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Chair

Mrs. Karen Vecchio

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● (0845)

[*English*]

The Vice-Chair (Ms. Pam Damoff (Oakville North—Burlington, Lib.)): Good morning.

Welcome to the 132nd meeting of the Standing Committee on the Status of Women. This meeting is in public.

Today, we'll continue with our study on the challenges faced by senior women, with a focus on factors contributing to their poverty and vulnerability.

We are pleased to welcome in the first hour, from the Hearing Health Alliance, Jean Holden, Advisory Board Member, and Valerie Spino, Advisory Board Member. Then from Pembina Active Living (55+), we have Robert Roehle, President, and Alanna Jones, Executive Director.

I'll now turn the floor over to the Hearing Health Alliance for an opening statement.

Ms. Jean Holden (Advisory Board Member, Hearing Health Alliance of Canada): Thank you very much, Pam.

My name is Jean Holden, and my colleague here is Valerie Spino. We represent the Hearing Health Alliance of Canada. We are representing a number of groups. We are representing consumers, hearing health care professionals, the hearing industry and foundations across Canada. On behalf of the Hearing Health Alliance of Canada, we thank the committee for inviting us to share our perspective about the important and often overlooked issue of hearing health.

In our meetings with some members of the House of Commons and Senate, some related personal experiences of how a mother or a grandmother cut off regular communication with family and friends, because of unmanaged hearing loss. This is like most people with hearing loss, who delay seven to 10 years before addressing their hearing challenges. Stigma, access to health care and the lack of understanding of the impact of unmanaged hearing loss in the public and the health care system contribute to this delay.

Hearing loss is one of the most prevalent chronic conditions affecting senior Canadians. Today, 78% of Canada's 4.8 million seniors have measurable hearing loss. By 2031, Statistics Canada projects that 5.1 million women will be seniors, so we can predict that almost four million senior women could have measurable hearing loss. This will have serious implications for the health of, and the health care services provided to, senior women.

Despite evidence-based research and statistics that show that hearing loss is widespread, with a serious impact on the health of Canadians, at a significant cost to government programs, hearing health remains a low public and health policy priority.

Women often experience gradual hearing loss as they enter their senior years. It's common for them to slowly withdraw from their social activities with family, friends and community, because it becomes embarrassing and stressful, and takes a lot of energy to cope in situations where they cannot participate and engage as before.

It is no surprise that unmanaged hearing loss is strongly linked to depression, anxiety and loss of self-esteem. Those who are socially isolated often reduce their exercise levels, contributing to other health conditions, such as high blood pressure, heart disease and diabetes. Research also strongly links unmanaged hearing loss in seniors with the onset of cognitive decline earlier, by two to seven years.

Most people are unaware that unmanaged hearing loss is significantly linked to the increase in risk of falls. The risk increases with the severity of hearing loss. Falls are the leading cause of injury-related hospitalizations among seniors. The most common injury is hip fracture, which occurs more often in women. It is very difficult for a senior woman to recover from a hip fracture. Many are admitted to costly long-term care facilities, and between 20% and 40% of seniors with a hip fracture die within one year.

For those with hearing loss, there is also a risk of reduced safety and security, with the inability to detect alarms, traffic and other audible threats in their daily living activities. It is clear that good communication is needed among doctors, other health care providers and patients, in order for patients to benefit from access to health care. Poor communication can cause mistakes in diagnoses—some of them are very serious—and mistakes made by patients when they fail to understand instructions from the health care provider.

● (0850)

I'm going to ask Val to continue. She will be speaking in French for our French-language members and then she will summarize our recommendations in English at the end.

[*Translation*]

Ms. Valerie Spino (Advisory Board Member, Hearing Health Alliance of Canada): The impact on health and costs resulting from unmanaged hearing loss have been well documented. Unmanaged hearing loss is too often linked to more hospital stays, higher rates of readmission and higher incidence of costly medical errors. This is the case for acute care admissions. We also know that isolation, depression, cognitive decline and falls are some of the top reasons for admission to long-term care facilities.

Canada is unprepared for the challenges of hearing loss. Culturally, hearing loss is often written off as a normal part of aging and carries a stigma.

Screening for hearing loss is often not a part of an annual physical exam. Health care providers across the system are often unaware of the signs of hearing loss, the impact of unmanaged hearing loss and the importance of addressing the issue.

All this adds up to serious problems for senior women, and especially for women who have low incomes or who live in first nations communities. Most of the time, access to hearing health services isn't covered by the health care system, and these services aren't sufficiently available in northern, first nations and rural regions.

[*English*]

One of our goals at the Hearing Health Alliance of Canada is to have more women pay attention to their hearing health. There's a role for federal, provincial and territorial governments to collaborate with various communities of interest to adopt policies and actions to promote hearing health.

First, we all need to do much more to increase public awareness to prevent hearing loss, to identify and manage hearing loss and to destigmatize hearing loss.

Second, there is an urgent need to integrate hearing loss assessment, diagnosis, prevention and treatment into existing health programs and to facilitate collaboration among front-line health care providers to promote hearing health as part of overall health.

Third, governments must address existing models of government funding and tax benefits to provide equitable access to hearing health care and assistive devices.

There is no doubt that making hearing health a high public policy priority will provide immediate and long-term benefits in the form of significant savings to our health care system and increase the quality of life for our seniors, especially women.

We thank you for your attention and consideration.

● (0855)

The Vice-Chair (Ms. Pam Damoff): Thank you very much for your presentation.

We'll now turn it over to the Pembina Active Living folks for their presentation.

Mr. Robert Roehle (President, Pembina Active Living (55+)): Thank you, Madam Chair.

I would like to begin by thanking this committee for inviting us, Pembina Active Living, to appear before you.

My name is Bob Roehle, and I'm the President of Pembina Active Living. Beside me is Alanna Jones. She's our long-term Executive Director.

As a senior and someone married to one, I don't need to be convinced of the importance of the issues and challenges faced by older people, particularly older women, issues like access to transportation, health services and medication, home care services, affordable housing, justice, widowhood and loneliness. These are all quality of life issues that should, in my opinion, be a right of Canadian citizenship. However, let me say up front that our experience and comments will focus more on the issue of social inclusion and connectedness.

My approach this morning will be to give you an overview of Pembina Active Living, who we are and what we do. Ms. Jones, who is the long-term, hands-on person in the organization, is prepared to elaborate in more detail.

Pembina Active Living came into being in 2009 as a result of a few community-minded seniors in south Winnipeg getting together to discuss needs of their peer group, folks like themselves who had retired and were living in their own homes, condos and apartments. They realized, from their own experience, that much of their social network and connectedness related to their careers and children, and these had come to an end, hence the need for an organization to bring these lost souls together with folks of their own generation and station in life.

Out of these discussions, Pembina Active Living was born. It has a simple mandate, to enhance the quality of older adults living in south Winnipeg. In 2013, PAL achieved charitable status from the Canada Revenue Agency, thus allowing it to issue charitable tax receipts to donors. As a word of explanation, Pembina Active Living is essentially a community club or a community centre for seniors.

With annual funding from the Winnipeg Regional Health Authority of approximately $40,000, plus membership fees of $20 per person and an ongoing fundraising campaign, PAL is able to retain the services of a part-time executive director and administrative assistant. This allows PAL to operate two and a half days per week out of less than adequate space in a local church. This is supplemented by renting space as necessary in local community centres. PAL's membership varies somewhat from year to year and within the year depending on the activities being offered. PAL's current membership is around 450 people. It has been as high as 500.

Without the assistance of over 100 volunteers contributing in excess of 6,000 hours of their time, PAL's $100,000 annual budget could not be stretched to do the things we currently do or offer the services we offer to seniors.

PAL is celebrating its 10th anniversary this year. While we are pleased with our accomplishments to date, we have much more to do. Besides the critical need for more operating funds, our other immediate challenges are as follows.

We need space. PAL needs a permanent home of its own, a dedicated office and storage space and a five-day per week drop-in centre with a canteen to serve coffee and perhaps a light meal at noon.

We need diversity. We must find better and more creative ways to reach out to our indigenous community, to new Canadians and to the rainbow community. A recently awarded and much appreciated New Horizons grant from the federal government of $25,500 should go a long way to helping us reach out to these other groups.

On social cohesion or connectedness, PAL must strive to become more holistic as a seniors centre, not just a place to take one-off inexpensive exercise programs.

● (0900)

Allow me to end my formal comments with a quote from an editorial in a recent issue of Maclean's magazine. It is referring to a study done by people at Brigham Young University, a psychologist by the name of Julianne Holt-Lunstad. It says:

> "Current evidence indicates that heightened risk for mortality from a lack of social relationships is greater than that from obesity," Holt-Lunstad's study concluded.... Being lonely is comparable to smoking 15 cigarettes a day.... It's also worse for your health than the...risks arising from alcohol consumption, physical inactivity or air pollution—all of which get much more official attention than loneliness.

Humans are social creatures, and avoiding the necessity of social contact can be devastating to our physical and mental health. I believe that applies equally to both young and old in our society. That's really where PAL is operating. It's trying to increase social inclusion among the older adults of south Winnipeg.

Thank you.

Ms. Alanna Jones (Executive Director, Pembina Active Living (55+)): Thank you, Bob.

Thank you to the committee for this opportunity.

I would like to acknowledge the federal government's commitment to seniors through its minister of seniors position, the national seniors strategy and the new horizons for seniors program.

As you know, senior centres are an important part of our communities. Through the promotion of healthy active aging, community involvement and social inclusion, senior centres provide valuable resources and opportunities to older adults all across Canada. Research on senior centres demonstrates that participation is associated with social, mental and physical benefits; and that by fostering the exchange of social support, senior centres protect older adults against the negative impacts associated with social isolation, making senior centres invaluable resources in the communities in which they operate. Given that older Canadians are now the fastest-growing segment of our population, with their numbers expected to double over the next two decades, the importance of our senior centres to the well-being of this demographic cannot be overstated.

Pembina Active Living (55+) is an non-profit, senior-serving organization in south Winnipeg. Our catchment area of Fort Garry comprises 11 communities, 77 square kilometres, and is home to 18,775 adults over the age of 55, or over 25% of the total population of our area.

PAL recognizes the diverse needs and challenges of older adults and is committed to the development of programming and opportunities that will enhance their lives. The well-being of older adults is one of our core values and we believe that active living and social inclusion can enhance physical and mental wellness. Research at the Canadian Centre for Activity and Aging found that fit people are half as likely to become dependent in later life. Health Canada's physical activity tips for older adults recommend two and a half hours of moderate to vigorous aerobic activity each week.

We address that at PAL through some of our weekly programs. We have 20 plus programs running through the communities, including older adult resistance and weight training, yogalates, line dance, seniors' yoga, zumba for seniors, cycling, bowling, a garden club and a lunch group. We have a movie group, a writing program that has published nine books, computer workshops, pickleball, three free annual community events, and a wellness, leisure and special interests speaker series that is free to all the community.

All this is great for those who can afford our programs, but for the many low-income older adults in our community, many of our programs and activities are out of reach financially. In addition, transportation to and from senior centres was the most common barrier to participation for older adults. These are two issues that, with our limited resources, we simply cannot address.

PAL has accomplished a lot in its 10 years with very few resources, and we have a lot to be proud of. At the same time, there is so much that we cannot do and many we cannot reach because we simply do not have the resources. We are at the limit of what we can do with a skeleton staff and a volunteer base who are already putting in approximately 500 hours a month.

In order to reach out to the thousands of older adults in our community, many facing social isolation and loneliness, we need support. We need stable annual operating funds, without which we will not be able to fulfill our mission. We believe that senior centres are perfectly poised in the community to address the various issues faced by older adults. The most impactful thing we believe the federal government can do is support senior centres through direct funding.

I just want to add that we did not specifically name women as the subject of our presentation, but our membership is 70% women.

All of these issues are directly impacting the senior women in our communities.

Thank you very much.

● (0905)

The Vice-Chair (Ms. Pam Damoff): Thank you.

We're going to start with our first round of questions.

Bob Bratina, you have seven minutes.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you.

This is a great topic.

On the question of hearing, first of all, one of the big issues with regard to hearing is the cost of hearing devices. There's a lot of confusion about what works. You see ads for things that are $29.95 that are just as good as a $5,000 device. Is there any advice you can give in that regard? Is there a way of determining good devices at proper prices?

[*Translation*]

Ms. Valerie Spino: I'll answer, since my day-to-day work involves bringing older people out of isolation and helping them return to their social lives. I'm an audioprosthetist. I spend my days answering these questions.

Yes, there's a range of hearing aid technology. A hearing aid is a computer. Take the example of two computers in an electronics store that look exactly the same. If you launch software such as Word while simultaneously surfing the Internet on one computer, it will be difficult to use, whereas you can launch all the software at the same time on the other computer, and it will work well.

A hearing aid contains a computer. A more sophisticated computer will manage sound better. It will certainly lead to a better understanding of speech and better audibility. The software in hearing aids can emphasize “s” and “f” sounds and contain a noise reducer. A range of technology exists.

It's often said that the best and most high-end hearing aids are the closest thing to normal hearing. All the available research and technology is used to manufacture high-end hearing aids. Basically, the latest technology is used to design a machine that most closely matches the human ear.

Unfortunately, not everyone can afford the Ferrari of hearing aids, or the largest and most efficient hearing aid. As a result, there are various forms of hearing aids.

Since I work in the field, I can see the difference between an entry-level hearing aid and a high-end hearing aid. The performance varies according to the quality of the hearing aid. Obviously, it's better to have an entry-level hearing aid than nothing at all. Science has understood for a very long time that it's better to have a hearing aid in each ear than a hearing aid in only one ear. At one time, glasses had only a single lens, but it was quickly understood that we use both eyes to see in three dimensions. It's the same principle for ears.

Yes, there are different qualities. In an ideal, utopian world, everyone would have high-end hearing aids. That would be best. However, unfortunately, that's not the reality. That said, certainly each increase in quality is a small improvement for the patient. We don't disapprove of the fact that there are hearing aids for all budgets because, unfortunately, not everyone can afford high-end hearing aids.

● (0910)

[*English*]

Mr. Bob Bratina: Jean.

Ms. Jean Holden: If you take a broader perspective and consider the value in return of preventing depression, isolation, loneliness, the kinds of challenges that we see with falls and early cognitive decline—if you take that into perspective—the investment in hearing health with hearing devices and a few follow-up visits is minuscule in comparison to what it costs the Canadian health care system with the results that may occur and do occur if people do not manage their hearing loss.

Mr. Bob Bratina: What do you recommend for people who feel it's time to think about a hearing device in getting information?

One way would be to go to one of the retail providers who may simply want to sell up; whereas the person may simply be wanting to get good information.

Ms. Jean Holden: The best solution is to discuss this with your physician, and/or go directly to an audiologist physician who would refer to a hearing instrument practitioner. These professionals are trained in helping individuals to understand their own situation and how it impacts their lives, and guiding them through the process of selection of solutions.

It's best to go to a professional who is trained in these behaviours. You don't really have access to go directly to a manufacturer in Canada. There are some direct-to-consumer devices that are starting to show up on the Internet that are claiming to be cheap solutions and so on. This has been a challenging debate in the industry, of course. It's more than just people in the industry trying to protect their services and technical device sales. It's really about being sure that consumers have the available devices that they need and that are safe for them.

There's a great debate in the FDA south of the border about these issues, and nothing has been passed there yet.

Mr. Bob Bratina: With regard to the prevention of hearing loss, the baby boomers were the first of the rock-and-roll generation who were warned that all of that loud rock-and-roll music was going to make them deaf.

Has that showed up in the longitudinal—

Ms. Jean Holden: Absolutely, 100%, it has. It's not just when you're in your middle years and as a teenager now with the MP3 devices and so on. As you age, if you have that noise-induced hearing loss, it exacerbates normal aging-related hearing loss. That's a huge challenge.

Again, we need public awareness. We need families to understand the issues related to seniors and hearing loss. We find that if—and this is studied by the psychologists—a family takes interest in their senior with hearing loss issues, that is the most significant factor to the uptake and the use of hearing devices.

Mr. Bob Bratina: I want to apologize because I was a rock-and-roll disc jockey. Sorry about that.

Ms. Jean Holden: We all listened to it.

The Vice-Chair (Ms. Pam Damoff): Thank you very much.

Rachael Harder, you have seven minutes.

Ms. Rachael Harder (Lethbridge, CPC): Thank you for taking the time to be with us today to share from your experience in working with seniors in Canada.

My questions are primarily going to go to Pembina Active Living.

Mr. Roehle, I'm intrigued by what you're talking about with regard to the centre and the services that you offer. I know that in my hometown of Lethbridge, Alberta, I've witnessed the same. We have two thriving senior centres within my community, and I watch as seniors go there. They find meaningful relationships. They find access to different exercise routines, sports and other meaningful activities such as crafts, technology, and learning how to use computers and other sources of IT as well.

Can you further comment on why these centres are so important, particularly with regard to prevention? I've heard it said that there's a lot of preventative care that actually takes place by giving access to these types of centres, but it takes place in a way that we might not traditionally term as preventative care. Maybe it doesn't fit within the scope of a doctor's office, but nevertheless, it does certainly serve seniors in a very meaningful capacity.

● (0915)

Mr. Robert Roehle: I think all of the evidence suggests that if you keep people active, particularly seniors, they spend less time in hospitals, doctors' offices and care homes.

The economics in favour of keeping people active are overwhelmingly in favour of spending public money that way. I don't know how it is in other places in Canada, but in Winnipeg, for example, the community clubs are funded by the city. However, historically, their role and their target audience is kids—hockey, soccer and all of those kinds of things.

Of course, families are smaller. We have a different range of children now with a lot of new Canadians, so they all have different demands. The other reality is that seniors are now a big cohort in society. In fact, I think I saw numbers that showed that seniors over 65 account for more people—I don't know if that's in Manitoba or in Canada—than kids under 15 do. I think the community centres have to start recognizing that and governments have to start recognizing that because the economics in favour of keeping people healthy and active are quite overwhelming.

Ms. Rachael Harder: Are either of you able to comment on elder abuse and what you have observed there anecdotally? What you would recommend in terms of responding to this problem?

Ms. Alanna Jones: I can't personally speak to it. However, I do know that we have a resource coordinator in our community, funded also through the WRHA, who provides referrals related to elder abuse, and there are elder abuse suites in Winnipeg, available upon referral. That position, the resource coordinator, is closely linked to us. We make referrals back and forth, but we haven't directly received any of those calls. I personally haven't even heard any stories, but I do know that it's happening and that there are resources available.

Ms. Rachael Harder: If an individual is facing a form of abuse, in your community where would they most likely go to disclose that? If not at your centre, then where would it be?

Ms. Alanna Jones: They would go to the Fort Garry Seniors Resource Council. It is a separate seniors resource. They do referrals for things like elder abuse, home maintenance, doctor finding and resources. In lots of neighbourhoods in Winnipeg we have the resource coordinator connected to the seniors centre.

In our case, we don't have a centre. We don't have a facility. I work from home. We don't have somewhere that seniors can go yet; we're working on it.

In other communities, they have that resource finder right in the centre so that the services are coordinated. We don't have that in our catchment yet.

● (0920)

Ms. Rachael Harder: Are there particular challenges that you observe women facing at a level that is more prevalent than for men?

Ms. Alanna Jones: We see mostly women at the centre. We're working hard to encourage the men to come out. We find that mostly the men are engaged at the leadership level and the women are coming out for the programs.

I think certainly transportation is a big one. We're finding that a lot of people, as they age and are no longer able to drive, become more reluctant to get out to whatever it is we're doing. Of course that leads to them spending more and more time at home and becoming isolated, and loneliness becomes a problem. I think transportation is a huge issue right across our province. That's probably one of the biggest ones, along with affordability of programming.

Ms. Rachael Harder: What about access to housing and accessibility?

The Vice-Chair (Ms. Pam Damoff): You have 15 seconds for a brief answer.

Ms. Alanna Jones: It's not something we address at the senior centre. Again, we don't have a centre. We don't have people milling about, chatting and talking. We have programs in satellite locations where instructors are out and people are going to them. I have not personally been dealing with housing at all.

Ms. Rachael Harder: Thank you.

The Vice-Chair (Ms. Pam Damoff): We'll go to Irene Mathyssen for seven minutes.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you for being here. Thank you for what you do.

At one point I was a seniors critic. One of the realities I discovered in my research was that seniors are not valued as they should be. You very clearly value the seniors of our various communities, and as was pointed out, the population will double over the next 20 or so years and they will be 25% of the population that we have to take care of because they took care of us and they're important.

There's a whole range of things that I want to ask about. You described the catchment area for PAL (55+) as quite extensive and you said that transportation has been identified as a significant problem. Of course a lot of seniors are intimidated by driving because driving is more complex than it ever was. What would you like to happen in terms of resolving the transportation issue? Is it more public transit? Is it funding for vehicles, for buses?

Ms. Alanna Jones: I'm thinking now of one of our board members, Bob, who is transitioning from driving himself. He has a scooter, so he's really mobile. Of course, our weather is a challenge for him to be able to use that throughout the year. The other issue that we face is the street cleaning.

For some, mobility and accessibility issues are a concern. Even if someone is comfortable taking public transportation, or even Handi-Transit, it's often difficult just to get to the bus because of those issues.

We address the issue through some programming. We have offered older adult driving courses several times. Also, public transit has come out to help older adults understand the public transit system, such as the different technologies now on the bus—how it can go down and up.

Educating older adults is also an important way of addressing the issue so that they know what their options are. In Manitoba, we have the Transportation Options Network for Seniors, which is actively looking at this issue on a city-wide level. Even with the dedicated group of people working on it, it still remains a challenge.

● (0925)

Ms. Irene Mathyssen: The whole issue of funding was discussed. You talked about membership fees and, of course, the fact that membership fees can eliminate quite a significant group of people because they just can't afford it. I am interested in what you had to say in regard to federal funding.

Mr. Roehle, did I understand that you had received some? Is it program funding or is it core funding? Would core funding make a difference in terms of the operations of all the things you do?

Mr. Robert Roehle: Certainly core funding would make a difference if it was ongoing. We've been depending largely on project funding. The New Horizons grant that we recently got is really an outreach grant. We want to outreach to new Canadians, the indigenous population, the rainbow population and so on. At the moment, we're only offering space and time for two and a half days a week. Our staff is part time. We really should be operating at least five days a week.

Ms. Irene Mathyssen: The time that is consumed by finding these little bits and pieces could go into programming and services much more effectively than worrying about project funding.

There was some discussion about hearing loss exacerbating cognitive ability. We're hearing more and more about the reality of dementia and Alzheimer's. That's something that every family faces in one way or another.

We've been talking about research and the need for research into these significant issues. Is that something that's come across your desk or is within your experience?

Ms. Jean Holden: Absolutely. Quite a lot of research is going on with trying to understand the relationship between hearing loss and dementia. We know that there are some published, peer-reviewed, well-designed studies that have linked cognitive decline to dementia, but there's much more work that needs to be done to truly understand the relationship between hearing loss, cognitive decline and dementia.

There's a lot of work going on in Canada and other major centres in the world to try to understand the function of the brain and what is happening in those relationships.

There are several theories. One is that with cognitive decline and hearing loss, you have an overload of the brain attempting to compensate for the signals that aren't coming in. There are theories that relate to functions in the brain slowly declining and dying off because they're not being exercised, just like exercising the body.

Those are the kinds of areas they're looking at. They're looking at relationships with causality for hearing loss and causality for dementia and how they link together. It is definitely on our radar and it's one of the top areas of research.

Ms. Irene Mathyssen: We've talked about the impact of lack of funding on individuals and the community. I wonder if you've had the chance to look at the impact on extended family.

The Vice-Chair (Ms. Pam Damoff): That's actually your time.

Can you give a really quick answer?

Ms. Jean Holden: A very quick answer is that yes, it creates a great deal of stress with extended family, communities and caregivers, and you can imagine that leads to depression and other challenges as well.

Ms. Irene Mathyssen: Thanks.

The Vice-Chair (Ms. Pam Damoff): We're now going to move to Sonia Sidhu for seven minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you all for being here. It is great testimony.

I used to live in Winnipeg, close to Pembina Highway. Congratulations on your 10th anniversary, and thank you for serving our seniors.

I've heard that there's a stigma out there, and it takes seven to 10 years to determine if a senior has a loss of cognitive ability. How can we raise awareness so people can find out about it when they are having this problem?

● (0930)

Ms. Jean Holden: We need to mount some very strong public awareness campaigns. Get it out there everywhere, so that families who support seniors and the seniors themselves understand that hearing loss is a major issue and it should not be considered a terrible thing as you age.

There is a stigma. People associate hearing loss with what happens to you when you're a senior, and they don't want to admit that they're getting older. Some of the people we've interviewed in our awareness-building admit that they themselves have a hearing loss. It impacts their daily activities and ability to continue with their work, and they don't want to admit it to their colleagues. They don't want to address it.

This is an issue. Also, because of the gradual hearing loss, people don't really know that over the years they've changed activities to compensate for their hearing loss. They don't realize that they're challenging people around them and that they're losing out and becoming more and more isolated. It's a gradual process, so there are issues around that.

We need to mount a public campaign.

We also find that in the health care system itself, people in hospitals—doctors, nurses, physiotherapists—don't understand that the patient they're working with doesn't understand a thing they're saying. We've had examples of people who were sent to a specialist to be assessed for dementia, and they didn't have a problem with anything else but their hearing. They corrected the hearing, and gradually those people were able to connect and live healthier lives.

Ms. Sonia Sidhu: Is there any way that we can collect central data and send it to them? Is there any centre where you are collecting data?

Ms. Jean Holden: We have some studies going on.

There is the "Canadian Longitudinal Study on Aging". I'm sure you know about this study. We were fortunate enough to encourage them to include not only survey analysis but audiometric testing. We've had one paper published, and we are on the cusp of having three additional papers published on the characteristics of people with hearing loss in Canada. This study involves 50,000 Canadians over the age of 45 at onset, and the evaluation is done every three years.

That data is just about to come out.

We have literature out there for Canadians from other jurisdictions, such as the U.K., the United States and Australia, to help us to convey the message that this is a serious issue with a serious impact.

Ms. Sonia Sidhu: Do you know of any other country that is doing a terrific job on this?

Ms. Jean Holden: We're all struggling.

Australia pays for every single service and device for seniors in their country. In the U.K., they do that also. The U.K.—to discuss a common issue here—has appointed a minister for loneliness, because it's a huge issue. Hearing loss leads to that, as does the lack of activity.

Ms. Sonia Sidhu: Thank you.

My next question is for Mr. Roehle. Do you have a seniors' service for language barriers?

Mr. Robert Roehle: No, we don't, and we really haven't connected all that well with people who speak a different language. That is one of the things we want to address with this grant. We want to figure out how to reach new Canadians, for example, and people who speak a different language, and to somehow have programs that reflect their cultures.

● (0935)

Ms. Sonia Sidhu: What are the effects on seniors when their needs are not met? Where do they go, for example, if they lack transportation?

Did you talk to the other levels of government, as well? I represent Brampton South, and we have some programs. We now have snow shovelling. City council will come to your group and then address that. Do you have a system set up in your organization so that leaders from different levels of government can come and address their needs?

Mr. Robert Roehle: We have a speaker series, which is open to everybody, to talk about topics that are of interest to seniors, as Alanna mentioned, like driving, medication and all those kinds of things. However, we're probably not nearly as comprehensive as we should be to completely address the issue of loneliness, and issues like transportation, for example.

Ms. Sonia Sidhu: Thank you.

The Vice-Chair (Ms. Pam Damoff): We're getting close on time, so for the next round, I'm going to give Ms. Leitch and Ms. Duguid four minutes each.

Kellie, it's over to you.

Hon. K. Kellie Leitch (Simcoe—Grey, CPC): Thank you very much for taking the time today to come and chat with us.

I have some personal experience with this. I have a gentleman in my life by the name of Kit Leitch, who is my father. His grandchildren now affectionately tell him regularly, "Papa, put your ears in", because for the longest time he did not want to grapple with the issue of hearing loss. As a single grandparent...it's made a world of difference to us, but it's very obvious when he doesn't have them on—shockingly, actually.

That being said, one of the things our family looked at, and was fortunate enough to be able to deal with, was the issue of cost.

I wanted to ask all of you. I'm sure, at the centre, you have also faced this. Many of your participants probably are using hearing aids regularly. It's not just the cost related to the actual device, its also the batteries and maintenance and everything else. What are your recommendations to our committee for how that should be dealt with?

I recognize that there is, "The government should pay for it," but what is particularly helpful to us—and I think to the committee—is to be specific. For example, we know that insulin pumps in the last five years have been added to the medical devices discount with regard to federal funding. Are there specific aspects of public policy that would be valuable?

Ms. Jean Holden: As for batteries—and I know they can cost a huge amount each month—the manufacturers are making rechargeable hearing aids, which is great.

As for support funding, it is so inappropriately done across the country. Some areas are more funded than others. In Ontario, the assisted devices program gives you $500 per hearing aid, and if you need a replacement, you have to hold your breath.

I think additional support could be presented in the context of saving: If you do this, you will save money in long-term care admissions, you will save money in the number of falls, injuries and hip fractures, and you will save money in the medical consultations required to support the onset of cognitive decline. The health care system needs to look at this from an investment and return perspective.

Hon. K. Kellie Leitch: I speak to both organizations with respect to this, as you both emphasized prevention and education.

Do you have specific pieces of literature? Do you have specific statistics that you would like us to communicate? I'm a health care professional, a pediatric surgeon, and I don't deal with hearing loss unless it's a birth defect. With respect to my colleagues, particularly the Canadian Nurses Association, having tangibles from industries or associations like yourselves that tell them specifically what the issues are that seniors are trying to grapple with, as opposed to guessing, would be extremely helpful.

Do you know of industry literature that could be made available? I know there are seniors associations. I have the Wasaga Beach Prime Time Club in my constituency who regularly tell me about what their issues are. Are there materials available?

● (0940)

Ms. Jean Holden: We can provide you with materials, even if we have to write them tomorrow.

We all know what needs to be understood. For health care providers, the mix of understanding of the impact of hearing loss and what it looks like to have somebody sitting in front of you who doesn't understand you—

Hon. K. Kellie Leitch: Yes, capabilities.

Alanna, were you going to say something just briefly?

The Vice-Chair (Ms. Pam Damoff): Just very briefly. We're over time.

Ms. Alanna Jones: I was just going to say that at the bottom of.... I'm not sure if you all received the copy of our presentation, but I did reference any of the data that I talk about. There's a little footnote at the bottom that has our studies.

Hon. K. Kellie Leitch: Thank you very much.

The Vice-Chair (Ms. Pam Damoff): We'll get that translated and distributed.

We have Terry Duguid for the final round.

Mr. Terry Duguid (Winnipeg South, Lib.): Welcome to Ottawa. Welcome to Winnipeg weather in Ottawa.

I'd thought I'd get a little chuckle out of that. Oh, well.

Hon. K. Kellie Leitch: I laughed, Terry.

Mr. Terry Duguid: Thank you, Kellie.

Those were excellent presentations, and you're doing fabulous work in the community. I'm very aware of it and the difference that you make in seniors' lives.

I'm very interested in the demographic change that you talked about—not only in Winnipeg but across the country—and the particular challenges that you face. Two big ones are space and, of course, the cost of space and the cost of putting on your program.

I happen to know the St. Norbert Community Centre, where you have some of your programming. Unfortunately, you have to spread yourselves out instead of going to one location, but it's empty during the day; it's not being used. Not only is it a waste of space, it's a waste of investment in what could be health benefits for seniors and others.

Is there a model out there anywhere in Canada that you have researched? I know we have the Good Neighbours facility in East Kildonan, which is what we call an intergenerational facility, seniors by day and young people and families by night. That's one model. I understand they're struggling financially as well because of the whole issue of operating costs. Again, with this aging dynamic that we have in all of our communities across Canada, and community centres basically being vacant during the day, this is not an isolated phenomenon.

Is there some scope for some sort of national program to look at that and for the three levels of government to put their heads together to see how we could use the space and the resources more efficiently to get the kinds of health benefits you mentioned?

Mr. Robert Roehle: I'm sure there is. You mentioned the Good Neighbours arrangement with the Bronx community club. We have talked to the city about that kind of partnership. The city is kind of cool on that these days because they don't see it working particularly well.

In the case of Pembina Active Living, we have a proposal in front of the St. Norbert Community Centre right now to essentially do what you're suggesting. It's based on the idea that seniors don't want to go out after dark, so their activities are all during the day—that's their preference—and community clubs are normally empty with nothing going on during the day. We're trying to work something out now. It would be a landlord-tenant arrangement in the short run.

Whether there's a new model out there, I don't know. I have proposed to the city that we do some thinking about a new model, and they didn't get back to me, so I assume that was their answer.

Mr. Terry Duguid: So this might be bumped up to the political level for some discussions on how we might make it work.

Mr. Robert Roehle: Yes, I think so. I think it's right because we've got a large component of seniors in this country. In some areas, like Manitoba, they've got even more than their share. I think governments are going to have to deal with it because those folks vote.

● (0945)

Mr. Terry Duguid: As you're aware, we have plans for a larger recreation centre in the area and when that comes to be, existing community centres may be vacant morning, noon and night. We will have to repurpose them and perhaps we should be thinking about that now. Again, this is not an isolated phenomenon in Winnipeg; it is happening across the country with demographic change.

Mr. Robert Roehle: You've got two conflicting ideas going on. The city, for economic reasons, would like to put a big campus in a central place within the whole south of Winnipeg. Meanwhile, city planners and the people—

The Vice-Chair (Ms. Pam Damoff): That's actually your time.

Mr. Robert Roehle: Yes, city planners would like to have community centres so everybody can walk to them.

The Vice-Chair (Ms. Pam Damoff): I'd like to thank all of our witnesses for being here with us this morning; it was very helpful to our study and we're going to suspend, very briefly, to set up for the second panel.

● (0945)

(Pause)

● (0950)

The Vice-Chair (Ms. Pam Damoff): I'm going to bring everyone back and we'll get started.

Before we get started, both witnesses have provided us with PowerPoint presentations that are in English only. Can we get a show of hands to get unanimous consent to do the PowerPoints in English only?

(Motion negatived)

The Chair: We don't have unanimous consent so we can't use the PowerPoints. We can get them translated and provided to the committee though.

Our next witness is Lori Weeks, from Dalhousie University. She's a professor with the School of Nursing.

Also, we have Tania Dick, who is the Vancouver Island representative in British Columbia for the First Nations Health Council.

I think we'll start with the video conference first, just in case we lose the signal there.

It's over to you, Professor Weeks.

Dr. Lori Weeks (Associate Professor, School of Nursing, Dalhousie University): Thank you very much for inviting me to present to you today. I'm sorry that I couldn't be there in person. I'm very pleased that your group is focusing on the needs of older women. There are certainly a lot of issues and not a lot of focus on this group, so I really commend you on this work.

I was asked to talk about issues that contribute to women's poverty and vulnerability, and hopefully you'll have access to my slides at some point.

We have a lot of intersections due to the issues of ageism and sexism. That's really the focus of this, I think, and it's what I'm going to talk about today. In addition to women who are older, there are additional groups of women who face additional vulnerability.

I'm really pleased that you have a person who is going to talk about indigenous issues and aging, so I won't focus very much on that component. That's another issue that can affect vulnerability in later life.

We know that there's a great deal of diversity among older women. We have a lot of older women in Canada who belong to a visible minority group, and that can also have a great impact on their experiences in later life.

One of the main things that I wanted to first focus on is the anti-aging industry. We have a lot of overt discrimination against older women. If you're watching commercials or any kind of media, it doesn't take long to see commercials that really are talking about why older people, women especially, should not look old. I think we really need to look critically at that. We don't have commercials saying why it's bad to be a woman or bad to be a young person, but we have a lot of focus in our society about women not looking old.

I think that's something that we need to change and really talk about in terms of a very overt form of discrimination that needs to be addressed in our society. I wanted to make that point very clear first of all. I teach a course on women and aging, with a lot of wonderful discussion amongst the mostly younger women in my course who are already absorbing these messages about wanting to look young. I think we need to have a lot of social marketing and a lot of campaigns around, “Why is it that we're allowed to discriminate overtly against looking like an older woman in our society?”

I'm sure that you are well aware of the demographics of our aging population, but we don't focus as much on the fact that there are more older women than older men—in my slides, you'll eventually be able to see some of the statistics around that—especially as we get older. Among people who are in their sixties, there's not a lot of difference in terms of the proportion of men and women, but it steadily increases over time. For example, for people who are 100 and over, it's about 90% women at that point. It's a steady increase in the proportion of women.

For any kind of services and supports that are focused especially on our frail older adult population—I'm thinking about things like home care, community-based supports and residential-based long-term care facilities—these issues are disproportionately affecting older women. Any time we have waiting lists and we don't adequately fund these kinds of services, it's really disproportionately affecting older women.

Another important demographic point that I would like to make is that as women get older, they are much less likely to live in a couple relationship than men are. A lot of older men have a spouse. For women, because women live longer and women often have a male partner who is older, it ends up being a situation in later life where there are a lot more women who are not in a partner situation, don't have access to a spousal caregiver and are living alone.

In Canada, we have a very large proportion of our older adult population living alone, but especially our older female population. We know that there can be a lot of challenges related to social isolation. It has a major impact on physical and cognitive health. Any efforts to reduce social isolation amongst our older adult population, especially our population of older women, are very important.

● (0955)

I've been really interested and engaged in research on housing for older adults for many years now. For the last couple of years, I've been focused on housing that supports social engagement. There are some really interesting and innovative forms of housing. One of them is called co-housing. I'm not sure if it's something that many people in the room are familiar with.

There are some examples of co-housing in Canada. They are very rare on the east coast, where I'm from. They are more common in central and western Canada. They are a form of intentional community where people come together and choose to live in a community. The size can range. Often they are somewhere between 10 and 30 units.

In Canada, there are a lot of regulatory challenges to these kinds of communities developing, but they are very mutually supportive. People choose to live in community with other people where they own their own unit, which is often some kind of apartment, but they participate in looking after the needs of each other and looking after the needs of the community.

This form of housing can also promote health in many ways. There's also some evidence starting to show that it can increase the amount of time people can live in the community versus using higher levels of care.

Some work we're doing on co-housing in eastern Canada has been really interesting because the only real model that groups have in Canada is to use a condo kind of model in terms of organizing these communities. Not all older women have the financial ability to purchase a home. There's no funding in particular to support these communities. They are not really a form of affordable housing. They are simply at the cost of building housing today.

I would like to think about whether there are any ways to support innovations in housing, especially housing that promotes community, social engagement and connection, but there are a lot of financial and regulatory barriers to these kinds of things.

I will turn now to economic issues. Again, we don't focus enough on this, but there's a very large income gap between older men and older women, for various lifelong reasons, where a lot of older women today have spent a lot of time in very important, but often unpaid, labour.

Many older adults, and especially older women, arrive in later life where they only have access to old age security and the guaranteed income supplement for their income. We have a very large number of low-income older women in Canada.

There are a few challenges with some of the financial programs that we have available. It is good that we live in a country where we do have income support programs for older adults. Of course, this is a wonderful thing, but the maximum monthly payment for old age security today is around $600 a month, and the person needs to be a Canadian citizen or a legal resident for at least 10 years after turning 18. This does preclude some older adults, especially older immigrants to our country, from gaining access even to very basic amounts of money in later life.

The guaranteed income supplement for those who have very low income is almost $900 a month. For many older women that is the amount of money they have to survive on between the old age security and guaranteed income supplement.

I've also read some research showing that some people have challenges in accessing some of these forms of financial support, especially the guaranteed income supplement. I think we need to take a look at whether there is enough education around how to access these kinds of financial support programs in later life.

There's also a new Canada caregiver credit, which is a wonderful thing to have in our country. However, for people who are providing support to a spouse, a partner or another dependent person in their life, such as a child or a parent, again, this is a program that would—

● (1000)

The Vice-Chair (Ms. Pam Damoff): Dr. Weeks, that's actually your time. Perhaps if you have other information to share, you can bring it up during questions.

I'm going to turn the floor over to Tania Dick for your presentation. Thank you.

Ms. Tania Dick (Vancouver Island Representative, British Columbia, First Nations Health Council): Good morning. Thanks for having me.

First, I'd like to acknowledge the Algonquin nation, whose traditional and unceded territory we are gathered upon today.

I was pretty excited to be invited to come and speak about senior care, because it is a broad issue, across the country, that we really need to deal with. More particularly, I was excited to look at it through the indigenous lens as well.

I am a registered nurse. It's wonderful to see Dr. Weeks, and hear her. Thank you for that.

I represent the First Nations Health Council, an advocacy group in British Columbia. We now fall under the First Nations Health Authority. We took over from Health Canada, which stops at the Alberta-B.C. border, and have created a community-driven, nation-based program. We are in the transformation stage around that.

Senior care is a big issue for us. We find in our communities that the majority of our elders, particularly over 50—we broke it in two different sections—end up leaving the communities, and rely on provincial services and acute care settings for their primary health care—all of their health care demands. In our communities, we only get physicians who fly in every two weeks, or once a month. The acuteness of their issues demands that they be moved to cities or towns where they are closer to access to those services. They no longer fall, per se, under Indian health or the First Nations Health Authority, and have to rely on the provincial health system. What we do federally— big-picture, umbrella-like—really impacts the indigenous community as well, through the provincial programs.

In B.C., in 2013 we assumed all of the programs and services from Health Canada, and the first nations and Inuit health branch, Pacific region. Our vision was to transform the health and well-being of B. C. first nations and aboriginal people by dramatically changing health care for the better. We have the opportunity, through the new organization, to work with surrounding provincial stakeholders. Bringing all of our data together really allows us to see what's working, or not working, and where the gaps are, which is really helpful. For quite while, we've been kind of stand-alone with Health Canada, so that makes a big difference. That relational piece among all of the stakeholders, provincially, is so important for closing those gaps. That has been a really exciting process as well.

Particularly for the analysis for today, we studied access to health care and medications, including data on chronic conditions, using the health system matrix for B.C. first nations senior women, broken out into two age categories: 50 to 64, and over 65. This was done in recognition that first nations communities themselves determine when a member has become an elder. The ages vary across B.C.

Some of the key trends we found preparing for today include a really increased reliance of first nations females aged 50 and over on accessing primary care in a hospital setting, particularly emergency departments. In 2014-15, first nations females between the ages of 50 and 64 were just over two times more likely than other resident females in B.C. to use the emergency department for basic primary care.

First nations women aged 50 to 64 have decreased access to primary care outside of hospitals. As I mentioned earlier, it depends on how we purchase services, and how isolated and remote the communities are. It's a general trend, across the board, for most communities purchasing those services, and having access to continual, consistent, adequate and safe primary health care for communities, particularly for our elders....

When we analyzed the prescription drug piece, we looked at 56,000 first nations members, through the health benefits program, particularly female clients. Some of the highlights are as follows: first nations women 50 years of age or older are significantly more likely than the general female population in B.C. to have prescriptions for hypertension—

● (1005)

The Vice-Chair (Ms. Pam Damoff): Could we pause for a moment? The bells are ringing, so there is a vote.

I need to ask the committee for unanimous consent for the committee to continue to sit, so that we can finish hearing Ms. Dick's presentation.

Rachael, are you all right with that?

Ms. Rachael Harder: Yes.

The Vice-Chair (Ms. Pam Damoff): Okay. Go ahead.

Ms. Tania Dick: I feel like I don't want to talk about that. Statistics and data show we've been the sickest people in the country for generations. So really that's kind of repeating that message and that story. It's about what we do and how we go about tackling that and changing that through the transformation of those systems that provide those services for us.

One of the biggest things we talked about and that came out of going through the data was mental health and wellness. We could only collect the data through the physicians service lens—their visits, hospitalizations for mental health and substance use. But when we talk a little bit to our nurses.... We have access to some of the nurses in our communities, and this was profound for me. I actually talked to my mom. She was a nurse too. She is 74 now and my dad is 68. So, we're talking about my parents when we talk about this issue. They are the seniors in the community today. They are the first survivors of the residential school. That is really ground zero of the whole mental health trauma-informed piece that we hear about. The approach and the delivery of service have to ensure that we get to those people at a level where they are going to be able to respond to that and live the healthiest life they possibly can. Mainstream systems are not working for our indigenous people with the lack of trauma-informed care. I think this intersection is a really great opportunity for the TRC recommendations that have been rolling out and for the health system to really get on board and jump on that train and work through it and for our seniors. It triggered for me that, as I begin to look at losing my parents as they move through their lifespan, that that really was the first flow-through of residential school survivors, and that's huge.

Some of the recommendations we came up with through the data points highlight, of course, the need for more access to better quality of health services, particularly primary care.

Increased attachment to general practitioners can facilitate better access to tertiary care and other important services for improving health and wellness for first nations senior women. The following provides a summary of recommendations through these shared resources and the stakeholders we talked to in B.C. before arriving here today.

One is to improve home and community care programs to accommodate clients discharged from hospital, many of whom require continuing care at home. My mom is a prime example. She has had bilateral hip replacements and ended up losing the apparatus completely. She is wheelchair-bound and requires a lot of home care. We had to move her out of the village. She is now off reserve and doesn't have access to or does not qualify for Indian health services anymore. She is a little too far from the health authority for provincial services to come in, so she gets limited access to those services. There really has to be a collaboration between the federal and provincial services to actually capture these individuals when they come out of those kinds of acute-care settings. Our labs and X-rays end at three o'clock when the technician leaves and jumps on the ferry and goes away. So we have to put them in an ambulance and drive them two hours and a ferry ride away. Quite often the procedure is done, the test is done, and they are discharged and left at the door. These are 72-year-old people who don't have an escort, don't have a wallet and are in a hospital gown. That type of thing happens on a regular basis in our communities.

Next is to increase population health promotion and programming at individual, community and population levels to reduce rates of chronic conditions among first nations. At the first nations health authority level, we are really tackling that at a community-driven nation base level, but it really has to be reflected in the provincial level as well, and we have to find ways to collaborate on that because the majority of our people are off reserve and outside of those programs.

Improving primary health care access for first nations is absolutely vital. We also have to prioritize mental health and wellness including substance use and needs.

The biggest thing for me is to increase cultural safety and humility within the health system through adequate training, through constant revisiting. It's a culture that I personally have been a big part of and it's like running into a brick wall every day. We have to tackle it together, because it's going to directly impact the health status of indigenous people regardless of whether they live on reserve or off reserve.

I think that's it.

● (1010)

The Vice-Chair (Ms. Pam Damoff): By the time the votes are finished, we won't have time to come back, so we'll have to adjourn. Would the committee like us to invite the witnesses back to answer questions? Yes. Okay. We will leave that with the clerk to arrange. I am sorry to have cut your time short. They were both excellent presentations.

Just before we adjourn, I want to let the committee know that our next meeting, on Thursday, will be televised. We have the Association québécoise de défense des droits des personnes retraitées et préretraitées. We have le Réseau FADOQ, the Canadian Association of Retired Persons, and Catherine Twinn and Madeleine Bélanger who are appearing as individuals.

With that, I will say thank you to our witnesses. We will see you again.

The meeting is adjourned.