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Chair

Mrs. Joy Smith

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): I will ask the members to please take their seats.

I'm Joy Smith, the chair of the committee. I want to welcome you back to committee. I am so pleased you were able to make it back, as the last time you were here, the bells rang, which happens from time to time.

As you know, pursuant to standing order 108(2), we are continuing our study of chronic diseases related to aging. We have Lynn Cooper from the Canadian Pain Coalition. We do remember your excellent presentation, Ms. Cooper. Thank you.

And we have, from the Canadian Coalition for Seniors' Mental Health, Kimberly Wilson. Of course, Kimberly, you were also here.

We also heard from Associated Medical Services Inc., from Mr. Jeffrey Turnbull, a member of the board of directors. We so appreciated your presentation.

We're going to to go where we left off, at our last presentation, by the Fédération interprofessionnelle de la santé du Québec.

Excuse me, Dr. Carrie?

Mr. Colin Carrie (Oshawa, CPC): Madam Chair, I was wondering if I could present a motion to the committee before we get started. It should be very brief.

The Chair: Absolutely.

Mr. Colin Carrie: The committee asked that the minister present before the committee as soon as possible. The clerk has distributed the motion. I'd like to read it out.

Salut. Oui?

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): I don't have it.

The Chair: One moment while we will make sure that you get a copy, Dr. Morin.

Do you now all have a copy of the motion in front of you? Dr. Sellah?

Dr. Carrie, would you continue?

Mr. Colin Carrie: Yes. I move:

> That the committee invite the Honourable Leona Aglukkaq, P.C., M.P., Minister of Health, to appear before the Committee on the Supplementary Estimates (B) on Monday, November 21, 2011, from 3:30 to 4:30pm.

The Chair: Is there discussion?

Dr. Morin.

Mr. Dany Morin: I think that one hour is short if we have a lot of questions to ask her. Would it be possible to have an extra 30 minutes to make it an hour and a half?

The Chair: Dr. Carrie.

Mr. Colin Carrie: I know the minister has a prior commitment; she is scheduled after that. In the past she has stayed as long as she absolutely can, and I know she's able to come at that time.

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

[*Translation*]

Ms. Anne Minh-Thu Quach (Beauharnois—Salaberry, NDP): Actually, what I wanted to say is along the same lines as Dany. If she can stay a bit longer, can we set aside an hour and a half, just to make sure we are giving her enough time?

[*English*]

The Chair: As Dr. Carrie said, she has a previous commitment and has committed to being here from 3:30 to 4:30. As you know with ministers' time...she has always come every time we've asked her.

Dr. Sellah.

[*Translation*]

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

I agree with the motion moved by my colleague Mr. Carrie, but I wanted to make sure that, during that hour, the questions are all going to be for the minister, not for the officials accompanying her.

We have a lot of questions for her. I would like it to be clear that the questions are for the minister only.

[*English*]

The Chair: Just to let you know, all questions are always directed to the minister. She has her officials with her if there's something she needs to double-check. The minister has always come in, always made the presentations, and she has done a very good job.

Yes, Dr. Carrie.

Mr. Colin Carrie: I do believe the officials will stay behind for the following hour, if there are any specifics for the committee.

The Chair: Let's deal with the motion, first of all.

Mr. Dany Morin: I have a short question. Considering that we have a lot of questions, could we find out how many blocks of seven or five minutes the NDP will be getting so we can prepare our questions?

The Chair: It will be the same as always.

Mr. Dany Morin: So it's going to be seven minutes in the first round and then the four of us will have five minutes to ask the minister—

The Chair: No.

Mr. Dany Morin: No? That is why I wanted to have some clarification.

The Chair: That's right.

● (1535)

The Chair: Let's deal with this motion. Are you all in agreement that minister come here on November 21 from 3:30 to 4:30?

Mr. Dany Morin: Could I have the answer to my question first?

The Chair: I did answer it: I said it will be exactly the same as usual.

Mr. Dany Morin: So it will be seven minutes, and then each of us will have five minutes.

The Chair: Yes.

Mr. Dany Morin: Thank you.

The Chair: You are very welcome.

Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah: Madam Chair, I could not agree more with my colleague Mr. Morin. If my math is right, based on the normal procedure, it takes two hours for everyone to be able to ask the minister one question. Yet the minister is only going to be here for an hour. So I'm guessing that not everyone will have the opportunity and the privilege to ask her a question.

[*English*]

The Chair: Just to give you some background, as I know you are new to the health committee, after we deal with the motion we'll let you know that the department and officials can stay for the second hour. So you will have ample time to ask any questions you may have. We will have the minister for the first hour and the officials for the second hour. The timing is as per usual, as the rules lay out, which is what you've done since you first came here as a committee member. She gives a 10- to 15-minute presentation, then you have seven minutes for the first round and five minutes for the next round.

Dr. Carrie.

Mr. Colin Carrie: Quite often, if you get together before the minister comes, there is a first seven-minute round, and it's often split so that everybody gets a chance. How you use your time is certainly up to you.

The Chair: Absolutely. You are free to split your time at any time. I'll be very pleased to make sure you all get on the docket.

(Motion agreed to)

The Chair: For the second hour we'll bring in the officials so you will have additional time to ask questions.

Is there another question, Dr. Sellah?

[*Translation*]

Mrs. Djaouida Sellah: You mentioned one hour for the estimates. Shouldn't it be two hours?

[*English*]

The Chair: That's the day for the estimates. It's one hour for the minister and one hour for the officials. The minister can only come for one hour.

[*Translation*]

Mrs. Djaouida Sellah: Can't we have the minister and the officials for one hour each?

[*English*]

The Chair: It's the same way we usually do it in the health committee. There are no changes.

Those are good questions.

Are we all set to go now? Are there any other questions? All right, I think we can go now.

We'll have our presentation from the Fédération interprofessionnelle de la santé du Québec. We have Madame Régine Laurent, the president. I've asked the clerk to help correct my French pronunciation. What a beautiful name. You will be presenting.

With her is Madame Lucie Mercier, the labour advisor.

You can proceed with a 10-minute presentation.

[*Translation*]

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

Good afternoon, honourable members.

The Fédération interprofessionnelle de la santé du Québec represents over 60,000 members, including nurses, nursing assistants and respiratory therapists working across Quebec. By virtue of our professions, we are concerned about health and diseases, chronic diseases in this case.

For us, the aging of the population, although real, is not the destiny that the advocates of the apocalypse would want us to believe it is. Only an increase of 1% in the costs of healthcare services is associated with the aging of the population. The effect of age and the effect of death should not be confused in the costs of healthcare services. Furthermore, we have to remember that the financial situation of the elderly is not necessarily an enviable one. And that is especially true when it comes to the poverty of elderly women.

In terms of chronic diseases, we have mainly relied on the definition of the Health and Welfare Commissioner, who says that chronic diseases include a great number of conditions: cancer, diabetes, disorders of the musculoskeletal system, and so on. It is therefore not surprising that they drain a lot of resources from the healthcare system. In fact, 5% of the population uses nearly 50% of the short-term care.

Moreover, we are well aware that you want to hear us talk about chronic diseases in the elderly. But with a broader view of health, we also look at data for people age 12 and over who suffer from chronic diseases. We are talking about 52.6% of people in Quebec. So chronic diseases are not just exclusive to the elderly. Unfortunately, they can affect all ages.

Different types of services are required by people with chronic diseases. Some are important to us: screening, diagnostic, treatment, support, rehabilitation, and also palliative care. Our organization appeared before a parliamentary committee in Quebec a few weeks ago. We believe palliative care is highly lacking.

Healthcare institutions are not always the best choice when the time comes to treat a person with a chronic disease. The literature is full of integrated models for the management of people with chronic diseases. Among others, there is the Chronic Care Model, a clinical model retained by the Health and Welfare Commissioner and the expanded model for the management of chronic diseases, which integrates aspects of prevention, community and population in order to have a greater impact on the determinants of health.

In terms of community development and clinical models, there is the SIPA model. This clinical model, which we also use, is built on case management, meaning that all services have clinical responsibility.

When we talk about chronic diseases, we also have to think about home care. Home care should be considered as medically required in the Canada Health Act and consequently, it should be covered by the public healthcare systems. The income level of people with chronic diseases, whatever their age, must be avoided at all cost in determining the care to which they will have access. This principle, which is the basis for the Canadian healthcare system, is still a consensus across Canada. Unfortunately, home care currently represents a small proportion of the healthcare expenses in Quebec and in Canada. We would very much want to see it go up.

We are also concerned about access to medications. In many cases, pharmacological treatments with the proper follow-up can replace hospitalizations. That is why it is of utmost importance that drugs be available at reasonable costs. We are concerned about the negotiations in progress to conclude the Comprehensive Economic and Trade Agreement between Canada and the European Union, more specifically the clauses on protection of intellectual property. That is very likely to result in an increase in the costs of medications, which are already very high. Let me take you back to the beginning of my presentation where I mentioned the poverty of elderly people. So they are being further penalized.

● (1540)

We think that palliative care, meaning end-of-life care, must also be included in the basket of insured services and not be the subject of disengagement of the state as is the case currently, where beds that were reserved are now closed and where the community must raise funds to finance palliative care hospices.

The last point I would like to make has to do with informal caregivers. It is undeniable that informal caregivers, generally women, greatly contribute to the well-being of people with chronic diseases. Furthermore, according to the Health and Welfare Commissioner, 25% of informal caregivers have been diagnosed with depression. But we have ways to support informal caregivers so that, if they want, they can continue taking care of their loved ones. They should benefit from conditions facilitating their care of those with a loss of autonomy. That is why we are putting forward the concept of compassion benefits.

We know full well that, in Quebec, health falls under provincial jurisdiction. We wanted to join you today because we are concerned about what is going to happen after 2014, given that the health agreement is surely being discussed again with the provinces. This is an important part for us. As I was telling you, all federation members work with people on prevention—and they would like to do more of it—but they also work with the elderly affected by chronic diseases.

Thank you.

Have I gone over my time limit, Madam Chair?

● (1545)

[*English*]

The Chair: No, you certainly didn't, and I want to thank you for your very insightful comments.

We will begin our first round of seven minutes for the questions and answers, beginning with Ms. Quach.

[*Translation*]

Ms. Anne Minh-Thu Quach: Thank you very much, Madam Chair.

Ms. Laurent, thank you for your presentation. You touched on some interesting things, especially in terms of access to medications, which is becoming increasingly difficult. The elderly actually have rather limited resources and they have trouble buying medications. The situation is only getting worse for them.

You talked about your concern over the Comprehensive Economic and Trade Agreement in terms of the cost of medication. Could you further explain the negative impact this could have on the increase in the cost of medication, as well as on patients?

Ms. Régine Laurent: I am going to answer your question about medications, and then, my colleague, who has really gone through the entire agreement, can give you an answer.

Here is our concern about medications. As soon as people are no longer in hospitals, as soon as they are at home in the community, they have to pay for medication. Unfortunately, given the poverty rate, especially among women, we see on a regular basis in our profession elderly people who are choosing between eating properly and buying medications.

As health professionals, we feel this is all linked. People should be able to eat well and should not have to choose between healthy food and medication. We are very concerned about this because we think that someone who does not eat properly will have other health problems at some stage. It is really about the big picture.

I was talking about clinical models. I think they might be useful for us because we deal with prevention. This includes all services, not just nutrition. We have to make sure that those people exercise, that their mental health is satisfactory and that they have the means to buy medications.

Mrs. Lucie Mercier (Labour Advisor, Sociopolitical Affairs, Fédération interprofessionnelle de la santé du Québec): In terms of the economic agreement currently being negotiated, the information we were able to get indicates that the chapter on the co-ownership of intellectual property is supposed to increase the protection period for patents. The duration of patents per se does not actually go up, but as a result of three factors, including data protection for clinical studies, the effect will be the same.

This was part of a study done by people in pharmacology at the University of Toronto, I believe. For Quebec only, the potential increase in the patent protection period would cost roughly $278 million. That worries us because medications are already very expensive and patent protection in Canada is one of the longest in the world, as we know.

[*English*]

The Chair: You have some more time.

[*Translation*]

Ms. Anne Minh-Thu Quach: Okay. Thank you.

I have another question about chronic diseases. You have said that healthcare institutions are not necessarily the best places to cater to the needs of people with chronic diseases. You have also said that there are a number of integrated models.

In addition, you talked about case management and clinical responsibility in relation to the SIPA model. Could you talk about it some more? Does Quebec have a model that the rest of Canada does not, or vice versa, and that we could use to make a difference in people's lives?

● (1550)

Ms. Régine Laurent: Actually, when we ask the elderly people with chronic diseases this question, they all hope to be at home, just like all of us. So we think there is a way to put in place a model in communities, regardless of which model we choose. The idea is to make sure that we are going to be able to address people's needs in terms of home care and all the other services that can be provided in the community.

As for models, I started to slowly implement this new model in Quebec. Let me give you an example. Why can't there be nursing clinics in the various parts of a city? I am thinking of Hochelaga-Maisonneuve, the district I live in and I am very familiar with. There are a lot of elderly people there. When you have a chronic disease, medication monitoring is often more important than a purely medical follow-up. So if there were nursing clinics in the community, we could follow up on the medication. The elderly person establishes a relationship of trust with the people who are close in the community. That might make it possible for the elderly to stay in their own homes in the community, at a very reasonable cost. To my knowledge, there is nothing like this anywhere else.

There is a similar model in Ontario. That is why we are in close contact with our colleagues in Ontario. We would like to see how we could adapt that model to Quebec. But I haven't had a large audience in Quebec yet.

Ms. Anne Minh-Thu Quach: Okay.

You have also talked about the new agreement of 2014, and about your concerns in terms of provincial jurisdictions. While respecting provincial jurisdictions, can the federal government speak up in order to help the federation improve care? Would you be able to suggest some ideas?

Ms. Régine Laurent: I think that what is generally important is leaving Quebec and its population the flexibility to decide how to deliver health care.

I will be more clear when it comes to my concerns. We have seen dedicated budgets in some places. We do not want that to happen in health care, because, when it comes to health care, we have to keep in mind each province's population. We are worried about being forced to have dedicated budgets, in the Government of Quebec. As a result, we might not be able to carry out certain projects that would be useful and would meet Quebeckers' needs. We would not be able to carry out those projects, as some budgets would be dedicated.

[*English*]

The Chair: Thank you very much, Ms. Laurent.

We will now go on to Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you very much, Madam Chair. Thank you to the witnesses for coming back for another round.

I wanted to address my questions to Ms. Wilson. It's good to see you.

We've heard from many witnesses during this study that seniors with chronic diseases often suffer from an additional disease of depression, or mental illness. I'm just wondering if we have any statistics or information on what sort of a problem we are dealing with there. What percentage of Canadian seniors are dealing with a mental illness?

Ms. Kimberley Wilson (Executive Director, Canadian Coalition for Seniors' Mental Health): Thanks for your question.

The data we have, sometimes we don't think is necessarily as accurate as we'd like it to be. A lot of the ways mental illness manifests in older adults aren't necessarily captured by some of the tools that we have. If you take depression, for example, some of our data show that in community dwellings samples the rates are similar across all ages, at 12% to 15%. We also think there are probably a lot of older adults who aren't being captured properly in those statistics.

However, if you look within long-term care, the numbers for depression go up significantly, with up to almost half of all residents in long-term care showing some symptoms of depression. Some surveys have shown between 80% to 90%.

I think probably what's most important know is that the numbers don't change as people age. In fact, we see an increase. If we're saying one in five Canadians lives with a mental illness, that would also be true for older adults with certain segments being at higher risk.

Mr. Mark Strahl: What are some of the common precursors that have been identified amongst seniors who are dealing with depression? Is chronic disease one of them? What are some of the others?

● (1555)

Ms. Kimberley Wilson: Living with chronic disease is absolutely one of risk factors. In particular, that's one of the risk factors for suicide.

There are a lot of physical illnesses that people experience as they age, but we also see psychosocial factors, such as bereavement, with the loss of partners and friends, and the loss of independence and autonomy. A lot of these life transitions that are more common to later in life are what we see as some of the risk factors for depression, in addition to the biological risk factors that we all have at any age.

Mr. Mark Strahl: Right, and maybe you can refresh our memories about how your organization is reaching seniors who find themselves suffering from mental illness or depression.

Ms. Kimberley Wilson: Right now, we work primarily with health care providers to give them knowledge translation tools and some of the best evidence about the information we have in terms of assessment, treatment, prevention, and management. We work with the health care providers who we hope then change their practices.

We've also done some work directly with older adults by creating some user-friendly brochures educating people about what depression is and what other common mental illnesses are, to try to take away some of the stigma so that people feel comfortable going in to see their family physicians, identifying some of the symptoms they may have, and asking for help.

Mr. Mark Strahl: In the system—provincial and federal—are we doing a good job of reaching seniors and letting them know that this is a danger they might face? And are we reaching out to their kids, who are often in charge of their care as they grow older? Are we doing a good enough job globally, I guess, of making seniors aware that this is something they may face and in trying to educate them on how they might mitigate those circumstances?

Ms. Kimberley Wilson: I think this is an area where we have a lot of opportunities to strengthen what we are already doing. There are certainly people who are champions across the country in local communities who do excellent work, but I don't think we're doing it well enough yet.

I think it's really important, too, to think about the two separate cohorts that we talk about: our current cohort of older adults who really grew up with a lot more of the stigma associated with mental illness than perhaps our next cohort may experience; and then the baby boomers, a very different generation, the one that we often talk about when we talk about this boom or tsunami that might be coming.

I think there are opportunities in the curriculum. Right now we know that medical students, for example, receive very little information about mental illness in general, and mental illness in late life in particular. Right now we don't have a lot of mechanisms to reach people who are currently in practice and to introduce them to some of the newer assessment tools, some of the risk factors, and the opportunities for treatment in late life.

Mr. Mark Strahl: Our government has invested significantly in mental health research, with $130 million previously, and has renewed that funding. Are you using any of the research that we have put into the mental health strategy? Is this something that you see benefiting Canadian seniors?

Ms. Kimberley Wilson: Yes, absolutely. I'm very privileged to be part of the Seniors Advisory Committee at the Mental Health Commission of Canada, so I'm very well aware and very proud of the work that has been happening at the Mental Health Commission.

Part of what we feel we've contributed, and which we hope to see change policy and practice, is our guidelines for comprehensive mental health services for older adults, which were funded by the Mental Health Commission and will inform part of the strategy moving forward. They will be released in 2012. So absolutely, but I think there are also opportunities to enhance that contribution as well.

Mr. Mark Strahl: Thank you.

The Chair: Thank you very much, Mr. Strahl.

We'll now go on to Mr. Casey.

Mr. Sean Casey (Charlottetown, Lib.): Thank you, Madam Chair.

First of all, you will have to forgive me. Hedy Fry is the regular member of the committee for the Liberals. I am standing in because she's not in town today. I didn't have the benefit of any of your presentations, except the ones that were made today. I come at this, on more than one level, from a position of ignorance. My apologies in advance.

The committee I normally sit on is veterans affairs. I was somewhat pleased in hearing your presentation, Madame Laurent and Madame Mercier. There is a bit of an overlap. What I want to ask you about ties into this, given what you've had to say about palliative care and the concerns of the nursing profession in caring for the aged. You are probably aware that in the province of Quebec right now, there are extensive negotiations under way for the transfer of the Sainte-Anne-de-Bellevue Hospital from the federal to the provincial government. I would be most interested in your perspectives and your organization's perspectives on what both sides should be considering in those negotiations, and your views on the potential impact on your profession, on health care in your province, and on the patients.

● (1600)

The Chair: Go ahead, Mrs. Laurent.

[*Translation*]

Ms. Régine Laurent: Thank you.

I want to begin by saying that we are not involved in the negotiations. Therefore, I will give you my point of view based on the information we have. That information came from government officials.

We share the concerns of our colleagues from Sainte-Anne-de-Bellevue: specific clients need specific care. For instance, earlier, I was talking about seniors with specific needs. So, we think that in order to take care of veterans, certain particularities must also be taken into account.

I saw our colleagues were asking that their current organization of health care be taken into account, and I agree with that. They say—and I believe them—that their organization is appropriate for patients with specific needs. They are worried that the way their health care is organized will change once they merge with the Centre de santé et de services sociaux de l'Ouest-de-l'Île, and I am also worried about that. That is why they asked that a separate board of directors be maintained for Ste. Anne's Hospital.

To my knowledge, the Government of Quebec has not consented to their request for a separate board of directors. However, we will give them all the support we can so that the current health-care structure, which meets veterans' needs, stays in place. We don't believe that being part of a health-care and social services centre means that everything should always be standardized, be it for veterans or other clients.

Mr. Sean Casey: Thank you.

I know that there is another hospital in the province—perhaps a few other hospitals—whose organization is not administered by regional directors. For instance, Shriners Hospital is one such model. If you could advise the federal government, would you say that it's important to insist on a separate organization only for that hospital?

Ms. Régine Laurent: I fully understand your concerns, and I share them. As far as I understand, unless the pressures are strong enough, they are asking for a separate board of directors for Ste. Anne's Hospital. I think that would be the best way to guarantee that the organization of health care remains unchanged.

However, it seems that the Government of Quebec wants to stick to its vision by not authorizing a separate board of directors. However, I think they can rely on us. We are ready to help and support them in achieving their goal.

You are right, there are other institutions in Quebec that do not operate like the others. One example from the other extreme is Shriners Hospital. It operates in a different way. I think that different client bases must be handled differently.

We will support them in their fight to keep the current health-care structure. As for the separate board of directors, I don't think the Government of Quebec will allow it.

● (1605)

Mr. Sean Casey: Is it true that the regional organization is currently experiencing financial difficulties?

Ms. Régine Laurent: In my humble opinion, the financial difficulties are just an excuse. To my knowledge, administering health care at Ste. Anne's Hospital does not cost any more than it does at Shriners Hospital or the McGill University Health Centre. Health care is structured, and money is set aside to meet the needs.

Oh, I understand, you are asking about the Agence de la santé et des services sociaux de Montréal, Montreal's health and social services agency. That agency receives money from the health department for the whole region. Normally, it is responsible for health care in the whole region. Therefore, there should normally be no reduction in the health care currently provided to veterans at Sainte-Anne-de-Bellevue.

[*English*]

The Chair: Thank you, Ms. Laurent.

Now we'll go to Mr. Brown.

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

And thank you for all the testimony so far.

I recall from a previous year, Mr. Turnbull, that you were telling us about how to keep costs under control in the health care system. You talked about a hospital bed being about 10 times the price of a long-term care bed. That's why it's interesting to talk about home care. With the pressures on hospitals and on long-term care in Canada, home care becomes something that is obviously very important for us to improve to enable more seniors to stay in their homes.

Do you know of any examples of what's being done internationally that Canada could look at? Can you think of concrete steps we could take within our federal jurisdiction to make it easier for seniors to live in their own homes for longer?

Dr. Jeffrey Turnbull (Member, Board of Directors, Associated Medical Services Inc.): There are several important initiatives we could look at internationally, in particular in Scandinavia. We have to understand that the issue we're facing is that of building a chronic disease management system around our acute care facilities. We have a very good acute care system, but we haven't built or accommodated an aging population that has chronic diseases. So we have to build the system around this.

Other jurisdictions, in Scandinavia and elsewhere, have been able to respond to that challenge. They provide services, as we've heard, using different approaches, such as team-based care outside of the hospital, including home-based care. They are moving care out into the community, with a patient-centred focus, so that you're not using the hospital. For example, there are health care units within community centres, in a nursing home, or a long-term care facility, all providing a centre of care within those facilities as opposed to having to use hospitals as the default for a failing chronic disease management system. So there are many opportunities for us to work differently.

But I have to say that this is a wholesale change in the way we practise medicine. Our ability to adapt will depict and predict how successful health care will be in the future. Our current model, no matter how we try to massage or adjust it, will never be able to accommodate the demands of an aging chronic disease management system. So we need to think of making substantive changes, not modest ones.

On your last point as to the role the federal government could play, I think it could play an enormous and very helpful role in looking at a long-term, home-based care strategy right across this country. You could use elements of the transfer payments system to facilitate change, change that we know is dramatically needed, through some form of an innovation fund. That change would spur a new generation of health services delivery and provide the necessary care for our seniors.

Mr. Patrick Brown: I think of my grandfather, who lived in his home until the last year of his life. One of the things which enabled that was his access to community care. There were regular visits to assist him with living independently.

A few weeks ago in Barrie, I was talking to a community access nurse who mentioned that they were actually cutting back and, therefore, wouldn't be able to reach as many patients. I was surprised by that, because I imagine that's a very valuable service.

Is having that type of service something you believe is integral to keeping seniors in their homes?

● (1610)

Dr. Jeffrey Turnbull: It is absolutely. All too often we hear that same story about community care access, getting providers out to the home with the necessary support systems, whether informal caregivers...and giving them support; getting pharmaceuticals for management of chronic disease; and getting providers, doctors, and nurses visiting in the home setting. That is much cheaper, but unfortunately the way we structure health care at the moment, it has to come from the acute care sector.

As you know, I'm the chief of staff of the fourth-largest hospital in the country, and our budget is over $1 billion. Yet today we spent about $60,000—that's in one day at one hospital—for care that could be provided much better out in the community. We must have systems in place that will allow us to move these institutional dollars into home care dollars. If we're going to be successful in the future, we have to do that. We cannot use our acute care sector as a default for a failing chronic disease management system.

Mr. Patrick Brown: Okay, thank you.

The Chair: Thank you very much, Mr. Brown. You have another minute if you want to extend that.

Mr. Patrick Brown: I'm just concerned about the statistics. For 2036, we're looking at 25% of the population being seniors and are inadequately prepared for that. I know in Ontario they're saying that there will be no significant new funds for health care in terms of hospitals or community care access. I know at RVH they said that may mean 1% or a freeze at our local hospital, which may mean a freeze of community care access. A freeze, along with collective bargaining agreements, would mean that you couldn't actually service the same population. So it's very worrisome.

Is that what you're seeing in all of the provinces, or is it something unique to the province where I reside?

Dr. Jeffrey Turnbull: It's certainly not unique to your province; it's right across this country. As provincial budgets are being pressured or restricted, we're looking in Ontario, for instance, where I work, at about a 1% increase. When you look at inflation, however, going at a higher rate than that, that 1% actually represents a reduction in services. So in trying to accommodate our fiscal challenges, we are pulling back everywhere.

I'm afraid it's not a very thoughtful planned reduction and a fiscal restraint. As I've said, we could support and save money if we were able to reduce the transfers to hospitals, but because of silos and lack of integrated health systems and a regional planning approach, we're not able to do that. Certainly our hospital, which is full, would be very pleased to transfer our 140 long-term care beds out into the community.

The Chair: Thank you, Dr. Turnbull.

We'll now go to our second round of five minutes of questions and answers.

We will begin with Dr. Sellah, please.

[*Translation*]

Mrs. Djaouida Sellah: Thank you, Madam Chair. My first question is for Régine Laurent.

You talked about the status of women in your presentation. Given that the population is aging, will the various chronic diseases affect mostly women, since they live longer and are more likely to live in poverty and serve as informal caregivers?

Ms. Régine Laurent: Thank you for your question.

It's a fact that women have been paid less than men throughout their lives, at least so far. They earn 70%—75% at best—of what men earn. Therefore, their income is lower once they retire. At the same time, they live longer, and they are the ones providing informal care.

We are well aware that poverty is a risk factor. At least, that's how we see it. For women, the risk of chronic disease goes up. At the same time, women in difficult financial and family situations do not have the tools to get out of those situations. Personally, I'm pretty sure that being an older woman with a chronic disease is not something to wish for.

● (1615)

Mrs. Djaouida Sellah: Thank you for the answer.

I also have a question for Dr. Turnbull.

The committee has heard many witnesses talk about prevention as an effective tool against chronic disease. How do you view the role of health care professionals when it comes to prevention?

[*English*]

The Chair: Excuse me, Dr. Sellah, I will be suspending the committee. I am sorry, but the bells are ringing. They're half-hour bells, so we will reconvene 10 minutes after the votes.

Dr. Morin.

[*Translation*]

Mr. Dany Morin: Since we are very close to the House, can we take 10 extra minutes? That would leave us 20 minutes to get to the other side.

[*English*]

The Chair: If we have the unanimous consent of the committee, we can do that.

Do I have the unanimous consent of the committee to continue for another five minutes?

There is no unanimous consent so we will have to reconvene later.

Dr. Morin.

[*Translation*]

Mr. Dany Morin: Can I ask that a recorded vote be taken on this?

[*English*]

The Chair: There's no recorded vote. You need unanimous consent.

[*Translation*]

Mr. Dany Morin: Okay. May I still ask for a recorded vote?

[*English*]

The Chair: As long as we don't have unanimous consent....

Did you say you want a recorded vote?

[*Translation*]

Mr. Dany Morin: Yes, in order to decide whether....

[*English*]

The Chair: There are no votes.

We'll suspend and be back in half an hour. We will resume 10 minutes after the votes.

As far as the witnesses are concerned, my apologies. This is the second time this has happened. I have no control over the bells, but we will be very pleased if you will be patient. We will come back.

Thank you.

● (1615)

(Pause)

● (1700)

The Chair: Could I ask everyone to please to take their seats, because we are short of time.

I thank the witnesses very much for their indulgence. That's been very kind of you.

Just to confirm for members, it has been clarified that there are no recorded votes when the committee is suspended.

Thank you, Mr. Morin.

Mr. Dany Morin: Thank you, but I just want to put on the record that all of the NDP members of this committee wanted to give just five minutes to the witnesses.

The Chair: Can we now take the remainder of the time to go to our questions, so we'll do something useful? Thank you.

Dr. Sellah, as we stopped at 2:09, I'll give you three minutes.

[*Translation*]

Mrs. Djaouida Sellah: Should I repeat my question for Dr. Turnbull?

The committee has heard from many witnesses claiming that prevention is an effective tool against chronic disease. How do you see the role of health care professionals in terms of prevention?

● (1705)

[*English*]

Dr. Jeffrey Turnbull: Thank you very much. I'll be as brief as I can.

Health professionals have an essential and fundamental role in promoting healthy lifestyles, especially among seniors, where they can have an enormous benefit in preventing falls and in promoting better nutrition, healthier bones, etc. So health professionals can play an essential role.

However, I would also have to say that we must create structures permitting health professionals and our elderly population to enjoy a very healthy lifestyle. We've heard about the poor, so we have to ensure that the poor have adequate access to a reasonable diet. We've heard of the need to have appropriate facilities in education, and so we need to have systems to communicate with the elderly, and to promote their better health.

There are lots of structural things that we have to do. But yes, health professionals of all stripes have to play an essential role in promoting the health of our elderly population.

The Chair: You have a couple more minutes.

[*Translation*]

Mrs. Djaouida Sellah: My next question is for Ms. Wilson.

Are mental illnesses, especially depression, inevitable for seniors receiving long-term care, owing to the types of institutions involved in such care? In other words, are the loss of independence and one's long-term home not significant changes that would lead anyone to be depressed?

[*English*]

Ms. Kimberley Wilson: Thank you.

No. A lot of those are risk factors for depression, but one of our most important messages is that depression is not a typical consequence of aging. It is not inevitable, and I think what's equally important is that, if there are a lot of these risk factors in place, and someone is diagnosed as having depression, there are very effective treatments, particularly for older adults—including medications and psychosocial interventions—all of which can be utilized within a setting like long-term care. Unfortunately, right now we don't always have the best structures in place to support people who do have a mental illness in long-term care.

[*Translation*]

Mrs. Djaouida Sellah: So there is a way to invest in structures.

[*English*]

The Chair: We'll now go to Mr. Gill.

Mr. Parm Gill (Brampton—Springdale, CPC): I'm actually going to pass my time to Ms. Block.

The Chair: Ms. Block.

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

I would like to also thank our witnesses for join us again today. I appreciate the fact that you believe the work we're doing is very important, and we agree with you.

I would like to direct some of my questions and time to Ms. Cooper. I know that you came and shared a little bit of your personal story with us, as someone who's been living with chronic pain since you experienced a workplace accident, I think in the mid 1980s. I would like you to have an opportunity to refresh our memories a little bit about your own personal experience, and tell us a little bit about the Canadian Pain Coalition, if you wouldn't mind.

Ms. Lynn Cooper (President, Canadian Pain Coalition): Thank you very much.

My story is really quite typical. I was injured 25 years ago, and I dealt with the health care system in my province of Ontario, which was not prepared to support me or my health care professionals with the necessary acute care management, which might have prevented the situation from going chronic—but definitely not in the treatment of the chronic pain.

Twenty-five years later we have made some inroads, but not very many. We know that the gold standard, if you will, for the management of chronic pain is multi-disciplinary, which means that you would possibly have medications with the involvement of your physician and/or have a physiotherapist, an occupational therapist, or someone who can help you learn to live with your pain—perhaps a psychologist using cognitive behavioural therapy.

Along with that intervention from the medical system, we have to involve the individuals who have the pain problem and get them very active in their pain care. We can no longer be passive.

Part of the problem is that most Canadians don't understand the difference between acute pain and chronic pain. Acute pain is the temporary pain that lets us know there's a problem and that we might have to seek medical assistance. Chronic pain serves absolutely no purpose to the body at all. This is what creates the suffering.

We need to involve everyone in this model. It is about the lifestyle changes I was able to make, including exercise, diet, and rethinking what my life was like with pain and how I was going to keep it productive. I found the Canadian Pain Coalition, which is an amazing organization that from the very beginning has fought to bring in the people with the problem, to bring a voice to the pain. And if you look at me now, you wouldn't know I'm sitting here in pain. If I had to give my pain level on a scale between zero and ten, or the worst pain I've ever had, I would tell you that I'm at a seven right now because of the travelling I've done.

What the coalition has done with the Canadian Pain Society is to create a national pain strategy for Canada. We will have that finalized at the beginning of January. We are going to launch that national pain strategy at a Canadian pain summit here at the Chateau Laurier down the street on April 24, 2012.

The idea behind the national strategy is that it's a policy document meant to inform all provinces about the changes necessary within the health care system to support our health care providers and people with pain. We're looking for all Canadians to endorse this as of the beginning of January.

● (1710)

The Chair: Thank you very much.

Your time is up, Ms. Block.

We'll now go to Mr. Morin.

[*Translation*]

Mr. Dany Morin: Thank you.

I have only five minutes and many questions. I ask that the witnesses keep their answers short. My first question is for Ms. Laurent.

In your presentation, you talked about home care. Based on your expertise, do you think that the next accord in 2014 between the federal government and the provinces should include the progress expected and the objectives concerning home care so as to hold the provinces accountable for investments and thereby move home care services forward?

Ms. Régine Laurent: It is clear to us that home care is lacking in Quebec. With the population aging, the only way to go is to further increase investments in home care—I'm saying "care", but I should be saying "home support". I apologize.

It's true that the home support budget must be increased. However, the existing needs in Quebec must also be outlined. I'm not against your idea, but I'm afraid that one amount will be earmarked for home support and another one for prevention.

Is that not what you're saying?

Mr. Dany Morin: I'm just talking about criteria. We know that the 2004 accord set out objectives for the provinces in terms of improving surgery wait times. I was thinking of something similar for home care.

Ms. Régine Laurent: Okay. Now I follow what you're saying.

We would definitely need something like that in Quebec. That initiative should be expanded; in other words, it should also include prevention and anything else that can be done in the community to support people at home. I am talking about support, with an acceptable quality of life. We would really benefit from that. I have been stressing prevention for a while because I believe in it very much. We, as professionals, believe in it. There is a major shortcoming in prevention when it comes to all health care services. That shortcoming is even more significant in the case of seniors, especially in terms of medication.

● (1715)

Mr. Dany Morin: Thank you.

My next question is also for you. You talked about informal caregivers and compassionate care benefits. The Government of Canada is currently providing benefits that I feel are insufficient. I would like to know what you think about that. Do you think that the benefits are insufficient and that the government should increase them?

Ms. Régine Laurent: Yes, I really think that the government should increase the benefits. Taking into account that informal caregivers are predominantly women, our interpretation of the facts leads us to believe that the benefits would be much higher if men were the ones providing that kind of care.

[*English*]

Mr. Dany Morin: Ms. Wilson, do you believe that the federal government should launch a national strategy on mental health? It's a big question, I know.

Ms. Kimberley Wilson: In 2012 the Mental Health Commission of Canada will be releasing its national strategy. I think that's a really important starting point. The role of the federal government in rolling out that strategy will be even more important, because the commission doesn't have the ability to lobby and advocate. It'll be really important for the federal government to be committed to implementing the strategy in the provinces, and in the federal jurisdiction as well.

Mr. Dany Morin: Thank you.

Dr. Turnbull, do you believe that the federal government should do more to support community health centres?

Dr. Jeffrey Turnbull: The federal government can certainly play an essential role in developing national standards and structures and in supporting innovation. Community health centres are a vital part of a new community-based strategy for long-term, home-based care for chronic disease management. I must say that from our polling, the public also expects it.

[*Translation*]

Mr. Dany Morin: Do I have any time left? I have about a minute?

[*English*]

The Chair: You have 30 seconds.

[*Translation*]

Mr. Dany Morin: Okay. My last question is for Ms. Laurent.

You talked about palliative care. We know that assisted suicide is currently a hot topic. What do you think about assisted suicide? Parliament will soon tackle that issue, and I would like to know what you think right away.

Ms. Régine Laurent: We talked about that last year before the parliamentary committee in Quebec. Here is our position. First, we want a public debate. Second, we carefully explained that, at this time, there aren't any real palliative care services designed specifically for seniors. So, before further examining the matter of assisted suicide and other issues, we need to look at whether we can provide real palliative care to seniors right now. We take for granted that, if someone is 84 or 85 years old, they will die. That's not true. There are people who need palliative care. We asked that palliative care be provided to elderly people.

We were even more adamant in asking for palliative care for children as well. We think that's important. In addition, someone at the Sainte-Justine University Hospital Centre is investing a lot of effort into explaining just how important palliative care is. Palliative care for children is different.

Therefore, we want current palliative care to be strengthened in order to meet the needs. In addition, we want a public debate to figure out what that means. For instance, what is an acceptable life?

[*English*]

The Chair: Thank you. We'll now go to Mrs. Block.

Mrs. Kelly Block: Thank you, and I want to thank my colleagues for giving me an opportunity to follow up with some questions.

I'm going to direct them to Ms. Cooper. I want to follow up on your observations from your own experience over the last 25 years. The federal government has, I believe, played a leadership role in working with the provinces and territories in promoting and supporting our health care system and innovation within the system. In fact, the Canadian Institutes of Health Research made pain, disability, and chronic diseases a strategic research priority following consultations with stakeholders. They have provided more than $96.7 million in funding for research on pain, including chronic pain, since 2000.

You mentioned that you will be launching a national strategy in April 2012 and that it will involve all provinces. In developing this national strategy, have you come across any best practices in the provinces that would feed into what your strategy on chronic pain is going to be?

● (1720)

Ms. Lynn Cooper: The strategy we have come up with will inform the provinces and help them create their own pain strategies within their health care systems. At present, British Columbia has a fairly active strategy and Quebec is coming along with the work it has done. But many of the other provinces are still not recognizing chronic pain as a chronic disease and thus are not implementing the necessary strategies. The strategy is meant as a higher-level document. From that we will need to drill down to create the necessary strategies.

Mrs. Kelly Block: In follow-up, your strategy will first highlight the need to have a strategy and encouraging provinces to develop one? Will your organization be providing the provinces with some of the best practices you have pulled together?

Ms. Lynn Cooper: Yes, the best practice is the multi-disciplinary approach. Across Canada we have some multi-disciplinary pain clinics. However, the wait list for those clinics can be as much as three to five years and they don't serve enough individuals. So we would be looking to bring the community into play and to have multi-disciplinary treatment and management of chronic pain happening there, as opposed to confining the services to the pain clinics—although we need those too.

Mrs. Kelly Block: I want to follow up with some information on the question that my colleague across the way asked about assisted suicide.

An all-party parliamentary committee was struck a year and a half ago, the Parliamentary Committee on Compassionate and Palliative Care. We were looking at four different areas and the report is going to be released in the next few days. It's something that I'm hoping most of you will read. You could go to the website if you don't get your hands on a copy. I think it will help to inform the debate that needs to happen, and address some of the issues that you raised.

The Chair: Does anybody want to comment? That's fine.

Welcome back, Mrs. Mathyssen. It's your turn now.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you very much, Madam Chair.

I would like to thank the witnesses very much for their informative and important testimony today. I'm very confident that it will help us to move forward in a significant and meaningful way. I'm also glad to hear you say that there's an important federal role in all of this, because we tend to say, "Oh well, health care is provincial". I too believe that there is a leadership role for parliamentarians, at this level of government, to play.

I'm the seniors critic for the NDP and we've been looking at the economic security of seniors. The last stats that we managed to gather say that 250,000 seniors live below the poverty line, and that least 154,000 of them are senior women. I'm very afraid that those numbers are escalating. In terms of that statistic and in terms of supporting seniors and making sure they're safe, we're asking questions about affordable, supportive housing and the lack thereof. Seniors are pushed out of their homes. There are not enough appropriate long-term care facilities, and they're very expensive. And there's a real dilemma.

Would you support—in addition to the information that you've provided in so many other areas—a national housing strategy that looked at the needs of those in our community who simply don't have appropriate housing?

● (1725)

The Chair: Who would like to have some input on that?

Ms. Laurent.

[*Translation*]

Ms. Régine Laurent: Thank you, Madam Chair.

Several organizations in Quebec—including our own—are campaigning for the building of public housing. We would like to have public housing that is better suited to seniors' needs. In other words, seniors would be provided with minimum care. That housing would have to be able to provide support to elderly people on a daily basis. We are campaigning for that type of housing.

I think that investment would quickly pay off because this initiative is a lot less expensive than keeping seniors in institutions. They would at least be at home in this type of housing.

I want to build on what Ms. Laurent said. She talked about mental health so eloquently. Living in communities and not being isolated does wonders for people's mental health. They are still part of society and don't feel like they've been cooped up somewhere.

I think that campaigning for public housing is a wonderful idea. Some people even make meals together in similar housing projects elsewhere. There are various ways seniors can socialize in such environments. This helps them maintain a very high quality of life and is not expensive for the health-care system.

[*English*]

Ms. Irene Mathyssen: The possibilities are very exciting. We talked a great deal about prevention, making sure that people stayed healthy with good food, diet, and exercise. In that regard—and you touched on this a bit—the ability to have a service hub within a community so that seniors could access those services that would lead to a healthier lifestyle is something that I'm certainly looking at. I wonder about your response to that.

[*Translation*]

Ms. Régine Laurent: For instance, nurses could be brought closer to communities. We know that every community has a community centre. Why not provide follow-up to seniors through community centres?

We know that establishing this trust is important. We know that because, as professionals, we deal with chronic diseases within health care institutions. Why not have systematic follow-up in communities? That would be one way to prevent chronic diseases.

By following the person, we can ensure that they're taking their blood pressure medication and beta blockers properly. The INR for people taking Coumadin must be checked. Therefore, it is a matter of prevention. It enables people, even seniors, to take charge of their health, because they can. When we take the time to teach and follow up....

[*English*]

The Chair: Thank you so much.

We have two more minutes.

Mr. Williamson, I will give it over to you.

Mr. John Williamson (New Brunswick Southwest, CPC): I will be quick and skip my preamble.

Dr. Turnbull, you said something earlier that was like a V-8 moment. You said that you'd like to move some beds out to save some money so that you could serve patients better.

All too often the solution to health care in this country is more money. We have the second most expensive system in the world. Some things we do very well; others we don't. How do we push innovation? How does the federal government ensure that the provinces and health authorities are making choices that ensure that dollars are spent wisely and are addressing some of these issues?

If you're waiting for a bureaucrat in Ottawa to push those beds out the door, I suspect you'll be waiting forever.

Dr. Jeffrey Turnbull: I think we have a unique opportunity through the 2014 accord. There is an opportunity, when those transfers are committed, to ensure that they actually do have strings attached to them and that there's an accountability framework to ensure that meaningful change actually happens as a result of the transfers. I would argue that 2014 should be the beginning of a transformed health care system. Any investment we make in terms of transfers should come with accountability.

The accountability doesn't have to be from the province or territory to the federal government; it has to be from the province and territory to their citizens. We should insist that this innovation, this change that we're hoping will take place as a result of the transfers, be done in a transparent and accountable way and that it be based on national standards. I think it's a great opportunity.

● (1730)

The Chair: Thank you, Dr. Turnbull.

I want to say thank you again to the witnesses for your patience today and for your insightful testimony.

Thank you to the committee for your indulgence and for getting back here on time.

The meeting is adjourned.

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