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Chair

Mr. Bryan May

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

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● (1535)

[*English*]

The Chair (Mr. Bryan May (Cambridge, Lib.)): Good afternoon, everybody.

I have some housekeeping things before we get started, because I will likely forget at the end.

November 7 is the last Tuesday before we break for Remembrance Week. The way the report is timing out, we should be done that week. I would recommend we extend the November 7 meeting by half an hour so that we can actually go through the drafting instructions with the analysts. The reason I'm requesting this is that we'll be wrapping up before Remembrance Week. It would give them that week to actually start drafting the report. Otherwise we lose that week, and it's not the most efficient use of committee time.

Does anybody have any questions about that? Is there any concern about extending that one meeting by half an hour?

Mr. Warawa.

Mr. Mark Warawa (Langley—Aldergrove, CPC): You said the 7th. The 7th is a Tuesday.

The Chair: Correct. We have one more session. I'm assuming people wouldn't want to extend on the Thursday for travel reasons. We're not talking about line-by-line study or anything like that. It's simply drafting instructions for the analysts.

Mr. Mark Warawa: Thank you.

The Chair: We'll suspend to go in camera.

● (1530)

(Pause)

● (1535)

The Chair: Welcome, everybody.

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 second of three panels that will be held on the subject of inclusion, social determinants of health, and well-being.

We have a very large panel today, and I am very pleased to welcome you all.

Coming to us via video conference from Grande Prairie is the Grande Prairie and Area Council on Aging. We have with us the director, Sherry Dennis, as well as an outreach worker, Anne Repetowski.

Can you hear me okay?

Ms. Anne Repetowski (Outreach Worker, Grande Prairie and Area Council on Aging - Seniors Outreach): Yes.

Ms. Sherry Dennis (Director, Grande Prairie and Area Council on Aging - Seniors Outreach): Yes.

The Chair: Thank you.

Also coming to us via video conference, from Burnaby, B.C., is Debra Hauptman, chief executive officer of Langley Lodge residential care home.

Welcome. Can you hear me okay?

Ms. Debra Hauptman (Chief Executive Officer, Langley Lodge, Langley Care Society): Yes. Can you hear me?

The Chair: Perfectly fine.

Here in Ottawa we have, appearing as an individual, Catherine Leviten-Reid, associate professor at Cape Breton University. Welcome.

From the Canadian Medical Association, we have Laurent Marcoux, president, joined by Stephen Vail, director of policy.

From Speech-Language and Audiology Canada, we have Chantal Kealey, director of audiology, and Meredith Wright, director of speech-language pathology and communication health assistants. I may want to talk to you afterwards about my pronunciation, which is clearly a weakness of mine.

You will all have seven minutes to open. When I give you a signal, it means you have one minute left. Don't get too flustered when I do that. You have lots of time.

We are going to start with either Sherry Dennis or Anne Repetowski, from Grande Prairie. The next seven minutes are yours.

Ms. Anne Repetowski: Thank you.

I'm Anne Repetowski, and I'm an outreach worker. Our concern for seniors is about the wait times for processing Service Canada applications for old age security, guaranteed income supplement, guaranteed income supplement estimates and allowances.

I will give you a bit of background about Seniors Outreach. We've been running for approximately 35 years in the city of Grande Prairie. We are a northwestern Alberta community, and we service a large region, with just over 6,000 client files. There were approximately 4,000 walk-ins to our office last year. We have three full-time staff and a part-time receptionist, and we have two outreach workers. Sherry is our director. In 2016 we saw 2,629 clients in the year. It's a fairly good volume for our little office. We try to help them, provincially and federally, with anything to do with the pensions.

Our concern with Service Canada—with old age security and the guaranteed income supplement—is the long processing times and how they affect seniors. When they have delayed old age security, have complex old age security because they weren't born in Canada or haven't lived in Canada their whole life, or have an estimate to do with retiring or pensions ending—or even something as simple as if they've been on income support provincially and Canada pension plan disability payments, and the disability is going down to retirement—the wait times for an estimate in Alberta are at 35 weeks, which is 8.75 months.

When you are on a very fixed income, it puts you into a struggle as to how you pay for rent, medications, and so forth, and there's a lot of anxiety, worry, concern, and stress for people. Sherry's been doing this for 25 years, and I've been doing this for 18 years, and one of the things we have noticed is that in the last six to seven years, the wait times have doubled or tripled. When I started, it was three months to apply and get your estimate done at the same time, and people would have a result quite soon. Now, with this 8.75-month wait, we're seeing it not just take that amount of time, but even go as high as 22 months. I've had one client this year—a very unusual instance—who had waited three years to have their case taken care of.

It's sometimes because people aren't as aware of the procedures with Service Canada, in applying and doing follow-ups, because they don't deal with it daily and this isn't their.... They're concerned about their finances but they don't know how to approach it, and sometimes there's a bit of worry in dealing with government. We're seeing, on average, especially at the beginning of this year, that it was 11 to 23 months as an average for processing those estimates, so that puts them in a really tight space in terms of paying for their basic necessities.

We also have an issue when they are in urgent or dire need, because they're behind on rent or there's a concern. There was an issue about even those being processed in under the four weeks we were being advised it could take: we were seeing two to three months for those to be processed. This year, for the first time, we went from a fifth-level escalation, which means you've phoned in five times in dire need, asking for urgent processing. We even went up to 11th-level processing in January, and in March I had clients coming in and telling me that when they phoned from home, they were told not to phone anymore and that it would be done when it was done. That's a concern, when they've been waiting for over a year for back pay.

People who are on fixed income, have lost a spouse, retired from employment, are on workers' compensation or employment insurance, or have private pensions going down, those are the people who are struggling, and they're on a fixed income already.

Basic old age security is at $585.49 this month, and people may or may not have Canada pension. In Alberta, if they get the guaranteed income supplement, the GIS, plus the Alberta seniors benefit, which is a small provincial program, the most they're living on is $1,750 a month. The rents up here in Grande Prairie are usually around $900 to $1,000 for a basic one-bedroom apartment. Seniors lodges in our area start off at about $1,100 a month. It starts putting them on a very tight income, especially when they have a medication assistance program and must pay the cost to have that administered in lodges.

● (1540)

Our concern is the desperation seniors have. They borrow money, and they use up credit cards, so, yes, when they get the back pay, it's wonderful, and it helps alleviate some of that stress, but it doesn't help with the interest and the worry for all that time, the anxiety and the stress, which seem to aggravate—and I'm not a health care professional—their health and their wellness. They're not familiar with the necessity to follow through with phone calls, that after eight months, if they haven't heard an answer, they need to phone in. They're not getting the responses, and that's why it's taking so long.

The other concern is that even basic correspondence takes 20 weeks, which means five months. If somebody is getting married, and we're helping them to write in to say they've been married, and it changes their eligibility for the guaranteed income supplement or the allowance, it can take five months. We've had a few people this last year, probably about four now, who have serious back pay by the time it's processed and looked at. A change of address; authorization to communicate when somebody is going into a designated supported living facility and they need family members to help them out; powers of attorney; all of those items are in such delay that we're talking half a year for backlog and correcting things, which is a serious effect for seniors. That's what our concern is. We're hoping that somehow we could make those processing times better.

Thank you.

The Chair: Thank you very much.

From Burnaby, B.C., we have Debra Hauptman, chief executive officer, Langley Lodge residential home care.

The next seven minutes are yours.

Ms. Debra Hauptman: I'd like to thank you for the invitation to appear before this committee and for the opportunity to participate in this important dialogue.

I will speak to you today about Langley seniors' experiences in accessing long-term care and the plans for long-term care in our community. I'll also speak on some other programs and initiatives that we're working on that could be part of a national strategy.

I represent a non-profit organization that operates Langley Lodge, a licensed residential care home providing 24-hour nursing care for 139 seniors. We've been operators in Langley for 43 years. We provide government-subsidized long-term care services for 121 of our beds under an agreement with our local health authority, Fraser Health. We also have 18 private-pay spaces. These are currently full and have a wait-list.

I'll start with sharing some facts about long-term care in Langley and my community. There are six care homes in Langley, government-operated and privately operated, with a total of 665 beds. All are currently at full capacity. The Fraser Health Authority has projected that Langley will need to add 70 long-term care beds by 2021. The well-known published projections for the senior population indicate that this will barely meet the need in 2021. We're not able to keep up with the demand at present.

The average age of our residents is 85 years, not just in Langley Lodge, but overall in our health authority. Seventy per cent of our residents are 80 to 101 years old. In 2025, the leading edge of the baby boomer demographic will turn 80 years of age.

Wait-lists for long-term care are already very long, often multiple years. In our experience, seniors wait until they've exhausted all of the available home supports and their caregivers can no longer cope. When they apply for a government-subsidized bed, they're surprised to learn that they will wait on a wait-list. We have had a 100-year-old gentleman admitted to a private-pay bed by his 99-year-old spouse. He was not approved for a funded bed. Every day we meet families who are desperate, anxious, and failing to cope, and who are astonished that they will not have access to long-term care in the short term. If they can afford private-pay, they will take that option. Many cannot afford it, the average cost being $190 a day.

Health authorities in British Columbia are employing strategies to manage the capacity that they have today to ensure that those who need it most urgently will get services. The unintended consequence is that other eligible seniors fall through the cracks, are turned down, or wait far too long. For example, we have a resident whose family admitted her to a private-pay bed due to advanced dementia. That was in 2014. This resident is still waiting for a funded placement. There are many stories of families liquidating assets to pay for care for their loved one. These include families who do not have wealth or where a primary spouse is still living in that residence.

The impact and burden on caregivers must be considered. Their voice must be heard at the planning tables. They are often the last to know that they will be impacted by changes in health policy and service plans.

It's also a fact that home care services are not sufficient today to support those who are turned down for long-term care, and they need to be ramped up further and more rapidly. There is a need for more publicly funded assisted living, respite care, and adult day programs. These are essential components of a spectrum of services that will ensure seniors are supported to the extent that they require along the aging journey.

Langley Care Society's vision and strategic plan is to expand service offerings and create a broader spectrum of care, for example, respite care and adult day programs. We have started with the most basic of programs, a volunteer-driven seniors peer outreach program that we launched this summer with a grant from the new horizons program. Our program engages volunteers who are seniors to provide outreach to at-risk seniors who live in our vicinity. We have identified 800 seniors in our local area who live alone.

The individuals who are participating in our outreach program are the older seniors. They're living alone and do not have family nearby or friends who are still living. They no longer drive. They've been recently widowed. They are experiencing declining mobility. The response to our program has been strong.

● (1545)

We know we are achieving the goals, and that it will continue to grow. In the next year or two we hope to add more health and wellness services, such as health promotion and primary care.

Langley Care Society also established a private foundation, the Langley Care Foundation, that is actively fundraising to provide resources for quality of life programs for our elderly residents. The monies raised ensure that our residents have music, art, and horticultural therapies, as well as spiritual care.

What is missing? We need a vision for seniors care in Canada. We need to be planning for 2025 and beyond, when 25% of the population will be over 65 years of age. A national seniors strategy could lead the way by establishing a vision for seniors' quality of life, health care inclusion, and income security. The national strategy could assist small organizations and communities like ours in Langley to adopt a planning strategy with a clear vision, access to information, and resources about types of programs and services that communities can set up with their existing service providers.

Long-term care organizations want to do more, to stretch our boundaries. We have the infrastructure, the knowledge, and experience to hit the ground running. A national strategy would help to focus efforts.

There is much work to do to prepare for the needs of the next wave of seniors. I encourage our federal leaders to lead the way with a national strategy.

Thank you.

● (1550)

The Chair: Thank you very much.

Appearing as an individual, we have Catherine Leviten-Reid, associate professor, Cape Breton University. Welcome.

Dr. Catherine Leviten-Reid (Associate Professor, Cape Breton University, As an Individual): Thanks for the invitation.

I want to talk about creating affordable rental housing for seniors that's accessible and that supports healthy aging. I'm basing my submission on research projects I have led on rental housing in Nova Scotia. This includes an inventory of rental housing stock in the Cape Breton regional municipality and case study research on affordable rental housing projects built specifically for seniors through the investment in affordable housing program.

The inventory of rental housing stock we did last year found that there is a limited amount of accessible rental housing in the Cape Breton regional municipality. We looked at public housing, non-profit rental housing, and market-based rentals, and found that 3% of rental units were fully accessible. There is more accessible housing in the non-profit sector compared to market rentals and public housing units.

The good news with respect to the work you're doing is that more of this accessible housing is targeted to seniors in our communities, so even though there is not a lot of it, it's intended mostly for them. But, with respect to affordability, shelter costs are higher for accessible units than non-accessible units. A one-bedroom apartment that's accessible is about $130 more per month, and a two-bedroom apartment that's accessible is almost $300 more per month. Also, accessible units are less likely to be vacant.

We also looked at rooming houses in our municipality, because rooming houses are an important source of affordable rental housing for single people, including seniors. We found that none of this housing at all was accessible.

Overall there are limited opportunities to living in accessible rental housing for seniors. They're more costly, and we know that renters will surely experience barriers to aging in place. We do know that almost half of renter households in our municipality experience activity limitations.

One recommendation that came out of this research is whether Canada Mortgage and Housing can collect data on accessible rental housing. It already collects data twice a year on the primary rental market. It asks about rental costs and vacancy rates. Can it also ask about accessibility?

The case study research we did identified what seniors value in housing and some of the constraints developers of rental housing face when they build it. We did this research in 2012. We looked at three housing projects, and they were all located in rural communities.

The seniors we spoke with very much valued shared space, so common rooms stood out. They're an extremely important feature. They facilitated formal gatherings and also informal interactions. Shared space was also used for physical activity. If there was a shared hallway, it was used as a kind of walking track, especially in the wintertime. Shared space also allowed tenants to check in on each other, but this shared space was inconsistently provided by housing developers, and when we interviewed them, of course they talked about needing a sound business case when they are building this housing, and shared space increased their costs.

Seniors talked about the importance of good housing design, but in the interviews we conducted, design-related barriers to aging in place were identified by almost everyone. Some tenants really thought all of the units being constructed should be barrier-free as a way to accommodate their changing needs.

At the same time, two of the development teams we interviewed talked about really learning as they went, and said that the affordable rental housing they were building was a one-time project. They were responding to a community need they identified for affordable rental housing, and they were really learning as they were going along. They said that if they ever did it again, they absolutely would change what they did.

I think it's also important to note that these housing developers had a different understanding of the rental housing they were building and who they were building it for. While the tenants were talking to us about quality of life dimensions of their housing, the developers were saying that this was unassisted, affordable rental housing for seniors, so they expected their tenants to be living independently.

Seniors, of course, noted that access to affordable transportation was important. The seniors not living in housing on a bus line absolutely experienced barriers to accessing amenities and services.

● (1555)

Again, housing developers have to think about the cost of what they were doing, and in two cases they were building on land that was contributed to them in kind.

Last, some of the seniors we interviewed spoke about the importance of having a mechanism through which they could participate in decision-making on housing that provides them input, such as the opportunity to be on the board of directors, or to participate in a tenant's committee.

As far as recommendations coming out of this research are concerned, first, can we think about affordable rental housing for seniors as more than a bricks and mortar strategy? It's not just about providing a place to live; it's also about healthy aging.

Some specific recommendations that might allow us to do may include the following. Can we be more specific with our developers about what is required in this housing with respect to how the units are designed, and how the buildings are designed? They need to be providing common rooms, and there has to be some kind of a mechanism for seniors to participate in decision-making.

Can we at the same time increase the funding that's available to build affordable, rental housing for seniors? Can we encourage or require partnerships among developers and organizations in our communities who are providing services to seniors?

The Chair: Thank you very much.

We'll now hear from Laurent Marcoux, the president of the Canadian Medical Association, and Stephen Vail, the director of policy.

The next seven minutes are yours, gentlemen.

[*Translation*]

Dr. Laurent Marcoux (President, Canadian Medical Association): Thank you, Mr. Chair.

I am Dr. Laurent Marcoux. As president of the Canadian Medical Association, the CMA, I am pleased to be here. Thank you for your invitation.

As the national organization representing more than 85,000 physicians, the CMA has been advocating for improvements to seniors' care for a number of years. In addition, more than 50,000 Canadians have reached us on demandaplan.ca, our website devoted to mobilizing patient support for a national seniors strategy.

For the last 50 years, Canadians have been living longer and are in better health. We are clearly delighted with the progress our country has made, but we also recognize the pressures on our health care system. We know that the number of seniors in Canada will double in the next 30 years, which will result in additional pressures on our healthcare system.

I must emphasize the exceptional work done by Marc Serré MP, whose motion on the need for a national seniors strategy is what started the study that your committee is undertaking.

The CMA brief before you today contains 15 recommendations that form the basis of a national seniors strategy. It is our view that these recommendations will help our seniors to remain active, contributing citizens of their communities.

Given the limited time I have available, I will focus on the three themes that your committee is addressing. So I will not go through all the recommendations in our brief.

First, I will talk about seniors' access to housing.

As I just mentioned, we know that the demand for long-term care will increase as the population of Canada ages. A recent report by the Canadian Institute for Health Information indicated that residential care capacity must double over the next 20 years in order to meet the needs of the elderly population.

Not only must we build new long-term facilities, we must also renovate current facilities and ensure that they are safe and ready to meet the needs of the patients. We rely too much on hospitals to provide that type of care, and it is neither effective, nor viable nor satisfactory for the elderly. It is critical for us to decentralize health care services from hospitals towards communities and home care.

The current situation is a major contributor to clogged emergency room services, the lengthening wait times and the cancellation of surgery. The situation is completely unacceptable and, I repeat, is not viable. It even threatens to put our health care system in danger.

We encourage the government to continue investing in infrastructure that provides long-term care and ongoing care, so that we can improve care for seniors, at the same time as we are relieving the pressure on the short-term care system.

To that end, the CMA has asked the Conference Board of Canada to conduct a cost-benefit analysis of meeting the demand for long-term beds in Canada. The report will be released in the coming weeks.

We were reassured to see the government announce, in its most recent budget, the new national housing strategy that will inject more than $11.2 billion into adequate and affordable housing for Canadians. It is our view that a significant part of that investment should be allocated to the needs of seniors.

Second, I will talk about income security for vulnerable seniors.

At retirement age, many of our fellow Canadians rely on various public programs to meet their needs, such as old age security, the Canada pension plan and the guaranteed income supplement. Sometimes, these measures are in addition to personal pensions and investments.

We all know that the health of Canadians tends to improve with income. It is therefore troubling to see that poverty among seniors has been on the increase for a number of years. We are also of the view that, thanks to those investments, a number of seniors will benefit from a basic level of financial security, which will allow them to remain in their homes or in communities that cater to seniors. However, the measures must be continued, and be better targeted to the needs of Canadian seniors.

● (1600)

On the topic of income security, we must protect seniors by supporting public awareness initiatives that bring attention to the financial abuse of seniors. Too many seniors are victims of it and it is an evil that must stop.

Third, I will talk about the overall quality of life and well-being for seniors.

The CMA is of the opinion that our country is able to respond to the health and social needs of our seniors. A strategic approach is needed, a national strategy on the care of seniors.

In that context, we need to make sure that access to home care is uniform all across Canada and that clear operating principles are established. We must also establish performance objectives and a degree of accountability from all levels of government. A measure of that kind is necessary in order to give the public and the patients greater confidence in the home care system.

We have to provide better support for family and informal caregivers by providing them with training, respite care and financial assistance. We must also invest in programs that encourage healthy aging, such as programs that focus on physical activity, nutrition and mental health.

All partners in the field of health must unite their efforts in order to ensure that seniors have easy access to the care they need, ideally at home. These measures include access to a family physician, supported by a multidisciplinary team, coverage for essential medications, and smooth transitions between the levels of care.

We must create supportive environments that allow seniors to remain independent for as long as possible. To that end, we must promote positive messages about aging, provide employment to those who want to work, and ensure that buildings, pedestrian areas and transportation systems are safe and accessible.

In simple terms, improving the quality of life of seniors in Canada is not just a matter of health care. We have to create an environment in which Canadians can thrive as they age.

Our 15 recommendations, which you have before you, make up a master plan for the health system of tomorrow. The time has come to create an effective, efficient and equitable health system for seniors and for all Canadians.

We will be happy to answer your questions.

Thank you.

● (1605)

[*English*]

The Chair: Thank you very much.

Last but not least, from Speech-Language & Audiology Canada, we have Chantal Kealey, director of audiology, and Meredith Wright, director of speech-language pathology and communication health assistants.

Welcome. The next 10 minutes are yours.

Dr. Meredith Wright (Director of Speech-Language Pathology and Communication Health Assistants, Speech-Language & Audiology Canada): Thank you, Mr. Chair, for the opportunity to address this important committee. My name is Meredith Wright, and I'm joined today by my colleague Chantal Kealey.

I am proud to represent Speech-Language & Audiology Canada, the national professional association for the two distinct but interconnected professions of speech-language pathology and audiology. Today, the association represents approximately 6,400 professionals across Canada.

As a speech-language pathologist, my scope of practice with seniors includes assessing and treating a wide range of communication and swallowing disorders, from the inability to communicate following stroke, to swallowing difficulties experienced by a person with dementia at the end of life.

As an audiologist, Dr. Kealey's scope of practice with seniors includes assessing and treating an array of auditory disorders, such as hearing loss, tinnitus, auditory processing, and balance problems.

For our association, the term “communication health” refers to everything within the scopes of practice of audiology and speech-language pathology. We know that the existence and extent of most communication and hearing difficulties is largely unknown by the Canadian public, but the statistics are eye-opening. Approximately one in six people in Canada has a speech, language, or hearing disorder.

As we age, we experience a decline in memory, and our ability to process information slows. Complex sentences, like the ones used by many health care providers, lawyers, and financial planners, become more and more difficult to understand. Aging muscles can contribute to the development of swallowing problems, particularly in frail seniors. Swallowing problems can result in choking, malnutrition, dehydration, and pneumonia. Hearing loss also gradually increases as we age. By 65, about one in three people has a clinically significant hearing loss, and by 75, about 50% of people are affected.

Seniors are by no means a homogeneous group, but certain changes in communication, swallowing, and hearing abilities are associated with normal aging. So even the healthiest of seniors need access to affordable and appropriate care as they age so they are able to have a high quality of life and stay in their homes as long as possible.

However, more significant communication, swallowing, and hearing changes can occur as part of an age-related health problem. With aging comes a higher prevalence of neurological conditions, such as stroke, Parkinson's disease, Alzheimer's disease, and other dementias. Communication difficulties experienced by people with neurological diseases vary depending on the type and duration of the disease and the part of the brain affected. For instance, people who have had a stroke may experience both communication and swallowing difficulties. People with Parkinson's disease may have speech and voice problems.

The relationship between hearing loss and dementia is receiving significant attention. Research suggests that hearing loss is more prevalent in seniors with dementia than in those with normal cognition. Indeed, some studies found that individuals with hearing loss had two to five times increased risk of developing dementia, although we should not assume a causal link at this time.

Furthermore, hearing loss, especially if not managed appropriately, can lead to balance disorders, which increases the risk of falls. The risk of falling is three to four times higher among older people with balance disorders, and falls are the leading cause of injuries in seniors.

Communication, swallowing, and hearing difficulties can be extremely frustrating, frightening, and isolating for the person experiencing the difficulties, as well as for their families, friends, and caregivers. Quality of life and personal relationships can be affected. Social withdrawal, anxiety, and depression can result. Caregiver burden can increase. Indeed, seniors with communication and hearing disorders may experience difficulty participating in many of the social interactions of day-to-day life. Even accessing basic goods and services can be a challenge.

Right now, we have an opportunity to build a better Canada for our seniors, one that includes universal access to appropriate communication health services. We need better training for service providers so they can communicate with seniors in more meaningful ways. Service providers who work in places like Service Canada, hospitals, banks, pharmacies, and law firms need to be prepared to communicate with seniors who may not be able to hear and speak the way I do.

● (1610)

For that reason, we need the new federal accessibility law to be inclusive of Canadians who have communication and hearing difficulties. We need to invest in more publicly funded, community-based health services, including communication groups for people with hearing loss, stroke, Parkinson's disease, and dementia, and also communication skills training for family and caregivers. We need more community-based screening programs for hearing, balance, and swallowing disorders, to ensure that seniors, particularly those living in rural and remote communities, are getting access to appropriate care in a timely manner.

Too often, we hear about publicly funded speech-language pathology and audiology positions being cut. This is deeply concerning since most Canadian seniors cannot afford to pay for private speech-language pathology and audiology services. We need to invest in more research in communication health as it relates to seniors, to ensure that Canadian seniors are provided with the best care.

Audiology and speech-language pathology researchers in Canada make substantial contributions to the evidence base for the care of seniors with communication difficulties and hearing loss. We need to continue to support research focused on communication health in seniors.

In conclusion, I urge this committee to consider these recommendations when developing its report, and to ensure the needs of seniors with communication and hearing difficulties are represented.

Thank you very much.

The Chair: I thank all of you for those great introductions. You all kept within the time, and that's wonderful. Thank you.

First off, we're going to go to MP Warawa for six minutes.

Mr. Mark Warawa: Thank you, Chair.

Thank you to the witnesses for being here.

I find your topics of expertise diverse and very interesting. I want to thank each of you for trying to improve life for our aging population by offering a better quality of life, and for showing dignity for those who need some help. Thank you for your work.

Many of you have provided recommendations. You may have more recommendations to give. If you would, please forward them to the committee, in short order, in the form of a written brief, so that they can be translated. Very shortly, we'll be working on a report to Parliament, and your recommendations will be considered.

You are diverse in the way you're assisting seniors across the country and in communities. My number one question is how we bring all this expertise in to meet the needs of seniors.

In Canada, the number of seniors is one in six, but in my riding of Langley, it's probably closer to one in five, or maybe one in four and a half. Because of the climate and topography, it's a nice place to retire, so there's a large senior population, just as there is in Richmond, as my colleague to my left here, Alice can attest.

How do we bring all the resources for seniors together so that we can meet the need? The common theme is also that we're not ready and that we need to have a national seniors strategy. As we've heard, the wait times in Grande Prairie are exceptionally long and they are getting longer. I think there's a problem with wait times right across the country, so I don't think it's the blame of any one government. We're not functioning the way we need to. We need to rethink how we provide services to seniors. How do we bring it together so we don't have silos but a real, functioning machine to provide for that need?

I'm going to start off with Ms. Hauptman in Langley.

You had mentioned that there are about 800 people living around Langley Lodge. Those are seniors living by themselves. I think you used two figures, 1,500 and 800. Is aging in place the silver bullet to be able to help seniors?

● (1615)

Ms. Debra Hauptman: There are 1,500 people over the age of 65 in our vicinity. Of those, 800 live alone. I don't think that aging in place is the silver bullet. I'm quite concerned that we're not thinking about what that will look like when we get there. In long-term care, for example, people are very elderly.

There are a lot of needs that we have to maintain our independence, even when we are healthy and younger and strong. These are simple things, like getting groceries into the home, being able to connect with other people—social connections—being able to get out to get to medical appointments. Those kinds of things become very real challenges, especially for these folks who are quite elderly and living alone.

In the U.K., they have started a program called the Silver Line, which is a helpline for older adults. In their first year, they had over a million calls. It's a 24-hour, 365-day call line. They have about 3,000 volunteers, and I think they said 10,000 calls a week now. They have volunteers who are simply volunteering to befriend isolated seniors.

There is a tendency to think that communal living is not great. I was interested in hearing the witness from P.E.I. talk about how seniors prefer shared spaces. There is a lot of benefit for seniors to share spaces. They can support each other a lot better, and it alleviates some of the social isolation. Some of those seniors may even have family and friends that others don't, and those families are quite willing to reach out, as we've seen in Langley Lodge.

Mr. Mark Warawa: I have a quick question. I'm running short on time.

You mentioned that there will be 70 more beds needed in long-term care in the Langley area in 2021.

Will those 70 beds be available? Are they under construction or are plans in place?

Ms. Debra Hauptman: I think they are going to achieve that by upgrading some of the existing older homes. There's no new development and no plans for new builds, just a rebuild of what's there.

Mr. Mark Warawa: Would you agree that we need to have a coordinated effort that includes government leadership from each level of government to achieve the needs?

Ms. Debra Hauptman: Yes.

Mr. Mark Warawa: Thank you.

Thank you, Chair.

The Chair: Thank you, sir.

Now over to MP Morrissey, for six minutes.

Mr. Robert Morrissey (Egmont, Lib.): Thank you, Chair.

My question is for the Grande Prairie and Area Council on Aging.

I find it appalling that in this age, it's a 35-week wait period on OAS or GIS issues. You also stated that this wait time has been increasing over the last six to seven years.

Could you specifically identify why the wait times have been going up? What is the problem from Service Canada? We see this not only in OAS and GIS, but in the employment insurance system as well. I want to specify the OAS and GIS system. What has happened in the last six to seven years that has created this wait time?

Ms. Anne Repetowski: That's a very good question.

I can't speak for Service Canada as to why it's taking longer, but I can tell you comments that I've heard from the call centre people when I've called in with clients. I've heard the comment as recently as two days ago, “We're at the peak because the baby boomers are peaking and it's going to get easier now.” They are attributing it to the baby boomers and the people aging at 65.

We see it as various things happening. Yes, there are people turning 65, and people becoming widowed between 60 and 65 and going on the allowance, which is old age security when they are lower income. We are also seeing people who are working until they are age 70 to 75, even 80, retiring and not having the funds, not having ever worked in a job where there were high enough contributions. It would have kept them out of being supplemented earlier, but then when they stop working, they need it to be able to live monthly because they don't have the savings. It could have been a health circumstance, a divorce, an unexpected death of a spouse, but they don't have the savings. So, it's a combination—

● (1620)

Mr. Robert Morrissey: I want to focus on the turnaround time, the service that was taking 35 weeks.

Ms. Anne Repetowski: The turnaround time?

Mr. Robert Morrissey: What in your opinion has been creating that problem?

Ms. Anne Repetowski: They're telling us it's because there are more people aging. There are more seniors than ever before. I don't think they have the plans in place. I can't speak for Service Canada. We're a non-profit, and we're only seeing what's happening. We think they haven't increased staff. I know that about four years ago there were staff being cut back in Service Canada. I don't know whether it was call centres or processors alone, but there were staff cuts, and then they didn't have the staff to process the forms.

Mr. Robert Morrissey: This is the human face we see when government follows the philosophy of smaller government. You don't have the personnel in place to provide these essential services to seniors, who are the most vulnerable members of our society, especially single seniors. Is that your experience in Alberta? This is what I'm seeing on the east coast.

Ms. Anne Repetowski: Yes.

Ms. Sherry Dennis: I think the processing time has become longer. It has become more complicated to process an application now, whereas 10 years ago it wasn't as complicated. They have to go back three years now in checking information. It has become worse. Now they have more processes to complicate things.

Mr. Robert Morrissey: So they need more people.

I want to direct my question on improving income security to Dr. Marcoux.

In your brochure, you pointed out that since 2012 the incidence of low income among seniors has been dramatically increasing. One of the first moves of our government was to increase the GIS for single seniors, who are probably the most fiscally hard pressed in our society. What would be your opinion on the fact that the former government raised the age of OAS/GIS eligibility, or was planning to do it, to age 67? Would that exacerbate the problem, or how would we deal with it?

[*Translation*]

Dr. Laurent Marcoux: Thank you for your question.

It is a little difficult to make a judgment about what the previous government did. Today, however, we are seeing more and more seniors living in poverty, probably because the cost of living has increased out of all proportion.

Housing is increasingly expensive. That means that seniors living in poverty are more vulnerable. It even puts their lives in danger. Statistics clearly show that less well-off people die sooner, and many reasons account for that. Poverty is a major social factor in matters of health, particularly among the most vulnerable.

[*English*]

Mr. Robert Morrissey: My other question would go to the witness from Cape Breton.

I was interested in your discussions on housing. Could you speak briefly on the unique situation facing rural seniors? A lot of the housing options you elaborated on would be in more urban communities. How do you see the housing situation for rural seniors?

Dr. Catherine Leviten-Reid: The research project we did was actually in rural communities. It was rural housing projects. In rural areas, there's a higher percentage of home ownership than rental in Atlantic Canada, so you have a situation where more seniors are living in their own homes and then eventually needing to move out. In Atlantic Canada, you have a greater shortage of rental housing options in rural communities than in urban ones .

The Chair: Thank you very much.

Next is Rachel Blaney.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thanks to everybody for being here.

I want to ask all the witnesses to answer a simple question: yes, no, or abstain. Do you believe the government should implement a national seniors strategy?

● (1625)

Dr. Catherine Leviten-Reid: Yes.

Mr. Stephen Vail (Director of Policy, Canadian Medical Association):

Of course.

Dr. Laurent Marcoux: Yes.

Dr. Chantal Kealey (Director of Audiology, Speech-Language & Audiology Canada): Yes.

Dr. Meredith Wright: Yes.

Ms. Anne Repetowski: Yes.

Ms. Rachel Blaney: Now we'll go to Langley.

Ms. Debra Hauptman: Yes.

Ms. Rachel Blaney: Finally, I'll ask you.

Ms. Sherry Dennis: Yes, of course.

Ms. Rachel Blaney: Thank you everybody. I wanted to make sure that was on the record.

First, I'd like to ask questions of the Canadian Medical Association. Your organization is responsible for a lot of the legwork that has enabled us to be here today. I think we must all thank you for that amazing work. It is clear to me that Canadians definitely want to see a plan.

I'll let either one of you answer, depending on the question.

The first question I have is, can you tell us what a strategy would bring to our current system and why you think we need one?

[*Translation*]

Dr. Laurent Marcoux: Your question deals precisely with the main reason we are here.

The Canadian health care system was established 50 years ago, and few changes have been made to it since. At the time, the population of Canada was 20 million and the life expectancy was 70. Since the life expectancy was 70, there were not many places for those suffering from chronic illness or for the elderly. Since that time, we have had the same system of health care, which is designed in such a way that we have to go to hospitals to get it.

As I said in my presentation—and it is also well described in the booklet we provided for you—the health care system is not designed to treat elderly people suffering from multiple chronic illnesses who do not want to spend their final days in a hospital bed, or in an emergency room with strangers or people who are not part of their circle. They want to be treated at home, and it is possible to do so.

When we say home care, we are not talking about the home care that involves going to change dressings after being in hospital. We are actually talking about health care that prevents people from going to the hospital. So, if people get up in the morning and do not feel very well, they can access a system without automatically having to go to emergency. They will be asked what is wrong and someone will be sent to the home, depending on the problem described. That is possible.

There have been very positive experiences with that in various parts of Canada. Nova Scotia is a good example. In Quebec, a local community health centre works on people's problems first, so that they are not forced to go to the hospital as soon as the problems arise. They go there as infrequently as they can.

The hospital in Châteauguay, where I was the medical director, has also conducted some experiments, especially with patients with heart failure. We gave the patients a device that looked like a telephone. Each day, the patients had to enter the quantity of fluid they had drunk the day before, their exact weight, their temperature, their pressure and their sugar level. We know that, to maintain cardiac function, you must not drink too much fluid. The device allowed people to see whether they had to pay a little more attention to that on any particular day. The hospital received results from dozens of patients. If physicians saw that something was not right, they would become involved. It also prevented the person's condition from destabilizing.

The experiment, conducted with control groups, showed that allowing people to look after themselves at home resulted in a spectacular drop in hospitalization rates and in the number of emergency room visits.

[*English*]

Ms. Rachel Blaney: If you had complete control of the process, how would you implement a strategy in the coming months? What would be the very first steps?

[*Translation*]

Dr. Laurent Marcoux: Strictly speaking, the strategy does not actually have first steps.

All the participants have to embrace a seniors' culture, whether it is about financial harassment in the home or about starting the debate on the reality of an aging population. The population of seniors is going to double in the coming years. The aging population is not a hypothetical concept. The seniors are here, and we have to take care of them. As a developed country, Canada cannot allow itself to let seniors die alone at home.

[*English*]

Ms. Rachel Blaney: This year there is a gap in residential care. We have an unmet demand in excess of 8,000 beds, and a projected need for 10,500 new beds per year over the next 19 years for a total of 199,000 new beds by 2035.

Do you think the current funding is adequate?

[*Translation*]

Dr. Laurent Marcoux: You have to ask yourself whether it is just beds you need. Your question is quite appropriate. We not only need beds, but we also need resources for seniors.

Some seniors will need a bed in a long-term care facility, because they may have major cognitive problems and difficulties with mobility that are so great that they cannot move around. However, all the others should have access to well thought-out and adapted home care. With that only, we can go quite a long way, and with satisfied patients.

We can also get family caregivers involved. Currently, family caregivers are the victims of a poorly organized system. They lose their jobs and they lose their financial resources. They put their mental health and their physical health at risk as they take care of the elderly. They need a little support. This is an important lever in the area of care for the elderly.

● (1630)

[*English*]

Ms. Rachel Blaney: We've received unclear messages from both the minister and the Prime Minister in the implementation of this strategy, so I certainly hope this happens because I hear loud and clear that it needs to.

[*Translation*]

Dr. Laurent Marcoux: I hope so too.

[*English*]

I hope very much for our seniors as well. Thank you very much.

Ms. Rachel Blaney: Thank you.

The Chair: Thank you, both.

Mr. Robillard, your have six minutes.

Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.): Thank you, Chair.

[*Translation*]

Ms. Leviten-Reid, what role must not-for-profit organizations, co-operatives and communities in the broad sense play in terms of supporting the population as it ages? In your opinion, how could the federal government come to the assistance of those organizations that assist seniors in return?

[*English*]

Dr. Catherine Leviten-Reid: That is a great question. A couple of people have already talked about this, but it's really developing partnerships at the local level. You talk about community organizations in partnership with housing developers. Are they sitting down and talking about healthy aging? It's not just about infrastructure development. It's working together to support healthy aging.

I think that's the role that community organizations play. With community organizations, you talk about co-operatives. It could be a credit union, for example, that becomes a partner in a housing project. Certainly in Nova Scotia there's a case of a credit union actually donating land to build affordable housing for seniors. There are those kinds of roles that they can play as well.

Community organizations can be champions in that they may have the expertise required to get a project off the ground, and again, credit unions have played key roles in multi-stakeholder health care co-ops, actually, in the province of Quebec.

With respect to the role of the federal government in particular, I'm not quite sure of the answer to that. Perhaps it's modelling what partnerships look like and presenting best practices for provincial level or community level organizations.

[*Translation*]

Mr. Yves Robillard: How must a national seniors strategy be tailored to those who are in pre-retirement? Are their issues different from those who have retired or even from those of seniors who are still working? What should the government's response be?

[*English*]

Dr. Catherine Leviten-Reid: Is that question for me as well?

Mr. Yves Robillard: Yes.

Dr. Catherine Leviten-Reid: With respect to affordable housing, I don't see necessarily that there's a difference between being retired or not and living in affordable housing. Several of the seniors we interviewed were still working but they were living in affordable rental housing, so I'm actually not sure there would be a difference with respect to that kind of unassisted housing.

[*Translation*]

Mr. Yves Robillard: Ms. Leviten-Reid, since you teach in Cape Breton, I assume you have very specific expertise in how people from the Maritimes age.

What can you tell us about the conditions of aging in the Maritimes, compared to those elsewhere in the country? What lessons can the country as a whole learn from them? Do you discuss the issue with other experts?

[*English*]

Dr. Catherine Leviten-Reid: I think I understood your question. Do you want me to compare the conditions of seniors in Atlantic Canada to the rest of Canada?

[*Translation*]

Mr. Yves Robillard: Yes.

[*English*]

Dr. Catherine Leviten-Reid: Okay. For one, the rates of home ownership are higher in Atlantic Canada compared to seniors in other parts of the country, and there is less rental housing available for seniors as a result in rural communities in Atlantic Canada compared to the rest of the country.

[*Translation*]

Mr. Yves Robillard: Do you discuss things among other experts?

[*English*]

Dr. Catherine Leviten-Reid: I'm not quite sure how to answer your question.

● (1635)

Mr. Yves Robillard: With the other provinces, I mean, between experts, do you share practices?

Dr. Catherine Leviten-Reid: With respect to housing development?

Mr. Dan Ruimy (Pitt Meadows—Maple Ridge, Lib.): With best practices.

Dr. Catherine Leviten-Reid: I guess I'm not quite sure how to answer that question either.

I'm thinking about the community-based housing research that I do and the organizations that I work with. Certainly we attend the Canadian Housing and Renewal Association conference and present there and listen to presentations from people from other parts of the country as well. There's the Canadian Alliance to End Homelessness. We go to that conference as well and learn from others.

So sure we do. I hope that's an acceptable answer to the question. If not, I can try to clarify further.

Mr. Yves Robillard: I will share my time with Mr. Ruimy.

The Chair: There are only about 30 seconds left.

Mr. Yves Robillard: That's good.

The Chair: Do you have a brief question? You have 25 seconds.

Mr. Dan Ruimy: I'll just make a quick comment, then.

Ms. Wright, you mentioned hearing loss and dementia. I'm quite interested in that because I think dementia has a big role to play as it's one of those diseases that is affecting our seniors. I'm not sure where we go with that.

How much time do I have?

The Chair: You're out of time, but guess what? You're up next, so you have six minutes.

Mr. Dan Ruimy: Thank you very much.

I'll come back to you in a moment.

Thank you, everybody, for your presentations.

Clearly, this is something that should have been dealt with in the last 20 years. We didn't pay enough attention to this, and we knew it was coming, overall. It's not to point fingers or blame.

One of the things we know absolutely is that if we figure out the housing, that changes a lot of the picture because we heard that the difference between a senior in B.C. and a senior out in the Maritimes is $400 extra left over each month compared to $1,400 left over each month. That's number one. We have to figure that out, but we know that.

I want to speak with Monsieur Marcoux about the medical system.

If you look at your practitioners across the country, what percentage, or how many practitioners, are actually specialized when it comes to seniors, or are there more GPs? What is the breakdown?

[*Translation*]

Dr. Laurent Marcoux: You raise a good point.

Seniors are generally treated by their family physicians until the end of their days. We need more assistance and more geriatricians than we currently have. Those geriatricians should be trained to work in communities more than in health care facilities. You do not find the elderly in acute care hospitals. Well, sometimes you do find them there, but they are getting poor care, because they should not be there.

In health care facilities in Canada, 20% of the beds are occupied by those awaiting placement. It is not in their interests at all and it is very expensive.

Recently, an old friend was admitted to a short-term centre. It is one of the best in Montreal. In terms of the care she received, it was incredibly sad. She was left alone. I am not saying that the people working there were not competent. It is just that the centre was simply not set up to provide the care required.

So we need geriatricians who prefer to practise in home-care situations. We have to create a system so that people at home can be cared for there and can remain there longer in safety and comfort.

I am very sensitive to the fact that we need accommodation and we need to increase the number of beds, but the beds are already there. Seniors are already in their beds, in their homes and in their environments. Let us keep them there as long as we can in safety. It also costs a lot less.

Mr. Dan Ruimy: How can we increase the number of physicians who specialize in geriatrics?

Dr. Laurent Marcoux: Right now, I have in my mind the example of a geriatrician in Quebec who wants to work for community organizations. However, the remuneration methods are not set up to accommodate work in a community setting. They are linked to services provided in hospitals. So we have a young geriatrician doing volunteer work because he really believes in it.

There has to be strong leadership on the part of the central government, provincial governments and associations like ours to bring about a change in methods in order to encourage home-based medical practice.

● (1640)

[*English*]

Mr. Dan Ruimy: Is the Canadian Medical Association taking a leadership role in pushing for more specialists in gerontology?

[*Translation*]

Dr. Laurent Marcoux: We did not do it directly, but the need is definitely there.

[*English*]

Mr. Dan Ruimy: Okay.

Part of the challenge we have is asking ourselves whether we need to blow up the whole system or whether we need to reallocate our resources so that we have more specialists who understand, especially when it comes to dementia and Parkinson's, because there is a lot of waste in the system.

I'm going to move to Langley Care Society.

Debra, you talked a lot about home care. We announced that we are giving to the provinces part of that $6 billion for home care. You've heard about that?

Ms. Debra Hauptman: Yes.

Mr. Dan Ruimy: Are you seeing anything coming to you through that? If not, what does the picture look like for home care? I'm curious to know.

Ms. Debra Hauptman: I haven't seen the funds flowing yet. We've just had a provincial election. I think they're trying to get everything rolling. There's a cap on home care of four hours per day. That's just tremendously inadequate. If we're talking about—

Mr. Dan Ruimy: Sorry. Who put the cap on four hours per day?

Ms. Debra Hauptman: That's provincial.

Mr. Dan Ruimy: The provincial government.

Ms. Debra Hauptman: Yes.

Mr. Dan Ruimy: Has it always been four hours per day?

Ms. Debra Hauptman: That's the absolute upper limit, yes.

Mr. Dan Ruimy: Okay.

That hasn't been adjusted with the new funds that were allocated.

Ms. Debra Hauptman: Not yet.

Mr. Dan Ruimy: Do you have any other ideas as to what home care should look like? What would you like to see for home care?

Ms. Debra Hauptman: It has to be so many more things. There have to be more hours available and more flexibility in how it's delivered, having people assigned to go to the same homes instead of a different person every day, three times a week. Overnight and on weekends, people need home care.

What does a 95-year-old spouse do for the other 20 hours a day to look after her 97-year-old husband?

Mr. Dan Ruimy: I have about two seconds left.

It was four hours. What would you see it being? What would make sense?

Ms. Debra Hauptman: It could be all the way up to overnight, 24-hour care.

The Chair: Thank you very much.

Now we go over to MP Wong, please.

Hon. Alice Wong (Richmond Centre, CPC): Thank you, Mr. Chair.

Thank you very much to all the guests who came from different parts of our provinces and territories—not from territories yet—different provinces and different disciplines. I can see that almost all our strategies are here.

Kudos especially to the Canadian Medical Association. We worked closely before. Thank you for your past services. Your submission has a lot of outlines for exactly what our strategies should look like.

I would like to especially comment on a few things that some of our witnesses mentioned, the whole idea of two situations where you have very healthy seniors who still need our services in other ways like staying healthy, and then those very frail seniors who need extra help, especially on the medical and caring sides. Also, we have lonely seniors who are healthy, but they don't know where to go. They feel lonely and end up becoming ill because of all the negative impact on their mental situation, which has also been documented.

I want to comment on a few things. You mentioned the Silver Line in the U.K., which a lot of seniors call. I understand that the new horizons program also funds local organizations to do exactly that, to have volunteers and train volunteers to do that.

Do you see a need for increased funding so that this part of our senior services can be really enriched?

● (1645)

Ms. Debra Hauptman: Yes, we have the new horizons program. We just started it this summer, but I think it could grow significantly. We're not looking at tremendous resources, because it is volunteer driven and volunteer supported. I think it is something that could be rolled out across Canada, that type of outreach program. We've had a good response from people who want to volunteer as well as people who want to participate.

Hon. Alice Wong: Thank you.

My next question goes to the big organizations.

Do you also see the need for longer-term funding, like three or five years, so that your organizations can really do something that is sustainable?

I'm referring to CMA or the audiologists.

Ms. Wright or anyone of you.

Dr. Meredith Wright: Yes, I think it's very important to have sustainable funding. The health conditions that seniors face relating to their communication and hearing issues will not go away. Programs need to be put in place that have sustainable funding.

What we've been experiencing in the last number of years is cutbacks in speech-language pathology and audiology positions within hospitals on the assumption that certain aspects of the care we provide should be provided in the community; however, funding has not gone into the community to have those services in place.

That fits with the Canadian Medical Association's idea of the medical home, for example, where there might be medical practice that would have other health professionals involved there as well in order to help address some of the speech and hearing issues in those more vulnerable, frail seniors.

Hon. Alice Wong: I heard a lot of issues regarding health care. Of course, this mainly falls under the jurisdiction of the provincial government.

Dr. Meredith Wright: Exactly.

Hon. Alice Wong: It seems to need more federal, provincial, and territorial coordination. We used to have the FPT senior ministers forum every year so seniors housing, health, everything could be communicated. The provinces also have their own jurisdiction over the cities. All three levels of government are tackling the same challenges.

Would you say that's a model we can follow?

[*Translation*]

Dr. Laurent Marcoux: You are raising a very important point by mentioning the financing of the system and by asking who the leader must be in this area.

In a country such as ours, we really expect the federal government to be the leader, the one who shows the way and sets the guidelines that the provinces will apply.

However, the investment you were talking about is very important. You need sufficient investment. Furthermore, if we are transforming the health care system, as I was suggesting earlier, there will certainly be a cost and hard work attached to that. It has been well documented that 20% of the beds occupied by people waiting to be placed cost nearly $1,000 a day in Ontario. The amount is similar in each province at $842 per day. But a place in a long-term care facility, the place for a patient who requires ongoing care, is $126 a day, and home care costs $45 a day. That's between $45 and $842 a day to keep these people at home in reasonable comfort, so there is room for manoeuvre.

Yes, an investment is needed, but the outdated health care system that has been around for 50 years must also be changed and must be adapted to a society that has evolved.

Change is always difficult. People say that it is important not to change only when there is a crisis, but this crisis is very close to us, and if we don't take care of it within 20 years, some of our loved ones will find themselves very disadvantaged in society.

[*English*]

The Chair: Thank you very much.

Now for six minutes we'll have MP Sangha, please.

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

Thank you, witnesses, for coming today with this valuable information regarding the care of seniors.

We talk about inclusivity regarding the engagement of seniors. In your statement, you talked about common spaces in seniors' social housing. Builders don't want to build it. It's costly if they leave the space, but that's the best place for seniors to get together and engage with each other.

What else do you think can be done besides providing more funds to build good housing?

● (1650)

Dr. Catherine Leviten-Reid: Besides additional funding to support the inclusion of the common space, what else could be done to support healthy aging for seniors moving into unassisted rental housing?

Mr. Ramesh Sangha: Yes, please.

Dr. Catherine Leviten-Reid: Paying attention to transportation comes up a lot when we're working with rural communities. The Nova Scotia government has an action plan now for an aging population, and one of their action areas is on building better transportation in rural communities. That's certainly one of them. It could be partnerships with non-profit organizations in communities that are providing services to seniors, including Meals on Wheels or exercise programs, for example. I've certainly seen that in the province. A whole host of things could be done to improve quality of life for people who are living in unassisted rental housing.

Mr. Ramesh Sangha: Thank you very much.

I'll share my time with Mr. Lauzon.

[*Translation*]

Mr. Stéphane Lauzon (Argenteuil—La Petite-Nation, Lib.): My sincere thanks to our witnesses.

You have made some very interesting and constructive points.

You talked at length about housing, but I would like to hear you talk about a greater role that the federal government could play. Do you think you have to go back to the National Building Code to build new structures? Do you think we should work with the provinces, territories and municipalities to change the building code so that the housing is adapted or adaptable, if necessary?

[*English*]

Dr. Catherine Leviten-Reid: I can go first. Maybe; that's an interesting idea. I'm not sure if it is absolutely required. With the money that's coming to the provinces and territories through the investment in affordable housing program, I think there are specific requirements to which builders have to adhere. For example, currently, just across the board for affordable rental housing in Nova Scotia, 10% of the units have to be barrier-free. That's an example—just changing that requirement.

If a project is specifically for seniors, then adding a common room would be an eligible expense, for example. There are other jurisdictions.... In the province of Quebec, when I was working on this research project in 2012, having a common room in certain kinds of housing was an eligible expense for developers.

Mr. Stéphane Lauzon: I think we work together for this.

Dr. Catherine Leviten-Reid: Absolutely.

[*Translation*]

Mr. Stéphane Lauzon: You also brought up an important aspect, the 20,000 beds that people could free up by returning to live at home.

Earlier, Dr. Marcoux mentioned that it would be very important to start with the basics, namely awareness of the need for existing infrastructure. This momentum must come from the major decision-makers, at the federal or provincial level.

Do you think it's possible to estimate the cost of those 20,000 beds?

If we invested that amount in housing, would that help us save money or would it cost more to keep those people at home?

Dr. Laurent Marcoux: Earlier, I said that beds in short-term facilities cost an average of $850 a day and that keeping people at home was much cheaper.

We certainly need to improve the accommodation of people at home, but the life of a senior is not limited to housing. The community must be welcoming to the elderly. That's why I was talking about changing the culture towards seniors. Sidewalks, pedestrian areas, entrances to public places must be adapted to encourage seniors to get out of their homes.

Healthy seniors don't stay within four walls waiting to die. They are involved in society and they feel that they are still part of it. That's very important, and that's why we say that the wealthy live longer. They have the means to go out, to be taken places, to go to the theatre or the cinema, and all the rest. For their part, people who have no means are confined to the house and wait to die. This is not the way to respect seniors.

● (1655)

Mr. Stéphane Lauzon: Do you think the federal government plays a significant role in isolating seniors, depending on the decisions we make?

[*English*]

The Chair: Make it brief, please.

[*Translation*]

Dr. Laurent Marcoux: You have to raise the red flag. It's up to you, your government is pan-Canadian. It is up to the federal government to raise the flag and tell the provinces that this problem is on the horizon and that it concerns us all.

[*English*]

The Chair: Thank you very much.

Now we go to Mr. Blaney.

[*Translation*]

Hon. Steven Blaney: Thank you very much, Mr. Chair.

As we can see, the federal government has a lot of work to do. The testimony has revealed problems with the incredible wait times in Alberta, for example, which have increased over the past two years.

We are talking about money for housing, but the money has not yet been invested, in British Columbia, for example, where the needs are significant.

Earlier, Mr. Morrissey mentioned the guaranteed income supplement. According to the Chief Actuary of Canada, 230,000 seniors will be denied the guaranteed income supplement. That’s $3 billion less for them. So there is work to do.

I will go to my two questions right away.

I'm going to speak slowly because I would like an answer from our anglophone witnesses.

[*English*]

A Quebec organization said that every government should look at every policy through a seniors lens. It's a growing part of the population. I'd like to hear whether you think it would be appropriate in a national strategy to include that any Canadian government would have to look at any policy through an elders lens.

I'll start with Debra, if you understood my question.

Ms. Debra Hauptman: Should the federal government, all levels of government, look at policies through a seniors lens?

Hon. Steven Blaney: Exactly.

Ms. Debra Hauptman: Yes, they should.

In the age-friendly communities design, which we have done in Langley...I was involved in a committee that took our township through those steps to become an age-friendly community. That is one of the measures of an age-friendly community. That's a good suggestion.

Hon. Steven Blaney: I will turn to my friend from Grande Prairie. It is a little like sustainable development. We said every branch should look into it. What about living people, our elders? Should the government have this seniors lens?

Ms. Sherry Dennis: I agree. I think they should.

We're a non-profit agency. Getting the information from the front-line workers, the caregivers who are right there with the seniors hand in hand helping them.... They have a very strong opportunity in the community to help the seniors speak. We're front line. We're there with them.

You can get more for less with non-profit oftentimes, because the caregivers are working overtime. We're there night and day taking their calls.

Hon. Steven Blaney: That's true. Actually, that's why my colleague Mark Warawa feels there should be a credit. Here in Ottawa, is there support for having this seniors lens? Are you in favour of that?

[*Translation*]

Dr. Laurent Marcoux: We are certainly in favour of that. I talked about the seniors' culture, which encourages us to do nothing without thinking that one in five people—and soon one in four—will be elderly.

Hon. Steven Blaney: In my riding in Lévis, it's already one in five people. It's an aging population.

Mr. Marcoux, you said that the number of seniors will double in 30 years and that they must be kept in shape. We introduced a tax credit for young people, but it was scrapped by the Liberal government.

In recommendation 9 of your brief, you talk about physical activity. Would a tax credit be a good incentive to keep young people and seniors active? You talked a lot about prevention.

Dr. Laurent Marcoux: The policy we are proposing provides for a tax credit for caregivers.

● (1700)

Hon. Steven Blaney: Yes.

Dr. Laurent Marcoux: Caregivers are overwhelmed by the burden of their task. They have to miss work and they are putting their health at risk.

Anyone can do this for a few weeks, but it is often impossible to care for seniors who are losing their independence and who have to wait a long time before they are placed somewhere.

Hon. Steven Blaney: There should be a tax credit for caregivers. Ms. Dennis also talked about it.

Mr. Marcoux, you are a doctor. We now know that the government wants to tax entrepreneurs, including doctors. Do you think that the infamous Morneau tax will help keep doctors in the regions? Will it have negative effects on seniors?

Dr. Laurent Marcoux: We talked about it yesterday at the Standing Senate Committee on National Finance. I'll say it again today: changing a system that has been around for 45 years will have unexpected, unpredictable and probably negative consequences.

Of course we must review the tax system. Any system, including the 50-year-old health care system, needs to be reviewed and adapted to modern times. However, you must take the time to check if the stairs are sturdy before you step on them.

Hon. Steven Blaney: So it should not be at the expense of seniors, which is what is happening right now.

Dr. Laurent Marcoux: It must not be at anyone’s expense.

Hon. Steven Blaney: Thank you very much.

[*English*]

The Chair: Thank you very much.

Ms. Blaney, you have three minutes.

Ms. Rachel Blaney: Thank you.

Catherine, I'd like to go to you.

In the research project measuring the co-operative differences, you demonstrated the advantages of third sector, or non-profit and co-op housing for the senior population. Can you quickly tell this committee what those advantages are, and how the federal government can grow this sector of the economy?

Dr. Catherine Leviten-Reid: One of the advantages is that there is a built-in mechanism for resident participation, particularly in the housing co-op model, either through a tenants-governed co-operative or a multi-stakeholder co-operative, where you have tenants on the board, but you might have a representative from the local health care clinic on the board as well. In any case, that's part of the DNA of a housing co-op. With a non-profit, you might or might not have tenant involvement, depending on how they structure their board. That's one advantage.

The second advantage is the community orientation of the housing provider. This is a different research project, based on the same data, where we looked at developers based on incorporation status. It was the developer that was incorporated as a for-profit that emphasized cost most strongly and did not have common space in the development. Of course, if something should happen to these rental housing projects, the assets of the co-op and the non-profit belong to the community. They don't belong to a private owner.

I would see those as the advantages.

What can you do? I know in the past you've had privileged partnerships with the co-op and non-profit sectors. I'm not sure that I'm prepared to say that should be done again, because so much of our rental housing is provided through private market rentals. They really are an important stakeholder. It's still, though, building the capacity of the non-profit and co-operative sectors. Again, these were the developers who were doing this for the first time. These were the developers who were learning as they were going, making phone calls to other organizations they knew of to learn about housing. So providing that technical assistance to these groups is a really important role you can play.

Ms. Rachel Blaney: Ms. Wright, quickly, I know that accessing your services is getting harder for seniors. I also know that speech and hearing issues can be mistaken for dementia and often people are wrongly diagnosed. Could you tell us a little about the impact of that?

Dr. Meredith Wright: Chantal, do you want to answer first about the hearing issues?

Dr. Chantal Kealey: In terms of hearing loss and dementia, as Meredith stated earlier, people with hearing loss are at greater risk for dementia. There is a lot of evidence showing this association. We, at this time, cannot determine any causal link. It's very important that we understand that there is no cause and effect as of yet, just a strong correlation.

In terms of that, it's really that people with hearing loss are expending a lot of their efforts and energies to listen, and listen meaningfully, especially in noisy environments. They're doing these tasks that take a lot of cognitive load at the detriment of other tasks, such as working memory. They're essentially consistently channelling their efforts to listen, to effortful listening, and it's showing that there could be some changes in brain connectivity where these other pathways are being weakened. There is that association.

● (1705)

Dr. Meredith Wright: Can I add a bit about speech?

The Chair: Be very brief, please.

Dr. Meredith Wright: Also, there are a number of communication disorders related to, say, Parkinson's disease and stroke. When a patient has communication disorders associated with those diseases, their intelligence usually is not impacted, but it might be perceived by caregivers or service providers that they are less intelligent than they actually are.

The Chair: Thank you.

That brings us to the conclusion of two rounds of questioning. So far in this study we've left it to the desire of the committee as to whether we would do a third or a modified third round. We could very easily have one question from each party, with as many minutes, even six minutes, for each if people have the desire to do that.

Hon. Steven Blaney: We would certainly welcome that proposal. We have a great member here with us.

The Chair: To that point, I will go to you, Mr. Blaney, just for protocol purposes, and if you'd like to share your time, you can do so.

Hon. Steven Blaney: If possible, I'd like to share my time with your former colleague.

The Chair: Perfect.

Will we do that? I'm seeing nods.

Ms. Vecchio, welcome back to the committee. We've missed you.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Thank you very much. I'm really glad to be here. I am working within our communities as the shadow minister for families, children and social development. It is such an important part of these discussions as we're moving forward with the housing strategy.

Chantal, I've seen you at work. I saw you speak to my father to look for that brain connectivity. As you know, with a hearing loss, we have to be very aware of those things and what can carry forward.

Are there any federal programs or is there anything we can do more, in effect, to educate seniors about their overall health when it comes to hearing, speech pathology, and dementia? Is there something that we can do at the federal level that we can help promote through public health?

Dr. Chantal Kealey: I think public awareness is a very important factor. When we think of early detection and intervention, we often think of children or babies, but we also need to be looking at our healthy adults and ensuring they understand the importance of early identification and intervention of hearing loss.

Right now, it takes people about seven to 10 years to seek help from the time they first notice a hearing impairment, and there's a lot of damage that can be done in that time. What is important is the earlier you do suspect a hearing loss you should be going for help, and we need to be educating the public about that. Certainly, with senior-related hearing loss, the typical intervention would be hearing aids, but that's not the only intervention that's out there as an option. In terms of wearing hearing aids, the earlier you start that, the more acclimated you become, the more your brain then relearns to hear all these sounds you haven't heard.

We find that with the elderly, hearing aid acceptance goes down tremendously when they can't manipulate the hearing aids. When you start a little earlier, you become a little more accustomed to all of that. It doesn't mean you're not going to have dexterity issues when you get a little older, but when dexterity and vision start to be compromised, it becomes even more difficult. If an 80-year-old is starting to wear hearing aids for the first time, it's much more difficult. They've lost a significant amount of time of auditory input, and that deprivation is what also leads people to withdraw and to become isolated. Hearing aids have been shown to correlate to less feelings of loneliness, but also lower scores on depression scales.

I think public awareness is very important.

Mrs. Karen Vecchio: Absolutely.

Meredith, do you have anything to add to that?

Dr. Meredith Wright: Also, I think the federal government can be a leader in ensuring communicative access for people with hearing and communication disorders through the new federal legislation around accessibility, and also be a leader, say, within Service Canada and the other government departments to enable people with communication and hearing disorders to access those services.

As well, the federal government has new funding for home care and community care. Performance indicators, including how much money you've spent on speech language pathology and audiology services, would give us an idea, province by province, of how much is being spent—like a report card—so we know where the funding is going and whether it is potentially going to people with communication and hearing issues.

● (1710)

Mrs. Karen Vecchio: Thank you very much.

I'm sorry I missed the first hour, but I recognize that we're talking about the guaranteed income supplement, Canada pension plan, and old age security processing times. The reason I want to share with that is I had worked for 11 years in a constituency office focusing on the needs of seniors.

My staff has brought forward to me some changes and maybe you can tell me if this is what you're seeing in your province compared to what I'm seeing in southwestern Ontario. We've seen that the Canada pension plan has gone to up to 20 weeks for processing. We used to look at between six and eight weeks, and it was up to about 2015 that we saw those. CPP survivors' benefits are going up to 24 weeks so we're talking about a half a year for processing on this. CPP death benefits are also going up to 24 weeks. The funeral homes are expecting their money. Usually I saw about a two-month turnaround time; now we're talking about a six-month turnaround time. CPP disability is four to six months, which is typically average with your hiccups happening.

One of the biggest things I'm seeing is with the guaranteed income supplement. Our most vulnerable seniors are at huge risk. These are the people who are having the guaranteed income supplement because that's what's paying for their food, that's what's paying for their housing, that's what's paying for everything.

Have you seen the same increased time frames that I have seen?

Ms. Anne Repetowski: We're actually seeing the CPP at a little less time than you. We're generally seeing it at 20 weeks, not 24. For old age security and the guaranteed income supplement; delayed old age security; complex old age security because you're not in Canada for the full amount of time; survivor's allowance; involuntary separation, when one goes to designated supportive living and one stays home...eight and three-quarters of a year, if you're lucky.

It is so stressful. That's why we're seeing so much more stress and anxiety in seniors. I had a person in the hospital for 12 days two weeks ago. His anxiety got so huge because he was worried that he was not going to be able to pay the rent in November when his.... He was actually under 65. He just turned 65 today. He was worried he couldn't pay the rent, because he's been on assured income support and now he will be.... We have the CPP in place. We actually did a "dire need" to old age security and we found out yesterday that it's been approved. He will have the money in November.

Mrs. Karen Vecchio: That's excellent. I'm glad for him.

Ms. Anne Repetowski: But he spent 11 days in the hospital because his anxiety was so huge.

Mrs. Karen Vecchio: We too worked on those dire needs assessments all the time. Someone shouldn't have to walk into their MP's office to get their old age security. That is such a common issue. I had dealt with it for years, but I am seeing it.

My assistant, Cathy Hayward, has been working on Service Canada files for nine years, so I went back to her for some of the historical data as well. We used to take everything and look at that, so it's really, really important.

The Chair: Thank you.

Mrs. Karen Vecchio: Are you making me stop?

The Chair: I gave you 25 extra seconds.

Mrs. Karen Vecchio: Oh, golly gee. You know I can talk for hours.

The Chair: I know you can, and that's why I'm getting you to stop.

Now for six minutes, and only six minutes, Mary Ng. Welcome to our committee.

Ms. Mary Ng (Markham—Thornhill, Lib.): Thank you so much.

I'm a guest here today. I'm filling in for one of my MP colleagues, Mona Fortier. I'm very happy to be here. I'm very pleased to hear from all of the witnesses today.

I have to take the opportunity, quickly, for 15 seconds, to talk about how important seniors are to this government. I look at some of the initiatives that this government has implemented. Our friend talked about needing support for caregivers. The increase of time, so that there is extended EI for people who are caring for families, is something we have done. Additional funding for home care is something we have done. For sure, with respect to affordable housing, there is going to be a priority put on seniors, including our veterans. That's really important. And there's increasing the GIS.

I'm not going to take my time talking about the government's initiatives, because people can have a look at them, but this is certainly something that is important to this government. It's heartening to hear about the culture around the wraparound kinds of services from all of stakeholders that needs to take place in order to look after our seniors into the future.

I want to focus on a couple of areas. This is about looking into the future. There certainly is a lot of work to be done. I love what we heard from Langley Lodge. It seems to me that this is an outreach program: volunteers who are seniors who are going to help other seniors.

I'd be interested in hearing from around the table, if you will, on the kinds of community-type innovations and initiatives that are already started that are helping our seniors. I think that's something we should be looking at, the innovations or some of the community collaborations that are already taking place.

I'll start with Langley, and I'd love to hear from Grande Prairie as well. You're on the ground, so maybe you are seeing some things that the community is already taking into their own hands.

I'll start it there, with Langley.

● (1715)

Ms. Debra Hauptman: Are you speaking to me or to our MP?

Ms. Mary Ng: I am speaking to you, please.

Ms. Debra Hauptman: With regard to some of the other initiatives that are starting in Langley?

Ms. Mary Ng: Yes, or that you're seeing as best practices.

Ms. Debra Hauptman: I mentioned the age-friendly communities.

The Township of Langley has formally become an age-friendly community. There is a formal designation, and there is quite a process to obtaining that. It looks at the World Health Organization definition for “age-friendly communities”, and there are a number of steps. That's something not ever community across Canada is doing, but more and more are. There are grants and all sorts of support to do that.

Ms. Mary Ng: Great.

Ms. Debra Hauptman: That's very good.

There are a number of action tables in Langley. Some of them are driven by the health authority, and some of them by local interest groups. They look at different things, like housing and transportation. In terms of transportation, Langley Lodge participated with two other organizations, Magnolia, which is a private for-profit provider, and the Langley Senior Resources Centre, and we formed a for-profit bus co-op.

Ms. Mary Ng: Oh, interesting.

Ms. Debra Hauptman: We share a bus—we share a few buses, actually—that are wheelchair accessible. We joined as members of the co-op.

It's been very successful. Instead of each organization having to own a bus, we can rent the bus. We have our own drivers. This is the bus that we're using for the new horizons outreach. We're going door to door to pick up those participants to bring them to the lodge for a nutritious lunch and a social program.

Ms. Mary Ng: In the interest of time, thank you.

I would expect that if we heard an example from you, there probably are many across the country. We'll look forward to exploring what those might be.

I'm going to direct my next question to Dr. Marcoux.

You talked about needing to shift the culture of the way we think about seniors. Rather than having seniors destined into places like hospitals or acute beds, more can be done in the community. I think about the opportunity for our country with respect to young people and new opportunities, new jobs, new skills, new training for those very young people, who could indeed work in the community.

Are you seeing across the country if there is anything like that? I'm thinking about young social workers, young nurses, young people, who are perhaps developing a future in caregiving, if you will, right in the community, that will help the health and well-being and aging of our seniors.

[*Translation*]

Dr. Laurent Marcoux: You are quite right in saying that young people should be encouraged to take care of older people because there will not be enough young people to look after them.

That said, we are lucky to live in the 21st century, when there is a lot of innovation in methods of communication. If seniors are shown how those means of communication work, they are able to use them and they feel less isolated. I'll come back to the example I gave you earlier, where people shared their health records with a remote team, which visited them occasionally.

The well-being of seniors is not just about medication. A whole host of factors make their lives enjoyable and make them feel part of society. The medical community, the recreational community, the transportation sector, everyone needs to think about focusing on that.

[*English*]

Ms. Mary Ng: In my own riding that's very diverse, and there's an opportunity for the connectedness of young people to the diverse communities. They can actually help seniors age. I think about a program that was funded under new horizons, where young people are teaching seniors how to interact with the social network so that they can, in fact, participate broadly in their communities.

Thank you for your testimony today.

The Chair: Thank you all.

We now go to MP Rachel Blaney for six minutes.

Ms. Rachel Blaney: Thank you.

I'm going to come back to you, Ms. Wright.

Speech-Language and Audiology Canada was part of the alliance for a national seniors strategy. Can you share with us specifically what your organization would like to see happen in this strategy and what the next steps should be for this government?

● (1720)

Dr. Meredith Wright: My discussion will relate almost always to speech-language pathology and audiology services.

As Dr. Marcoux mentioned, the acute care hospitals have been primarily the place where care has been provided. However, now that we have a changing health care system, with both positions and beds being cut in hospitals, we need to be developing the community services. Our organization is very much focused on looking to see what services can be provided in the community and through home care for our patients and elderly seniors.

We need services in place to maintain people who are relatively high-functioning but, say, are developing hearing loss. We need access to services those individuals can afford. Private speech language pathology and private audiology services don't come cheap. Not all seniors, especially those on low and fixed incomes, can afford them, so we would need access to publicly funded services for that particular group.

We also need to ensure, as part of a seniors strategy, that there is appropriate community and health care for ill and frail seniors, and people with neurological disorders, to help them manage in the best way they can. We need to have those services in place, but we also need to make sure they link with other services, the family health care team, and other social services as well.

We have pockets of excellence in service providing in the community. I'm thinking locally of the Aphasia Centre of Ottawa, which provides community-based services for people following a stroke and follows them for years afterwards. It's a collaborative approach with a social worker.

These services are available in the city, but not necessarily in rural and remote communities and across all provinces. I'd like to see us look for examples of excellence, not only in clinical practice but also with the current research that's happening in our professions of audiology and speech language pathology. We have leaders in research developing different sorts of intervention strategies with caregivers and with people with dementia and other degenerative conditions. I would like to see the programs they have developed actually being translated into practice, as well.

Ms. Rachel Blaney: I also know your organization supports the revising of definitions terminology and requirements for the disability tax credit. Can you tell us how the current interpretation isn't working?

Dr. Meredith Wright: Chantal, can you answer that one?

Dr. Chantal Kealey: For the hearing portion of the disability tax credit, the language is very ambiguous, and audiologists often find themselves wondering if they should be certifying a given individual. The language in there basically asks if the individual is markedly restricted in an environment that's quiet with somebody they know. The problem is that we don't live in a quiet environment, only speaking to people we know, so that language really needs to be changed. That will then provide a bit more assurance that the audiologist—or the physician or nurse practitioner, who can certify certain parts of the disability tax credit—is doing the right thing and helping the client when it's necessary.

Anecdotally, I have heard from a number of people that patients do a little shopping around to see who will actually sign this for them, because a lot of people just don't feel comfortable when they have to use those criteria.

Ms. Rachel Blaney: Thank you.

I'm going to come back to you, Dr. Marcoux.

I did 11 town halls on seniors issues in my riding because I have a huge rural riding with a lot of remote communities. I'm wondering if you can tell me about the challenges that you're seeing in remote and rural communities and how a national seniors strategy can assist those communities with moving forward.

Dr. Laurent Marcoux: I think it's about providing them with services, providing them with housing. In a small area, there are less services available for them, so we need to have a larger community to bring people services. They are more isolated in the remote areas. The youngest have gone to town, as we know. They are very isolated, and they can't go to the nearest [*Inaudible—Editor*] It is a problem to be a senior in a remote area because of the isolation and lack of services.

● (1725)

Ms. Rachel Blaney: Many of the seniors that I work with talk about the fact that they have a lot of social infrastructure in their smaller communities. When somebody is sick, people will drop by and help them out. They have all that structure. Moving away means they're suddenly in a new community, and they don't have that social infrastructure. In terms of health care, how do we value social infrastructure and how important it is?

Dr. Laurent Marcoux: For remote areas? I think it was true before, but now there is no such support when they are in a small, remote area. They know their neighbours. They know the community and the community knows them, but they are so isolated. They don't have time. It's good for a short period of time, but with time, after years, they become more isolated.

We have to use modern communication like the Internet. They can use it. I have an example of a woman with only one son. He lives in Europe, in Germany, and she talks with him every day via Skype. It's not difficult to do that, and she doesn't feel isolated. She's happy. When I see her, she says, “I talked to my son, and he talked about my grandson.” She's not isolated. To be isolated is to not have contact with the people who are close to us.

Ms. Rachel Blaney: Thank you.

The Chair: Thank you all very much.

For the committee, I just have some future business notes.

On October 31, there is going to be another panel on inclusion as a social determinant of health and well-being. On November 2, there is going to be the panel on housing and aging in place.

Thank you so very much for being here, for taking time to video conference in. All of your input is going to be used to formulate our report, and I thank you very much for participating in this study.

Thank you to all my colleagues and to all of those who made today's meeting possible and allowed us to communicate in our particular languages.

Thank you, and we'll see you next time.

The meeting is adjourned.