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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.

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 housing and aging in place.

Welcome to all of our esteemed panellists. Welcome back, all of our committee members.

I have a couple of notes. We're going to get started right away with opening remarks of seven minutes. When you see me signal, it means you have one minute left. Don't panic. A minute is a long time. I usually try not to startle you when I do this, but I have had the occasion where I've caught people off guard, but don't panic. You have lots of time.

Also, this is a reminder that committee meetings are fully bilingual. Witnesses may be asked questions in either English or French.

To begin, we're going to introduce the panellists.

Appearing as individuals, we have Melissa De Boer and Andrea Dresselhuis. They are students of the school of nursing, Trinity Western University. Thank you for coming.

From the Canadian Home Care Association, we have Leighton McDonald, president of Closing the Gap Healthcare. Thank you, sir, for coming.

From Centre action générations des aînés de la Vallée-de-la-Lièvre, we have Michèle Osborne, executive director; and Julie Mercier, coordinator of activities.

From Elim Village, we have Ron Pike, executive director.

From FORREC, we have Steve Rhys, executive vice-president.

We're going to get started right away with Melissa De Boer and Andrea Dresselhuis.

The next seven minutes are yours.

Ms. Melissa De Boer (Student, School of Nursing, Trinity Western University, As an Individual): Thank you for having us today.

I'm a graduate student and an RN with critical care, home care, and palliative care experience. I'm with my colleague, Andrea.

Ms. Andrea Dresselhuis (Student, School of Nursing, Trinity Western University, As an Individual): I'm also a graduate student. My nursing background is in oncology and palliative care.

Ms. Melissa De Boer: Nurses are the eyes and ears of health care. We bear witness to the triumphs and suffering of seniors, as they make up much of the population we care for. Today we want to talk about three issues. First is housing as a social determinant of health. Second is wraparound home care that allows seniors to age well in place. Third is dying well.

Social determinants of health are those conditions in which people are born, grow, live, work, age, and die. We urge you to view housing as a social determinant of health, because unsuitable housing contributes to considerable differences in quality of life among Canadian seniors. Inadequate housing can lead to negative consequences, including the onset of disease and the worsening of chronic conditions.

Nurses assess home environments regularly for potential challenges faced by seniors, such as snowy sidewalks, unsafe lighting, unhygienic environments, or something as simple as stairs or clutter. However, our assessment goes beyond the physical structure to those things that transform a house into a home, allowing seniors to thrive and flourish in place.

Through the lens of housing as a social determinant of health, a nurse may also consider the location of one's home in terms of access to reliable, affordable, safe transportation not only to medical appointments, but to social outings and for access to their hobbies and interests.

Addressing housing for seniors then must, in policy, be multisectoral, considering how housing shapes all aspects of positive aging. The development of a seniors strategy has to practically assist, through provision for maintenance, upkeep, or renovations.

Volunteer driving programs and affordable public transportation will also support seniors to remain in their home. As Pat Armstrong highlighted in her presentation to this committee last month, social inclusion cannot happen if a senior is socially isolated in their residence.

We urge this committee to recognize housing to be a social determinant of health as a necessity to advancing inclusion and quality of life for seniors. This is an upstream approach, requiring a health-in-all-policies strategy to improve health outcomes and quality of life for seniors. An upstream approach will prove more cost-effective than paying downstream for the negative health consequences of poor housing and social isolation.

Ms. Andrea Dresselhuis: Most seniors prefer to live at home, autonomous, active, and independent, surrounded by family and friends. To age well in place, Canadian seniors require community-based health services provided by integrated, interdisciplinary health teams. The reality is that aging in Canada today is synonymous with living with multiple chronic illnesses, and health decline is often not gradual but punctuated by episodic medical events, with each event carrying the risk of hospitalization and even death. As nurses, we see the sad and sometimes devastating results of needless or lingering hospitalizations for seniors. Such hospitalizations can be avoided when interdisciplinary community-based health teams work together in innovative ways. Seniors stay in their homes, not in hospital hallways.

One such successful initiative in B.C., the nurse Debbie model, does exactly this. Family physicians, nurse practitioners, and home care nurses work together to identify frail elderly individuals and care for them in their homes. In the year of its inception, 2015, the annual salary of one RN avoided 260 emergency room visits and over 8,000 hospital days. Now, two years later, local B.C. health authorities have hired 18 other nurse Debbies to build and strengthen this initiative. Its success lies with the expert home care nurses connected with frail elderly Canadians in their homes, who then collaborate with their family physicians or nurse practitioners. Imagine the upstream and cost-saving benefits from initiatives such as these.

● (1540)

Ms. Melissa De Boer: Social inclusion and quality of life for Canadian seniors also extends to dying well. Nurses advocate for dying well as an extension of living well. It is estimated that 90% of Canadians will require care and support at the end of life, yet currently less than a third of Canadians are estimated to have access to high-quality palliative care services. Palliative care must extend beyond care for those who are dying from cancer to also support those who are dying from chronic conditions.

Professor Sheryl Reimer-Kirkham is involved with a University of Victoria research team led by Dr. Kelli Stajduhar on end of life care for persons who are under-housed. This research is showing how dying happens in the cracks between our health and social services, and that end of life care is often provided by volunteers and shelter staff who know little about how to care for the dying. Other times, vulnerable seniors are dying alone on the streets.

Bill C-277, a framework on palliative care in Canada, is a chance to address this. We need a coordinated approach to palliative care, coordinated across sectors, jurisdictions, and levels of government. Linking a national seniors strategy with a national home care plan and a pan-Canadian palliative care strategy will ensure that a shared-care model is coordinated, comprehensive, and effectively administered across governmental sectors.

Ms. Andrea Dresselhuis: To conclude, Canada's seniors have given generously to their family and loved ones, and to their country's economy, all the while straddling change in a rapidly advancing world. Canada's seniors are in many ways surprising us with innovative and feisty strategies to aging, with many working into their seventh and eighth decade.

We recommend three calls to action: one, safe, affordable, and accessible housing; two, aging well in place with skilled inter-professional teams; and three, enhanced access to palliative care.

Thank you.

The Chair: Thank you very much.

Mr. McDonald, you're up for the next seven minutes.

Mr. Leighton McDonald (President, Closing the Gap Healthcare, Canadian Home Care Association): Good afternoon, and thank you very much for the opportunity to present to you today.

The Canadian Home Care Association is a national not-for-profit membership association dedicated to advancing excellence in home care through leadership, advocacy, awareness, and knowledge. Closing the Gap Healthcare, the company I work for, is a sustaining patron of the association and works closely with them in order to advance key priorities in home care.

Supporting older Canadians to live at home with dignity, independence, and quality of life is a priority for all home care programs across the country. To achieve this goal, our health and social care services and communities must support an environment where older people not only age in place but are also active and productive members of the community. Older Canadians want to remain in their homes and believe that home care is a critical part of making this happen.

Unfortunately, there's chronic underfunding and suboptimal capacity for the delivery of these important services across all jurisdictions. On average, provinces spend only 3% to 4% of their health care budgets on home care, even though this is proven to be more effective than acute care and is the preferred setting of care for seniors with a frailty.

Even with the federal government's commitment to investing $6 billion in home care in the next 10 years, publicly funded programs will remain challenged to provide these services with the increased demands of an aging population. However, there are a number of innovations taking place, and I think it's important to highlight some of these.

The first one I'd like to speak about is one that facilitates social connectedness among socially isolated seniors. The World Health Organization states, “Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health.”

In Canada, in a study of seniors who were surveyed, those over 60 years of age, 43% reported feeling lonely, with 13% feeling chronically lonely, and 30% suffering from episodic loneliness. It's estimated that 1.3 million Canadian seniors suffer from chronic loneliness. Studies show that health deterioration is twice as high in those who have chronic loneliness than with those who do not. As health deteriorates, quality of life deteriorates, as does the increased burden on the health care system. Individuals who engage in meaningful social relationships are healthier, happier, and live longer. However, there are many in our society who are not able to have these social interactions due to a number of limitations.

There are innovative programs, such as one called Keeping Connected, which is offered by Closing the Gap Healthcare. It supports seniors, from a social health and well-being perspective, through planned telephone calls, anything from one to three times a week, with those calls lasting 20 to 30 minutes at a time, based on the assessment of the loneliness of that senior.

When comparing loneliness scores from intake to discharge on this program, findings indicate that Keeping Connected is effective in supporting lonely seniors. In the study that was done, findings included that 97% of these clients felt involved during the calls; 88% felt the companion understood them; 96% of clients looked forward to the calls; 73% felt companions made them feel less lonely; and 99% would recommend the service to other seniors. This is a truly low-cost, high-impact solution to social isolation.

Another one I'd like to raise is leveraging technology to meet the needs of seniors in their homes. With this chronic underfunding and the lack of capacity, we need to leverage technology. Technological advancements have created new options for care delivery, improving people's health, and at the same time improving efficiencies and reducing costs of care. Technology-enabled home care focuses on prevention, independence, and quality of life. For frail seniors with complex care needs, deployment of innovative technology-enabled home care solutions can mean the difference between being an active participant in their community or living their remaining years isolated or in institutional care.

The benefits of innovative technology-enabled home care solutions include better control of chronic illness through remote patient monitoring; improved safety in the home due to the ability for technology to alert caregivers and health care professionals of early signs of deterioration in health; enhanced self-care and person-centred care through the provision of education and active patient engagement; improved safety and medication management for people in their home, a challenge we know that elderly people have; and increased access to appropriate care in rural, remote, and hard-to-service areas, and we have lots of those in our country. Supporting the vital role of family caregivers is also an important part of this.

It's easy to envisage a future health system fully immersed in a range of technologies that support seniors care in the home. However, our collective challenge is how we attain this vision. In advancing the adoption of technology, we need a cohesive strategy, long-term investment, policy changes, and a structured change management process.

● (1545)

In closing, I would like to bring light to a vital part of the home care and health care system: family and friend caregivers.

Canada needs to do more to support caregivers, especially when their continued dedication and contribution are the reasons why so many older Canadians have been and will remain able to age in their places of choice for as long as possible.

A 2012 Statistics Canada study found that one in10 caregivers spends more than 30 hours a week providing care. That's equivalent to a full-time job. They contribute $25 billion in unpaid care every year to our health care system. As 50% of carers are between the ages of 45 and 65, their prime working years, there is a considerable cost to the economy as well, estimated to have been $1.3 billion in 2012.

Although caregiving can be rewarding, caregivers often compromise their health, incur out-of-pocket expenses, and face employment challenges in the absence of appropriate support. Canadians want governments to do more to help seniors and their family caregivers.

Five priority areas have been identified by caregivers and caregiver support groups across the country, and these are: one, safeguard the health and well-being of family caregivers through the funding of caregiver respite programs and other community-based services; two, minimize the financial burden placed on carers by improving awareness of the new Canada caregiver credit and amending this to make it a refundable tax credit; three, support caregiver access to information and resources by developing a national resource database that links with current jurisdictional initiatives; four, assist employers to provide supportive workplaces that recognize and respect caregivers' needs by funding an employer-for-caregivers consortium that would equip employers with information, tools, and resources; and, five, invest in research on caregiving as a foundation for evidence-informed decision-making.

While we have made advances in some of these areas, there is much more to be done to ensure caregivers are recognized, valued, and supported in their vital role.

Once again, Canadians believe that home, not a hospital or a long-term care facility, is the best place to recover from an illness or injury, manage long-term conditions, and live out one's final days. Our federal government can enable the meaningful change that will be needed to meet the growing and evolving needs of our aging population by playing a key leadership role on this issue of significant national importance.

Thank you very much for allowing me to share this with you. I'm happy to elaborate during question time.

The Chair: Thank you very much.

Now we have Michèle Osborne, executive director, and Julie Mercier.

The next seven minutes are yours.

● (1550)

[*Translation*]

Ms. Julie Mercier (Coordinator of Activities, Centre action générations des aînés de la Vallée-de-la-Lièvre): Hello everyone.

The mission of the Centre action générations des aînés de la Vallée-de-la-Lièvre is to foster the well-being, autonomy, and vitality of seniors in Vallée-de-la-Lièvre, in the Outaouais region. All our services are designed to develop the full potential of seniors to remain in their own homes as long as possible, as they wish to do.

The organization's objectives are to prevent isolation and loneliness in seniors; to foster contact among seniors and retired persons; to encourage retired persons to devote their time to seniors; to utilize seniors' skills; to inform seniors about their rights; to emphasize the personal and collective responsibility of seniors; to change the community's perceptions of seniors; to facilitate cooperation among the various stakeholders who work with seniors; to support the civic participation of our seniors; and to help seniors stay in their own homes. In short, we are familiar with the needs of our seniors and know what is happening with them.

We also offer various services that enable us to reach out to seniors. The services are tailored to their needs. For example, we offer: transportation assistance for medical appointments; the Bouf' Mobile service, which delivers fresh or frozen meals to their homes; friendly visits and phone calls through our volunteer matching system; a tax clinic; a reference and information centre in both official languages; and help filling out various forms.

We also have a support group for seniors' family caregivers and local employment initiatives for vulnerable seniors, which we call ITMAV. We have two ITMAV officers in our offices.

We also offer various activities to help seniors maintain their autonomy and foster their vitality. These activities focus on prevention and the promotion of healthy lifestyle habits, including presentations and crafts workshops, cultural workshops, and discovery workshops. We also offer recreational and cultural workshops.

We support the development of seniors' potential by getting them involved in democratic life though community kitchens and a community garden. We support individuals in their natural environment by offering all these services and all these activities. As a result, we are often in the field and converse with seniors. Finally, we encourage them to be active in their community.

The area we serve extends from Val-des-Bois, in the north of the Outaouais, to Thurso, and includes Buckingham, Masson-Angers, Mayo, and Lochaber. We serve about 16 municipalities.

Since we know our clients well, we are in a position to make certain recommendations. Further, I would add that our organization has 1,000 members and 120 volunteers.

I will now give the floor to Ms. Michèle Osborne, who will tell you about our recommendations.

Ms. Michèle Osborne (Executive Director, Centre action générations des aînés de la Vallée-de-la-Lièvre): Hello. Thank you very much for the opportunity to be here with you today.

The region we serve includes both rural and urban areas. It includes many very isolated villages where there are few home services to help clients age in their homes. Our recommendations are designed to provide long-term funding for our mission, for organizations such as ours, and for other organizations that offer services to seniors to allow them to age in their own homes. I think all Canadian seniors want to stay in their own home for as long as possible. By offering transportation assistance, we help seniors get to the hospital and medical clinics at a low cost. These individuals also have trouble getting transportation to go shopping or for social outings.

Funding is needed for services that are effective, rather than constantly trying to innovate. Innovation is needed for seniors, but priority should be given to services that have been demonstrated to be effective in allowing seniors to age in their homes.

We recommend that funding applications for grant programs be simplified. Calls for proposals are often issued in the summer, with three or four weeks' notice. For community organizations such as ours, it is not easy to submit proposals. This also makes it difficult for other organizations to submit proposals.

Furthermore, our organization has to draft about eight major reports on results each year. It goes without saying that if we spend our time filling out forms, seniors do not receive as many services. We suggest therefore that the reporting requirements be reduced.

Additional support for family caregivers is also needed. Many seniors are able to live at home thanks to their family's support, and this must be recognized, financially, in particular.

We recommend adding social housing in urban and rural areas, and improving the effectiveness of public networks that provide services for seniors, specifically by tailoring them to their reality. For example, ATMs and bank counters have been closed in many small municipalities, so seniors do not have access to an ATM. That leaves them at a loss and they often find it a very impersonal process.

We recommend that seniors should have access to local health services in all municipalities to enable them to age in their homes. There are many villages where, unfortunately, there are no more family doctors, nurses or services offered by the health network. As a result, people have to go elsewhere to get those services, which means they cannot remain in their homes.

Grants should be offered to make seniors' housing universally accessible. Their living environment should be adapted as they age, for example through home visits.

We therefore recommend financial support to businesses that want to install lighting for seniors and improve accessibility for persons using a walker.

Financial support could also be make available to recreational organizations. Seniors do need to get out of the house and enjoy recreational activities.

We also recommend financial support for affordable transportation initiatives, as well as support programs to help seniors who have been subject to intimidation and ageism.

Thank you very much.

● (1555)

[*English*]

The Chair: Thank you.

You had lots of time left. You had about 26 seconds, so you were good.

[*Translation*]

Ms. Michèle Osborne: Would you like me to continue?

[*English*]

The Chair: No, that's okay.

Now, it's over to Mr. Ron Pike, executive director for Elim Village.

The next seven minutes are yours, sir.

Mr. Ron Pike (Executive Director, Elim Village): Good afternoon. Thank you for the opportunity to present at today's session, and thank you for the meaningful and vital work you're initiating through this committee.

I'm honoured to be here today representing an incredible group of residents, staff, and stakeholders who have played a variety of roles in creating a great senior living community called Elim Village. My hope is that by sharing our story with all of you today, we can inspire thinking, positive dialogue, and most importantly, action in other communities in order to advance inclusion and quality of life for Canadian seniors.

The Elim story begins in the early 1990s, when a small Bible study group got together. One of the couples in this group shared a challenging personal circumstance, in which they were required to place their parents into separate care facilities due to differing care needs. You can imagine the heartbreak when, after 50 years together, they were separated in the last stages of their lives. As a group they were moved by this story and began to envision a place where, despite differing care needs, spouses and friends would never have to worry about being separated again. They envisioned a community that had a variety of housing options, was professionally managed, was enriched with amenities, and allowed residents to celebrate life's joys and meet life's challenges together.

This story inspired the creation of the Elim Foundation, which began working within the community to raise the required funds to move the project forward. In the end, a total of 64 investors raised $1.5 million in equity, enough to put the vision in motion. Over the course of the last 15 years, the initial $1.5 million investment has grown to over $170 million in real estate assets and two senior living campuses. Our main campus, located on 25 beautifully maintained acres in Surrey, B.C., is home to over 650 residents and provides meaningful work to over 400 staff and volunteers. Our housing inventory provides our residents with flexibility and choice by offering a wide range of sizes, styles, and designs, including duplexes, condominium-style apartments, and private individual units for those requiring residential care.

On site we have both private and publicly funded units integrated within the community. The majority of our 250 independent units are private life leases and operate similarly to a strata with a monthly maintenance fee. Our foundation has also purchased five independent units, which they rent out to individuals who may not have the financial means to purchase a life lease.

Within our 109 assisted and supported living units, 50% are private, with the remainder being subsidized by BC Housing and Fraser Health. The majority of our 193 residential care units are publicly funded through the Fraser Health Authority, with a small private pay inventory set aside.

Our second project, located in Chilliwack, B.C., occupies nine acres and is in the initial stages of development.

At its core, the story of Elim Village is a real life example of the power of community. It's through community and the associated congregation of people and assets that we have created a number of advantages.

Through community we have raised investments to initiate and support the acquisition of land and building projects.

Through community we have been able to offer a wide range of housing and care options that reduce the physical and emotional impact of transition and change on older adults. In fact, we've had over 200 housing transitions, and we've been able to keep over 80 spouses together on the same property with differing care needs.

Through community we've added on-site amenities including a 400-seat auditorium, a small bistro, community gathering spaces, walking trails, a doctor's office, and a pharmacy.

Through community we have attracted other individuals and organizations like the Fraser Health Authority, which has been a key partner in integrating care services throughout the village.

Through community we have been able to make wellness a priority. Our programming supports this in a variety of ways, from concerts to wellness fairs and education, from fitness classes to dementia-specific programs. An important area of wellness is also found in spiritual care through the pastoral care program, where we increasingly deal with residents, families, and staff with end of life issues, including grief and loss.

Through community we have also been to engage a group of capable and caring staff members who serve the residents by listening to their concerns, answering questions, providing guidance and support, advocating for their interests, and even coming in to change the occasional light or fix a toilet.

Finally, through community we've been able to create a home for residents where they feel valued, supported, and secure. Similar schedules, interests, and shared experiences and histories allow them to engage and interact with one another on a daily basis, serving to combat the feelings and issues associated with isolation and loneliness.

While we are thankful for our situation and optimistic about the opportunities ahead, we recognize that we are among the fortunate few in our field. Our size, scale, and not-for-profit status have provided us with some financial margin to strategically invest in the community. The relatively recent addition of our residential care has given us service contracts with better than average care hours, and the fact that much of our infrastructure has been constructed during a period of low interest rates has provided us with beneficial financing.

● (1600)

That said, like many other providers, we're concerned about a number of trends we are experiencing. We are increasingly challenged to do more with less, as care needs within assisted living in residential care continue to rise while staffing levels remain the same. Expectations with respect to quality of life are increasing, and dare I say they'll be higher with the baby boomers, yet we have little time and resources available to enhance areas like dining, food quality, and wellness services.

Finally, compliance requirements in all areas, from by-laws to building codes to workplace safety and standards related to clinical best practice, continue to rise. In isolation, these are positive things. However, in combination, they place service providers in challenging positions.

In order to ensure that the older adults of our country are appropriately supported and cared for, we need to be strategic with our use of time, energy, and resources. To this end, I would like to leave you with recommendations from the BC Care Providers Association, put forward in the January 2017 publication “Strengthening Seniors Care: A Made-in-BC Roadmap”, which I believe has application to the national conversation as well.

They are encouraging taking a four-pillar approach to strengthening seniors care in Canada. Pillar one is to encourage continued investment in infrastructure to ensure that the care we provide is supported and not hindered by buildings in which we work every day. Pillar two is to provide for appropriate hours of care and the necessary human resources and training to support it. Pillar three includes focusing on quality of life as much as quality of care. Both go hand in hand, and they must be put on the same playing field. Last, pillar four is to make strategic investments in innovation. We need to better use technology and ensure that proven pilot projects are supported and scaled in order to benefit more seniors.

Thank you.

The Chair: Thank you very much, sir.

Next is Steve Rhys for seven minutes.

Mr. Steve Rhys (Executive Vice-President, FORREC): Thank you to the committee for inviting our firm. I feel like we are at the opposite end of the spectrum, and the table was set very nicely to lead this up to where we are. We are not experts on seniors' living. We are not experts on health care. We are experts on life experiences: how we enjoy them on a day-to-day basis and how we apply what we've learned in the entertainment industry to resort living, as well as, now, to seniors' community living.

I'll leave the expertise to the people who deserve the expertise. We are at the design end of the spectrum, where we are trying to create environments for places where people want to live the rest of their years, post-career.

The opportunity came to us as a project in Florida. There was a community being built, but the entrepreneurial spirit of the owners who were developing it had a question that they were struggling with: If we provide the best care, and if we provide the best housing type, what is the environment in which people want to live? When they have a choice, where will they want to live? If they decide they are going to move more than 15 kilometres from where they raised their family and have their friends, Florida is that big jump. The big question for them was, why would people come here?

If we could pull that issue apart, aside from the distance they had to move when they relocated, the question is, what was the choice they were really making? They were looking for a place where they could live the next 20 to 30 years of their life, with new family and friends, building a new society around what their next few years were going to be like.

The key question here is, what are we trying to achieve? I have only two examples to point to for you right now, but I'll tell you that since these issues came up through discussions in the last two or three months, and the media caught on to this, people from the retirement home industry—many of you here are involved in that—and from the development industry have been asking how these two things come together.

We don't know how that's going to influence what your committee is considering. We don't have a clue. What we are doing is sharing with you a very real discussion that's going on. People want a choice. The boomers, right now, are driving that. That wave started in the early 1990s. We saw what was happening in Arizona, California, and then moving into Florida. The boomers are now at the peak of that wave, maybe a little past the peak, and they are driving the question of choice. They are choosing earlier. They want to choose earlier, because they don't want to move somewhere in the end stage of their lives, when they really need care. They want to start earlier and start a new life, and be sure that where they move to has the rest of the things, those essential ingredients that you have all been talking about.

They want to age in place, with their new friends, and of course they also want their family to be able to join them whenever they please. Isolation becomes an issue. They don't want to feel like they are in a community where the seniors live behind a wall, and the rest of us are driving on the streets nearby. That's a key ingredient when we design these communities. It's a community that is inclusive.

I'll talk about the two examples that I want to cite. One is where we really learned and tested our craft on this subject matter. That was at The Villages in Florida. When I met them, they had 12,000 residents, mostly in trailers, park side model trailers. They now have 120,000 residents living in three distinct communities, each one with its own set of services and commercial areas to support their everyday living.

There are 216 golf holes on 34 golf courses. There are community centres, a hospital, numerous memory care centres, and numerous assisted and full-care health care facilities. We had nothing to do with any of that.

● (1605)

They realized that when they brought people to live in a new community, they were going to want to stay. They made sure that they were given that opportunity to stay and to not have to leave unless they chose to. That was 22 years ago.

The second project is in Hamilton. I was telling Ron that it was like sending a message out into space to see if there's other life. Twenty-two years ago we wondered if what we were doing in Florida resonated with anybody. Twenty-three years later, I got a call from a guy in Hamilton who was asking me exactly the same question they asked us in Florida: “I'm wondering what a community for seniors would look like if Disney designed it. What would that feel like?” He said, “I imagine it would feel like a resort.” I said, “Okay, now you have to go down and see what...”.

We can't take all the credit, honestly, but that way of thinking has permeated the discussion on what boomers and others are trying to do, or on the decisions they're trying to make.

The project in Hamilton is 144 acres. There's a charity housing project already there, which is not sustainable, so as those people age in place and leave the community, they are being replaced with new residents, boomers who are buying or renting property, and who expect to live in an environment similar to the one I just described—Canadian-style and in Hamilton, somewhat urban, not suburban.

I welcome you to ask any questions. Pictures would have been a lot better, but I'd be pleased to answer any questions you may have.

Thank you.

● (1610)

The Chair: Thank you very much.

I agree that pictures would have been nice. I was looking at your website as you were talking, and there's some very impressive work there.

Thank you to everybody. That was great. Everyone actually kept under time. That was wonderful.

We're going to get started with questions.

Before we do that, I just want to let everybody know that, depending on the timing, we will probably wrap up just after five o'clock. We do have some committee business that we need to attend to.

Without further ado, Alice Wong, you're up first.

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

Thank you to all the witnesses who came from different parts of our nation to share with us their expertise and excellent recommendations.

I hear again and again about the need to support the informal family caregivers. Statistics show there is a growing demand for family members or even friends to look after seniors.

CARP, a very hard-working, non-profit organization for seniors issues, stated that an estimated $25 billion, or 80%, of care, is provided annually by eight million informal, unpaid caregivers. They are making urgent calls for action to reduce the devastating emotional impact on caregivers, nearly half of whom experience stress or depression. Our job is not only to look after seniors but also to look after those who take care of them.

We have seniors homes and nurses who are well trained to take care of the seniors in their own institutions; however, when we talk about aging in place and about how seniors prefer to stay in their homes, this is a great issue. Then, of course, on our side, we are proposing actions that the government should start working on to support Canadians who are balancing caregiving and working.

My first question is directed to Mr. McDonald from Closing the Gap Healthcare.

You mentioned supporting informal family caregivers. Can you explain more on that?

Mr. Leighton McDonald: I think there are a number of things that can be done. One thing that springs to mind—and we're involved in some pilot studies—is the provision of respite care and having that managed by the provider. For example, we're working with some hospitals in Toronto where, as the patient, the client, is transitioned out of hospital, an arrangement is made for the caregiver to have access to a certain number of hours each month. That caregiver is then given an allocation of hours. Say they're given seven hours a week, they can choose whether they want an hour a day, or whether they want to take their seven hours on a Saturday and go away for the day. That actually then gets a personal support worker into their home to look after the person they're looking after in order to give them a break. The fact that it's self-directed actually gives them much more control. We've had great results with that.

In collaboration with that, we've also set up a caregivers' network and virtual workshops through which people are able to share their frustrations and realize that they're not the only ones dealing with these issues. They share solutions, and actually a camaraderie develops.

There are a number of things that can be done.

Hon. Alice Wong: Thank you.

My next question is directed to Julie and her group.

You mentioned that in your centre you have done a lot of good work supporting groups for family caregivers. Can you expand on that? We need to know more about their challenges.

● (1615)

[*Translation*]

Ms. Julie Mercier: Yes, of course.

We have a support group for seniors' family caregivers. We are subsidized by L'Appui, an organization that supports seniors' family caregivers. L'Appui offers support workshops for family caregivers; they are held every three weeks and last two hours each. A psychologist is present to help seniors' family caregivers talk about their problems, get information, and talk about their feelings. These workshops also provide tools to help them deal with stress or distress.

That is one thing we do. We also celebrate National Caregiver Week. On Thursday, November 9, we will be giving a presentation, together with the Société Alzheimer de l'Outaouais québécois, on dealing with refusal from a patient with a cognitive deficit, such as Alzheimer's, in order to help family caregivers communicate with the persons they are helping who have a cognitive deficit.

In our next grant application—we said there are a lot of reporting requirements and this is one of them—, we will ask for at least one more support group to help seniors' caregivers. Our group currently has 16 registered members, although we normally accept 12. Given that demand is so high, that public services have unfortunately been eliminated, and that a family caregiver group at our CLSC has been cancelled, we are trying to make up for that.

We have increased the number people accepted per group to 16, and there are currently 4 more people on the waiting list. Unfortunately, we cannot provide the service to these people, although they do need it.

Does that answer your question?

[*English*]

Hon. Alice Wong: Yes.

There is also the balance between work and family caregiving. I would like to ask the nursing students about when they visit homes. There are actually seniors looking after seniors, so they have informal family caregivers. Have you noticed anything?

The Chair: Give a very brief answer, please.

Ms. Melissa De Boer: Yes, we have noticed. It's maybe spouses caring for spouses or families caring for family members. To echo what they have said, respite care is extremely important to allow these caregivers to also remain family members, not simply caregivers.

Ms. Andrea Dresselhuis: We can't reiterate enough that caregivers need support. It's not just fatigue from compassion and the emotion, but it's also the financial toll. Financial incentives and access to respite care is a huge piece.

The Chair: Thank you very much.

Now we'll go to MP Ruimy, please.

Mr. Dan Ruimy (Pitt Meadows—Maple Ridge, Lib.): Mr. Chair, I'm going to be sharing my time with Parliamentary Secretary Lauzon.

Thank you, everybody, for coming today.

It's been quite clear right from day one that this problem we are facing hasn't happened overnight. It's been around for decades, and we have not overall as governments responded very well, bringing us to where we are today. That's the problem. It's a problem that did not start overnight, and it's not going to be solved overnight.

I have a couple of quick questions. One of the common aspects we keep hearing about over and over again is loneliness. Mr. McDonald, you mentioned Keeping Connected. What's the cost of that?

Mr. Leighton McDonald: It depends on the frequency of calls and everything. It's a very low cost. I don't have the figures with me. It really is a telephone service run by specially trained companions who are not registered health professionals but who work in collaboration with health processionals. It basically comes down to the cost of the resources for the core companions and the telephone calls.

Mr. Dan Ruimy: Is it a centralized call centre, so to speak? Can this be rolled out throughout the country? Loneliness we've heard about time and time again.

Mr. Leighton McDonald: We run this from our offices which are based in Mississauga, and we run it across Ontario and Nova Scotia.

Mr. Dan Ruimy: Do you have any metrics on this system?

Mr. Leighton McDonald: We do. I don't have them with me, but we certainly have them.

Mr. Dan Ruimy: Could you submit them to the clerk, please?

Mr. Leighton McDonald: Sure.

Mr. Dan Ruimy: Thank you very much.

Mr. Pike, I love your concept and what your community is all about. I have a quick question. What's the average cost per patient to stay there?

Mr. Ron Pike: With respect to which area?

Mr. Dan Ruimy: If you can break that out, that would be great.

Mr. Ron Pike: With respect to our independent living, or life leases, these are.... A life lease is a market rate on the housing. On average, people would require just over $300,000 to come into those. Within our assisted and supported living, it would probably be $3,000 to $3,500 a month. Residential care, on average, is about $200 a day. Again, depending on the integration of the public and private systems there, it's paid for in different ways.

● (1620)

Mr. Dan Ruimy: It's not cheap.

We have seen, again, the haves and the have-nots.

Hon. Steven Blaney (Bellechasse—Les Etchemins—Lévis, CPC): It's not cheap.

Mr. Dan Ruimy: May I continue?

For those who have money, it can cost up to $5,000 a month, and they are very well taken care of. For those who don't have money, it's whatever their CPP is. That becomes a challenge, because the care there is not as great.

Thank you.

I'm going to pass my time to Parliamentary Secretary Lauzon.

[*Translation*]

Mr. Stéphane Lauzon (Argenteuil—La Petite-Nation, Lib.): I would like to thank the witnesses for their excellent presentations.

Ms. Osborne and Ms. Mercier, I was struck by the number of volunteers in your organization. The fact that you are able to mobilize that many volunteers to break seniors' isolation could really serve as a model throughout Canada.

Can you tell us how you go about recruiting those volunteers and the role you give them in your organization?

Ms. Michèle Osborne: First, we have to recognize the work of the volunteers and thank them. The volunteers are almost all aged 55 and over and work with clients aged 55 and over. We try to make a good match between the person and the volunteer. For someone who wants to say at home and have friendly visits, we have to find the right person. Being a volunteer is very rewarding. We simply have to talk about it.

Mr. Stéphane Lauzon: Does your team use a program, model or grid to recruit volunteers, for example with criteria rated from 1 to 10 to determine whether they meet the requirements?

Could you provide that grid to us if you use one?

Ms. Michèle Osborne: There is one, but there are so many ways to recruit volunteers. Sometimes they were family caregivers whose loved one has died, but they want to stay involved. There is no magic formula for recruiting volunteers, but, in my opinion, the organization's reputation is a very important factor.

In any case, our organization has 120 volunteers and it does happen that someone is not in the right place. We have to listen to the volunteers to make sure they are assigned to the right service for them. There is no magic formula.

Ms. Julie Mercier: I would like to add a few details about how we recruit volunteers. We have a questionnaire with a lot of questions so we can find out the person's interests and preferences. People volunteer because they enjoy it, so it is crucial that they do the kind of thing that motivates them. It goes without saying therefore that we give them duties that they enjoy. That is important.

Mr. Stéphane Lauzon: You have talked a lot about partnership. You have an outstanding team that looks after the rural areas. As you said, seniors want to stay in their own homes as long as possible. Winter is coming, though, which leads to isolation. There is snow, it is cold, and people do not go out as much.

What plan would you suggest to our government to help seniors in rural areas who have no choice other than to leave their home?

What possible solutions could you suggest?

[*English*]

The Chair: Please answer very briefly.

[*Translation*]

Ms. Michèle Osborne: I keep saying that all Canadians should have the right to stay in their own homes for as long as possible and receive the services they need to do so. If seniors want to age in their own village, infrastructures must be created to support them instead of taking them away from the community where they have lived for 75 or 80 years and moving them to the city. That completely uproots those people. Infrastructures have to be created in each village so people can age at home. That is the option that must be given priority.

[*English*]

The Chair: Thank you very much.

Now we move to MP Rachel Blaney, please.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you for being with us today.

I'm going to start with a simple question, and I would ask each one of you to answer “yes“, “no“, or “abstain”.

Do you believe the government should implement a national seniors strategy?

I'll start with you, Melissa.

Ms. Melissa De Boer: Yes.

Ms. Andrea Dresselhuis: Implicitly, yes.

Mr. Leighton McDonald: Definitely, yes.

[*Translation*]

Ms. Michèle Osborne: Yes.

Ms. Julie Mercier: Yes.

[*English*]

Mr. Ron Pike: Yes.

Ms. Rachel Blaney: Everybody said yes. Thank you.

Mr. McDonald, I would like to start with you.

I really like the Canadian Home Care Association's proposal that Employment and Social Development Canada improve access to education and training for rural, remote, indigenous, interprovincial, and territorial populations for care aides.

Could you tell us how that would work?

● (1625)

Mr. Leighton McDonald: There needs to be a focus, first of all, on making it an attractive option for people, because that's one of the big issues we have. People are not attracted to it. It's not a glamourous role, and it doesn't pay well. It's a matter of making sure that people can sustain themselves. That's the first side of it.

Then it's making sure that we have the curricula at the colleges in order to do this and that quality standards are in place. It's a matter of putting that structure in place.

The overarching one is making sure that people want to do it. We are continually battling with people. We work, for example, in some rural areas. During the summer, our personal support workers become servers at restaurants because it pays better. We battle getting capacity in summer because people go work in restaurants.

I think the way in which we recognize and remunerate these very important parts of the health care system needs to be looked at.

Ms. Rachel Blaney: Thank you.

The need for a national principle-based home care standard seems to be growing and is really evident.

Can you give us a few examples of standards that are needed in the home care industry right now?

Mr. Leighton McDonald: The Canadian Home Care Association is busy working on this.

I think one has to ask, first of all, what people can expect. I really think getting expectations is critical. People must know what is going to be the government's responsibility and what is going to be their responsibility. I think that's really where the departure point is.

Once those services are being delivered, it's identifying what people can expect from a point of view of the match to their needs against what is being delivered.

Then, it's clinical standards and various professional standards, depending on what profession is in there, whether it's personal support work, nursing, or one of the therapies. It's overall, and then by profession.

I hope that helps.

Ms. Rachel Blaney: That does help.

We know that unregulated workers provide the majority of home care services, between 70% and 80%.

How can the government support the development of continuing education standards for unregulated workers and develop proficiency through education and practice standards?

Mr. Leighton McDonald: Again, we must make sure we have those curricula in place. We've seen a drop-off in that, so it needs to be looked at from a college point of view. Then we need to recognize people by way of increasing remuneration for various training. What we're seeing is people come on to the workforce at a certain rate, and despite any additional education, their rate doesn't necessarily go up. That's something that I.... We've done it in our workforce, but they are very, very small increments. There needs to be more to recognize ongoing professional development.

Ms. Rachel Blaney: I've also heard that it would be great to start to introduce some of these opportunities in high school to encourage young people to see that there are professions that are right in their community. I agree completely with remuneration.

Do you feel that high school should be included, not just college?

Mr. Leighton McDonald: Very definitely, because you want to plant the seed early. You want to raise the profile of what is being done.

Ms. Rachel Blaney: We talked about indigenous communities. We know that one of the challenges is that a lot of indigenous communities want to stay close to where they're from. I think this is a great opportunity for them.

How do we include the indigenous community and educate them more about these opportunities?

Mr. Leighton McDonald: We make sure we're addressing their needs. In many cases, when we are providing services to these communities, it involves an enormous amount of travel. It means that we need to remunerate for travel. That's something that is not being well done, I don't think, for rates for personal support workers. We need, first of all, to make sure that people are incentivized to get out and provide those services.

I think it's standard practice now that most home care organizations have client and family advisory councils. That needs to include representation from all sectors of the population.

Ms. Rachel Blaney: Thank you.

Could you tell this committee how the Canada Mortgage and Housing Corporation should enhance and simplify the accessibility and adaptable homes program to provide easier access to more individuals?

Mr. Leighton McDonald: It's not an area of my expertise other than to say we need to again.... It sounds like I'm wanting incentives for everything, but I think one needs to look at tax breaks for investment in these things in order to keep people out of facilities that are much more expensive.

Ms. Rachel Blaney: Yes.

I'm going to end there, because I only have 30 seconds left and I want to ask more robust questions.

● (1630)

The Chair: Okay, next we have Mona Fortier.

[*Translation*]

Mrs. Mona Fortier (Ottawa—Vanier, Lib.): Thank you very much.

I will share my speaking time with Mr. Lauzon.

Thank you for your very interesting presentation today. It is in line with some of the conversations I have had with seniors in my riding. These people told me their concerns about housing and social inclusion.

Ms. Osborne, Ms. Mercier, do your projects include services that meet certain needs?

In the riding of Ottawa—Vanier, for example, there is much talk about linguistic, racial, ethnocultural, and religious minorities, as well different sexual orientations.

Do you consider these issues in your projects?

Ms. Michèle Osborne: Our environment is very inclusive, but it is still difficult for certain individuals who are in a minority. It is difficult for seniors who are in a minority. A senior who has a good support network, a family, can find the services they need.

We work a lot with vulnerable people, those with low income who have trouble reading and writing and who, in many cases, have unfortunately been on social assistance all their lives. At 65, they did not apply for the Quebec pension plan so we help them fill out those forms. This is a very disadvantaged client group.

As part of one of our initiatives, local social workers travel around and reach out to the informal network of seniors in order to find these individuals. They contact the mechanic, the parish priest, their hairdresser, and the grocer. As soon we are aware of a vulnerable and isolated person, we try to establish trust with that person to identify their needs and direct them to the appropriate resources. It is an incredible service. Our organization has two local social workers. Every year, they locate between 100 and 150 seniors who are not familiar with the network.

It is easier for a person who has support, especially from their family. It is much more difficult for those who are isolated, alone, and especially for members of a minority. Being part of a minority is very difficult.

Mrs. Mona Fortier: I will give Mr. Lauzon the rest of my speaking time.

Mr. Stéphane Lauzon: You also talked about the need for transportation for seniors. You are not the first ones to raise this issue as a number of witness groups have talked about it. Public transit is designed to get people downtown for work, but since there is none in rural areas, seniors cannot use it to get to their activities. In some regions, there is transportation for persons with disabilities, yet transportation for seniors who want to get out to see people is considered a grey area.

What specifically could our government do to support transportation in rural areas and even in municipalities?

Ms. Michèle Osborne: The organizations that offer those services need support. Every year, we provide transportation assistance for about 950 appointments at medical clinics, but it is needed for more than medical care. A transportation cooperative was just created, but it might have to close down because it does not receive enough funding. Since transportation is expensive, organizations need help to offer it a lower cost.

We can count on volunteers. We match people up and provide a lot of transportation assistance. That being said, we cannot go to Valdes-Bois, because it is 50 kilometre return. Seniors cannot afford 43¢ per kilometre. That is much too expensive. Many of them forego health care. They do not get to their medical appointments at the hospital because they cannot receive transportation assistance.

Mr. Stéphane Lauzon: If I understand correctly, you are suggesting that an existing organization...

Ms. Michèle Osborne: I think support is needed for the organizations that already offer those services. There must be an effort to offer support or promote transportation with the help of volunteers. It works very well for us, but we cannot meet all the needs.

Mr. Stéphane Lauzon: Quite right. You talked about partnership and programs to break isolation, but you have not talked much about the intergenerational aspect. No one seems to have reached out to young people who can play a role. I could be wrong, but I don't think I heard you say that.

Can you talk to us about the intergenerational aspect?

● (1635)

Ms. Julie Mercier: That is correct, I did not address the intergenerational aspect in my presentation.

We have a community garden, in partnership with Carrefour jeuneusse emploi de l'Outaouais and Centre Actu-Elle. Together with the Carrefour jeunesse, we encourage young people and families to work in the garden with seniors. So we do have an intergenerational aspect.

Furthermore, we are developing computer skills workshops with youth and seniors' centres so young people can teach the seniors.

Mr. Stéphane Lauzon: That might be a good way of helping seniors use Facebook and Google and learn to read and write on those platforms.

You talked about training. Do you have an employment skills program for seniors who want to get back into the work force, either full-time or working in the community for a modest wage, just to make ends meet?

This question is for all the witnesses except the nurses.

[*English*]

The Chair: You don't have time to ask all the panel. Maybe pick one and I'll give you time for a brief answer.

[*Translation*]

Mr. Stéphane Lauzon: Do you have programs like that?

Ms. Michèle Osborne: No, but we promote it. We receive a lot of people and match them up with centres that do that kind of thing.

I saw a major advertisement about employment skills for those aged 50 and over, but our centre does not have that kind of program. That might be an option for us to consider.

[*English*]

The Chair: Thank you.

Monsieur Robillard.

[*Translation*]

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

My questions are for Ms. Osborne and Ms. Mercier.

I would like to hear your thoughts on two aspects of the missions of your respective organizations.

How do you encourage civic participation among seniors? What do you do to change the community's perception of seniors?

Ms. Julie Mercier: As to civic participation, we have a lot of volunteers, as we said.

We have three coffee meetings: one in Thurso, one in Notre-Dame-de-la-Salette, and one in Buckingham. These coffee meetings are managed by volunteers. Groups of six to ten volunteers organize the activities, purchase what is needed, and do the planning. I help them of course, but they get involved in the community by organizing and preparing activities themselves. Seniors participate in all these activities on a voluntary basis. They help me organize activities and promote them. We include them a lot in our activities. So it is not just employees, but primarily seniors who are involved.

Ms. Michèle Osborne: We do promotion and prevention by giving presentations to these people on all kinds of topics, such as finance and health. We do this in the interest of prevention.

Mr. Yves Robillard: Still with regard to your missions, how do you inform seniors of their rights?

Finally, what do you do to encourage cooperation among the various stakeholders working with seniors?

Ms. Michèle Osborne: Two weeks ago, for example, there was an activity called Caravane 360° pertaining to elder abuse. It was launched by the legal clinic, Clinique juridique Juripop. We always keep abreast of that kind of preventive activity, whether pertaining to abuse or other topics. This activity by the Clinique juridique Juripop was very interesting. Among other things, it dealt with powers of attorney for incapacity, rights at the end of life, and the law on medical assistance in dying. We provide a lot of tools of that kind to seniors.

Mr. Yves Robillard: According to the testimony the committee has heard, seniors who stay in their homes do not necessarily have to stay in a house that could be too expensive, that requires too many repairs or too much upkeep, or that would be difficult to adapt for an owner with reduced mobility.

The definition of “aging in place” has been expanded to “aging in community”.

To what extent is there a need or is it feasible to offer support options in the communities and neighbourhoods where seniors live?

What role could the federal government play to establish the necessary services for seniors who have to leave their home, but who could stay in the community if they had support?

● (1640)

Ms. Michèle Osborne: I think it is a question of urban planning. Neighbourhoods have to be tailored for seniors. That means having stores nearby and good lighting, as well as easy access for people in wheelchairs or who use a cane or walker. Even today, some stores still have a step that has to be climbed to enter. The print size on messages also has to be visible, such as the opening hours. Everything has to be examined so seniors feel as comfortable as possible in their communities. That includes safety as well as various other factors.

There was a program called Women in Cities International, through which we took some very interesting exploratory walks. We walked through neighbourhoods with seniors. There were selection criteria, such as lighting and safety, and we then adapted the environment according to their recommendations. It was a very interesting program.

Mr. Yves Robillard: No doubt that was reassuring to them as well.

Thank you.

Ms. Michèle Osborne: Thank you.

[*English*]

The Chair: We have about a minute and a half left. Does anybody want to ask a question?

Stéphane.

[*Translation*]

Mr. Stéphane Lauzon: Thank you, Mr. Chair.

You know how important this issue is to me. All MPs have the opportunity to hold round tables and consultations with seniors in their respective ridings.

We had the opportunity, Ms. Mercier and Ms. Osborne, to take part in a round table, which I actually facilitated for a whole afternoon. In the remaining 30 seconds, I would like to hear what came out of that meeting. In your opinion, did it further the cause of seniors?

Ms. Michèle Osborne: We were at the table for local services. We did of course talk a lot about the work of patient service associates, which is not appreciated. There is currently a shortage of about 41% of patient services associates, who make it possible for seniors to stay in their homes. So I think their work needs to be recognized. Patient service associates are often women, and it is a job that is not very well paid.

There has to be some stability. Taking a bath is a very personal thing. When there have been four different people who have helped a senior take a bath, that is not optimal service to seniors. Basically, I think this work needs to be recognized.

Mr. Stéphane Lauzon: Very well.

[*English*]

The Chair: Thank you very much.

Now we'll go to MP Steven Blaney, please

[*Translation*]

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

Thanks to each and every one of your for your commitment to our seniors.

[*English*]

One witness said that we are about to face a grey tsunami.

I'm proud to be seated next to the last seniors minister, who is very dedicated to that cause. She was just showing me that we had a strong action plan. It's been two years, and we certainly will be supporting a strategy, because the demographic is getting more dramatic.

I will turn to the nurse from Trinity Western.

You mentioned in your testimony that only one-third of Canadians have access to palliative care. Canadians are very proud when newborn babies come into the world, but I believe—I am an engineer—that there's a life cycle and there's an end.

Is it socially acceptable in 2017 that two-thirds of Canadians are kind of left by themselves? Can you comment on this? What would be your recommendation to the government in that regard?

Ms. Melissa De Boer: The way we are dying in Canada has changed over the years as we advance with more and more chronic conditions. This reality must be translated into education for both our nurses and our medical system as we understand and approach palliative care.

Seniors should not have to fear the end of their life due to inadequate supports and inadequate access, and a lack of feeling of choice in a country such as Canada. I believe, as a federal government, how we care for our seniors at the most vulnerable time in their life reflects our priorities as a nation. We need to be providing seniors with choice, up until their last days, to have high-quality access to relieve their suffering. We have an ability to do it.

Hon. Steven Blaney: It certainly is a matter of respect.

As you say, the way we treat the most vulnerable tells a lot about us.

Does anyone want to comment on palliative care?

[*Translation*]

Does your organization provide palliative care?

Ms. Michèle Osborne: We do not offer palliative care at the Centre action générations des aînés de la Vallée-de-la-Lièvre. It is provided at Maison Mathieu-Froment-Savoie, which is very well known in Gatineau.

● (1645)

Hon. Steven Blaney: In Lévis last week, we raised $250,000 for two palliative care beds. The community still has to come up with between 70% and 80% of the funding needed. This creates tremendous financial pressure within communities, and yet this is part of health care from cradle to grave. In my opinion, the government should pitch in the remaining amount.

I would like to go back to Mr. Robillard's point:

[*English*]

aging in place, aging in community. Aging implies a loss of ability,

[*Translation*]

simply to make meals, for example.

[*English*]

My fear with housing is we build a nice house and put the elder in it, and then we say, “Okay, get on with it.” Then we forget about the needs of this person, such as the fact that she may not want to cook her meals herself.

How do you see housing and aging together? Is there a new way to set up housing as Canadians are getting older? That's an open question.

Ms. Andrea Dresselhuis: Housing is a social determinant of health, and it is so important to look at housing through that lens. What does that look like? We need to think about how housing is accessible, and in each situation we have to look at what that senior needs. Having the community wrap itself around that person's needs in their home is important.

Hon. Steven Blaney: What type of housing are you talking about? Are you talking of individual housing? Are you talking of community housing? Are you thinking of support for the elder?

Ms. Andrea Dresselhuis: Yes, all of those things, because in so many ways 80-year-olds are the new 60-year-olds. We have to think about that. We have 80-year-olds who are still delivering babies, and we have 80-year-olds and 60-year-olds who are frail and in their home and can't walk up stairs. It really depends. There's no cookie-cutter solution, but we need to be addressing these needs based on the elders as they age and hit these different multiple illnesses.

Hon. Steven Blaney: Mr. McDonald, you've mentioned the strategy for home care. How can we get Canadians more involved in supporting elders in their needs?

Mr. Leighton McDonald: There's no problem with the concept. Everyone accepts that it's something that has to be done. It really comes back to looking at the way in which we fund the health care system and making sure we're increasing funding to the home care environment. We have a very hospital-centric focus. It's not only the wrong place for people to be because they get sick in hospitals, but also we find that they land in hospitals and then can't come out because they don't have the supports at home. That's the major problem we have in hospitals here, so it's a matter of actually looking at the budget and asking how we fund it and how we can make sure to put those supports in place for people to come out of hospital and actually go back into the community.

Hon. Steven Blaney: What is the share of home care? You mentioned it in your presentation.

Mr. Leighton McDonald: It's 3% to 4% of the budget.

Hon. Steven Blaney: Three to four per cent of the overall health budget goes into helping elders at home.

Mr. Leighton McDonald: Yes. Acute care is very expensive care. It's something we need to have as the last resort.

Hon. Steven Blaney: That goes back to the upstream approach of the nurse from Trinity Western.

Thank you.

The Chair: Now for six minutes we have Ramesh Sangha.

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

Thank you, witnesses, for the valuable input you have provided today.

Our present study is regarding inclusiveness and engagement of seniors. Everyone has talked about home care for seniors, except Mr. Ron Pike. You were talking about houses, resources, and community. That's also good, because they're making new friends, but home care is care in the home, with people living close to each other.

Melissa, you talked about upstream, and about social inclusiveness and the rapid advancement of the world. Can you suggest a new system we could adopt, using innovative methods, to bring this inclusiveness and social gathering together?

● (1650)

Ms. Melissa De Boer: When you read the brief we submitted on advancing inclusion and quality of life for Canadian seniors, our colleague shared a story in there about caring for both of her aging parents, one in Canada and one in Scotland, both with advanced dementia. The level of home care, support, and social inclusion that was considered and funded and supported by her neighbourhood and her community allowed her mother to age well in place in Scotland, avoid hospitalization, and remain in her home despite critical advancing dementia. By contrast, her father-in-law in Canada did not have nearly as good and positive an outcome. To think upstream we must shift, as Mr. McDonald suggested, from a hospital-based model —these institutions of isolation—to a more wellness-oriented, community-based model that supports an attitude of inclusivity and age-friendly communities.

Mr. Ramesh Sangha: What type of federal involvement in partnership with the provinces, territories, and the stakeholders should there be to remove this solitude and to bring inclusiveness into society?

Ms. Andrea Dresselhuis: What can the feds do to promote social inclusion and prevent isolation? We need a mind-shift in how we look after people in institutions and how we think of people at home. There has to be a seamlessness between getting sick and needing critical care in a hospital and being at home and then needing care.

You need to be supported in your home, so we need to come up with and support initiatives where you have the identification of frail, elderly people and work in small interdisciplinary teams so that these people are able to stay in their homes as long as possible. We need to consider upstream and cost-effective solutions that keep people in their homes.

What does that look like? It means we invest in those kinds of programs and stop thinking so much about hospital care. The Canada Health Act doesn't include home care.

Mr. Ramesh Sangha: I will share my time with Mr. Morrissey.

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

The presenters over the last number of meetings have been consistent on the issues with seniors, but I want to be clear that it was our government that voted for the private member's bill put forward by my colleague from Sudbury to bring in a seniors strategy. Our government believes in developing a strategy. We are very much in line with the development of a seniors strategy supported by our government. As well, we have approved $6 billion in new funds over the next 10 years for improving care in the home, which is a significant investment.

Mr. McDonald, given that we are now looking at a strategy, what is different now from what we were doing in the past decade? What was done then versus where we are now? We're committed to a strategy and we have put additional money into it. Can you tell us how that compares to what occurred over the past 10 years?

Mr. Leighton McDonald: There are different demands now. We have a much higher demand for health care generally, and for home care specifically, than we had in the past. I think a lot of the investment we are seeing is unfortunately coming a little too late. We know that, but of course it's welcome.

Mr. Robert Morrissey: Excuse me, if it's coming too late now, when should it have occurred?

Mr. Leighton McDonald: It should have happened a long time ago. We should have done some demographic planning. We should have had a look and had a long-term strategy in place. There is one thing I was going to mention when the previous question was being answered. What we need is a long-term strategy to turn the ship around. It can't be reliant on election cycles. We need a long-term strategy that all political parties agree with. It should say what we need to do over the next 20 years in order to sort this out. We need principles that will be adhered to.

Mr. Robert Morrissey: Where would you say the discussion is today versus the past number of years?

● (1655)

Mr. Leighton McDonald: We're still seeing a number of small initiatives taking place that are not entirely aligned with a long-term strategy. I have seen new initiatives, but unfortunately not all of them point in the right direction.

The Chair: Thank you.

Now, we'll go to Mark Warawa.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Thank you, Chair, and my thanks to the witnesses.

Mr. Pike, you mentioned that one of the challenges is that you have to do more with less. You said that there are more seniors but less care providers. Did I get that right?

Mr. Ron Pike: I think it's the resources that are being brought into the equation. We're finding the acuity levels of people coming toward long-term care increasing and this means more care. There are more transitions. All of those require staffing time. That accounts for some of the pressure on us, particularly in staffing and the number of hours we have to dedicate to it.

Mr. Mark Warawa: Do we need more people trained as nurse practitioners or care aides?

Mr. Ron Pike: I would probably argue that this is one of the fundamental things that will be huge on the agenda over the next little while. Health human resources is significant.

Mr. Mark Warawa: To change the way we provide health care.... I believe the average right now, as reported, is that 13% of people who could be in an alternate level of care find themselves in acute care. My understanding is that the target should be around 5% in acute care, so that means a lot of people coming out of acute care and going into residential care or assisted living. Am I correct in those?

Mr. Ron Pike: I'm not sure of the exact numbers. I'm not an expert in that area, but I would echo Mr. McDonald's comments that we are very acute care centric. Within British Columbia, there are constant stories in the news with respect to the number of older adults who are in hospitals and could be somewhere else.

Mr. Mark Warawa: I'm sorry to interrupt.

Fraser Health is where you get some of your funding from. Fraser Health is $1,800 a day for acute care, as opposed to around $200 a day for residential care. If we were to close some acute care beds and get them into more beds in residential care, that would be heading in the right direction. I think Fraser Health is headed in that direction. Is that correct?

Mr. Ron Pike: Yes, Fraser Health had some initiatives over the past year that leaned in that direction.

Mr. Mark Warawa: Thank you.

I have a quick question for Ms. Osborne.

My understanding is that you do not have palliative care at your facility. Is that correct?

[*Translation*]

Ms. Michèle Osborne: Yes, that is correct.

[*English*]

Mr. Mark Warawa: Do you provide medically hastened death, assisted dying, at your facility? If somebody wants to end their life, can they have that at your facility?

[*Translation*]

Ms. Michèle Osborne: You are referring to a senior who wants to commit suicide?

Mr. Mark Warawa: Yes.

Ms. Michèle Osborne: We certainly hear a lot about that. Loneliness is the main cause. I think seniors need to be heard. They have to be able to verbalize what they want at the end of life. They are not used to talking. If we could teach them to express...

[*English*]

Mr. Mark Warawa: I'm sorry, excuse me. I have to go to the next question.

You have at your facility no palliative care, but they can receive medical assistance in dying. That's what I think you said.

A voice: It's an organization....

Mr. Mark Warawa: Okay. *Excusez-moi*.

Trinity Western, how do we encourage more people to get into the field of geriatric nursing and care aides?

Ms. Andrea Dresselhuis: Gerontology desperately needs highly skilled professionals. When you compare it to other health professions, it's not an attractive option that people run to. I think nursing schools that are offering really great gerontology programs are a huge piece of this. Let's say somebody's gone into gerontology training, and they have a loan. Maybe the feds could forgive that. I would say that could be.... I welcome something—

Mr. Mark Warawa: Again, I have to apologize. I'm almost out of time.

Mr. Chair, in the interests of what we're hearing and what we're hearing from CARP, I think it's time that we move on to the next stage of actually doing something, what it is that we need to do, because this study is ending now.

My motion is that after we're done with this, we begin a study on what federal initiatives are needed to assist caregivers, to get more people in that, and accessibility requirements. We need to make it possible for people to age in place, so we need to look at what those accessibility requirements are and what federal incentives are needed to actually do this.

I introduced a motion last week, and I would like to move that motion now.

● (1700)

The Chair: That's fair enough.

I just want to remind Mr. Warawa that we do have time in committee business to do this. We're going to have to interrupt the session in order to discuss this—

Mr. Mark Warawa: I think I'm the last one.

The Chair: No, sir. We have Ms. Blaney to speak, but to give you an opportunity.... Obviously, you can table it whenever you wish, but we will have to ask folks to leave at this point if that's the case, or we can do this in committee business.

Mr. Mark Warawa: I would prefer to do it now, Mr. Chair, because it gives us a couple of minutes. Everybody can speak to this issue, but I'm concerned that it was two years ago that I started advocating for a national seniors strategy. It was two years ago that we started calling for a minister for seniors. It 's been two years that we've been discussing and calling for a discussion on this. And the discussion—

Ms. Rachel Blaney: Chair, I would really love my time.

The Chair: Sorry, we'll come to you. Mark still has the floor.

Mr. Mark Warawa: It's really important that we not shelve what we're doing, do a report and then move on and go on to a different topic. We have the ball in our hand. This is the opportunity. This is the timing. It's critical. We've heard about the grey tsunami. I've also heard it called a tide. The tide is up to here on us. We have to take action on this now. We've heard a number of examples from different witnesses of effective ways of doing this: there's low-hanging fruit and there's changing the paradigm of how we provide health care.

If we do not do it now, Chair, if we do not continue on this study, then I think we've lost a very important opportunity on a critical issue. We're already hearing that seniors are not having their needs met, and it's only going to get worse. In my life, I think I have a moral obligation to advocate for this. This is the time. That's why we have this motion before us.

Hon. Steven Blaney: On a point of order, Mr. Chair, I just want to let you know that if we are willing to continue this discussion, we would be more than happy to let Ms. Blaney ask her questions, as long as we are keeping this motion on the floor.

The Chair: Fantastic. We're good?

Mrs. Mona Fortier: I want Madam Blaney to have the opportunity—

The Chair: She's being given the opportunity. Thank you.

Ms. Blaney, go ahead for three minutes, please.

Ms. Rachel Blaney: Thank you so much.

The Chair: Actually, sorry. I just want to backtrack, and I'll give you your full time, I promise. I just want to correct the record. I want to make sure that we have accurate information. I think I witnessed a bit of a misunderstanding in the question. I just want to give you the opportunity to correct the record.

Your facility—yes or no—has the capacity to provide medical assistance in dying, or is that something you do in your facility? That was the question.

[*Translation*]

Ms. Michèle Osborne: No.

[*English*]

The Chair: That's what I got from that exchange, but I just wanted to make sure it got on the record that, no, that wasn't the case. Thank you.

Ms. Blaney.

Ms. Rachel Blaney: Thank you so much.

Mr. McDonald, your association encouraged Health Canada to study the impact that technology can have on supporting and enabling carers, as well as ways to accelerate the use of technology. Can you tell us a bit about the kind of technology and how the technology can better the lives of carers, and how that will also impact small and remote rural communities?

Mr. Leighton McDonald: There are a number of opportunities. For example, I know one would be remote patient monitoring. That would actually just be for, as an example, a senior with a cardiac condition. You could take their blood pressure regularly during the day. There are a number of devices that would be able to take that reading very easily and put the information up into the cloud. That information is then accessible to the provider by remote login, as well as by the caregiver and the family, who can go in just to check that their parent is taking their blood pressure, and to see what their blood pressure is.

Those monitors can send notifications so that if a blood pressure reading is high, they will send an SMS to a designated person. There are a number of technologies that can actually facilitate monitoring. Those technologies also have the capacity to do two-way video conferencing, for example, so if there is an issue if a notification comes through, that person can then speak to either their caregiver, if their caregiver is remote, or their health care professional to address the issue.

That would address some of the resource issues, because at the moment we would send someone out there to see them, whereas it might actually be easier just to speak to them. Home monitoring is critical.

● (1705)

Ms. Rachel Blaney: I'm just curious; have you seen any challenges for remote communities that don't have the Internet connection that will make this work?

Mr. Leighton McDonald: It is a challenge where there isn't a signal. There are ways around it, in that you can actually do the remote monitoring and then the information can be transferred when it is in range of a signal. Communication can be an issue where there isn't any wireless signal. It can be a challenge.

Ms. Rachel Blaney: Perfect.

For better home care in Canada, the national action plan includes short-term, one-year, medium-term, and long-term recommended actions. Where are we in terms of those recommendations? Can you quantify the progress for us?

Mr. Leighton McDonald: We are working and doing bits of it. It's in the milieu of the lack of a long-term plan, as I mentioned. We need a long-term plan in order to tie those two together. There are a number of initiatives taking place, and I think they're all valuable. There's great work being done, but it's not all being done in a streamlined fashion that's pointing in the right direction.

Ms. Rachel Blaney: Okay.

This is my last question. How do we support integrated community-based models of care?

Mr. Leighton McDonald: It's complicated. It's a matter of partnerships. It's a matter of actually developing these plans at the federal, provincial, municipal, and neighbourhood levels and having that cascade in place. It's identifying all the resources and putting those plans in place with all the stakeholders to make sure we have an integrated plan that doesn't have gaps and doesn't have duplication.

It's a process. I think the chair mentioned earlier that it's not going to happen in a day. We need to make sure that we're actually going in the right direction. Essentially, the way to look at it is as a continuum of care. If you have well seniors on this side, and seniors needing palliative care on that side, what are all the services required across the board, and how do we make sure we have that infrastructure in place? It's a 20-year plan.

The Chair: Thank you very much.

Before we get back to committee business, I just want to take the opportunity to thank all of you here today for participating and contributing to this very important study. Thank you very much.

We're going to suspend for just a moment.

[*Proceedings continue in camera*]