level then, given my understanding of the federal and provincial interaction, you can't have governments held liable or responsible to each other. There's a kind of "first among equals" sort of thing.

I think you look at it from the patient's point of view. If the system is accountable to the patient, then at the end of the day the patient has to have a redress. We talked about a patients' charter, and in actual fact a patients' charter was one of the things that one of my predecessors took out. I think therein lies the nugget of a mechanism by which you can make the system work to the interests of the patient who actually funds it and needs it at the time.

Turning to how you do that, there are various ways you could craft a system like that. But I think at the end of the day you've got to look at it from the patients' point of view—what is equitable? We've heard very clearly across Canada that they wanted an equitable system; they want those kinds of opportunities. How you craft it: a patients' charter may be your answer to that.

That's the short, two-cent version.

Ms. Barb Mildon: Thank you very much. That's a good question.

One of the things that CNA has been talking about is an accountability framework. We'd be glad to send more information to the committee.

First of all, I want to thank the federal government for the leadership it has influenced in health care, given our constitution and the difficulties that it raises. I'd like to be a bit provocative and talk about, or at least allude to, the example of the HST and the kinds of harmonization issues this has caused in various jurisdictions.

In terms of an accountability framework, it's the ability, then, to grant funds to our jurisdictions with the provision that they demonstrate, for example, how they have harmonized or integrated their multiple governance systems. So does home care have to be separate from acute care? Do there have to be separate entities providing those services? What kind of accountability can we demand in terms of accepting the funding that the federal government's provided to bring to bear?

The Chair: Ms. James.

Ms. Roxanne James (Scarborough Centre, CPC): Thank you, Madam Chair.

I'd also like to thank each of the witnesses here today. I listened to each of your speeches. I'd like to especially thank Dr. Haggie for acknowledging this government's support of caregivers with our caregiver tax credit. So thank you for that.

I'm just going to touch base on what my colleague Mr. Williamson has mentioned, as well as Dr. Morin across the way. The common theme or thread from each of the speakers seems to be tied into preventive measures. I heard from Ms. Mildon regarding—I actually wrote it down—the ability to fully diagnose hypertension. If you don't, it leads to stroke and cardiac disease. I've heard that the onset of chronic diseases can be delayed if we actually get to younger patients and change their lifestyles. So I want to thank you each for touching on that.

Given that young people—and we all were young at one time, and some of us still may be—tend to see themselves in a different light, that they are invincible, that they're not going to fall into the path of chronic disease or other sorts of ailments, I'm just wondering.... I've heard we should get to the students in schools and so forth, but what age group do you think should be targeted so that later on in life—in our sixties and seventies and so on—chronic disease can be prevented, realistically keeping in mind that young people tend to do what young people are going to do? I'm just curious to know, and I'm not sure who the question should be directed at.

● (1720)

Dr. Eleanor White: I would suggest that the age group that should be approached should contain those who are most impressionable, if you want to make an effect. We will be impressionable for various reasons at various ages. But I see no reason why education regarding healthy living shouldn't begin right from the start, in kindergarten.

An American politician was objecting to sex education and sex roles coming out in some kindergarten material, which was meant in a very kindly manner, but he misinterpreted it. Perhaps, if we're going to entrust kindergarten children with that kind of information, we can at least tell them how to eat properly.

As we head into teenage years, another excellent opportunity is what is cool and what isn't. For a long time, when I was a kid, it was smoking, and now it is not. So those changes about what is socially acceptable are particularly important to a teenager, and not so much to a kindergarten participant. It varies with age, but I don't think there is an age that is too young in the schooling system.

Ms. Roxanne James: I understand what you're saying, and I welcome any other answers as well. I agree that nutrition education may be important in the schools. We've certainly been doing that, I guess, in our school systems. But again I know—not necessarily from personal experience—that you go to your doctor, you get your physical and so on, but until you're actually told there is a problem, you don't necessarily listen up.

So how do you see the medical profession getting to a target group before that age when chronic disease sets in? I understand what you're saying about education, but again I think there's got to be some sort of age group where you think people may actually start listening and applying it to themselves.

So is there any other input?

Dr. John Haggie: I would suggest that what you're talking about is not education purely and simply; it's actually changing people's behaviours. Education is simply a component of that. The medical profession and the professions that are represented here are simply people who can provide the information. The ability to persuade someone to change or to get a person to alter what they're actually doing isn't one that necessarily resides in any one spot, and therein lies the complexity of the problem. There isn't the Harry Potter spell; you can't just wave your wand and—poof—everybody stops smoking.

It's taken probably more than 60 years to cut smoking down to a level where it now is no longer cool, most people don't, and you can actually go and sit in a restaurant without gasping for air. And it's great. But you go back to the fifties or the time when I was a kid and that was very unusual. You went out to a restaurant and the place was filled with smoke. That's the example, and you see how hard it is to get that change. It's taken 60 years.

So the kind of change you're looking at may not actually occur in a shorter period of time, but the facts of the case are that if you don't make the effort now and start on that first step on what is actually a very long journey.... And it really probably doesn't matter where you start, but kindergarten may be as good a place as any.

The Chair: Thank you, Dr. Haggie.

We'll now go to Dr. Fry.

Hon. Hedy Fry: Thank you very much.

Earlier on, when we were talking about all of the aspects that lead to and impact on chronic disease and aging, we talked about the physical ailments and the neurological issues and part of the biological problems. We talked a little about the mental issues, but we didn't flesh out the mental issues.

For instance, it's my understanding from some of the recent studies that many seniors, because of isolation, etc., are quite depressed. In fact the suicide rate among seniors is extremely high, and when they attempt it, they usually are very successful. How do you see this?

As we talk about gaps in services, you mentioned that Canadians didn't want gaps in their services; they wanted to see it seamless. You can't just say “I'm sick; look at me now and then ignore me for the rest of the while, or only see this part of me and ignore the other part of me”. We know it's all a very interrelated and complex thing.

We don't have services for mental health. If you break your arm, you can go to an emergency room and get something. If you have a mental illness, you are struggling to find resources. So how do we look at this very at-risk group for mental illness, and how do we deal with this in a real way? What are the ways you see us dealing with the mental health component of this? Because we don't have a lot of psychiatric nurses in the community. We don't have a lot of psychiatric nurses, period. We don't have a lot of family doctors who understand how to deal with depression and aging. That's a huge gap. How do you see us filling it?

● (1725)

Dr. John Haggie: I think you have to take mental illness out of the closet, quite honestly. People go to work and they say they've taken three days off because they twisted their ankle or they've got a cold or a runny nose. No one's going to say they had a bout of depression and took to their bed for three days or they drank themselves into a stupor because they're depressed, they're unhappy. They're not going to do that.

Until you can start to destigmatize what is a huge issue for a lot of people, you can't even begin to talk about it. I think merely accepting and actually announcing it's an illness and actually acknowledging that we need to deal with it is a huge enabler—it's not because you're weak or spineless or you're just having a bad day. Really and honestly, it's not in the publicly funded system.

Unless you go and see a psychiatrist referred by your family doctor or you pitch up in the emergency department having slashed your wrists or taken an overdose, chances of your accessing acute psychiatric care are slim. So the first step has got to be acknowledging you've got a problem. There's an epidemic out there of people killing themselves.

Hon. Hedy Fry: Perhaps Barb might be able to do this, and maybe Dr. Molnar.

One of the things is that we're not trained. Very few people are trained to recognize early signs of depression, early signs of mental illness. Is there a training that is necessary? Is that a huge piece of it, training social workers, community care persons, nurses, family doctors, various other people that come into contact with a patient in the community?

Ms. Barb Mildon: Thank you so much for raising such an important issue, and I want to thank the federal government for its work with the commission on mental health. My day-to-day job is at Ontario Shores Centre for Mental Health Sciences, in Whitby, Ontario, so it's a subject that's very dear to my heart.

We know that one in five Canadians suffers from a mental health illness. We were having great success across the age continuum with using peer support in the schools. This week at our facility, we've partnered with Dr. Stanley Kutcher, from Nova Scotia, to put education modules into our public schools so we can begin the education and awareness raising right at that stage, and from there, right on up.

I certainly agree with you that there are other services that can be done, and there is more that can be done to raise awareness across the continuum.

The Chair: Dr. Ricketts.

Dr. Maura Ricketts: I want to mention three initiatives I have become aware of, to demonstrate that there is so much room for something to go so much better with mental health care. The first one is the understanding of how successful cognitive behaviour therapy is. That can be provided by non-physicians, yet we don't pay for the non-physicians to do that work. I think it's a big gap in our system.

The second thing is that when you have an integrated clinic and a number of different kinds of staff—some of whom are on salary and some aren't—you end up with opportunities, such as nursing staff, who can phone patients who haven't shown up for care to have them come in to make sure they're taken care of. I think that's a wonderful thing.

In terms of training, in Alberta—I'm not sure if it's Edmonton or Calgary—to train young medical students on how to better work with people with mental illnesses and how to avoid stigma, the evidence is that there is only one way to do that. You can't teach it by providing people with books. You have to get out, you have to actually work with people who have severe mental illnesses.

The Chair: Thank you, Dr. Ricketts. We only have two minutes more.

Mr. Brown, two minutes.

Mr. Patrick Brown: I'll do a quick question that I wanted to touch upon.

Dr. Molnar, you mentioned the 500,000 Canadians, and 100,000 new ones a year, with Alzheimer's. I want to know where that figure comes from. I'm curious. One of the things the population study was asking for was that we were extrapolating our numbers; we didn't know for sure how many Canadians had fallen ill with this disease. One thing they said is that the study would give us a clear indication of how extensive it is. They said the numbers they were using were simply extrapolations based on U.S. numbers, given that Canada is 30 million.

Where are those figures from? It is a powerful reason for why there needs to be help.

● (1730)

Dr. Frank Molnar: It is an extrapolation from a number of studies, from American studies, from the Canadian study of health and aging, which is the largest study of dementia in the world. It is an extrapolation of those studies.

But I agree, the next step is to do the neurological study you're talking about to try to get harder numbers. The scale is probably not going to be that far off; I imagine it would be more precise than high.

The Chair: Thank you so much. Maybe that's something we can keep in mind and bring Dr. Molnar back again during our neurological studies.

This has been an extremely fruitful and insightful dialogue, and we want to thank you very, very much for bringing your expertise here today.

Ladies and gentlemen, the committee is adjourned.

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