HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 031 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Thursday, November 17, 2016

Chair

Mr. Bill Casey

Standing Committee on Health

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● (0845)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Order. We have a little anomaly today in the way the committee is working. We are presenting a report today on opiates, and two of us will be leaving early to present the report in the House of Commons, but the meeting will carry on.

I want to seek the direction of the committee members. Normally we just say that we're tabling the report of the standing committee and then table it, but I would like to add my comments. I want to make sure it's okay with everybody if I just say that we really were impacted by the testimony, that it was very moving testimony, and that we hope that the minister and the department move forward with our recommendations.

Is that okay with everybody if I just say those words? Does that reflect what everybody thinks?

Some hon. members: Agreed.

The Chair: Okay. So that's all right with you.

It was moving testimony. I know I certainly felt the emotion in the words from the presenters. It was hard to miss how urgent the situation is.

So I will add those comments when I table the report.

This morning we're having our first meeting on Bill C-233, An Act respecting a national strategy for Alzheimer’s disease and other dementias

To our guests this morning, welcome. We look forward to your testimony.

We have Mimi Lowi-Young, who I understand is working with Dale Goldhawk, the vice-chair of Alzheimer's Disease International; from the Canadian Society of Palliative Care Physicians, Dr. David Henderson, who's from Truro; and from the Council of Senior Citizens Organizations of British Columbia, by video, Kathleen Jamieson, chairperson, and Sheila Pither, treasurer.

We welcome you all to our committee.

I understand we'll start with you, Mimi Lowi-Young, and you're going to share your time with Mr. Goldhawk. You have 10 minutes. Thank you.

Ms. Mimi Lowi-Young (Former Chief Executive Officer of the Alzheimer Society of Canada and Health Care Executive, As an Individual): Good morning to the chair, Mr. Casey, to the two vice-chairs, Mr. Webber and Mr. Davies, and to the members of the Standing Committee on Health.

I'm Mimi Lowi-Young, and I'm very honoured to be a witness for this committee's examination of Bill C-233, an act respecting a national strategy for Alzheimer’s disease and other dementias.

Presenting with me today is Mr. Dale Goldhawk in his capacity as vice-chair of Alzheimer's Disease International. Mr. Goldhawk is a veteran journalist and broadcaster. For the past 20 years, he has been an Alzheimer's volunteer and a former president of the Alzheimer Society of Canada.

Mr. Dale Goldhawk (Vice-Chairman, Alzheimer's Disease International): Good morning, Mr. Chair, honourable members, ladies and gentlemen.

Alzheimer's disease killed my father. The unrelenting emotional and physical stress also led to the death of my mother. That was 30 years ago, when we knew very little about this disease.

Dr. Alois Alzheimer first studied it in 1901, 115 years ago, and still there's no effective treatment, let alone a cure. I think that underlines the vital importance now of the passage of Bill C-233, and, following that passage, meaningful funding to help people whose lives are being profoundly affected by the heartbreak of dementia.

Just three years ago, there were only 13 countries in the world with dementia strategies. Now we have 28. I can say that after years of inaction and little progress, enthusiasm, optimism, and real action appear to be at hand. For one thing, the World Health Organization at its assembly in May of next year hopes to pass a global plan of action on dementia. It has a very blunt message: governments must implement national plans to fight dementia, take action, and do it now.

Alzheimer's Disease International research says that every three seconds, a new case of dementia is recorded in the world. Momentum, of course, is building in Canada. It begins with the passage of Bill C-233, which we need, and the Senate report on dementia released yesterday, which we also need, to help build that forward motion to chart a course of action behind the bill.

I know of no one better equipped to talk about that course of action than my colleague Mimi Lowi-Young. She has worked hard formulating that action for several years now.

Mimi.

● (0850)

Ms. Mimi Lowi-Young: Thank you very much, Dale.

I come to this committee as a former CEO of the Alzheimer Society of Canada and the author of the “Canadian Alzheimer's Disease and Dementia Partnership” and the national strategy and action plan submitted to the government about four years ago now. I've also held positions as a regional health authority CEO, and I've worked in probably every segment of the health system, including acute care, rehab, and long-term care. I was also recently appointed to the institute's advisory board of CIHR as a member of the institute on chronic disease. My work will continue in an effort to help people with dementia and their families.

My mother also suffered from vascular dementia, but in those days it was identified as senile dementia. She suffered for many years, and she died spending the last month of her life in the ICU with a breathing tube.

Ladies and gentlemen, the time has come that Canada moves from writing reports, number-crunching, and vague statements about a national dementia strategy. There is a need now to make a firm commitment to a national dementia strategy and action plan, including a pan-Canadian, non-partisan entity, the Canadian Alzheimer's disease and dementia partnership, with a commitment of funding of $30 million per year, which is just less than a dollar per Canadian per year, to invest in research and knowledge translation; prevention; and living well with the disease. These are the three critical pillars of a national dementia strategy and action plan.

Let me set the context for the specifics, which should be articulated in Bill C-233, that will lead to action by the Government of Canada and the jurisdictions who have the responsibility of delivering health care services in accordance with the BNA Act and the Canada Health Act.

I would be remiss if I didn't acknowledge the outstanding and comprehensive report issued by the Senate Standing Committee on Social Affairs, Science and Technology on Tuesday of this week, chaired by the Honourable Kelvin Ogilvy and the deputy chair, Honourable Art Eggleton, P.C. This report speaks to the urgency for action and the areas of focus for the Canadian Alzheimer's disease and dementia partnership and a national dementia strategy and action plan, which I will cover in some detail shortly.

Please indulge me to give you a few numbers, even though I just said we shouldn't be number-crunching anymore.

In Canada, dementia has touched over half a million people with the disease, and it has touched many more. The number of people with dementia will double in less than 20 years. Unpaid caregivers, families, and friends involved in the care and support of individuals with dementia are also directly impacted. They are touched in so many ways by this disease, which is progressive. We have no cure or disease-modifying therapy to avert or curtail the disease.

Women are most affected by the disease, both by having the disease, at 65%, and being the primary caregiver, at 72%. Over 65% of individuals currently residing in long-term care homes have some form of dementia. A number of them could and should be being cared for in the community if there were adequate services in home and community services. Our emergency wards care for many individuals with dementia, as there are few services to deal with the many challenges of this progressive disease.

Overall, this disease has significant impact on the social and economic fabric of this country at a cost of $10.4 billion per year. This number will double in the next few years as the population ages. We have more people over the age of 65 than under the age of 14.

Another cruel reality of dementia is the stigma related to the disease. Individuals with the disease become terribly isolated from their friends and family, which leads to further deterioration of their condition. As well, physicians are reluctant to provide an individual the diagnosis of dementia, as they know they have no treatment or cure to offer.

In Canada we have research initiatives and we have programs and services available to individuals with dementia and their families, but the amount of research is very limited. Only 5% of CIHR funding goes towards dementia. The number of such programs and services is also very limited, and access depends on where the individual lives. There is poor and inconsistent coordination of care and services among health care providers in different parts of the health system. Evidence from research and best practices are inconsistently implemented, or not implemented at all: Canada is known as “pilotville”.

● (0855)

Is there a solution to this compelling national public health priority? Ladies and gentlemen, the answer is, yes, of course.

We need the commitment from Parliament that a national dementia strategy and action plan will be established with oversight provided by a newly established Canadian Alzheimer's disease and dementia partnership.

What are the components of a strategy and action plan? There is a desperate need to increase the investment in research. As well, the Canadian Alzheimer's disease and dementia partnership could and will bring together researchers and institutions to reduce duplication, promote sharing of information, and determine effective knowledge translation and exchange strategies, which means using evidence to improve practice and care and delivery by practitioners. Efforts to encourage innovation, investment, and drug discovery is really important.

In the area of prevention, the second pillar, the government should complete the implementation of the surveillance system for dementia by the Public Health Agency of Canada. The government should set targets for health practitioners to achieve with regard to early and improved diagnosis of the disease. The government should actively promote the evidence-based actions Canadians can partake in to reduce the risks, such as exercise, diet, blood pressure control, and the elimination of smoking, just to name a few.

The last pillar is living well with the disease. Ongoing support of Dementia Friends, with an emphasis on developing dementia-friendly communities, will assist in reducing the stigma of the disease and will improve public awareness. In an effort to maintain the independence of persons with dementia for as long as possible, the Alzheimer Society's First Link program, which is a referral program, should be standard in every community in the country.

Improved access to home and community services provided by health care providers who are trained in the delivery of care for individuals with dementia is critical. The federal government should continue to pursue efforts to support unpaid caregivers through employment insurance reform initiatives.

Finally, to prepare for the rising tide of dementia, the amount of ongoing training and education of health professionals in geriatric medicine and care must be improved and increased as soon as possible.

There is truly a window of opportunity for this government and the Parliament of Canada to provide the necessary leadership to implement a national dementia strategy and action plan for the following reasons. The conditions are right and ripe.

First of all, there's a commitment by this government to add $3 billion for home and community care, including palliative care. There is the ability to negotiate a new health accord.

There is the desire by Canadians to have a national dementia strategy. Eighty-three per cent have told us that they want one.

The Council of the Federation has identified dementia as a key priority for its health committee. Many provinces are creating provincial dementia plans, and some have already implemented them.

People with the disease and their families have growing needs and a desire to be directly involved in decision-making and policy development.

There is a rising tide of aging and dementia in Canada.

Let me conclude with a short story about Mr. and Mrs. G. Mr. G was a very successful restauranteur, and his wife worked in a hairdresser's shop serving many customers for 30 years. Mr. G had a stroke three years ago, with limited physical deficits, and Mrs. G retired two years ago.

Mrs. G needed a haircut but delayed having one for nearly a year, as she forgot about the appointments and kept calling to make the same appointment over and over again for her and Mr. G. As a result of the stroke, Mr. G now has vascular dementia. Their daughter lives with them at home but travels extensively. Mr. G still drives and Mrs. G still cooks. They're both emaciated and probably don't eat or cook very much anymore.

This situation can turn into a major disaster. Is there no safety net for a situation like this? How many more Mr. and Mrs. Gs are there in Canada?

For my final comment, I would like to quote Margaret Chan, Director-General of the World Health Organization, who captures the essence of the dementia crisis. She said:

> I can think of no other disease that has such a profound effect on loss of function, loss of independence, and the need for care. I can think of no other disease so deeply dreaded by anyone who wants to age gracefully and with dignity.
>
> I can think of no other disease that places such a heavy burden on families, communities, and society. I can think of no other disease where innovation, including breakthrough discoveries to develop a cure, is so needed.

● (0900)

Mr. Chairman and members of HESA, please ensure that any modifications to Bill C-233 will only strengthen what Canada needs, a national dementia strategy and action plan, and the Canadian Alzheimer’s disease and dementia partnership. No more studies. No more number-crunching. We need action now.

Thank you for giving me the opportunity to present my perspective. I am committed to seeing Canada implement the strategy and plan so that Canadians with dementia and their families now and into the future will know that they can depend on their country for care and support.

Thank you very much.

The Chair: Thank you very much for your comments.

Now we will hear from the Canadian Society of Palliative Care Physicians with Dr. David Henderson.

Welcome to our committee.

Dr. David Henderson (President, Canadian Society of Palliative Care Physicians): Thank you very much, Mr. Casey, honourable members, and guests.

It's with great pleasure that I'm here to speak on this, because not only am I the president of the Canadian Society of Palliative Care Physicians but I am also the son of a lovely lady with dementia. It's very timely for me to come and speak on this.

Today we have several members here who will be speaking about personal experiences and such, so I'll keep my comments to the palliative care aspect of this issue.

Our society is made up of around 500 physicians from across the country, and that includes regional leaders in palliative care, residency directors, clinicians, educators, and family physicians with a special interest in palliative care. Our society is proud to say that we support Bill C-233. I'm going to start off by giving you a few of our key messages that we want to get across.

Alzheimer's disease and other dementias are a tremendous challenge for many Canadians and their families. The needs of caring for someone with dementia are many. A national strategy clearly identifying and developing mechanisms to help Canadians manage the needs is essential, given the expected increase in the diagnosis with our aging population. Clear direction, goals, and funding for further research is imperative. Education on prevention needs to be expanded, and education on a palliative approach to care for dementia patients and families needs to be enhanced.

As we've just heard, Canada has an aging population, with one in six people having reached their 65th birthday by July 2015. That number is going to exponentially increase over the next few years. By 2024 the number of people over 65 will be more than 20% of our population. Again, as we've heard, the number of people up to age 14 is less and less. What that's telling us is that the baby boomers are climbing, we have an exponential rise in people over 65, and we don't have the same number of youth, coming up behind, to become caregivers. That will be quite an added load for everybody to be carrying.

As we've heard, dementia is a progressive deterioration of memory, reasoning, communication, orientation, judgment, and abstract thinking capacities, leading to the loss of ability to perform independent activities of daily living and eventually all activities of daily living. These are life-limiting conditions, and there are no curative treatments. Only about a third of people get a formal diagnosis. Changes in behaviours and emotions are common reasons for placement in residential care. Often these people receive very poor end-of-life care.

There are several dementia subtypes. Alzheimer's disease makes up about 47%. You can have a mix of Alzheimer's disease with other types of dementias, accounting for about 27%. There are vascular dementias, fronto-temporal dementias. With Parkinson's, you can get a Lewy body dementia. These all carry different sequelae with their symptoms.

The illness trajectory can often be long, with great disability along the way compared with that of other life-limiting conditions. From a physician point of view and from a health care point of view, communication with the person and their family early on is essential to determine their values, wishes, and goals. Within palliative care education, we spend time teaching approaches to having these conversations with primary care physicians, home care nurses, long-term care nurses and physicians, PSWs or personal support workers, and social workers.

Recently we had a wonderful education tool developed through Pallium Canada. There is education material we've been using for palliative care called “LEAP”, or learning essential approaches to palliative and end-of-life care. They recently developed “LEAP long-term care”. We were part of a pilot project with them, this being a country of pilot projects. It's amazing, even for someone who's been working in palliative care for a number of years, to look at the difference between what we're teaching for an adult and youth population versus what we're talking about for a more geriatric population. There are significant differences. You don't tend to see cancer near as much in that elderly population, basically because they have outlived the time when they are most likely to develop some of the cancers. Much more often, you're seeing multiple comorbidities such as heart disease, lung disease, and certainly cognitive diseases with dementias.

● (0905)

It is a wonderful nationally recognized and nationally accepted education tool. The key is to get that education out there so more practitioners and health care providers get that education. It's also multidisciplinary. This isn't something that just physicians need to be dealing with—we need our social workers, our pharmacists, our nursing staff, our PSWs, who make up much of the workforce in long-term care, to truly understand how to manage these conditions.

With palliative care in general, we're talking about a health-discipline focus on improving quality of life for people living with serious life-threatening illnesses. We have something now we've developed nationally, called the palliative approach to care. We will never have enough specialty palliative care teams to be able to care for everyone who needs access to palliative care, and nor should we. A palliative approach is really coming back to the grassroots and ensuring that we educate up our home care nurses, our family doctors, our nurse practitioners, and also our specialists, even within gerontology, to help ensure they have good palliative care knowledge and skills to be able to translate that care to the community and the home. Our cardiologists, our nephrologists, our oncologists all need to have these skills.

Grief and bereavement is something I want to make sure we bring up with too. It was alluded to earlier. As you can all imagine, if you get a diagnosis of cancer, that's a pretty shocking thing to hear. Most people will automatically think they're going to die, and you start on that trajectory and you may or may not. We don't often get told of a diagnosis of dementia until quite far into the diagnosis. So the person sometimes has a harder time understanding and coping with it.

You can only imagine what somebody goes through with a diagnosis of dementia. We all forget where we put our keys sometimes, but sometimes we start to recognize that this is getting worse and worse as time goes on. You go through repetitive losses with that. You're starting anticipatory grief earlier on, starting to recognize that you've experienced this, especially more and more now that perhaps you've seen somebody else in your family, a grandmother or great-grandmother, go through this. So you kind of know what to expect. That can be pretty devastating.

In my family, we are scattered across the country. I have sisters living in British Columbia, Alberta, and New Brunswick, and I'm in Nova Scotia. Families are more typically scattered now, and often lack the family support required to care for people. So now you often end up with a single caregiver, who is often elderly as well, often with comorbidities of their own, other health issues, trying to care for somebody with dementia. They're going through anticipatory grieving as well, and their entire lives end up being changed. There's much that needs to be done to help support these people.

I also want to point out that men who lose their wives, whether through cancer or dementia, are at a much higher risk of suicide. It's often not recognized that way. Our health system isn't necessarily responsive to that and doesn't always recognize it. It is a population to which we have to give a little extra care and do good risk assessment for bereavement.

To conclude—to take Mr. Trudeau's comments—we're palliative care and we're here to help. Our society is committed to help support Canadians with life-limiting illnesses, especially with Alzheimer's and dementia. We're happy to be part of any strategy that moves forward to try help develop a good system for Canada.

Thank you.

● (0910)

The Chair: Thank you very much for your comments.

We're going to now move to our video conferencing with the Council of Senior Citizens Organizations of British Columbia.

Please go ahead.

Ms. Sheila Pither (Treasurer, Council of Senior Citizens Organizations of British Columbia): Thank you very much for providing us the opportunity to speak to you this morning. We have been granted 10 minutes, so we'll be brief.

We're members of the Council of Senior Citizens Organizations of British Columbia and also members of the COSCO Seniors' Health and Wellness Institute.

First of all, I'll speak about the workshops that COSCO has. We have 43 different topics and they're presented free of charge all around the province. There's a focus on the ways we can influence our own well-being mentally and physically. Then my friend Kathleen Jamieson will speak about the need for home care for seniors with some form of mental health or cognitive decline.

Early in 2007, COSCO began a program of health care workshops. We realized as we looked at health care in British Columbia that obviously acute care is essential, but we felt that there needed to be more attention paid to preventive measures that could delay and even prevent if health literacy programs were established. We prepared the workshops in several ways. First they were prepared by medical students at the University of British Columbia under the supervision of their teachers. From the beginning, we realized that mental and physical health were intertwined, so as the time went on and we experienced a huge demand for the fall workshop, which was our first one, we gradually added others until now we have 43 different topics. We don't give advice in a personal way; we provide information and we provide resource direction, you might say, in that every workshop is accompanied by a list of organizations that people can turn to to ask for help and assistance.

We gradually through the years added workshops. Up until now, more than 30,000 people have attended. Everybody, when they're there, is asked to think about how the facts that we're giving can be used for their own well-being. We have a mental health workshop. We have a social connectedness workshop. We want to remind people how important it is to keep in touch with others. We have a caregiver workshop. We alert people to the possibilities of burnout and ways to avoid it.

Our facilitators are all seniors. They're given five days of training before they present workshops. They're not paid. They get out-of-pocket expenses. In fact, everybody involved with the program is a volunteer. We have no paid staff. We don't have an office. We are gradually reaching out to more and more parts of the province as we get facilitators around the province—Okanagan, the Kootenays. We have funding from grants and donations, and we have a pan-Canadian approach to our work. We've trained people in both Alberta and Newfoundland to facilitate workshops, and our power point presentations have been provided to other provinces.

● (0915)

From the very beginning, mental health and physical health have been part of the institute's programs. Many seniors tell us that they fear mental incapacity more than they fear physical incapacity. The goal of our workshops is to increase understanding and minimize fear, avoidance, and denial.

This is the final workshop I'm going to mention, but our “navigating the health care system” is a fine example of how to proceed, how to get the most out of the care that is available.

Kathleen.

Ms. Kathleen Jamieson (Chairperson, Health Committee, Council of Senior Citizens Organizations of British Columbia): Thank you.

Good morning from Vancouver. I'm going to speak today about my personal experience. I want to emphasize the absolute need for the promised billions of dollars in new home care funding from the federal government to include a very strong accountability framework. I'm going to explain what happened to me personally as I tried to access the health care system for my husband.

I cared at home for my husband, who was diagnosed seven years before he died with a rare, progressive neurological disease called multiple system atrophy, MSA, for which there is no cure or treatment. I have no nursing or medical experience. I had no health issues, however, so I believed I was able physically and emotionally to care for this person whom I loved.

I'm glad I was able to do this. I think with proper support systems, many others would be able to live at home with dementia and with complex neurological diseases, and to die at home, as so many Canadians want to do.

However, as time went on, and my husband became more uncomfortable and needed more care, I began to feel extremely tired. I sought help. I thought I needed some professional direction for the care I was providing. Despite my urgent calls to my local health authority, Fraser Health, in B.C. over the final sad months of my husband's life, I was not able to access any nursing care or any home support. He declined rapidly, physically and mentally.

He died suddenly at home one morning after falling. I tried to give him CPR, instructed by the 911 operator. Because he was not receiving any nursing or home care services from Fraser Health, and so designating as being palliative, the police and the coroner were called by the first responders who had tried unsuccessfully to revive him. Two days later I received a letter from a medical research group based at St. Paul's Hospital in Vancouver, informing me that the first responders had performed an unspecified experimental procedure on my husband as they were attempting to revive him. They said they had no need to ask permission from me as the next of kin—and I was close by—or specify what procedure they did. I followed up. I was subsequently informed by the principal researcher and emergency physician at St. Paul's that they had no need to inform me: they were sorry.

I don't want to speak today about the impact this whole experience had on my physical and mental health. I felt it must be something like PTSD. I have now met many others seniors who have had similar experiences with the B.C. health authorities. Lack of compassion is not a strong enough phrase to describe what our health care system offers to seniors in this province of B.C. I call it callous and cruel.

The Canadian Nurses Association recently noted that there's inequity in access to high-quality, publicly funded home care. They call for a robust accountability framework for home care to be part of a new health accord. We agree. Nothing less will make a difference [*Technical difficulty—Editor*]

● (0920)

The Chair: We'll just suspend for a minute while we address our technical difficulties. We need to reconnect.

● (0920)

(Pause)

● (0920)

The Chair: We're reconnected. Sorry for the interruption.

You can continue with your comments, please.

Ms. Kathleen Jamieson: At what point did we disconnect?

The Chair: You were talking about the inequity of access to home care.

Ms. Kathleen Jamieson: That might have been near the end of what I had to say.

What I want to emphasize is the need for the billions of dollars that are going to be allocated, presumably for home care over the next four years, and that there be a strong accountability framework negotiated in the health accord.

I spoke before that about my personal experience of trying to access some high-quality health support for my husband, who died of a very serious neurological disease with dementia. I could not access any care. I must say that 11 days after he died, I got a call saying that they were now ready to assess him. I'd had three quite lengthy interviews by telephone before that, but I didn't get the care when I needed it.

I just want to emphasize the need for much better home care, and for equal access for everybody. They don't have to be important persons. Everybody should be able to access good home care when they are older, and when they have mental illness or dementia, so that they can live at home comfortably, have some quality of life, and die at home. I think we can do that. It's not happening.

Thank you.

The Chair: Thank you very much for your testimony. It has not fallen on deaf ears, I can assure you. It was very meaningful. Thanks very much.

Now we have our last presenter, who I overlooked in our introduction, and I'm sorry. Tanya Levesque is a caregiver and has helped victims of Alzheimer's for a long time. She advocates for their benefit in this area.

Tanya, please go ahead with your presentation.

Ms. Tanya Levesque (Caregiver, As an Individual): Thank you, Mr. Chair.

Good morning, everyone. My name is Tanya Levesque. I'm a young caregiver for my mother, Suzanne Levesque, who is now 65. I recently turned 41.

First, I want to thank you for the invitation to speak. It's truly a gift from God and a privilege for me, so thank you for the opportunity.

Mom was diagnosed with moderate-stage vascular dementia with significant brain atrophy in 2013 and mixed dementia in 2015-16. Dementia is a family affair. Her mother, my grandmother, is 86, and lives with Alzheimer's. Also, my grandmother's sister, who is 88, lives with Alzheimer's.

My mom's behaviour changed over several years. In my mid-thirties I really didn't know enough about dementia to start getting her tested. I thought that it was menopause or that she was just very tired from travelling. I now see the red flags when I reflect back. Educating people and promoting earlier diagnosis and intervention would possibly have helped her in her mid- to late-fifties.

There are two parts to my story. Part one is the difficulties I experienced while I cared for my mother at home for two and a half years, and part two is the difficulties I encountered during the long-term care process and beyond.

Part one begins in 2013. At the age of 37 I decided to take a leave of absence without pay to care for my mom at home. Where I work, my collective agreement says I have five years maximum to care for an immediate family member. I tried to make our limited financial resources work. My father died at a young age, leaving my mom with a little pension, and my mom didn't have a pension.

Here are some of the financial barriers I encountered. I was unable to access EI benefits, especially the EI compassionate care benefits. The criteria need to change for caregivers. I was unable to qualify for social assistance, and I certainly don't have job security. When I decide to go back to work in the next couple of years, they're going to place me on a priority list, and hopefully somebody will pick me off that priority list. Retirement is questionable at this time. There is a lack of subsidies for household expenses, which keep increasing, especially to fix a house that hasn't been repaired in 60 years. With increased food costs, I actually had to change my eating habits so I could save money, and I had to make sure my mom could eat properly as well.

Other difficulties I encountered were that there is no one-stop shop for information. The Alzheimer Society helped me quite a bit with the First Link program, but I had to do a lot of enquiries and research on my own. The program I had my mom involved with couldn't provide the activities they had actually wanted to, like pet therapy, because of the costs associated. They need more funding. In terms of home care services, my mom received 15 hours maximum for her daily care and activity. The staff really weren't trained to do a lot of things with her. They did watch television and go for walks. Some were good and some weren't, so I stayed home most of the time to make sure things went smoothly and she was still participating in life.

Part two is the difficulties I encounter in the process of long-term care and beyond. Here are some of the difficulties. I had to work on a plan B for my mother, because I was hospitalized in June 2015. With more home care services, I actually would have kept her at home so that I could care for her after the hospitalization and surgeries that I ended up having. My mother actually moved seven times in the time frame from December 21, 2015, to mid-June 2016 of this year. In less than seven months, she moved from a private care facility to a long-term care home. In the long-term care home, she moved three times to three different rooms, and then they sent her to the Royal Ottawa mental health facility. There she moved three times into three different rooms.

This was very hard for her. She was sent to the Royal Ottawa mental health facility because she had significant behaviours with the dementia, and I'm still convinced it's because of the medication they were giving her and all this moving about. This caused her a lot of distress. Her displacement is still not done to this day. Once she stabilizes at the Royal Ottawa, she's going to be moving into long-term care.

People with great difficulties with dementia end up being bounced around from long-term care, or from home, to a hospital, such as the Royal Ottawa. After they're stabilized, they're sent back to long-term care, and if the long-term care home can't reintegrate them back into the facility, they're bounced back either to the hospital or the Royal Ottawa. I've met some of these families.

More training and research funding needs to include dealing with special behaviours, like high anxiety and aggression, or at least have some homes that are specifically designated for people with special behaviours so that they have the necessary specialists, because homes are not prepared. We need to adapt to the sick person, and not have the sick person adapt to us and our policies.

● (0925)

I, like many other people, had to hire a private caregiver in long-term care to spend time with my mom, which was about two hours a day. I had to negotiate the salary, because I couldn't afford it. Staffing ratios need to increase and administration work needs to decrease, because they need to be spending time with our family members.

There is a brain imaging centre here at the Royal mental health facility, which is excellent, by the way. I wanted my mom to be tested or looked at, because I wanted them to do a comparative analysis of her brain now with the other scans she had over the years, but it's used only for patients who are in research projects, and there is no dementia care research funding. Our mental health facilities need funding for dementia care.

There was a Royal Ottawa special behaviours unit program that was run out of one of the Ottawa long-term care facilities, but it was placed on hold this year. They have to move the program to another home. This could take up to a year. Meanwhile, people are still suffering from special behaviours that they have.

The Phoenix pay system was rolled out this year, and I actually started receiving my bilingual bonus. This is adding to the interest that I am earning on little savings and an inheritance that I'm pulling from. Household income is considered when applying for subsidies, so there is a possibility that I may not qualify for a subsidy. Income tax is going to have to include these payments, and this may change the balance: either I owe you guys, or I am refunded from the government.

I could continue, but I will conclude. In my research, I found that Canada is very far behind other countries when it comes to dementia research, national strategies, and care. Collaboration with all the stakeholders is needed to create a good health care policy. The federal government can take the lead with this bill. Stay-at-home moms, executive assistants, professors, theatre directors, scientists, and priests are only some of the people with dementia I have encountered on my journey, along with their family members. They need your help, as do we caregivers. Passing Bill C-233 would be a significant stepping stone for everyone involved in this long and difficult journey.

Thank you.

● (0930)

The Chair: Thank you.

Thank you, all, for your testimony. I think it's safe to say that everybody around this table has had some exposure to Alzheimer's or dementia of some sort, but your personal testimony certainly crystalizes the challenges, and some of the new ones. Kathleen's story is incredible. We want to thank you for your personal comments. It helps us move forward with this.

We'll start a series of questions. There will be seven minutes for the questions and the answers.

Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair.

I want to thank all the stakeholders for coming here with their testimony.

I couldn't agree more with Kathleen and Tanya. That was very moving testimony. I know first-hand how helpful home care is, because my wife has suffered with mental health issues. Since 2005 we've had home care. It's not to the extent it should be, as Tanya mentioned, but it really turned our lives around. I got elected in 2008. I ran in the 2004 election. I wouldn't have been able to do this if it weren't for home care. I am here because of home care. We definitely need to do more for home care.

Lots of our seniors with dementia, lots of people with mental illness, want to stay in their homes. They don't want to be put in long-term care homes. We need to do more. If we put more into home care, it will save us lots of money on health care costs. It's a revolving door. My wife, with her mental health, used to go into the hospital for two weeks: a week home, two weeks in, a week home. Ever since we got home care, she has been home all the time. Do you know how much money it has saved us on the ambulance? She has a nervous breakdown here and there, but that could be contained with the help of home care.

Thank you very much for sharing your personal experiences here. That is my personal experience.

Coming back to the questions, we have people over 65 suffering. The seniors population will double by the year 2030. Do we have any numbers on young people, under 65, who are suffering from early onset?

● (0935)

Ms. Mimi Lowi-Young: Yes, a growing number of people under the age of 65 have early onset dementia. Approximately 50,000 people today under the age of 65 have the disease. We haven't paid enough attention to this group. There is a growing need. We have seen examples—John Mann and others—where we see it happening in the younger population. I think we are now starting to get a better hold on the actual numbers, because it's being reported more, and being recognized, as an illness. It's not a natural course of getting older that you get the disease, but we are now seeing an increase in the number of people who are younger with the disease as well.

We don't have the exact numbers. We have an idea of how many there are today, but no sense in terms of being able to project it going forward.

Mr. Darshan Singh Kang: I think by the time year 2030 rolls around, it will have a very big impact on our health care costs and maybe on our productivity as younger people are getting this disease too.

Anyone can answer this question. Can you describe both the current and future economic and social costs associated with the increasing number of Canadians being diagnosed with Alzheimer's disease and other forms of dementia?

Ms. Mimi Lowi-Young: Right now the cost is $10.4 billion, and that's expected to double in less than 20 years. The costs are going to increase exponentially. We've sometimes talked about $33 billion, but based on some re-examination of the numbers, we know today it's about $10.4 billion per year on direct and indirect costs. Indirect costs are costs to society as well as direct care costs.

On the comment about home care, yes, home care is extremely important, but I think what we're hearing from people is that the people who are delivering the care, people like PSWs, are not formally trained in caring for people with dementia. We can have all the wonderful care for home care, but if people are not adequately trained, then they cannot support people with dementia in their homes, and therefore that leads to early admission to long-term care.

Mr. Darshan Singh Kang: You talked about prevention. Do we have some kind of framework in place on how to do the prevention before it snowballs?

Ms. Mimi Lowi-Young: The issue here is there is a lot of research being done in the area of prevention or efforts to reduce the risks of getting dementia. We know for a fact that in terms of exercise and diet, heart healthy is brain healthy. Some of the research has shown that. We need more research in the area, obviously, but we know there are definitely things people can do to reduce their risks. We're not saying eliminate it, but reduce. Diet, exercise, controlling blood pressure, definitely cessation of smoking are critical areas. Those are the kinds of things that are being promoted by the Alzheimer society and Health Canada and PHAC. These are important elements in terms of preventing or reducing this.

Mr. Darshan Singh Kang: You see this costing $10.4 billion. How much are the medical costs alone? Do you have any number on that?

Ms. Mimi Lowi-Young: Not here—

Mr. Darshan Singh Kang: If you do get the number, would you please write to the committee through the chair.

In your opinion, what other national objectives should we include in the strategy? Are we covering everything here with this Bill C-233, or should there be more?

Ms. Mimi Lowi-Young: Yes, if I'm looking over the bill, there are the critical elements of the three pillars we talked about—research, prevention, and living well with the disease. It's a good start, but ultimately Canada needs a national dementia strategy and action plan. I emphasize the action plan because strategy is not going to get us to where we need to go. We need to develop specific actions that we can take around some of the ideas I presented today.

● (0940)

Mr. Darshan Singh Kang: I have first-hand experience with home care. Could the fourth pillar in this be home care?

Ms. Mimi Lowi-Young: Well, home care fits into living well with the disease, because people then can live as long as possible in their homes with dementia, as Tanya spoke to. It's very important because changing environments is very hard on somebody with Alzheimer's disease or dementia. When they need long-term care, yes, it needs to be available for them and they need to be cared for properly in the long-term care home. But people generally want to stay in their own homes and their own communities as long as possible.

Mr. Darshan Singh Kang: The reason I stressed home care is because it works. I don't want to see home care lumped in with something else. If home care would stand alone, maybe it would go a long way to help Canadians. That's why I stress home care, because I know it works.

The Chair: I'll end that there.

Mr. Kang, I want to thank you for your testimony and your questions. Your comments were very meaningful.

Dr. Carrie and I have to leave to go to the House as part of our procedure on another bill. The House procedure requires us to do a certain thing at a certain time, and we have to leave. I don't want the witnesses to think it's because we're not interested in their testimony. I just wish that everybody could hear your testimony.

At any rate, we have to go now, but we'll be back as soon as we can.

Mr. Colin Carrie (Oshawa, CPC): We have to go now?

The Chair: We have to go now if we're going to be there by 10 o'clock and in our seats and ready.

I'm going to ask the vice-chair, Len Webber, to take over.

Mr. Darshan Singh Kang: Is there a vote at 11? Do we have to leave at 10:30? Is the vote at 11?

The Chair: Bells are at 10:30.

Mr. Colin Carrie: We don't have to go now.

The Chair: Well, the routine proceedings will take place.

Mr. John Oliver (Oakville, Lib.): Yes, before the bells ring the first time.

The Chair: We have to go to routine proceedings. Then I don't know. Is the vote for sure? Are the bells at 10:30?

I'm sorry; I don't know what's going to happen here.

A voice: The bells are at 10:10.

Mr. John Oliver: Let's just continue on with our questions.

The Chair: We are not masters of the agenda here, but we'll do the best we can.

Your testimony is very important to us and very meaningful, and I want to thank you all for it. I hope I'll be back.

Mr. Webber.

The Vice-Chair (Mr. Len Webber (Calgary Confederation, CPC)): Thank you.

The next one on our list is Ms. Harder.

You have seven minutes, so go ahead with your questions.

Ms. Rachael Harder (Lethbridge, CPC): Thank you.

Like my colleagues, I want to say it's really a pleasure to have you here. Thank you so much for taking the time to be with us today and for offering not only your experience but also your expertise and your understanding of this disease.

Like many around this table, I think, my life has certainly been impacted as well. I have two grandmothers who both have dementia, one of whom we've watched decline in health quite severely and at a rate that is unprecedented. I'm having to learn about this condition as well and figure out what it is to look after those with dementia. Again, I have a great appreciation for your testimony.

I have a number of questions here. Perhaps I will direct my first question to Kathleen.

I'm wondering if you can just outline for me your thoughts with regard to palliative care, if that would be something that is needed, and what that might look like in order to help families who have a loved one with dementia.

Ms. Kathleen Jamieson: My whole upbringing was in another country. One of the things I saw as I was growing up was that you cared for old people. You cared for them at home, respectfully and very thoughtfully. I didn't ever occur to me that I would agree to my husband going into any kind of institution. But I do feel that at the end of life, there may be times where there are people, especially if they come from other countries and don't have many family members here.... I had only one family member who lived here. I could see that there would come a point where I might have to agree to some form of palliative care in some place other than our home. It was getting extremely difficult; I can't tell you.

I hope that answers your question.

● (0945)

Ms. Rachael Harder: Thank you.

Tanya, you mentioned that you've done some research, looking at other countries and what they offer, and you made the comment that Canada is actually quite behind.

I'm very pleased to see this bill come to the floor with regard to putting a strategy together. I think the intent would be, certainly, to see an action plan as well. I'm interested in what other countries are doing and how effective they are. A part of this bill, actually, is working with countries abroad to find out what their practices are. I'm wondering if you can briefly outline one country that does it well and some of the best practices we could borrow from that country or learn from.

Ms. Tanya Levesque: I know that the United Kingdom is well advanced with their dementia care research. The U.S. is a little further behind than the U.K., but I know, for instance, that they do stem cell research in the United States. I met a gentleman a couple of years ago whose wife suffers from Alzheimer's, and he actually brought her to California to have stem cell therapy. In Canada I have never come across that in my research. We have some drug trials here. There are more in other countries.

Speaking to the idea of collaboration, that's what's needed. Other countries have a better grasp, provide more home care, and provide payment for caregivers, which helps them out in keeping them at home. These are some of the strategies. Some other countries have national strategies, as I said. The U.K. is probably at the top with their dementia-friendly society and the way they care for the elderly.

Mr. Dale Goldhawk: Mr. Chair, I could elaborate on some of that in terms of the countries with strategies. The G8 summit on dementia was convened in 2013. Before that, there were only 13 countries in the world that had effective and meaningful strategies, which means policy and funding as well. After that conference, the number grew quite rapidly, and we're now approaching 30. Canada, with its strategy, would make either number 29 or number 30 on that list.

In terms of Canada being behind, I can only speak from the perspective of many of the researchers I've talked to around the world in my years with ADI. As far as research is concerned, Canadian researchers are renowned in the world. They are some of the leaders in neurological study and research and share that with the rest of the world. What has kept us behind is the fact that we do not have a strategy. It happens often that when I attend board meetings in some part of the world, I'm always asked when the strategy is going to come. It was with great pleasure that I was able to say, well, very soon. After that, hopefully, meaningful funding, as mentioned in the Senate report, will make it a workable reality.

Ms. Rachael Harder: Thank you very much.

Mr. Chair, do I still have a few more minutes?

The Vice-Chair (Mr. Len Webber): You have a minute and 17 seconds.

Ms. Rachael Harder: Thank you very much.

Mr. Henderson, as you were talking, the question that came to me was whether you've seen any improvements in our system over the years in terms of research or providing care. Have we improved at all, or have we stayed fairly stagnant over the last number of years?

Dr. David Henderson: There have been some improvements, and it's always good to try to recognize those when they are happening. In the last year, I've been constantly saying that we are a country of pilot projects. We have a lot of good pilot projects that never seem to go anywhere, even if they're successful. Basically, we need to stop the pilot projects. We need to look at what's already been developed and we need to start implementing them. It's hard to do that without a national strategy, both for this, specifically, and for palliative care in general.

I know your time is running out here, but I just want to quickly clarify something. When you ask about palliative care, there's often a misperception that palliative care is in a facility, whereas most palliative care is in the home setting. With the last health accord, one of the targets of monies for home care was the enhancement of palliative care. Fortunately and unfortunately, probably the only thing that we saw happen in many provinces—although I certainly can't speak for every province—was that there was actually a bit of an augmentation to home care services if patients were attached to palliative care services. So it's still something to look at. Unfortunately, some palliative care programs look at more of a time-based, prognosis-based time to be involved versus ours in particular, where we look at needs-based.

Palliative care is really intended to be accessed early on. That's when it's most effective. That's when you can start working with people, their primary care physicians, and their specialists to augment things, to help make sure that things like advanced care planning are done to determine the goals and wishes of patients. If staying home is the goal, that's the time when you can ensure that you have other teammates around to help navigate the system to make sure that this happens. Now, unfortunately, that doesn't happen everywhere, but it is something that should be happening. Again, it should be happening earlier on for people. I have cared for people with that same kind of condition in their homes. There are a lot of factors, but those people have been able to stay at home quite comfortably.

● (0950)

Ms. Rachael Harder: Yes.

Dr. David Henderson: At the same time, though, a lot of it depends on family support.

Ms. Rachael Harder: Thank you very much.

The Vice-Chair (Mr. Len Webber): We'll move on now to Mr. John Oliver.

You have seven minutes.

Mr. John Oliver: Thank you.

Thank you very much for your testimony. It has been very significant. It's really important to hear it in terms of palliative care, home care, and just the impact of living with and supporting people with dementia.

Like my colleague Rachael, I have family members and friends with different issues. I have a mother with Parkinson's and I have a father with vascular dementia. I've had a lot of exposure to these conditions, and I'm aware of the complexity and the lack of a focused approach to managing people with dementia. I'm very sympathetic to the need for a national dementia strategy and for an action plan for dementia.

I do want to focus, though, on the bill itself and ask you, specifically, about the weighting of the bill towards Alzheimer's versus all of the other forms of dementia. Alzheimer's is a disease; dementia is a syndrome. So with dementia, there are different groups of symptoms, and Alzheimer's is, right now, the predominant cause of those symptoms. I think about 50% to 60% of dementia cases originate with Alzheimer's. This morning we were at a session with regard to the tsunami of diabetes, and whether vascular disease will eventually be as equally prevalent in the cause of dementia.

The bill itself is not about a national dementia strategy. It's about a national strategy for Alzheimer's disease and other dementias. When you look at the conference that the minister is directed to hold, and when you look at the committee that will be formed to give advice going forward, there's a weighting towards Alzheimer: thus the Canadian Alzheimer association and Alzheimer groups.

I just want to get your perception on this. Is the goal here a dementia strategy or is the goal here an Alzheimer's disease strategy? I'd like to hear from all of you on this one, if I could.

Ms. Mimi Lowi-Young: If I may, I'd like to start off the conversation about this.

The word “Alzheimer's” is often used—we say Alzheimer's Disease International and the Alzheimer's Society of Canada—and we've often been asked, “Why don't change your name to the Dementia Society of Canada?” I think we need to recognize that dementia is the umbrella, and that, yes, people with Alzheimer's make up the largest proportion of people with dementia. I think we should talk about dementia, because that's the umbrella, and all the different types of dementia fall under that, although Alzheimer's is the largest.

We're seeing much more now—I think it's because our efforts with good diagnoses—that we're understanding mixed dementias. There are many more mixed dementias. Some people have both vascular dementia and Alzheimer's disease.

I think the naming of the bill is interesting, but from my perspective, I think we're really talking about dementia and being able to care for people with all the different types of dementia. There may be different needs for the different types, but dementia should be the overall umbrella. We should not just focus on Alzheimer's.

● (0955)

Ms. Tanya Levesque: I could also add something to that.

I didn't know the difference between Alzheimer's and dementia until I took a course at the Alzheimer Society. That's when I learned that dementia is an umbrella and Alzheimer's is under that umbrella, as is vascular dementia. As to the naming of the bill, as she said, it's interesting, but it should be a dementia strategy to include everybody.

Dr. David Henderson: We could go with what the public often calls it: old-timers disease. Often people haven't heard the word Alzheimer's; they hear “old-timers”. Some of my older patients and families especially will call it that.

But I agree with what everybody is saying. It really needs to be all-encompassing. The reality with the strategy is that most of what comes out of it will address the needs of all the underlying types of dementia as well. It could be part of the education process, too.

Mr. John Oliver: Do you have any reaction in British Columbia to focusing on dementia versus the Alzheimer component?

Ms. Kathleen Jamieson: Speaking just for myself, I would prefer the term dementia. I feel that labels are useful, but they do change over time. Since dementia is a broad category, it makes sense to call the bill dementias rather than Alzheimer and dementias.

Mr. John Oliver: If we're looking at the bill and the construct of it, I'm also a bit concerned about naming a society in it. I would hope this piece of legislation has legs for 20 or 30 years, and societies come and go.

You'd be comfortable, then, as a group of witnesses with us turning away a little bit from specific reference to that entity and to embrace Alzheimer and other associations—the Canadian Stroke Network, Parkinson's, obviously Alzheimer's, even the Canadian Diabetes Association, and a number of different groups—would be dealing eventually with the consequences of dementia.

Mr. Dale Goldhawk: Perhaps I could add to that, Mr. Oliver. In the world, many of the strategies that I spoke of speak of dementia strategies and don't necessarily mention the Alzheimer tag, although in the beginning there were all these Alzheimer societies. They're very involved in that whole process. But I don't believe that anyone, anywhere, engaged in the fight would object to the fact that it would be a dementia strategy.

Mr. John Oliver: I just want to emphasize that I totally support the need for this across Canada. In every community, we have Canadians who are suffering from forms of dementia. We have caregivers who are often feeling abandoned and alone trying to deal with patchy home care, with unclear or very uncertain financial resources, and the burden on Canadians of this set of symptoms. We need to get on and address it.

I want to thank you again very much for bringing forward your testimony and sharing your personal stories and personal experiences with us.

With that, I think my seven minutes are probably up.

Ms. Mimi Lowi-Young: Mr. Chair, may I just make a comment?

The Vice-Chair (Mr. Len Webber): Yes.

Ms. Mimi Lowi-Young: I just want to reassure Mr. Oliver in terms of his thinking. Already many of the societies and associations are working together with a focus on dementia. Heart and stroke, Alzheimer's, and diabetes just recently came together with a common submission to government about prevention.

The Vice-Chair (Mr. Len Webber): That's excellent. Thank you.

We'll move on now to Rachel Blaney for seven minutes.

Ms. Rachel Blaney (North Island—Powell River, NDP): First, I want to thank you all so much for your amazing work. A special thank you to those of you who are in B.C. I am a B.C. MP, and I know exactly what time it is there, so I thank you so much for being here with us so early in the morning.

I want to first mention that in 2012, former NDP MP Gravelle introduced Bill C-356, a national dementia strategy, in Parliament. Unfortunately, his bill was defeated in May of 2015 by a single vote. It was a vote of 140 to 139. I think it was a really sad day for many of us. The Canadian Medical Association called this defeat “a lost opportunity to make lasting progress in the serious and growing problem of dementia in Canada”. The bill was opposed by a majority of Conservative MPs, including the member for Niagara Falls, who is the sponsor of today's bill, Bill C-233.

New Democrats, we will support Bill C-233, but it is less ambitious in its scope and implementation provisions than the former Bill C-356. Some of the concerns we have are around the establishment of the advisory board. In Bill C-233 there's a statement that says: “The board is to advise the Minister on any matter related to the health care of persons living with Alzheimer’s disease or other forms of dementia.” But unlike Bill C-356, the legislation offers no remuneration for the work of the advisory board members, nor any reimbursement for travel costs.

I come from a very rural riding, and I understand that the experiences of people across the country are very different. In your view, could this impact the formation and work of a national advisory board?

● (1000)

Ms. Mimi Lowi-Young: If I may, that is why in my presentation I talk about the Alzheimer's disease and dementia partnership. What's really important is that we've seen success in the Canadian partnership against cancer, where the organization became an entity that convened, integrated, and brought together the researchers, providers, and people with the disease to make a real difference in terms of the action plan. That's why the strong recommendation that this needs to be considered.

Otherwise, there's no teeth in terms of getting things done. We'll study again and we'll put more reports out, but now we need to take some action. I think that was the whole idea of Claude Gravelle's effort in the previous bill. Yes, I understand some of the issues around a private member's bill, but I think there's an opportunity here to lay some groundwork for building this to something that will be significant.

Thank you.

Ms. Rachel Blaney: Thank you.

I ran a non-profit organization for over a year, and I was also a volunteer for a hospice. I also volunteered with respite care. I have to say that in my time with respite care, the majority of the people I supported were family members who were living with a form of dementia. I remember doing things like taking them out to shop and do things. I remember one of the people I worked with saying, “It's so nice that once a week I get to feel like a normal human being, where somebody picks me up, takes care of me for the day, and then brings me home.” So I understand the amazing work that volunteers do.

One of the concerns with this legislation is that it doesn't contain any provision to augment the capabilities of the voluntary sector through investment and training. In B.C. I know you and everyone has done so much in preparing people and preparing volunteers as well. Can you explain the importance of volunteerism to the work being done every day to support individuals and families affected by dementia?

I will take answers from anyone.

Dr. David Henderson: I can speak to that briefly.

Within the palliative care world, we're starting to move forward with something that's becoming more of an international phenomenon, although it's based on work done by Allan Kellehear from Ottawa, called “compassionate communities”. Its focus has been looking more at people with terminal illnesses, and when we're dealing with dementias, we're dealing with incurable, life-limiting illnesses. I think that's something that needs to be promoted more, and not only with volunteers in the official capacity. With all palliative care programs, there are generally volunteer components through hospices and such, but it's also linking with community businesses. We're starting to have businesses approach our local hospice and say they're already faced with this. They often have people within their companies who have been diagnosed with a terminal illness, or they have caregivers, and they need to know as a business how to support these people best. These are wonderful employees, and they want to enable them to do what they need to do, while keeping them healthy so the companies can get a return on their investment and have them come back.

It's wonderful to see the business communities reaching out to us to ask for that. We're starting to do more education with businesses, a lot of different organizations, to help them understand this and how they can be part of it. It's a wonderful initiative, and there are some areas around the country that have already taken this on, and some towns and cities that have been labelled as compassionate cities and towns. It's something that we as a society need to try to continue to push forward.

You've heard the saying that it takes a village to raise a child. Well, we can't stop raising that child when they become 18. Lifetime is from beginning to end, and we need to support people right through as a village rather than as individuals. That's something that doesn't really need to cost us a lot of money. It's just getting our society back on track and starting to recognize that there's a lot of value in becoming a volunteer and becoming a provider to help with this.

● (1005)

Ms. Rachel Blaney: Thank you.

One of the things I heard—I think it was from you, Mimi—was around the size of the community and the accessibility of services. I represent a large riding in B.C., North Island–Powell River, where there are a lot of really remote communities. One of the challenges I've heard from my constituents repeatedly is this feeling that they're being forced into larger urban centres. They don't have the services that they require there, but they do have that village, that community that supports and cares, brings in food. I'm just curious, in relation to this strategy, where you see us looking at how we service people regardless of the size of their community.

Ms. Mimi Lowi-Young: I think part of the way to deal with this is setting some standards and targets. No matter where you live in the country, you should be able to access certain services, and there should be some accessibility standards being set. Some of the basic home care services should be available wherever you are.

With respect to specialty services and whatever, there are means to access where people don't have to go to the centres. We talk about the use of technology and telemedicine and so on that can really keep people in their own communities to get the necessary care and support. It's happening for a number of things, so why not for this? This includes education and even direct service delivery.

We talk about remote and rural areas, but we also need to talk about first nations, which we haven't talked about here. That is also an important part of the population that needs to be served, and served in a way that's culturally sensitive.

To your point, yes, people can access services, and we've found ways of dealing with other diseases where we've been able to provide either specialty training or training of some kind, and we can do it remotely, but there should be some set standards across the country around care that everybody can expect, no matter where they live.

The Vice-Chair (Mr. Len Webber): Thank you for that.

We have a little bit of a surprise here: the bells have started in the House.

We need unanimous consent to continue this meeting or else we have to adjourn.

Mr. Oliver.

Mr. John Oliver: With all respect to the witnesses—I wish we had more time to hear from them—I do believe it's important that we be present in the House for the vote if the bells are ringing. I move that we adjourn.

The Vice-Chair (Mr. Len Webber): All right. Let's second that motion, anyone...? I think we have Mr. Ayoub.

We will have to adjourn this meeting because of proceedings in the House. We do apologize, but we sincerely appreciate your testimony here today. I had a whole list of questions that I will probably jump at a few of you before I leave. Thank you sincerely.

Mr. Ayoub?

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Maybe we can ask if they are available some other time, if perhaps we have the time to have them back.

The Vice-Chair (Mr. Len Webber): Absolutely.

Ms. Harder.

Ms. Rachael Harder: Through the chair, could we ask the witnesses to submit any further thoughts that they would like us to consider in terms of this bill going forward?

The Vice-Chair (Mr. Len Webber): Sure. That's a good suggestion. Thank you, Ms. Harder.

We would welcome your input through hard copy.

Ms. Young, you have something to say just quickly?

Ms. Mimi Lowi-Young: I would be very happy to submit in writing to the committee our presentation that we made verbally.

The Vice-Chair (Mr. Len Webber): Thank you sincerely.

Thank you to you all, and the meeting is adjourned.

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