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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1535)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Order. I offer my apologies again. We had a vote and that is why we're a little late. Thank you to the members who made the supreme effort, put on their running shoes, and got here ahead of time. That's very much appreciated.

Today, pursuant to Standing Order 108(2), we're studying chronic diseases related to aging. We have some excellent witnesses, and we will be going until 5:20. We'll have very brief business at the end of our committee meeting.

We have the Associated Medical Services Inc., with William Shragge, chief executive officer.

Welcome, Mr. Shragge.

Dr. William Shragge (Chief Executive Officer, Associated Medical Services Inc.): Thank you very much.

The Chair: We have the Canadian Coalition for Seniors' Mental Health, Ms. Wilson, executive director. Very good. Thank you.

From the Fédération interprofessionnelle de la santé du Québec, we have Régine Laurent, president; and Lucie Mercier, labour advisor for sociopolitical affairs. Welcome.

We have the Canadian Pain Coalition, with Lynn Cooper. Welcome. We're so glad to have you here.

We'll begin with 10-minute presentations. Then we'll go to our Qs and As. We will begin with Mr. William Shragge.

Dr. William Shragge: Thank you very much. Good afternoon, ladies and gentlemen.

I am going to apologize at the front end for my tardiness. A brief will be available that will give full background to my presentation. At the end of the presentation, I will have some English copies, but the translated copies will be made available in the usual fashion. I apologize for not having them available today.

Let me begin by thanking all of you for the opportunity to speak to you today on the theme of chronic disease related to aging. I will particularly take the perspective of the health care provider in my remarks. I might add that this is a perspective that is often overlooked and that is becoming increasingly significant as we re-emphasize patient-centred care.

By way of introduction, my name is Dr. William Shragge. By background, I am a cardiac surgeon, educator, and medical administrator. I am currently CEO of Associated Medical Services. My remarks to you today are on behalf of this organization, which I represent.

Our organization has a long and I'd say proud history of providing health care and being involved with the health care system, particularly in Ontario. Associated Medical Services was founded and incorporated in 1937 by Dr. Jason Hannah as Canada's first physician-sponsored, not-for-profit, prepaid health care organization. When AMS's role as a health care provider ceased with the birth of OHIP and medicare, the Ontario government permitted the corporation to use its remaining reserve fund for charitable purposes; hence was born the new AMS, a philanthropic organization that disburses around one million dollars a year.

The initial focus of AMS was to support scholarly activity in the history of medicine. AMS has also contributed to the advancement of the health and health care of Canadians in the areas of bioethics, end-of-life care, and medical education, particularly in its sponsorship of educating future physicians of Ontario, the so-called EFPO initiative.

The focus of this committee is to study those chronic diseases related to aging. This review is long overdue. This review reflects two overarching themes. First is the demographic reality that will see aged Canadians making up an increasingly significant component of the consumption of health care provider services. Second, the spectrum of those diseases, both chronic and acute, related to aging is growing dramatically as our life spans continue to increase.

Central to this entire conversation is someone we urgently need to revisit, namely the beleaguered health care provider, a health care provider who is beleaguered by a myriad of unrelenting challenges that are growing exponentially. All of this is superimposed on a population that can be incredibly challenging to manage, from the health care provider perspective, and is taking place in a workplace environment that is often very problematic, from the perspective of the aged and their families.

Health care has lost its way. Focused on the path of technical progress, we have failed to notice the increasingly desolate landscape into which we have travelled. It is a landscape of treatments and techniques, assessments and efficiencies, routines and guidelines, and hierarchies and regulations. Patients and their families move through this landscape neither knowing us nor feeling that we know them as individuals with fears and desires as well as signs and symptoms.

● (1540)

With our patients passing by in a blur and our work reduced to a frenzy of tasks, we can be deaf to the calling that brought us to health care, the call to caring. We grope blindly for purpose, while the absences of caring relationships in health care demoralize both us and those who look to us for care.

The “AMS Phoenix Project: A Call to Caring” is based on the premise that health professionals provide the best care when they are able to balance human compassion and technical expertise. This is especially significant in the care environments that characterize the provision of chronic care for the aged, care environments often lacking in the elements essential to the provision of patient-centred care.

AMS will act as a catalyst for change by making strategic investments and working with educators, health professionals, workplaces, and other partners to nurture and sustain education and workplace environments that support this balance, a balance between compassion and technical expertise.

The AMS Phoenix Project seeks to resurrect caring, empathy, and compassion in health care and rebalance human compassion and technical expertise through strategic investments to promote, first, champions for caring relationships; second, creative strategies for teaching and practice that focus on caring; and finally, third, communities of practice, both face-to-face and virtual.

Some of these themes, which the Phoenix Project will explore, were articulated within the just-completed federally funded Future of Medical Education in Canada Project, the so-called FMEC report.

Dr. Dorothy Pringle has been appointed chair of the AMS Phoenix Project advisory committee. A member of the board, Dr. Pringle is an accomplished nursing leader, educator, and researcher. Dr. Brian Hodges has been appointed project lead. Dr. Hodges is an internationally renowned educator and is now the vice-president of education at the University Health Network in Toronto.

The thrust of our initiative, an intense focus on the health care provider, framed around empathy, compassion, and caring in the context of the learning and workplace environments, resonates intensely with the theme of chronic disease in the aged. Again, the focus is around the health care provider. We at AMS, and specifically those involved with the Phoenix Project, very much look forward to working with this Commons committee in moving forward this extremely important agenda.

We again emphasize our focus on the health care provider and the importance of making health care provider issues—within the broader framework of patient-centred care—meaningful parts of your deliberations. The health care provider in any area that you will be discussing remains the common denominator, and the health care provider, we suggest, is the factor that is most often overlooked.

At the end of the day, delivery of care in a balance between compassion, caring, empathy, and technical expertise will be the foundation to all aspects of the issues your committee will be deliberating upon, and this remains the focus of our five-year initiative.

AMS would like to thank the committee for this opportunity to present before you, and as I've said, we look forward to continuing to work with your initiative in any way.

● (1545)

The Chair: Thank you very much, Dr. Shragge.

We'll now go to Ms. Kimberly Wilson from the Canadian Coalition for Seniors' Mental Health, please.

Ms. Kimberly Wilson (Executive Director, Canadian Coalition for Seniors' Mental Health): Thank you.

Madam Chair, honourable members, thank you for the opportunity to speak to you today regarding chronic diseases related to aging. I am very pleased to be able to speak on behalf of the Canadian Coalition for Seniors' Mental Health.

As a brief introduction, the CCSMH is a national coalition with approximately 3,000 members from coast to coast to coast, representing a full range of health disciplines, sectors, government and administrators, including older adults and caregivers themselves.

Our mission is to promote the mental health of seniors by connecting people, ideas, and resources. Our primary strategic goal is to ensure that seniors' mental health is recognized as a key Canadian health and wellness issue. With that goal in mind, I commend you for initiating your study on chronic diseases related to aging and for including mental illnesses in your definition of chronic disease.

As you are well aware, 2011 marks the year that the first baby boomers will turn 65, an important milestone for our aging population. Planning and foresight are required to ensure our systems and structures adjust to best accommodate this demographic shift and to ensure we don't buy into apocalyptic demography or the oversimplified notion that population aging will have catastrophic consequences for our society.

Recently I had the pleasure of co-authoring new guidelines for comprehensive mental health services for older adults in Canada. Copies of these guidelines are on USB keys that I think have been distributed. These were funded and published by the Mental Health Commission of Canada. Within these guidelines we clearly outlined four distinct populations living with mental illnesses in later life, populations that I hope you'll keep in mind as you continue your study on chronic diseases. They include those growing older with a recurrent, persistent, or chronic mental illness; those experiencing late mental illness for the first time in late life; those living with behavioural and psychological symptoms associated with Alzheimer's disease and related dementias; and those living with chronic medical problems with known correlations with mental illness, for example, Parkinson's disease, cerebrovascular disease, and chronic obstructive lung disease.

As outlined in the Chief Public Health Officer's report on the state of public health last year, in 2009 chronic conditions were widespread among seniors, with 89% living with at least one chronic condition and many experiencing multiple chronic conditions. One in four seniors aged 65 to 79 years and more than one in three of those aged 80 and older reported having at least four chronic conditions, including arthritis, high blood pressure, diabetes, heart disease, cancer or stroke, Alzheimer's disease, and mood and anxiety disorders.

I will remind you that many of the common chronic illnesses of late life have known correlations with mental illness. For example, major depression occurs in about 40% of patients who have experienced an acute stroke. As outlined in the recent Alzheimer Society of Canada report, “Rising Tide”, we also know that the number of new cases of dementia in 2038 among Canadians aged 65 plus will be 2.5 times the number in 2008, with a projected incidence of 257,811 new dementia cases per year by the year 2038.

Comorbidities make accurate diagnosis of mental illnesses much more challenging. Untangling the symptoms of physical illnesses from somatic presentations of mental illnesses such as depression can be difficult, and without proper training, health care providers can and unfortunately do let treatable illnesses go unnoticed. Health outcomes can also be negatively impacted by an untreated depression, as indicated by a recent report from the Canadian Institute for Health Information, suggesting that residents of long-term or residential care homes who are diagnosed and treated for depression have better health outcomes than do those who are not.

I'd also like to highlight that despite the chronic and sometimes progressive nature of all of these common mental disorders in late life, there are successful treatment options and strategies to promote recovery and well-being, and despite the fact that some, such as Alzheimer's disease, currently have no cure, we can move towards recovery and well-being. Additionally, primary, secondary, and tertiary prevention strategies can be employed to reduce occurrence and severity of symptoms as well as medical comorbidities. Older adults who are on a journey towards recovery and well-being are important contributors to our society. They are valued as volunteers, as caregivers and social supports to family, friends, and community, and they are an investment worth making.

As you are likely aware, the UN summit on non-communicable diseases, held in New York this September, highlighted the need to recognize that mental and neurological disorders, including Alzheimer's disease, are important causes of morbidity and contribute to the global NCD burden.

● (1550)

These priorities are also reinforced by the World Health Organization's statistics, indicating that by the year 2020, depression is projected to reach second place of the ranking of disability-adjusted life years for the sum of years of potential life lost to premature mortality and the years of productive life lost due to disability, calculated for all ages and both sexes.

And of course the most tragic complication of depression is death by suicide. I again would like to commend your committee for the recent discussions in the House of Commons about the need for a suicide prevention strategy in Canada, and also take this opportunity to remind you that older adults are not immune from suicide. In fact, according to the 2008 Statistics Canada data, men aged 90 and older have the highest rates of suicide in Canada, just under double the national average, with a suicide rate of 33.1 per 100,000 population, compared with the overall rate of 16.8.

And for the context of your study, you should consider that research by Heisel and Flett, published in 2005, indicated that mental illnesses and medical illnesses such as chronic lung disease, neurological disorders, moderate or severe pain, and cancer are some of the risk factors for suicide among older adults.

We currently live in an acute care system, despite the compression of morbidity we see in late life. So what can be done? I would like to suggest several action items for the consideration of this committee. When discussing chronic diseases related to aging, I would encourage you to approach this topic within a social ecological model, with consideration of intra- and interpersonal factors and processes, institutional and community factors, and public policy. The model predicts that efforts focused exclusively on the individual at the expense of other factors are likely to fail, and thus efforts to improve an individual's health should be directed at multiple levels simultaneously.

I would also suggest that the life course theoretical model be used as a lens for considering chronic disease and aging. This theory is a necessary vehicle to look at the older adults in the context of time and social structures, and it has influenced a body of research on social inequalities and how these inequalities tend to become pronounced as a person ages—the notion of accumulated disadvantages.

I would also urge you to look beyond academic literature and to value evidence informed by people with lived experience and their caregivers when looking for interventions to improve the lives of people aging with chronic diseases. One such example is the philosophy of self-management, which empowers older adults and their caregivers to be active and engaged partners in their health care and disease management.

I'd also ask that you consider a functional approach to health, where we consider people of all ages and their ability to interact in the world rather than labelling people by their diagnoses. As eloquently stated by my colleague, Dr. Elaine Wiersma, chronic disease prevention and management is often disease focused and should be life and person focused.

I would also urge you to work with partners such as the Mental Health Commission of Canada to implement strategies that address the stigma that may prevent older adults from accessing services and/or may lead to the improper assumption that some of their struggles are attributed as just being a part of growing older rather than illnesses that can be addressed. I would also remind you that for those older adults living with mental illnesses, they face the double whammy of stigma, both of ageism and the all too common stigma associated with mental illness.

In closing, it is my belief that the federal government can play a crucial role in the issue of chronic diseases related to aging, despite provincial jurisdictions over health. As we approach the renewal of the health accord, I urge you to consider some of the recommendations made in the 2009 Senate report on aging, including:

> To provide leadership and coordination for multijurisdictional approaches to addressing the needs of our aging population;
>
> To provide support for research, education and the dissemination of knowledge and best practices;

And finally:

> That the federal government develop a federal initiative which would provide financial support to the provinces to facilitate the move toward integrated models of care for the elderly as a model for quality care for all ages.

I'd like to thank you again for this opportunity, and I look forward to ongoing dialogue in the future.

● (1555)

The Chair: Thank you so much for your very helpful information, Kimberly.

We'll now go to the Canadian Pain Coalition, Ms. Lynn Cooper.

[*Translation*]

Ms. Régine Laurent (President, Fédération interprofessionnelle de la santé du Québec): Good afternoon. Thank you, Madam Chair.

[*English*]

The Chair: I'm sorry. I was going to go to the Canadian Pain Coalition, Ms. Lynn Cooper, president.

Ms. Lynn Cooper (President, Canadian Pain Coalition): You caught us a little off guard there.

The Chair: That's okay.

Ms. Lynn Cooper: Thank you, Madam Chair and committee, for inviting the Canadian Pain Coalition to speak about the issues of pain facing all Canadians and older people in Canada, and for, in your way, recognizing that chronic pain is a disease.

One in five Canadians live with under-diagnosed, under-managed, and unrelenting daily pain. Children are not spared and prevalence increases with age. I am a person who has lived with persistent pain for 25 years since I sustained a back injury in a preventable office accident.

In my role as president of the Canadian Pain Coalition, people describe their pain to me like this: “It burns, it stabs, it throbs. It's like an electric shock going down my arm! It makes me feel so alone. My mother is afraid of falling because of the pain and eats alone in her room. The pain never stops—I'm going to lose my mind, and for a while you know I thought I almost would.” Chronic pain is so pervasive that it almost takes on an identity of its own.

People affected with pain ask, “Why don't people believe me when I say I have pain? How long is this going to last? Why can't they just fix it? How will I support my family? Will I ever be able to play with my granddaughter?”

Pain affects every aspect of a person's life. It impacts our ability to lead happy and healthy work, family, social, and personal lives. Pain is isolating and it's depressing. It is demoralizing, disabling, dehumanizing, and deadly. Research shows that there is double the risk of suicide as compared to those individuals who do not have chronic pain. You might be interested to know that the average cost for people like me who live with chronic pain is over $17,000 per year for out-of-pocket costs. This includes costs for medications and health care that are not covered by our health policies. The psychological, emotional, and relationship costs to individuals and their families cannot be measured.

It is hard enough for adults to endure the assault of this constant pain; however, the impact on our children and older Canadians is devastating.

As we age, we experience a progressive generalized impairment of function, resulting in the loss of adaptive response to stress and in a growing risk of developing diseases. Life's schedules and obstacles that we were once able to handle become increasingly challenging. Our voices gradually become silenced.

Most health conditions associated with aging carry a substantial burden of pain. Common chronic conditions include musculoskeletal diseases like arthritis, degenerative spine conditions, shingles, cancer, fibromyalgia, post-stroke pain syndromes, and diabetic peripheral neuropathy.

The overall prevalence estimates for pain range from approximately 25% to 65% of community-dwelling seniors and up to 80% of older Canadians living in long-term care facilities. Thirty-two per cent of Canadians over the age of 85 live in those facilities. Despite its prevalence, pain is under-treated in our senior population.

Demographics show that in the year 2026, 20% of the Canadian population will be 65 years and older. If pain management practices remain unchanged, considerably more Canadians, including me, will suffer needless pain as seniors.

There are myths about pain that prevent Canadians from recognizing chronic pain as a health priority and a chronic disease in Canada. The first myth is that all pain is the same. It isn't.

● (1600)

Acute pain serves as the body's warning system that something is wrong and there is need to take action. It is temporary. Chronic pain lasts longer than three to six months, or in my case 25 years, or beyond the normal time of healing. Chronic pain serves no purpose and it is maladaptive. We know from research that poorly managed acute pain can turn to long-term pain. People suffer the shame of pain because they are judged as complainers, malingerers, and drug seekers. Misunderstandings about the nature of chronic pain lead to comparing a bothersome acute headache with intractable migraines that go on for days and weeks.

Another myth is that chronic pain is a symptom of a chronic disease but not a disease itself. Functional MRI research shows that chronic pain changes the nervous system, and it changes the brain. Once established, chronic pain has its own set of mechanisms, hence it should be recognized, as you have done, and treated actively as a disease.

The final myth is that chronic pain is something you need to live with. There is much that can be done to moderate our pain. A multidisciplinary approach is recognized as best practice standard of care for chronic pain. This includes a combined use of medications, physiotherapy, and occupational and cognitive behavioural therapies, to name a few, as well as complementary modalities like massage therapy. Canadians in general have limited access to this gold standard treatment. Why is that? It is because we lack community multidisciplinary care and the cost for out-of-pocket treatment is very high.

Seniors living on reduced income and with more limited mobility would be less able to afford, schedule, and attend pain treatment sessions in their communities. The person with pain must take an active role in their pain management through making educated, informed decisions about their pain care and by adopting an adaptive lifestyle that includes a healthy diet, sleep, hygiene, and also exercise. As a caregiver for both my mother and father, it became clear to me that being involved in health care decisions as well as the ability to adapt and to do personal care became more and more difficult with age and the severity of pain.

In addition to the myths that I have outlined, barriers specific to effective diagnosis and management for pain in older persons have been identified. These include the entrenched, misleading notion that having pain is natural in older persons; increased stoicism and fear of being labelled a complainer makes older people unwilling to report their pain; sensory and cognitive impairment, including dementia, reduces ability to report pain; the pain itself also disrupts cognition and behaviour; and overestimation of the risk of addiction to opioids also causes a barrier. The final barrier I would like to highlight for you is the fact that Canada's health care systems provide inadequate support.

The International Association for the Study of Pain, which is recognized throughout the world, states that the effective treatment of pain in adults of advanced age requires specialized knowledge and training in pain management. Canadian research shows that our health care professionals are receiving inadequate education. Our veterinarian students receive three times more pain education than our human health professionals and five times more hours than our medical students. There is currently no accreditation for pain in Canada. That's the bad news. The good news is that the Royal College of Physicians and Surgeons has recognized this gap and has created an accreditation. Those graduates will not be appearing on the scene for three to five years, so we wait.

● (1605)

The number of physicians trained and willing to work in long-term care facilities is declining. Fewer medical students say they are willing to take up a practice in long-term care. A smaller percentage are specializing in geriatrics. There is inadequate funding for pain research—

The Chair: I'm sorry, Ms. Cooper. You're going to have to wrap up. We have to go to the next people.

Ms. Lynn Cooper: Oh yes, I'm just about done.

The Chair: Just say a couple of words, please.

Ms. Lynn Cooper: Yes.

I would like to thank you. I would like you to know that the Canadian Pain Coalition and the Canadian Pain Society have created the national pain strategy.

The Chair: Thank you very much.

We'll now go to Fédération Interprofessionnelle de la Santé du Québec.

[*Translation*]

Ms. Régine Laurent: Thank you, Madam Chair.

I want to say how much I appreciate the opportunity to discuss the issue of chronic illness and the elderly with the committee. It is an important consideration for us. The 60,000 members of our federation work with the elderly in various settings and are very concerned—

[*English*]

The Chair: I am sorry, but the bells have just begun to ring and we have been called back.

We have 30-minute bells, and my instructions are that we must suspend and go to vote.

They're 30-minute bells. That takes us to 25 minutes to 5. It will take us another 15.... We won't be finished until 5. I am wondering whether the committee, after bells, would like to return to finish and listen or.... I know it's pretty tight.

Dr. Fry.

● (1610)

Hon. Hedy Fry (Vancouver Centre, Lib.): I want to apologize to everyone, including the witnesses, for being late. I have to tell you, I am learning that the challenges of being here are extremely great.

Three of us were waiting in line. Dr. Sellah is still waiting to get on a bus to come here, because there's only one bus that has only one place for one wheelchair. And now I'm going to have to try to get a bus to get me back in time for the vote and then to come back.

There is so much to learn from this, if we as volunteers can do something about mobility access in Parliament.

The Chair: Dr. Fry, I saw you come in. I very much admire you for sticking with it. Instead of jumping out of the wheelchair, you're actually sticking with it and getting the feeling.

I have to apologize to the witnesses. We would like you to come back again, if that's possible.

Is it possible for you to return another time?

Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Madam Chair, I was going to see whether you would make that request, because the witnesses we have today travelled to be here. Frankly, I think they have a lot to contribute. I was touched by Ms. Cooper's comments, but also by the courage she has to be here.

Unfortunately, these things happen. I would ask the committee to be agreeable to inviting the witnesses back, because we're not going to be able to do them justice.

The Chair: Could you make that into a motion then?

Can we just agree, everybody? Thank you.

You have our profound apologies. We have no choice. This breaks our hearts. I'm going to have to suspend, but we will invite you back again.

Thank you. We're adjourned.

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