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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

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

I'm Joy Smith, the chair of this committee. I'd like to welcome our witnesses. We're very pleased to have all of you here today. I think there's a little information that wasn't given to you. You understand that today is Halloween and the guests traditionally bring the treats for all the members. Don't let that worry you. This being a health committee, they have to be healthy treats...just kidding.

Voices: Oh, oh!

The Chair: But I do have to say that we will be right on time today because we have a lot of mums and dads around this table who want to have the opportunity to take their children out trick-or-treating. The little people really enjoy that, so we'll be right on time.

We're very pleased that you're here for this very important study of chronic diseases related to aging. It's something that this committee has taken very seriously, and we want to be able to gather as much information as we can from all of you.

I want to welcome Suzanne Garon, who is here via video conference.

Ms. Suzanne Garon (Principal Investigator, Research Centre on Aging, University of Sherbrooke, As an Individual): Thank you. I am going to speak in French.

The Chair: That is *trés bon*. There's my French. I have three kids who speak it very well, but unfortunately their mum keeps trying to learn and never gets the time to do it consistently. That's a problem. I love the language. Please speak in French. We have translation here.

We also have with us, from the Canadian Pharmacists Association, Jeff Poston, the executive director, and Phil Emberley, director of pharmacy innovation.

Welcome. We're very glad you're here.

We have, from the National Initiative for the Care of the Elderly, Dr. Sandra Hirst, executive board member.

Welcome.

On the translating research in elder care project, we have two people who are going to be speaking about a project together, I understand.

We have 10 minutes, so you'll each have five to do that.

As individuals, we have with us Dr. Carole Estabrooks, professor, Faculty of Nursing, University of Alberta—my sister is a nurse, so I appreciate all the good work you folks do—and Dr. Dorothy Pringle, professor emeritus, from the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto.

Welcome.

We will begin with each organization giving their 10-minute presentation.

Madame Garon, please.

[*Translation*]

Mrs. Suzanne Garon: Thank you for receiving me. I am very pleased to be here today.

I would like to tell you about the Age-Friendly Cities Project, or Villes amies des aînés in French. It is an international project that has received Canada's full support from the very beginning. More specifically the Public Health Agency of Canada has played a crucial role since the project was in its infancy. The first stage went from 2005 to 2007.

I handed out a short document. The project resulted in research being done in almost 33 cities in 22 different countries, including Sherbrooke. So we were involved. This enabled the World Health Organization to establish some broad parameters for dialogue and development on several themes related to our aging population and to explain how we can make our cities more suited to, and more liveable for, seniors.

This was a first experience for Quebec and I was still working with my colleague Marie Beaulieu at the time. With the research team that I am leading at the moment, we have developed a participation model for seniors, built around the broad parameters set by the World Health Organization. One of the parameters is active aging, which is built on three major pillars: health, safety and participation.

We feel that a framework of analysis has to include a holistic approach to health and that those three components contribute to better health.

I would like to draw your attention to what we call social participation. Social participation has a major impact on seniors' health. All studies show that seniors who are active and feel they contribute to society are in better health objectively, meaning it is a proven fact. They also feel—their subjective health—that their health has improved. This reduces morbidity and mortality in addition to increasing their feeling of well-being and satisfaction.

It is also scientifically proven that participation greatly reduces depression and symptoms of depression. This plays a role in keeping cognitive decline in check and in reducing the feeling of being in pain. It increases muscle strength and physical performance, while reducing the need for home support services.

For all those reasons, it is important to have age-friendly cities with appropriate facilities so that our seniors can take their rightful place and be full-time participants.

● (1535)

Together with seniors, we have started a project designed for them based on those principles. As a result, our seniors can act as decision makers since they are involved in every step of the project, including the assessment in their communities and their cities. They determine the process, identify what doesn't work and what could be improved. In addition, the seniors committee plays an active role up to when the project is implemented through an action plan. The seniors are even also invited to participate in finding solutions at that stage. So they are not just waiting for services, but they also have a say in those services. They become people who contribute to their communities through their associations and their involvement in the research stage. The seniors help to form control groups in which they are both participants and analysts at the same time.

As expected, the areas of focus at the World Health Organization are the major determinants of health. Each of those eight areas—outdoor spaces, transportation, housing, social participation, respect, inclusion, employment and civic participation, whether in the context of community support or communication as a way to be heard—is taken into account. For each of them, projects have been set up in our cities.

There is a key aspect. In Quebec, we have carried out dozens of projects. In some pilot projects, we have had over 450 people involved. For the projects currently underway, the model has been set up in the same way. We have seven pilot projects in 316 different communities. We also have committees in charge of pilot projects and of the control groups made up of seniors. One of the themes connected to the major determinants of health I just mentioned is obviously housing, having a home. That is a crucial finding.

I would like to share some of the things that came up. One of them is the importance of having housing conditions that work for seniors and that can help them stay in their homes for as long as possible so that they can be socially active without depending on services. For that to happen, adapted, adaptable and affordable housing is a must, since not everyone can afford to live in expensive homes.

I will quickly go on with my presentation. In order for aging to take place at home, it is also important to have access to local services. Those include groceries, leisure activities, health services, as well as a safe environment that is walkable or that has good public transit. Home support services for daily activities and seasonal work must also be set up.

There are 316 communities involved in Quebec. In Canada, over 500 cities are currently setting up those types of projects. The Quebec model is based on five years. The World Health Organization adopted the model as having three stages: assessment, action plan and implementation. Everything gets seniors involved in projects that are designed for them. Canada also uses that model. Seniors are at the heart of it. This initiative brought a new way of working together for various housing and health partners who, in most cases, did not know each other. It also makes knowledge transfer possible in terms of research. Research data are collected a number of times. The transfer is done between our research team at the Research Centre on Aging at the Université de Sherbrooke and non-profit organizations that administer and work with each of the cities in order to implement the model.

● (1540)

So, we went from seven pilot projects to 316 towns in very little time. That funding comes from Quebec's department for families and seniors, the ministère de la Famille et des Aînés du Québec. According to our minister, Ms. Blais, that is a social investment. That is basically all I have to say about Quebec.

Things are also going very well in Canada. With the help of the Public Health Agency of Canada, several provinces have moved on to the implementation phase. Three provinces are extremely active: Manitoba, which also has a centre for aging research; and British Columbia and Nova Scotia, which have been involved from the beginning and still are.

Internationally, our team and Canada play a key role as a global leader. Most researchers who developed the model are part of the World Health Organization's foundation. Together with my French and European colleagues, I am currently working on creating a francophone subgroup that will be ready next June.

I have used all my floor time, right?

[*English*]

The Chair: Thank you very much, Madame Garon. That was very interesting.

We'll now go to the Canadian Pharmacists Association, to Mr. Jeff Poston, please.

Dr. Jeff Poston (Executive Director, Canadian Pharmacists Association): Thank you, Madam Chair, and thank you to the committee for the invitation to present today.

My name is Jeff Poston, and I'm the executive director of the Canadian Pharmacists Association. With me is Dr. Phil Emberley, CPhA's director of pharmacy innovation. We are the national association representing pharmacists in all areas of practice. CPhA is also Canada's largest publisher of drug and therapeutic information for health care professionals. We provide evidence-based information to support doctors, nurses, and other health care practitioners in clinical decision making.

By 2021, the population of Canadian seniors is expected to reach 6.7 million. Currently, 74% of Canadians aged 65 or older are taking at least one medication. In 2008 over 75% reported having at least one of eleven chronic diseases, which included cancer, chronic pain, diabetes, heart disease, and depression.

Additionally, we spend about $833 per person per annum on drugs, making us one of the highest spenders among OECD countries. Maintaining affordability and obtaining value for money are key challenges. Evidence also tells us that elderly people are more likely to experience drug-related problems and adverse reactions to drugs. This is as a result of being on one or more medications due to a number of chronic diseases, and to the diminished capacity of the body to handle drugs as we age. Chronic disease also poses challenges in younger people, particularly with respect to continuation and adherence to drug therapy.

Pharmacists are the medication experts in the health care system. Today, pharmacists receive at least five years of university education, including training in patient care settings. Recently, most provinces have passed legislation that provides pharmacists with a degree of prescriptive authority, which allows them to change a patient's drug therapy to improve patient outcomes. This is obviously done in collaboration with the patient's physician and other members of the health care team. I shall say more about collaborative care later.

Given such legislative change, pharmacists, as both medication experts and the most accessible health care professionals, are ideally positioned to assist in delivering services to the aging population. Pharmacists can play a significant role in chronic disease management by providing comprehensive medication management. This involves critically assessing patients and their medication regimen for appropriateness, effectiveness, safety, and convenience; identifying any problems that may exist with drug therapy; and developing a plan to fix them. This plan has to be shared with the patients' other health care providers, and then pharmacists must follow up with the patients to make sure that desired outcomes are achieved.

Research has demonstrated that such services save money and help patients. An estimate by the Ontario Pharmacists' Association reported that expanded scope services would save $72.4 million a year in health care in Ontario in one year alone. In a large U.S. study, pharmacist-led medication management services provided a return on investment of $1.29 for each dollar invested. Furthermore, over 95% of surveyed patients agreed or strongly agreed that their overall health and well-being had improved as a result of these services.

In addition to the new legislation, pharmacists are also working in new collaborative models of practice, such as family health teams. Studies have shown that pharmacists in such teams can play a key role in managing diseases such as high blood pressure, raised cholesterol, asthma, and other chronic conditions. Improving drug therapy through collaboration leads to fewer emergency room and physician visits, and thus allows for potential health care savings. As we go forward, ensuring a pharmacist presence in inter-professional health care settings is an important component of the care that we need for our aging population.

In June 2010, this committee, in its report dealing with health human resources, offered several recommendations aimed at enhancing inter-professional collaborative care, including the pursuit of greater collaborative care for federally served populations. We would support these recommendations, and suggest that the committee may consider repeating these recommendations in its final report.

Investment in electronic health records and e-prescribing systems is also necessary to support collaborative care and improvements in the continuity of care.

● (1545)

We are encouraged to see provinces beginning to fund new pharmacy services. For example, in Ontario, the government is paying pharmacists to help patients quit smoking and to optimize drug therapy for patients on multiple medications, those receiving home care, and patients with diabetes. Pharmacists are also funded to review patients' drug treatments in Quebec, Saskatchewan, and Nova Scotia. British Columbia is currently funding a pilot study.

We recommend that the federal government explore funding of pharmacist medication management services as part of federal employee health care programs and for clients of the Federal Healthcare Partnership and the first nations and Inuit health branch.

The federal government already has a number of programs and investments in place to address chronic disease and aging, such as the federal tobacco control strategy and the Canadian diabetes strategy. We've worked closely with the government to provide programs to develop pharmacy services and improve patient outcomes with respect to smoking cessation and diabetes management. CPhA would encourage the government to continue to strengthen its support for those programs.

The accessibility of pharmacists in the community setting also positions them well to play a major role in the early detection and prevention of disease. This involves screening for diseases such as raised blood pressure, the provision of immunizations, smoking cessation, and promoting wellness and healthy lifestyles. Recognizing the potential for pharmacists to provide vaccination services, governments in British Columbia, Alberta, New Brunswick, Manitoba, and Nova Scotia have passed legislation to enable pharmacists to perform such services. These developments allow Canada to be able to better respond to public health challenges.

Research has shown that pharmacy-based screening programs reduce hospital admissions. As an example, a large Canadian study published this year showed that pharmacy-based blood pressure screening programs in 39 communities in Ontario resulted in a 9% reduction in hospital admissions for heart attack and heart failure in patients 65 and older.

As we move toward the renewal of the 2004 health accord, CPhA would urge governments to make health promotion and disease prevention a cornerstone of the new accord in 2014, particularly as we believe this will be a reflection of the needs of the aging population.

I'd like to touch briefly on the Canadian Pharmacists Association's role as a publisher of drug and therapeutics information. Our online service, e-Therapeutics+, provides doctors, nurses, and pharmacists with an up-to-date, evidence-based source of drug and therapeutics information that helps them make better decisions to support improved patient outcomes.

CPhA would like to work with Health Canada and Canada Health Infoway to increase point-of-care access to this resource through integration in electronic health record applications, including e-prescribing.

In conclusion, pharmacists have a key role to play in managing and minimizing the impact of chronic diseases on Canada's elderly. By working to help strengthen that role, either unilaterally in partnership with the provinces and territories or with pharmacists themselves, the federal government can play a lead role in helping Canadian seniors access the quality care they rightfully deserve.

Thank you very much.

● (1550)

The Chair: Thank you very much. That was a very insightful presentation.

Now we'll go to the National Initiative for the Care of the Elderly, with Dr. Sandra Hirst.

Dr. Sandra Hirst (Executive Board Member, National Initiative for the Care of the Elderly): Thank you, Madam Chair.

I offer my apologies for not bringing either carrot snacks or apple wedges, but I'm not sure they would have fit in my briefcase.

As context, the National Initiative for the Care of the Elderly was established about five years ago through funding from the national Centres of Excellence. It brings together geriatricians, health care professionals from nursing, social work, and other disciplines. Since its initial establishment, it has now grown to more than 2,000 members and includes lawyers, police officers, and a variety of other individuals committed to promoting the health and well-being of older adults.

My own background is that of a registered nurse working primarily in long-term care, with an adjunct appointment in home care, so these comments are influenced by my perspective.

I would like to address my remarks specific to aging, older adults, and the presence of chronic disease in the format of key messages. I am sure that with the number of witnesses you have called and are calling, you are well aware of the increased presence of chronic disease in Canada and of the supporting statistical data.

Key message number one is that aging is a lifelong process. In Canada, older adults are typically described as all men and women aged 65 years and over. This large and growing population is a highly diverse group, reflecting different values, educational levels, socio-economic status, and the presence of varying chronic conditions, all of which, again, influence health status in the broadest perspective of the term.

Women and men experience aging in different ways and thus experience the presence of chronic disease and its management in different ways. There are significant differences between life at age 65 and life at age 75 or 85. Aging may reflect varying levels of independence and dependence—again, influenced by the presence of chronic disease.

The majority of older Canadians, more than 90%, live primarily independently in the community and want to remain there. Thus the term “aging in place” is well known and is used in resource planning and service delivery activities. But perhaps we should be considering aging in the right place with the right resources.

I would also point out that today's generation of older adults will not be the senior generation of tomorrow, and policy-makers and service deliverers both need to address this reality, because this will affect how we respond to the presence of chronic disease.

Key message number two is that chronic disease is not a corequisite of growing older. While the presence of chronic disease does increase with age, aging and chronic disease should not be perceived as inseparable twins.

Chronic diseases are the result of a complex web of causation, including genetics, gender, environment, and lifestyle factors. Modifiable risk factors, such as unhealthy diet—which is why I would suggest the carrot snacks—physical inactivity, and tobacco use, in combination with the non-modifiable factors of age and heredity, explain the majority of most chronic diseases in older adults.

The increasing presence of chronic disease and the increasing numbers of older Canadians, especially those over the age of 80, is well documented. Supporting healthy aging will promote a healthy and active population, consequently helping to reduce or delay the presence of chronic disease and the need for health care services.

Key message number three is that chronicity is associated with poor health and disability for some older adults. Poor health and disability in old age are largely a consequence of chronic diseases and conditions; for example, deterioration in vision and hearing, or a reduced sense of balance coupled with injuries due to falls.

The World Health Organization has recently pushed non-communicable diseases up its health care agenda, and WHO has focused on four chronic conditions: cardiovascular disease, diabetes, cancer, and chronic respiratory disease. These are responsible for premature mortality. They also focus on four risk factors: smoking, harmful alcohol use, lack of physical activity, and high-salt, high-fat diets.

The majority of older adults living in the community—about 80%—have at least one chronic condition, and of this group, 33% have three or more chronic conditions, compared with 12% of younger adults. For older adults, diseases such as cancer, cardiovascular disease, and dementia are especially significant. In addition, between 10% and 15% of older adults in the community suffer from depressive symptoms and/or clinical depression, another chronic condition.

Polypharmacy—and in no way, gentlemen, am I even mentioning anything other than polypharmacy—is a recognized health challenge and is often associated with the presence of chronic disease.

● (1555)

A key message is that maintaining independence should be a key objective. Maintaining independence as one grows older should be a key objective of individuals, of the community, and of policy-makers. Dependency is highly related to the presence of chronic conditions and associated pain.

Supporting activities and choices that help older adults delay and manage chronic disease and pain—for example, appropriate physical activity and falls prevention programs—may reduce dependency associated with chronic conditions and ultimately support their ability to live in the community. This would require a shift in priorities away from medical treatment and acute care towards health promotion, disease and injury prevention, healthy aging, and family and community support.

Another key message is that developing and using self-management programs is required. Self-management refers to the tasks that an individual must undertake to live well with one or more chronic conditions. These tasks include gaining confidence to deal with medical management, lifestyle management, and emotional management. This is usually a process for the older adult that is done in partnership with a health care professional.

One key component is education. The older adult needs accurate and current information to be able to make informed choices about how to manage his or her chronic disease. We often say that an older adult made an inappropriate or—quote, unquote—stupid choice, but in realty we have to question what information they were given to make an informed decision. There are a number of self-management programs in Canada, the first of which was at the University of Victoria.

Here is another key message. Support for informal care providers is essential. Caregiving—such as support for older adults who are aging with a chronic condition and who may need help with grocery shopping or travel to a doctor's appointment—is largely provided by family members, but these same family members remain largely invisible. They also lack training in or education on the aging process; for example, how to address minor health needs associated with a chronic condition, how to distinguish normal aging changes from dysfunctional ones that may flare up in a chronic condition for their older family member, or how to advocate within the health care system.

Family members provide billions of dollars per year in support, with estimates ranging between $60 billion and $80 billion in support provided by informal care providers. But health care expenditures—for example, loss of time from work by a daughter—can impoverish some families.

However, we need to consider fatigue, caregiver burden, and burnout as challenges faced by family members. We often relate to students in our training programs that they have two patients: they have the older adult and they have the one standing beside the bed, but they are only funded to care for one.

Here is another key message. Social relationships can contribute to quality of life. There is strong evidence that higher levels of social integration are associated with lower morbidity and mortality rates. Higher levels of social integration have been found to provide protective effects against a wide range of physical and mental illnesses.

In one recent U.S. study, loneliness was prospectively associated with increased risk of incident coronary heart disease, after controlling for other multiple factors. A study of older adults in Thailand recently found that social support buffered the impacts of dependency and disability and reduced the risk of depression.

Social participation may be a health-motivating factor for older adults with a chronic condition, one that we need to seriously explore, yet at the same time, transportation challenges—for example, getting to a local bus stop or obtaining a ride with a family member—are serious concerns that may impede social relationships.

Here again is a key message: acute care hospitals are not designed for those with chronic conditions. Acute care hospitals are designed for short-term interventions aimed at curing presenting signs and symptoms. They focus on the presenting health problem and often do not note that the older adult is a whole, with both challenges and strengths associated with personal aging. The presence of older adults who often enter acute care hospitals with pre-existing chronic conditions—for example, hypertension or diabetes—challenges the attitudes of doctors, professional nursing staff, and others.

This is another key message: intervention should start in the early years. Chronic diseases do not come as a birthday gift when one turns 65 years of age. Health promotion education needs to be a clear and mandated thread within all educational programs across the country, starting in the earliest grades.

● (1600)

I would like to thank this committee for hearing our views.

The Chair: Thank you, Dr. Hirst. That was excellent.

We will now go to the translating research in elder care project.

Dr. Estabrooks, will you be doing the major presentation for this project?

Dr. Carole Estabrooks (Professor, Faculty of Nursing, University of Alberta; Canada Research Chair in Knowledge Translation, As an Individual): Yes, and Dr. Pringle will conclude.

The Chair: Thank you. You may begin now.

Dr. Carole Estabrooks: Thank you, Madam Chair, and my thanks to the committee members.

Canadians are living longer and are healthier than ever before. Some of us, however, will develop the chronic disease of Alzheimer's or another age-related dementia. Even though we will be able to stay in our homes or communities longer than in previous years, sooner or later our care needs will overwhelm our families and communities and we will be moved to a nursing home, where we will spend the last few years or months of our lives. In 2038, we expect that one million Canadians will have Alzheimer's or a similar age-related disease. Three-quarters of those are expected to die in a nursing home.

Dementia is a progressive disease of unrelenting losses. There are losses of memory and of the ability to manage one's affairs and to recognize family members. Ultimately, there is the loss of the ability to perform the most basic activities of daily life: feeding, walking, talking, swallowing, going to the toilet. There is no cure.

Because many of us cannot imagine what it is like to live in a nursing home, I would ask you to imagine for a moment an experience we are each all too familiar with: flying, and not the Ottawa-Toronto or Ottawa-Montreal junket, but a flight from Ottawa to Sydney, Australia.

The organization of everyday life in a nursing home can be likened to the organization of everyday life in an airplane.

You have no choice of who you sit beside, and there's a risk that the seatmate may smell, slurp food, chatter endlessly, or refuse to participate in even occasional exchanges of pleasantries. You have to stuff your few allowable personal belongings away so they do not encroach on your neighbour or the aisle. You eat on the schedule imposed by the airline, not when you are hungry—assuming you're fed, of course—and moreover, you have little choice over what you eat. You have to use and wait for communal facilities such as bathrooms, and you can't get to the toilet when needed because there is a cart in the aisle or the seat-belt sign is displayed. Television sets are turned on regardless of your interest in watching them. You have to wear a restraint to protect against the rare possibility of injury. There is nothing to do and nowhere to go.

Notably, the quality of service can also depend on your ability to pay. As airline travellers, we put up with these temporary constraints on our space and autonomy because the trade-off is that it gets us to where we want to go.

We then might ask, “What is the trade-off for residents of nursing homes?” These old people who live and die in nursing homes do not contribute any longer, as they did in their youth and middle adulthood. They do not teach, or police, or doctor, or nurse. They do not build, renovate, act, or govern, or swim, ski, or run like the wind any longer. They no longer vote. They are Rita Hayworth and Ronald Reagan, Norman Rockwell and Tommy Dorsey, and Winston Churchill and Margaret Thatcher. More importantly, they are our mothers, fathers, sisters, brothers, husbands, and wives, and sometimes they will be us.

We care tenderly, and with all of our knowledge and skill, for our frail and vulnerable premature newborns. We place them in some of the most high-tech and expensive facilities in the country: neonatal intensive care units. We think nothing of doing this, believing that a life to be lived is precious and with inherent value. At the other end of life, however, we place our frail and vulnerable old people in nursing homes, the least expensive and least knowledge-driven environment in which care is delivered in Canada, raising questions about the value Canadians place on a life that has been lived and has built the country.

We can tell you a lot about what is wrong with nursing homes in Canada and with the services we do and do not provide to seniors: the ill-designed and fragmented residential system that fails to provide effective, efficient, and compassionate care for frail, vulnerable older adults; the mounting evidence in provincial, national, and international reports of poor quality of care and poor quality of life for institutionalized elderly; and the reduced quality of work life for their care providers.

Rather than go through these, however, we think it might be helpful to highlight how some of these things can be improved.

I will start by saying that we would endorse anything that will keep older Canadians out of nursing homes as long as possible, in their own homes and communities, although not at the expense of the health and well-being of their family caregivers at home. But we cannot dodge the nursing home reality or the fact that some 80% of caregivers are unregulated, with little or no training. Nor can we dodge the fact that the residential long-term care sector has the lowest proportion of funding of any sector in which health care is provided, the fewest numbers of researchers, and the lowest rates of research funding.

● (1605)

Nursing homes are a segregated part of our system that few of us know much about. We simply don't give them much thought until a loved one needs one. They are one of the few settings where we have not completed de-institutionalization.

However, nursing homes in 2011 are a far cry from those of 10 or 20 years ago. Levels of privacy are better. Restraint use is less. Newer homes and more modern models of care offer more home-like environments, safer access to the outdoors, and better management of pain. We have these glimpses of better ways to make the lives of these older Canadians better, with some pleasure in some of everyday life.

One way we do this, and the reason I believe we were invited, is through applied practical research—in our case, the translating research in elder care program, or TREC. Thus far, TREC has been a good success story, and we think a good model for helping to change this part of the system—good because it is large. It received a $5-million grant from the Canadian Institutes of Health Research, a strong vote of confidence for much-needed work in the area. It includes to date some 40 nursing homes, 3,000 care aides, and 500 regulated health professionals, as well as thousands of resident health records.

This enables us to study the considerable variation across provinces and the variety of conditions in those provinces. We need more large-scale applied health services studies, and those need to be complemented by clinical studies that will show us how to manage problems of mobility, pain, and incontinence, and to create enjoyment in daily life.

In TREC we have been able to identify nursing homes where staff use new knowledge more often and are healthier and less burned out, and thus are able to provide better care. We have also successfully identified strategies to engage and mobilize the front-line care staff to work on and improve care practices and to use new knowledge that will improve quality of daily life and quality of end of life, safety, quality of work life of the care providers, the use of best practices, and support for family and other informal caregivers.

The TREC system does this by helping us to identify key areas for action and key areas of good practice that we should spread, to produce comparative reports so that nursing homes can benchmark, by providing a platform on which we can test the effectiveness of new strategies and programs, and by identifying important areas for additional and future work.

Dr. Pringle.

● (1610)

Dr. Dorothy Pringle (Professor Emeritus, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, As an Individual): What actions need to be taken if we are to improve care of the frail elderly living in nursing homes at the end of life? Let us suggest two areas in which we believe the federal government can play a leadership role.

TREC has demonstrated that we need a coordinated, system-level approach that assists in bringing together the many jurisdictions involved in the care of frail and vulnerable older Canadians. The federal government needs to develop, as soon as possible, a long-term care act for community and residential care that parallels the Canada Health Act for acute care and physician coverage.

The act needs to include a long-term care insurance fund, such as has been adopted in many European countries. The act will need to specify standards for quality care, including what constitutes adequate and appropriate staffing. Across the country, the variation in resources available to support long-term care and in the rules governing access to this care is considerable, making it difficult for families to relocate older members in need of community or residential long-term care closer to them.

Secondly, we need to expand the volume of research to inform long-term care, particularly in supporting large-scale studies such as TREC that are expensive to mount and sustain. The threat of a budget cut to CIHR has the potential to constrain the already inadequate level of research—and even shrink it.

Most importantly, the number of researchers devoted to clinical and health services research focused on the older population in long-term care must be increased. This will require an expansion in the graduate and post-doctoral awards needed by students to support their studies.

Without a near-miraculous discovery that will prevent and treat age-related dementia, we are faced with a serious national challenge that will stretch over our lifetimes and those of our children and grandchildren. Even with a dramatic discovery, nursing-home care will be with us for a long time. We need to figure out how we are going to do it well.

Research is important, but it's not sufficient to create the changes needed to appropriately serve frail elderly Canadians with dementia. That will require a willingness of Canadians and their public servants to focus needed and coordinated attention on a group of citizens who once did contribute, but no longer can in the same way, to the nation's productivity, but who, we argue, still contribute to the fabric of Canada.

Thank you.

The Chair: Thank you very much. That was a very good presentation.

We'll now go into our session of Qs and As, with seven minutes each. We'll begin with Dr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): I want to thank our witnesses for being here today.

My first question is for Mrs. Garon.

You talked a lot about housing needs, especially in the case of low-income seniors. Do you have any suggestions on the financial measures the federal government should take to help with housing for low-income seniors? It could perhaps even invest directly in housing. I would like to know what you think about that.

Mrs. Suzanne Garon: Housing or living at home were key issues for all the focus groups, both in Quebec, as part of pilot projects, and in other parts of Canada or in towns elsewhere in the world. According to the prevailing models in Canada and Quebec, living at home usually means living in an apartment where we have always lived only to spend our last days in a nursing home.

There are several types of apartments, several possible approaches, but it hasn't been thought out. There is not enough research on ways to live at home properly, in a specific environment, and to avoid ending up in some sort of home for seniors. There is a lack of research, but there is also a lack of funding for well-designed social housing that would include units that go beyond option A or B. For the time being, there is nothing between the two. We really need to give this some thought and make services and housing of that type available. We need funding programs for social housing.

I didn't use much time for my presentation because there was an issue with the time indicated on the screen. Therefore, I would like to tell you that, as part of focus groups, we have received written accounts from people from virtually every town. Some of them were telling us that they were 80 years old, and that the pension fund they had contributed to would allow them to live until they turned 86. They were asking what would happen to them if they were to live a healthy life until 90. They said they could not stay in their current apartment that cost $1,000, $1,200 or $1,300 per month.

So, we need to give some serious thought to the living at home issue—which is a social phenomenon—and invest in that area.

● (1615)

Mr. Dany Morin: Thank you very much.

My next question is for Mr. Poston.

[*English*]

You talked earlier about the medical health records. You mentioned them briefly. What is your assessment of the work we have been doing in Canada since 2004 with regard to connecting the various pharmacies with the medical health records?

Most importantly, what is the next step for the 2014 accord? What do you, as a member of the Canadian Pharmacists Association, expect will be related to the medical health records in the next health accord?

Dr. Jeff Poston: Thanks. I think that's an important question.

The critical thing that we've seen happen to date, I think, is that nearly every country that has taken an expensive top-down approach to try to develop electronic health records has struggled to actually achieve that. If you look at the United Kingdom and Uganda, you'll see that they have spent even more money than Canada has and have made probably only slightly more progress.

I think we do need continued investment. There is a view—I think amongst many people—that we've somehow spent enough money. I think we probably still need some continued investment.

I think we have to encourage more local initiatives. I think we have to look at some of the options that can be developed on a regional basis.

I think we're seeing some changes. For example, eHealth Ontario is moving to trying to develop a very pragmatic, locally funded, local initiative. I think that's probably going to be our best chance in achieving it.

It is going to be critically important, though, that in order to address many of the issues we've heard—for example, long-term care and home care—we are going to have to be able to exchange information and have good sharing of information along the continuum of care. Getting electronic health records right is critically important. I don't think we've found out how to do it yet, and it will probably need some further investment. It needs to be a priority as we move forward.

[*Translation*]

Mr. Dany Morin: Thank you.

My next question is for Ms. Pringle.

[*English*]

This comes from your article on interdisciplinary collaboration and primary health care reform:

> In addition, the current way physicians are paid works against collaborative interdisciplinary practice in primary care. Innovative reinvestment of health care dollars could support nurse practitioners, nurses, and other health professionals....

What changes would you propose for the 2014 health accord?

Dr. Dorothy Pringle: Well, I think we have pretty good evidence from a number of places and a number of different countries that a fee-for-service way of funding health professionals does not encourage interdisciplinary care—and it does not lead to the best possible care, either.

I think that's a huge change, though, because we have a tradition of funding most medical practitioners, although certainly not all of them, and not all of them in primary care. As we move to true primary care as opposed to family practice, I think we're seeing a move away from fee-for-service and other means of remuneration that support well all the health professionals.

I think that's a fundamental change that is needed in order to move us more universally to that.

● (1620)

The Chair: Thank you, Dr. Pringle

We'll now go to Mr. Gill.

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

I'd like to thank the witnesses for being here.

First, to Dr. Hirst, I understand your organization is beginning to develop a tool to help seniors themselves better understand depression and how to treat it. Can you please expand on this project?

Dr. Sandra Hirst: We actually already have a tool that we adopted from the Canadian Coalition for Seniors' Mental Health, which is funded by the Public Health Agency of Canada. NICE's focus is to take strong tools that are evidence-based, that are primarily Canadian, and distribute them for all health care practitioners. Because the Canadian Coalition for Seniors' Mental Health has had exceptionally good tools differentiating delirium from depression and dementia, we use their tools.

Am I answering your question, or would you like more details?

Mr. Parm Gill: If you have any more details, I'd like them, but....

Dr. Sandra Hirst: The tools are actually available on our website and distributed nationally, across the country. Right now we're tracking, and we've had probably half a million tools distributed, of which a significant percentage have been linked to depression, delirium, dementia, and that area.

Mr. Parm Gill: I also understand that your organization has an ethnicity and aging "theme team". Why has your organization created this theme team, and what health-related issues are different when you have seniors from different ethnicities? Can you elaborate on that?

Dr. Sandra Hirst: That is a relatively recent theme. Just for your information, we initially started with five theme teams—caregiving, for example, and elder abuse. About 18 months ago we were asked by a number of our members and people in the public to look at the concept of ethnicity, recognizing the diversity of this country.

Chinese Canadians make up one huge population group for us. It's not that the health care issues for Chinese people themselves may be different; how they respond to those strategies that may be different; how they interact with their neighbours, and the terms they use, may be different. So we're trying to get an enhanced sense of that specific cultural group, of how they would define the terms, how they would use the terms, what behaviours work for them or not, and how that differs from the larger Canadian context so that the information can go back into practice.

That applies to Chinese Canadians, but it also applies to those from India and from Ghana. It's just understanding the diversity of this country and putting it back into practice every time.

A common example is with some of our recent immigrants from Thailand. For the older adults, the word "cancer" does not exist in that vocabulary, but it's part of their health care reality. The word "depression" may not exist for older adults from Thailand, but the expressions for feeling blue and feeling sad do exist.

It's to give us as health care professionals a clue so that when you're working with a certain ethnocultural group, you really begin to understand the language, and the choices they make, and you can better enhance and support their health.

Mr. Parm Gill: Is there a list of ethnic groups that you guys are targeting in particular, and maybe a reason why?

Dr. Sandra Hirst: The Chinese Canadian group was the first. The most important reason was because of its percentage in the population, of course. The second reason was that we have certain colleagues who have a strong interest in ethnocultural issues with Chinese Canadians. Since we simply cannot do everything, we'll start with that group, see what our progress gives us, and potentially expand.

The other area where multiculturalism does play a key role for us is in the issue of abuse and neglect of older adults and some of the cultural connotations coming through there. We've used Chinese Canadians there. We've used some first nations as well, and some Indochina and southeast Asia cultural groups.

Mr. Parm Gill: A lot of ethnic communities tend to keep their parents and the elderly with them, so basically they're staying with families, with their children, or grandchildren, and others. Are you looking at that? Is there any sort of information you have in that respect which may be different from others"?

● (1625)

Dr. Sandra Hirst: It's not a key priority for us right now in terms of our theme teams, but it's a well-established fact within the research community in this country—and I would defer to my colleagues as well—that caregiving practices and the health status of older adults from a variety of ethnic backgrounds may change, in our view. But the research also shows us that when you immigrated to this country will impact your health status, whether you're a first generation or a second generation.

There is not extensive, but certainly strong evidence in this country about multicultural and immigrant needs.

As an aside, we do have an emerging study underway looking at health care status among immigrants who are first generation over the age of 65, what they are saying about their health, and how they utilize health care services. But it's just beginning. It's a huge area, but we're starting.

Mr. Parm Gill: Thank you.

The Chair: Go ahead, Mr. Poston.

Dr. Jeff Poston: Could I just add something? One of the practical things that our members deal with on a regular basis is the young child who comes into the pharmacy with either their grandparent or perhaps an aging parent and essentially acts as the go-between in terms of translation. I think it's a big issue in terms of developing the right cultural sort of setting, the right language.

We have a lot of drug information materials that are translated into a whole range of languages, but often in practice the use of the child as the go-between is what many health care practitioners face.

Mr. Parm Gill: Thank you.

My next question is actually targeted towards the Canadian Pharmacists Association. Electronic health records have been discussed as a means of improving collaboration and the flow of information between health care professionals. What is your organization doing to help facilitate this? How might electronic health records be helpful in reducing the impact of chronic disease among aging Canadians?

Dr. Jeff Poston: As a specific activity, we've been working with Canada Health Infoway.

As a national association, our big commitment is to the development of national standards to actually make sure that, rather than having to sort of reinvent the wheel in terms of the electronic health records done in every province, we try to establish pan-Canadian standards, which means the technology can be built in one way, if you like, to serve the whole country. Advocating for pan-Canadian standards has been one of our important activities.

The other area that we've worked on, together with colleagues in medicine, in nursing, and with Health Infoway, is the developing of standards around the information that should be in a record and the information that needs to be exchanged across the continuum of care. Those are two examples of where we've worked on the issue.

The Chair: Thank you very much.

We will now go to Dr. Fry.

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

I want to thank everyone for their excellent presentations. You've identified some of the core issues that we need to talk about. One of them is the issue of aging at home.

I was recently at the Baycrest conference in Toronto. They said that from their research, when you take a senior out of their surroundings.... Because their surroundings always help them remember: when they see a picture or something familiar, they keep their memory together. When you take them out of that and put them in a nursing home, all of those little markers that used to prompt their memory are gone. They become quite confused and disoriented and start to go downhill after that, so it isn't whether the quality of care of the nursing home is good or bad, it's that this is a major factor in moving people out of those surroundings.

You've talked a lot about home care, community care, long-term care models, and collaborative models, which I know the college of family practitioners is now speaking about: integrated models with multidisciplinary teams that are managing chronic illness in the community. But in order for that to happen.... I know that during the 2004 accord there was money put aside to do some of those projects, to see what worked and what didn't work. We now know that this kind of system works.

I would like to hear your comments on whether you see this being a huge piece in the 2014 accord. Would you like to see this change? How would you like to see it change?

On pharmacies, you've said that the cost of providing prescription drugs is exorbitant. There's the concept of looking at a pharmacare plan. Again, that was in the 2004 health accord. It is essential, for it to move forward, to look at how you can provide necessary medications for people who can't afford them anymore, especially as we become seniors.

Dr. Pringle, you floated a very interesting plan about a long-term care act and a long-term care insurance fund. I'd like to hear you elaborate on that a little more, because I think that is what we have to learn to do: to provide care outside of a hospital, as you say, in a facility that is appropriate and that gives the right kind of care, and by a person who is not necessarily a physician, because the Canada Health Act is physicians and hospitals.

One final question—

● (1630)

The Chair: Okay, Dr. Fry. Would you like them to answer these questions before your final question?

Hon. Hedy Fry: No. I just want to throw out one final question to the pharmacists.

The Chair: They may or may not have time to answer.

Hon. Hedy Fry: Okay.

Just quickly, you talked a little about e-prescribing. There are some things that I'm a little concerned in terms of e-prescribing. Who prescribes? How do you know you have the right prescriber? Also, can we hear a little about drug shortages? I'll leave you guys to it.

The Chair: Thank you, Dr. Fry.

We'll get to most questions as best we can.

Hon. Hedy Fry: Dr. Pringle?

The Chair: Who would like to begin?

Hon. Hedy Fry: Sorry, Chair.

Dr. Dorothy Pringle: I'll take on the aging at home. I'll begin, and my colleagues can contribute.

I don't think there's any question that we lag in having good community support. We have some good models. SIPA and PRISMA, from Quebec, really demonstrate how we can keep people at home much longer using interdisciplinary teams with case managers who can move money around—who have that control to move money when somebody moves into a hospital—and who can then set up the services, very rich and intense services, for a short period of time to get them back out of hospital.

I know Ontario best in terms of that. We started off with a robust aging at home program that got eroded over the years. We don't have a federal act that addresses home care, and somehow the funds got transferred to meet our waiting times. They really got put into the acute care system, which is like a big sucking vacuum cleaner. It pulls in all the resources.

That's why we proposed what we did. We're not original in this. I think Neena Chappell, whom you might know, from the University of Victoria, and Marcus Hollander proposed what they call a continuing care act, a long-term care or continuing care act, in order to give continuing care, home care, and long-term care. If we have good continuing care, we can delay the need for nursing home care.

I don't mean to eliminate nursing homes. Probably Denmark has gone about as far as you can in that, because they have such a well-coordinated and intensive home care program. Before we're going to get that, we need federal leadership to establish this continuing care act. Then to complement it, it needs some funds.

Dr. Réjean Hébert, from the University of Sherbrooke, has recently written about the need to establish this long-term care insurance plan. It would serve community care and nursing home care and provide funding so that it can't be eroded by the demands of acute care. It would be tax funded, publicly funded.

What he proposes is a fund whereby provinces could set up their own schemes. That may include putting funds into the hands of family members or of older people requiring community long-term care so they can purchase their own. Or they can rely on a provider, who would be paid publicly, but that may very well be through a public or a private agency.

Hon. Hedy Fry: Could you send that to us, if it's in both languages, so we can have a look at it, please?

Dr. Dorothy Pringle: Yes, absolutely.

Hon. Hedy Fry: Could you answer a quick question about e-prescribing and drug shortages?

Dr. Jeff Poston: E-prescribing has a lot of potential to actually improve the safety of drug use if it's done properly. However, as you're perhaps aware, there are some studies of e-prescribing where in fact it has created more errors than it has solved. It has to be done carefully. It has to be done by paying attention and making sure—and I think most provinces have done this—the privacy issues are addressed.

We still are in a situation where physicians prescribing for patients may not know all of the medications that a patient is receiving, and we've seen provinces try to do that as a first step, to make sure there's a complete medication record for all patient. I think that's important.

Drug shortages are a major issue currently in Canada. It's a global issue at the moment—

● (1635)

The Chair: Thank you, Mr. Poston. I'm sorry, but we're way over time.

We'll now go to Dr. Carrie.

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

As well, I would like to thank the witnesses today for excellent presentations.

I would like to follow up a bit on what my Liberal colleague was mentioning about the best profession for delivery of services, because we did do the human health resource study.

Mr. Poston, I think you were here then, and we got the same recommendation from you to recognize scope of practice. You mentioned that Ontario—I come from Oshawa, Ontario—would save $72.4 million a year if we would just coordinate the service delivery with pharmacists.

I was wondering about this. Basically, delivery of services is a provincial jurisdiction, but I'm curious about this. What is the obstacle? There seems to be a hodge-podge across the country. Pharmacists can work within their scope of practice, but other provinces don't recognize that. What would be the obstacle there?

Is there anything the federal government could do to help jurisdictions start working to recognize scopes of practice? Because we're having a demographic shift, and that's why this study is so important. What can we do to help out those jurisdictions?

Dr. Jeff Poston: Thank you for the question.

Certainly we see variations, but it's just a reflection of provincial governments passing legislation. The nature of legislation and the stage the province is at in terms of developing primary health care vary from province to province. I think that's part of the reason why we have this patchwork quilt at the moment. Probably Alberta has been the most progressive province, closely followed by the Maritimes. B.C. and Ontario, in some ways, have been less progressive than some other provinces.

One thing in the 2004 accord was that we created the primary health care transition fund federally. That helped to fund a lot of the studies that have supported these developments, so the federal government's role is leadership, and that is absolutely crucial on a range of issues. We've heard about continuing care. I think pharmacare is probably another one. I think making best use of health human resources is another.

So leadership, pan-Canadian standards, funding the development of demonstration projects and pilot projects.... I know it's not sexy and there's a lot of criticism around pilot and demonstration projects, but these are critical areas—and I think we've heard of some today—where investment in research is really important to help move the agenda forward.

Mr. Colin Carrie: Thank you. I know there is a lot of frustration because, as I've said, the provincial jurisdiction is the lead in delivering the different services and to get all the provinces to agree to something is always a challenge.

I wanted to ask you about adverse drug reactions. I've had family members who were on over a dozen drugs per day. Many seniors are on multiple medications. What does your organization do to help seniors manage adverse drug reactions?

Dr. Jeff Poston: One of the critical things is that, as I mentioned, we provide this digital service e-Therapeutics+, and we post every Health Canada advisory that becomes available, alerting physicians, pharmacists, nurses, and other prescribers to any new adverse drug reaction that's out there. We play a role in the dissemination of information.

We're also very interested in some of the proposals to look at new approaches to drug regulation that would allow a combination of strategies, where you could perhaps get drugs to the market earlier but at the same time be more effective at collecting data relating to adverse drug reactions. I think it's something that we still need to work on. I still think we have under-reporting of adverse drug reactions, but as an association we do what we can through our digital information service to make sure that prescribers have up-to-date information around adverse drug reactions, to guide their decisions.

● (1640)

Mr. Colin Carrie: Our health care system now seems to be based on acute care. Some of the presenters brought that up. It's very expensive.

As we're starting to manage these chronic diseases, what are your organizations doing to promote more chronic care self-care and education for seniors? I'd like the panel, if I have the time, to give their comments.

The Chair: Who would like to take that one on first?

Dr. Hirst.

Dr. Sandra Hirst: From our perspective, our primary role is the education and support of health care professionals, because if we can educate health care professionals on how to work with and for older adults and their families, we can reduce acute care waiting lists. We can reduce acute care admissions. We can teach about fall prevention and dealing with falls. If we can work with the health care professionals first—and I'm saying that deliberately because that builds capacity to respond—so working with the collector group....

But at the same time, we have our curriculum design for professionals across the country that we're moving on implementing in various ways to ensure the content in reference to older adults: the management of chronic conditions, acute care admissions, and polypharmacy issues are addressed in every health care curriculum. That's a huge issue in itself, but that education is key.

From my perspective, those are probably our key thrusts right now.

Mr. Colin Carrie: Perhaps I could get a response from the pharmacists too. I know that Britain has a self-care program. Have you embraced that?

Mr. Phil Emberley (Director, Pharmacy Innovation, Canadian Pharmacists Association): First I'd like to echo that: we are promoting the education of our pharmacist members as well. We see that as a key role in enhancing the service they provide in pharmacies.

As changes of scope occur, the tools and the knowledge required to provide those services are critical, so we have a number of courses—on chronic disease states, on diabetes, and on smoking-cessation programs as well—to help our members to deliver in those areas. We're also looking at promoting self-care to seniors so they can manage their own disease, because that is critical in helping them manage their diseases effectively.

Dr. Sandra Hirst: I'll just add that there are a number of self-management programs in this country, one at the University of Victoria. I've totally forgotten the name, but it's just one of a number. They're not massive in scope, but they are certainly demonstrating that they are cost-effective and that they promote quality of life for older adults.

The Chair: Thank you. We're over time now, so we'll have to go into our second round, which is five minutes for Q and As. I'll just remind the committee that at 5:20 today we will be suspending to go into 10 minutes' worth of business.

We'll now begin with five minutes for Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Madam Chairperson.

First of all, thank you to the witnesses for coming today. I thought your presentations were all really well researched and had excellent information.

I think the thing that leaps out is that while there are some very good things going on, you actually only have to look at the map of age-friendly cities Madame Garon presented to see how much disparity there is across the country, whether it's the 40 nursing homes you're looking at or.... I think this is a glaring issue.

I also thought it was quite alarming to hear—I think it was from you, Ms. Estabrooks—that 80% of caregivers are unregulated. This is very alarming and I think it speaks to the need to have something like a continuing care act.

I have two questions.

Home care was in the Romanow report. It was meant to be the next big thing. It was in the 2004 accord. How do we move forward on this idea of a continuing care act? Do you see it as being under the umbrella of the Canada Health Act principles or is it something completely different?

In terms of drug safety, Mr. Poston, I agree very much with what you said. You touched on some very key points.

I wonder if you're familiar with the Therapeutics Initiative at UBC, which I think the pharmacology department is very involved with. It's happening in one province. I know that you're doing some stuff with your e-Therapeutics+, but it seems to me, again, that there's nothing across the country dealing with this issue of drug safety and drug affordability. Again, it was in the accord, but no progress has been made.

If you're familiar with the Therapeutics Initiative, is it something like that we should be rolling out? That, at least, would be giving us some progress.

● (1645)

The Chair: Dr. Estabrooks, would you begin, please?

Dr. Carole Estabrooks: With respect to long-term care and a continuing care act, we think it should parallel the Canada Health Act. There are some important principles there, such as the principle that enables us to receive services regardless of which province we go to. The inability to move an aging parent is a major issue right now for many families.

We think, however, that one of the areas we need to address in the part of the act that would look at residential long-term care in particular, but also at home care, is the issue of health human resources. Not only do 80% of care providers constitute an unregulated group, but we don't know how many there are in the country. We can't count them. Registries are not mandatory, and voluntary registries are pretty spotty across the country. That means tremendous variation. Many of these health care workers can't speak English well enough to answer a survey. It's unclear how that affects their provision of care. In English-speaking facilities, this is an issue.

We really need to have the guidelines and the umbrella principles under which to grapple provincially with issues of health human resources in terms of both qualifications and numbers. We need the ability to count them and the ability to address the needs of that workforce. Many of these women, primarily immigrant women in urban areas, work two full-time jobs. They work 16 hours a day and are themselves a vulnerable group that is caring for this complex group. We would see this as one of the major areas for which we need guiding principles that parallel some of the principles we have in the Canada Health Act.

The Chair: Go ahead, Mr. Poston.

Dr. Jeff Poston: If I can address the Therapeutics Initiative, I think that for some of the work this initiative has traditionally done, the common drug review is sort of doing some of that work now. However, I think it is important that we look at aspects of the work of the Therapeutics Initiative at a provincial level.

One of the things we've called for in successive submissions to the finance committee is funding for what we've called a national medication management centre. We have quite a lot of information relating to drugs. We have CADTH. We have CIHI. We have PMPRB doing their stuff. There's a lot of work and a lot of data that gets gathered. I think we need to look at better ways of actually getting it utilized at the provincial level.

I think you could imagine a network of centres at a provincial level, similar to the Therapeutics Initiative, but perhaps doing less on drug evaluation and more on playing their role in the academic detailing of physicians to improve prescribing outcomes. I think there would really be merit in looking at some sort of national network of such centres.

Ms. Libby Davies: If you've presented on that before, could you forward to us that information on the idea of a national...what did you call it?

Dr. Jeff Poston: National medication management centre.

Ms. Libby Davies: A national medication management centre. Could you forward that information?

The Chair: Yes, perhaps, Mr. Poston, you could forward it to the clerk, and she'll distribute to all members of the committee. Thank you so much.

Thank you, Ms. Davies. Now we'll go on to Mrs. Block.

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

I'd like to thank each of our witnesses for being here today.

My first question will be directed to Ms. Garon. Among other measures to improve the quality of life for aging Canadians, our government provides funding to non-profit organizations through the new horizons for seniors program. With an annual budget of $28.1 million, this program helps improve the quality of life for seniors and their communities through what I believe you would call social participation.

My question for you is this: how do community organizations encourage or address social participation for aging Canadians living with reduced mobility? For homebound seniors who don't get out into the community, what does your organization do to encourage that participation?

The Chair: Mrs. Garon.

[*Translation*]

Mrs. Suzanne Garon: I will answer in French.

Can you hear me?

[*English*]

The Chair: We hear you just fine.

[*Translation*]

Mrs. Suzanne Garon: Okay.

A person's social participation is certainly reduced if they are in a wheelchair or in a confined environment.

● (1650)

[*English*]

The Chair: Excuse me. We just lost translation.

Do we have it now? Okay?

Go ahead. I'm sorry for the interruption.

[*Translation*]

Mrs. Suzanne Garon: Social participation is certainly reduced if a person has poor mobility or is in a wheelchair. If someone is unable to go out, it's even worse.

However, in organizations or in Villes amies des aînés, or senior-friendly towns, there is a desire to try to reach these people. We are not talking about immediate or direct participation. We must use sentinel programs to target socially isolated people, give them access to services they never thought they could receive and put an end to their isolation in terms of human interaction.

All that does not happen right away. Time is needed for those people to regain a level of participation that would be closer to that of the rest of society.

There are some nice examples in the town of Granby, where there are a number of different stakeholders. There are firefighters, social workers and, especially, senior organizations that take advantage of the program you talked about earlier. I think that program should be better funded because the work being done in the field is really impressive. It is being done for and by seniors. So, there is a long way to go when it comes to funding, especially for this kind of program.

There are initiatives in the field that are also used to seek out isolated people and make them more socially involved. A lot of interdisciplinary and intersectoral cooperation is needed. Social workers in health care and firefighters are involved, among others. Some of them are referred to in fire halls as “seniors' firefighter friends”. That's a step in the right direction. You can really see that people are working on making things better.

Did I answer your question?

[*English*]

Mrs. Kelly Block: Yes.

To follow up on that question, when you talked about age-friendly cities, my question was, what does an age-friendly city look like? You've answered and you've given me some examples, but I imagine it would require organizations like yours to have strong relationships with the elected officials in municipalities to address some of those issues. Can you describe what you're doing at that level?

[*Translation*]

Mrs. Suzanne Garon: I am a professor at the University of Sherbrooke, in the school of social work. I have been doing this research for three years.

Tomorrow, I am meeting with the administrators of Quebec's ten largest cities: Montreal, Trois-Rivières, Quebec City, and so on.

We will spend a whole day working with city representatives on how to increase seniors' social participation and how to make their cities more open to using arrangements they already have available, in particular. In fact, our towns are working with universal accessibility and social development policies. What needs to be done so that our seniors are seen not as consumers but as citizens?

[*English*]

The Chair: Thank you so much, Madame Garon.

We'll now go to Madame Quach.

[*Translation*]

Ms. Anne Minh-Thu Quach (Beauharnois—Salaberry, NDP): Thank you, Madam Chair.

I will follow up on what my colleague, Kelly Block, was saying. I will continue asking you questions, Ms. Garon.

I want to thank all the witnesses for joining us today. If there is time, I will have other questions for you.

Could you tell me what criteria a town needs to meet to become senior-friendly? Who sets those criteria? What about infrastructure costs? I don't know if you have the answers to these questions, but perhaps you will know more tomorrow. Do you promote intergenerational interaction? How should a city's environment be adapted? How much time is needed to implement all that? That's a whole bunch of questions for you.

Mrs. Suzanne Garon: I would first like to get back to the fact that, in Quebec—I can talk about Quebec—the program is funded by the ministère de la Famille et des Aînés. Two million dollars are invested annually to help towns implement what I call "the model". That model has already contributed to an increase in seniors' participation in in-house steering committees. We now sometimes hear from seniors in city councils, although we had never thought about hearing from those people before. We are working with them, not only because they are voters, but also because they have something to say about their towns.

The model makes that possible and is funded by the ministère de la Famille et des Aînés. MAMROT, the department in charge of municipal infrastructures, funds a $9-million program for small transformation and municipal infrastructure projects to increase accessibility for people in their towns. Sometimes, that may involve installing an elevator or rebuilding sidewalks that were poorly thought out in some places. That way, these programs are making it possible to rethink or rebuild those infrastructures. That's part of the answer to your questions.

Regarding recognition, the question you asked is very important. The model must be recognized by the World Health Organization. I think that now, in English Canada, work is being done with the Public Health Agency of Canada. Personally, as a researcher, I have been recognized by the World Health Organization from the beginning, and the models used have been adopted by that organization. We are also recognized by the ministère de la Famille et des Aînés du Québec. Criteria are currently being implemented, especially criteria on social participation based on the model. In fact, people need to participate from the outset, not only as consumers, but also as citizens. This model must be examined.

I am currently working with a research team on assessing the implementation and the impact on towns. We sometimes work on achievement indicators for those programs. Recently, I made a presentation on that topic in Ireland. I did not mention that in my presentation because it is more research-oriented. This is a very important issue, and I know that Manitoba has adopted a recognition policy to prevent non-participating towns from calling themselves "senior-friendly". That way, each province would plan assessment procedures. However, we are all working together, with the Public Health Agency of Canada, on developing those recognition criteria.

Does that answer your questions?

● (1655)

Ms. Anne Minh-Thu Quach: Yes, absolutely, thank you.

My second question is for Mr. Poston. It's about pharmacists.

Since people take more medication as they get older, and some medication is very expensive, does the Canadian Pharmacists Association possibly foresee using more generic drugs to give seniors access to more affordable medication? Is that something your are considering?

[*English*]

Dr. Jeff Poston: Yes, in fact, for most provincial drug plans that cover the aging population across Canada, pharmacists are required to dispense a generic drug if it's available, even if it's prescribed as a brand name, unless the physician writes "no substitution" on it. We see the extensive use of generic drugs in Canada. Obviously, a critical value is that they reduce the overall cost of prescriptions.

The Chair: Thank you, Mr. Poston.

Now we will go to Mr. Brown, please.

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

Thank you for all the commentary so far.

I recently had both of my grandparents in seniors residences. One of them was afflicted with Alzheimer's. I know that it is certainly pressed.... One thing that surprised me was the limited capacity that existed. I know that every province is different, but for a lot of the long-term care facilities, if you're non-urgent, you'll be on a waiting list of four or five years, as is the case in my community.

I realize that this is a provincial jurisdiction, but what concerns do you have about the lack of capacity, given the fact that we have an aging population? I think the Alzheimer Society's Rising Tide report suggests that it's going to get monumentally worse. What advice would you have for us as federal politicians, given the fact that a lot of this is regulated by individual provinces? Where can we help? Where are our opportunities?

● (1700)

The Chair: Who would like to answer?

Mr. Poston.

Dr. Jeff Poston: I can start.

I think we have a tremendous opportunity with the 2014 health accord or the renewal of health care transfers in 2014, however we want to describe that. I think there is a real opportunity for the federal government to provide leadership on a whole host of issues: home care, pharmacare, continuing care.

I think a feature of the 2003 health accord, the idea of tying the money to key priorities, has to be looked at seriously. I think the federal government has a critical role in providing leadership and I think a critical thing to consider—and I know it's administratively challenging and difficult to do—is tying money to some specific priorities that will meet pan-Canadian standards, whether they relate to pharmacare, home care, or long-term care.

The interesting thing with regard to long-term care is that greater investment in long-term care is essential to shortening wait times in emergency rooms. The problem of getting access to emergency rooms is created by not being able to move patients out of emergency rooms and admit them quickly enough, because the beds are full of people who should be in long-term care.

I think there is a real responsibility for leadership by the federal government to tie money to some specific priorities.

Dr. Carole Estabrooks: We would agree that the accord and the guidance that might come with that would provide stimulus for some of the actions we need to take.

The issue you speak to about waiting times is another version of the wait-time issue we have in the country. The last place we want frail, older adults is in acute care. It's a dangerous place for a frail, older adult. One of the things we need to do is figure out how to keep them in their homes or in their residences or receiving primary care in the community, more so than in acute care, and when we send them to acute care, we want them to stay there as short a time as possible. If they fracture a hip, they need to get in and out.

The issue of the wait times—the wait for long-term care—is actually quite complex. It's not as simple as an A and B relationship: that if we build more nursing home beds, we will shorten emergency room crowding problems. It's not quite that straightforward. This individual moves through the system and touches a lot of parts of the system, so it's going to take a coordinated effort.

We know that seniors are particularly vulnerable at points of transition. The nursing home-emergency department transition, for example, is a very important transition that we need to look at. Any guidance we get that provides stimulus from activities that happen as the accords work through will help us, I think, with things like residential and continuing care acts that will provide a framework within which we can look at tying funds to key performance areas.

The Chair: I think Dr. Hirst wanted to make a comment, Mr. Brown.

Dr. Sandra Hirst: One of my concerns is what's called a "first bed policy" at a nursing home: an older adult in acute care may be transferred to the first available bed. That means that it may be 30 or 40 kilometres or miles away from where their family is. Although we want to reduce the acute care waiting list and free up beds in acute care, the suggestion for the first bed policy really needs to be looked at and examined, because it contributes to increased confusion and delays family relationships being maintained.

I'm sure Dr. Estabrooks would agree.

Dr. Carole Estabrooks: It's a serious issue.

Mr. Patrick Brown: I know that one of the comments the CMA made as well was on the cost of acute care beds. I think they said that being in a hospital bed costs 10 times as much as being in a long-term care bed.

I have just another general question—

The Chair: Mr. Brown, I am so sorry. I have been trying to get your attention. Your time is up. My apologies.

Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair. I want to thank the witnesses for coming to provide us with some clarification. To start, I have a question for Dr. Pringle.

In one of your articles, you talk about the need for better cooperation among health professionals.

Could you explain to the committee what you have in mind and how that would help prevent and treat chronic diseases?

[*English*]

Dr. Dorothy Pringle: When I was talking about medical professionals, I was really talking about health professionals, not just physicians. We know we get better care when it's team care: where we have the opportunity to have the best prepared person for a particular area—it kind of goes back to scope of practice—who can be called upon from the team to deliver the care. It's really about that need to work in teams.

Frankly, with regard to the complexity of the care required by older people, and particularly those with dementia, they usually don't just have dementia. They have dementia, heart disease, diabetes, and arthritis. It's that complex care. It's more than what we can expect any one health professional to manage well. You need the team, and you need to have that team working well together with the resident, when that's possible, and with the family, always, in terms of assessing, making decisions, and then enacting that care.

That's the intent. We have to move from single providers. A problem in many nursing homes is that there is no team. We have very few registered nurses, some practical nurses, and then, mainly, health care aides. There may be a bit of help from physicians, who may visit weekly. Sometimes there is a bit of physiotherapy time and a bit of recreational therapy.

But frankly, given the numbers and the need, we don't have enough other professionals participating in teams to provide the best daily life and the best outcomes for the residents.

● (1705)

The Chair: You have another minute.

[*Translation*]

Mrs. Djaouida Sellah: Okay.

My next question is for Sandra Hirst.

What should be the priority for the renewal of the 2014 health accord when it comes to long-term care and home care, although there is no federal legislation on long-term home care?

[*English*]

Dr. Sandra Hirst: Yes, you're right. There is a national home care association, but it's primarily voluntary.

If emphasis could be placed on a national home care policy that recognizes and supports family members who want to give good care, but that doesn't assume they are the only care provider and that looks as well at the opportunity for family members to move an older adult across the country in a smooth transition, a national home care program would be exceptionally valuable.

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

We will now go to Mr. Williamson, please.

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

Thank you for being here today.

[*Translation*]

Ms. Garon, I have a question for you.

I see in the summary that there are 316 senior-friendly towns in Quebec and 563 of them in Canada. I would like to know why there is such a big difference.

Is it a matter of research or a matter of programs that don't exist anywhere but in Quebec?

Mrs. Suzanne Garon: It is a matter of funding. Canada does not fund in the same way Quebec does. It's as simple as that.

Since this fall, Quebec has had a comprehensive program in place. That program is funded by the ministère de la Famille et des Aînés and a number of other departments, including, I believe, the department of municipal affairs, regions and land occupancy, or the ministère des Affaires municipales, des Régions et de l'Occupation du territoire, and the department of transport, or the ministère des Transports.

So, three or four departments are involved in this. They have put up money to fund projects, while the Canadian program consists of local initiatives.

Those initiatives come from the towns themselves. To answer your question, they don't receive as much support across Canada as they do in Quebec.

Mr. John Williamson: Does the funding provided by the Government of Quebec come from the health care budget or from somewhere else?

Mrs. Suzanne Garon: It comes from the budget of the ministère de la Famille et des aînés, which is actually made up of two departments, the department that deals with family matters and the one that deals with seniors' issues. The minister responsible for seniors, Marguerite Blais, implemented the Villes amies des aînés project in Quebec, an infrastructure that helps increase seniors' social participation. The department has released funds for that purpose. The funding is not huge; we're talking about $2 million for towns for seniors' participation in society as citizens and about $9 million to $10 million for infrastructure, as I was explaining earlier.

Despite the fact that the funding is not huge, I must say that a real trend has emerged. Currently, there are 316 towns involved, but I know that other towns are on a waiting list to participate in the program, However, there is no more money available. The best thing that could happen would be if the federal government were to provide funding for Canada. The town of Saanich, in British Columbia, is having a wonderful experience as are other places in English Canada. So it would be interesting to hear more about what is being done. However, those are local and not federal initiatives.

● (1710)

Mr. John Williamson: I have a quick question for you. Why are you talking about a program that is working very well in Quebec and asking for a federal program for the rest of Canada? Why don't you talk to the other provinces?

Mrs. Suzanne Garon: Actually, the Public Health Agency of Canada is doing a lot of work on knowledge sharing and is supporting Canadian towns. I think that the best way to check what is being done in the rest of Canada would be through that agency. Although I am a member of some national committees, I am still not familiar with how each province works. In addition, I know that this is a provincial responsibility. I know that a small program was just implemented in British Columbia, but I don't know how much money was earmarked for it.

Mr. John Williamson: Thank you very much.

[*English*]

Dr. Poston, you mentioned the U.K. and their electronic records. I'd be curious to see if you could fill us in a little bit.

I read that the government there had pulled back. I'm asking this in part to determine the standard we're trying to achieve with this savings. Is it to take pharmacists out of the equation and have a system where it's between a patient and her doctor and these records? What's the role for a pharmacist? The pharmacists are still part of the equation. What's the point in spending so much money on a system that's not working particularly well?

Dr. Jeff Poston: The main benefit is improved safety. You get rid of the badly written prescription. That's one of the obvious advantages. It also enables information to be transferred between health care practitioners. My colleagues here have talked about the challenges with patients getting moved between different parts of the health care system. An electronic health record would allow for continuity of care over that time.

The Chair: Thank you, Dr. Poston.

We'll now go and welcome—

Mr. John Williamson: I have a question. Could I have 30 seconds on the U.K. system? You often give other members additional time.

The Chair: We don't have time. I'm sorry, Mr. Williamson. My apologies.

We'll now welcome Mr. Bruinooge to our committee.

It's your turn.

Mr. Rod Bruinooge (Winnipeg South, CPC): Thank you, Madam Chair. I'd be happy to provide some of my time to Mr. Williamson.

Mr. John Williamson: That's perfect.

The Chair: There—our problem is solved.

Mr. John Williamson: Would you be able to address some of the problems they've been having in the United Kingdom?

Dr. Jeff Poston: I think the issue was that they wanted to create a large national system, with a mega-investment of funds, and they seem to have run into a variety of technological and structural problems. There are numbers of reports. I'll find them and make them available to you.

The interesting thing is that there are few places in the world that have been successful at this. Scandinavia is one. I don't know whether it's their sense of social justice, their public funding model, or Scandinavian discipline that's made it happen. There are not many good examples of where it has happened around the world. Galicia, in Spain, is another one, which is interesting, but I'll provide information to you that summarizes the U.K. situation.

A voice: To the clerk....

● (1715)

Mr. John Williamson: Yes, to the clerk, please.

Is it Mrs. Estabrooks or Dr. Estabrooks?

Dr. Carole Estabrooks: Doctor.

Mr. John Williamson: Doctor? Excuse me, please.

Look, your report was interesting in terms of some of the almost jaw-dropping numbers, but I'm not sure what the solution is or what it is you're suggesting when you talk about an unregulated workforce. My experience with some of these centres is that people work hard, that they're over-worked, and that there is a lot of pressure, but I actually tend to think that a lot of these people are doing a pretty good job despite that.

When you talk about some of the difficulties, what are you looking for? What I'm trying to get at is, if there are deficiencies, having common standards is a good thing, but at some point, when does regulation begin to result in even fewer people being available to help people who are entering their sunset years?

Dr. Carole Estabrooks: Regulation isn't a panacea for everything. It's part of the solution.

One of the things that has happened to us in residential care is that the population has changed quite dramatically over the last decade or decade and a half, but the provision of care has changed hardly at all. People used to come to a nursing home and often stay for eight or ten years.

When we started our study five years ago, they stayed an average of 18 months. Four years later, they were staying an average of 12 months, so we're being quite successful in the community, but they're coming in very late in the trajectory so they're more complex, and we haven't changed the model. As a matter of fact, if anything, the model has become worse in many ways in terms of staffing, because the retention issue has become very big in nursing homes.

In Alberta, where I'm from, when the economy is as hot as a pistol it's very difficult to staff these environments compared to when it slows down, so it's very cyclical. The providers are doing the best they can, but we also have a mixed model of provider in long-term care that we don't have in the publicly funded acute care system. We have private for-profit, public, and voluntary faith-based organizations, so we have a number of models also mixed into this.

We think that if we could even count the unregulated workers, that would be a beginning. If we could look at minimum educational standards, minimum training standards, and if we could look at some kind of minimal re-certification standards or something analogous to that in the industry, it would help. It wouldn't solve everything, but it's a beginning.

If we could look at the sorts of standards that ought to be in place around.... We haven't really addressed end-of-life care in these organizations, which is a bit different from palliative care. A palliative care model can be very expensive, but nursing homes are end-of-life care environments now, and we haven't really addressed how that looks different from what we used to do for mom and pop 20 years ago in a nursing home.

There are a lot of things we can do without regulating ourselves and painting ourselves into a corner from which we can't escape. I mean, we have to be cautious about regulation.

Mr. John Williamson: Do I have 30 seconds?

Is the mixed model working, by and large? Do you see that as a strength in this issue that's going to get larger as we go forward?

Dr. Carole Estabrooks: My read on it is that the jury is still out on that. In some jurisdictions it appears to be working reasonably well, but there are mixed reports about quality depending on the model you have. Some will say that it doesn't seem to make a difference, and some think it does. I don't think we have a really good handle on whether the private for-profit model is working in the residential long-term care sector.

Dr. Dorothy Pringle: I think there is more consensus that the quality is better in the not-for-profit model, both in community care delivery and in residential long-term care.

The Chair: Thank you so much.

Thank you, Mr. Williamson, for your generosity to Mr. Bruinooge. I really appreciate that.

We want to thank our witnesses for coming today.

We have some brief committee business to do so I'll suspend the meeting for two minutes. If anyone has conversations they have to carry on, would you kindly do it outside the door?

Ms. Libby Davies: Madam Chair, before you suspend, could I raise a point of order?

I notice that our committee business is in camera. I don't think we'll be discussing details of witnesses, so I don't understand why it should be in camera. I'd like to move that we continue with our public meeting until 5:30. I move that as a motion.

The Chair: Is there any discussion on this motion?

Dr. Carrie.

Mr. Colin Carrie: We usually have our business meetings in camera, so I'd like to continue that going forward.

● (1720)

Ms. Libby Davies: I'd like a recorded vote, please.

The Chair: A recorded vote: all in favour of having it in camera, raise your hands.

An hon. member: In camera—

An hon. member: What are we—

The Chair: We'll have a recorded vote.

[*Translation*]

Ms. Anne Minh-Thu Quach: Could you tell me more about the procedure before we continue the meeting in camera? Can that request be made at any time and for any reason? I just want to know why we are continuing our discussion in camera.

[*English*]

The Chair: We'll proceed with the vote first to deal with the motion.

[*Translation*]

The Clerk of the Committee (Mrs. Mariane Beaudin): I will answer your question, but a recorded vote has been requested and I will first proceed to that business.

[*English*]

The motion is to proceed in public.

(Motion negatived: nays 6; yeas 5)

The Chair: The motion is denied, so we shall suspend for two minutes.

Thank you.

[*Proceedings continue in camera*]

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