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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 used the gavel softly, Mona, so it wouldn't scare you.

[*Translation*]

Mrs. Mona Fortier (Ottawa—Vanier, Lib.): Thank you. That's very kind.

[*English*]

The Chair: Before we get started with our witnesses, we were to meet with Benjamin Fulton on the lawn a few moments ago, but unfortunately, he is running behind. He is going to be here, so we can do a couple of things. When he gets here, I can recognize him, and we can have him speak—we'll just interrupt the witnesses—or we can push it to the end. We are going to do a photo op at 5:40 with Mr. Fulton. We can discuss where we want to do that. It's going to be pretty dark if we do it outside, so we could do it inside somewhere. We can chat about that later. I just wanted folks to know that we are still expecting his attendance.

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 we have the final of three panels held on the subject of housing and aging in place. I'll just quickly remind everyone that the deadline to submit a brief for this report is tomorrow at midnight.

I'm going to introduce our incredible panel.

Appearing as an individual, we have Donald Shiner, professor, Atlantic Seniors Housing Research Alliance, Mount Saint Vincent University.

From the Canadian Association of Occupational Therapists, we have Nicola MacNaughton, president, and Janet Craik, executive director.

From Hospice Care Ottawa, we have Lisa Sullivan, executive director.

From Revera Inc., we have Ron Pike. Is it Ron Pike who's with us today?

Mr. John Beaney (Vice-President, Operations, Revera Inc.): No, I am John Beaney.

The Chair: It's John Beaney. Sorry about that. I have Ron Pike on here. At least I knew that was wrong.

From Senior Empowerment Assistance Centre in Peel, Ontario, we have Olufemi Adegun, president.

Welcome to all of you.

For those who have not been to this type of forum before, you will each have seven minutes to give your opening remarks. I will signal when you have a minute left, which is a long time, so you don't have to rush too much. Usually I'll give you a couple of seconds if you need it.

We are going to get started right away. As I said, at some point we are going to be interrupted. We'll make the decision at that point whether we want to pause for a mid-session break to hear from Mr. Fulton.

To kick us off, we are going to hear for the next seven minutes from Mr. Donald Shiner.

Dr. Donald Shiner (Professor, Atlantic Seniors Housing Research Alliance, Mount Saint Vincent University, As an Individual): That means I can't waste any time by thanking the committee for inviting me here on the same day that veterans were able to go to Parliament Hill. As a wounded veteran from the Yom Kippur War of 1973 between Israel and Egypt, and receiver of a military pension for life, I can only encourage you to give modern-day veterans the same privilege that I have.

The Chair: Thank you.

Dr. Donald Shiner: Thank you. My statement will begin now.

In my research on seniors, I've had the privilege of studying how members of our aging population in Atlantic Canada view their homes and the challenges they face to continue living in them. The concept of a home is complex. It consists of many parts. To many, it is those simple rituals that link us with the sequences of the day and the patterns of time. These are the rituals that surround the gathering of food, cooking, washing, eating, sleeping, and cleaning, and connect us to almost all of humanity.

The meaning of home, of a protected refuge, is very often connected with comfort, relationships, family, relatives, friends, and all those traditions that give meaning to our lives. Yet we do very little to celebrate or pay tribute to these rituals that centre on and link us to that diverse, but collective, experience of home. This is borne out by the trauma people experience after a break-in, loss of home through a marital breakup or a natural disaster.

People experience both positive and negative emotions about their homes. For example, a place may be important psychologically because it has connections with the past, but it may also offer a poor physical environment that no longer meets a person's physical needs. This is a common experience for many older Atlantic Canadians. Perhaps the most difficult situation comes when an elderly person or couple is forced to move out of their home because they can no longer manage their physical surroundings. Research has shown that people facing a move see this change of environment and living circumstance as a major obstacle. In fact, only 12.6% of Atlantic seniors have even considered any plans to move, and all fear this change.

In terms of moving and changing homes, this fear relates to the seniors' attachment to where they have come from and to the impact that moving may have on their self-identity in relation to issues of belonging, permanence, and security. They feel they will lose control of their life if they move.

Overwhelmingly, our elders want to continue to live as long as possible in their current homes. If they must move, they want to remain in the community they know where they have a network of friends and neighbours so these connections are not lost.

What is making successful aging in place unlikely to happen for many Canadian seniors is that they live in older homes not designed for ease of movement and safety. This challenge is compounded when these homes are in rural communities where there are fewer options for moving to smaller, more appropriate, accommodations. We also know that much of our housing stock is older and not designed for accessibility for any age, particularly when walkers and wheelchairs become part of the equation.

We know that as our population ages, there are challenges with providing appropriate care in the home in our many small rural communities. We also know that if we made homes more accessible, people would be able to live in them longer, yet it seems we insist on acting like Peter Pan, building homes designed for people who will never grow old and never get sick.

Having our aging population remain in their homes and communities for as long as possible is important now, and it's going to be even more important in the future. As the cost of acute care in Canada grows, at already over $1,000 a day, and the number of bed spaces proportional to the growing demand diminishes, our society will be forced to find other solutions.

Another compelling factor is the pending shortage of trained staff to take care of a growing senior population. Despite these trends, the obvious solution for making it possible for Canadians to age in place is not being championed.

The first theme running through my research on successful aging in place is the need to focus on building a sense of community, reducing isolation, and giving the residents control of their everyday living. The friendship and community feeling is what sets apart emerging solutions occurring in other countries, such as co-housing, from typical Canadian seniors housing approaches.

The second theme is that every project incorporating the 16 standards developed by the Rowntree Foundation in the U.K. for the My Home Life project has been judged as having a significant impact on both the lives of seniors now and for future housing stock when and where it has been implemented.

● (1540)

Third, most seniors, nine in 10, are not actively thinking about alternatives to staying in their homes and are not prepared for unexpected life changes. Moreover, most seniors, eight in 10, are not aware of programs and services available to them. They are missing valuable assistance to help rehabilitate, repair, or restore their dwellings. Moreover, my research indicates that one in five Atlantic seniors spend approximately 40% of their income on where they live and that almost half of seniors in Atlantic Canada have an income of less than $30,000.

Part of our magical thinking about the future means that seniors don't plan for life changes and their impact. Most seniors are fully committed to staying in their homes and aging in place as long as they can. In Canada, this is 93% of seniors. In fact, couples often develop compensating skills and abilities that allow them to remain independent by exercising interdependence, but when one of them dies or is institutionalized, it can become increasingly difficult to maintain independence in the community.

Physical solutions, such as attaching grab bars, widening doors, and making behavioural adjustments, such as sleeping downstairs in a two-storey house or taking a sponge bath rather than a tub bath, are common lifestyle adjustments older people employ. Although many home modifications are not without cost, they are often one-time only expenses, beyond the reach of most Canadian seniors.

There are four possible solutions. The first would be a program of education aimed at those over age 70, those under 70, and Canadian home builders and contractors to help them prepare for home changes and modifications.

The second action would be to initiate a national program of home accessibility tax credits for eligible home accessibility expenditures for work performed or equipment installed. The temporary credit would provide an immediate incentive for Canadians to undertake new renovations or to accelerate planned projects.

The third action would be to support a CMHC demonstration project that proved the viability of modern technology to encourage people to age in place safely.

In addition to these three major actions, I would like to have a home accessibility audit program that would certify a home built to lifetime home standards. I would like to see Canadian building codes changed so that the 16 standards of the lifetime home standards were compulsory for all new residential home construction in Canada. Homes could be certified by inspectors drawn from the senior population.

In conclusion, seniors overwhelmingly want to age in their homes and their communities, but this is unlikely to happen. Without action today, our housing stock will only continue to be less suitable for aging in place, and future generations will face the same challenges we do now. As our population ages, the cost of current solutions will only escalate unless we act now to make changes that will encourage and support staying safely in one's home for as long as possible. Thank you.

● (1545)

The Chair: Thank you, sir.

From the Canadian Association of Occupational Therapists, we have Nicola MacNaughton, president, and Janet Craik, executive director. The next seven minutes are yours.

Ms. Nicola MacNaughton (President, Canadian Association of Occupational Therapists): Good afternoon, and thank you to the members of the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities for inviting us to speak today. We applaud your efforts in undertaking this study on advancing inclusion and quality of life for Canadian seniors.

Our comments today will focus on the first theme: how to improve access to housing for seniors and, in particular, support seniors aging in place.

I'm Nicola MacNaughton, an occupational therapist and the president of the Canadian Association of Occupational Therapists, or CAOT.

Ms. Janet Craik (Executive Director, Canadian Association of Occupational Therapists): My name is Janet Craik. I'm the executive director for CAOT. I'm also an occupational therapist.

CAOT is the national organization representing 16,000 occupational therapists across Canada. Our mission is to advance excellence in occupational therapy, and our vision is that someday occupational therapy will be valued and accessible across Canada.

For those who don't know, occupational therapists are regulated health professionals who work with people who are unable to participate in important activities of daily living, ADLs, due to a range of challenges or conditions. For our seniors, these conditions often involve declining mobility, dementia, or vision loss, and they create barriers to everyday living. Occupational therapists are here to create solutions for living.

Today we really want to talk to you about the problems confronting seniors, and low-cost, high-impact solutions that will enable them to live at home, minimize the risk of injury, in particular falls, and save on expensive hospitalization and institutionalization. We want to focus on solutions to help seniors live at home, improve the quality of their lives, and save the health care system money.

We also want to talk about the challenges associated with accessing these solutions in homes and communities across Canada. We share a common goal, which is to keep seniors in their homes, active and engaged, contributing to their families, their communities, and our society. We can offer recommendations for health care system improvements and innovations.

Our current health care system is oriented to helping seniors once they have experienced a health decline and have landed in hospital or the doctor's office. We can do better than this. Preventative measures can be done, such as home modifications and ADL training, so that injuries and falls do not happen. This enables seniors to remain in their homes, connected to their families and communities, and out of hospital.

Ms. Nicola MacNaughton: Let's talk about Karen. Karen is an 81-year-old woman who lives alone and has experienced many falls in the bathroom. Due to her fear of falling, she has now stopped bathing in her tub and avoids going out of her home. She is depressed and socially isolated.

An occupational therapist working with Karen recommended bath adaptations to help her gain independence and confidence in bathing. These recommendations included the installation of grab bars, a bath lift chair, and a transfer pole to help support Karen during her daily bathing routine, in turn reducing her reliance on personal support workers and home care nurses.

As highlighted in Karen's story, occupational therapy interventions can decrease the need for home care, saving up to $50,000 a year. Occupational therapists can also be involved in home modifications, collaborating with renovation professionals to improve the accessibility and safety of homes.

The Royal College of Occupational Therapists recently shared an example of an occupational therapist who recommended a walk-in shower renovation for a client. The total cost of the therapist's time and the shower renovation was $11,000, compared with an annual cost for a personal care support worker of $35,000 if the shower had not been put in place.

We know that appropriate prescription and training regarding adaptive equipment and suitable home modifications have the potential to reduce hospitalization costs. For seniors in Canada, these upfront investments and results are a significant health care savings, as seniors age 65 and over record the highest rates of hospitalization: 20 in 100,000 are hospitalized.

● (1550)

Ms. Janet Craik: Now let's talk about Pierre and Marie. Pierre is 89 years old and Marie is 87. Pierre has been diagnosed with dementia. Their children have great concerns about how their parents are going to remain safely living at home, and they wonder how they're going to manage when Pierre's condition deteriorates.

Again, an occupational therapist can work with Pierre and Marie, recommend environmental adaptions, and provide memory aids and strategies to help them with important ADLs such as taking their medications. These interventions have the potential to postpone entry into residential care, with savings up to $48,000 per person per year.

Ms. Nicola MacNaughton: Elizabeth is 82 years old and has vision loss. She was experiencing a general decline in her health and had been in and out of the hospital several times. On her last visit to the hospital, she was seen by an occupational therapist. Elizabeth's occupational therapist assessed her needs for support at home and referred her to an OT in the community.

A recent study by Johns Hopkins University identified that occupational therapy was the only category of health care spending within hospitals that resulted in reduced hospitalization readmission rates. This is because occupational therapy's focus is on assessing whether a client can be discharged safely, and addressing potential barriers in the home and community environments.

The Royal College of Occupational Therapists estimates that occupational therapist services result in avoidance of unnecessary hospital admission and/or reduced hospital stays, saving an average of $15 million annually.

Ms. Janet Craik: I'll be brief.

While occupational therapy is well suited for supporting seniors in communities across Canada, and minimizes hospitalization and institutionalization, access to this is patchy at best. Publicly funded systems, as well as our extended health insurance, do not support universal coverage of occupational therapy. Without coverage, seniors, particularly those on fixed incomes, do not seek our services, and doctors and other health professionals do not refer them to occupational therapy despite the known benefits.

Investment in cost-effective, clinically effective solutions in the community to enable our seniors to age in place, which include home safety assessments, home modifications, adaptive equipment, and ADL training for caregivers and seniors, is needed now. It is all possible through low-cost, high-impact solutions.

Our recommendation is simple. Part of the $5 billion in federal transfers to the provinces that has been earmarked for home care should be allocated to ensuring that occupational therapists are an integral part of the health care teams that provide services to seniors so that seniors can age in place in their homes and in their communities.

We're not asking for more money, simply a better use of our existing resources.

Thank you.

The Chair: Thank you both very much.

We're now going to Lisa Sullivan, executive director of Hospice Care Ottawa.

Ms. Lisa Sullivan (Executive Director, Hospice Care Ottawa):

Thank you for giving Hospice Care Ottawa the opportunity to make this presentation today.

I'm here today to increase your awareness, I hope, about what hospice palliative care is and to ask you to address the growing need to support and fund hospice palliative care services in our community, whether they are at home or in some other setting.

Hospice palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying. There are many different settings for care, including people's homes, residential hospice, long-term care homes, retirement homes, and other institutions.

Our definition and understanding of hospice palliative care is adapted from the Canadian Hospice Palliative Care Association's "A Model to Guide Hospice Palliative Care". It defines hospice palliative care as "appropriate for any [individual] or family living with, or at risk of developing, a life-threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care". It is a person- and family-centred approach respecting social, spiritual, and cultural practices. It includes end-of-life care, although it's not limited to that, and it's also not limited to the time immediately preceding death, so it can include bereavement and grief support.

This philosophy is perhaps best summed up by a quote by Dame Cicely Saunders, who is the founder of the modern-day hospice movement in London, "You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

Who is Hospice Care Ottawa? Hospice Care Ottawa was formed in 2013 by the amalgamation of two smaller hospices in our city. We're a small, non-profit, community-based organization and we provide residential hospice care, volunteer in-home visiting, day hospice, bereavement support, and caregiver support. Our mission is to accompany and support individuals and their families through their end-of-life journey by providing compassionate, high-quality care. Our goals are to improve the quality of life for palliative care clients and their caregivers, and to reduce the burden on the health care system from unnecessary hospitalization.

All of our programs and services are provided at no charge to patients or their families, and we work closely with our local hospitals' home and community care organizations to provide and coordinate that care.

Currently we have some residential hospice beds in the city at two sites, but most of our programs are community-based programs. Last year we served over 360 people in residence and over 1,500 clients in the community. We provide our services with professional staff, but we do it primarily with the help of over 1,000 volunteers who last year provided over 50,000 hours of service and community support.

Hospice services in Ontario and in most provinces are not fully funded. At Hospice Care Ottawa, we receive less than 60% of our services from the local health integration network. That translates into us needing to fundraise almost $2 million a year just to provide our existing services. That's quite a feat for a small community organization. In addition, we have to fundraise the entire amount for any new builds or capital costs.

Last year Hospice Care Ottawa spent the majority of its budget, 76%, on direct programs and services rather than administration. As all charities know, fundraising is becoming increasingly difficult. This increases the administrative costs of charities. If we cannot raise sufficient funds from private donations, our existing services are in jeopardy. If we cannot increase our private funding, we cannot offer additional services such as those that are needed by particular communities of need, like the francophone communities in our area. It's inappropriate that the ability of Hospice Care Ottawa to provide palliative care in our community, which is an integral part of our health care system, should be in such a tenuous position.

Hospice Care Ottawa can and does provide a variety of alternative end-of-life services, but all of these options are underfunded, as I mentioned. In a recent study, Canada ranked ninth globally in a quality of death index. It is shocking to observe that only 16% to 30% of Canadians who die have access to or receive hospice palliative or end-of-life care services. Despite significant progress to advance hospice palliative care both locally and provincially, there continues to be this inadequate and inequitable access to comprehensive care. It is estimated that in our community there is need for hospice care bed services for six people out of 100,000 population. In Ottawa we have only 19 beds for a population of close to one million. Although we work really closely with our partners to ensure hospice care in the community, this continues to be a struggle.

● (1555)

In addition, we all know that our population is aging—indeed, that's part of the work of this committee—with the number of those age 65 and older to double in the next 20 years. Having increased numbers of seniors leads to more people using hospital and emergency rooms, which of course increases the cost to the systems and wait times. Those who are older are going to experience more chronic and life-limiting illness.

Hospice palliative care in the community is far less expensive than is hospital care. The Auditor General of Ontario noted that in 2014, hospice beds cost the system $460 a day, while acute care hospital beds cost over $1,100 a day. Hospice palliative care frees up much-needed acute care hospital beds and services. In Ottawa, our current services save the health care system approximately $4 million a year. Just imagine what we could do if we had more services.

Within the spectrum of hospice palliative care, there are some subpopulations with special concerns and unmet needs. For example, the lack of funding has made it very difficult to reach populations such as francophone, multicultural, and indigenous populations in our community.

In terms of the level of palliative care needs, we know that about 10% of all deaths are sudden and from an unexpected cause, such as an accident or a homicide. A further 30% will die with a steady decline in health status from a predictable or progressive disease such as cancer. The remaining 60%—and I would suggest this is a large part of our senior population—are people with advanced chronic illness, and they represent one of the main areas of unmet needs in palliative care. The vast majority of deaths arise from advanced chronic diseases such as heart disease, stroke, chronic obstructive pulmonary disease, renal failure, and Alzheimer's. The population is often the elderly experiencing a general decline secondary to physical and cognitive issues. They tend to be frail and unstable and to have those high-care and medical needs that sometimes require acute care. They are the large proportion of our seniors.

These are the patients who are filling our acute care beds. They do not need the expertise provided by acute care but are often too poor functionally or have symptoms issues that are too difficult for them to be properly managed in long-term care settings. When they are stabilized, they go back to long-term care, but as soon as they have an issue, they're packed into an ambulance and sent back to emergency rooms. The acute need is for services to care for patients within so-called chronic palliative settings, which I suggest is the majority of our senior population.

Most of what these patients need is personal care, such as washing, dressing, feeding, and toileting intermittently because they come symptomatic in some way. Our existing health care services are not responsive.

I'm probably done. Am I?

● (1600)

The Chair: If you want to conclude that's fine, but—

Ms. Lisa Sullivan: No, I have a bit more.

The Chair: We'll get you at questions.

We'll go now to Mr. John Beaney, vice-president of operations for Revera Inc., for seven minutes.

Mr. John Beaney: Good afternoon, Mr. Chair, and members of the standing committee.

Thank you for inviting me. It’s a great honour for me to be here today on behalf of Revera. I have worked in the senior sector since 2005, and know how important the partnership between government and industry is in delivering on our shared goal, which is to provide the best possible living options for seniors.

Let me begin by sharing some background on Revera. We are a leading Canadian-owned company, with over 55 years' experience as an owner, operator, and investor in the senior living sector. We own or operate, either directly or through partnerships, more than 500 properties across Canada, the United States, and the United Kingdom. We serve more than 55,000 seniors and employ more than 50,000 staff, who are dedicated to providing exceptional care and service.

In terms of senior living options, we have two fundamental models. First, our retirement residences work on a private-pay, social model. Retirement living offers seniors a safe residence with access to care, meals, and their choice of social services. Some of our residents live independently, but many need assistance with the activities of daily living and medications. Increasingly, we are home to seniors with various forms of dementia, such as Alzheimer's disease, who need to live in a secure memory care area In Canada. We have 97 retirement residences, which are home to 10,000 residents, served by more than 7,000 staff in six provinces.

Second, our long-term care homes operate on a public-pay medical model, where residents, most of whom are seniors, require a significant amount of care. Approximately 80% to 90% of the residents have some level of dementia. Governments at all levels, depending on the province, assess and place residents in our homes, manage our wait-lists, and fund the care we provide.

Revera provides care for over 10,000 residents in 76 long-term care homes, served by 12,000 staff in four provinces. We actively support today’s vibrant seniors as they live their lives to the fullest every day. We also care for vulnerable seniors, those who need help eating, bathing, dressing, toileting, and taking medication.

Revera therefore brings a unique vantage point for how we can improve the aging experience for Canadians. It is from this perspective that we approach our participation in your study on advancing inclusion and quality of life for Canadian seniors.

We have four considerations to share with the committee today.

First, we believe that choice and flexibility are key to any discussion around senior living options. Housing is a very personal choice, and this does not change as you age. Seniors need and want the ability to choose the housing solution that best suits them, whether that is living in their family home, downsizing to a condo or rental apartment, opting to live in a seniors apartment, a retirement residence, or ultimately moving to a long-term care home. Only seniors know first-hand the importance of flexibility in a system focused on seniors housing. We must find a way to accommodate their individual needs and incorporate their wisdom. All too often our staff are faced with the heartbreaking task of informing seniors who have lost their health that we are not able to accommodate their specific needs. We often have to tell long-time couples, people who have been married for 50 or 60 years, that they must now live separately because one member of the couple needs to move into a long-term care home and there is no place for their spouse.

Second, it is imperative that the committee understand that the delivery of care, particularly medical care, is fundamental to any discussion focused on seniors housing. Often we see access to care as one of the most important considerations for the seniors who choose to move to a retirement residence and, of course, care is the single deciding factor that brings someone to live in a long-term care home. Mental health is also an important consideration, particularly for seniors who live alone and therefore face social isolation, which often results in depression. We frequently see this condition affecting seniors who have limited mobility due to either physical or financial limitations, yet are still living in single family homes.

Third, we believe that Canada's private sector is a key player in the future of seniors housing. Companies like Revera play a key role in advancing the innovation required to meet the growing demand for senior living options. The private sector is part of the solution because we are motivated to drive innovation. We take risks and adopt new approaches to housing and care delivery, and we do this by investing our own capital.

● (1605)

Finally, as I mentioned earlier, we believe that seniors themselves need to be at the centre of any discussion regarding housing. Often, housing options for seniors who need care are tied to complex regulatory frameworks and government policies, making it difficult to understand the choices available. Housing, support and care services are often organized more around government, regulatory and organizational imperatives rather than around the needs and wants of seniors and their families.

We strongly urge the committee to speak with seniors who are currently facing decisions regarding housing or who have already made their decision. Revera would be happy to arrange for the committee to speak with residents living at Revera to understand first-hand the challenges the aging experience places on such decisions. As a leader in the sector, Revera is happy to be part of the conversation today and in the future to help shape a national strategy focused on senior living options.

As you may know, our company is a leading advocate against agism, which is the most socially accepted form of discrimination in Canada. We actively advocate for seniors to be respected as relevant, vibrant, and valued contributors to society. We have earmarked a significant innovators in aging fund, through which we invest in new products and services designed to help make the aging process more comfortable. We have dedicated significant resources to research and raising awareness around how society, and Canada’s business community specifically, can lead in the fight against agism.

Let me conclude by saying that Revera shares the core beliefs that underpin the committee’s efforts to advance the inclusion of, and quality of life for, Canadian seniors, and we thank the committee for undertaking this important work.

The Chair: Thank you very much, sir.

From the Senior Empowerment Assistance Centre, Peel, Ontario, we have Olufemi Adegun, president.

Welcome, sir.

Dr. Olufemi Adegun (President, Peel, Ontario Branch, Senior Empowerment Assistance Centre): Thank you very much, Mr. Chairman, for giving me this opportunity to be part of this conversation. I would also like to thank members of the committee for inviting me to this forum this afternoon.

These conversations could not have come at a better time in view of the fact that 25% of the current working population is going to retire in the next seven to 10 years. I'll be speaking as the president of the Senior Empowerment Assistance Centre in the Region of Peel, which is composed of Mississauga, Brampton, and Caledon.

I'm here this afternoon to share with you how we can go about tackling the problem of senior exclusion, and advancing their quality of life in Canada. I'll be talking about the consequences of social isolation and the benefits of social inclusion. I'll also be talking about how our Senior Empowerment Assistance Centre has devised a five-point strategy, which we are using in the Region of Peel, to address this problem with seniors in our society. I'll also be talking about how organizations such as ours, composed of NGOs, the private sector, and the government—because the government cannot do it alone— can collaborate to address this problem with seniors. It is very important, because what we are seeing right now is what we call the wisdom of this age. There's a kind of generation gap whereby seniors above the age of 60 or 65 who retire cannot pass down that wisdom to the younger generations, and so there's a drift.

In the Region of Peel, which I represent, that gap is present right now. This wisdom cannot be passed down to the younger generations. The seniors need to tell their stories other than to their kids and down the lines. A lot of them have worked for over 25 years to 35 years, and a lot of the younger people are struggling trying to enter the system. There must be a bridge of that gap between seniors and the younger generations. This is part of what our organization is doing to address this problem.

Social inclusion is defined as the process of improving the chance of participation in society, particularly for people who are disadvantaged, to enhance opportunities, access to resources, and to voice their respect for rights. On the other hand, social exclusion is described as a state in which individuals are unable to participate fully in economic, social, political, and cultural life, as well as the process leading to and sustaining a social state.

If we look at the consequences of social exclusion or isolation, it leads to poor physical and mental health, to loneliness and emotional distress. In the Region of Peel that I represent, seniors wake up in the morning and go to Tim Hortons or McDonald's and sit there reading newspapers. We call them the boys and girls club. A lot is being done to address these issues, but I believe the government can do more by collaborating with the private sector as well as end users such as us. When seniors who can still contribute positively to society end up sitting in Tim Hortons or McDonald's for almost eight hours wasting life and tangible wisdom that can be passed on to the younger generation, then there is something wrong in society.

This leads to confinement and lack of contribution to society. When they are not educated about government, social services, and support, there is no way the mission of the government can succeed if these seniors are not engaged and included in programs and policies that would enhance their life. The engagement of seniors is very crucial to whatever programs and policies the government is setting up.

Also, there is disengagement from social networks. It reduces social participation, induces poverty and depression, and reduces their quality of life. I'm going to share some statistics from years back from the Region of Peel. Now, after taxes, the median household income in Peel is about $84,000, and 47% of families aged 55 to 64, according to research done three years ago, have no accrued employee pension benefits.

● (1610)

We have a lot of immigrants coming through the system. We are so blessed in that region, because when people migrate, let's say, from India, from Asia, they come with their extended families. They sponsor them, and an outcome of that is that when this group doesn't have the means to support themselves, of looking forward to retirement, that becomes a problem. On the other hand, we have, even within this family structure, caregivers, family caregivers, who render tremendous help in managing and helping these seniors.

Let me quickly talk about the five-point strategy we are using. We are using education, enlightenment, empowerment, engagement, and entrepreneurship. These are the five key points of the strategy we are using to address the problems of seniors in Peel.

I'll be discussing more later. Thank you very much.

● (1615)

The Chair: Thank you very much.

We're going to move on. We apparently have an update. Mr. Fulton is here; however, his guide dog has not done its business all day, so Mr. Fulton has gone for a walk. I just want to get that on the record. I just want to give you an update, in case you're worried. He's over an hour late.

First up is Mr. Warawa, please.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Thank you very much for that presentation.

I want to thank the witnesses for being here, for their heart, for their dedication to the Canadian aging population, and for the incredible work they do.

The challenge we have at this committee is how we can help federally, and I would appreciate your input on how we can help. How important is it that we help now, or is it something we could do over the next 10 years?

We've heard from Ms. Sullivan, and I saw the program on *The National*. It's heartbreaking, but it's part of life, to see a death in the family and to see that brave woman and her husband and daughter. It gives us a glimpse into the reality of the end of life. To watch that program and think of hospice care being provided here in Ottawa...if you weren't there, what would be the options for that family?

So, God bless you. Thank you so much for the work you do.

We had a volunteer from hospice care in Langley here last week. She shared the challenges they're having with funding, too. Occupational therapists have also shared with us their challenges with regard to funding.

Funding paradigms are very difficult to change, so how do we do that? You've both highlighted the importance.

Mr. Shiner, thank you for your testimony on the importance of housing. How do we change the paradigms we have? How necessary is it to do it now, or can we wait 10 years? What type of leadership does the federal government need to provide? Should this committee, now that the windows and doors are open and we see the major crisis before us, move on and discuss another topic, or should we finish this topic and finish well?

I'd like your input, Ms. Sullivan, Ms. MacNaughton, and Ms. Craik.

Ms. Janet Craik: Can we wait? We cannot wait. If we want sustainable health care options, we need to smash the status quo. I think the opportunity at the federal government is that when you get the federal, provincial, and territorial health ministers in a room, you put these important topics on the agenda.

As I said, the health care system right now is oriented to helping those whose health is declining, whereas we know that the evidence is very strong that preventative measures can save money and improve health and quality of life. I think it's about getting it on the agenda now, and looking at how best to spend the money that is already there. We can spend it more efficiently, absolutely.

Ms. Lisa Sullivan: While I would agree—I support what you say, Janet—I think where I'm coming from is that obviously those people who are at end of life.... The reality, to put it frankly, is that the older you get, the more chance you have of dying. I'm sure you all know that. It's not something we can pretend isn't going to happen. The preventative piece, I think, is very clear, but we have a population that's living much longer with these chronic illnesses. They will need more supports as they move into their end-of-life process.

I think it is a paradigm shift to get government at all levels to think about how we support people living with these chronic illnesses as they age and how we take it out of acute care hospitals. Acute care hospitals are wonderful when you have an acute illness, but they're no place to be when you're dealing with a chronic illness or when you're at end of life.

We know that 75% of people would prefer to die at home, and “home” could be the retirement home or the long-term care home or the home they've lived in. We need to think about shifting those funds away from acute—trying to fix it—and into supporting people to live and die in their own home.

● (1620)

Mr. Mark Warawa: So it's critical that we deal with this now.

Ms. Lisa Sullivan: Absolutely.

Mr. Mark Warawa: Okay.

Mr. Shiner, thank you so much. We honour your service as a Canadian veteran. Sitting off to your right is my office chief of staff. She was with the Israeli military. Thank you for your service.

I'm probably out of time.

The Chair: You have one minute.

Mr. Mark Warawa: Okay.

The savings are tremendous if we take people out of acute care and get them into hospice care. Do we have enough occupational therapists? You'll save us money. Do we have enough to do the assessment and make sure that people can age in place? You're critical. Do we have enough occupational therapists?

Ms. Janet Craik: Right now we're a workforce of about 16,000 across Canada. The employment rate is high at 93%. We do have some shortages as far the workforce is concerned. Fortunately, B.C., your province, is one place where we don't have the demand. The B. C. occupational therapy workforce requires input from those trained out of province. It has the largest percentage of out-of-province trained therapists. Ontario is another province that relies on a big influx of occupational therapists. Saskatchewan is another region where the percentage of occupational therapists serving the community is very small. The pressure has been on the government since 1966 to get an occupational therapy school in Regina.

So there are some workforce issues. Globally we are a strong workforce as well. We can rely on internationally educated occupational therapists.

You mentioned acute care. We are failing seniors if they land in acute care. I think we have to look at hospice models and community-based programs. Once they're in acute care.... It's not the place for them.

The Chair: Thank you very much.

Mr. Ruimy, please.

Mr. Dan Ruimy (Pitt Meadows—Maple Ridge, Lib.): Thank you very much. I'll be sharing my time with the parliamentary secretary, Adam Vaughan.

We've been hearing the same themes with all of our witnesses: isolation, loneliness, community, housing, and that sort of thing.

Mr. Shiner, again, thank you for your service, sir. The Yom Kippur War was quite an event.

You brought in a stat that I hadn't heard yet, that 93% of seniors don't plan to age in home. Is that correct?

Dr. Donald Shiner: They don't plan to ever leave their home. They have no plan. They deny it.

Mr. Dan Ruimy: They have no plan to leave their home. Okay. So how do we as a government change that mindset? It is a mindset.

Dr. Donald Shiner: Yes. We need an education program.

Mr. Dan Ruimy: Give me two or three things, for example, a policy change, that you think the federal government could do to encourage that. Let's face it, if you're not planning for this, if you're not planning for retirement, if you're not planning for anything, then you're not moving anywhere.

Dr. Donald Shiner: It's magical thinking. We exist in a world of magical thinking. We believe we are never going to grow old and get sick; therefore, we don't prepare for that future.

We need to undertake education. Those under 70 need to do their home construction incorporating lifetime home standards. Around 60 or 70 is pretty well when you stop building new homes. At 60- or 70-plus, you renovate. We need to make sure those renovations are done right, economically and efficiently.

The third group that needs education is Canadian home builders. They need to understand that we have evidence from England and New Zealand, where the lifetime standards are very entrenched, that it costs approximately $1,400 to incorporate the design changes at the time of building the home—$1,400, and you have a lifetime home.

Just think of the young child who breaks a leg at hockey or soccer and comes home in a wheelchair. They have to be carried up the front steps. They have to be carried up to their bedroom. They have to be assisted in the bathroom. If your grandmother is getting out of the tub and falls towards the bathroom door, and the door opens inward, it would require the emergency response crew to break it down while your grandmother is lying there naked on the floor. Why is the door built to open inward? It's not in the building code.

We do things without thought. We need to educate people so they think about this and prepare to take responsibility themselves.

● (1625)

Mr. Dan Ruimy: Thank you.

I'm going to pass my time to Mr. Vaughan.

Mr. Adam Vaughan (Spadina—Fort York, Lib.): Thank you. I have a couple of questions.

You say there is an emerging market, a clear need and clear cost savings and therefore profit. Why hasn't the private market responded, then? Why would some suggest that we rely on the private market to provide this housing, if the private market is not responding?

Dr. Donald Shiner: Some builders are trying to respond. There is a stigma about aging, and there is a perception that a lifetime home looks like some place that you would retire to, with grab bars and other things. I have a very good friend who heads HomesRenewed, the American program on aging in place. He is a carpenter, and he says that the best solution to aging in place is a two-by-four, a hammer, and some nails at the time you are building the bathroom, in the right place. It costs pennies.

It's just that kind of thinking that we don't have.

Mr. Adam Vaughan: Universal design.... If the government, for the first time in well over a decade, is now going to step in and start building new public housing, would you support thresholds around universal design to accommodate an aging population, as well as people with disabilities?

Dr. Donald Shiner: It has to be, for visitability—we can call it "visitability"—for lifetime home standards, and for accessibility. They are all the same ball of wax. Of course, any public building should incorporate those standards.

Mr. Adam Vaughan: You mentioned that 93% of people believe they are going to age in place comfortably and stay in their homes, but that is a tricky number because they are not living in homes that work. Just having the housing is not enough; the adaptability of the housing is the critical component of it.

Dr. Donald Shiner: When I say 93% of Canadians.... As they approach older age, they don't think about aging in place. They believe they are going to be healthy enough and well enough, so they don't make any preparations. They don't think about it until the emergency—the broken hip or the accident. We need to help educate them so they think about taking responsibility themselves for getting things ready ahead of time.

Mr. Adam Vaughan: Lisa Sullivan, you talked about hospice care, but hospice care for people who are homeless and people with psychiatric needs or addiction issues is often just beyond their reach. Does your facility provide that segment of the population with hospice care? If it does, what are the assistances that are available to you?

Ms. Lisa Sullivan: We are really fortunate in the city of Ottawa. Hospice Care Ottawa does not have a particular target of street-involved population, but we have another partner in the community called the Ottawa Mission. Their entire focus is the street and homeless population. What we find with the street and homeless population for end of life is that it comes back to this notion that we look not just at the last couple of weeks of life, but at chronic illness. Those on the street dealing with chronic illness are going to have a lot more complications. The mission has a number of beds but also provides service on the street for people.

Mr. Adam Vaughan: Would you support a move that may not be directed specifically at seniors, a move toward supportive housing for people with chronic conditions as a way of managing hospice care at the end of life?

Ms. Lisa Sullivan: Yes, that's not what I'm saying exists; I'm saying that's what I think we need, because that chronic population is going to be all of us. We're all living longer, and it will be seniors and supporting people wherever they are, whether that is in their home or—

Mr. Adam Vaughan: We also have an issue with transformation in public attitude towards members of our community or families who are lesbian, gay, bi, transsexual, or two-spirited. There is a phenomenon of going back into the closet to fit into seniors programs, because all of a sudden, you're in a generation that maybe hasn't experienced the transformation.

● (1630)

The Chair: We're going to have to come back.

Mr. Adam Vaughan: I'm curious as to what policies you have in place and what policies you would suggest.

The Chair: Be very brief, please.

Ms. Lisa Sullivan: That's really interesting. We do a lot of training with our staff and volunteers even on language around admission so that we're not asking people their gender, for example, or husband or wife. It's partly presenting yourself as an inclusive organization that I hope will break down those barriers.

Mr. Adam Vaughan: If public money is there, that should be—

The Chair: Sorry, Adam, I have to cut you off.

Rachel.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you, Chair, and thank you all so much for being here.

Before I start with my questions, I would like to ask you quickly to answer one question with a yes, no, or abstain. Do you believe the government should implement a national seniors strategy?

Dr. Donald Shiner: Yes.

Ms. Nicola MacNaughton: Yes.

Ms. Janet Craik: Yes.

Ms. Rachel Blaney: Everybody said yes. Thank you so much for that.

Ms. Sullivan, thank you for being here today. I was a volunteer for hospice, so I really appreciate the work that you do, and I know how incredibly meaningful it can be for families when they're in such a lovely space and how important it is for the families as well who suddenly have access to being comfortable when somebody they love is dying. Thank you so much for your work.

In your strategic plan from 2016 to 2019, you definitely identified funding as a major challenge for your organization. How are you funded? You're talking about having to raise $2 million a year. Are you funded provincially or federally? Is there a wider gamut? How does that work?

Ms. Lisa Sullivan: Our funding is provincial. We're funded through the LHIN, our local health integration network, which is, as you know, our arm of the health ministry funding. We're funded differently for our community and our residential programs, but in total it works out to less than 60% of our costs, so the rest is fundraised. That's one of the reasons volunteers are critical to our services as well.

Ms. Rachel Blaney: I ran a non-profit organization for eight years, so I really understand the challenges of paying the administrative costs that are so imperative if you're going to do the work of raising money. It is an important thing to understand that the volunteers really add a profound service, but if we don't have the resources to hire the appropriate people to manage those volunteers and to administratively support fundraising, it can be a huge challenge.

Ms. Lisa Sullivan: Yes, exactly, and I would even add that most of our volunteers are seniors, depending on what the age cut-off is. It's very fulfilling work for seniors. They play a really key role, for sure, in the work we do.

Ms. Rachel Blaney: Perfect.

The Conservative government stopped investing in Canadian Institutes of Health Research funding for palliative care in 2009, and then they disbanded the end-of-life care secretariat and stopped work on the national palliative and end-of-life care strategy. That's important, because we know that end-of-life care and having a strategy for that is so important.

Do you think an end-of-life care strategy should be part of a national seniors strategy, and how could additional research be beneficial for hospice and palliative care?

Ms. Lisa Sullivan: As I said earlier, I do see the end-of-life strategy as part of aging and seniors and how critical it is to stop fooling ourselves. Not only are we going to need more supports, but we all eventually will die, and it's very costly to die in a hospital. Nobody wants to die in a hospital, so end-of-life care has to be incorporated in that.

The other piece I'll quickly add, which I didn't mention and is the elephant in the room, is about medical assistance in dying. One of the things we've been advocating strongly for is that although that is a human right and it's legal for people, it's not part of the hospice care philosophy, and if we're making that available to people, we have to make quality hospice palliative care available to people, too. It's not an either-or, and that's always a concern when there is funding and strategies around medical assistance in dying.

Ms. Rachel Blaney: Thank you so much.

One of the things we know is that this is a huge savings to the taxpayer as well. I think the difference is $640 a day, which is very significant. How does it work? How do you coordinate this type of approach? There is no coordination around the system of end-of-life care despite the growing need, so how would this move forward, if it could?

Ms. Lisa Sullivan: I can only speak from the Ontario perspective. I think we actually have made some good strides in Ontario in the coordination of hospice palliative care. All the LHINs are required to have a coordinated regional palliative care program. It's not perfect, but at least everybody's talking together. In Ottawa particularly, we modelled a central referral and triage system so that anybody who is requiring hospice palliative care doesn't have to go to six different people to get six different services. We work with our home care and our LHIN. I think that's a good model. It needs more support, again, because I think the funding needs to be directed into the community.

I'll just clarify, too, that when I talk about hospice care, although we have residential hospice beds, hospice care can and should often be delivered at home. That really is poorly funded. There isn't the support to coordinate that care and support at home over a long trajectory.

● (1635)

Ms. Rachel Blaney: Thank you so much.

I'm going to move to Mr. Shiner.

I just have a couple of seconds, so I will come back to you in the next round.

I think you've done a really good job in your report identifying the challenges involved with aging in rural Canada. Can you give us some recommendations as to how the federal government can be a positive actor in reducing some of those barriers?

Dr. Donald Shiner: The most important action I've seen, from all my research, is that we need to encourage lifetime home building. I'd love to see it incorporated into the Canadian building codes. I know how difficult that is as a challenge, but we need to build homes for the future that people can live in with full accessibility, homes for life. If we don't start sometime, it means we're always building homes that are not very accessible.

Ms. Rachel Blaney: Thank you.

The Chair: Thank you very much.

Now we'll go to MP Sangha, please.

Mr. Ramesh Sangha (Brampton Centre, Lib.): Thank you, Mr. Chair, and thank you to all the witnesses for participating here and giving valuable input.

We have heard everybody discussing caregiving for seniors, maybe long-term care or in their own homes. We have also talked about isolation and exclusion. Professor Adegun has talked about loneliness and seniors' empowerment and all those things.

My question is for the Canadian Association of Occupational Therapists.

What do you suggest to the committee for seniors who are not critically ill but are living in their own homes? Could you indicate four or five things to consider for better living in their homes?

Ms. Nicola MacNaughton: Sure. If I could, I'll just give you a brief 10-second synopsis of what would happen.

I would arrive at a client's home. The first thing I would see is that there are four steps to go up to enter the home, so risk number one has been identified, and I haven't met the client yet. I knock on the door, and I see the senior lady, and she's shuffling down the hallway with her big fluffy slippers on. I know that she may be comfortable and have warm feet, but she's not walking in safe footwear, so we'll talk to her about having proper footwear on her feet so she's not going to fall.

She offers me a cup of tea. Of course, I accept, because she loves being social in her home. I know that it's important for her to get out of her home, and it's also important for her to invite guests. She goes to make her cup of tea, and she reaches over the stove with her sweater hanging, and I'm worried about her sweater catching fire. I can provide her with a long-handled reacher for $10, and we now have eliminated that risk. That's in the first 10 minutes of an occupational therapist being in her home. There's a scatter rug in front of the bathroom where she goes in, so again, she's at risk of falling. We remove the bath mat, or we make sure that it's properly secured.

There are so many simple solutions to allow seniors to stay safe in their homes.

Mr. Ramesh Sangha: Thank you.

Professor Adegun, you have talked about social empowerment and social networking to improve the standard of living of seniors. What do you want to say in just one minute?

Dr. Olufemi Adegun: Actually, I would like that kind of situation, because we have a five-point strategy, as I said, concerning education, enlightenment, empowerment, and engagement, which is very crucial.

If you are trying to address the problems of a particular group, you have to engage them. You cannot isolate them. You have to engage them within the community. That is why our association is raising community-based seminars in conjunction with the cities of Brampton and Mississauga, to actually enlighten the people in the community.

In the city of Brampton, the home care caregivers play very important roles, as I mentioned in my introduction. The government needs to mobilize these sets of groups and work them into the national strategy the government is working on. The home care caregivers are the backbone. There are a lot of them. We don't even know the statistics.

The government has to integrate because, as I said earlier on, we need the government, we need the private sector, we need the NGOs. We need everybody to be able to act, because this is a very crucial problem in society.

● (1640)

Mr. Ramesh Sangha: Thank you.

Dr. Olufemi Adegun: I would suggest that the home care caregivers within the family...we should try to get through community-based seminars and all that.

Mr. Ramesh Sangha: Thank you, Professor.

I will share the rest of my time with Mr. Vaughan.

The Chair: You have about a minute and a half.

Mr. Adam Vaughan: I too would like to get back to Mr. Shiner for a couple of quick questions, and the others could comment.

Many of the areas you referenced.... The building codes are primarily provincial, although there is a national building code, but it's more aspirational than enforceable. The provincial building codes are the ones that actually govern construction against the national building code, but it also relates to some of the other challenges around subsidizing housing and subsidizing the fixing of housing.

When there are clear national standards required, would you support intervention on provincial jurisdiction in order to get the issues you've addressed dealt with?

Dr. Donald Shiner: The building code is a complex issue, as you've alluded to, but in reality, the provinces adopt the Canadian national building code. They do modify it in a couple of instances, but they adopt the standards almost carte blanche across the way.

I'm getting back to your example. You forgot to mention the fact that the door you went through after you got up the four stairs—

Ms. Nicola MacNaughton: Yes, it was only 32.

Dr. Donald Shiner: —is only 32 inches wide. According to the building code, section 91.5, a 32-inch width...if it was a wheelchair that lady was in, it wouldn't fit through the front door, which needs to be 39 inches for an electric wheelchair, in case no one's told you how wide.

Anyway, the building code is extremely difficult to change. There are a lot of interest groups involved in it. In England, they tried to make it a national change in Parliament, and they failed.

Mr. Adam Vaughan: Would you support federal action, even if it's provincial jurisdiction in order to achieve the goals you've set out?

Dr. Donald Shiner: Absolutely. We need to have accessible homes.

Mr. Adam Vaughan: Rest assured, the building code and the national seniors strategy are being pursued by the government.

The Chair: Thank you very much.

Now, we go over to MP Fortier, please, for six minutes.

[*Translation*]

Mrs. Mona Fortier: Thank you very much, Mr. Chair.

I'm really glad that we are here today to hear your testimony. I am also pleased to see that my colleagues, including the ones opposite, agree that action must be taken and efforts made in this area. It may be necessary to invest in housing. We must really take action today, not sit on our laurels just by studying the issue. We must take action; that's what I'm hearing.

Ms. Sullivan, I'm very pleased that our committee is having you appear today. As a member of Parliament for the Ottawa region, I would like to thank you and congratulate you for the remarkable work you do for the community. I would also like to point out that you work with people who have specific needs, whether they are francophones, anglophones, first nations, Métis, Inuit or immigrants. You have the opportunity to respond to these needs.

As we know, you receive funding from the provincial level because a significant portion of your services are offered province-wide. However, if the federal government could do something, what two priorities would you suggest we choose here, in committee?

● (1645)

[*English*]

Ms. Lisa Sullivan: I'm not sure if this quite answers your question, but the first priority is to make hospice palliative care services accessible to the entire population. Right now, it is not accessible. We don't have enough resources. We certainly don't have enough beds, and we don't have enough resources to help people at home. Inside that priority is meeting the needs of some subpopulations. It may be different in every community, but in Ottawa we are trying to look specifically at our French-speaking community, as well as trying to increase diversity with some of our multicultural groups.

The second priority is what I was speaking about earlier. It is well understood, and people are quite sympathetic when we talk about end of life and people dying. They see that as a very important role we play, and I'm very proud to be part of it. However, there is that much longer period of time when people are dealing with an illness that doesn't have a cure. They're not going to get better, but the supports are few.

[*Translation*]

Mrs. Mona Fortier: Thank you.

Mr. Beaney, I'm pleased to meet you.

First of all, I want you to know that I had the privilege of working at the Montfort long-term care centre, which is one of the residences your company works with to provide services.

Do you have centres that offer mixed services? I know that, for example, at the Montfort long-term care centre, only people who needed long-term care were welcome. As you mentioned in your testimony, some couples can't live together, because one spouse needs a particular long-term care service, but the other doesn't. Does your company have mixed centres, by any chance?

[*English*]

Mr. John Beaney: That's an excellent question. Revera has a number of homes that provide both retirement and long-term care on the same premises, even in the same building. It is a complex solution, in that retirement and long-term care are governed by completely separate legislation. Even though we provide that care and support in the same environment, each environment has to answer to and is inspected by entirely different legislation and an entirely different inspection team.

Managing that adds tremendous complexity, and thus cost, but we have it. It provides an excellent answer and solution to married couples—to your example—who can at least remain in the same building and spend time together every day despite their different care and support needs.

[*Translation*]

Mrs. Mona Fortier: Finally, I would like you to explain how vulnerable people living below the poverty line can access affordable housing in your residences. Is there a way to accommodate them?

[*English*]

Mr. John Beaney: It is different, depending on retirement and long-term care. In our retirement homes, that's a private-pay model, as I indicated earlier. Generally, we wouldn't see folks who have financial restrictions in a retirement home. It is a solution for a certain element of our senior population.

In long-term care, that is different. It is a government-funded business, and seniors who have difficulties with funding or a limited income have the ability to apply for additional support from the government to ensure that long-term care is available to everybody. We have many people in that position across our portfolio.

The Chair: Thank you.

Now, over to MP Wong, please.

Hon. Alice Wong (Richmond Centre, CPC): First, I would like to thank every witness who came to our committee and presented to us valuable information about the good work they've been doing and continue to do, and about some of the challenges they're facing. Thank you to each and every one of you.

I have several questions, so just give very brief answers, please.

The first is about funding. If we look at financial updates and ways and means, the money originally promised by the former Liberal minister of health for hospice funding is no longer there, or has been incorporated somewhere where we couldn't find it. Do you think there should be a specific item only for hospice funding?

Ms. Sullivan.

● (1650)

Ms. Lisa Sullivan: I think it should be within the community care spectrum. For instance, currently in Ontario, there is the former CCAC, which is now called home and community care, linked with our LHIN. I see end-of-life care as part of that continuum. There should be a special pot of money but not a separate service, if I'm describing it correctly. I don't think we should have a separate entity providing just hospice palliative care; instead, it should be part of that continuum of care that we provide people who are in the community. Organizations like mine are part of that system but not a separate group altogether from what we already—

Hon. Alice Wong: Yes, but you should have access to that funding.

Ms. Lisa Sullivan: Absolutely.

Hon. Alice Wong: Then, to the occupational therapists, thank you again for the good work you've done, especially for your checklist for identifying elder abuse, because the minute you go into a home, you know that somebody might have been abused physically or mentally, and there should be a checklist.

About funding, you have received, in the former government, the new horizons for seniors program, which doesn't only cover one year, but covers more than a year.

Do you see the need for longer-term funding, say for the new horizons program? I know most of your organizations here have received some money through that program. Do you believe that there should be a longer-term strategy so that we can plan ahead three years, for example?

Ms. Janet Craik: Yes. All the funding into the research and longitudinal studies to help us understand and to really put our resources in where they're going to get the greatest impact is critical.

Hon. Alice Wong: The third question is about family caregivers. Again and again I keep hearing about support for family caregivers who are not paid family caregivers. Some of them may not be on EI. Some of them have to give up work in order to care for families. They are stressed, and they need special help.

Do you see the need for looking into that in more depth so that the right kind of help—instead of just tax credits—would be available?

Dr. Olufemi Adegun: It's very important to look into this aspect. Our policy is really a strategy that the federal government should incorporate into the national seniors strategy, because even right now, we don't even know.... There are a lot of them, and we don't even know the statistics for the family caregivers. They contribute a lot. They're a tremendous help in stabilizing families and in helping these seniors. I will say definitely more research should be done.

What we are doing as an organization in the region of Peel is mobilizing this set of people to engage them, enlighten them, educate them, and even empower them. In fact, next week we are looking forward to fundraising in Mississauga and Brampton to be able to do more projects and programs for these kinds of people.

The family caregivers strategy is very, very important to what we are discussing, so I quite agree with you that the government should look in depth into these kinds of people, because right now they are not getting any benefits. The government should help them in the form of tax rebates so as to encourage that, to motivate that, to be able to support seniors in society.

Hon. Alice Wong: Thank you.

The CAOT did a good job in their update lately about the loss of productivity, the number of hours family friends or family members have been doing for caregiving. England, as I mentioned again and again, has a very good model, and I think it's about time we looked into that.

Also, we mentioned a lot about the need for co-operation between the federal and provincial governments. Do you see the need to continue a federal, provincial, and territorial forum for seniors, ministers for seniors, working together? It's an open question for any of you.

● (1655)

Dr. Olufemi Adegun: Yes, I see it as very important, especially with the territories. It's very close to the grassroots that knows what is happening at the grassroots level. It's very important at the federal level, at the provincial level, and even at the municipal level to be able to work together to form this national strategy.

Definitely, as I said, there should also be collaboration through a kind of educational enlightenment through private organizations, through NGOs. Let us come together as a bloc in formulating this national strategy. There's no way you can exclude seniors from this national strategy, because they have to be fully engaged to be able to support anything that affects their lives. Everybody has to work together in view of the importance of this problem confronting seniors.

The Chair: Thank you very much.

MP Morrissey, please.

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

Mr. Beaney or Mr. Shiner made reference to how CMHC should probably pilot a project to demonstrate technology for the aging. Was it Mr. Shiner? Could you quickly tell us what technology you'd be looking at?

Dr. Donald Shiner: The challenge right now is that a whole range of very expensive technologies is emerging, such as motion sensors and alarm systems, but we're lacking evidence that these are cost-effective, and that they truly help people to age in place.

Mr. Robert Morrissey: We don't have the demonstration anywhere that we—

Dr. Donald Shiner: We have some small projects. One at the University of Toronto is very interesting, but CMHC should seize this opportunity to show and prove measures that these approaches actually help, because it is extremely costly to equip a home with all this type of technology. We need to prove it helps them.

Mr. Robert Morrissey: That's good. Thank you.

We've heard different witnesses who are targeting various levels of care to seniors. If you had a choice between doctor, nurse, or occupational therapist and the ability to stay in the house because both the medical sides look at the medical that has already happened.... Your points were well taken.

Where would you put your priority, from the aspect of living?

Ms. Janet Craik: I think the answer lies in the right care and the right person. It depends if—

Mr. Robert Morrissey: You're skirting it now.

Ms. Nicola MacNaughton: Let me answer.

The occupational therapist.

Ms. Lisa Sullivan: I would agree with Janet. It really has to be a team model, and if I've learned anything—

Mr. Robert Morrissey: But within the team, and the ability to stay in the home longer, which would rank in priority?

Ms. Janet Craik: It's on the spectrum of things. At the preventive level with a senior whose health is not in decline, I think as an occupational therapist, we can project their future needs.

Mr. Robert Morrissey: Madam Craik, re the allocation of home care money to the provinces, I'm a former provincial politician, and health care is usually on the front line of delivery. You made reference that the federal government should attach some strings to the allocation as it relates to home care. Our government has put significant...and signed agreements with each of the provinces targeting home care because the provinces tend to move the money all around.

Could you expand a bit more on how you would like to see that specified to the provinces?

Ms. Janet Craik: That $5 billion earmarked for home care is in the provinces' hands. Can this discussion be done at the federal-provincial-territorial meeting of the health ministers so the money is spent appropriately on home care services to keep seniors out of hospital? Sometimes I know the federal government is looking at the outcome they want to see. We know the hospital readmission rate should be monitored closely.

● (1700)

Mr. Robert Morrissey: If you were going to prioritize within that envelope, what would you put at the top?

Ms. Janet Craik: For those home care dollars?

Mr. Robert Morrissey: Yes.

Ms. Janet Craik: Occupational therapy.

Voices: Oh, oh!

Mr. Robert Morrissey: I do not disagree with you.

Ms. Janet Craik: I don't mean that in jest. I do think we are undervalued.

Mr. Robert Morrissey: Is there a common certification across the country?

Ms. Janet Craik: In Canada, we have 14 educational programs. They're at master's level entry. All schools are accredited.

Mr. Robert Morrissey: How does cost compare in the delivery of the service, occupational therapy versus nurses?

Ms. Janet Craik: The cost factor at the educational level?

Mr. Robert Morrissey: No, at the delivery level.

Ms. Janet Craik: I'd have to get back to you on the exact numbers per hourly rate.

Mr. Robert Morrissey: How long is the course to become an occupational therapist?

Ms. Janet Craik: For the most part, it's a two-year master's program plus 1,000 fieldwork hours.

Mr. Robert Morrissey: Is that a master's program built on any field?

Ms. Janet Craik: Any field, so it's multidisciplinary.

Mr. Robert Morrissey: Okay, interesting.

My last question is a follow-up on a comment made by my colleague, Mr. Warawa. It was an interesting question that he put.

What leadership should the federal government provide in its array of programs? You go from health to housing and all in between. How would you advise this committee as it's doing its report on recommending the federal government show leadership? You're telling us we're at the early age of the tsunami, and the size of the tsunami that's coming depends on who is presenting to this committee.

Ms. Janet Craik: One thing I'm hearing across all the witnesses is to take a biopsychosocial approach to health, not just a sickness-medical model. I think if we use that paradigm to help understand the social needs of the seniors aging in place, their psychological needs and their physical needs and attend to those, it will save us in the long run.

Mr. Robert Morrissey: Mr. Shiner, you referenced that in Atlantic Canada, 40% of a senior's income goes towards housing. How does that compare across the country? What does that 40% number look like across the country?

Dr. Donald Shiner: It's highest in Atlantic Canada and it gets lower as you move west, because the age curve diminishes as you move west. In other words, the provinces are younger as you move further west, so we have more older people in Atlantic Canada who are on low income. As a result they're in housing stress.

The Chair: Thank you.

Next is Steven Blaney, please.

[*Translation*]

Hon. Steven Blaney (Bellechasse—Les Etchemins—Lévis, CPC): Thank you, Mr. Chair.

First of all, I would like to thank you for your testimony.

This is the last meeting at which we'll receive witnesses for our study. Thanks to the quality of your testimonies and that of the other people we have heard from, I think we are going to produce one of our best reports in some time. That's what I told the committee members. This is an extremely critical issue. As Mr. Morrisey said earlier, we're talking about a tsunami.

[*English*]

Mr. Shiner, you said that we will never grow old, we will never get sick, and I guess we will never die, either.

I would like now to go into this very end area and ask your view, because we have not yet covered this issue. If you know that your leaving will be a burden for those you leave behind, if you leave people behind, it certainly impacts your quality of life.

I would like to hear about the issue of someone who dies who is facing what we call “death care” services. Is it an issue, is it a problem for some people? I'd like to hear from you and maybe I can turn to Madam Sullivan.

Ms. Lisa Sullivan: Sure.

If I understand correctly, you're talking about services after someone dies.

Hon. Steven Blaney: Funeral and burial services, yes.

Ms. Lisa Sullivan: Yes, okay.

In working in palliative care, one of the things that we know is really important is having the conversation about advanced care planning. As my colleague here has said, people don't think about it, don't prepare for it, and they sure don't prepare for death.

Sometimes, if they've done a will, people think it's all they need to do, but there is a lot more to it. I think the advanced care planning and preparation, and having the conversation with your loved ones about what you want and what you don't want are really important.

In terms of costs for a funeral—I think that's what you're getting at—I'm not as familiar with that. I do know that we do a lot of work with those who are bereaved and some end up being in stressful financial situations because they haven't the funds to deliver the kind of service or whatever it is they want for their loved ones.

● (1705)

Hon. Steven Blaney: Thank you.

Does someone else want to comment on the issue?

Monsieur Beaney.

Mr. John Beaney: Thank you very much. It's a really important question.

In addition to Ms. Sullivan's comments, I think it is very important not only to plan financially and resource-wise, but most importantly, for what we see quite often in our long-term care homes: the unexpected death of a loved one. Families are not prepared for that. They are not prepared emotionally.

As Ms. Sullivan has commented, there is a great need to have that discussion, to prepare people emotionally, to help them understand the conditions that their loved ones are suffering from. They are often complex and we can't solve them; we can't make them better. We are often managing people with those complex conditions and helping them come to terms with those conditions as part of their aging process, which is actually one of the most important parts of palliative care and end-of-life planning.

Hon. Steven Blaney: When we work, we have the right to what is called a death benefit from CPP. I just learned that it has been frozen since 1998 at $2,500, and is not indexed. My understanding is that it's really not enough.

Do you think the federal government could play a role, either financially or even in other ways, as you've just mentioned, in terms of preparing Canadians for the eventuality that we will all face? Maybe others would like to comment, so feel free to do so.

Mr. John Beaney: It's a very important question to help in planning. I would very much engage in different programs and ideas for financial planning, in the event of both managing the processes of death of the loved one and also, perhaps, supporting the family members as they cope with that afterwards. Sometimes they're not able to work.

It's part of a bigger discussion around planning for death and those end-of-life happenings, but also for the care they might need moving up to death or approaching that end-of-life time. People need to start planning sooner in life. We actually need to start talking about our younger generation here, to plan sooner in order to afford the care they may need as well as prepare for the time when they eventually pass on.

Hon. Steven Blaney: Thank you.

Mr. Adegun,would you like to comment on that? Are death care services an issue in your community?

I have 20 seconds.

The Chair: Maybe 15 seconds.

Hon. Steven Blaney: Ten seconds.

Dr. Olufemi Adegun: Definitely it's an issue. We are talking about...big rates all over Canada. It's very important to plan ahead. That's where the government supports come in at this particular point in time.

You raised the issue of something being frozen since 1998, so this is the time to bring it back. I believe, definitely, that the committee will do something right now to bring it back, to support the planning of death for our seniors.

The Chair: Thank you very much.

MP Rachel Blaney, please, for three minutes.

Ms. Rachel Blaney: Mr. Shiner, I'll come back to you.

I appreciated the report "Seniors' Housing in Atlantic Canada". Unfortunately, many of the stories in that report we also heard here from our witnesses across Canada. Thank you so much for making sure this testimony was brought here.

In the report, you mentioned that homes need to be adapted, and you talked about that quite a lot today. CMHC used to have a program called the residential rehabilitation assistance program, the RRAP. Unfortunately, a lot of that has been downloaded to the provinces and municipalities. Do you think the federal government should invest in such a program again?

Dr. Donald Shiner: I advocate a home rehabilitation tax credit program, just like the energy renovation program. It's revenue neutral for the Canadian government, by giving back the HST rebate on renovations that allow people to live longer in their homes safely. It would encourage people to do things.

I might also point out that the current American tax reform negotiations include a $30,000 deduction proposed in the United States for exactly that activity.

● (1710)

Ms. Rachel Blaney: When you talk about that, I hear what you're saying, but what about people with really low incomes who are struggling and are trying to adapt their homes? What kinds of programs do you think would support that?

Dr. Donald Shiner: Every province has some form of low-income subsidy program.

The challenge is that the cut-off levels of low income and the demand are not synchronized. In other words, there's way more demand than there is supply of money to help seniors on a low income make home adaptions.

Anything that would enhance the ability to adapt the home would certainly allow people to age in place longer.

Ms. Rachel Blaney: One of the other recommendations that I believe really merits some consideration is increasing the amount of money allocated to seniors through programs such as OAS and GIS, programs for people with disabilities, and programs for aboriginal or indigenous seniors. Can you tell us a bit about why this is fundamental in addressing seniors issues?

Dr. Donald Shiner: I'm not sure I'm the best person to answer that question.

My focus is on the home and encouraging programs that allow people to age in place while they're healthy.

Ms. Rachel Blaney: Also, it's making sure people are really telling the truth.

When I bought my home, there was a ramp to the front door. They said it was a wheelchair-accessible home. There were stairs in the home, and you couldn't get into one of the bathrooms.

That's also an important part, making sure that when people say it, there are standards people can measure in the real estate part.

Anyway, that's my time. Thank you.

The Chair: Thank you very much.

Thank you to everybody here today. This is the last session for this study. I can say the witnesses who we've had and the contributions that we've had are absolutely amazing. I will remind you, if you do want to provide a written submission—I know this goes by really quickly and I'm sure there's more that you want to add—I believe tomorrow at midnight is the deadline for written submissions. If you wish to get something in, please do so.

We're going to do things a bit out of order here, so please bear with me.

We'd like to welcome Mr. Fulton, the recipient of the 2017 Centennial Flame Award.

Voices: Hear, hear!

The Chair: Mr. Fulton's research will focus on the contributions of David Lepofsky, a respected crown counsel, professor of law and disability rights advocate. The award is granted each year by the committee to a Canadian with a disability to enable him or her to conduct research and prepare a report on the contributions of one or more persons with disabilities to the public life of Canada or the activities of Parliament.

We will be doing a photo. We'll be providing a press release with that photo, and it will be posted on the committee's website shortly.

Welcome. I understand you had a little bit of difficulty getting here today, sir, so I'm very pleased that you were able to make it. I'm wondering if you have any desire to address the committee at this time.

Mr. Benjamin Kane Fulton (Recipient, 2017 Centennial Flame Research Award, As an Individual): Hi. My name is Ben Fulton. I'm a third-year law student at Osgoode Hall Law School. While there, I was fortunate enough to encounter an individual by the name of David Lepofsky. Some of you may have heard of him before my proposal. He's a blind lawyer himself. He graduated from Osgoode in 1979, and has done a lot of work with the Accessibility for Ontarians with Disabilities Act. He's currently an advocate with the Accessibility for Ontarians with Disabilities Act Alliance, the AODA Alliance.

He personally sued the TTC, Toronto Transit Commission, because they wouldn't install an auditory signal in the buses or the subway that would tell people where the stops are. He started with soft advocacy, just writing letters and asking them to make the changes. He had to escalate his efforts and take legal action. As a result, it's a very precedential case because not only did he win, but it encouraged other transit commissions to make those changes more pre-emptively, which is actually more cost-effective than fighting it in court.

I've conducted a few interviews with him and I have a lot of his published work on advocacy. I'll be reviewing a lot of that and delving into more of the other organization that he's been involved with during his many years as a lawyer. He no longer practises law. He is an adjunct professor at the Osgoode Hall Law School. He's a charming individual. He's really great.

I'm very honoured to be accepted to receive this award and to be able to conduct this research. Thank you to the members of the committee.

● (1715)

The Chair: You're more than welcome.

Voices: Hear, hear!

The Chair: We had a very large number this year, probably the largest we've had in a very long time, of applications for this, so you're among very good company in terms of the applications that we received.

We're very pleased to see you here. We have a photographer coming at about 5:30, and we'll be getting a photo at that time with you just out in the hallway.

We do have some committee business that we need to attend to, so I'm going to suspend briefly, and we'll see you out in the hallway in due time. Before we do that, does anybody have any questions for Mr. Fulton at this time?

Obviously, we'll be awaiting the study.

Alice Wong.

Hon. Alice Wong: I really want to applaud you for all your great efforts.

Members may know that my husband has lost his total sight. Before he lost his sight, we were both volunteers for the CNIB. He completed his master's degree in spite of his challenges. I'm very proud of the fact that you are a lawyer or are going to be a lawyer, fighting for the rights of those who are visually challenged, especially in a cultural setting in which some people would not like to declare this openly. There is a lot of stigma, especially in many cultural communities. I'm very proud of the fact that you've gone so far.

I want to acknowledge my husband's own contributions in supporting me here. I just want to acknowledge that openly.

The Chair: We will suspend briefly. I would ask those who can't be here to please leave. Thank you very much.

[*Proceedings continue in camera*]