# Standing Committee on Health

HESA NUMBER 013 1st SESSION 41st PARLIAMENT

**EVIDENCE**

## Wednesday, November 2, 2011

## Chair

**Mrs. Joy Smith**

# Standing Committee on Health

**Wednesday, November 2, 2011**

● (1535)

[*English*]

**The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)):** We'll call the meeting to order.

We have a very special guest today. Of course, we have our witnesses, Maureen O'Neil, from the Canadian Health Services Research Foundation, and Elizabeth Badley, as an individual. Elizabeth is a professor from the Dalla Lana School of Public Health, University of Toronto. And you're a senior scientist, I understand. Wonderful. We're so glad you could join us.

Also today we have another guest. Today it's Kids Come to Work Day, where they accompany their parents. We have Michael Norris at the back, who is Sonya's son. There he is. He's going to get firsthand experience of what it's like to come to the health committee. Welcome.

Having said that, we are going to start our presentations. We have a 10-minute presentation from both people, and then following that we'll go into our Qs and As.

We'll begin with Maureen O'Neil, please.

**Ms. Maureen O'Neil (President, Canadian Health Services Research Foundation):** Thank you very much.

I'd like to thank the committee for inviting the Canadian Health Services Research Foundation to appear on this very important subject.

[*Translation*]

The Canadian Health Services Research Foundation is a non-profit agency funded by the federal government. It's mission is to accelerate healthcare improvement and transformation for Canadians.

[*English*]

My presentation will focus on how health systems should be adapted to better meet the needs of patients with chronic conditions. Although provincial and territorial governments have primary responsibility for health care delivery, federal investments through health transfers, research, and spreading innovations are absolutely essential to reform.

To start with some good news, we know a great deal about how to realign health care services to meet the needs of patients. Unfortunately, the reality, the bad news, is that actually making the changes is extraordinarily difficult politically, particularly for provincial governments. However, it is quite possible that the needs of aging boomers and the reality that as we age we experience more chronic illnesses will create sufficient momentum to change the way in which we organize and pay for health services.

On Monday, the U of T's Mowat Centre released a report by Will Falk that explained that we actually don't need new revenues, nor do we need to privatize services to meet our needs. Change can actually happen within the public system.

[*Translation*]

The fact that chronic disease management has become the main duty of our healthcare systems shows the effectiveness of modern medicine. Illnesses such as heart disease, some forms of cancer and AIDS, which at one time was fatal, are now chronic diseases.

A recent assessment conducted by the Canadian Academy of Health Sciences indicates that there is a considerable gap between how the healthcare system currently functions and the needs of patients with chronic diseases. It isn't just the people with chronic diseases who would benefit from a new organization of healthcare services, it would be good for all of us.

In a report prepared at the request of the CHSRF, Jean-Louis Denis, a full professor and a Canada research chair in governance and transformation of health organizations and systems, is proposing a strategic harmonization of front-line services, the management of chronic diseases and the health of Canadians.

[*English*]

In preparation for a national meeting of health care CEOs next February, we commissioned a health policy expert from Saskatchewan, Steven Lewis, to answer the question, what actually needs to be done to achieve integrated high-quality care for people with complex chronic conditions? He said much the same thing as Professor Denis. He defined integrated care as needs-based, comprehensive and holistic, convenient, seamless, easy to navigate, team-based, oriented toward patient participation and self-management, and, most important, evidence-based and data-driven. He has identified seven barriers to improving performance and seven solutions.

One thing he said was that it's actually rare in Canada to find true team-based shared care models. Non-physician practitioners are generally not practising to their full scope. For example, in the U.K., in England, most chronic care is delivered in the community by nurses.

He also drew our attention to the difficulties that the current payment systems create for modern use of communications. Many high-performing systems in the States allow patients to communicate by e-mail with their physicians. In some places in Canada, physicians cannot be paid for e-mail or telephone communication.

He also points out the exponential danger for patients taking five or more drugs, and some patients with chronic conditions are taking up to 10. If there isn't a comprehensive electronic health record and more integration of pharmacists, that really combines to make the problem more difficult.

[*Translation*]

To help answer questions about changes to how the healthcare system functions in order to meet the needs of Canada's aging population, we organized round tables in six cities. Over 200 policy-makers, health system leaders, researchers and so on took part. Members of the Senate Special Committee on Aging also participated in these round tables.

Several solutions proposed by Mr. Lewis and Professor Denis were explained during these round tables. They also pointed out that we need to think about the issues particular to the very specific population groups. For example, a good number of aboriginals have only limited access to transportation and housing. They also have a higher than average rate of chronic diseases. They have also asked to strengthen partnerships. They have asked organizations like ours to disseminate these innovations because, otherwise, we won't move forward.

● (1540)

[*English*]

Last year we helped in the spreading of innovations in primary health care through a conference called “Picking up the Pace”, where we featured 47 innovations in primary health care delivery, many of which highlighted better ways to care for patients with chronic conditions. For example, the Centre de santé et de services sociaux-institut de gériatrie de Sherbrooke and a research team from the Research Centre on Aging in Sherbrooke, first developed, in 1999, an integrated service model for seniors that was unique in Quebec. They had real success in reducing the number of elderly people who were going into residences, and they also, and this was very important, put the brakes on the deterioration in the health of elderly people during hospitalization because fewer of them were in the hospital.

This was shared in the Province of Quebec, but as in many instances, people cherry-pick, and they pick some things but not others, so it would be interesting to see whether or not the results were quite as sterling as they were in Sherbrooke.

I'd like now to turn to a concrete example of how the Northwest Territories is working with us to develop an integrated chronic disease management strategy.

The NWT estimates that 70% of all deaths, half of all hospital admission days, and costs of over $136 million annually are related to chronic disease.

Working with the territory at the nexus of policy and delivery, our focus has been on mental health, diabetes, and kidney disease. We're bringing together researchers who've spent years studying these topics, together with the territorial policy-makers, health system managers, nurses, and doctors. Drawing on their mutual strengths, they are identifying improvement opportunities and building solutions across their extraordinarily large territory. Closely associated with this work is evaluation to ensure that the ideas and practices spread.

Governments across Canada are working to meet the challenges posed by chronic diseases. We know in recent scans that we've done across the provinces that there are activities everywhere. This is a big concern of all systems.

At the pan-Canadian level, the federal government has supported a number of disease-based frameworks, strategies, and bodies that also are attempting to mobilize support across the country and reduce the burden of specific chronic conditions, whether it's the Mental Health Commission of Canada, the Canadian Partnership Against Cancer, or through the Canadian Institutes of Health Research, the strategy for patient-oriented research.

These federal investments are essential in the reform of health care, so we at CHSRF continue to search for ways to improve health care for Canadians and to share these innovations across the country.

Thank you very much for your invitation to appear.

I'll be happy to answer questions later.

**The Chair:** Thank you.

Could you please give us your presentation, Dr. Badley?

**Dr. Elizabeth Badley (Professor, Dalla Lana School of Public Health, University of Toronto; Senior Scientist, Toronto Western Research Institute, University Health Network, As an Individual):** Thank you very much for giving me the opportunity to come today. I'm going to continue with the theme of chronic disease, and I'll change the tempo a little bit to be a bit more personal.

I'm very delighted that you're interested in chronic diseases related to aging. This is my long-term research interest as an epidemiologist and health services researcher. My particular expertise is in arthritis and other musculoskeletal conditions.

What I want to do today is help put arthritis more firmly on your radar screen and convince you that you must include arthritis in your deliberations on chronic diseases and aging. Of course, this is a huge topic, so I've chosen to focus on a couple of aspects that I think you'll find most relevant.

These are, first, how arthritis and other chronic diseases are related to each other, and second, why this is important to healthy aging.

I should first set arthritis in a Canadian context. It's one of the most common chronic conditions and is by far the most frequent cause of disability in the population. One in six Canadians, about 4.5 million people, report having arthritis, and that is a lot. A great many of these people are aged 65 or older, representing over 1.7 million seniors. That's the same as the populations of Manitoba and Newfoundland and Labrador combined. On top of that, there are a further one million, about the same as the population of Saskatchewan, who already have arthritis and will become seniors during the next 10 years.

I don't have time to go into a lot of detail about arthritis. If you need to know more, please do ask. An excellent source of information is this report from the Public Health Agency of Canada. It's called *Life with Arthritis in Canada*, and it gives a very good picture of the personal and public health challenges of arthritis.

Arthritis is a broad family of diseases, and I'm just going to talk about one of them: osteoarthritis, or OA, as we call it. More people have OA than any other kind of arthritis. About one in eight people in Canada have it, and a lot of them are seniors.

OA, like other kinds of arthritis, is linked to other chronic diseases. Take, for example, a friend of mine, a real person, who I'll refer to as Marie. She's a very lively, positive, creative person with a great sense of humour. My husband calls her the one-woman walking cabaret. Marie is only in her late sixties, but she's had OA for about 20 years. She has big problems with mobility. Just walking and climbing stairs is difficult and painful. Over the years I've watched as the pain and stiffness of her OA have made her less and less physically active. That's meant that she's put on weight. The more weight she puts on, the worse her arthritis gets, so she's caught in a vicious circle of arthritis pain, less activity, and more weight gain. Another effect of her weight gain has been that she's developed hypertension and heart problems. And on top of everything else, she's now been told to watch what she eats, because she's on the cusp of getting diabetes.

Marie is not alone in having a combination of other health conditions, as you've already heard. Most seniors have more than one chronic condition. A recent Stats Can survey targeted to healthy aging showed that 90% of seniors with arthritis have at least one other chronic condition.

The interesting thing is that we're now learning that these co-occurrences of arthritis and other conditions likely don't happen by chance.

We all know that lack of physical activity and excess weight are associated with an increased risk of heart disease and diabetes as well as some cancers. So we can speculate that Marie's disability and weight gain brought about by her OA may have contributed to her other health problems.

A well-known side effect of anti-inflammatory medication for arthritis is an increase in blood pressure, and that in turn can increase the risk of a heart attack. In fact, for this reason, Marie's doctor has stopped giving her these meds, which means that she's left with a lot of pain.

It's hardly surprising that the wonderfully positive Marie sometimes get depressed. This is worrying, because depression increases the risk of having a heart attack.

There's yet a further twist to the story. Arthritis is the most common cause of inflammation, and research is beginning to suggest that inflammation itself might be bad for you—bad for your heart, your diabetes, and a number of neurological and other conditions.

● (1545)

This may sound like terrible news, but the good news is that it's opening the door to understanding how and why different chronic conditions can occur together. Knowing what leads to what and why raises the exciting possibility that we might find new ways to prevent chronic diseases. CIHR's initiative focused on inflammation is certainly a step in the right direction.

Let me spend my remaining time focusing on what can be done about arthritis.

There's a powerful myth that influences both people with arthritis and their doctors, that OA is an inevitable part of aging for which nothing can be done. This is not true. Younger people have arthritis, and, for the record, the major treatment strategies for OA are medications for pain and inflammation, maintaining a healthy weight, exercise, and for end-stage arthritis of the hip and knee, joint replacement surgery.

Marie has had both knees replaced, which has helped a lot, but she still has arthritis in her feet, hands, and back. One of her problems is getting access to expertise within the health care system. Many primary care doctors aren't confident in dealing with arthritis, which can probably be traced back to a lack of arthritis training in medical education. Our orthopedic surgeons focus, of course, on surgery, such as total joint replacement, and our rheumatologists are busy dealing with rheumatoid arthritis. This raises the question of where people like Marie can go for expert advice on disease management. And, don't forget, she represents a very large number of Canadians who suffer from arthritis.

This is where we need the kinds of innovations in the health care system you've just heard about. We need innovations in the way we deliver arthritis care to ensure people like Marie can get the help she needs. There are some encouraging beginnings across Canada. CIHR has also funded research looking at new models of delivery of care for arthritis, some of which involve professionals such as advanced practice physiotherapists and nurses. But there's still a long way to go.

And of course we can't forget that arthritis is associated with other health problems. As you know, this is a challenge for our health care system, which typically deals with one condition at a time. Marie spends a lot of time going to medical appointments with different specialists to deal with her various health problems. This issue is not unique to arthritis, and I know you've already heard about the need for a more integrated health care system and patient-centred care. However, the discussions about this, and particularly about chronic disease management, do not always include the needs of people with arthritis. It's vital that this is changed, given the large number of people with this chronic disease.

I'm trying to encourage Marie to take advantage of various community-based treatments such as exercise, physical activity, and weight loss, as well as chronic disease self-management programs. The good news is that these are the same things that are recommended for other chronic conditions, as I'm sure you know. However, we need to keep in mind the needs of people with arthritis. For example, the current Canadian recommendation for physical activity for seniors is at least two and a half hours of moderate to vigorously intense aerobic activity each week. Marie can hardly get out of her house. We need ways to help the Maries of this world deal with the pain and stiffness of arthritis and to be able to gradually ramp up to full physical activity and at the same time reduce their risk of other chronic conditions. Physical therapists and chiropractors can help with physical activity, but, as you've already heard, we need to deal with some of the financial and other barriers that stop seniors and low-income people from taking advantage of their help.

The thing is, exercise works. I have another friend, Jeanette, who has arthritis in her back, hands, and knees. Two years ago, she had to hang onto her husband's arm for support when she was walking outside. This year, she began to meet daily with a personal trainer and started a graduated exercise and walking program. Two weeks ago, she walked 21 kilometres in the Toronto marathon. This, more than all the scientific studies that I've read, convinces me that support for physical exercise for people with arthritis can reduce disability, and may even potentially postpone the need for joint replacement surgery.

● (1550)

In conclusion, I hope I have helped to convince you that when thinking about healthy aging and chronic disease, we cannot and must not neglect the needs of the large number of people with arthritis.

There are three reasons for this. One, arthritis is important in its own right. It is the most frequent cause of pain and disability, especially in older people. Two, having arthritis increases your risk of other chronic conditions, and this knowledge needs to be built into chronic disease prevention and management strategies. Three, we have to recognize that having arthritis pain and disability may prevent many older people from getting the maximum benefit from existing chronic disease strategies.

This is a quick look at some of the most important issues, but there is a lot more. If you'd like to know more about this important disease, I'm sure the Arthritis Society and other members of the Arthritis Alliance of Canada would be more than happy to help you, as would I.

Thank you for your attention. I would be very happy to answer questions.

**The Chair:** Thank you so much, Dr. Badley.

We'll now go into our first round of questions, which will be seven minutes for the question and the answer.

Also, just a reminder that we will suspend at 4:45 for the business portion of our meeting.

We'll begin with Madam Quach.

● (1555)

[*Translation*]

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

I'd like to thank you for your presentations and for giving us information about your organizations.

My first question is for Mrs. O'Neil.

You spoke about a number of interesting things. First, you said that, according to one report, it isn't necessary to privatize healthcare to help patients and that there is still a gap between how things are currently working and the healthcare needs of seniors.

How can the federal government adapt to intervene and improve the healthcare offered, particularly when it comes to chronic diseases?

[*English*]

**Ms. Maureen O'Neil:** First of all, I want to underline the research that U of T has just put out, which Will Falk was responsible for. It looked at all of the potential efficiency gains that could be made within our system if we used technology more effectively and if we used different professions to the limit of their capacities. It would mean reordering who does what among doctors, nurses, physiotherapists, etc. It would mean approaching the organization of services differently and approaching the services in a way such that the patient is at the centre. That is an extremely important point to make.

He also noted that, in his view, there is enough money in the system to achieve this. This does not cover, of course, the issues that have been left out so far, which are questions of pharmacare, etc.

This point was reinforced as well by the CMA in its own briefs, that a public system, reorganized with the same amount of money—or the amount of money that rises depending on population—can cover this without any particular need to privatize payment of services.

That doesn't mean you can't have different organizations actually providing services, but the research seems to suggest that there are enough inefficiencies in the way in which we do things now that, with a reorganization of those services, the needs could be met.

[*Translation*]

Can you repeat your second question? I'm not actually sure if I answered all your questions.

**Ms. Anne Minh-Thu Quach:** Yes, you did, but with respect to the Toronto research, would it be possible to have the results of the research sent to the clerk?

**Mrs. Maureen O'Neil:** I think they are on the site of the Mowat Centre for Policy Innovation at the University of Toronto. I think it was posted on Monday of this week, so two days ago.

**Ms. Anne Minh-Thu Quach:** You also talked about partnerships with aboriginals and the fact that they have specific problems. You mentioned the problem of access to transportation and social housing. You also said that we need to work in partnership to improve the conditions and prevent an exaggerated rate of chronic diseases in that group in particular.

Do you have any ideas about strategies that can be implemented so that the federal government can get involved in this?

**Mrs. Maureen O'Neil:** Yes, but as you know, the federal government has a lot of responsibilities related to aboriginal health. But they are often shared with the provinces.

I think Manitoba has implemented an initiative. Two weeks ago, it was announced that government airplanes instead of ambulances were going to be used to transport patients. Ambulances can't be used in many communities anyway. A study was done establishing that using the small government airplanes costs almost the same as using ambulances in the cases of patients in regions that are very far from Winnipeg.

It was a recommendation that came out of our round tables on aging. I should mention that we always need to think about specific populations, rather than think only generally, because the situations are very different.

● (1600)

**Ms. Anne Minh-Thu Quach:** I have a question that perhaps you both might answer. You both spoke about grouping teams of professionals to help seniors. We know that there are only 200 geriatricians in Canada to treat seniors. We know that the number of people 65 years and older is going to increase exponentially in the coming years.

Do you know whether the research under way is providing enough information about the need for healthcare professionals to adapt to demographic changes? Is there enough training? Should there be more?

**Mrs. Maureen O'Neil:** I can answer, but I think Dr. Badley will have something to say as well.

It's well known that there is a shortage of people trained in gerontology. You will probably invite the scientific director of the Canadian Institutes of Health Research's Institute of Aging. He is really the leader when it comes to the research and organization of services in Canada.

We can say there's a shortage. It takes nearly 10 years to train a specialist. This shortage is serious.

[*English*]

**The Chair:** Dr. Badley, would you like to make some comments on that as well?

**Dr. Elizabeth Badley:** Thank you. I'd just like to add to and echo what you said earlier about using other health professionals.

A lot of health care for older people in the community and people as they age can be delivered by physical therapists, particularly for musculoskeletal disorders, by nurses, and we can use chiropractors, occupational therapists. For some of the needs not directly related to health care but to well-being we can use social workers. There is a whole range of professionals out of there. There are exercise therapists, who can be used to help people remain active and to deal with physical activity and the consequences of obesity. And pharmacists have been increasingly used to advise people around drugs, for example.

**The Chair:** Thank you, Dr. Badley.

We'll now go to Mr. Brown.

**Mr. Patrick Brown (Barrie, CPC):** Thank you, Madam Chair, and thank you, witnesses, for your comments so far.

I want to get your perspectives on the CIHR's Institute of Aging. We were previously told that there has been a funding allocation of $122 million and that it's one of the strategic priorities of the CIHR.

Do you have any impressions of this Institute of Aging? Is it accessible for research? Is it helpful to have CIHR put a focus particularly on the theme of aging?

**Dr. Elizabeth Badley:** In a word, yes. They're doing a great job. They have e-mailed researchers who are interested in the field regularly to keep them up to date about their calls. I'm very grateful to them, because I've just gotten a grant from them to investigate whether baby boomers are in fact going to be less or more healthy than their older counterparts, because we don't know the answer to the question, whether it's going to be better or worse than we feared.

They sponsor a number of targeted competitions, which are very important for the research community, that enable the research community to look at aging more broadly—not only looking at diseases, but also at health.

**Ms. Maureen O'Neil:** They were excellent partners when we were doing these six round tables across the country on aging. They were extremely good partners in terms of sharing the basic research they have accumulated over the years and in making extraordinarily useful interventions in round tables that included, as I mentioned, a real mix of people, from researchers to people at the community level to providers of health services.

**Mr. Patrick Brown:** It was my hope to hear that. It's certainly nice to see the CIHR have that focus.

When I think of the $122 million, I also imagine that there are grants available through the cancer research funds and through neurosciences that would also have many links to aging.

One thing this committee has taken an interest in is the neurosciences. Concerning the population study that is also being funded, what do you hope from Minister Aglukkaq's funding of $15 million for the neurological charities to figure out the exact prevalence of neurological disorders in Canada? I know we've taken estimates, but what are your hopes concerning what this will help establish?

● (1605)

**Dr. Elizabeth Badley:** Neurological disorders, I think, have been largely neglected. They are perhaps one of the most common causes of very severe disability and of course occur more frequently with aging and also in conjunction with other conditions. It will be very good to get prevalence estimates and also to learn more about their consequences for individuals.

I would also say that the Public Health Agency of Canada has recently focused on living with chronic diseases and has had other looks at hypertension and arthritis and related conditions. We commend the agency for commissioning research to look in depth at a number of different chronic conditions, because the general population health service, while extremely useful, often does not give those in-depth insights that we really need. So I think the work on neurological disorders and other disorders is an extremely welcome thing.

**Mr. Patrick Brown:** Has the Canadian Health Services Research Foundation, which you, Ms. O'Neil, head up, done any research in the area of neurosciences, in terms of Alzheimer's and dementia?

**Ms. Maureen O'Neil:** No. We're a very small agency. You talk about the $122 million in the institute and the agency; our total budget is just over $10 million. We work much more at the nexus of policy and delivery with the provinces, with the health institutions, regions, etc., working on the way in which they organize services rather than being a financing agency for primary research. Canadian Institutes for Health Research do that. Also, many of the health charities focus on primary research.

In many areas, such as the work on neurological conditions, it's primary research that we need as much as—I would say even more than—we need research on how to organize services for people. In fact, we simply don't have good answers to many of the questions they're dealing with.

**Mr. Patrick Brown:** I think you highlight that very well. One thing I'm always perplexed by is how little we know when it comes to neurological disorders. I hear positive reviews of government programs, such as the New Horizons program, which has programs for seniors' homes, such as arts programs and physical activities, to stimulate and delay the onset of neurological disorders.

At the same time, you can look at individuals such as Ronald Reagan and Margaret Thatcher, who fell ill with neurological disorders, and I couldn't imagine individuals who have busier days. It really leaves you perplexed, wondering what we can do to delay onset or prevent some of these horrible diseases. Do you have any policy advice on programs that the government should look at and that would be helpful in this field?

**Ms. Maureen O'Neil:** I would say obviously research, but I think something else. I think that as we become much better at using electronic health records and become better at engaging clinicians who are seeing people every day—one of the CIHR programs is attempting to get physicians who are actually in contact with patients every day to use the data on their own patients and share that evidence—we're also going to have a much better way of building up knowledge of the people who are coming to see their doctors now. Even if we don't actually know what the cause is, we'll get a much better sense of how people's disease progresses.

In other words, without electronic health records, we are working with one hand tied behind our back. We're not able to accumulate the information. If you imagine how companies who want to sell us things and companies who are able to use our credit card information, let's say, to develop a profile as a consumer.... They're way ahead, in their capacity to understand us, of where our physician is.

**The Chair:** Thank you, Ms. O'Neil.

We'll now go to Dr. Fry.

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

I want to change the channel a bit and talk about seniors who have mobility problems. Many seniors have mobility problems, for one reason or another. There's a sense as well that if you move these seniors from their homes and put them into an institution or long-term care facilities, you actually increase the rapidity of them getting memory loss and Alzheimer's and disorientation and all of those kinds of things.

How, then, can one ensure that elderly mobility-challenged people can stay in their own homes, especially if these homes are not easily accessible? What sorts of changes do you see that wouldn't be very costly? You would have to change every single home, or every single unit of every single apartment in a community, if you wanted to improve their mobility without having to remove them to an institutional setting that has mobility access. How do you see that happening?

Today at the research caucus lunch, the woman from the United Kingdom was telling us that part of the multidisciplinary team they use in managing chronic care includes a housing person and a social worker. When we talk about multidisciplinary teams, we don't think about these two people.

Can you elaborate on that and tell us what model you think we could use?

● (1610)

**Ms. Maureen O'Neil:** That actually raises the much broader question about the way we organize health services. If you imagine Ottawa, there isn't anybody in Ottawa whose job it is to be responsible for all the initiatives that have an impact on people's health.

We don't have any locus of management in our health system. It's not like they've got a pot of money and can decide it would make more sense to subsidize ramps in people's houses than it would to do X, Y, or Z. Nobody has the control over reallocating money, and that's a big part of the problem in terms of the way we organize ourselves to look after people's needs.

I think the work that human rights commissions have done on disability have not been focused on elderly and chronic. On the positive side, there are benefits in the obligations that public spaces have for them, but that will not get at the issue of the adjustment of private spaces.

Who is going to pay for these kinds of questions becomes the issue. It helps their health. We save money if they're there. Whether it's a private or a public responsibility is going to be the debate on many issues over the next decade.

**The Chair:** I think Dr. Badley would like to make a comment.

**Dr. Elizabeth Badley:** I have two very quick comments.

One is that only a tiny minority of older people are actually in wheelchairs. Most can walk, probably not very well, but they can walk.

So there are two things. One, as I indicated in my presentation, is to stop people from deteriorating because they lack physical fitness. They lack physical fitness. They get less fit. They're less able to do something.

The other thing is simple adaptations to the home: stair rails, getting rid of trip rugs, rearranging the furniture in somebody's home so they can hold on to the furniture as they walk around. These can keep people active in their own homes. Putting a grab bar in a bathroom, or a rail by a toilet so somebody can easily get out of the seat, raised toilet seats, don't cost a lot of money.

**Hon. Hedy Fry:** I realize that. But I think Ms. O'Neil was saying that somebody has to coordinate all of this so they know what the needs are.

In some provinces there are regional health authorities, and they're given sums of money to look after these things. Is this the appropriate group to look after them? Or do we need to develop someone, like this woman from the U.K., who does that, or who is in charge of a group that does that?

**Ms. Maureen O'Neil:** The health authorities across the country have different scopes and responsibilities. Some have a lot more than others. We can't forget that in the United Kingdom there is an actual health service organization. We have payment systems that allow us to access health services. We have doctors who can work independently. We have hospitals where you find nurses, and so on, but we don't actually have systems that are integrated, and that's a really big difference.

The optimistic view of health authorities, say, 40 years ago was that they would become the locus of management for this range of questions. But I think if you look across the country, sometimes they have a lot of scope and other times they don't. Sometimes they are responsible for, say, just the hospital and long-term care budgets, but they might not even have public health. Then somewhere else there are community care access centres, and somewhere there's housing, but they don't have all of them together.

● (1615)

**Hon. Hedy Fry:** Do you see this as part of a transformative change model that could go into a 2014 accord?

**Ms. Maureen O'Neil:** This is a really interesting question. Certainly, except for the extraordinary political difficulty of doing it, this is something that provinces can do. I guess the interesting question would be whether there is a way to sweeten the pot. The fact is that if a province is very brave, it can do that now. It, after all, holds the money for the physicians, holds the money for the hospitals. Now there's the problem of what is not funded, some professions that are not funded, that in fact could be extraordinarily helpful to people with chronic diseases. But the provinces can do this. The provinces could do this, but it's not easy. Every time there's a change in the health system, there are a lot of people who line up and are not keen on it.

**Hon. Hedy Fry:** Our health system is based on hospital and physician funding right now. You cannot fund long-term care. You cannot fund community care, but the accord had a sweetener in it for doing just that in 2004.

**The Chair:** Thank you so much.

Now we'll go to Mrs. Block.

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

Thank you to our witness for being here. I'm truly enjoying this study we're doing. My first question will be for Ms. Badley. I'm very interested in the project you mentioned that you just received grant money for through the CIHR, because I'm an individual at the tail-end of the baby boomers, and I truly do believe that we need to take what appears to be a huge challenge looming on the horizon with baby boomers aging and turn it into an opportunity. It sounds to me that perhaps the project you've received funding for might contribute to doing that. I don't know if you'd like to describe for us even the process you went through to receive the funding. Perhaps give us a little bit more of an idea of what your project is going to look like.

**Dr. Elizabeth Badley:** Well, very briefly, first of all, I looked at the literature. I found over 1,000 papers that mentioned the baby boomer population, and they said things like, oh, it's going to be awful, there are going to be a lot more people, we won't have any health professionals. When I whittled it down, I found only 20 papers that actually had evidence out of that 1,000.

What I'm going to do is use data from the national population health survey, because I need to be able to compare people who are 55 or 65 now with people who were 55 or 65 ten years ago and look at time trends in their increasing disability, their self-rated health, and their use of care over time, and see if the slope of the trajectory is the same for different generations—older baby boomers, younger baby boomers, and what I've called the wartime babies, people who were born between 1935 and 1945. I hope that in about a year's time I'll be able to give you some of the results.

There are reasons to suppose we might be healthier. We know we've had better health care. We have better education. We've had antibiotics. On the other hand, we're more obese. One of the other difficulties is that people are living longer with chronic diseases when they otherwise would have died. So I think we're going to have two little groups in there: healthy people who look after themselves—probably those of better social class, the richer, the more privileged—and probably the poorer and the more obese, and then the survivors. So I think it's going to be quite complicated, but at least I think it might help us target health care a little bit more practically, and also it might mean that it's not going to be as bad as we think it's going to be.

**Mrs. Kelly Block:** Thank you.

Do I have...?

**The Chair:** Yes, you have a few minutes.

**Mrs. Kelly Block:** My next comments will be for Ms. O'Neil.

First of all, I'd like to congratulate you on receiving the Order of Canada in June. That's quite an accomplishment.

I'm from Saskatchewan, so I do know Stephen Lewis, and I know him to be a very passionate and motivational speaker and advocate for reforming or reorganizing the health care system.

This committee has heard from many health professionals that the health care system should be transitioned progressively from one of acute care to one that is more about prevention, management, and health promotion. The committee has been told that over time such a model could incur significant savings. I'm wondering, from the work you're doing, can you share if you're aware of any research that absolutely supports that, or might even refute it?

● (1620)

**Ms. Maureen O'Neil:** I think the research on that question is rather like the research Dr. Badley looked at. In looking at all the papers that make a lot of very big assumptions, there isn't a lot of evidence associated with them.

I think the research that needs to be done is the kind of research we're doing together with Fraser Health in British Columbia and the Institute for Health Systems Sustainability, where we're in the process of looking at, first of all, how much money actually flows into that region for health, no matter how it's going in—whether it's for hospitals or for physician payment, whether it's for drug payments that turn up, all of that—so we know what the quantum of the money is. We know another study will look at what the population health characteristics are. Then we imagine the overlays like in those books on the body that little kids look at.

We know what the characteristics of a well-functioning health system are, that is, integrated—all of the words that Stephen Lewis used in describing it. Then the question is asked, how far are we from that? Given the amount of money we have, could we pay for that here in Fraser Health? What would the barriers be to getting the money flowing in that direction? As Dr. Fry said, our money comes in very specific ways in the health system, and that sometimes can be a barrier to doing the things we know need to be done.

That kind of study, where you're looking at a real place with calculations of real money flowing through the system, and putting that overlay of what a really good system looks like and then saying, how far are we away from it and how will we get there, I think, is the kind of study that's going to help us answer that question.

**Mrs. Kelly Block:** Thank you.

**Ms. Maureen O'Neil:** Again, as Dr. Badley said, in a year, if you're still studying this, we will have a much better answer, because this will have been looked at together with the organizations and institutions that are actually delivering the care.

**The Chair:** Thank you, Mrs. Block and Ms. O'Neil.

We're now going to go into our five-minute rounds of Q and A.

We'll begin with Dr. Sellah.

[*Translation*]

**Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP):** Thank you, Madam Chair.

I'd like to thank Mrs. O'Neil and Dr. Badley for enlightening us.

I did a little research on both of you and, as Mrs. Kelly Block, who preceded me did, I'd like to congratulate you, Mrs. O'Neil, on receiving the Order of Canada in June.

I know that the mission of your foundation is to accelerate healthcare improvement and transformation for Canadians. I know that your association works with governments, policy-makers and health system leaders. I also know that you have at least three priorities. One of those priorities in particular caught my attention. It was promoting policy dialogue. In your presentation, you also mentioned that among the existing barriers are the lack of collaboration between the various healthcare services and the fee-for-service model.

What do you think would be the best way for the federal government to contribute to resolving these problems? Should the federal government create a way to share best practices?

**Mrs. Maureen O'Neil:** That's a very good question.

I think that the Canadian Medical Association has already suggested investing much more money into sharing innovations. We fully agree with the association. In fact, the opportunities for action by the federal government are limited, except in the case of the populations it is responsible for, such as aboriginals, people connected to the Department of National Defence, and so on. In those cases, it's different.

But if we're talking about the others, it's mainly a question of research funding, which is very important. We cited a number of studies today. It is absolutely essential that this continue.

There is always the possibility of creating very specific programs. A number of programs have been mentioned, such as the Canadian Partnership Against Cancer and the Canadian Mental Health Commission. I could add that our organization, as well, was supported by federal funds years ago. These are the levers available to the federal government.

However, there is something else. I find that the federal government could encourage exchanges between the provinces and researchers, and especially sharing between the provinces. They are not all organized in the same way, but in a fairly similar way. The broad outlines are the same. I think we need to continue having a pan-Canadian conversation to try to resolve the problems.

We have always worked very closely with Quebec. I know that Quebec is aware of the changes that take place in the other provinces. It's the same thing for the others, but the employees of the departments of health who work on the operational plan do not have the chance to share with the others.

To move forward, it is essential that Nova Scotia share what it has done with British Columbia, for example. Actually, the provinces all do things a little differently, and we can all win if we share with each other.

● (1625)

**Mrs. Djaouida Sellah:** Do I have any time left, Madam Chair?

[*English*]

**The Chair:** You have one minute.

[*Translation*]

**Mrs. Djaouida Sellah:** My question is for Dr. Badley.

What do you think the federal government's role should be when it comes to establishing priorities and even new frontiers in healthcare? Chronic diseases are, in some way, a new frontier.

[*English*]

**Dr. Elizabeth Badley:** I think there are a number of things. A dialogue at the federal-provincial level is essential. We need research because we need to understand a lot more about co-morbidity, the issues of people who have more than one health condition. One health condition can interfere with another and may lead to yet another. We tend to think of diseases one at a time, and we need to take a more holistic view. There is not a lot of research out there in that area. I'm a researcher, and that's the way people can help. I think the public health agency can help with information on that.

**The Chair:** Thank you, Dr. Badley.

I will now go to Dr. Carrie.

**Mr. Colin Carrie (Oshawa, CPC):** Thank you, Madam Chair, and my thanks to the witnesses for being here today. I found your presentations excellent and really forward-looking.

Before I got into this business, I was a chiropractor and I ran wellness clinics. It was trying to put together something like you were talking about, a multidisciplinary team. We have an acute care health system and everybody is in silos in this country. But the model doesn't quite fit with the management of chronic conditions. We should be looking at cost savings, outcomes, patient satisfaction, and having a system that's more patient-oriented and flexible.

It's something that is coming together, thanks to the testimony we're getting at this committee. You mentioned a study the Mowat Centre did. We've been told that a different model would over time save a lot of money for governments. I was wondering whether you were aware of research that supports or refutes this claim. Are there other models around the world that are starting to do this?

● (1630)

**Ms. Maureen O'Neil:** The reality is that practically since the ink began to dry on medicare, there have been studies and reports done in Canada on different ways of organizing health services. In fact, when I was a young analyst, I worked on the Manitoba white paper on health policy, which talked about exactly the kinds of questions we're talking about today. It recommended multidisciplinary regional health authorities and all of this, with money allocated in a block and population health being the main decider of how you would allocate your money. We're not short of this.

Various aspects of this do pop up in different parts of the country. It's just that unlike some other countries, we have not embraced it as the main way of doing business.

I'm sure you know better than I that to make changes in the way different professions are funded, organized, and work together requires, first of all, a vision that people are going to stick to over a period of time. This has been talked about so many times, and it's been written about so many times. As I said in my presentation, maybe now—unless Dr. Badley finds that in fact the boomers are not going to suffer from lots of chronic diseases—the pressure is rising. It'll become inescapable, if we want to continue to have a public, financially sustainable health care system, that we can't put off any longer those sorts of changes, which have been written about for 40 years.

**Mr. Colin Carrie:** Are you aware of any models or any systems out there? There seems to be a little bit of a disconnect in training professionals, too. We see certain specialties in medicine that aren't that busy. Other ones could be a lot busier.

I think my colleague brought up that there are only 200 gerontologists in Canada, or something along those lines. I remember from friends of mine that each of these patients would take half an hour or 45 minutes for a visit, and if you're trying to run your office, it is very difficult if you're getting paid per service.

Is there any advice you could give us on training and connecting that with what the population needs?

**Ms. Maureen O'Neil:** There are in fact other models in other countries, but there are also models of doing it in Canada. It's just that they don't get expanded.

The study from the Mowat Centre that Will Falk did focused on some of that. But also, even within the acute care setting, different professions are not used up to their full scope of practice, and technology is not necessarily managed. Even just within that there is a lot of scope for change. It's like changing personal habits. Somebody has to be really inspired to stick with it to make these changes. There are models around the world of approaching things in a multidisciplinary way. There are different training programs. But lots of this we've known.

**The Chair:** Thank you, Ms. O'Neil.

We'll now go to Madam Hughes. Welcome back to the health committee.

**Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP):** Thank you very much. I didn't think I'd get a chance here, so my mind was going in a different direction.

What we're hearing today is no different from what we heard at the HHR study we did: multidisciplinary teams are the way to go.

This past weekend I was up in Hearst and heard about a woman,

[*Translation*]

*une femme sage.*

**A voice:** *Une sage-femme.*

**Mrs. Carol Hughes:** She is a wise woman, in any case.

**Voices:** Ha, ha!

**Mrs. Carol Hughes:** She works with the doctor. They have a good relationship, that is truly unique, just like the fact that they agreed to work together. We don't see this in the rest of Ontario. They are shown as an example at some conferences.

I think it is very important to say that a number of studies have been done and that the results are always the same. We really need a government that is taking action now in this direction. I'd like to know if you agree.

● (1635)

**Mrs. Maureen O'Neil:** Instead of talking about the government, we should be talking about governments. As I just said, the provinces have the power to act, but the policy surrounding this makes the task very difficult for them.

For example, when the Government of Ontario decided to use nurse practitioners, who have advanced training, a good number of members of the Ontario Medical Association were a little frustrated by the decision.

In healthcare, every time a decision needs to be made, for example to close a small hospital—actually, it's a little dangerous to have small hospitals where the employees are not up to par—there are geographic and political considerations. Each time something needs to be done, there is a sometimes almost violent reaction.

If we were the ministry of health of a province, we should have the trust of people to act, including that of the Prime Minister. But, as we have already pointed out, the reactions to the changes are always there.

We may wonder whether the federal government can or cannot help us in this difficult political process. Is it the responsibility of the provinces to make changes? It's not a money issue, but a policy issue. It is important to act with great wisdom to organize the changes, to say that changes are necessary.

**Mrs. Carol Hughes:** Thank you for your intervention. It's really the question we are asking ourselves, and the answer is always the same. We hope that someone is going to move forward.

I have another question, but we may not have enough time. Since I want to make sure my colleague will have an opportunity to ask a question, I'll share my time right now with Jinny.

[*English*]

**Ms. Jinny Jogindera Sims (Newton—North Delta, NDP):** Thank you very much for your presentation. We all are the baby boomers or the end of baby boomers. We're experiencing that time in our lives when we're looking after our parents who are aging.

You're absolutely right, they don't have only one ailment. It's a multiplicity. One of the things that I found with my father—he developed Alzheimer's and then had three strokes and multiple other things—was that what really assisted us as a family was when he ended up in a facility where there was the kind of integrated care that you're talking about.

It not only helped him. It actually helped us and reduced the stress level of the six siblings facing this.

As I look to the future, am I hearing from you that an integrated approach to care of the elderly could be done within our public system if there was the will? If so, what role could be played by the federal government—because that's the only thing we have any control over—to facilitate, nurture, and encourage this kind of a move?

**Dr. Elizabeth Badley:** When we're talking about integrated care, I also think we need to refocus and think about integrated care in the community. There are some people who need to go into institutions, but we need to keep a lot of seniors at home. That was a re-referencing. And then the funding—

**The Chair:** I'm sorry, time is running out, so if you would wrap up quickly, please....

**Ms. Maureen O'Neil:** Very quickly, I think the federal government's capacity to facilitate the sharing of knowledge of what works across the country, the reports of committees like yours but also reports on what's working, and also facilitating discussions among the provincial officials at the working level who are focused on these changes, that is the way to go. It's like consciousness-raising.

● (1640)

**The Chair:** Thank you, Ms. O'Neil.

We'll now go to Mr. Williamson.

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

Ms. O'Neil, I'm curious because during your discussion you said that privatization was not necessary, which is fair enough, but sometimes people hear what they want to hear as opposed to what you actually meant. In the first round of questions you then said that, working within the system, delivery was open to negotiation, open to change. I'm curious if you can tease out those ideas a little more because they seem to run counter to one another.

**Ms. Maureen O'Neil:** The important question to pose is this: is the payment for services private? That's one big thing, and certainly the study I was citing said no. It didn't get to that; it just said there's enough money in the public system now to do what we need to do, if we're able to work up the courage to do the required reorganization.

We also have to remember that as Canadians, unlike citizens of other countries, we already pay privately for about 30% of health services: drugs, many physiotherapists, psychologists, etc. We do not have a completely paid for public system.

In answer to your question about the best delivery model, I think there's lots of room for experimentation with that, if you think of—one always picks up one—the Shouldice Hospital in Ontario, which is private but publicly accessible, and that's interesting, but I think there are many problems that can go along with that. We have a hard enough time in Canada keeping the standard of care high and safe. I'm sure everybody followed in the newspapers in Ottawa the story about private clinics, where it turns out there are fewer regulations than for restaurants, in terms of levels of cleanliness, etc.

There are a host of other problems. It's very easy to glibly say, yes, we can split up our system and have it run differently, but we have to then have a regulatory framework that makes sure it's safe. We have a hard enough time keeping it safe in the system we've got. If we start looking at other ways of delivering it, it's not necessarily bad, but we then have to ask ourselves how we manage it so that it's safe.

**Mr. John Williamson:** Often when people talk about it not being a question of money, that it's a question of politics, that's a polite way of saying it's a question of doing what the public doesn't want politicians to do. When you talk about federal oversight in Quebec, for example, where some rather innovative reforms are being made to tap into private health care, but all within the barrel of the medicare system, is that an area where you think the federal government should be applauding them or putting up roadblocks as they experiment to meet their health care needs in a way that fits within the budget of Quebec?

**Ms. Maureen O'Neil:** I think what Quebec—and I'm sure they're doing this—and the federal government should be doing is evaluating very carefully whether these forays into private medicine are delivering the outcomes that were hoped for. How are the costs being spread around? Are people getting good care? Are they not? What was expected of them? Are they delivering it? I think it's extremely important to evaluate all of this, because you're quite right.

Since the Chaoulli decision, a lot of shifts have been happening, and I think there are probably more shifts happening around the country than people are aware of. But I think the key thing is that these are closely evaluated. Are these really delivering what we hoped for? Who's bearing the cost burden? Who is accessing them? Are they getting the right kind of treatment? Are they getting too much treatment? There can be too much of a good thing. How many MRIs do people need?

The important thing is to follow very closely what is going on, which reinforces the federal role in supporting that kind of evaluation.

● (1645)

**Mr. John Williamson:** Sure, but in that it sounds as if your organization opposes....

You trust but verify; keep an eye on it, but allow it to happen.

**Ms. Maureen O'Neil:** I don't think our organization believes or disbelieves. We think that change in health care should be based on evidence, so if you do something, track it and look at it in five years, and ask both the equity questions, the optimal outcome questions—

**Mr. John Williamson:** You don't take the view that it must be delivered through a public delivery. You're prepared to look at different models and experiment, or consider those, and then we have the evidence down the road.

**Ms. Maureen O'Neil:** It also depends on what you mean by private. If you look at global evidence, there isn't evidence anywhere that suggests that a massive private delivery is going to offer equitable, high-quality health care.

**The Chair:** Thank you very much, Ms. O'Neil.

Our time is up now. I want to thank our witnesses very much for coming to give us this very important and insightful information. I have a whole page of new ideas.

We now have to go into committee business, so I ask that the room be cleared.

Thank you so much.

[*Proceedings continue in camera*]

Canada Post Corporation / Société canadienne des postes

Postage paid | Port payé
Lettermail | Poste–lettre
1782711
Ottawa

*If undelivered, return COVER ONLY to:*
Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5

*En cas de non-livraison,*
*retourner cette COUVERTURE SEULEMENT à :*
Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5



**Published under the authority of the Speaker of the House of Commons**

## SPEAKER'S PERMISSION

**Reproduction of the proceedings of the House of Commons and its Committees, in whole or in part and in any medium, is hereby permitted provided that the reproduction is accurate and is not presented as official. This permission does not extend to reproduction, distribution or use for commercial purpose of financial gain. Reproduction or use outside this permission or without authorization may be treated as copyright infringement in accordance with the *Copyright Act*. Authorization may be obtained on written application to the Office of the Speaker of the House of Commons.**

**Reproduction in accordance with this permission does not constitute publication under the authority of the House of Commons. The absolute privilege that applies to the proceedings of the House of Commons does not extend to these permitted reproductions. Where a reproduction includes briefs to a Committee of the House of Commons, authorization for reproduction may be required from the authors in accordance with the *Copyright Act*.**

**Nothing in this permission abrogates or derogates from the privileges, powers, immunities and rights of the House of Commons and its Committees. For greater certainty, this permission does not affect the prohibition against impeaching or questioning the proceedings of the House of Commons in courts or otherwise. The House of Commons retains the right and privilege to find users in contempt of Parliament if a reproduction or use is not in accordance with this permission.**



**Additional copies may be obtained from: Publishing and Depository Services**
**Public Works and Government Services Canada**
**Ottawa, Ontario K1A 0S5**
**Telephone: 613-941-5995 or 1-800-635-7943**
**Fax: 613-954-5779 or 1-800-565-7757**
**publications@tpsgc-pwgsc.gc.ca**
**http://publications.gc.ca**

**Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca**



**Publié en conformité de l'autorité du Président de la Chambre des communes**

## PERMISSION DU PRÉSIDENT

**Il est permis de reproduire les délibérations de la Chambre et de ses comités, en tout ou en partie, sur n'importe quel support, pourvu que la reproduction soit exacte et qu'elle ne soit pas présentée comme version officielle. Il n'est toutefois pas permis de reproduire, de distribuer ou d'utiliser les délibérations à des fins commerciales visant la réalisation d'un profit financier. Toute reproduction ou utilisation non permise ou non formellement autorisée peut être considérée comme une violation du droit d'auteur aux termes de la *Loi sur le droit d'auteur*. Une autorisation formelle peut être obtenue sur présentation d'une demande écrite au Bureau du Président de la Chambre.**

**La reproduction conforme à la présente permission ne constitue pas une publication sous l'autorité de la Chambre. Le privilège absolu qui s'applique aux délibérations de la Chambre ne s'étend pas aux reproductions permises. Lorsqu'une reproduction comprend des mémoires présentés à un comité de la Chambre, il peut être nécessaire d'obtenir de leurs auteurs l'autorisation de les reproduire, conformément à la *Loi sur le droit d'auteur*.**

**La présente permission ne porte pas atteinte aux privilèges, pouvoirs, immunités et droits de la Chambre et de ses comités. Il est entendu que cette permission ne touche pas l'interdiction de contester ou de mettre en cause les délibérations de la Chambre devant les tribunaux ou autrement. La Chambre conserve le droit et le privilège de déclarer l'utilisateur coupable d'outrage au Parlement lorsque la reproduction ou l'utilisation n'est pas conforme à la présente permission.**



**On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt**
**Travaux publics et Services gouvernementaux Canada**
**Ottawa (Ontario) K1A 0S5**
**Téléphone : 613-941-5995 ou 1-800-635-7943**
**Télécopieur : 613-954-5779 ou 1-800-565-7757**
**publications@tpsgc-pwgsc.gc.ca**
**http://publications.gc.ca**

**Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca**