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Chair

Mrs. Joy Smith

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Welcome to committee, everyone.

I am Joy Smith, the chair. Welcome to all of our guests today.

I want to say to members that I know a lot of you have flown in today. Members are telling me they wish to have some fruit and so on for our next meeting. I want to let you know that we are going to have some food at our meetings to help you out a little bit. If everyone is in agreement, please raise your hands. Good.

Now we'll start with the orders of the day: Standing Order 108(2), a study of chronic diseases related to aging.

We're very pleased today to welcome our witnesses. From Baycrest, we have William Reichman, president and chief executive officer. Thank you, Dr. Reichman, for being here. It's a pleasure to welcome you.

From the Emergency Medical Services Chiefs of Canada, we have Mr. Michael Nolan, the president. Thank you for joining us today to give us your insightful information.

As individuals, we have Professor François Béland, Department of Health Administration at the University of Montreal. Thank you for being here. And of course Dr. Mark Rosenberg, a professor from the Department of Geography and Department of Community Health and Epidemiology at Queen's University.

We will begin with ten-minute presentations and we'll start with Dr. William Reichman, please.

Dr. William Reichman (President and Chief Executive Officer, Baycrest): Thank you so much for inviting me here, on behalf of my organization, Baycrest, to share some thoughts. It's quite an honour for us to be represented here.

Baycrest serves 2,500 Canadians per day across a full continuum of health care services, from home-based services to hospital to nursing home to a wide array of community-based programs, and it's home to the Rotman Research Institute, which is one of the top-rated cognitive neuroscience institutes in the world.

I want to start by commending you for addressing the challenges presented by the aging of our society and the anticipated increase in prevalence of chronic disease that will result as we live longer into older age. As David Crane said in the *Toronto Star,* in 2007:

> Rather than wringing our hands, we should recognize that the changes an aging society will bring are quite manageable if we take the necessary steps now, and celebrate the fact that Canadians are living longer and healthier lives.

What I'm going to say over the next few comments is that with the challenge of an aging population and the burden that chronic disease will present to us also comes a very significant opportunity to make transformative change across Canada in how we keep people well and how we deliver health care services.

I'll commence my brief comments with the following questions, which I would ask everyone sitting around this table to consider.

Number one, must it be inevitable that so many Canadians suffering from chronic diseases such as diabetes, heart disease, musculoskeletal infirmity, chronic obstructive pulmonary disease, hypertension, and dementia end up being treated in an acute-care hospital, coming in through an emergency department because we lack community-based capacity to keep them well and stable with their conditions?

I'll pose another question for us to consider. Why should nearly 40% of seniors, especially the oldest old, have to spend an average of the last two years of their lives in an institutionalized care setting such as a long-term care facility or nursing home, separated from their families and other supports? It's because we lack community-based capacity to keep them in their own homes or in the homes of their family members.

I would ask you to consider this for yourselves. Can a nursing home—even one as special as Baycrest, which is world renowned and which I have the privilege to lead—ever be so great that any of us would choose to live there instead of in our own homes? If the answer to that is no, we would rather live in our own homes, then I would ask that we now take the steps necessary to enable that to happen.

Aging boomers—or, as is said here in Canada, zoomers—expect society to now offer our parents who are living more than what society ever offered our grandparents. And quite frankly, we are a sufficiently self-indulged cohort that we expect society to give us even more than what society will ever give our parents. Certainly we hope that society will offer our children more than we were ever offered in keeping us well and taking the best possible care of us in the best possible place and with the best possible value extracted from that health care dollar.

I think it's important for us together to set some achievable, concrete, tangible, sustainable goals along the lines of the following. If any of us do truly need to be in a nursing home, let's set as a goal that it will be on average for the last two months of our lives, not the last two years of our lives. To achieve this kind of goal, as well as several others that I'm sure we'll discuss today, will require deliberate transformative change—not nibbling around the edges, not small incremental initiatives, but transformative change that can benefit Canadians no matter where across this great nation they happen to live.

In reference to these issues, my comments today will be couched in three principles that will help Canada change the journey of aging for the better and position this nation, if it so desires, to be a global leader in innovations to serve the needs of an aging population.

What are these principles? For one, we must be willing to take risks through experimentation and innovation in health promotion, health care delivery, and the reimbursement of health care services. We must be willing to take risks, which means that while we will celebrate the successes that result, we must be willing to tolerate the inevitable failures. To truly innovate and transform, there will be failures along the way, and we must tolerate them and learn from them.

● (1535)

We need to understand that to keep people well involves more than just providing good health care. We must provide economic incentives to businesses and organizations that promote healthy lifestyle practices. I'm sure we'll talk about some tangible examples of that this afternoon. We must provide tax incentives, rebates, and credits to individuals who show progress in adopting healthy lifestyles, compliance with medical therapies, and attendance in prevention programs.

I also believe it is critical to financially incentivize families and other informal caregiving networks, such as volunteers. At Baycrest —and perhaps we'll have a chance to talk about this later—we have an active volunteer corps of 2,000 seniors. They spend the bulk of their time caring for other seniors who are more frail and needy. Experimentation and innovation will require that we test new models of integrated care tied to reimbursement methods that can achieve more than cost effectiveness, and take into account outcomes, not just inputs.

The present focus on acute-care emergency department wait times in some of our provinces, such as Ontario, and an alternative level of care is too narrow. We must look more comprehensively. For example, across the nation, from the Maritimes to B.C., there are organizations involved in senior care and chronic disease management that are holding their own against organizations in western Europe and elsewhere in introducing innovations. The difficulty we have is not the creativity that resides within our health care sector and other parts of our community; the difficulty we have is in taking these best practices and translating them across a broader swath of the nation. But with the right structures in place and the right incentives, we can take best practices that are occurring in Saskatchewan, Quebec, and Toronto, learn from them, and scale them up across the nation.

Let me give you some examples of the kinds of innovations that can be successful, and not in a narrow place like north Toronto under the guise of an organization like Baycrest. Baycrest was the first organization in North America to invent senior day care and dementia day care in the 1950s. Baycrest was the first organization in North America to demonstrate that if you spend some dollars on implementing electronic health records and computerized physician order entries, it leads to reduced medication administration errors within a long-term care setting.

Baycrest was the first place to demonstrate that you could develop units in a hospital or nursing home setting to provide diversion from emergency departments in acute-care hospitals. So if a patient is getting sick in the community, the reflex right now is for their primary care doctor to tell them to go to the emergency department. Or if the patient gets sick in a nursing home in the middle of the night, the reflexive response is to call an ambulance. The patient is transferred to an emergency department, which is just about the last place that any of us would want our parents or grandparents to be if they were sick in the middle of the night. Baycrest and others across this nation have developed wonderful programs that are cost-effective, keep seniors away from acute-care hospitals, and get them out faster when they are in acute-care hospitals.

The difficulty is not that we don't have the ideas; it is that we don't have the reimbursement methodologies in enough places across the nation to incent that kind of program delivery. We don't have the methodologies in place to take a best practice in one jurisdiction of the nation and ensure that it can be tested in another jurisdiction.

I mentioned earlier that it goes beyond just thoughtful and innovative health care. We should be providing economic incentives to businesses that can promote healthy lifestyle practices. That's an essential ingredient that could change the way people age. It means healthier food choices on restaurant menus and in food stores, documented gains in workplace wellness programs, better physical education in schools, and healthier lunch programs in workplace and school settings.

When we think about how to mitigate the impact of chronic disease in seniors, we tend to focus on the final destination in life—old age—instead of understanding that how we age is very much determined by the particular journey we're on as adolescents, as young and middle-aged adults, and finally as seniors. So the best way to prevent heart disease in an 80-year-old is to ensure that our children are not obese.

There are other kinds of lifestyle transformative notions that we have to build into this kind of dialogue.

● (1540)

I mentioned before that we can provide, and should provide—

The Chair: Can you start thinking about wrapping up, Dr. Reichman? It's extremely interesting, but I know our committee members are anxiously awaiting the time to ask you some questions.

Dr. William Reichman: Okay.

I'll mention a few last points and then I will close.

The Chair: You have about five seconds.

Dr. William Reichman: Okay. Then I won't mention a few points.

I will ask you to consider whether Canada can really lead globally in this effort. There is no single nation that owns this issue. It's a challenge across the globe. We have sufficient strength in the nation, so let's leverage it.

The Chair: Thank you, Dr. Reichman.

You have brought us some very compelling documentation. Thank you for that.

We'll now go to the Emergency Medical Services Chiefs of Canada and Mr. Nolan, please.

Mr. Michael Nolan (President, Emergency Medical Services Chiefs of Canada): Thank you, Madam Chair.

Good afternoon. My name is Michael Nolan and I'm the president of the Emergency Medical Services Chiefs of Canada. I'm here today to talk with you about how paramedics can contribute to the health care system, and specifically how community paramedics can strengthen the resilience of Canadians and support chronic disease self-management.

[*Translation*]

Good afternoon. My name is Michael Nolan and I am the president of the Emergency Medical Services Chiefs of Canada. I am pleased to be here today to talk to you about how paramedics can contribute more to the Canadian health care system.

● (1545)

[*English*]

Emergency Medical Services Chiefs of Canada represents over 30,000 paramedics and chiefs from coast to coast. Paramedics are the third largest health care provider group in Canada. Paramedics serve on the front line of health care in every community across the country, providing essential health care. We are a reliable and constant force, from the most rural and remote communities to our largest cities.

I appreciate the opportunity, Madam Chair, to inform you and the committee of the important contribution that paramedics make in our communities, and especially to share examples of how paramedics are working today to assist Canadians in becoming more resilient through supporting chronic disease self-management and by providing innovative opportunities to receive care in their homes and in their communities.

Community paramedicine is not a new concept. These programs have been in existence in Canada for many years. However, it is only recently, as a result of the shifting demographics and the move toward de-institutionalizing health care, that community paramedic programs have begun to gain momentum in Canada and around the world. Community paramedics are health professionals who focus their practice on providing prevention and rehabilitation care.

While in some cases this requires an expanded scope of practice applying specialized skills, it is routinely a paramedic who is working with a targeted population, such as with those experiencing a chronic disease, to improve their quality of life and reduce their reliance on our institutional health care system at large.

We know that any frail senior who possesses multiple co-morbidities is receiving care that routinely revolves around interactions with paramedics and acute-care hospitals. Subsequently, their functional status deteriorates during their hospital stay while waiting for permanent placement in long-term care. It has been estimated that 37% of these patients waiting in Ontario hospitals for a long-term care placement have needs no more urgent or complex than those of individuals who are cared for in their homes.

System redesign is identified as essential to transform the health care system to meet the needs of our fragile seniors, the majority of whom want to live in their homes—and should be able to—and be able to rely upon community support to assist with their health and social needs. An excellent example of a community paramedic program that is addressing this need is happening right here in the Ottawa Valley. The Deep River aging-at-home program supports patients with chronic disease in an effort to allow them to remain in their own homes. All of these patients are currently on the waiting list for long-term care with a diagnosis of one or multiple chronic diseases.

With community paramedics acting both as advocates for the patient and as a member of an interprofessional team, this program has achieved an 88% diversion of 911 calls and, equally importantly, a decrease in hospitalization and emergency department visits in excess of 66%. Madam Chair, it is important to note that these gains have been achieved from this client group that is also historically among the highest users of the paramedic service and the hospitals in this community.

The landscape of care within the home and community environment is certainly a challenging one. These hurdles are worsened when trying to access services as an individual with complex and often unresolved needs, invariably resulting in a high need for high-cost resources in the acute-care setting.

While not always a direct result of lack of care in the community, many chronic disease patients experience emergency department visits that often lead to a vicious cycle of readmission. Within Ontario, 15% of all patients discharged from hospital are readmitted within 30 days. That's 15%. An increased focus on effective care transition has been identified as a means to help reduce this burden. The community paramedic is absolutely a means to reduce re-hospitalization.

On Long Island and Brier Island in Nova Scotia, community paramedics collaborate with a nurse practitioner and an off-site physician, and are assisting patients to effectively manage their chronic diseases. As a result of these efforts through community paramedic clinics, there has been a 23% decrease in emergency department visits from islanders to Digby since this delivery model began in 2002.

Other innovative community paramedic programs from Nova Scotia include one in Halifax, where patients living in long-term care facilities now receive care from community paramedics on an as-needed basis. As a result, there has been a 73% treat-and-release rate, meaning that the community paramedic is able to treat them fully in the home. There was also a 27% facilitated transfer rate. This means that the remainder of patients would be seen by community paramedics, who would then schedule their diagnostic treatment and, whenever possible, treat them in the home. They go, for example, straight to the X-ray department and then return to the nursing home. They are not in an alternate level of care beds and not in the emergency department.

● (1550)

This program has helped over 600 patients in Halifax alone since February of this year. Hospitals in both in Parrsboro, Nova Scotia, and in Spirit River, Alberta, are now staffed overnight by paramedics, keeping the emergency departments open in these small communities and preserving limited physician resources for daytime clinics the next day.

In Saskatoon, an innovative program called the Health Bus has paramedics and a nurse practitioner moving from neighbourhood to neighbourhood in an RV-style vehicle. They see over 3,000 patients per year in Saskatoon. One third of the patients they see are children.

In Toronto, the community paramedic program targets patients with a high historic utilization rate for paramedic services, truly our “frequent flyers”. This program has achieved an 81% reduction in demand from this group by ensuring they receive appropriate community support. Of these referrals, 66.4% were for new clients to the community care access centre. So we are finding new people earlier in the system, and it's an advantage for them and an advantage for the health care system at large.

Nationally, approximately 60% of paramedic responses, Madam Chair, are for patients over the age of 60, while patients over the age of 80 represent 27% of all requests for assistance through 911.

Paramedics can and should be used to ease the increased pressure on the health care system. Paramedics perform assessments, post-surgical home care, chronic disease monitoring, health education, administration of antibiotics, and other primary care functions. Paramedics are a valuable service in your communities. Paramedics are important health care providers to meet the growing needs of seniors and other vulnerable populations.

Other benefits of paramedics increasing their role in health care include significant savings based upon a reduction in 911 calls, emergency department visits, hospitalization, and off-load delays; an improvement in the alternate level of care bed availability; a reduction in demand for long-term care beds; and ultimately, an improvement in morbidity and mortality rates in Canada. Paramedics are well positioned to lessen these cascading problems for our health care system overall.

Madam Chair and members of the committee, I sincerely appreciate the opportunity to discuss the role that community paramedics play in strengthening the resilience of Canadians and supporting the principles of chronic disease self-management.

It's important, however, to reinforce that the intent of the community paramedic programs is not to augment existing services but to enhance quality of life. Paramedics continually see chronically ill patients whose needs range from reassurance and advice on self-management to clinical interventions. Community paramedics are here in your communities to serve Canadians.

The Emergency Medical Services Chiefs of Canada ask that this committee recognize the role of the paramedic in the future of chronic disease management.

Thank you for your consideration. I will be happy to answer any questions, Madam Chair.

The Chair: Thank you very much. I'm so glad you came today. That was very compelling testimony.

We'll now go to Professor François Béland, from the Department of Health Administration.

[*Translation*]

Prof. François Béland (Professor, Department of Health Administration, University of Montreal, As an Individual): Good afternoon. I will be speaking in French.

I would like to thank the committee for having invited me to appear before it to discuss a topic that has interested me for many years.

In essence, I will try to cover 3 points in 10 minutes, and in each case, I will provide examples that may be the subject of questions afterward. I will first speak very quickly about costs, among others the costs of aging for health care services; second—and on this I agree with Mr. Reichman—I will talk about the need to integrate health care services for seniors, and finally I will present a few guidelines for possible policy, in particular policy that could be developed by the federal government.

You have my notes in your hands. There are tables and figures. The first table is on health care expenditures in Canada. It is important to make a distinction that is not usually made when talking about health care costs: we must absolutely separate what is included in the services covered by the Canada Health Act, that is essentially medical and hospital services, and all other services, at least in terms of funding. Only once this distinction is made do we start to understand what is happening.

There is another very important aspect, and on this matter, I have taken the advice of François Vaillancourt, a colleague who is an economist at the Department of Economics of the University of Montreal. He believes that, for citizens, what is important is not what each level spends, but rather what government spends. What concerns and interests me, therefore, as a citizen, is what government spends on health care services. In Canada, even though health is under provincial jurisdiction, there is federal spending. It is important to take into consideration all government spending, whether it be federal or provincial.

In the first chart, we can see the changes in health care expenditures. Look at the middle line, between 1989 and 2008. It is the proportion of spending on doctors and hospitals by all governments in Canada. It therefore includes the federal budget and provincial budgets. We see that in 1989, spending on doctors and hospitals covered by the system constituted 12% of spending by all governments. In 2007, that proportion was still 12%. There has been absolutely no change in these aspects.

When we look at what is not covered by the Canada Health Act, we see a constant increase over time. In fact, it is precisely in this sector that there are user fees, charges and coverage that are neither public nor universal and that are applied where provincial governments, especially, are investing to make up for what is not covered by the private system. It is precisely this sector that explains the increase in the burden on the provinces, and insofar as the federal government funds health care services, on the federal government. There is therefore an increase in the burden and not in the amounts allocated.

Finally, much is said about health care spending on seniors. Let's look at the second chart. There are at least two elements in all health care spending when we are talking about a population. There is the increase in the population or in different age groups. You see health care spending going up because the Canadian population is increasing, and concurrently, because there are more seniors. That is shown by the bars on the right that you see here. What you see is the increase in health care spending in Canada due to aging and the increase in the population. There is a significant increase between 1989 and 2007 in Quebec.

● (1555)

The curve illustrates the increase in intensity. In Quebec, from 1989 to 2007, the intensity of services provided to the elderly decreased. In this case, you must consider both demographics and the intensity of services which are provided to the elderly. In Quebec and basically everywhere else in Canada, there was an increase in the proportion of seniors in the population. However, the intensity of services which were provided did not increase at the same pace. Further, this intensity increased more for those aged 55 and over, or rather, for people between the ages of 45 and 64, rather than for people aged between 64 to 75.

Let's now look at the overall increase in health care costs. There is the average spending growth for all age groups in Quebec, and there is the spending increase for the various age groups. Surprise! People over the age of 75 saw their health care spending increase over the last 10 years, and at exactly the same pace as for the rest of the population. However, it is rather the baby boom population, those between the ages of 45 and 64, that saw an increase. So when people say that the elderly are responsible for the stunning increase in health care services, they are wrong, because they have not correctly analysed the data. People often make a very opportunistic analysis of the data as a whole.

As Dr. Reichman and Mr. Nolan said, on the one hand, elderly people who need intensive services are relatively few in number, and on the other hand, they really do need these intensive services. We have known for a long time that this was coming. I will quote some words, which I translated into French, from an American observer who said this back in 1975: “[...] about 1 of every 5 people aged 65 and over will eventually need a combination of intensive and extensive social and health care services [...]”. Since 1975 at least, we knew what was coming our way. In fact, we have known this for about 36 years.

● (1600)

[*English*]

The Chair: I just want to let you know that you have three minutes left. I know you've covered only one topic. This is just to keep you aware.

[*Translation*]

Prof. François Béland: Let's skip the numbers. At the very least, it is important to understand that there is a tiny proportion of elderly people. You could say that there are between about 5% to 8% of elderly people who live in private homes or in the community, and who need intensive services. These people need an integrated approach to health care.

We know what to do, don't we? There are Canadian examples, such as SIPA. I distributed an article on that subject. Another program could have been a good Canadian example, if the Canadian Department of Veterans Affairs had implemented the report of the Gerontological Advisory Council, a report it had produced for the Department of Veterans Affairs, in 2006. This report recommended the creation of an integrated system which would have allowed the federal government to create a benchmark system integrating health care services for the elderly, in this case, elderly veterans.

In conclusion, I believe that the federal government has three roles to play which are all very important. First, the government must develop a benchmark sector for a certain part of the population, such as veterans, and, of course, first nations, and this sector would fall under federal jurisdiction. In so doing, the government would have the opportunity to test certain things, and to implement policies that may eventually be beneficial to all Canadians.

Second, funding is important, as well. There are other figures in the articles I have given you, and which I talked about. Regarding the elderly, it is impossible to separate health care services and social services. The elderly are in a unique situation. Therefore, funding must reflect that particular model. It is important that funding be appropriate for a category of people, and that it support all health care services. But to achieve this, we must think beyond the Canada Health Act.

Lastly, as Dr. Reichman said, innovation, innovation, innovation. The federal government will have to invest in innovation. It has done so in the past, but it seems to have forgotten about it along the way, and it is time that it reinvest in innovation.

[*English*]

The Chair: Thank you very much.

We'll now go to Dr. Mark Rosenberg, please.

Dr. Mark Rosenberg (Professor, Department of Geography and Department of Community Health and Epidemiology, Queen's University, As an Individual): Thank you. Madam Chair, honourable members, thank you for the opportunity to speak to you today about the older population of Canada and chronic diseases.

Some of you might be asking yourselves why a professor of geography, who's also cross-appointed as a professor in community health and epidemiology, should be speaking to you at all.

The Chair: I asked myself that.

Dr. Mark Rosenberg: I'm going to answer it.

In 1989 my colleagues from Queen's and I produced the first atlas of the elderly population, funded by Health and Welfare Canada's review of demography and its implications for economic and social policy, better known to some of you as the Demographic Review.

What that atlas did was open the eyes of policy-makers and academics to the fact that the older population of Canada needs to be understood, not just at the national level or the provincial level, but at the local level, when we try to think through the services required to treat chronic diseases and the access to those services required by older people to manage their chronic health problems. Having read through many of the presentations that you've already received, I feel this point deserves as much emphasis today as it did in 1989.

Canada is a complex geography of communities, where the needs of those with chronic diseases and the services required have to be thought about in their local context, whether we're discussing the older population of your riding, Madam Chair, or of the ridings of each of the honourable members of this committee.

My graduate students and I are now in the final stages of a project funded by the Social Sciences and Humanities Research Council of Canada. Our project asks how close did we come in our forecast in 1989 to how the older population would look in the first decade of the 21st century.

Our forecasts from 1989 turned out to be fairly accurate in terms of the local geographies of the older population. What we did not, however, foresee—and indeed I have seen very little in previous testimony that takes this into account—is that the older population of Canada today is a much more ethnically diverse older population than it was in 1989.

Why is this critically important to take into account? Coupled with my first point, ethnic diversity of the older population is very much a phenomenon of our largest cities, but not so much in small towns and rural Canada. Although there have been a very small number of studies published on the challenges that older Chinese Canadians and South Asian Canadians face in accessing services for their chronic health issues, we only have a rudimentary understanding of how older people's life experiences affect how they understand and manage their chronic diseases. I might add that we have few examples of culturally sensitive models of service delivery that actually work.

You might also note that I draw a distinction between Canada's largest cities and small towns in rural Canada. In other research my group and others are doing, we find there are unique challenges in living with chronic diseases in small towns and rural areas in Canada. The research shows that small towns and rural areas already have amongst the highest percentage of older populations in Canada. Many already have populations where the older population is well above 25% of the total, and will have even higher percentages in the future.

In other words, when we talk about 25% of the population being over 65 some time between 2031 and 2036, this misses the point that in many small towns and rural areas, the percentage of the population that is 65 and over will be much higher. In absolute terms, the numbers are and will be small, and the distances that either older people or service providers have to travel in rural areas are far and on average will be far greater than in urban areas. The implications for providing services, either for treatment or management of chronic diseases, are that models that might work in larger urban areas, predicated on large numbers of older people and, relatively speaking, short travel distances and times, might not be relevant in small towns and rural areas of Canada.

Parenthetically, I might add that there's already indirect evidence that the private sector is not prepared or is unwilling to provide services in small towns and rural areas for these very same reasons. Even the voluntary sector is challenged by these issues in small towns and rural areas.

There are two issues raised by previous witnesses to your committee, to which I'd like to add some comments and perhaps provide some additional insights.

What research there has been on the particular challenges of providing services to treat and manage chronic diseases in small towns and rural areas generally emphasized, as I have done, the small numbers of older people and the distances that need to be travelled by older people and service providers alike. This research emphasizes the demand side of the equation.

● (1605)

Other witnesses who represent professional associations and consumer organizations have talked to you about increasing the supply of geriatric and gerontological professionals. No provincial government has found an effective way to solve this problem, to address the lack of geriatric and gerontological professionals in small towns and rural areas. In fact, the supply issue in small towns and rural areas is far more profound and critical than in the areas of primary, secondary, tertiary, chronic, and home care. Without first addressing the supply issue, we are likely to fail to find ways to encourage professionals in the care and management of chronic diseases. We failed to do this in the past, and we are currently failing Canadians living in small towns and rural areas.

Coming from the university sector, I'd like to suggest that to address the supply issues I've raised, the federal and provincial governments will need to work together on structural issues found in Canadian universities and colleges, which train young people for jobs that focus on the young instead of jobs that focus on the older population. I'd like to give you one example.

In Ontario alone there are 13 faculties of education graduating thousands of students each year as qualified teachers. According to one national website approved by the Ontario College of Teachers, there were only 26 teaching jobs available in all of Canada last week. With all respect to my colleagues in the faculties of education, I do not question the quality of their work, the training they provide, or their commitment. But we cannot address the supply issue for geriatric and gerontological professionals if we continue to train young people for jobs that do not exist today and will not exist in the future, while we claim a shortage of resources to train young Canadians in areas of demand such as services and management of chronic diseases in the older population.

The other issue I'd like to address is the need to take into account the older aboriginal populations. It is still the case that most health researchers that focus on aboriginal populations are working on critical health issues of young aboriginal populations. There's only a small group of researchers focused on the older aboriginal populations. Yet the older-age cohorts of the aboriginal population are the fastest growing. By the middle of the century, the older aboriginal population will be in double digits as a percentage of the aboriginal populations. The older aboriginal populations will have many of the same service and management issues as the non-aboriginal population. In addition, they will have many service and management problems related to chronic diseases unique to their particular life courses and geographies. We need to prepare now and not make the mistake of waiting and then trying to catch up, which has brought us all here today to discuss the aging population and chronic diseases.

As someone who has spent more than 30 years carrying out research on access to health services, much of it related to Canada's older population, I'd like to comment on two issues that need much more attention than they currently receive. First, much of our research is constrained by our inability to designate levels of severity and to design service delivery models that differentiate between those living in the community with chronic diseases and those who need more intensive modes of treatment and management of their chronic diseases.

Second, we have at best a poor understanding of the transitions from living in the community with chronic diseases to moving into residential care settings. In other words, when is the optimal time to leave home and move to a residential care setting? To answer this question, CIHR in general, and the CIHR Institute of Aging in particular, needs more resources as well as assurances that long-term research investment such as the Canadian longitudinal study on aging will be supported now and sustained over the next 20 years.

To sum up, I respectfully urge the committee to emphasize in its final report the importance of complex local geographies of Canada, the diversity of the older population, and the growing older aboriginal population. Leadership in changing the structure of Canadian universities and colleges is required to shift resources to train young people in the fields required to address the needs of the older population who live with chronic diseases. Support for research on the older population with chronic diseases needs to be increased and then sustained.

Thank you for the opportunity to speak to you today.

● (1610)

The Chair: Well, that was perfect timing. My goodness, that was a compelling presentation. All of you have had extremely compelling presentations today.

We're going to go into our Q and A section now.

We'll begin with Madam Quach.

[*Translation*]

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

Thank you to all of the witnesses for coming here and providing us with information. Despite the fact that we have already held a dozen meetings, we always seem to learn something new. It is very interesting.

My first question is for Mr. François Béland.

You briefly mentioned the fact that services provided to the elderly decreased between 1989 and 2007. What explains this decrease? The demand is still there, and I presume it is growing. What explains the fact that health care services decreased?

● (1615)

Prof. François Béland: No, the services did not decrease. What happened is that the growth in intensity decreased. The growth rate decreased, not the health care.

When we make forecasts, we use growth rates. Take the hypothesis that care for the elderly is generally more intense, given that some say that this care sometimes includes therapeutic obstinacy, and one hears other such arguments. This seems to indicate that the intensity of care given to the elderly increases systematically.

However, if the intensity of care is increasing, it is not increasing as quickly as health care given to other age groups. In other words, the rate of increase in the future will go up much more quickly for people between the ages of 45 and 64 than for people aged 65 and over.

So just because the rate of increase is not as high does not mean that fewer health care services are being provided. The rate of increase is not as fast, but it does not mean there are fewer services.

Ms. Anne Minh-Thu Quach: You also referred to the 2006 program for veterans, which was not implemented, but which could have been a positive program, in your opinion. Why did it not work, and what could have been done to improve it?

Prof. François Béland: You have the document I distributed. It was produced by the Gerontological Advisory Council, which was set up by Veterans Affairs Canada, but does not exist any more. I believe it ceased to exist about two years ago. I was a member of that council from start to finish, that is, for about 10 years. The council worked closely with the Department of Veterans Affairs. The follow-up given to the committee's advice was very interesting. In fact, every member of the council, in particular academics, all had a very positive experience in working with the department to improve all services provided to veterans.

In 2005 or thereabouts, we thought it would be interesting to review all of the services provided to veterans, especially because there were two other projects in Quebec, namely SIPA and the PRISMA research project, which provided integrated services to the elderly. So we suggested to the representatives of Veterans Affairs Canada that they emulate that model.

There were three major components. First, health promotion. At the time, the idea was to help veterans who were still in terrific health to stay healthy. Most of the elderly were in fact in very good health.

The second component involved what we called guides. Some people called them navigators. These were people who helped individuals who were beginning to develop functional disabilities and one or two chronic illnesses, but who were still in a stable situation. They were given the appropriate services. This group represented between 25% and 30% of the elderly.

Lastly, there was the largest group amongst the veterans. In the elderly population in general, this group represents about 8%, 10% or 12%. But the last component was a truly integrated system which was based on the PRISMA and SIPA models. It meant that veterans with very complex needs had access to all the services they needed, both social and health services, to help them maintain the best possible quality of life at the end of their lives. But this model was not adopted by the Department of Veterans Affairs. In fact, it was the only measure which the advisory council recommended which was not adopted by the Department of Veterans Affairs.

Ms. Anne Minh-Thu Quach: At the beginning of your presentation, you talked about the costs related to treatments which were not covered. You said that these costs have increased significantly and that this has increased the burden on the provinces.

Can you explain this cost increase? Given the demographic trends, should we integrate some treatments into the current system?

● (1620)

Prof. François Béland: There are several ways of looking at this. You are asking a difficult question. When I was younger, we talked about the $64,000 question, but today, it is probably the $64 million or $64 billion question. It is very difficult to give a clear answer regarding that aspect. I would say that the Canada Health Act is extremely restrictive, because it only covers medical, hospital and diagnostic services.

However, the more people age, the more they need hospital and medical services, but that is not really where things play out. In fact, the increase in medical and hospital services is much more due to treating people during the last years of their life—one or two years—meaning that the increase in the health, medical and hospital services is not due to aging, but to the time leading up to a person's death. In fact, if you die at the age of 65, you will usually cost much more to the system in terms of hospital and medical services, than if you died at age 85.

However, as far as the other services are concerned, and in particular what we call long-term care services, these go up with age. Integrating these two types of funding is important.

[*English*]

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

We'll now go to Dr. Carrie, please.

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

I want to thank all the witnesses for being here today. It is an excellent panel. I don't know where to start because I have so many questions, but perhaps I could start with Mr. Nolan.

I like your idea about the community model of keeping people in their homes. I think Great Britain has been experimenting with this for people who are discharged from hospitals. They will send people out.

As you said, there is a huge readmission, 15%, within less than a month. I was wondering, when you talk about this model, what are the cost savings? When you diverted 88%—you said the diversions from the emergency or the hospital—and there was a 23% decrease in emergency visits, have you calculated what the cost savings to the system are?

Mr. Michael Nolan: In terms of the calculation, I don't have a number for you today. However, one of the goals of community paramedic programs—paramedic services across the country, of course—is that we are attempting to offset increase in pressures.

Whether you look at the 40-year to 60-year cohort, or the 60 years and above cohort, we know that with the epidemic for health care need and the baby boomer population, we're having a very difficult time keeping up today. Our offsets are a start to attempt to flatten this tsunami, this wave, of age that's approaching us, as well as the exponential increases in call volume we've experienced over the last 10 years.

I'd be happy to provide the committee with exact dollar values in terms of the estimates of cost savings. But when you look at a single patient who is diverted from an emergency department as a result of not calling 911, receiving appropriate care in the home—prevention of a fall that results in a fractured hip—we know those cost savings are enormous to Canadians when you start to look at reductions of between 60% and 88% in terms of utilization.

We also know these folks are our highest risk group. They are our high flyers. They're the people we know bear down on the health care system at large.

The Chair: Mr. Nolan, before I forget—and I'll make up your time—this is a very important point that Dr. Carrie has brought up. If you could bring that estimation and give it to the clerk's office, we'll see that it's distributed to all members of this House.

Mr. Michael Nolan: Wonderful. Thank you, Madam Chair. I'd be happy to.

Mr. Colin Carrie: I have a couple of quick questions. Out of curiosity, how long does it take to educate a paramedic in Canada?

Mr. Michael Nolan: A primary care paramedic, which is the entry-to-practice level in Ontario, is two years. In much of Canada, it's one. Then, an advanced care paramedic requires an additional year.

There are significant cost savings from starting out to becoming a clinician...and of course the costs of paramedic salaries are less than many of the health care providers we have compared in terms of the skills and services they provide.

Mr. Colin Carrie: I was going to get nosey, but I'm not going to ask you how much you make per year.

What would the average paramedic cost the Ontario health care system per year?

● (1625)

Mr. Michael Nolan: It would be between $50,000 to $70,000 per year.

Mr. Colin Carrie: You mentioned the scope issues and expanding the scope. We've heard, basically from all the associations, that we should be utilizing the professionals we have out there within their full scope of practice. What do you find are the barriers to expanding your scope or to being utilized to the best of your abilities?

I was listening to Dr. Reichman, and he was saying that we have to be a little bit bold and look at innovation. The question he asked was whether they must be in acute-care beds. That was a great question. You know what? I'm going to ask you that question.

Mr. Michael Nolan: Great. Our goal is to keep people out of acute-care beds. Of course, much of Canada is rural and remote. Our health care system relies on people coming to services, not receiving services in their communities.

In the case of Long Island and Brier Island, for example, the paramedics do blood sampling and analysis in the community so that we can have just-in-time diagnostics so that a patient's treatment regime can be adjusted, for example.

On other diagnostics and services in Halifax, the paramedics who are going into nursing homes are now suturing patients in nursing homes. Instead of taking the person to the service, we're bringing the service to the patient. Really, paramedics do house calls every day, and the individual skills they require to serve Canadians best should not be hampered by regulation, for example. They should be finding the appropriate place and time to deliver the service.

Mr. Colin Carrie: That's one of the challenges.

I'm from Oshawa. I had a wellness clinic. I'm a chiropractor, and I work with medical doctors. I know that my colleague across the way is also a chiropractor. One of the things we always used to hear was that one day in an acute-care bed would pay for a year's worth of chiropractic care.

It just amazes me that it seems that we still can't direct people to the right professional at the right time.

Dr. Rosenberg, I'm quite pleased to see a geography professor here, because it seems that we have had a lot of health care professionals and the standard people, let's say, we would expect to have here.

I liked what you had to say. In your bio, you mentioned that you were planning to do more research on volunteerism. You also brought up the differences between small towns and urban areas. A lot of Canadians are in small towns. How does that relate to volunteerism? How can we use volunteers in a better way?

Dr. Mark Rosenberg: Certainly my colleagues here on the panel probably could offer as many examples as I can. The work we have been doing on volunteers I think is both a good news story and a bad news story. The good news story is that, particularly in the older population, older persons are perhaps the most dedicated volunteers for the other older people in their communities. Particularly in small town settings and in rural communities, they are also very vulnerable.

Often, when the older persons who are volunteers start to have their own health issues, the volunteer system starts to break down. I think what we're facing in a lot of our small towns and rural areas, and we do a lot of research in small towns and rural areas, is the fragility of these systems. They tend to work just the way they work in the larger urban areas, but they tend to be much more fragile, because the numbers are small. When the key people can no longer volunteer or when they burn out, which is one of the other findings we've had, those volunteer systems break down.

That's why you're also seeing how difficult it is for the volunteer sector to step in, in these communities, where the private sector isn't prepared.

The Chair: Thank you, Mr. Rosenberg.

I want to welcome Mr. Eyking to the committee. You're next, Mr. Eyking.

Hon. Mark Eyking (Sydney—Victoria, Lib.): Thank you, Chair.

This is my first time on the health committee, and I'm glad I'm here at this time, when your esteemed witnesses are doing quite the job of telling us what challenges we face in the health care system. I'm from small-town rural Canada. You see it with your neighbours, the challenges they're facing. Many times the so-called children, adult children, don't live in the community anymore, and many times the seniors are taken out of the home because there's nobody there to take care of them. You mentioned this, that it's two or three years sometimes that they're in the hospital.

Mr. Nolan, you talked about Brier Island and how they're dealing in creative ways by helping on-site. I think we have to have some more incentives out there. The Australians are doing a lot more to keep rural health care workers in rural communities, whether it's helping them with their loans or giving incentives to doctors, and I think that's one way. The other thing that's been thrown around is that if you stay home with a sick one, you could get EI coverage. If you look at the net return you're going to get—if you can keep a senior or somebody sick in a rural community in their own home, it saves thousands of dollars, and really, it's EI for one year to help that person.

I'd like to hear more about incentives, what government can do to keep people in their homes. I had a gentleman next door who was 85 years old. He was still able, but he had to have a health care nurse come. He was going to stay in his home until he died, and he did, but they'd haul him out because his driveway wasn't clear—little things like that. If somebody had cleaned his driveway, somebody could've been in checking on him. You just wonder sometimes. We don't have creative ways of keeping people in their homes in a rural community.

Should we be doing more on that, getting more services in rural Canada and helping people who are going to stay home, maybe with their mom and dad, or even a sick child that has cancer? How can we help them out more?

● (1630)

The Chair: Who would like to take that?

Mr. Nolan.

Mr. Michael Nolan: I'd be happy to speak to that, Madam Chairman. Thank you.

On the individual side, the Deep River program is a great example of where often the paramedics are called the oldest child. As you say, they've moved away. They've stepped in as the lightkeeper, if you will, in the community. They're doing home visits. They're holding their hand when they need their hand held. We're putting in home monitoring devices and connecting people to the appropriate services.

As the EMS Chiefs of Canada we've been working with this government to have the paramedics included in the loan debt forgiveness program so that we can increase the number of advanced care paramedics in rural communities in Canada. Advanced care paramedics on the emergency side can intubate you, can put a pacemaker on you, and so on, but on the primary health care side, they can also come into your home and rehydrate you with an IV. They can provide you with antibiotic care so that you're not being shuffled back and forth a couple of times a day should you have sepsis or a significant infection.

We'd like to increase our presence and the services we're providing in the community, and we'd like this federal government to assist us in doing that. But I think as well we provide an opportunity through chronic disease self-management, working with the individual and the family so that they have the appropriate answers when it comes time to care for their loved one, because ultimately that's what we all want to do in terms of taking care of our parents.

Hon. Mark Eyking: My second question deals with the aboriginal community. It's the fastest-growing community in Canada. When you talk about resources we're going to need—we're going to need more nurses, more doctors—you'd think if that's the fastest-growing community we could hopefully draw from that community to have trained people. But the sad reality is that it's the most unhealthy community we have in our country. I have the largest aboriginal community in Atlantic Canada. It's just terrible. I know the truck drivers who bring in tractor-trailer loads of Pepsi and cola; two litres of pop is cheaper than a litre of milk.

You see these things and you see the health problems, and you see such a great potential we could have with the aboriginal community. How are you going to break the cycle of the unhealthy native community we have, and how can we encourage them to be part of our solution to a shortage of people power?

The Chair: Mr. Rosenberg, would you like to take that one?

Dr. Mark Rosenberg: I'll make a couple of brief comments.

As one of my colleagues here alluded to—I think it was Dr. Reichman—the issue of obesity in this country or the issue of poor diets I think is not unique to the aboriginal population. I think it really is a crisis across all groups. In truth, I think both researchers and governments and communities need to come up with a much more coherent and successful strategy if we're going to change health behaviours.

The other issue is the fact that there is a very significant body of literature at the population health level that tells us that at a general level, as people's economic prosperity rises, their health improves. So in some respects, with the aboriginal populations, it's a health question; it becomes a question of economic and social well-being and policies to ensure that the aboriginal populations' economic and social prosperity rises. As that rises, some of the health problems we see now will not necessarily disappear, but the older aboriginal population will increasingly look like the non-aboriginal population with respect to their health.

● (1635)

Hon. Mark Eyking: Can I ask one more?

The Chair: I'm so sorry, Mr. Eyking, your time is up, but they were very good questions. Thank you.

We'll now go to Mr. Brown.

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

Thank you for the interesting comments so far. It pleases me to see Baycrest here. Obviously, you have a great reputation with everything you do with Alzheimer's and dementia. My riding is in Barrie, Ontario, so I hear a lot about Baycrest. We also happen to have a bunch of the hockey players that play in your Alzheimer's tournament who happen to reside in Barrie.

I want to know if there is anything in your Baycrest model that you think we should be adopting in communities across Canada. In Barrie, where there are day programs for patients who have dementia and other Alzheimer-related challenges, they are very helpful, I suspect, in delaying onset, but there is obviously not enough space and they're difficult to get into. Are there programs you offer at Baycrest that go beyond the typical day programs you have in senior residences in small towns?

Dr. William Reichman: What people with dementia need is both support for the patient as well as, vitally, support for the caregiver. Programs like dementia day care provide support for both. The patient is involved in an engaged environment, their health is looked after, they are with other people, and they are with staff who understand their special needs. But the caregiver, during this time that a patient is in a dementia day care program, is also getting respite, so they can go and attend to their own needs and to maintain their household. Dementia day care is a very, very valuable service, and it can be expanded, so there needs to be more capacity in communities across the nation for dementia day care.

But we can also leverage technology. For example, there are caregivers who don't have the wherewithal to take their loved one to a dementia day care program, who perhaps can't even afford a dementia day care program and would really rather be supported better at home caring for the person who has the affliction. So what we're doing is leveraging technology. For example, if you're a caregiver and you need support, you don't have to go to a meeting somewhere to get the support and you don't have to have a human being come to your home. Through web-based technologies, you can participate in caregiver support groups; you can get immediate access to a professional who can tell you how to manage a difficult problem you're having at home. And this is a very inexpensive leverageable solution, using technology.

The other thing is that one of the great burdens for families caring for somebody who has Alzheimer's and other aspects of dementia is when that patient is no longer themselves, when they start to behave in a way that betrays that they're no longer the husband in the way he was before. These behavioural problems are what often is the tipping point to then seek nursing home placement. What we can do now, and what Baycrest and others are doing across Canada, is send professionals into the household to make an appraisal of what these disturbed behaviours are and to help the caregiver be able to manage them more effectively.

As well, there are some patients whose behaviour is so terribly disturbed they can't be effectively managed at home, so there are special care units now in Ontario, a few—and this is being piloted in other parts of Canada—where the patient gets admitted to a special care unit for a time-limited stay, the behaviour gets managed, the caregiver gets trained, and the patient goes back home.

There's a whole array of these different kinds of programs that have been piloted here in Canada, as well as across North America, western Europe, and elsewhere.

● (1640)

Mr. Patrick Brown: I know you do some research at Baycrest as well.

Dr. William Reichman: Yes, we do quite a lot.

Mr. Patrick Brown: One thing we heard during our neurological disorder subcommittee was that physical and mental activity helps delay onset. It was sort of pointed out to us in a broader concept, not specific studies. Has your research reconfirmed that theory that physical activity is very helpful in delaying onset?

Dr. William Reichman: Yes.

Of all the things we could potentially do to lessen our risk for cognitive failure in later life, whether it's frank dementia—Alzheimer's being the primary cause—or whether it's a milder version, called mild cognitive impairment, the data are most compelling that physical exercise in mid and later life is the most important protective thing we can do. And that's something we have control over.

Whether, ultimately, it reduces the risk of our ever getting Alzheimer's disease is still an open question. But in order to maintain cognitive health, just like maintaining cardiovascular health, good nutritional practice and physical exercise is where the most compelling data reside right now.

I think the critical message there is that if you ask boomers what they are most afraid of when they get older, as much as we will accept physical frailty and the dependence that may come with physical frailty, what we most fear is giving up autonomy. When do we have to give up autonomy? We give up autonomy when we can no longer make decisions for ourselves, and that's because of cognitive frailty, not physical.

At Baycrest, as well as other places across Canada, there are research programs growing now, looking at how to maintain good brain fitness, good cognitive fitness. Let's not wait until somebody has dementia to first think about how to restore cognitive health. We don't wait until advanced congestive heart failure to think about how to improve or maintain the cardiovascular fitness of a population, so why would we do that with brain fitness, which is exactly what we've been doing for the last 30 years? But it's shifting, and a lot of the research we do now is focused on how middle-aged people can keep their brains as vital as the rest of their bodies.

Mr. Patrick Brown: I know the new horizons program funds things like computer labs in seniors' homes, and art programs—

Dr. William Reichman: Yes.

Mr. Patrick Brown: —but it would probably be worth investigating whether we could fund physical activity programs as well, whether it be a gym in a seniors' home.... I guess the challenge is that if it's long-term care it's already too late, and it's difficult to change habits. What would your advice be as to how the government could stimulate physical activity in an aging population?

Dr. William Reichman: I think the first thing the federal government can do in association with advocacy organizations like CARP is to confront some stereotypical myths about what seniors want to do or what they don't want to do.

For each of us in this room—those of us who are middle-aged, as well as several who are younger—the things in our lives that give us a sense of purpose, that give us gratification, that give us a reason to get up in the morning, those things that are meaningful to us are also meaningful to seniors: staying engaged recreationally and socially; keeping your brain challenged; and keeping your body in good shape. It's a myth that people outgrow that need as they get older. It's a myth.

The Chair: Thank you.

On that note, I will say thank you. My goodness, this is even getting better than when it started. Brain fitness, good—I hope I'm better at that than I am at the physical fitness end of it.

Now we'll go into the five-minute round.

We'll begin with Ms. Davies, please.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, and thank you to the witnesses for coming today.

I feel as if you've all given us these universal truths that we hear over and over again, so it's very perplexing that we can't get it right. One of those truths is that there are too many people in acute care, and that people are being forced into acute care because they don't have other options. Of course, it's the most expensive and the least efficient. We all get that, and that we need to divert people into community care.

I think you also brought out a very interesting observation today, and that is that I think there is a myth that older people are burning up the system. I think each of you in a different way has refuted that. Most seniors are healthy, and the ones who have chronic diseases...if we just managed them differently, we'd be doing a heck of a lot better job. We hear this over and over again, that baby boomers and seniors will eat it all up and we won't be able to sustain medicare and health care. So I think you've helped respond to some of that.

Why don't we seem to be able to change the system? I don't know myself why we can't do that. Where do we begin? Supposedly, the health accords we have are meant to deal with that.

Is one of the questions that we need to look at who is in the ER? Do we even know? Who's going there and possibly is over-represented in terms of what they are presenting when they go to the ER? If any of you have any research or know of research on that, I think it would be useful for the committee.

In terms of diverting people into a much more responsive community care setting and all those varieties, it seems to me that integrated primary care centres.... You've talked about the paramedics, you've talked about your day programs, for example, but why do we have so few integrated primary care centres, or what we commonly call community health care centres? Isn't that where we should be going, where you can go to something that's community based, maybe community controlled, integrated? You've got a variety of services. To me, it's just so obvious, yet we don't seem to be able to get there.

Any of you who would like to address that can respond to those two questions.

● (1645)

Dr. William Reichman: The good news is that we don't have to invent something that hasn't already been demonstrated to work. There are programs in different parts of Canada, and I would be happy to get you this information, where it's been demonstrated that if you bulk up a primary care practice by adding other kinds of disciplines to that practice, whether it's a pharmacist, an OT, a PT, or perhaps even a paramedic...by bulking up these primary care practices so they're more interdisciplinary, there are better outcomes and patients get better access because they can be seen by another professional in the practice. It doesn't have to be that physician to get many of what their health needs are that caused them to go into the office.

Ms. Libby Davies: What if we just added nurse practitioners?

The Chair: Can I just interrupt for a minute, because Professor Béland and Mr. Nolan would like to comment on your question.

Ms. Libby Davies: Okay.

The Chair: Please, Professor Béland.

[*Translation*]

Prof. François Béland: Health care systems and the provinces, but especially Quebec, have basically tried two things up till now.

First, they tried to change the structures. Hospitals were merged, demerged and remerged. Regions were created, regions were eliminated, new ones were put in place, they were made bigger, and then the department was changed. I think you get the picture.

The second thing is that the funding was changed. However, when you change the funding, virtually all provinces come to see this as being a way to control health care institutions and doctors, rather than as a way to mobilize resources.

As Dr. Reichman so eloquently said, the areas where we need courage, and which we really need to change, are clinical practices and professional practices. We have now reached that point, but it will be the most difficult thing to achieve. We need to change clinical practices and professional practices. We must bring about change in both clinical and professional practices so that they align with the needs of individuals.

To make these changes, organizations will also have to align with the requirements of the clinical approach to treat elderly people who have several chronic illnesses. We also need the proper amount of funding.

For example, the member talked about snow removal earlier. In our SIPA project....

[*English*]

The Chair: I'm so sorry, our time has run out. We're in five-minute rounds.

I'll have to go now to Mr. Williamson.

Mr. John Williamson (New Brunswick Southwest, CPC): Thank you, Chair. I'm going to try to pepper some questions, actually.

Michael Nolan, you talked about things in Nova Scotia and how resources were allocated more efficiently. How did that happen?

Mr. Michael Nolan: The Nova Scotia government is quite integrated within its paramedic service. First and foremost, they have their hands on the wheel, if you will. Of course, within their system as a whole, they've been able to maximize the role of paramedics. Not unlike the situation in many other provinces in Canada, there has been a shortage of nurses and physicians for quite some time. They recognized early that paramedics could play a much more significant role in primary health care, and they gave them the tools, skills, and policy support to be able to do that. We're seeing, as in the Parrsboro example I gave you, seven other emergency departments this year that are slated to be staffed by paramedics at night to depressurize their physician shortage.

Long Island and Brier Island are rural and quite remote in fact. You have to take two ferries to get there. They said they have a resource. The only resource left standing in the community is paramedics. What do they need to be able to serve this population better? They did it over 10 years ago, and it has proven to be a big success.

● (1650)

Mr. John Williamson: Very quickly, do you have any idea what the savings were from freeing up resources to be used elsewhere in the health care system?

Mr. Michael Nolan: What types of resources, do you mean?

Mr. John Williamson: What dollar amount did this change? You might have addressed that before, and if so, please excuse me.

Mr. Michael Nolan: No, that's okay. Dr. Carrie asked me earlier about overall health savings. We can certainly speak to that from the perspective of what a reduction of one 911 call means for the system. We're looking at this more globally in terms of overall health economics. It's absolutely significant, both on the response side and on the resourcing side. A paramedic making $25 per hour, plus or minus $5, puts you into that $50,000 to $70,000 range I spoke to earlier. On the front end there are savings. In many parts of Canada there are underemployed paramedics. We're not in the same situation as many of our peers. We have an availability that is significant and available to all Canadians.

Mr. John Williamson: Thank you.

[*Translation*]

My next question is for Mr. Béland.

On page 3 of your presentation, you talk about

[*English*]

expenditures on MDs, hospitals, and other health services.

[*Translation*]

The upper curve of the chart presents... I will read it in English.

[*English*]

It's total HCE.

[*Translation*]

Does this represent the federal transfer, the cash transfer only?

Prof. François Béland: No. It represents total health spending in Canada.

This spending includes medicare and all amounts spent by the provinces. This line only represents public health care spending. This line includes everything which CIHI, the Canadian Institute for Health Information, deems as being public health care spending. For example, it would include medication, lodging services, services at home, and so on.

In short, the line includes all public health care spending, whether it is provincial or federal spending. The federal government, among other things, also provides health care services to the military, to veterans and to first nations.

Mr. John Williamson: Unless I'm mistaken, these are public expenditures.

Prof. François Béland: Yes. That represents overall public health spending.

Mr. John Williamson: As it now stands, it is 22%.

Prof. François Béland: That's right. Let's consider all public administrations, as they are defined by Statistics Canada. I can give you the definition.

Mr. John Williamson: Does this curve include...?

[*English*]

If we take these two lines and add them together....

[*Translation*]

the one at the top?

Prof. François Béland: Yes, it should be the one on top.

Mr. John Williamson: That makes sense now. Thank you very much.

[*English*]

Dr. Reichman, you seem to be an advocate of 10 laboratories of innovation in Canada. You're suggesting provinces go out there and just do things, and we'll find the ones that work best, and other jurisdictions should copy them. Things that don't work as well won't be copied, obviously. How is that working? What can the Government of Canada do to encourage that, as opposed to doing something else?

The Chair: Dr. Reichman, please respond quickly, if you could. I know our time is up, but we would really like to hear your answer.

Dr. William Reichman: I believe there's great creativity in each of the provinces here, and there are provinces as well that are looking outside of the four walls of Canada and looking at models abroad. Many of these models may work in Canada, several of them won't, but we won't know unless we try it.

What we've been advocating at Baycrest is to leverage all of this talent across the nation, create a Canadian centre for innovation in aging, bringing together the very best practices that have been demonstrably effective in different jurisdictions of the nation, and then distribute those results where they are most needed. What can be distributed is not only best practices of demonstrable effectiveness from Canada, but as well best practices that have been demonstrated to be helpful from other jurisdictions. Right now we have a very fragmented approach to that in the nation.

● (1655)

The Chair: Thank you, Dr. Reichman.

Dr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): My question is for Mr. Béland. You briefly talked about aboriginal populations. You also said that the Government of Canada should innovate in areas where it has full jurisdiction over the health care for certain populations, such as veterans.

Can you tell us a little more about what you mean when you talked about a test-tube experience with regard to the aboriginal population?

Prof. François Béland: Aboriginal people are not really my area of expertise. I know that the federal government often claims that health does not fall under its jurisdiction, but it is nevertheless responsible for certain populations. I mentioned aboriginal people, since the federal government indeed is responsible for their health care needs.

Regarding aboriginal people in particular, some approaches should be taken. In my opinion, they are different from those which should be taken for other groups. In that regard, I agree with Dr. Rosenberg. However, since we are talking about elderly people and chronic illnesses, all of these approaches must include a vision which promotes good health, as Dr. Rosenberg said.

However, within native communities, and among veterans and other groups within Canada, there are elderly people who have serious disabilities, in addition to chronic illnesses, depression and cognitive deficiencies. It costs an awful lot of money to look after this group.

What approach should we take for aboriginal people? Obviously, we will have to take an approach which is very different from the one we would take for veterans, for example. We have to call upon all communities. This is the responsibility of the federal government. The government has an opportunity to show the provinces what it is doing and to tell them that it has an opportunity to innovate.

Dr. Reichman and Dr. Rosenberg are absolutely right. All kinds of solutions are available. There is, for instance, SIPA, the research program on integrated services for the elderly, as well as PRISMA, and other projects in Canada, which have demonstrated that it is possible to develop both health care and social services which meet the needs of the elderly. We know what is needed. The issue now is to figure out how to bring everyone together to get things done.

Mr. Dany Morin: Do you feel that there is a lack of leadership on the part of the federal government?

Prof. François Béland: I do not want to point the finger at any government in particular, but as I said earlier, I believe that we are at a crucial junction for the entire health care system. I do not believe that we are going to find solutions by just tinkering with our structures and with funding. We need to figure out how to organize care around the individual.

Until now, there has been talk about integrating structures. But we have to begin by talking about integrating services around people who need care. If we do that, we will be able to say that people need a whole range of services. For example, elderly people who are very disabled need to have snow removal services at home. The funding would have to cover that type of cost. The funding would have to align with the needs of individuals. The organization has to align with the needs of individuals, and not the opposite, namely patients should not have to align with the needs of organizations and with the funding requirements of the health care system. We therefore have to flip our approach around.

Mr. Dany Morin: In that case, is the government's current solution, a 6% increase in its transfer to provinces, the right solution to bring our Canadian health system up to date? Should we go further?

Prof. François Béland: The whole issue of the accord renewal funding would require separate consideration. One thing is certain: the funding is not sufficient, but it is critical.

In addition, we have to innovate, and we know how to do that.

● (1700)

[*English*]

The Chair: Thank you so much. Thank you, Dr. Morin.

We'll now go to Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you very much.

I would like to start by saying I think a 30% increase in funding is better than the alternative. Three of you spoke about innovation and about how, basically, we won't tolerate the status quo for our parents. We certainly expect better for ourselves and hope for better for our children.

We've heard time and again, as Ms. Davies said, about innovation, about too many people in acute care. Is it legislation? Is it politicians? What is standing in the way of that innovation taking hold and getting to that next level where we're actually seeing demonstrated results across the provinces?

Mr. Reichman, would you like to start?

Dr. William Reichman: First, I think it's critical to articulate a concrete goal of what we're trying to achieve through innovation, and that will then rally people around that goal. That's what I think is the proper role of the federal government, to articulate goals that Canadians are entitled to achieve. And the means of achieving the goals, most of that responsibility, with the right federal support, can exist at the provincial level.

For example, at the very beginning of my talk I threw out a very specific goal. I said that rather than having the nursing home be the last two years of your life, it will now become the last two months of your life. That's a very specific goal. And it's going to require a whole series of efforts to get us there that include much better support in the community to keep people who would otherwise go into nursing homes out of nursing homes.

So I think it's important to articulate very specific goals. Every Canadian who wants to die at home instead of in an acute care hospital is going to die at home.

Now, let's talk about what it's going to take to get us there. Every Canadian who needs a primary care doctor is going to have a primary care doctor. Let's talk about why we're not there. What are the obstacles? Let's do it. If we can send a man to the moon and safely return him back to earth, we can certainly do these things.

Mr. Mark Strahl: Mr. Nolan, do you have any comments? You mentioned innovation as well, as a key part of your organization's goal.

Mr. Michael Nolan: I think we need to take some chances within the system. We need to take chances amongst the professionals who are providing the services and to look at opportunities to work together like we never have before.

There was a question earlier about reaching out to senior populations and providing exercise opportunities. Here in Ottawa, the University of Ottawa Heart Institute has a heart-wise exercise program that's across all of eastern Ontario, and into the greater Toronto area now. We provide, through community paramedic programs, volunteer instruction so that people in long-term care facilities can get out and self-manage by walking in the halls of those nursing homes, and doing it in a way that's predictable in terms of improving their health.

I think overall, from province to province, we've seen variations in care. One of the things we're asking for in Canada is to define the standard of care in paramedic practice. We believe community paramedicine is an essential part of that. We believe that by looking at best practices, by having the federal government take a leadership role in saying, break down the professional silos, provide the services in the communities, stop putting money into bricks and mortar, and start putting money into people's homes so that they can manage their own care, that has been demonstrated to save significant dollars and empower people who truly want to continue to care for themselves.

The Chair: You have one more minute.

Mr. Mark Strahl: Okay. The final question would be this. Are the provinces sharing the innovations that are taking place in their jurisdictions with one another? Or is there resistance to doing that? And if so, why would that be?

Does anyone have an answer?

[*Translation*]

Prof. François Béland: In my own experience, I've noticed that the Quebec government encouraged such sharing, especially between Quebec and Ontario, regarding performance, performance measurement and the way to use performance indicators.

In addition, information now circulates. For example, the Canadian Health Services Research Foundation now plays a much greater role in information sharing. Canada is one of the countries where the sharing, the transfer of knowledge, is encouraged to quite a remarkable extent.

There are also initiatives supported by the provinces. For example, in Quebec and in the whole of Canada, there is a movement to adapt hospitals who serve elderly people and those with chronic diseases. That's ongoing and there are concrete programs in that regard. There are a great many such examples.

● (1705)

[*English*]

The Chair: Thank you, Mr. Béland.

We'll now go to Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): We have been talking about the increasing number of seniors.

The committee has learned that this population will increase from 14% to 25% by 2036. This demographic trend will also affect health professionals. I am truly astonished to learn that there are currently only 200 geriatricians in Canada.

Has your organization studied what the impact of this demographic increase will be on the labour force, whether in 2036 or right now?

We are told that there is a shortage, both of paramedics and medical personnel. I was happy to hear Dr. Reichman say that we've reached a point where we can send people into space, but we aren't able to provide a family physician to all Canadian families. I find that very troubling.

[*English*]

The Chair: Who would like to answer that?

We'll start with Mr. Nolan and then go to Dr. Rosenberg.

Go ahead.

Mr. Michael Nolan: Thank you, Madam Chair.

Certainly in the case of paramedics, while being the third largest health care provider in Canada in terms of our demographic, we're not on the health human resource planning horizon. We're not currently being studied by the federal government in terms of the army of resource that's available to you. However, our demographic is significantly younger than that of the physician group and the nursing group by virtue of the advent, if you will, of paramedics over the past 40 years across Canada, and we're now quite a bit younger and have greater capacity in terms of our ability to shift both culturally and geographically given our prevalence in rural and remote communities across Canada.

In terms of the patient demographic, if you will, we are certainly experiencing significant challenges. To recap one of my points earlier, 60% of our responses are to patients who are over the age of 60, and when you look at those over the age of 80, that's 27%—almost a third of our response is for people over the age of 80. We recognized earlier, from Mr. Béland, that may not be the largest group of people in the population, but they do use our services at an exponential rate from earlier age groups, and as a result, we're able to respond to that with a younger workforce.

[*Translation*]

Mrs. Djaouida Sellah: Okay.

[*English*]

The Chair: I'm sorry....

Dr. Rosenberg, go ahead, please.

Dr. Mark Rosenberg: I would just make one quick comment, and that is that the supply of health care professionals is really a function of decisions that are made by provincial governments with respect to the resources they wish to spend on their university and college systems. The other issue is indeed that the universities and colleges, in essence, respond to those decisions that are made by provincial governments, and until the provincial governments, in a sense, incentivize the universities to shift resources more into health care professional training, the shortages will not be solved.

I think we fool ourselves in this country, when we talk about shortages of physicians, nurses, chiropractors, and all other health care professionals, if we think there's any other solution than shifting resources into training, and all these other discussions—with all due respect—are really in a sense smoke and mirrors. It's purely a function of policies being made by provincial governments to the universities, and the universities and colleges responding.

● (1710)

The Chair: Thank you so very much.

Now we'll go to Mrs. Block, please.

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

I, too, would like to thank all of you for being here today. It has been a very good discussion so far. I know we've talked about expectations, those that exist and those that will exist for future generations. We've also talked a lot about innovation and even incentives.

I've had the privilege of living in both urban and rural Canada, about half my life in either place, and also in serving on rural district health boards and the largest health board in the province of Saskatchewan. It seems to me that these issues are not necessarily new, that they've been around for a very long time.

I want to pick up on something that you've shared, Mr. Nolan. When I was chairing a health district board, we had EMTs. You referred to other levels of paramedics that are probably new since that time. I know that in rural Saskatchewan we needed paramedics and we didn't have paramedics, so I understand the kind of care that needed to be provided in small towns in rural Canada and couldn't quite get there sometimes.

Also, I do have to put a plug in for the health bus in Saskatoon. That's where I'm from. I had the privilege of being at the grand opening of that health bus, I think it was about four years ago. I know they are opening up a new one this coming Friday. You referred to the other one being a refitted RV. This is actually a bus that's been built to provide the service to the community, and it's very exciting.

My question for you is, how has new technology assisted EMS professionals in being able to respond to the demands of the population?

Mr. Michael Nolan: Certainly, we appreciate your acknowledgement of the innovation in Saskatchewan as it relates to the health bus. To use that as an example, from a transportation perspective, we are quite literally pulling the bus into underserviced areas of the population. In Saskatoon, we pull into neighbourhoods that are predominantly first nations and reach directly into pockets of society that have traditionally underutilized resources in an appropriate time, otherwise waiting too late. Or we've been able to open the doors to populations of immigrants, for example, and been able to reach out to them without having walls around us from a hospital's perspective. It becomes more inviting because we're doing it on their doorstep.

Innovation has also assisted us in being able to provide technologies in the community. For example, you once would have to go to the hospital to have an ECG. Paramedics are now able to do not only a 3-lead but a 12-lead, a full endocardiogram, in the home, and that ECG can be interpreted in the RV, or the health bus in that example, in the back of the ambulance, or in your living room. So we can now do early detection of disease with the advancements of technology. And we're able to do other tests in the home and in the community for which at one time you'd have to wait for a laboratory to get the results. Basics like blood glucose monitoring, for example, and other diagnostics in the home can be done with the prick of your finger. Paramedics can now do that diagnosis and work with other health care professionals to ensure that you get timely access to service.

Mrs. Kelly Block: I want to follow up with what sorts of changes have been made in the last 15 to 20 years in terms of providing an equal level of service in small towns and rural Canada. I know we used to lament about an eight-minute response time in the city when we were looking at half an hour in rural Canada, and also that golden hour that we've talked about before in terms of the timeliness of getting out to some place in rural Saskatchewan or other provinces.

You have new designations here. What is happening in rural Canada to address those issues in those communities?

● (1715)

Mr. Michael Nolan: Certainly Human Resources and Skills Development Canada, over 10 years ago, assisted the Paramedic Association to identify the national competency profile, so educational institutions now have a standard language of what a paramedic is or isn't. A primary care paramedic is what would be known as an EMT, and an advanced care paramedic is like an EMTP, for EMT paramedic, as you may have noted in your jurisdiction. However, the provinces are not required to have a baseline of any sort as it relates to ambulance or emergency medical service or paramedic care. It's the educational institutions that provide those varying levels of graduates, and then it's up to the province to determine how many of what type of provider are available.

The Chair: Thank you, Mr. Nolan.

I'm sorry about that. I have the rare privilege of asking a question now, because they've put me on the roster, which is very nice. Thank you, colleagues. I'm keeping time, right?

This has been a very interesting dialogue today. You know, what we're hearing is really about thinking outside the boxes. We talk about end-of-life issues and seniors issues being centred in the home. We talk about paramedics who can do things so that seniors don't have to go to a doctor's office and wait in line. They take blood pressures and administer IVs and do all those important things.

Dr. Rosenberg brought up an extremely important point, which was that a lot of our older citizens come from different ethnic communities—the Polish, the Ukrainian, the Chinese, etc. In five years, we are going to have more senior citizens than younger people in our country. We have to think differently.

Now, I wonder if one or two of you can make a comment or two, having looked at this myriad of paradigms that have shifted across our nation. We used to think of hospitals, doctors, and nurses. Now we're thinking of chiropractors, paramedics. We're thinking about a whole global community that can contribute in a major way.

I wanted to ask you if you think it would be useful to look at the innovations across this country and to use them to compile a list of best practices. We hear a lot of different things. We go through a lot of different things, everything from H1N1 to MS. You name it, we have it on this committee. I can hear all the committee members saying in unison that we need to think outside the box, in a more innovative way, to look at the best practices and include all these important health care components.

Then there's the education factor. Dr. Rosenberg, you were very astute when you made the observation that there are thousands of teachers graduating but not enough jobs even for hundreds. Is that right? I know my own daughter is going through health care now, and there are jobs all over the place. It's just where you fit in.

Could some of you comment on what my thoughts are on this question?

Mr. Nolan.

Mr. Michael Nolan: Thank you, Madam Chair.

We would welcome this committee and this government looking at best practices in Canada. We believe strongly that interdisciplinary solutions are the way of the future. We believe that paramedics have a strong role to play. We also believe that, through the health accords, the dollar value changes as well as the population health metrics. Looking at significant requirements as it relates to funding spurs innovation through the outcomes. We would welcome participation in this effort.

The Chair: Thank you.

What are your thoughts, Dr. Reichman?

Dr. William Reichman: I would just caution not to take a quick look at best practices and feel as if we've done our job. The field is dynamic; innovations are being introduced every day. I would ask that there would be an institutionalized federal effort to keep track of innovations in aging, both within the nation and outside our borders, and to find the means to work in partnership with the provinces to incentivize Canadian health care providers and others in academic settings to test new models and demonstrate why they are advances over the past.

● (1720)

The Chair: I'll go to Dr. Rosenberg.

Dr. Mark Rosenberg: I think the value-added that needs to be worked on is getting the provinces to accept these best-practice models and diffusing them through their systems. I think there is a tremendous effort going on in organizations like CIHR to disseminate research findings, but I think the provincial governments are slow to push these models through their systems.

The Chair: Thank you so much.

I've run out of time. Very briefly, Mr. Béland.

[*Translation*]

Prof. François Béland: In fact, one of my proposals was that the federal government reinstate the health innovation funds. Indeed, work has already been done regarding best practices. Amongst other things, reports were tabled with the health department, namely Hollander's work, Chappell's work, ours and those of our Quebec colleagues, like Réjean Hébert. Already, best practices are—

[*English*]

The Chair: Thank you. I'm so sorry, I have to stop you there, but I'd be very happy to talk to you at a later time.

Now we have Mr. LeBlanc. Welcome to our committee.

Hon. Dominic LeBlanc (Beauséjour, Lib.): Thank you.

The Chair: We have time for one more. Ms. Davies, did you want to ask a question? You have time.

Hon. Dominic LeBlanc: I'm happy if Ms. Davies has questions.

[*Translation*]

If there are other colleagues—

[*English*]

The Chair: It's an opposition question.

Ms. Libby Davies: Actually, I would give some of the other panellists an opportunity to respond to my questions because I really think it is about shifting the system.

I'd really appreciate knowing whether or not.... It seems to me that we need to do something that's really big and broad and has a big impact; it has to be a shift to community care. It could be scattered in a thousand directions and we don't know what the impact would be.

If we linked the human resource issue Mr. Rosenberg referred to with the need to have integrated primary care centres that are more community focused and closer to home, would that, in your mind, be the kind of dramatic shift we need to see that would provide better care and be a much more efficient use of our system?

I feel we need to get a handle on something that is both big enough and broad enough to produce this kind of—some people say the word "transforming"—systemic change in our health care system. We keep missing the boat.

So I'll give you an opportunity to respond to that.

[*Translation*]

Prof. François Béland: Very briefly, I would say that there are—

[*English*]

Ms. Libby Davies: Actually, if you don't mind, it was Mr. Béland who replied to my question last time, and I'm not sure the others got a chance—so my apologies to you.

The Chair: Who would you like to hear from?

Ms. Libby Davies: Certainly Mr. Rosenberg, Mr. Reichman, and Mr. Nolan.

The Chair: All right. Go ahead, Dr. Rosenberg.

Dr. Mark Rosenberg: I certainly think community health centres have a greater role to play, particularly in those provinces that have been slow to take them up.

I hate to come back to this basic point: you can create a building in your community and call it a community health centre, but if you can't staff it, it's not going to make the kind of shift that you're asking for. I'm so sorry to have to say this, but I think we really do need the federal government—since the provinces are reluctant—to take a look at the human resources issues in a much more serious way, and to shift resources into training across all fields.

● (1725)

Ms. Libby Davies: If I could, I'll just jump in there about the point I was getting to earlier. If there were a big shift to, say, nurse practitioners, who seem to have a much greater role to play in the system.... For example, in B.C. we have very few nurse practitioners. Here in Ontario, it's a much better situation. I don't know whether nurse practitioners play a significant role in Quebec.

But even if we did that, would we be having an impact in terms of the human resources input?

Dr. Mark Rosenberg: I'll make one quick comment.

The Ontario government did put resources into creating nurse practitioners. Most of those nurse practitioners, who they were hoping would go to rural and small town communities, stayed in the largest urban areas and, generally speaking, practice in group practices in those large urban areas.

But it really goes beyond nurse practitioners. There are needs for physiotherapists, occupational therapists, home care workers.... If we want to have truly integrated community health centres, all of these areas.... And we've said almost nothing, which I've noticed has been spoken about in other committee meetings, about the kinds of mental health workers who are needed to work with the older population as well in these centres.

The Chair: Mr. Béland, I know you wanted to say something.

[*Translation*]

Prof. François Béland: Very briefly, I would tell you to beware of "big bangs". When the provinces organized most of the big bangs, there were changes to the structure. Today, we need to change practices. In some provinces, there are indeed changes in practices. I don't quite agree with what Dr. Rosenberg said.

In Quebec, we have set up, and we continue to set up, family medicine groups located in the communities. As I mentioned earlier, hospitals are making an effort to adapt to the needs of the elderly. So, there are both small measures that are extremely important and very difficult to implement, and new directions that need to be developed on a larger scale.

You know, when we talk about big bangs, we're talking about brighter futures. In fact, we're talking about tomorrow. Usually, things seem brighter the next day, but the following day, we start thinking seriously about what we did.

[*English*]

The Chair: I let everyone go over because it was a very important topic. You certainly have done an amazing job of opening a lot of different aspects to this very important topic. I want to thank you for being here today. We look forward to any other information that you can forward to my office. If you do that, I'll make sure I forward it to the clerk, or to the clerk's office, so we can disseminate it amongst the members.

Thank you very much for joining us.

The meeting is adjourned.

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