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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, ladies and gentlemen. Welcome to committee.

I would like to start right away so we can make sure we get our witness testimony in.

Yes—

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Madam Chair, point of order. I would like to confirm that the committee will continue to sit after the vote.

[*English*]

The Chair: We will discuss that when we find out when the bells ring, for sure. Apparently that's up in the air. I'll ask the committee what their will is at the end of the time, Dr. Morin.

Now we'll begin with the presentations from the witnesses. We have with us, as an individual, via video conference, Dr. Margaret McGregor. She is a clinical associate professor, department of family practice, University of British Columbia.

Thank you so much, Dr. McGregor, for joining us today. We're very pleased to have you.

As an individual, we have Dr. Sylvie Belleville. We're glad to have you here as well. You're from the research centre of the Institut universitaire de gériatrie de Montréal. Did I do that well?

And we have, from Lakehead University, Dr. Michel Bédard, Canada research chair in aging and health.

We're very pleased to have you all here. We will have ten-minute presentations.

We'll start with Dr. Sylvie Belleville because I understand you have to catch a train or a plane or some mode of transportation soon.

Thank you, Doctor.

[*Translation*]

Ms. Sylvie Belleville (Director of Research, Research Centre, Institut Universitaire de Gériatrie de Montréal, As an Individual): Madam Chair, members of the committee, I would like to thank you for inviting me to speak on the issue of chronic diseases related to aging. As a researcher, I feel it is important that I tell you how my work and the work of my colleagues could be useful to your study of this issue. As you probably know, the first baby boomers were born in 1946 and they turned 65 in 2011. This year therefore marks some major demographic changes that will shape the social, economic, and medical landscape in Canada.

In Canada, one person out of five will be over 65 years old by 2026. The number of people over the age of 65 will be higher than the number of those under 15 in 2015. This is already the case in Quebec, New Brunswick, Nova Scotia, Newfoundland and Labrador, and British Columbia. Those are the kinds of changes Canadian society will be facing based on these demographic changes. Canada will have to work particularly hard in order to meet the needs and expectations of those seniors who built today's society so that they can continue to play a key role in the world of tomorrow. I think it is urgent that we put aging at the top of our priorities, and I thank you for undertaking this study.

I am going to make three points in my remarks. First, the importance of training, second, chronic cognitive issues associated with aging, in particular those caused by Alzheimer's and similar illnesses, and finally, the importance of prevention for healthy aging.

I would like to begin by underscoring how important it is to provide our future health professionals with better training. Individuals who care for the aged often have insufficient tools to do so. One could think that that is no longer the case and that our university and college institutions are now training our students to meet the challenge of aging, but it is most likely not the case in many areas in Canada. In 2011, the geriatrics committee of the Réseau universitaire intégré de santé de l'Université de Montréal undertook a survey that showed that aging is not sufficiently covered in most of the training programs of future physicians and health professionals.

Therefore there hasn't been a true change within our educational institutions. That has to be changed through a two-tiered strategy. Professionals already working have to be trained—that's professional development—but aging must also be included in the university curricula. This change has to be multidisciplinary because aging implies changes from a health point of view but also from a psychological, social, economic and sociological point of view. This will obviously inform how we are going to prevent and treat chronic illnesses. In order to deal with this complexity and diversity related to aging, we have to take a pluri-professional approach to health and include physicians as well as professionals and practitioners working in the areas of social and economic sciences and the humanities.

I would now like to speak about the prevalence of cognitive issues that accompany chronic diseases related to aging. A very broad study on the health priorities of Canadian seniors was undertaken by a researcher from the Institut universitaire de gériatrie de Montréal, Cara Tannenbaum, and it covered 1,500 women. The study showed that the priorities of female seniors dealt more with conditions that can prejudice their quality of life rather than diseases that can be life-threatening to them. For example, these women stated that memory issues were at the top of their health priorities. They also identified factors that limit their mobility, such as falls or osteoporosis, and vision problems. What was quite troubling was that these women also stated that health professionals do not pay enough attention to those factors, and in particular, to their concerns about memory and Alzheimer's.

This study demonstrates that we have to pay particular attention to both care and research and the policies on those diseases that can cause memory or cognitive problems for seniors.

● (1535)

The decline in cognitive function is one of the most worrying consequences of aging, and its repercussions are manifold. You probably know that if we reach age 65, 2 out of 10 people—about 5 people here—will have Alzheimer's disease or a related disorder.

Today, half a million Canadians have Alzheimer's disease, and every five minutes a person develops the disease. Just during our meeting, nearly 25 new people will be diagnosed with it in Canada. Clearly, Alzheimer's disease causes significant, long-term disorders, which greatly affect quality of life and for which we have no cure. The disease also affects caregivers, who are often elderly themselves and who go through a lot of distress and exhaustion.

Currently, Canadian researchers, including me, are investing their time and their passion in trying to better understand this disease, but there remain many questions without answers. We do not know what the causes are yet, which makes it difficult to find medication to treat or eliminate it; we do not diagnose it well yet. Currently, there's no sure marker of the disease while the patient is alive, and studies that have looked at the brains of people diagnosed with Alzheimer's disease indicate that many of them had in fact another disease. This is a significant problem when we try to find effective medication, because when we assess the effectiveness of medication, we do it in people who have very different diseases and who do not necessarily have Alzheimer's disease. It is therefore absolutely crucial to be able to find ways to better diagnose the disease.

Another significant problem has to do with the fact that this disease develops silently during many years and that we currently diagnose it much too late, when the disease has already devastated patients' brains. For this reason, many researchers believe that we must try to establish a "pre-clinical" diagnosis, that is before the person has significant memory problems. This is very crucial because we will have to be able to identify patients rapidly and early when we have found the medication.

The pitfall for early diagnosis is that our current techniques are imperfect. Some are not sensitive enough, while others identify people as being at risk for Alzheimer's disease, when in fact they will live a very long time and die without developing the disease. Ethically, it will be important to ensure that we do not stigmatize people by diagnosing them early and inappropriately.

For these two diagnostic problems, my team's work indicates that combining memory tests, simple neuropsychological tests and neurological brain exams will be the most promising way of contributing to a correct diagnosis, but only research will help us identify these tests.

There is also hope in the methods of intervention. One of the very great advances in recent years has been to show the extraordinary plasticity and reorganization abilities of the human brain, even when it is aging. Researchers already knew that children had this plasticity, but studies have recently shown that brain plasticity also exists in older people. With aging comes the loss of cells, the brain loses cells, but the brain compensates by recruiting other areas to perform the cognitive tasks requested of it. My team has shown that this brain plasticity, this compensatory plasticity, is present even during the first stages of Alzheimer's disease, and that it can be amplified by relatively simple stimulation programs.

This data obviously leads to significant opportunities regarding research and the care of patients likely to develop the disease. It proves the potential role of brain plasticity in Alzheimer's disease and indicates that, perhaps, lifestyle factors could contribute to delaying the onset of chronic cognitive disorders, such as those caused by Alzheimer's disease.

● (1540)

[*English*]

The Chair: Thank you so much, Dr. Belleville. I'm sorry, your time is up.

Ms. Sylvie Belleville: I have finished.

The Chair: That's okay.

We'll now go to Dr. Margaret McGregor. Dr. McGregor, you have 10 minutes. Could you please give us your presentation?

Thank you.

Dr. Margaret McGregor (Clinical Associate Professor, Department of Family Practice, University of British Columbia; Research Associate, UBC Centre for Health Services and Policy Research and Vancouver Coastal Health Centre for Clinical Epidemiology and Evaluation, As an Individual): Thanks for inviting me to speak to the Standing Committee on Health on the topic of chronic diseases related to aging. I'm a researcher of health services, particularly in the area of frail elder care. Those are individuals with chronic diseases that have resulted in a significant loss of function. I'm also a family doctor at a place called the Mid-Main Community Health Centre in Vancouver, and many of my patients have one or more chronic conditions.

My presentation today is therefore informed both by my research on chronic disease in the frail elder population and my practical experience in supporting patients to manage chronic diseases at all stages of their conditions and their lives. I will try to briefly cover four topics today. My first is about defining chronic disease. Since the committee is charged with looking at chronic disease, I'd like to point out that our definition of what is and isn't chronic disease is ever-expanding. Let's take diabetes, for example. Ten years ago, to be a diabetic, my patients had to have a fasting blood sugar of over eight. Today, this threshold has moved down to seven. When the cut-off changed, all of a sudden those who had not been diabetic were now classified as having the disease.

Likewise, we've expanded our definition of what is and isn't high cholesterol, and we now diagnose osteoporosis based on the results of a test, whereas in the past we diagnosed this disease based on clinical signs and symptoms of bone loss. These types of shifts are significant. One researcher calculated that simply expanding the diagnosis of what is high cholesterol from 6.2 to 5.2 in the United States resulted in an 82% increase in individuals with a diagnosis of hypercholesterolemia, or over 4.3 million people.

In some cases, this could be a good thing. There is some evidence that the earlier we detect certain conditions, the better we're able to prevent progression of disease. However, the expansion of who we define as having disease also has some potential downsides. One downside is that when we diagnose chronic disease based at such an early stage, it's impossible to predict which individuals will actually end up developing noticeable complications of the condition, and we know that labelling alone, telling someone they have a chronic disease, can have negative health implications. Unnecessary labelling will cause avoidable harms to patients and their families.

Another downside is that a simple decision to lower the bar for who is a diabetic has implications for costs to the health care system that go far beyond one person who now becomes labelled as having the disease. With more frequent diagnosing of diseases comes more frequent laboratory testing and increased prescribing, so that in 2009 we Canadian physicians wrote 80%, that's eight zero percent, more prescriptions than we did 10 years earlier.

A recent British Columbia study reported a 42% increase in public expenditures from laboratory testing over the last decade. This was highest for those over 75 years, but the increase applied to all age groups.

As these changes to our definition of who has disease remain, there's been no discussion about what are the societal impacts of such a decision. Is all this increased activity of medical testing and prescribing really improving our population health, and what other things might the money be spent on?

While one might question whether our current and seemingly relentless medicalization of life is actually increasing the health and quality of life of our population, it is true that if management of our diseases like diabetes and heart disease are not well done, the result is recurrent visits to the hospital, declining function, and poorer quality of life. So the next topic I'd like to address is what does the research tell us about the best way to care for individuals with chronic disease.

We now have very good evidence that supporting patients to self-manage their disease is one of the most effective approaches. Self-management support involves a combination of helping individuals develop confidence in their ability to monitor their conditions, manage their symptoms, adopt healthy behaviours, and actually participate in decisions about their care. There's also evidence that the best way to do this is to provide those with chronic illness with a primary care medical home that can integrate and coordinate their care, give them continuity of care from a team of family doctors, nurses, and other providers, health professionals, and support workers who know them, understand their values, and are available 24/7, so that when things go wrong, they are able to help them respond in the most appropriate manner.

The presence of an electronic medical record is also essential to provide care in such a model.

● (1545)

Here in Canada, as part of the 2004 health accord, all of the provinces began to experiment with ways to improve primary health care, with the goal of doing a better job of supporting patients in chronic disease management. In many jurisdictions, doctors' offices have begun to deploy sophisticated reminder systems to identify patients with diabetes, heart disease, and other conditions. Some practices, including my own, have begun to experiment with group visits, in which our diabetic patients are invited to come into the office at the same time. Apart from providing regular proactive follow-up care, group visits also give patients an opportunity to share strategies for disease management that we physicians have never even thought of. So the challenge of the next decade is to devise ways to scale up these successes so that our primary health care system is robust and prepared for the expected gradual increase in patients with chronic disease as our population ages. As part of this challenge, we also need to integrate our primary medical care and our home and community care. These are currently functioning as two separate entities. Integration of both those systems is very important.

Thirdly, I'd like to focus on those individuals whose diseases tend to get worse as they get older despite everybody's best efforts. With age, people often accumulate multiple and more serious conditions that often have a significant impact on day-to-day function. Shopping, banking, housekeeping, to say nothing of the simple tasks of getting in and out of bed and toileting and so on, can all be impacted. We clinicians tend to refer to this as frailty. Frail elders with multiple chronic diseases, especially those with advanced Alzheimer's, in general do not fare well in the traditional medical system. We doctors are poorly trained to care for them. Our high-tech acute-care hospitals focus on rescue and on life prolongation, rather than on quality of life or the alleviation of distressing symptoms.

Frail elders have a short life expectancy, often despite aggressive medical intervention. My colleague Dr. John Sloan has written an excellent book on the importance of building models to care for frail elders outside of the hospital using a paradigm that tries to understand and support their health goals. Some family doctors and nurses are experimenting with models of care that try to do this. These models need to be expanded and scaled up in the decades to come.

Finally, even if we do a good job of caring for frail elders outside of hospital in their homes, there will still be a need for full facility-based long-term care with 24-hour nursing supervision for the most disabled, who are no longer able to function independently. It's predicted that by 2041, 4% of Canadians—that's 1.6 million individuals—will be aged 85 and older, and all provinces will likely need to expand their nursing home beds. In most provinces, long-term care is publicly subsidized, but service delivery is provided by a mix of public or government-run non-profit and private for-profit organizations.

Health policy in many provinces appears to be moving in the direction of increasing contracting of residential care by health ministries to for-profit facilities. Based on my own research and my review of the Canadian and U.S. research evidence on the link between ownership and care quality, contracting out care to private for-profit facilities is likely to result in care of inferior quality compared to care provided in public and non-profit facilities.

For example, one key measure of quality in residential care facilities or nursing homes is staffing levels. Studies have consistently found that for-profit facilities have lower nurse staffing levels than do non-profit and public facilities. Other indicators of poor care quality, such as rates of pressure ulcers or bedsores, are also found to be higher among residents in for-profit facilities. The link between for-profit facility ownership and poorer care does not imply that all for-profit facilities provide poor care; far from it. However, the evidence suggests that, as a group, such facilities are less likely to perform as well as non-profit or public facilities.

In summary, first, the rules about who does and who doesn't have a chronic disease are changing, and as a society we may well wish to have broader inputs into that conversation. Second, there's increasing evidence that chronic disease care is best provided by supporting individuals to self-manage their condition through primary care medical homes.

● (1550)

While family doctors and other service providers in the community are making baby steps toward building these homes, this work needs to be scaled up in the years to come.

Thirdly, for those with multiple chronic diseases who have become functionally disabled—usually frail older people—we need to develop a new approach to care that involves understanding individual values and goals of care and keeping care provision outside of the hospital setting as much as possible.

The Chair: Thank you so much.

We'll have time for questions and answers, and you can get your final points in then. I've gone over time for both Dr. Belleville and for you because both of your presentations were outstanding. Thank you so much, and we'll hear from you again soon.

Let's now go to Dr. Michel Bédard. Thank you so much. You have 10 minutes.

Dr. Michel Bédard (Canada Research Chair in Aging and Health, Department of Health Sciences and Centre for Research on Safe Driving, Lakehead University): Thank you.

Madam Chair and committee members, it is a great pleasure and honour for me to present today. I thank you for this opportunity. I will make my presentation in English, but I would be happy to answer questions in either English or French.

The research I have been conducting aims to support older adults in enjoying independence and quality of life. Chronic diseases present a serious threat to this goal.

I would like to touch on two issues in relation to chronic diseases today. The first is caregiving and the second is driving.

The role of caregivers, who are typically family members, is becoming increasingly important as greater numbers of older adults remain in the community. There is recognition at various levels of government that seniors want to age in place. Yet it is difficult to imagine how strategies to support aging in place can be effective without a caregiving component. The longevity of many adults and the potential increase in the number of chronic diseases and disabilities they will experience mean that many children will end up caring for very old parents, even as they themselves progress well into their senior years.

It is well documented that caregiving creates considerable strain on a large segment of the population, but it is important to emphasize that a healthy caregiver is the best resource for a care recipient. In today's situation, few older adults in need of support can remain in the community without caregivers.

The problems faced by caregivers and the negative health outcomes of caregiving are among the major contributing factors leading to the institutionalization of care recipients. This illustrates the reliance of the public sector on caregivers.

Health care providers perceive informal caregivers as an important source of contribution. However, it is not clear if caregivers can provide more than they already do, nor what roles caregivers should play versus the state. At a minimum, we need to support caregivers to ensure a sustainable and effective health care system. To provide this support, it is reasonable to propose that the equitable allocation of health care and social program resources should include caregivers.

A variety of interventions have been proposed to support caregivers. However, most interventions studied to date have targeted the most strained caregivers rather than focusing on a population-based approach. It would be desirable to examine the feasibility of implementing community-based interventions.

A recent report from the Special Senate Committee on Aging has also suggested national programs, such as a national respite program. As we consider such interventions, it is important to bear in mind that approaches based on illness prevention and maintenance of good health in caregivers are likely to be superior to reactive approaches that focus on treatment of caregivers in poor health.

While much effort will be required to support caregivers, it is worthwhile remembering that caregiving does not occur in isolation. Caregiving and its impact have ramifications for individuals and the whole society.

The effectiveness of caregiving as an activity depends on a host of individual and system-based supports. Therefore, it is increasingly evident that the caregiving situation and the needs of caregivers overlap to a large extent with those of the public system of care. The extent to which the public system supports caregivers will indicate the value it places on aging in place.

Now let me touch on the issue of chronic diseases and safe driving. In 2001, along with colleagues, I published a study in which we projected a significant increase in vehicle occupant fatalities involving people aged 65 and over. Others also published similar dire scenarios. Yet despite important increases in the number of older adults and their greater use of the automobile, these projections did not materialize.

It is true that when we account for their exposure or kilometres driven, older drivers have an at-fault crash risk equivalent to that of younger drivers. However, in absolute terms, older drivers have fewer crashes than any other age group because they drive less and tend to self-regulate.

Older drivers as a group do not pose a great threat, nor will they in the near future. Nonetheless, we should do everything we can to assist them in being as safe as possible and to identify drivers who are unsafe.

Of course, this also applies to drivers of all ages. Let me emphasize that crashes are preventable events and that we all have a role to play toward their elimination, regardless of our age or position in society.

The driving challenges that older drivers experience are linked typically to health-related changes. Hence in most Canadian jurisdictions, physicians are mandated to report drivers who are unsafe due to medical conditions. This mandate exists despite physicians' reports that they lack the necessary knowledge and tools in a clinic setting to evaluate fitness to drive.

The existence of a knowledge gap does not mean we should rush the implementation of new tools without first substantiating the evidence of their effectiveness and studying the full impact of their implementation.

● (1555)

We are seeing evidence of such a rush starting to happen in Canada. British Columbia put in place a new five-minute screening tool to identify drivers who may have a cognitive impairment affecting their ability to drive safely. The adoption of the tool is based on a single study with multiple methodological limitations, and there is little evidence that adopting the tool represents a significant advance over current practice.

There is, however, evidence of the potential for harm. There is a genuine risk that, based on the tool, some drivers may be deemed unsafe to drive and be required to relinquish their driving privilege even though they may be safe enough to pass an on-road examination. Furthermore, some of the drivers labelled as “safe" by the tool may fail the on-road examination. The harm that may come from individuals losing their driving privilege when safe or being allowed on the road when unsafe is substantial. Moreover, my preliminary review of the test suggests that 50% of all drivers aged 70 and over would be required to undertake further testing. We would not accept this level of uncertainty with other medical tests.

In short, this new five-minute screening test does not meet physicians' needs, and, perhaps more importantly, its use risks erosion of the confidence older adults have in their physicians, and may even discourage some older adults from seeing their physicians for health concerns if they perceive they may risk losing their driving privilege without cause.

The burden of the process is also placed squarely on the shoulders of older drivers who risk losing their mobility or incurring unnecessary costs to prove they are safe—a comprehensive driving evaluation costs around $500. Unsafe drivers should not remain on the road, but using a flawed process represents an unfair social and financial burden on older drivers. Furthermore, we don't have the capacity to do a comprehensive driving evaluation for half of all drivers aged 70 or more, and such an approach is not supported by data. In B.C., the preferred approach for a comprehensive driving evaluation is not referral to specially trained occupational therapists, who are in my view the professionals with the best expertise to evaluate driving skills, but rather referral to a private, for-profit provider. Here, again, the evidence to support this approach is lacking.

Any process to identify at-risk or unsafe drivers needs to be developed carefully and be grounded in sound research methodology and evidence. The Canadian Institutes of Health Research, in its foresight, has invested in Candrive, a national program of research that uses appropriate scientific rigour to answer many of the pressing issues related to older drivers. Such issues include, to name just a few, identifying unsafe drivers, enhancing driving skills, and understanding the impact of transitioning to non-driving status. There are several research groups in other countries working on the same issues. Hence, much high-quality evidence will be available soon to support the development of sound, evidence-based policies.

In closing, I would like to emphasize again that chronic diseases are significant threats to the independence and quality of life of aging Canadians. Mitigation of this threat will require the adoption of innovative policies grounded in the best possible evidence. While this evidence is being acquired, we must resist the reflexive implementation of policies simply because there is a need.

Thank you.

● (1600)

The Chair: I thank you so very much.

We'll begin our seven-minute Q and A right now, and we'll begin with Dr. Morin.

[*Translation*]

Mr. Dany Morin: First of all, I would like to thank you for participating in this video conference. It is very much appreciated.

My first question is for Ms. Belleville.

You talked about the hospital resources designed to help our seniors. Do you think we should invest more in long-term care and home care?

The 2014 Health Accord will soon be negotiated. It could be a good strategic opportunity for the federal government. It would allow it to recommend this direction to the provinces to resolve the problem we are discussing today, the chronicity of diseases in our seniors.

Ms. Sylvie Belleville: That is an extremely important point. You are talking about the two extremes, which is good. On the one hand, there are the people who would like to stay home longer, but in safe conditions. I think there is really a significant investment to be made in that area and that it will be beneficial, at the end of the day, because if these people stay home, the burden will be much lighter on the health care system.

On the other hand, there is long-term care. I would say that even in terms of research, it is very much overlooked. We really need to invest effort, energy and passion to find ways to adapt long-term care, to increase the quality of it and to ensure that people who work in this area are valued. In my opinion, this work is not valued enough currently. People have the impression that what they do is not respected.

I also think there is work to be done regarding the training and supervision of people who provide long-term care to seniors. Don't forget that the vast majority of people who receive long-term care have advanced Alzheimer's disease. In other words, they are people who mainly have significant cognitive disorders.

Mr. Dany Morin: You open the door to the issue of mental health and Alzheimer's disease.

Do you think the federal government should set up a national mental health plan? Witnesses often tell us that mental health is the most neglected aspect of health.

Ms. Sylvie Belleville: I am on the advisory board of the Institute of Aging. One of us was mentioning today that she is on a mental health research committee and that there's very little mental health research related to aging. It is as if we were very interested in mental health in young people, but when people are older, suddenly all of that is not important.

I will take the example of Alzheimer's disease, which is very often accompanied by problems deemed "behavioural" at the very beginning, that is to say that people can have manifestations that are not only memory problems, but also behavioural problems. It can be aggressiveness, or someone who suddenly thinks that people are mean to him or her. It is very similar to mental health problems and it is what causes the most difficulty. People start to be aggressive, patients start to wander, to wake up at night, to say that their things were stolen. Those are the most disturbing things.

The aspects related to mental health are therefore very integrated in dementia problems and Alzheimer's disease problems. I don't think we can deal with one without dealing with the other.

● (1605)

[*English*]

Mr. Dany Morin: Merci.

My next question is for Dr. McGregor. You mentioned inferior quality in for-profit institutions. Could you tell us more? I think you believe our health system, which is free, universal, and comprehensive, should be maintained. Can you tell us more about that that would prove your point?

Dr. Margaret McGregor: Sure. First, nursing homes and residential long-term care generally are outside the Canada Health Act. Every province funds long-term care somewhat differently, and unlike acute-care services and doctors' services, which are publicly funded and generally—at least, hospitals are publicly delivered, for the most part. Long-term care is usually a mix. For instance, in Manitoba, 20% of all nursing homes with public funding are in the for-profit sector, and 80% are non-profit. In B.C., the distribution is 70/30. In Ontario, interestingly, it's a little the other way. It's about 60% for-profit, and the rest is non-profit. When I'm talking about that, I'm talking about facilities receiving public funding. I'm not talking about the small number of facilities that are completely outside that system whereby people pay a large amount of money every month, which really comprise a very small minority. I'm talking about public funding of different ownership models.

We have most of the evidence around that from south of the border because a very large for-profit sector receives funding there from Medicare and Medicaid in the U.S. An overwhelming amount of evidence from the U.S. demonstrates that staffing levels are lower, there's a higher rate of pressure sores.... A number of articles show there is a higher rate of hospitalization for what we call care-sensitive conditions.

In Canada, the research evidence is much slower to come in, but this is one of my own areas of research interest. We have looked at this question in the province of British Columbia with respect to levels of staffing and with respect to hospitalization for things like pneumonia, dehydration, anemia—things that one would assume, if the care were better, there would be a lower rate of hospitalization for it. We found in all those studies that generally the evidence is similar to the U.S., that there are higher rates of hospitalization in facilities that are for-profit and lower rates particularly in facilities that are public and non-profit.

The Chair: Thank you, Dr. McGregor.

Now we'll go to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair. I'll split my time with Madam Block, if that's all right.

I want to direct my first question to Dr. Bédard. You mentioned driving. My background before I got into this job—I'm a chiropractor. We did a lot of rehab. We did a lot of work with seniors. You could see the restricted ranges of motion on some of my patients. The importance of driving.... It is so good for seniors to continue that as long as possible to maintain their independence and their ability to live at home.

You did the research. I was wondering whether you found any research on assisted devices that could help seniors continue driving. How common is it for seniors with chronic diseases to continue driving? Is it something that most of them do, and is this something that Canadians should be concerned about?

● (1610)

Dr. Michel Bédard: Thank you.

That's a very good question. I would state first that typical assistive devices tend to be for people who have serious physical disabilities. On the other hand, most people have some kind of chronic disease, and as people age, most of us will be labelled with some chronic disease or another, and people do continue to drive.

What's really quite fantastic about older drivers is they tend to self-regulate. They will adjust their driving. They will not drive in all the more difficult circumstances. They don't tend to drive in rush hour, at night, or in bad weather. So they really adjust their driving, and, again, they drive less, and that's why, overall as a group, the number of crashes they're involved in is not greater than any other group—actually it's less than any other age group.

Canadians should not be worried about older drivers as a group. There are some drivers we have to look at, and we have to continue looking at ways to identify who needs more assistance, who may need help to drive or maybe transition to non-driving status. But I think as a society we shouldn't be worried about them.

Mr. Colin Carrie: The statistics seem to support that they're okay to be on the road for a longer period of time. But I was wondering if there are things like special mirrors or anything like that on the market to help seniors, because backing up can be a problem.

Dr. Michel Bédard: Well, there's lots of stuff on the market. Unfortunately, the evidence is not there to support their use. Again, I think what we've seen is that people tend to adjust differently if they have difficulty, as you mentioned, with range of motion and turning sometimes. They become more adept at looking in their mirrors in a different way to kind of cover the blind spot or some other difficulty they have. So there's a lot of adjustment taking place.

I think we shouldn't worry too much about the marketing of all those products, whether they're tools for the car or...we even hear about these brain-training products, because there's little evidence for all those things in terms of what they do. I think we have to be cautious about making sure we have evidence before we recommend those products.

Mr. Colin Carrie: Oh, for sure.

Kelly.

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

Thank you very much, Madam Chair.

And thank you to our guests for being here as well. I'm going to ask a couple of questions of Dr. Sylvie Belleville, if you don't mind.

I'm very interested in the work you do in terms of studying and monitoring the cognitive abilities of people who tend to get Alzheimer's disease. I understand you have found that certain tests, including tests of memory, attention, and perception can accurately predict whether people will get the disease.

I'm wondering, once you know whether someone will tend to get the disease, what you do with that information. How do you advise individuals and how do you monitor that?

Ms. Sylvie Belleville: What we actually do now is identify people that we.... We have a term, "mild cognitive impairment"—

The Chair: Excuse me, Dr. Belleville, the bells have started to ring, so I have to end the dialogue. But I want to thank you all very much for coming. I appreciate it.

I think we have half-hour bells, do we not? Yes. By the time we get to the House of Commons, it will be quarter to five, and then the votes. We'll be pushing five o'clock or a little later. Oh, the vote is at 4:40.

What is the will of the committee right now? Should we resume, coming back for the business portion?

Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): The reason they have half-hour bells is for the distance, so you're not supposed to start until half an hour after the vote. If the vote is completed at five o'clock or 4:50, you're back here at 5:20. There's no point for 5 or 10 minutes at best.

The Chair: Yes, that's my feeling as well, because we are a considerable distance away from Parliament Hill.

Does anybody else have something to say?

Dr. Morin.

[*Translation*]

Mr. Dany Morin: If we do not discuss committee business later, when we come back, will we receive confirmation regarding the time? Would it be next Monday, at the end of the meeting?

[*English*]

The Chair: It will be at the next committee. I'll put it at the next committee, so we can have it, because we have a smaller number of witnesses next time.

I will dismiss the committee now. We have to dismiss now; the rules say that.

Hon. Mark Eyking (Sydney—Victoria, Lib.): I just have one quick thing.

Because the Liberals didn't get their questions in, maybe the next time, the next go-round, we can be the first up.

● (1615)

The Chair: No, we have a pattern that we follow, and that happens sometimes.

The committee is dismissed.

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