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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, everybody. How are you?

I will call the meeting to order, please. Thank you.

We are very pleased to be studying the issue of chronic diseases in the workplace.

We're very pleased that we have our witnesses here.

From the Canadian Life and Health Insurance Association is Stephen Frank, vice-president, policy development and health.

I hope I pronounce this correctly: we have from the Fondation Docteur Benoît Deshaies—how did I do there?—Mr. Robert Guimond, member of the board.

Thank you so much for being here with us.

We are going to have 10-minute presentations, and then we'll go into the Q and As, with seven-minute rounds, first of all.

Mr. Frank, would you begin?

Mr. Stephen Frank (Vice-President, Policy Development and Health, Canadian Life and Health Insurance Association Inc.): Thank you.

Madame Chair, members of the committee, I'm very pleased to have the opportunity to be here today on behalf of the Canadian Life and Health Insurance Association. We welcome the opportunity to share our views with the Standing Committee on Health.

[*Translation*]

Today, I will provide you with an overview of the types of services and support that our industry provides to Canadians in terms of chronic diseases and aging. I will also provide some general thoughts on potential policy changes we feel should be considered to help Canadians adequately provide for their needs and health care as they age.

It is particularly appropriate to engage in this discussion in 2011, as baby boomers are beginning to retire this year. The aging demographic is critical to understanding the future pressures on long-term care in Canada. Although we are living better and longer, the older we get, the more likely we are to be managing a chronic disease and the more frequent our contact with the health system becomes.

[*English*]

As of today, roughly 7% of Canadians over the age of 65 reside in health care institutions. Also, consider that one in eleven Canadians over the age of 65 is affected by Alzheimer's disease or a related dementia, and about 50,000 strokes occur in Canada each year, with stroke being the leading cause of transfer from hospital to long-term care. As the relative age of Canadians rises in the coming decades, it's quite reasonable to expect that these numbers will rise dramatically. It's important to ask whether Canadians are ready for the financial and other implications of this.

It's critical to acknowledge up front when discussing this issue that Canadians are by and large responsible for funding their own care in old age. Within this context, the private insurance market currently plays an important role in helping Canadians plan and save for their long-term care needs, although, as I'll discuss shortly, more needs to be done.

Long-term care and critical illness insurance products are types of supplementary coverage that may become payable when an individual is struck with a debilitating, severe, or chronic illness. These types of plans provide benefits that are over and above the typical income replacement coverage. While these solutions have been available to Canadians for some time now, it is fair to characterize both markets as being underdeveloped.

With respect to critical illness, a typical policy helps pay the costs associated with life-altering illnesses. If you become sick with an illness covered by your policy and survive the waiting period, you receive a lump sum cash payment and you are free to decide how to spend the money. Types of diseases vary by plan, as does the amount you will be paid, which ranges from $10,000 to several million. In 2010 there were 1.2 million Canadians with critical illness insurance. Cumulatively, the industry paid out roughly $200 million in benefits.

With respect to long-term care, there are generally two types. One reimburses the insured for eligible expenses received on a given day, up to a pre-set maximum. The other is the income-style plan, which offers a pre-set monthly payment amount. Typically these benefits are payable when an individual can no longer perform at least two essential activities of daily living, so bathing and dressing or bathing and feeding themselves, for example. As of 2010 there were only about 385,000 Canadians with long-term care coverage, and the industry paid out $12 million in benefits.

It's clear to us, in particular, that the long-term care market is very underdeveloped in Canada. Most Canadians simply do not know that the government will not cover their long-term care needs. In addition, Canadians are very sheltered from the costs of health care, and as a result they are often surprised at the price of long-term care solutions. This lack of knowledge prevents individuals from purchasing such coverage. Together these factors make long-term care solutions a challenging product for insurers to sell in the Canadian context. It should be noted that this situation differs materially from that in the U.S., where the long-term care market is much more developed and consumers are more proactive in seeking coverage.

Accordingly, we believe the government has an important role to play, both in educating Canadians about the need to save for their long-term care and in providing support for such activity by providing tax and financial incentives to assist them in taking more responsibility for their long-term care needs through the purchase of long-term care insurance. In terms of the insurance industry, I can say that we are actively exploring options to offer this product at as low a cost and as effectively as possible.

The life and health industry also offers important income replacement supports to employers and workers that help them deal with their illness and return to work as quickly as possible. In 2010 the life and health industry provided 4.6 million Canadians with short-term disability coverage and more than 10 million Canadians with long-term disability protection.

Typically a group plan provides three different levels of coverage for an employee. The first to kick in would be your sick leave, which is typically at a full rate of pay for a short period of time, typically a few days to a couple of weeks, and that depends on the employer. Short-term disability kicks in when your sick leave runs out. Most STD plans pay a portion of normal earnings, say up to about 70%, for a period of time. Fifteen to 26 weeks is fairly common, although that can differ by employer. Finally, long-term disability starts when short-term disability runs out. Typically these plans will cover 60% to 70% of normal earnings. These benefits are payable for up to two years if you remain disabled from your own occupation. Beyond that, benefits continue for those who remain disabled from any occupation.

● (1535)

[*Translation*]

As an industry, however, we strongly embrace the concept that work is healthy and that preventing disability in the workplace is possible. That is clearly in the individual's best interest as well as the employer's. As a result, many plans include rehabilitation provisions designed to help individuals return to work. For example, benefits may be continued while a person participates in return-to-work programs or undergoes vocational training. These types of programs support individuals who may not be able to return to their usual jobs after a period of disability, but can return to the workforce in a different capacity.

Employers rely on our industry's return-to-work support and rehabilitation expertise to assist their employees. Our member companies work closely with employers who may need assistance understanding and implementing accommodation requirements.

[*English*]

In addition, our industry provides employers with stay-at-work programs, where supports are provided on the job to prevent deterioration of a condition. We also provide dedicated workplace wellness initiatives to promote both physical and mental health in the workplace.

On this latter point, it's important to recognize that one of the leading causes of disability today is related to mental health conditions, and they can also be chronic in nature. The CLHIA is proud to support initiatives that promote mentally healthy workplaces. In the fall of 2009, the CLHIA released guiding principles to support good mental health in the workplace. These principles are best practice benchmarks for our member companies on mental health in their own workplaces.

In summary, the life and health insurance industry in Canada plays an important role in helping Canadians who've had the misfortune of contracting illnesses, both acute and chronic in nature, and need ongoing long-term care. We work very closely with employers to help employees return to work, and to avoid illness and disability altogether where possible. That being said, more can be done to educate Canadians on the reality of who is responsible for their care as they age, as well as to help them save adequately for this eventuality.

It will be my pleasure to answer any questions you have.

● (1540)

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

This is a very important study, and that is why we asked you to come in to give us some insight. It's quite compelling when you see some things that people go through.

We'll now go to Mr. Robert Guimond, please.

[*Translation*]

Mr. Robert Guimond (Secretary, Fondation Docteur Benoît Deshaies): I want to introduce myself. I'm a 67-year-old retired lawyer. I have 30 years of experience in work-related accidents and diseases. I want to start my presentation with some comments.

Our foundation, the Fondation Docteur Benoit Deshaies, works with people who receive no wages and have no income or insurance. The people our foundation works with have no income and no long- or medium-term insurance. They have none of that. Most of them do not receive employment insurance benefits. That's why the Fondation Docteur Benoit Deshaies exists. It provides support to people without an income on an as-needed basis. Those people either no longer receive benefits from the Commission de la santé et de la sécurité du travail du Québec or have no insurance.

The Fondation Docteur Benoit Deshaies has two main roles. Its first role is to pay for treatments, especially those not covered by public plans, such as fibromyalgia treatments, massage therapy, occupational therapy and acupuncture. None of those are covered by public plans. That's why workers turn to the foundation to be reimbursed for their treatments.

The second element the foundation is involved in is medical assessments. Medical assessments are required before the courts. Do you know what the cost of a medical assessment is? It's not $600; it's often $1,300, $1,500. In the case of specialists, it can go up to $2,000 or $2,500. The foundation pays for medical assessments when they are needed, especially before the courts, the Commission des lésions professionnelles, the Supreme Court or any other court. When a medical assessment is required, the foundation pays for it.

I would like to make some comments about the core issue the Standing Committee on Health is discussing. I will comment on the passage of time and chronic problems in the workplace, which are a major source of concern for Canadians.

● (1545)

I have a few comments about the passage of time. Of course, we are all affected by that passage. It's unrelenting and cannot be avoided. However, I want to stress something before this committee. We must give ourselves tools to slow down the aging process, to slow down physical and psychological deterioration.

My main point when it comes to aging is avoiding isolation. I would like the Standing Committee on Health to keep that in mind. I will provide you with some examples.

Let's talk about where people live. I think that having a comfortable and safe place for seniors is a key consideration. They must have somewhere safe; they must feel safe in terms of their future. I want to really stress that.

Insurance can also help those who have it. The people we work with don't have insurance. Resource support is essential when it comes to aging. What does resource support mean? It's the experience that the foundation has, that we have and that I have at my age. I am talking about social workers seeing people regularly and occupational therapists visiting people at home on an ongoing and regular basis. I want to emphasize the words “ongoing” and “regular”. When it comes to people who are getting older, those visits should not take place on a monthly or weekly basis; continuous monitoring is needed. That's important for overall resource support when it comes to aging. You will get old. You know that because you have parents, uncles, aunts, and so on. You know what it means to need ongoing and regular support.

Another element I want to emphasize as far as aging goes is community support. People need to be surrounded and supported by others like themselves. It is important for people who live in a nursing home, a residential and long-term care centre, to be able to get together, talk, and play poker or any number of card games. People need to be together.

The last element is about the passage of time. I want to stress that. This may surprise you, but it's necessary to develop not only our physical abilities, but also our psychological abilities. When we get to—

A voice: Oh, oh!

Mr. Robert Guimond: Oh, oh! Am I making you laugh?

● (1550)

[*English*]

The Chair: Excuse me, is there some mischief on my committee, Mr. Holder?

[*Translation*]

Mr. Ed Holder (London West, CPC): My apologies, Madam Chair.

I apologize, sir.

[*English*]

The Chair: Okay. Thank you.

Please continue.

[*Translation*]

Mr. Robert Guimond: I think that developing our physical and psychological abilities is extremely important as we get older. Do you know how old Dr. Deshaies is? He is over 80 years old. He is 84 and is still active within his foundation. He's an example of the fact that, when we are willing, when we apply ourselves and plan ahead, we can live and slow down the aging process. I want to stress that.

I will now talk about chronic illness.

How much time do I have left? You can just cut me off.

[*English*]

The Chair: Your time has just run out. I'm sorry. I am reluctant to stop you because everything you are saying is so interesting. I think it's so relevant, especially with your background and expertise.

I'm going to be generous with the time for everybody. It will be equal.

Mr. Robert Guimond: Okay. I'll be quick.

The Chair: Please just wind up now.

[*Translation*]

Mr. Robert Guimond: The foundation deals with chronic diseases in the workplace. I could talk about that for hours. For instance, someone who has a shoulder problem cannot lift their arm to where I'm holding mine right now.

[*English*]

The Chair: Thank you.

I have to cut you off. I tried to be as generous as I could, but we need to get to Qs and As.

Ms. Quach, you have seven minutes.

[*Translation*]

Ms. Anne Minh-Thu Quach (Beauharnois—Salaberry, NDP): Thank you, Madam Chair. I want to thank our two witnesses.

Mr. Guimond, I will start with you. That will probably allow you to complete your presentation. I think it's interesting that you say we need to work on people's isolation in the workplace, especially seniors' isolation. They need support and help in overcoming their diseases.

You talked about resource support. I assume that also applies to the workplace. Social workers, massage therapists and psychologists need to be present in the workplace. Do you have any statistics, any data that would help us see how much difference having those professionals in the workplace makes? Are there any results? Are there any businesses that have hired psychologists, social workers, massage therapists? I think that approach is very useful for prevention. It does exist. Could you tell us more about that?

Mr. Robert Guimond: Unfortunately, I have no statistics. All I have is practical experience. By the way, I want to specify that I mostly deal with workplace matters, but not exclusively so. My involvement is general, in the workplace or not.

In the workplace, the resources—social workers, occupational therapists, massage therapists—work together with the foundation. I did not specify at the beginning that the Fondation Docteur Benoît Deshaies works on a daily basis with social workers from the Polyclinique médicale populaire—that is what we call it. We work together in order to help people who have no income, especially by giving them access to a psychologist.

I want to point out that, currently, the predominant need older people in the workplace, as well as people in general, have is psychological. People are isolated and are wondering how they can help themselves. Psychologists and psychotherapists are an extremely useful tool for helping people in the workplace. The foundation works on that with the Polyclinique médicale populaire. Those professionals are also extremely helpful for people who are struggling with the passage of time in general.

I cannot provide you with any statistics because we do not compile them. In other words, we just provide services. If 20 psychological treatments are needed, we provide them and pay for them. If 20 occupational therapy, massage therapy or acupuncture treatments are needed, we pay for them. If someone needs 20 additional treatments, the foundation pays for them. However, we do not compile statistics. We just provide services.

● (1555)

Ms. Anne Minh-Thu Quach: That also echoes the Romanow report that talked about expanding the range of services available to low-income individuals. That is what you do.

Do you think that the federal government should use your foundation as an example? I assume other organizations also work with free polyclinics to provide health care to Canadians who can't necessarily afford health insurance to cover the costs associated with a chronic disease.

Mr. Robert Guimond: If the federal government wanted to help, it could provide us with funding. There would be home support and resource support services for low-income individuals. Programs would be set up for that, and the government could work on an agreement with the provinces to set up programs for the client base our foundation serves. I think that the federal government's assistance would be a very nice initiative that would help us move forward.

A medical assessment costs between $1,300 and $1,500. This year, our foundation paid for $65,000 in services. If the federal government were to provide funding for assessments and treatment, and if it worked out an agreement with the provinces—that goes without saying, as health care comes under provincial jurisdiction—there could be cooperation and specific federal programs.

Ms. Anne Minh-Thu Quach: Do I have any time left?

[*English*]

The Chair: You have about half a minute.

[*Translation*]

Ms. Anne Minh-Thu Quach: Are there currently any programs that provide people with such services? Could there be other similar programs? Do you work with any other groups in Quebec—or even elsewhere in Canada—that should also be better known?

Mr. Robert Guimond: We work with the Commission de la santé et de la sécurité du travail du Québec, Quebec's worker compensation commission, and with doctors from the Polyclinique médicale populaire. However, we have very little contact with the federal government.

● (1600)

[*English*]

The Chair: Thank you very much.

We'll now go to Dr. Carrie.

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

I want to thank our witnesses for being here today.

I wanted to start off today by talking to Mr. Frank. I was looking at page 4 in your presentation, and the quote you had was:

> Accordingly, we believe [the federal] government has an important role to play in both educating Canadians about the need to save for their long term care as well as providing support for such activity by providing tax and financial incentives to assist them in taking more responsibility for their long term care needs through the purchase of [long term care] insurance.

One of my colleagues, James Rajotte, has actually put forth a motion or bill on financial literacy. I've been amazed at how there's really a lot for Canadians to learn about responsibility and financial literacy. If you look at some of the health services that are and aren't covered in our country by the public system.... I have the honour of working with a colleague of mine, who is a chiropractor, and there are so many health services out there that people, throughout their lives, may need a plan to utilize, but they just don't think about it, whether it's chiropractic, physiotherapy, even psychology.

You mentioned in your opening statement the importance of mental illness. We've heard from other witnesses how much this is starting to tax the system and to stop people from working and being productive. Recently Canada observed World Suicide Prevention Day, and we did start bringing about the issue of mental health.

I was wondering what your organization does and how it works with businesses to address mental illness in the workplace and to help support Canadians who suffer from this horrible condition.

Mr. Stephen Frank: To answer your question with respect to what we do to support the treatment of mental illness in the workplace, I'll say, first of all, that CLHIA is very supportive of a Canadian mental health strategy. It's something we're very engaged with. A number of our members sit on that steering committee. We think it's a critically important piece of work, which we're very supportive of, because mental health will become a larger issue as the relative age of Canadians continues to grow. We're very supportive of that.

The perspective of the insurers, the perspective of the employers, and the perspective of the employees are all actually aligned on all of these chronic disability issues, whether it's mental health or other issues. It's in everyone's interest to keep people at work and to keep them productive. We don't want them to be isolated. We don't want them to be at home, cut off from the colleagues they chat with every morning over coffee and whatnot. We spend a lot of time with and have a lot of supports for employers to help them intervene in the workplace to help people get over mental health issues.

Anyone who has worked in a corporation may be familiar with an employee assistance plan or any type of plan that gives you a number to call to get counselling or other support in the event of mental illness. Those are examples of the types of services we help our clients, the employers, put in place to help people deal with mental illness and, to the greatest extent possible, stay at work. That's our largest focus in any intervention for disease and chronic illness.

I'll just quickly come back to your point, if I may, on financial literacy. I think there's potentially an interesting analogy here in the health care space. We almost need to increase Canadians' health literacy with respect to what is and is not covered. To your point, most people, I would say, from our polling, do not understand that there is not a government program for them as they get older. They don't understand that long-term care is essentially their responsibility to cover.

Putting some kind of program in place to help people understand, at the very minimum, what they're accountable for is a first step in their taking action, whether that's purchasing private insurance or using some other mechanism. That will be for them to decide. What concerns me greatly is that in a lot of cases, they are sort of in a position of ignorance. You don't want people to get to the point where they need that support and they suddenly realize that it's not there. I think a role for the federal government to play, and any government, really, is in making it clear to Canadians what is and is not covered and what they are expected to support.

Mr. Colin Carrie: What kind of support do you provide businesses to ensure that their workers are covered for things like long-term care, if they need it? Are you going out there educating businesses about issues, such as affordability of insurance for their employees?

● (1605)

Mr. Stephen Frank: If you think of a typical sales cycle for a group plan, for example, what happens is that an employer will usually work with a broker or with a consultant of some kind to design the employee benefit program they want to have. That will cover a whole range of services, including things like chiropractic, physiotherapy, and prescription drugs. Things like short-term and long-term care tend to be bundled within those benefit plans. The employer does a lot of thinking up front with the advisor. Then when the insurer enters into that discussion, we bring our expertise to the table. We help people understand the standard within their industry and what a comparable plan for other employers would be.

With respect to the question of affordability, you can design a program to be as expensive or as inexpensive as you want, depending on how you structure your benefits. That's a discussion that's customized for every employer. When we understand what their needs are, we try to design a solution that's as affordable for them as possible. The range of solutions is as varied as the employers across the country. Those are discussions you have with a group sponsor at every opportunity.

Mr. Colin Carrie: I was wondering if you could comment on what the private sector could do to help prevent chronic diseases in the workplace. How would that connect with the insurance industry?

Mr. Stephen Frank: Employers today are starting to make efforts to keep people healthy in the workplace, whether it's by providing massage therapy benefits or by bringing chiropractors and acupuncturist services into the workplace. They're starting to do that. The economic benefits, obviously, of keeping people healthy are very compelling. So the employer has a role to play there.

Insurance tends to kick in when there has been a disability or some other illness has been identified. That's the traditional role of an insurance product. But increasingly, we're starting to take the view that we need to be in the prevention game as well. So we're being a lot more active in helping employers design stay-at-work programs and other types of preventative programs that prevent people from getting ill in the first place. It's in the insurer's interest for that to happen; it's in the employer's interest and it's in the employee's interest. We're working a lot more with employers on those types of preventative efforts.

The Chair: We'll now go to Dr. Fry.

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

I would like to first of all congratulate Monsieur Guimond for a very in-depth understanding of the needs of people as they get older. You are suggesting that you don't get any funding from the government at all. I would like to take that statement and tie it in with what Mr. Frank was saying, because I heard him responding to Mr. Carrie's question just now.

Is there room, do you think, for the federal government? Currently, anything we do with regard to medicare is for physicians and hospitals only. The government has not been able to deal with this whole group of people who are living longer, aging in place, and getting chronically ill. All we have is what was put into the accord, which was really to look at programs that would consider this issue.

Do you see a role for the federal government and the provinces in developing some kind of infrastructure, and I use the term broadly, either people infrastructure or general infrastructure, perhaps with private insurance companies and non-governmental bodies, that would assist people as they age?

Some people don't have insurance, because many of our seniors today didn't do any paid work. They stayed at home and looked after the kids. They don't have any money to buy insurance. Sometimes this was because of their socio-economic status. We have a lot of people in the net, some who can afford insurance, some who cannot, some who have different levels of needs. Can you see a system made up of people and physical resources that could help people who are chronically ill through the various levels of care they may need, a system in which government, the private sector, and NGOs could play a role together? Do you have a broad-based model in mind?

● (1610)

Mr. Stephen Frank: I support the intent. Long-term care and chronic care need to be viewed as a continuum. People should be at home for as long as possible, and supported in the home, if that's their preference, and then transitioned into higher degrees of support. That's one of the areas where the system breaks down today. We tend to be very institutional-based, and we don't smoothly move people through that continuum. The concept, though, I am 100% behind.

The important thing is that we start having these discussions. There are lots of different mechanisms that could help to achieve such a system in any society. I wouldn't want to pre-judge those discussions, but I would say at the outset that we are not having these discussions today in Canada. We're just starting to. I think that's a positive thing. We need to start with those, and we need to have all stakeholders at the table to address the issue. It's a complex problem to solve with so many players. We need to have those discussions, and there could be lots of innovative ways to meet that ultimate policy goal.

Hon. Hedy Fry: Do we have time for Mr. Guimond?

The Chair: Mr. Guimond, would you like to make some comments on what Dr. Fry was asking?

[*Translation*]

Mr. Robert Guimond: I would like it to be in French.

[*English*]

Hon. Hedy Fry: Oh, there was no translation.

The Chair: Are you on the right channel?

The bells have started to ring. I guess we will dismiss the committee.

Ms. Libby Davies (Vancouver East, NDP): Are we going to come back?

The Chair: No, we're not going to be returning. The bells are ringing. There's no need to do anything else.

Thank you so much for joining us, and we thank you for all your testimony.

The committee is dismissed.

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