HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

HUMA • NUMBER 067 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Thursday, October 19, 2017

Chair

Mr. Bryan May

Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

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● (1530)

[*English*]

The Chair (Mr. Bryan May (Cambridge, Lib.)): Good afternoon, everybody, and welcome. It is a pleasure to be here.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Thursday, May 4, 2017, the committee is resuming its study of advancing inclusion and quality of life for Canadian seniors. Today is the first of three panels that will be held on the subject of inclusion, social determinants of health, and well-being.

We have an amazing panel with us today. First we have, coming to us from Vancouver, British Columbia, via videoconference, Dr. Margaret M. Cottle. Also appearing as an individual is Alison Phinney, a professor in the School of Nursing at the University of British Columbia, also by way of videoconference but coming to us from Winnipeg, Manitoba. Appearing here today we have, from the Canadian Centre for Policy Alternatives, Pat Armstrong; from the National Initiative for the Care of the Elderly, Raza Mirza; and from Réseau FADOQ, Danis Prud'homme and Caroline Bouchard.

Welcome. We will begin with opening statements, which will be kept to seven minutes. I will indicate when you have one minute left to wrap up.

We'll start with Margaret, coming from British Columbia. The next seven minutes are yours.

Dr. Margaret M. Cottle (Palliative Care Physician, As an Individual): Thank you very much.

My name is Dr. Margaret Cottle. I am a palliative care physician and a clinical assistant professor at the UBC Faculty of Medicine. For almost 30 years I have devoted my practice solely to the care of patients with serious illnesses and to their loved ones, especially—

The Chair: I'm going to step in here. We're hearing a really loud crackle on this end. People are having a hard time hearing you.

While they work this out, I suggest that we move on to the next person. We'll see if we can figure this out and then come back to you. I apologize for it.

Dr. Margaret M. Cottle: Okay.

The Chair: We'll now go on to Alison Phinney, who's also appearing via video conference.

The next seven minutes are yours.

● (1535)

Dr. Alison Phinney (Professor, School of Nursing, University of British Columbia, As an Individual): Thank you for the invitation to appear today.

As a nurse, my research has largely focused on vulnerable older people who are living in the community, especially those with dementia, but also more broadly, older people with physical impairments and social vulnerabilities. These are people who are isolated, maybe living apart from family, with a narrowing circle of support. Essentially these are people who find it difficult to get out of their homes, and when they do, they find there are fewer opportunities for engagement, for them to be connected with the larger community.

My research has explored the rather broad question of what is meaningful activity for this group, and more to the point, what can we do to support it? I'm going to briefly describe some of what we've seen through this research that might suggest some possible solutions.

I'm a community-engaged researcher. I'm really on the ground, so I'm not going to speak so much about top-down solutions but rather what I see happening from the bottom up.

Over the past several years we've seen ever-increasing numbers of small, community-based programs offering various kinds of group activity for older people and those living with dementia. These groups are diverse, they're often very innovative, and they exist largely outside the health care system. People are gathering in community centres, in church halls, and even in hotel meeting rooms. Our research has shown that these groups offer a range of health and social benefits, and against all odds, they seem to have staying power. They're really not disappearing.

In the interest of time, I'm just going to share two examples from some of the research we've been doing in B.C.

The first example is Paul's Club, a group for younger people with dementia, people between roughly 50 and 75 years of age. It's a social enterprise run on a volunteer basis. They have one part-time paid staff member. It was the brainchild of Nita and Michael Levy, a retired couple from Vancouver who wanted, really for very personal reasons, to do something for this particular population. They have over the past five years basically invented an approach that combines physical and social activity, all happening in the heart of the city. They have about 15 members who meet three full days a week.

These were people whose dementia had progressed to the point where they were no longer able to get out and about on their own. They were isolated at home but also unable to be left alone. Paul's Club has provided for them a new community of friends within the group, and it has them out walking in the neighbourhood every day where they are visible, active, and engaged with the broader community.

The second example I will share is Arts & Health: Healthy Aging Through the Arts, a program in which community centres across the city are offering weekly workshops for older people to work together for a year with a professional artist. It targets those who are identified as being at risk for isolation and marginalization. Our research showed that this program enabled these groups to make a real contribution to their community, bringing their artistic creations into public space and building social connections, while also improving members' physical and emotional health, but probably most importantly, what we saw was that it allowed them to build a real sense of belonging.

The program began in 2006 as a collaboration initially between the city and the regional health authority. It's my understanding that the health funding has essentially disappeared over time, but the programs themselves have continued, and in fact they've grown, becoming much more deeply rooted in their local neighbourhoods.

This research is really offering examples of how these kinds of groups can improve physical and emotional health for seniors, but the strongest finding, consistently, is how it enhances their social inclusion.

I'm not the kind of researcher who's going to argue that it will reduce health care costs. That's not the work I do. But I do argue that these are the kinds of supports we want to have in Canada as we grow older. It's not only to support well-being and quality of life so we feel and do better as individuals, but that we want our society to be one that welcomes age and that allows space for older people to not only be well supported but to contribute as active social citizens.

● (1540)

As for “where next?”, the evidence is growing that these kinds of programs work, especially for the groups that are offering physical and creative activities for older people. These are becoming increasingly popular across Canada and internationally as well.

To some extent, it's now a matter of sorting out details—what kinds of programs work best for whom, and which particular approaches work best—but the big question remains, which is about how to create solutions that make these kinds of grassroots initiatives more broadly accessible. There are very real challenges, of course, and there's always the matter of funding. These groups tend to expend a lot of energy finding sufficient money to keep going, so what kinds of funding models might work better?

Also, reaching the target group isn't easy. Those who are isolated can be very hard to find. Even when we succeed, transportation is a really important issue. How do we bring people together, especially when they're outside urban centres? Transportation isn't just about making sure people get to the doctor's office. It's also about seniors getting out to attend meetings and to meet with friends and stay connected.

My final point is about the community capacity to provide these kinds of programs, which remains quite limited. Here, I'm talking about two things. There's capacity in terms of the knowledge and skills that are required to work with a population that can be quite complex, but also, and I would say more importantly, we need to build capacity in terms of our collective awareness and understanding around aging and, in particular, dementia. For too long, our awareness has been couched in fear of the so-called grey tsunami. Our work is showing that we really need to confront that problem of underlying ageism if we're truly to be an aging-inclusive society.

Thank you.

The Chair: Thank you very much.

For the next seven minutes we will hear from Ms. Pat Armstrong, a research associate from the Canadian Centre for Policy Alternatives.

Dr. Pat Armstrong (Research Associate, Canadian Centre for Policy Alternatives): I am also a professor at York University.

Thank you for inviting me here today, and for your attention to advancing inclusion and the quality of life for seniors. My presentation is based on my many years of research, which have made it clear that inclusion and quality of life are at least as important within health services as they are outside of them.

Today I want to focus on three main issues—namely, access to appropriate health services, the scope of home care, and the quality of long-term residential care.

I begin with health services. As I am sure you know, the 1964 Hall Royal Commission on Health Services concluded, on the basis of a thorough investigation of the evidence, that covering the full range of services was the only logical and money-saving way to coordinate care, ensure that people were receiving appropriate care, and eliminate both the expense and the delay of sorting the deserving from the undeserving. But the federal government decided it would start with hospitals, and then doctor care, before moving on to other services—an expansion that never happened.

The evidence gathered by the royal commission is still relevant today, and the need for universal, coordinated coverage of the full range of services is even more urgent with population aging. The growing numbers with chronic health issues need to be able to move smoothly among services and be treated within them by those who understand geriatric care.

We need a national initiative, similar to the Canada Health Act, to ensure universal, accessible, and comprehensive care, and to finally complete the project begun long ago. Our seniors, who struggled to bring us our most popular social program, deserve no less, and our search for equity requires it.

I now turn to my second issue. Care at home is claimed to be the first choice of everyone, and certainly this is what my friends say, but my friends are middle class and have pensions and a wide circle of family and other friends. The notion that everyone is best cared for at home ignores the fact that many people have no safe, healthy homes, and that many homes are not havens in a heartless world, as the feminists used to say.

Smaller families, more singles, and the need for children to move to find employment are among the factors that mean that many people have no family or friends near enough to provide care or companionship. The aging-in-place solution also ignores the fact that many people require skilled care that cannot easily be provided by partners and friends, who are themselves getting older, and it ignores the fact that many people live in places unsuitable for those very heavy care needs. I live in an old Victorian house that is full of stairs. You have to use three sets of stairs to get into it, and I can tell you that those lifts you see on TV won't fit on my stairwells.

Finally, care at home often means isolation at home, as we just heard, especially if the only accessible groceries are at Walmart, miles away, and the local bank has closed. Isolation is the opposite of inclusion.

The focus on care at home often ignores the conditions of work for those providing paid and unpaid care, at the same time as it fails to understand the skills as well as the risks involved for both patients and care providers. In other words, we cannot rely on care at home to provide for many of the current care needs. For those who can be cared for at home, we need to provide enough paid staff with appropriate skills, and create working conditions that ensure quality of life for those who provide, as well as for those who need, care.

Finally, I want to focus on long-term residential care. Very few people plan to go into long-term residential care, and most governments, as well as much of the population and many staff, see it as a last and worst resort. But no matter how much we focus on aging in place, we are all potential residents and have a vested interest in ensuring the quality of care there.

As a senior manager we interviewed in Ontario explained, “The average length of stay or living in the home is 18 months, and every day I say, ‘If you had only 18 months to 24 months of life left, what do you want it to be?’ And it's our job to make that the best it can be.” The job belongs not only to that manager and those staff, but to all of us. Our eight years of team research and studies of 27 care homes in six different countries have convinced us that the conditions of work are the conditions of care. You cannot have resident-focused care without creating the working conditions that allow for such care.

● (1545)

Right now in Canada, we too often fail to provide those conditions, which is one reason why those who provide direct care in these homes have the highest rates of absence due to illness and injury. Indeed, staff in care homes are more likely to get injured than police officers or firefighters.

If we are to focus on adding life to years rather than simply focusing on adding years to life, we need to understand the importance of not only having enough staff but also having enough staff with appropriate education and conditions that ensure continuity in staff. Higher turnover rates and reliance on casual, part-time, and agency staff increases the risk of injury while undermining the care relationships that prevent violence and provide quality of life for seniors, to name only some of the working conditions at issue. A significant body of research also indicates that ownership matters, and that the quality of care tends to be lower in for-profit homes.

In conclusion, I would add that the consequences of our current system are profoundly gendered. Women live longer than men, use the health system more, and have fewer economic resources, so the failure to provide care has a gendered impact. The impact is unequal among women as well. Women also provide the overwhelming majority of paid and unpaid care work, so poor conditions of work have the greatest impact on them. In home and residential care, a significant number of those women are from immigrant and racialized communities. We need a federal initiative to ensure universal access to the full range of health services delivered by non-profit organizations based on the same principles as the Canada Health Act. This also means a human resource strategy that ensures appropriate conditions of work. We need to do it now, before it's too late.

Thank you.

I'm sorry about my voice, I have a chronic issue in my throat.

The Chair: There is no apology necessary. We've all been there.

Thank you very much.

We are now going to the National Initiative for the Care of the Elderly, to Mr. Raza Mirza, network manager.

You have seven minutes.

● (1550)

Dr. Raza M. Mirza (Network Manager, National Initiative for the Care of the Elderly): Thank you, Chair, and thank you to the committee for having me here today.

I'm both a senior research associate at the University of Toronto and the network manager for the National Initiative for the Care of the Elderly, also known as NICE. I'm here today in my capacity as the network manager to represent the board of directors and the scientific director of NICE, who was unable to join us today due to other commitments.

What NICE is here to suggest today is that the foundation for improving the overall quality of life and well-being for older adults, including those factors associated with community programming, social inclusivity, and social determinants of health, is by building capacity among older adults to become mainstream social citizens instead of being ghettoized through separate health and service systems. This foundation also requires new policy and practice responses based on well-funded research and evidence that captures the complex issues facing an aging population.

As an organization, NICE is an international centre for excellence, funded by the national centres of excellence, and is a not-for-profit charitable organization that was initiated in 2005. NICE is a knowledge transfer and exchange network that works to improve the care of older adults in Canada and abroad. We accomplish this by placing valid and reliable knowledge on aging into the hands of those who need it. This includes older adults, their family members, practitioners across disciplines—which includes nursing, social work, and law enforcement, as some of the examples of these disciplines—students, and policy-makers.

NICE accomplishes this work through a few different mechanisms. One mechanism is through research. Another is through the use of theme teams, where our teams are led by a researcher and a practitioner, who do work on different aspects of aging. NICE currently has 12 theme teams, which includes teams working on issues related to elder abuse, dementia care, mental health, dental care, caregiving, and financial literacy, to name a few. The third mechanism is making tools from evidence-based research that has never seen the light of day.

NICE is fortunate to have a very large membership, with close to 4,000 members worldwide and official representation from 14 different countries. We continue to find ways to build up our membership to facilitate access to knowledge on aging around the country and the world. Our international arm, ICCE, the International Collaboration for the Care of the Elderly, gives Canada a world footprint in aging, but benefits us through returns on knowledge about aging and diversity. Our network is an important resource for many, as current professionals are not always up to date. The knowledge base in gerontology and geriatrics remains thin, and attracting new students to the field is still a challenge.

NICE has conducted research regionally, nationally, and internationally. This has provided us with important insights and lessons. As a result, the work we have undertaken at NICE has been evidence-based, and as a result we have developed over 200 tools in various languages to help improve the care of the elderly. These tools have been developed from the research we have conducted—I will speak specifically about this research today—and we focus on those insights that can provide us with the opportunity to work with older adults and improve the overall quality of life and well-being for seniors.

From the NICE perspective, it is crucial that decisions are made with older adults and not for older adults, that one of the ways to do this is to fund more gerontological research that partners in a meaningful way with older adults in Canada, and that we make sure we translate this knowledge to action through evidence-based changes to policy and practice.

We achieved a historic milestone in Canada last year, with Canadian older adults outnumbering their counterparts for the first time in our nation's history. This milestone was met with hope and optimism as older adults, in general, are living longer, are healthier, and are wealthier. However, we at NICE have also met this milestone with renewed efforts in our research, our training, and education programming to further improve the quality of life for more older adults.

When we look beyond the general experiences of older adults in our country, and the average older Canadian, we get a better view of the most vulnerable populations needing support. Our research has specifically focused on those populations, and includes victims of elder abuse; older members of the aboriginal community; those who are socially isolated, and often from diverse and rural communities; grandparents who are parenting again in later life; older adults who may not be financially literate; those living in poverty, mainly older women; those vulnerable to grey divorce or financial abuse and exploitation; and those who are unable to access quality end-of-life care with respect to hospice and palliative care.

As a dimension of unequal social citizenship, older adults are frequently subject to ageism, which is manifest in many subtle ways through discrimination in the workplace, transportation, the denial of the right to quality care, and ghettoized housing and services.

● (1555)

If older adults are not treated like all other citizens, they're often socially excluded within their own communities. NICE is firmly committed to the perspective that older adults are indeed adult citizens and have the right to be responsible for themselves.

Social citizenship for older adults has been identified as a priority topic in Canada by the Standing Senate Committee on Social Affairs, Science and Technology, Employment and Social Development Canada, the National Seniors Council, and the Ontario seniors strategy, to name a few. Social citizenship, broadly defined, suggests equality of status in society and the right to membership of a community, the right to economic welfare and security. When we link this to quality of life and the social determinants of health applied to an aging population, the importance of social citizenship becomes even clearer. Although the research on the implications of differing rights and opportunities and social citizenship is very thin and limited, research has shown that approximately one in four older adults in Canada desire greater social involvement within their communities. Social inclusion was identified as a priority topic for social determinants of well-being.

Social isolation has also been flagged as a major health and social problem in older adults, and is not a normal part of aging. In particular, persons from diverse ethnic backgrounds may be at higher risk for social isolation, since they may be recent immigrants and may not be fluent in English. Social isolation is a complex issue, and may be a result of physical and social environments that are not built to support older persons and may be age-unfriendly.

To conclude, NICE is committed to the development of evidence-based knowledge supported by designated funding for research with older vulnerable populations, and for better training of gerontological geriatric students, policy-makers, and practitioners. Most critically, the straightforward education of older persons themselves sends the message that they can become active citizens, and are expected to be active citizens, contributing to Canadian society.

Again, we at NICE would like to emphasize the importance of research in gerontology and geriatrics that may better inform the directions we take in developing a national seniors strategy that matches the realities of a new generation of older adults in Canada.

Thank you very much.

The Chair: Thank you very much.

Now we're going to go to FADOQ.

Danis Prud'homme, the next seven minutes are yours.

Mr. Danis Prud'homme (Chief Executive Officer, Réseau FADOQ): Thank you, Mr. Chairman.

I'll be making my presentation in French, although you do have copies of my presentation in English and French as well as the full briefing.

[*Translation*]

Members of the Standing Committee on Human Resources, Skills and Social Development, and the Status of Persons with Disabilities, hello.

I am honoured to represent the Réseau FADOQ today as part of these special consultations which we sincerely hope will lead to the development of a national strategy on aging in Canada.

Allow me first to introduce you to our organization. Founded 47 years ago, the Réseau FADOQ is the largest seniors' organization in the country, with nearly 500,000 active members aged 50 and over.

The Réseau FADOQ is the undisputed leader among organizations defending the rights of seniors in Québec, seizing any opportunity to speak out and advance our main cause: to obtain an adequate quality of life for all seniors. The Réseau is also a strong advocate for active aging, as we offer a wide range of sports, recreational and cultural activities that get more than 70,000 seniors a week moving. In addition, there are nearly 1,500 discounts and privileges available with a FADOQ membership card, which help seniors maximize their purchasing power at a time when many of them are increasingly impoverished.

The Réseau FADOQ doesn't hesitate to use the enormous power of influence conferred by our impressive number of members in the service of critical issues. The gains obtained by the Réseau in recent years are significant. Whether working alone or in collaboration with partners, they include: the abolition of accessory health care fees, automatic enrolment in the Guaranteed Income Supplement, and the reinstatement at age 65 of eligibility for the provincial age amount tax credit, to name just a few.

For some years now, the Réseau has been calling for the development of an aging policy in Québec, because we believe that coordination and the introduction of a holistic vision of aging are the cornerstones of real improvements in the quality of seniors' lives. In addition, for the past five years, the Réseau has represented Canadian seniors' organizations at the UN in the Open-Ended Working Group on Aging, which is striving to create a comprehensive and integrated international, global instrument for the promotion and protection of the rights and dignity of the elderly.

It is therefore only natural for the Réseau FADOQ to applaud the consultations that are taking place now, which will lay the foundations of a strategy on aging for the entire country. The policy that will emerge for seniors' quality of life is crucial, not only for seniors, but for the future of the country. We firmly believe that such an instrument is the only way to adequately address the demographic challenges that are already underway, and increasing at record speed.

It goes without saying that we offer our full collaboration in this essential process, for which we have high hopes, because it will provide a common and unique direction and be conducive to action. Indeed, what is the purpose of cooperating and sharing our different expertise, if at the end of the day we do not follow up with concrete action? We must put knowledge into action; otherwise, the exercise will be in vain and seniors will pay a high price.

I come now to the main recommendations contained in this brief, resulting from nearly five decades of work entirely devoted to all facets of seniors' quality of life.

First, the Réseau FADOQ recommends the creation of a seniors' secretariat under the Federal Executive Council. We also suggest that all current and future public policies be looked at through a "seniors' lens." And we would welcome an upgrade of the National Seniors Council, so that it might become a locus of collaboration for organizations such as ours.

In terms of income, it is clear that the management and administration of the GIS must be reviewed and that this benefit must be improved. As for employers, the government must commit to raising awareness of their role in intergenerational equity and the financial health of future retirees, and encourage them to offer supplemental pension plans.

With regard to housing, the Réseau FADOQ believes that the Canadian government must showcase innovation and be a strong proponent of universal accessibility standards for all new construction financed with public funds, so that communities can evolve according to demographic needs. In addition, the Canadian government must lead by example in encouraging businesses to maintain local services.

Moving on to the central theme of health, I should mention the urgent shift towards better home care. The federal government needs to provide leadership on this issue and mobilize the provinces. To this end, one essential route is to provide better health transfers exclusively dedicated to home care and services.

● (1600)

In addition, we believe that the Canadian government should enshrine, in the Canada Health Act, a plan to provide minimum and equitable access to home care and services for all Canadians.

With respect to the Canadian health care system, it is essential to ensure its universality. With regard to measures directly related to health, the Réseau FADOQ suggests that the federal government be inspired by the National Health Plan presented by the Canadian Medical Association, including the framework specific to the rise of dementia currently faced by society.

Another request is the establishment of a national drug program, which would ensure equity among Canadians. In the same spirit of equity, as well as to better support seniors experiencing loss of autonomy, we hope that health transfers will take population aging into account and be paid out according to the proportion of seniors in the populations of each province and territory.

We can’t talk about the health of seniors without addressing the almost inhuman experiences of some family caregivers, whose numbers are expected to grow rapidly. On their behalf, we demand more substantial compensatory measures and a guarantee of employment for family caregivers in urgent situations.

Finally, we would like to remind you that adequate intervention is based on a situational analysis that is as accurate as possible. In this regard, it is important that future censuses allow seniors living in private seniors' residences to complete their own questionnaires, rather than making it the responsibility of the residence’s management.

In conclusion, let me assure you of the Réseau FADOQ’s full collaboration in the development of a national strategy on aging in Canada. Our expertise is at your service and we will closely monitor what is most essential to this process: the deployment of real actions that will improve seniors’ quality of life, today and tomorrow, throughout the country.

[*English*]

The Chair: That's fantastic. Thank you very much.

And now—our fingers are crossed—I believe we have Dr. Cottle not on video conference but on phone conference.

Can you hear me?

Dr. Margaret M. Cottle: Yes. Can you hear me?

The Chair: We can, and it's crystal clear.

Dr. Margaret M. Cottle: Okay.

I won't be able to see you indicate when my seven minutes are up, but I did time my presentation twice. I'm just going to read the whole thing and you will have to bear with me.

● (1605)

The Chair: We'll allow you to do that. Thank you very much for your patience. I'm glad we'll be able to hear from you.

Dr. Margaret M. Cottle: Thank you.

I'm sorry to have missed many of the other presentations. They were very interesting, and I'm very grateful to be part of the conversation.

My name is Dr. Margaret Cottle. I am a palliative care physician and a clinical assistant professor at the UBC Faculty of Medicine. For almost 30 years I have devoted my practice solely to the care of patients with serious illnesses and to their loved ones, especially in home care settings. I have many years of first-hand experience with patients and families who are enduring exclusion and a diminished quality of life mainly due to the lack of will in our society to provide the necessary resources. I find this distressing, since we seem to find the funds for multi-million dollar contracts for sport and entertainment celebrities.

Canada is a signatory to the United Nations' Universal Declaration of Human Rights. The preamble begins:

> Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Article 25.1 states:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

At present, we in Canada fall far short of this very basic standard.

Loneliness, isolation, and vulnerability have been front and centre in my practice. A patient I will refer to as Joe is found in his home dehydrated, delirious, and combative. The open wound caused by his facial cancer is crawling with maggots. In the middle of a large, affluent city, he has no one to care for him. Even when family members are able to help, they are often stretched past the breaking point both physically and emotionally, and they face financial hardships and repercussions in their workplaces. We are scandalously tight-fisted, and do not provide enough sustainable support to the families who do this crucial work more cost-effectively and with deeper love than anyone hired to do so.

Frail senior citizens have many concerns in common with people in the disability community. Dr. Carol J. Gill of the Department of Disability and Human Development at the University of Illinois at Chicago, herself a polio survivor with significant motor and respiratory disabilities, has interesting insights into vulnerability. I commend to you for your review her two excellent articles. Although written for different contexts, they are extremely pertinent to our discussion. She points out that vulnerability is socially constructed rather then inherent in our physical or cognitive conditions. Her example is as follows:

> All my life I've been told that I can't get into my neighbourhood restaurant because my legs won't take me up stairs. Now I know it's because the restaurant owner won't build a ramp.

She also notes that needing help is a “socially created indignity”.

She continues:

> It is the way people with disabilities are treated and regarded socially that leads anyone to feel ashamed if they need help to use a toilet. It is the stigma of disability that strikes fear into the heart of individuals who can no longer live independently or appear “normal”. It is the economics and social arrangements of disability that transform ill people into family burdens or nursing home inmates.

She writes:

> The public generally equates disability with suffering. Because I have physical limitations, need help from others, and use devices such as a wheelchair and ventilator, many observers perceive me as a sufferer. I do not draw the same conclusion. Ironically, their prejudgments cause me more suffering than my impairments do. Having suffering incorrectly attributed to us when we are simply living our lives differently is a quintessential disability experience.

Again, she writes:

> We are, in fact, much more frightened by the doctors who are out to help us but who see our lives as burdensome and who know little about options that make life with disability valuable. We know that the misplaced pity and pessimism of such doctors is reinforced by the medical institutions surrounding them, the policies that guide them, the health care funding system that rewards them for holding costs down, and the prevailing culture that influences their thinking about disability.

● (1610)

She also says the following:

> It is difficult for most people to believe that life with an extensive disability can be anything but suffering, and that suffering can be anything but dehumanizing. Perhaps, along with tolerance for imperfection, the public spirit has lost some of that down-to-earth courage in the face of human difficulties that carried previous generations through very hard times. I have also noticed how narrow the public imagination has become about what makes life valuable—so unimaginatively narrow that it cannot seem to encompass those two realities—disability and full humanity—simultaneously.

Here's one final quote from Dr. Gill:

> Anyone at any age can benefit from measures to enhance her/his self-determination, including dignified professional assistance at home, respectful responses to one’s everyday preferences, companionship or privacy as desired, and reassurance that the changes of aging and illness do not reduce one’s humanity and worth.

My conclusion is this. Every person deserves to be respected and cared for not “as if” she or he were a member of the human family, but precisely because he or she “is already” a full member of the human family. I hope that we will dream big dreams, that we can envision a Canada where love and community support are extended to every member of the human family; where all our citizens enjoy freedom, justice, and peace; that every life will be acknowledged as one worth living; and that we count it a privilege, not a burden, to care for each other, even when it is difficult. Government programs cannot change hearts, but they can foster compassionate communities and facilitate systems of care that will support those who bring love into the lives of every citizen. I sincerely hope that you will find creative solutions that can be implemented without delay. The need is profound and urgent.

Thank you.

The Chair: Thank you, Dr. Cottle, and well said. I'm very pleased that we were able to hear your words, if not see you deliver them.

Before we get into the first round of questions, I have just a little bit of housekeeping. We are expecting bells at about 5:15, and we will have to wrap up at that point. We also have some committee business to conduct. I'm going to suggest that we will likely have time to get through the two rounds of questions, but we'll shoot to break for committee business at five o'clock.

I'd like to welcome and thank MP Doherty for joining us here today.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Thank you.

The Chair: Our first batter up is MP Warawa.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Thank you, Chair.

Thank you to the witnesses for their excellent presentations.

We have limits in time to hear from you, and I'm sure you have a lot more to share with us than the seven minutes and answering some questions will allow you. Could you each ensure that you have provided us a written brief along with your recommendations, which we would translate? The purpose of today is to hear your testimony. We'll be creating a report with recommendations to the government. If you have specific recommendations, it would really help to condense what you are recommending that the government include.

The focus is on whether we need a national seniors strategy. Do we need to have a recommendation of leadership in all the different levels of government? We heard some comments on that. Does the federal government, in providing leadership, need to have a minister for seniors? We heard about the secretariat. It sounds very interesting. Do we recommend that each province have a person who is in the lead so that we have a point person in every level of government? From the last witness we heard that the need is profound and urgent. We have a very quickly aging population, and it's not consistent across Canada. Some areas have a very large senior population.

I will start off with you, Dr. Cottle. Your examples were profound and actually gut-wrenching that we are not taking care of our senior population already. We heard that there is limited involvement in geriatrics. You are a physician in palliative care. There are not that many. In my riding of Langley, there is one palliative care doctor with a population of around 140,000 people. It's a great place to retire. I don't know statistically the percentage right now, but I'm guessing probably about one in four or one in five is a senior. Even around this table, you probably have one in four who is a senior. I'm a senior.

● (1615)

Hon. Alice Wong (Richmond Centre, CPC): I'm a senior.

Mr. Mark Warawa: My good friend Monsieur Robillard is a senior. Maybe even a half of us qualify for that discount.

How do we, in a very short period of time and in a coordinated and effective way, meet the needs of seniors? From the examples we heard from you, Dr. Cottle, we're already not doing it. What is the low-hanging fruit that we can quickly enact so that we can start moving in the right direction? At this point, I see we're not prepared and it's already not happening. Could you comment on that, please?

Dr. Margaret M. Cottle: I suppose if I had that answer, I could rule the world. One thing that's been very interesting to me is that I have heard—it would be something for the committee to look into—that in the country of Denmark, they have not opened any new hospitals and have closed some long-term beds. They have put their money and their resources into home care.

I know that home care is not for everyone. I was very interested in the things one of the other witnesses was talking about, that it isn't for everyone. But is for a lot of people. Many people are not getting home care because they aren't supported. They can't get time off from work that's significant enough. There have been some recent changes in the EI laws and regulations, but it's not enough for someone who is dealing with caring for a parent with dementia, for example, which may take five or 10 years to do so.

We have great resources with our families. I have been taking care of people at home for 30 years. The families are more committed on the whole—it's not universal, but on the whole—and more loving toward the patients and their loved ones than anybody you can hire from the outside. They also tend to understand the person and what the needs are. But they need help. They need to have some outside help to come in and give them a break. They need help with their work.

To be honest, I think supporting the people who are already doing the work, and making sure they don't burn out such that the loved one ends up in a nursing home or dumped in an emergency room, would be certainly a good place to start.

Mr. Mark Warawa: Pat Armstrong, you talked about training more people in geriatrics. How do we get more people trained? Pediatrics has the attraction of beautiful babies, and you get paid more in pediatrics. How do we get more people involved with geriatrics?

Dr. Pat Armstrong: I think one of the things we need to do is make it part of the apprenticeship program that doctors and nurses go through. You actually have to do a cycle that is with older people. I think the idea of bringing a seniors lens to all of our strategies is a really good place to start. It's about housing. It's about all of our policies. It's not just a seniors policy that is isolated from other policies. We really do have to think about that.

I also want us to think about long-term residential care. I think it is really important. We basically don't want to talk about it—Romanow didn't talk about it—because we want to forget about it. There are an awful lot of people who are going to have to live in long-term residential care. We need to think about ways to make it as good as it can be rather than say we'll put everybody at home, because we can't do that. I really want to make an extra plea for long-term residential care.

The Chair: Thank you very much.

We'll now go to Mr. Robillard for six minutes.

● (1620)

[*Translation*]

Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.): I have five questions for you, Mr. Prud'homme. If I don't have time to ask them all, I will work with the clerk of the committee to submit them to you in writing so you can answer each of them, and we can then in turn consider your answers in our study. I hope you are agreeable to that.

First, I would like to thank you for everything you do for our seniors in Quebec and welcome you to the HUMA committee. I believe your network has a program that helps seniors get acquainted with iPads and other technologies such as Word and Excel.

Can you tell us about the success of that program?

Mr. Danis Prud'homme: Of course. Thank you for giving me the opportunity to talk about it.

We had to implement this program, which has been around for about 10 years. The groups now have a maximum of eight to ten people, and the instructor is a volunteer close in age to the learners. We train about 5,000 people per year. We started this to keep pace with changes in society, which is completely natural. We must not forget our people though. Today's teenagers were born with those devices in their hands, whereas our seniors never had access to them at that age. So we have to teach them to use these tools if we want them to learn to keep pace with us and include them in our society.

Mr. Yves Robillard: Can you tell us about the trends among seniors that your network is seeing?

What issues and needs have become more pressing since the Réseau FADOQ was founded, in 1970?

Mr. Danis Prud'homme: Our first objective was to break their isolation. Even at that time, the aging population was isolated. We had to create spaces where women and men could interact and engage in activities they enjoyed. That was the first thing we noticed.

A few years ago, we created something we call a social contract to foster an acceptable quality of life for seniors, based on the four pillars of health, safety, well-being, and belonging. These four pillars cover all the problems we see today. People are poor and isolated, need housing, activities, and adequate income.

Mr. Yves Robillard: As I understand it, anyone in Quebec aged 50 or over can belong to your organization. It does not matter if the person is retired, not yet retired, or still working.

Can you elaborate on the strategy you adopted in this regard?

Why not use age as a criterion? Do you think that is more effective and produces more positive results for our citizens aged 50 and over?

Mr. Danis Prud'homme: When the FADOQ network was created, we focused on the sector of the population that was having problems, such as individuals who were isolated.

Over time, we have seen this sector of the population shift from the age of 60, to 55, and now to 50. We hope it does not get to age 25 some day, because that might point to problems that are not being addressed and that we would have to address.

In the case of experienced working people, for example, we now see that it is increasingly difficult even for individuals aged 45, or closer to 50, to find a new job if they lose theirs.

Our approach is based on the difficulties experienced and, after the age of 50, people start having more problems.

Mr. Yves Robillard: How could a national seniors' strategy be geared to individuals before they retire? How do the issues differ as compared to retirees or seniors who are still working? How should the government respond?

Mr. Danis Prud'homme: We do not like the word “retired” actually because it is not properly defined. Retired means that a person takes back their life and uses it differently, rather than not doing anything at all. These are people who are still active.

We have 15,000 volunteers and 800 boards of directors in our organization. Without volunteers, the FADOQ network would not exist. Most of our family caregivers are people who work, at least the women in some cases, and are 60 and over. These people all contribute to society.

In talking about retirees and people before they retire, we see age as a continuum. When we are born, we need help. At the end of our lives, we need help. We give back to society, whether we are working or not. Volunteers contribute more than people who are working because they are not paid. The contribution is very positive and there is a good return on investment.

● (1625)

Mr. Yves Robillard: Do I have any time left?

[*English*]

The Chair: You have one more minute.

Mr. Yves Robillard: It's a long question. Can I pass my time and come back later?

The Chair: You can't pass your time and do it later. If you're done, you can share.... Go ahead and get it on the record.

[*Translation*]

Mr. Yves Robillard: I understand that the FADOQ network has joined the UN's Global Action on Aging committee, or GAA, to establish an international convention on the rights of seniors. Your website indicates that you defend the following causes: dying with dignity; equality between senior women and men; experienced workers; housing; poverty; abuse; and retirement income.

What can you tell us about your work with the UN to help develop our government's national strategy for seniors?

[*English*]

The Chair: Keep the answer very brief, please.

[*Translation*]

Mr. Danis Prud'homme: After five years of work, it has been shown that seniors are not protected, in any part of the world. We need a tool to protect them, such as a convention. A convention provides the basis for a policy to ensure that things are done properly. Those two aspects are interrelated.

Mr. Yves Robillard: Thank you.

[*English*]

The Chair: Thank you very much.

Now we'll go to MP Blaney.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you so much, everybody, for being here today.

I want to start by asking a very quick question. Perhaps you could just answer yes, no, or abstain. The question is this: do you believe the government should implement a national seniors strategy?

Dr. Cottle, perhaps I could ask you first.

Dr. Margaret M. Cottle: I'm going to equivocate—I know this is a political meeting—because to me it would depend what it looked like.

Ms. Rachel Blaney: So you abstain.

Professor Phinney.

Dr. Alison Phinney: Well, I won't abstain. I would say, yes, I believe there should be a national strategy.

Ms. Rachel Blaney: Thank you so much.

Pat.

Dr. Pat Armstrong: It depends. So I guess that's an abstention.

Ms. Rachel Blaney: Thank you.

Yes, no, or abstain, Dr. Mirza?

Dr. Raza M. Mirza: It's a yes for me.

Ms. Rachel Blaney: Mr. Prud'homme.

Mr. Danis Prud'homme: It's 100% yes.

Ms. Rachel Blaney: Thank you so much.

Pat, in previous discussions we've heard witnesses talk about national standards for senior care providers. Do you think we should have minimum direct care staffing, things such as hours per resident per day?

Dr. Pat Armstrong: Yes, absolutely. The problem with minimums, of course, is that they often become the maximum, but without at least a minimum, people aren't getting enough care.

Ms. Rachel Blaney: Yes. Thank you.

The other thing we've heard a lot about is just staffing for long-term care. Training and a lack of qualified people have been the top two concerns shared with me. Could you share your thoughts on that, and also give your opinion about working conditions as a major factor, with a few examples of how to make working conditions better and how that would make a difference?

Dr. Pat Armstrong: I can tell you one difference it would make. Our project has Nordic countries in it, as well as Canada, and a number of years ago we did a survey that we're now repeating on people who work in long-term residential care and home care. One of the things we asked about was violence. The levels of violence experienced by the Canadians who are providing care are reported to be much higher than those in the Nordic countries. The major difference is staffing levels. I think that's the fundamental condition.

The other condition, and this goes back to what we've heard from other people, is that continuity in care providers is absolutely critical to care, to the kind of care we heard about from Dr. Cottle, about knowing the person. You can't do that with casual staff. You can't do that with agency staff. You can't do that with people who don't know if they are going to have a job tomorrow. You have to do it by having as much full-time and regular staff as possible.

Ms. Rachel Blaney: Yes. You said that really well, that the amount of care, and the good care, is really based on the working conditions of the people. I think that's really important.

You also mentioned your concern about for-profit long-term and home care. Could you tell me a little about what those concerns are? And could national standards be part of a solution to some of those concerns?

Dr. Pat Armstrong: A host of research has been done, in part by Margaret McGregor and Charlene Harrington, both of whom are part of our research team, and by people here at Bruyère who have looked at hospital transfers, for instance. You're much more likely to have transfers from nursing homes to the hospital from for-profits than from not-for-profits. The verified complaints are much higher. The injury rates are higher. We have a whole host of indicators that suggest that the quality of care and the quality of the working conditions are different.

Now, it's a pattern; it's not exclusive. Certainly there are some good for-profit ones, just as there are some bad not-for-profit ones, but it's a significant pattern. There's a significant body of research indicating that you're better off in a non-profit home. In Ontario the wait-list for non-profit homes is way, way longer than for the for-profit homes, because people hear their reputation and look at the indicators.

● (1630)

Ms. Rachel Blaney: Can you talk a bit more broadly about how a national seniors strategy could promote care as a relationship?

Dr. Pat Armstrong: It's partly what I was trying to stress with this committee, that it's about human resources. Human resources has to pay attention to the conditions of work. We are relying increasingly on people from other countries to come to Canada to do this work. It's harder and harder to attract people within Canada to do the work, in part because it's insecure. It's precarious. In-home care is lower paid than in long-term care, and long-term care is lower paid than in hospital care. The work is heavier.

We need a strategy about training, but we also need to have the conditions so that people can use their training. We hear this all the time from people in long-term care, that they go home at night and cry because they could see what should have been done but couldn't do it. They just didn't have the time. So unless we have enough staff, and unless, to go back to the prior question, they have the kind of training they need...but the training's no good if you haven't the capacity to use the skills you have.

Ms. Rachel Blaney: We've heard that accessibility of the training is also a huge concern.

Dr. Pat Armstrong: Absolutely.

Ms. Rachel Blaney: It's not across the country in a fair way, and that adds to it as well. I think it goes back to the value of seniors—I have seven seconds left, Chair—and how we care for them.

The Chair: Actually, you don't, but thank you.

Ms. Rachel Blaney: I timed it.

The Chair: Mr. Ruimy.

Mr. Dan Ruimy (Pitt Meadows—Maple Ridge, Lib.): Thank you all very much for coming today and presenting.

Clearly, we have some challenges ahead of us. As a first-time member of Parliament, first-time politician, a question ran through my mind: what have we been doing over the last 20 or 30 years to get us to this point?

There are so many different directions to go in, but I want to focus first on this. When we talk about care, we have the haves and the have-nots. I'll give you two stories. One, I'll say, is actually my father. We can't afford to put him in a home and pay for it, because that's $5,000 a month. So he's in a government organization, which is brutal, absolutely horrible. I have a friend whose father is going into...for the same thing. There's an opportunity, because they can afford $5,000 a month. That facility is miles ahead of where the government facility is.

I see this across the country. I see this in my riding. We have a great assisted-living facility, but you have to pay $5,000 a month. I don't know where you're going to get the money from. My concern is that if you can afford care, great, but what about the people who can't afford care?

Dr. Cottle and Ms. Armstrong, the things you're both talking about are great. It's all about compassion. It's all about home care. It's all about families. It's about love. But we need to be able to transfer that into actionables. That's where I want to focus.

Perhaps I can start with you, Pat. What are the actionable pieces that we need to do starting now, moving forward? It's not going to happen overnight—we know that—but we need actionables.

Dr. Pat Armstrong: First of all, I've been in a lot of really good non-profit homes, or homes that are publicly subsidized. In Canada we have an incredible provincial range. One of the papers out of our project, actually, is on the variation in the fees charged provincially and territorially in Canada, and whether they are means-tested. There's an extraordinary range just there. If we had some standards on that, it would help.

Everybody charges accommodation fees in the publicly subsidized homes. I think we do have some examples of working...but it needs more money. As I was saying before, what we hear about most in long-term care is staffing, food, and clothes, or laundry. Those are absolutely critical. In some provinces we're giving people three or four dollars a day to feed people in long-term care. Well, it's no wonder it tastes.... We've tasted them in every place, and I have to say we couldn't identify some of it.

We need more money but we need standards, and we don't need more regulation. I know that might sound surprising from me, but our response has been to add more and more regulations, which means they have to do more and more documentation, which takes more and more time away from providing care. We need to have more people providing the care rather than filling out forms about the care they didn't provide.

● (1635)

Mr. Dan Ruimy: Dr. Cottle, your thoughts?

Dr. Margaret M. Cottle: I certainly endorse everything Pat just said. I also agree; by talking about home care, I'm certainly not denigrating long-term care. We really need it. I have done palliative care in long-term care homes, and they are not all created equal. I had one where I had to get the gardener to let me in, and I couldn't find a nurse on two floors.

So it's desperate, what's happening. I think what government could do is not make more regulations but have some national standards. We need people who can get to know their patients. More people will come and work in that setting—because seniors are wonderful to work with—if it isn't so heart-wrenching when they get there.

In B.C. we just had a big court case and now in the schools they have to have a certain number of students. Okay, let's do that for our seniors too. Let's say you have to have a certain staffing ratio. You have to have a certain percentage of full-time staff so that the residents get used to the people who are there. That's what they really need, that relationship. The people who are working there will stay there if they can provide the loving care they're trained to provide for the people they're caring for. They're not going home in tears. They can do those things that they can see will make a big difference.

Mr. Dan Ruimy: I have very little time left, Dr. Cottle, but perhaps you can just quickly address dementia. Certainly there are mild cases, but once it goes full-blown they become a danger to themselves, and they can become a danger to the people around them.

Dr. Margaret M. Cottle: Yes.

Mr. Dan Ruimy: How do we even tackle that?

The Chair: Be very brief, please.

Dr. Margaret M. Cottle: Well, it's not a brief thing, but I would say we need to look at what's happening in other countries. Even in Quebec there are some wonderful models there that are based in homes. There are facilities that are doing a better job than we're doing just warehousing people. It's very hard for people to be cared for at home in the final stages, but we need to look around the world, find the things so that we don't reinvent the wheel, and then do those things that would be helpful in our settings.

The Chair: Thanks.

Next we have MP Sangha. Maybe he could share some of his time with Mr. Ruimy.

Mr. Ramesh Sangha (Brampton Centre, Lib.): Thank you very much.

Thank you to all the expert witnesses giving input to the committee today.

To Mr. Mirza, we've been talking here about isolation and inclusion in the system. We've also been talking about the reasons that people become isolated, such as critical health conditions or other things. Everybody talks about providing better services to seniors. Every one of us knows that we will get to that stage. How would you recommend that social inclusivity, engagement, and healthy aging of Canadian seniors be addressed within the context of the national seniors strategy that we've been talking about?

● (1640)

Dr. Raza M. Mirza: I'll quickly go over some of the risk factors that we have from our own research at NICE. We looked at social isolation within the context of age-friendly communities. That is one of my overall suggestions, that we look at how to empower communities to support older adults who stay in their homes. We know that older adults want to age in place; we've heard this a lot. We know that older adults want to not go to long-term care if they can stay within their communities and stay in their own homes and remain engaged.

We know from the literature that an individual who is over 80 years old, who is living alone, who has a compromised health status, who doesn't have a child or a contact with family, who lacks access to transportation, and who has low income or is disabled will be at risk for being socially isolated.

One of the problems that we encountered in the research studies we conducted through NICE on age-friendly communities, and we've heard this from other witnesses as well, is the fact that individuals who are socially isolated are very difficult to identify. They're isolated; therefore, we can't reach them. Often the problem is that when we do reach socially isolated individuals, it's in a state of crisis, so you'll find them in the emergency department. The next problem is that you've identified someone who is socially isolated, you've assessed them for the risk factors and they're at risk of being isolated, so now where do you refer them within the community? What services do you provide to those individuals? Where can you send them?

Within the larger context of social isolation, one of the risk factors we've also uncovered as a result of our work is that little opportunity for engagement within the community is a big problem, but the larger problem that participants from our study also suggested was that it's not mutually rewarding. The programming and the community initiatives have to be mutually rewarding. The older adult has to feel that they're contributing something to the programming and to the community, that the programming is not just for them but that they're able to contribute something back. That's the way we should approach programming.

Mr. Ramesh Sangha: There are two situations here. One is that those who are very critically ill need to go to long-term care. But there are the other seniors, those who can stay home and can be taken care of by the family members and by some experts from time to time. Those people who are taking care of them at home are doing it out of love and affection. That's what Dr. Cottle talked about, that we have to be compassionate, that communities have to be compassionate, but the government has to do something.

What steps do you think the government can take?

Dr. Raza M. Mirza: If we look at it in the bigger picture and the fact that age-friendly communities, compassionate communities, and what we're talking about doesn't happen in a vacuum, and if we have to support those individuals who are going to participate in these communities and provide care for their loved ones in their homes and keep them out of hospital and out of long-term care, there has to be some flexibility built into income supports for caregivers. Caregivers are often having to choose the loved one, as you mentioned, at the expense of their own professional development, their own professional growth.

Having flexible work schedules or an accommodated schedule around an illness or a critical illness is important. I know there's compassionate care and bereavement leave, but—

Mr. Ramesh Sangha: Mr. Mirza, I have another short question.

Dr. Raza M. Mirza: Sure.

Mr. Ramesh Sangha: For those who are seniors and who are, say, new immigrants who are not very good at conversing in English, or haven't had a good education in IT and using the system, is your organization, NICE, doing something to help them? What would you suggest that the government adopt in terms of a program to help those types of seniors?

The Chair: You have 30 seconds.

Dr. Raza M. Mirza: I'll make it very brief.

There are three points I want to raise about immigrant communities. In our work at NICE, there are two groups of immigrants we're dealing with. There's a group of immigrants who came to Canada a long time ago, who've grown older in Canada; and there's a new group of immigrants who've come to Canada. Both of these groups are facing very similar challenges. Within the context of elder abuse, within the context of financial literacy, and also within the context of age-friendly communities, we do education and training and we conduct research to help facilitate, but it is on a very small scale. What I have been suggesting is that we need more education and more training, but we can't have that without the evidence and the research that goes behind it.

● (1645)

Mr. Ramesh Sangha: Thank you very much.

The Chair: Thank you very much.

MP Wong, please.

Hon. Alice Wong: Thank you, Mr. Chair.

Thank you very much to all the witnesses who took the time to respond to our questions.

First of all, I want to contextualize my question. I'd like to remind this committee that the previous government made seniors a top priority. I was honoured to have served as Minister of State for Seniors for five years. I have also had the honour of working together with NICE, and then with the long-term funding...and they've done an excellent job as well. In the previous government we were able to really look at issues of care, worker support, and taking care of the caretakers. What is unfortunate is that the current government does not prioritize seniors and their caretakers enough to continue our hard work on the file through a dedicated ministry.

I believe it was Danis who mentioned that you need a secretariat to really focus on seniors and then coordinate everything. You also need somebody who actually gives directions to the secretariat. I'd also like to say that, yes, some of the policies have been able to pass from the 41st session of Parliament to the 42nd—for example, the new horizons for seniors program. That is good funding for all the community groups that are helping to fight against elder abuse and helping, especially, seniors in isolation.

My question is this. Do you believe there is enough to address the dire financial straits many caregivers find themselves in? I know that our friends across also mentioned that about family caregivers. In some of my observations, some of them are also working at the same time.

I'd like to see if maybe Mr. Mirza could shed some light on that.

Dr. Raza M. Mirza: The group of caregivers that we think about are women. That's the first thing I'll tell you, and the literature will support that. The research we do at NICE will support that it is often a very gendered issue.

I want to focus for just one second on a group that we work with very heavily, which is grandparents raising grandchildren. They have stayed off the radar for a very long time, but we have conducted two national research studies with grandparents raising grandchildren. I can tell you about the situation for those caregivers. We don't often see that group as caregivers, we see it as a family responsibility when something has gone on, and it's an issue of family dynamics. Their financial situation is very dire. I can tell you that most of the participants in our study, 75% of them, were making between $15,000 and $50,000, and their legal fees for the year were way more than that. As a group of caregivers, that's very problematic.

I think we have to start to look at caregivers in separate groups. Dementia caregivers have different responsibilities and roles. Caregivers who are working with older adults who are in institutions are faced with different challenges and responsibilities. Caregivers for parents who are new immigrants who have language barriers also have very different challenges and roles. We have to start to unpack some of the ideas we hold with regard to caregivers and start to look at them as separate groups requiring very specific, targeted supports. I don't think the current support system is helping everybody out to the maximum level they can. We do work with vulnerable populations, and oftentimes they are heavily represented by caregivers who are women.

I'll tell you one last point, and then we can move on to someone else. Caregiving actually leads to a lot of family strife. Within the context of age-friendly communities, one of the things we recognized is that for those who are socially isolated, oftentimes it is as a result of family dynamics issues. It comes because of caregiving responsibilities sometimes. So if we can help support caregivers, we can empower and strengthen our communities and also take better care of our older citizens.

● (1650)

Hon. Alice Wong: Can I ask the same question of you, Dr. Cottle, my fellow British Columbian?

Dr. Margaret M. Cottle: Are we giving enough money to the caregivers?

Hon. Alice Wong: To help the family members who are working and also looking after their parents and grandparents.

Dr. Margaret M. Cottle: It's a very big issue. I think one of the things the federal government could do would be to give some tax incentives to people who are doing these kinds of things.

Our first witness talked about the informal community programs and how they can be supportive. Giving money to those types of programs will get you much more bang for your buck. In my opinion, we need to have our whole society engaged in caring for seniors, where, as I said in my brief, each person “is” part of our human family, not “as if” they're part of our human family. We all need to see this as our responsibility to care for each other, funding some of these grassroots programs that will be unique and helpful within the situations where they are. What you'll have in Weyburn, Saskatchewan, will be very different from what someone will need in the west end here in Vancouver. We need to support those community groups, through the seniors lens, who can give us, using lots of volunteers, really good value for the dollars we invest.

The Chair: Thank you very much for that.

MP Fortier, you have six minutes.

[*Translation*]

Mrs. Mona Fortier (Ottawa—Vanier, Lib.): Thank you very much. Your presentations were very interesting and very informative.

I have a number of questions, but above all I want to understand better.

I will begin with Mr. Prud'homme.

Your expertise in this area is really outstanding. If there were a better practice or model that we should examine more closely and invest in, or a strategy that we as the federal government could focus on, what would you suggest to us today?

Mr. Danis Prud'homme: That is a million-dollar question.

I would say that the situation in many places in the world should be studied. In Nordic countries, there is complete home support. The way they go about it, the budget they provide, and the various methods they use are determined in partnership with governments or family caregivers, but also with social economy enterprises and the community. A family caregiver cannot do everything alone, and neither can the government.

There are other examples from around the world. As to the social participation of communities, there are places where residences are built with day care centres alongside seniors' housing, that is, intergenerational housing, but on a larger scale. This is all about inclusion, keeping people active. In terms of isolation, as someone said, keeping seniors in their homes is one thing, but if there is no public or community transit in age-friendly municipalities, or AFM, if there are no services that seniors can use, and they are not considered when changes are made, such as if pedestrian walkways are not long enough, they will become isolated, even if they have home support.

It is a very complex issue.

Mrs. Mona Fortier: Thank you.

[*English*]

Madam Armstrong, following your presentation, I was trying to identify a solution or best practice that you think we should look at. If you could share that with us more precisely, it would be appreciated.

Dr. Pat Armstrong: In our current research, we've abandoned the term “best”. We talk about “promising”.

Mrs. Mona Fortier: Sure.

Dr. Pat Armstrong: To go back to Raza's answer, I think it depends on what the population is. I do think that if we have a national seniors strategy, it ought to be a strategy that parallels, as we heard earlier, the Canada Health Act, that sets down the standards, rather than standardization. There's a huge difference, I think. If we set down the principles that we're trying to attain in terms of seniors, which would include, I think, making sure that all strategy is analyzed in terms of its impact on seniors, then I think we could go a long way towards getting there if we set out a set of principles that are to apply more broadly, as opposed to saying that there is one single right way that we should approach this. It has worked in terms of our hospitals and doctors.

● (1655)

Mrs. Mona Fortier: Is there anywhere in the world that you've seen, maybe in your research, going forward with that approach?

Dr. Pat Armstrong: Certainly in my current research project, which is now eight years old, we have Germany, Sweden, Norway, the U.K., the United States—don't go there, especially not Texas, which is where we've been—and Canada. There's no question that we saw some very interesting practices in Germany, Sweden, and Norway especially. They don't have to do with regulation. They have to do with appropriate funding and appropriate staffing and trust as opposed to regulation and constant monitoring.

To go back to what I said about regulation, too much of our solution has been auditing again and again as opposed to figuring out how we can improve the situation. That would be one of the principles I would put in a national set of standards for seniors care.

Mrs. Mona Fortier: Thank you very much.

[*Translation*]

Mr. Prud'homme, since your organization is active throughout the province, I would like to turn to rural regions.

How can we support programs or initiatives in rural regions in particular?

Mr. Danis Prud'homme: The quick answer is through connection, that is, helping seniors stay connected to the rest of the world since, as we know, nearly everything is done over the Internet now.

As to transit, people in the regions need a driver's licence and a car since there are no transit services like those in big cities. People will therefore be isolated. As to community transit, there are different approaches. Services are very important. When services in a village are cut, the young people leave, while the seniors stay and die off slowly.

[*English*]

The Chair: MP Doherty, you have five minutes.

Mr. Todd Doherty: Thank you.

In these committees, sometimes we tend to be partisan, and we tend to say, “This is what we did; this is what they're not doing.”

I really appreciate being here today. This isn't the committee I normally sit on, but I think I can speak with some experience, because I've done a lot of work within my own community in terms of our women's shelter. I know that one of the most prevalent demographics in recent years in terms of those who are using our women's shelter is widowed seniors, females, who are now being housed in our women's shelter.

This is going to be more of a statement than a question, if that's okay with the committee. I very much appreciated the testimony of the witnesses who are here today, both on the phone and in person.

I would like to tell you a little about my family. My mom worked for a very long time in long-term care as well as home care. She is all of about five foot nothing, and she spoke quite a bit about the violence she encountered at the hands of some of her patients. She also spoke, over that time, about being all alone and having to restrain somebody who was much larger than she was. She first injured her back because of a violent outburst of a patient who didn't mean her harm but didn't know what he was doing at the time. She subsequently talked about, and does to this day, how she wishes she were still doing what she was doing, but she was unable to continue because of the lack of resources, whether it was in Alberta or in British Columbia, where she finished her career. She also talked about the fact that there was no lifting mechanism in the rooms, how sometimes she would have to physically try to move a patient who was much larger than she was, and how that impacted her physically.

If she were here today, she would talk to you, emotionally, about something that hasn't been mentioned today. She would talk to you about going into a first nations community to help a first nations senior.

I believe it was Ms. Phinney or Dr. Cottle who mentioned that sometimes home care isn't the best care for our seniors—not necessarily because of bad intentions but because they don't have the capacity to care for the seniors the way they really should be cared for.

I remember one where my mom told me that she went in to deal with this gentleman. It was on a Monday. The last she had seen him was on a Friday. She said her heart broke, as the gentleman was still sitting in the same spot he was sitting in on the Friday. He had not been moved. He was still sitting in the clothes and the undergarments and the sanitary products that she had put him in on Friday. The rash and the pain that this gentleman was in, and the frustration for being left there, looking out a window—that broke my mom's heart.

Now I'm going to talk to you about my brother, who really is my hero. He's battled cancer twice. He is a senior care aide in a long-term facility in the Okanagan, and he works with the union, representing those who are in those facilities in the Okanagan. He tells me about the pain that the care aides go through, because they want to do better. They are in this profession because they want to help.

Mr. Chair, you can tell me if I'm going too long. This is more of a grandstand than it is anything else.

● (1700)

As I mentioned to my colleague, I really applaud the group that is around the table here. I don't think this is a time for partisan politics. I think we need to move forward. I can tell you quite confidently that when you're speaking to those who are in this profession, they want to help, but they don't have the resources. They haven't been given the resources. Far too often they are faced with overtime. They're tired. There is emotional stress on them. They care for these people, and they see their charges suffering because not enough resources have been given to help care for them.

I applaud you for looking at this, but I challenge you to come up with something that is manageable and that will have an impact, because we need this. Whether it is in Nova Scotia or British Columbia, we have seniors who are suffering. Every government is well intentioned, but we can do better and we must do better. I can tell you from examples that I know all too well.

I want to talk to Ms. Cottle and Ms. Armstrong, if I have a second.

The Chair: I'm afraid you don't. I've let you go on for an extra—

Mr. Todd Doherty: Okay. I'll be real quick.

I also have a grandmother who is in a care facility, a for-profit care facility, who will tell you that her milk has been cut to skim milk, and she's trying to put weight on her bones. It is a real concern.

I applaud you all for being here, and I thank you, witnesses, because it is uplifting that you guys are actually working on this. Thank you.

The Chair: Well said, sir.

I'd like to very quickly go to Rachel Blaney.

You have three minutes.

Ms. Rachel Blaney: Thank you.

I want to come back to you again, Pat. One of the things we talked about very briefly was the realities of remote and rural communities. I know in my riding we have a lot of people leaving large urban centres as they retire. They're buying a great house and feeling fabulous, but then as they age, they're in isolated communities, in houses that are much too big. I'm just wondering about some of the solutions around geriatric care in those communities, and whether there is any solution. Have you seen that in any other country?

Dr. Pat Armstrong: I think one of the things that we are starting to do actually here in Canada is to combine hospitals and long-term care and assisted living, creating a community of those facilities. Rather than closing all our tiny hospitals and closing all of those things in small communities, we can combine all of the services to make them one real service.

I grew up in a tiny town in northern Ontario, and I've seen it work there. It's working in some of the Nordic countries. We were in a place in northern Sweden—we go in for over a week with a team of 14 people to look at these places—and their nursing home is physically part of the town swimming pool and the town recreation program. It's all one great big community. The cinema is there. By integrating all of the services, I think that we could do that in some of the small rural communities in a way that would keep them there.

The other problem for people in rural areas, which we heard about earlier, is the question of transportation. Of course, it's magnified for people in rural communities, which is something we need to look at as well.

I think step number one is combining services and keeping the hospitals. If you're old, you can't live in some place that is 60 miles away from a hospital, especially in Canada, given our weather, so you need to have those kinds of services there. We could do that by combining them rather than eliminating them.

● (1705)

Ms. Rachel Blaney: In your words to us, the last thing you said was that we need to do something before it's too late. Can you just tell me what that means for you?

Dr. Pat Armstrong: Well, I think we need to right away start putting resources into health services that are combined, that cover the full spectrum, and that are based on principles and standards that recognize seniors.

If I could say one last thing, I was going to talk about learning iPods. I've hired a teenager to teach me how to use my electronics.

Voices: Oh, oh!

Ms. Rachel Blaney: That's very useful.

Dr. Pat Armstrong: That's probably the best advice I can offer today.

Voices: Oh, oh!

Ms. Rachel Blaney: Thank you.

The Chair: Thank you very much to all of you who are here today.

I apologize for the technical difficulties earlier, but I'm glad we were able to hear from everybody clearly. I appreciate the contribution that all of you have made to this study.

We are going to break for literally a minute, maybe two, as we do have some committee business, so I do have to ask you to shuffle on out fairly quickly.

Again, I sincerely thank you for being with us today.

[*Proceedings continue in camera*]