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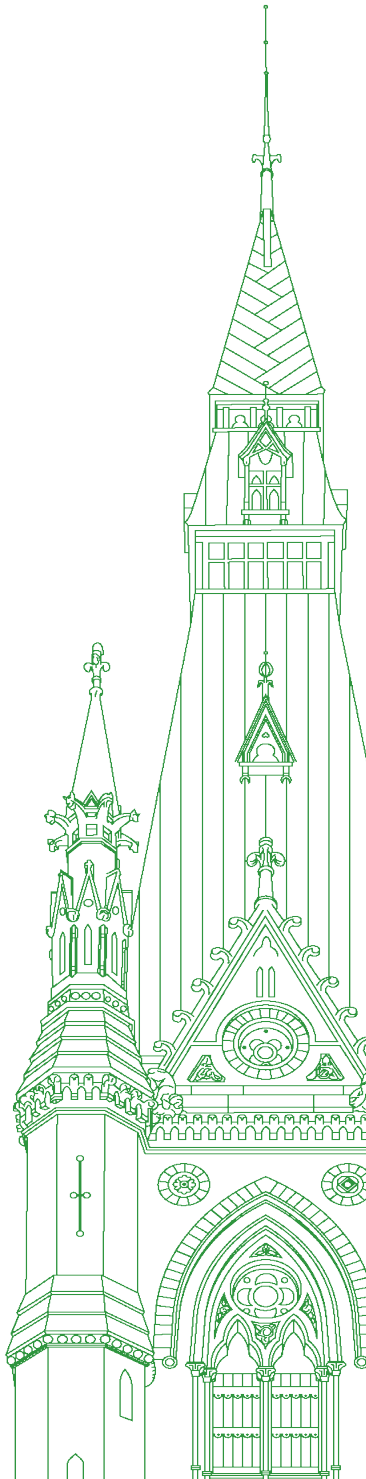

Chair: Mr. Ron McKinnon

Standing Committee on Health

Wednesday, May 13, 2020

● (1605)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I now call this meeting to order.

Welcome to meeting 20 of the House of Commons Standing Committee on Health. Pursuant to the orders of reference of April 11 and 20, 2020, the committee is meeting for the purpose of receiving evidence concerning matters related to the government's response to the COVID-19 pandemic.

In order to facilitate the work of of our interpreters and to ensure an orderly meeting, I would like to outline a few rules to follow.

First, interpretation in this video conference will work very much like it does in a regular committee meeting. You have the choice, at the bottom of your screen, of floor, English or French. If you will be speaking in both official languages, please ensure that the interpretation is listed as the language you will speak in before you start speaking. For example, if you're going to speak English, please switch to the English feed and then speak, and if you are going to speak French, switch to the French feed, and so forth. This will allow better sound quality for interpretation.

Before speaking, please wait until I recognize you by name. Once questioning starts, the witnesses can speak as appropriate. When you are ready to speak, click on the microphone icon to activate your mike. Should members need to request the floor outside of their designated time for questions, they should activate their mike and state that they have a point of order. I remind you that all comments by members and witnesses should be addressed through the chair.

When speaking, please speak slowly and clearly. When you are not speaking, your mike should be on mute. If you have earbuds with a microphone, please hold the microphone near your mouth when you are speaking. Should any technical challenges arise, please advise the chair or clerk immediately and the technical team will work to resolve them.

Before we get started, could everyone click on their screen in the top right-hand corner and ensure they are on gallery view? With this view you should be able to see all the participants in a grid-like fashion. It will ensure that all video participants can see one another.

I would now like to welcome our witnesses.

We have, from the Canadian Association of Retired Persons, Ms. Marissa Lennox, chief policy officer; from the Council of Senior Citizens' Organizations of British Columbia, Ms. Gudrun Langolf, the immediate past president; from the Conseil pour la protection des malades, Paul Brunet, president; from the Office of the Seniors Advocate of British Columbia, Isobel Mackenzie, seniors advocate; from the Canadian Association for Long Term Care, Jodi Hall, chair; and as individual, Pat Armstrong, distinguished research professor of sociology, York University.

We will begin with the Canadian Association of Retired Persons and the Council of Senior Citizens' Organizations of British Columbia. I understand that they will share the slot, with five minutes each.

Please go ahead, Ms. Lennox, and I'll signal you at the halfway mark.

Ms. Marissa Lennox (Chief Policy Officer, Canadian Association of Retired Persons): I'd like to thank all of you for having me here.

Ms. Hall, it's so nice to see you again. We spoke together in front of the HUMA committee.

CARP is a national, not-for-profit, non-partisan organization with 320,000 members who come from every province and territory across Canada. It's important to distinguish that while a lot of our members are retired and enjoy above-average education and income, an overwhelming majority consistently support that CARP represents the interests of all older Canadians across Canada. We believe all older adults deserve to live in dignity and with respect, regardless of income level, family support and health challenges.

It is with the following areas of health care that COVID-19 has undermined these fundamental principles of aging well and revealed a lack of planning and preparation that would secure the health and well-being of seniors during a pandemic.

The first and most obvious area is long-term care. If COVID has revealed anything, it has revealed that we warehouse seniors who are frail and very ill in unsafe situations that are underfunded and understaffed, including those who often have little or no certified training. We expect individuals and/or their families to pay a significant part of the privilege to be in those facilities. We placed both residents and staff at immense risk by not prioritizing the availability of PPE in long-term care soon enough. Too often, health system planning stops at the budget line of what government funds. We think it's time we reconsidered this during a pandemic.

It is unconscionable that of 5,000 deaths in Canada so far from COVID-19, 82% were among a population we are duty-bound to protect, and we failed. This is not the responsibility of the federal government alone, but it is the duty of the federal government to make sure that it doesn't happen again. If we've learned anything, it's that we didn't have a real plan in place for seniors in long-term care in this kind of pandemic. This is despite having advance warnings from other countries, seeing previous crises of similar scale like SARS and MERS, and having experience with seasonal influenza that spreads in these settings and claims seniors' lives annually. These are our most vulnerable members of society. We can and we must do better.

The second area is home care supports. CARP has long been examining the positive outcomes of other countries around the world who have met the challenges of long-term care with innovative solutions in leveraging home care options. Denmark, Norway and Finland are a few examples. In Canada it's reported that at least 20% of residents in long-term care could have their needs met at home.

That said, for those who are leveraging community-based home care supports with personal support aides, workers, and other in-home supports, several issues arose as a result of COVID-19. The first was the lack of PPE, which, along with the cross-utilization of personnel between retirement care homes and individuals requiring in-home support, contributed to a greater rate of community transmission in both settings. There was a clear lack of direction and guidance for caregivers and family supports, reinforcing the fact that in-home caregivers were not considered a part of the pandemic response.

The third issue I'd like to raise is the surgical backlogs. Many diagnostic, treatment and surgical activities have fallen victim to the focus on COVID-19. It includes a reluctance by Canadians to seek treatment for new non-COVID symptoms. This is not just a possibility; it is very much a reality today. CARP fears what this might mean for the health of our older populations who suffer from chronic conditions as well as such life-threatening disease conditions as cancer and cardiac care. Attention to this backlog, and conditions requiring such care, need to be prioritized.

If I have time, I'd like to draw your attention to two more things.

● (1610)

The Chair: You have a minute.

Ms. Marissa Lennox: Okay. I'll be quick.

The first area is protections for vaccine-preventable illnesses in older adults. As initial information suggested that COVID-19 was a precursor to an advanced pneumonia-type response, this has created serious concern within the older adult community. As PHAC previously reported, they anticipate that less than 10% of older adults are fully up to date on their vaccines. A follow-up survey of individuals shows that this number may actually be closer to 3%. Older adults do not have the same access to mass vaccination programs as those, for example, administered in schools to children.

Seniors, now more aware than ever, are hyperconcerned about other potential weakenings of their immune system, and want a fighting chance if they contract COVID-19. As CARP helps to communicate the importance of routine vaccination as an important part of the health care of an aging population, this also represents a great opportunity for the government to achieve maximum uptake on vaccines by older adults. This has been echoed by our 26 chapters across Canada in both rural and urban areas. CARP is looking for vaccines to be among the first inclusions in provincial or any potential national pharmacare formularies, with public funding and inclusion of the best-in-class vaccines to combat seasonal influenza, pneumonia and shingles in older adults.

The Chair: That's five minutes.

Ms. Marissa Lennox: Okay. I have one more sentence.

Especially as we prepare for a second wave of COVID-19, this will provide seniors with baseline protections.

Thank you.

The Chair: Thank you.

We go now to the Council of Senior Citizens Organizations of British Columbia.

Go ahead for five minutes, please.

Ms. Gudrun Langolf (Past President, Council of Senior Citizens' Organizations of British Columbia): We are part of the Council of Senior Citizens Organizations of B.C. We are the largest independent, volunteer-run and operated federation of seniors organizations in British Columbia. We have approximately 100,000 members and we come from all socio-economic backgrounds. We are very proud to be non-profit and to accept no commercial sponsorships, for example, donations from pharmaceutical companies or for-profit service providers.

As citizens and senior citizens, we are proud and extremely grateful that Canadians have responded to the call for action to reduce the transmission of the virus to others, and especially to vulnerable people like us, seniors. We thank you for all of your efforts in dealing with this unprecedented health crisis that caught many of us by surprise. The opportunity to let you know our thoughts and recommendations about long-term care in particular and seniors' health care in general is very welcome.

By the way, we appreciated your report on national pharmacare and are looking forward to some fruition from that.

Almost half of the COVID-19 related deaths in Canada have been of seniors living in institutions that masquerade as care homes. Appalling conditions that came dramatically to the public's attention existed for several shameful decades long before this pandemic. Much of public policy seems to be based on baked-in anti-age prejudice, much like racism or sexism. Combatting and eradicating discrimination based on age will take concentrated, systemic attention over time.

No seniors we know are looking forward to going into care. That's because there is a real reluctance to go into a warehouse to wait for the inevitable end, and everyone has heard a bad story or many more. In an unprecedented effort to consult with seniors in care, our British Columbia seniors advocate interviewed as many residents as possible. A large number of the interviewees were somewhat reluctant to voice specific complaints beyond the ones about regimented time, lack of showers and that sort of thing. As well, and very telling to us, was that a huge proportion of them confessed that they really did not want to be in there. The reports are available online, by the way, so I won't go into parsing the data.

Mistreatment and neglect of seniors represents a violation of the basic human right to security of the person. Allowing that discrimination to exist and flourish is a result of chronic underfunding of health care of seniors and other vulnerable people in Canada; accelerating privatization and commodification of seniors care; non-existent or ineffective government oversight of international investments in seniors care; no consistent, enforced national standards for care; and a lack of nationally coherent, shared vocabulary describing services provided or offered to seniors.

We call for the complete reform of long-term care provisions in Canada and for independent seniors' organizations like ours to be consulted in the process. Our recommendations are as follows:

One, that the federal government immediately begin transformational reform of long-term care laws, regulations, practices, and funding levels. Two, that the federal government initiate a national inquiry into the ongoing privatization of seniors health care. Three, that seniors health care in long-term care as well as allied care facilities become part of the Canada Health Act. Four, that government ban international investment in private long-term care homes, and phase out private ownership of long-term care homes. Five, that federal and provincial governments ban the contracting out of essential services that protect the health and safety of seniors. Six, that national principles and standards be grounded in national and international human rights legislation and be developed specifically to protect the human rights of seniors in long-term care in Canada. Seven, that accountability and enforcement measures be developed based on national reporting systems for regular monitoring of the provision of seniors care, and that a Canadian seniors advocate be appointed to monitor the implementation of these changes and to report directly to government.

● (1615)

It is clear that no one with the power to make any changes listened to seniors themselves until now. If they did, there is no evidence that things have changed. The fact that almost half of all the deaths from COVID-19 in Canada are of institutionalized seniors is a wake-up call for Canadians.

The Chair: Could you wrap up, please?

Ms. Gudrun Langolf: Okay.

The conditions are not news. I've provided my speaker's notes to the committee, and I urge you to look at those for the final comments.

Thank you very much.

The Chair: Thank you, Ms. Langolf.

We go now to the Conseil pour la protection des malades.

Mr. Brunet, please go ahead. You have 10 minutes.

[*Translation*]

Mr. Paul G. Brunet (President, Conseil pour la protection des malades): Good afternoon. My name is Paul Brunet, and I am the president of the Conseil pour la protection des malades, or CPM, which is now in its 46th year. The CPM is an independent not-for-profit charity and has submitted hundreds of briefs to Quebec's National Assembly and a few to House of Commons committees, as well. Our last brief was submitted in 2015, during the medical isotope crisis.

From the documents and information obtained, our analysis shows—

[*English*]

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chair, I'm not hearing any interpretation. I'm sorry. I'm on the appropriate interpretation channel, English, but I'm not hearing any interpretation.

● (1620)

The Chair: Perhaps you could toggle it to French, and then back to English, and see if that makes a difference.

Mr. Don Davies: Okay, I'll try.

It's okay now.

The Chair: Okay, we're good to go.

Sorry, Mr. Brunet. Please carry on.

[*Translation*]

Mr. Paul G. Brunet: From the documents and information obtained, our analysis shows that the public health emergency in Quebec, which the Quebec government declared on March 13, 2020—nearly two months after the World Health Organization, or WHO, issued its first warning—did not include screening or testing in residential and long-term care centres, or CHSLDs, retirement homes or private seniors' homes.

However, by then, the WHO had already issued four warnings and Quebec's minister of health and social services had received a confidential memo on the concerns regarding seniors, not to mention the dozens of news reports around the world, including several in France and the United States, warning about the risks related to seniors and retirement homes.

The same documents and information obtained reveal that, prior to March 13, 2020, the health minister's own chief of staff, Mr. Valois, stated that, although preparations were beginning slowly, it wasn't an all-out effort to prepare for battle at that time.

With the public health director, Dr. Horacio Arruda, on vacation in Morocco for a few days in late February, and even the premier, Mr. Legault, on vacation until March 8, it would seem that, in Quebec at least, COVID-19 was not considered a national emergency requiring that senior patients be identified, tested, isolated and treated.

At least, that is what the lack of screening, isolation and treatment measures recommended by the WHO since the beginning of February, particularly with respect to seniors in CHSLDs and retirement homes, suggests.

It was only three months later, on April 7, 2020, after four WHO warnings and a private memo to the health minister on the hundreds of news reports around the world, that the Quebec government finally decided to do something about seniors in CHSLDs and retirement homes. In Quebec, 81% of COVID-19 fatalities were residents of CHSLDs or private retirement homes.

On April 7, the Quebec government issued a news release in which Premier François Legault stated that his priority was to protect seniors. On April 10, 2020, as though they had been living under a rock, Mr. Legault's staff learned that COVID-19 was spreading like wildfire among seniors in CHSLDs and retirement homes. That was nearly three months after the WHO's first warning, the last of which came on March 1.

[*English*]

Moreover, “Early reports suggest that illness severity is associated with age...and co-morbid disease.” This is from the March 1, 2020.

[*Translation*]

In our view, the Government of Canada and the authorities responsible for the administration and health and safety of Quebec's CHSLDs, in particular, failed shockingly in their duty to prepare for health crises like COVID-19. They delayed introducing measures to test and treat the residents and staff of CHSLDs, as the WHO had been recommending since February 5 and March 1, 2020.

It is our position that they have violated the basic rights of thousands of Canadians and Quebeckers, people who were entitled to the right to life, including the right to receive life-saving care, to have bedsores treated, to be properly nourished, to be able to drink when thirsty and to be hydrated. Emergency doctors in Quebec told us that patients were hospitalized, not because of COVID-19, but because of dehydration and malnutrition.

These are people who had the right to integrity of the person, the right not to be housed with infected people, and when severely disabled, the right not to be lifted or changed by often well-intentioned but incompetent staff or volunteers. They had the right to dignity, the right to be treated like a human being, the right not to be left wearing a soiled diaper for days, the right to have assistance to use the toilet, the right not to be abandoned and the right not to die alone without dignity.

The authorities responsible for Quebec's CHSLDs were not prepared for COVID-19, despite recommendations by the Public Health Agency of Canada and the public health protection branch within Quebec's ministry of health and social services dating back to 2013.

How could the Canadian and Quebec governments have left seniors in these conditions and not responded sooner to the WHO's warnings and the information coming out of a number of countries around the world?

● (1625)

Thank you.

The Chair: Thank you, Mr. Brunet.

[*English*]

We go now to the Office of the Seniors Advocate of British Columbia. Ms. Mackenzie, please go ahead. You have 10 minutes.

Ms. Isobel Mackenzie (Seniors Advocate, Office of the Seniors Advocate of British Columbia): Thank you. Good afternoon and thank you for inviting me to give my thoughts and observations on our initial response to the COVID-19 pandemic—

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, sorry—

[*English*]

Ms. Isobel Mackenzie: —as it relates to seniors. I'm hearing an echo in the background.

[*Translation*]

Mr. Luc Thériault: There's a problem, the same one I raised before the meeting began. The interpretation wasn't working properly the entire time the previous witness was speaking. For the sake of expediency, I put up with it, but I can't do it for the next three hours. The problem has to be fixed. It's happening not just with one interpreter, but with most of them. A microphone keeps going on and off in my ear as I listen to the interpreters. It has to be fixed. I bring it up at every meeting. I don't want to sound grumbly this afternoon, since it's such a nice sunny day here, but I can't take it anymore.

[*English*]

Ms. Isobel Mackenzie: Did I perhaps not have my interpretation button correct?

The Chair: I'm not sure that it's a problem with you. I think it may be something wrong in the interpretation booth.

I would ask the clerk if that's something we can address right away and whether we should suspend. Let's suspend for a couple of minutes and see if we can sort this out.

● (1625)

_____(Pause)_____

● (1630)

The Chair: We're resuming the meeting now.

Please go ahead, Ms. Mackenzie.

Ms. Isobel Mackenzie: Thank you, Mr. Chair.

Thank you for inviting me to give my thoughts and observations on our initial response to COVID-19 as it relates to seniors. I say "initial response" because we're not through it yet. Inevitably we're going to discover some future issues that are not obvious right now. As you know, we're only two and half months into what is going to be a year long or 18-month journey.

I think most of us have seen, as we have responded to this pandemic, that fault lines have appeared that relate to a lot of things in our society and our economy, but particularly as they relate to seniors. I think we need to recognize that the impact of COVID-19 is different for seniors depending on their income, their social and health status. What one senior experiences in not necessarily what every senior is going to experience.

I've tried to break it into categories to look at where these differences are. If we look at the category of low-income seniors, I think there has been a different impact on them than other aspects of society. As most of you probably know, seniors have the lowest personal income of any age cohort over 25. They are very sensitive to small cost increases.

It's true that seniors have not yet felt an impact from a decrease in income. Pensions obviously have remained the same. Impacts from investment income haven't really been felt yet. The degree to which that will be felt is still to come. I'm sure many MPs on this committee have constituents who are low-income seniors who are sensitive to price increases. I'm sure you've heard about the experience of increases in food costs, in part because of actual increases in food, and in part because seniors who normally go from supermarket to supermarket or store to store looking for specials have not been able to do so. A $50 or $60 a month increase in the food bill of a low-income senior's budget does have quite an impact.

Low-income seniors are also less likely to be savvy in the virtual connections we have, like Zoom, in part because they are less likely to have devices and they are far less likely to have the Internet. One of the things that the federal government can look at in the future is how we're going to be able to provide low-cost Internet. We have focused a lot on the provision of the Internet to all parts of Canada, including rural parts. That is very important. We cannot ignore the fact that the Internet is also very expensive, especially for low-income people, and particularly for low-income seniors who can't necessarily bundle everything together on a smart phone.

I think the impact on low-income seniors wasn't immediate. It wasn't on day one, but it has compounded over time. I think it will continue to compound as they are susceptible to these small price shocks that I think we're going to see over the next year.

As we practise our safe distances, our six feet apart, as we isolate at home and certainly as seniors are made aware of the need to stay away from people more so for them than others, we need to recognize that seniors are more likely to live alone. Indeed, 23% of people 65 to 85 live alone. That goes up to 41% when you look at people 85 and over. Compared with the population under the age of 65, less than 10% between the ages of 35 to 65 live alone. When you're socially isolating in your own home, it looks different when you have a partner or kids to talk to versus having nobody to talk to. I think we have to be sensitive to that impact, which is going to build over time. You're not going to notice it as much in week one or week two, but as the weeks become months, I think we're going to have to recognize the profoundly disproportionate impact on seniors because they are disproportionately likely to live alone.

● (1635)

The COVID-19 response looks different depending on your health status as a senior. If you're 65 or even 90 and you're robust and living independently and can perform all your activities of daily living and your independent activities of daily living on your own and you're living with your spouse and you have sufficient income, that looks one way. It looks not unlike how many of the rest of us are responding to COVID-19. However, if you are like the majority of seniors over the age of 85, you need some help with your activities of daily living and perhaps even with your independent activities of daily living, so you're going to feel an impact. Certainly Marissa, and I suspect others, will talk about home care as well and how the availability of home care and the impact of COVID-19 on its delivery is going to affect some seniors.

COVID-19 will also have a mental health impact on some seniors as it dawns on them just how vulnerable they are when they need some help with their activities for daily living. They may not have appreciated it when they were getting the steady flow of home care, but as it became apparent that there might be some challenges in having that continue, I think there might have been an undercurrent of additional anxiety among some seniors as they recognized how vulnerable they were going to be when living alone without the ability for others to come in and help, although to the best of my knowledge we didn't see that big of an impact. Certainly here in British Columbia, we fortunately did not see an impact on home care services for seniors living at home.

There are also those who are in assisted living and in the long-term care system. For them, the economic challenges aren't profound, but the other challenges have been. Number one is the fear, but there is also the inability to visit with family members, which is still the state of events here in British Columbia and I think in every other province to date. Hopefully we will find a way to reintroduce some capacity for family visits in a way that's safe so that over the next year, we can allow some of the connection to happen that's been lost over the last couple of months. That has had a profound effect.

There are also the family members of those living in long-term care and assisted living. They will be profoundly affected on two fronts: in their inability to visit their loved ones and in what they are hearing, seeing and learning about what is happening in parts of our long-term care systems. I think it is important to acknowledge and understand that many care homes have had no outbreak of COVID-19, and some that have had outbreaks of COVID-19, like those here in British Columbia in the last month or so, have been able to swiftly contain their outbreaks. I think it's important to remember—and Gudrun talked about when we went out and surveyed residents in long-term care pre-COVID-19—that while many of them do not want to be there, do not feel it's home-like and do not receive the kinds of things they want to receive, many do as well.

I found it interesting when we went out and surveyed all of our care homes. I don't think it had been done to this magnitude in any other province. Every single publicly funded care home, every single resident and every single family member was surveyed by my office, independently of the care home and the health authority, and literally 50% of them said home care was pretty good and 50% said it was not very good. Many of those people were in the same care home.

We have to appreciate and understand that your experience in a long-term care facility is linked to a number of things: your expectations and experiences before you went into a long-term care home and your health status in a long-term care home. Not surprisingly, levels of dissatisfaction rose as levels of complexity rose. The more help you needed, the less satisfied you were. The less help you needed, the more satisfied you were. I think that speaks to some of the fault lines that have been very publicly revealed now in the staffing levels and staffing models that we have in long-term care throughout Canada. Those folks have a different experience with COVID-19.

● (1640)

What are the major challenges that we have? Certainly, I want to start at the income level. There is no doubt that for about a third or maybe 40% of Canadian seniors, income is a problem. Many seniors have sufficient income, arguably more than sufficient income, but we can't forget....

One measure that I use is the GIS measure. If a senior is on GIS, they have a pretty low income. It's linked to their—

The Chair: I'm sorry, Ms. Mackenzie, could you wrap it up very soon?

Ms. Isobel Mackenzie: Okay.

I think we need to look at that, and when we look at long-term care, as I think others have spoken to, there are things that we need to do there and in home care. Again, about 20% of people could live in the community if we had a better home care system.

In wrapping up, I also want to talk about the silver lining that I have seen in all of this, particularly here in British Columbia. That is the outpouring of support we have seen for seniors I believe across Canada, and absolutely here in British Columbia. To put it in perspective, we opened up a 211 “call if you need help or call if you want to volunteer” line, and it crashed. Thousands of people were calling in to volunteer to help seniors. In the last seven weeks, volunteers in B.C. have delivered over 54,000 services, and there are many more. Just through this one program there were 36,000 virtual visits.

The Chair: Wrap up, please.

Ms. Isobel Mackenzie: I think we need to look at building on what I think of as this great repository of desire from Canadians to make things better for seniors in Canada as well as in British Columbia.

Thank you.

The Chair: Thank you.

We go now to the Canadian Association for Long Term Care, to Ms. Jodi Hall, chair.

Please go ahead.

Ms. Jodi Hall (Chair, Canadian Association for Long Term Care): Thank you.

I'd like to thank the members of the committee for inviting me to present here this evening....

Can you hear me okay?

The Chair: I can hear you well, except I'm getting the French translation channel.

Ms. Jodi Hall: Yes. I think I'm experiencing that as well. I'm sorry.

The Chair: We will have to sort that out.

Can we check that we're getting the proper translation on the English channel?

Okay. Great. Now I'm getting the English channel, and it looks like we're good to go on the French channel.

Ms. Hall, please go ahead and start over. Thank you.

Ms. Jodi Hall: Thank you for the opportunity to speak to the committee this evening.

The Canadian Association for Long Term Care is the leading voice for quality care in Canada. Our members deliver publicly funded health care services to seniors right across the country.

I will start by acknowledging the seniors who have died of COVID-19. Our hearts are with those families. I'm sure that you all join me in extending deepest condolences to them.

I'll also take this opportunity to thank our front-line health care providers, who have worked tirelessly and with great compassion to deliver the care that has been required.

As we reflect on COVID-19, we will take the time to understand what could have been done differently, but we believe the impact of COVID-19 on long-term care homes could have been mitigated if governments had been proactive in supporting the sector prior to this outbreak.

Some of the challenges I will be discussing today have been exacerbated by COVID-19 but really represent systemic issues our members have been raising for many years. I want to be clear that all types of homes have been affected by COVID-19 and each have had a different type of experience. This has been an extraordinarily difficult and painful time for everyone involved, including residents and families, the front-line staff, but those who operate long-term care homes as well. We just ask that the efforts of the nation continue to focus on rallying and supporting those who are in long-term care homes.

The differences in experience with the virus have been based on a range of factors. These factors have included infrastructure, the staffing situation in the homes both pre-outbreak and during, and how rapidly the homes have been able to access personal protective equipment and staffing support when they really needed that assistance.

In the early days of the pandemic, testing, the ability to cohort their residents, and infection control measures were focused on seniors and caregivers who showed symptoms. Infection control experts and public health scientists now understand that asymptomatic carriers are highly contagious and that the incubation period for COVID-19 is far longer than for other viruses. As a result, homes that were affected early by the virus seem to have been hit the hardest.

I'd also like to clarify some misconceptions. Any and all care that is provided in long-term care homes, whether that care is provided by a doctor, a nurse or another type of health care provider, is covered by provincial governments. Each province regulates long-term care a bit differently, but generally the homes receive a funding envelope for care, programming and staffing.

In Ontario, for example, the government funds all long-term care homes with highly prescriptive expenditures, which are audited through the government departments that oversee them, and the findings of those audits are always reported back to government. With every dollar that is allotted to nursing, to personal care and to food budgets that are specifically earmarked, if there are any dollars left over in those envelopes, they have to be returned to the provincial government; there is no profit on any of these funding envelopes.

In other areas of operation, the staffing levels are highly prescribed and the funding model is extremely complex. It's highly prescriptive, tightly regulated and monitored on a regular basis by each provincial government.

I will now speak to some of the systemic issues we have noted that we feel have been an exacerbating factor with COVID-19.

The first one is infrastructure. Many older long-term care homes have three- and four-bed wards. They do not have private rooms, and it makes it a challenge to implement cohorting and isolation measures. They generally have narrower hallways and there's only one centralized dining room in the majority of homes, which makes it much harder to socially distance residents appropriately.

● (1645)

The Public Health Agency of Canada released an interim guidance document on infection control for long-term care homes, and some of the guidelines such as restrictions to certain work zones and the use of single rooms for certain types of care are almost impossible for homes to implement across the board, especially in these older facilities. Any existing outbreak management plan that these older homes have, including the isolation of asymptomatic residents, is really hindered by inadequate space and the layout availability, and we can see just how devastating shared rooms can be in an outbreak.

We know that there are at least 400 long-term care homes across the country that require updating and some form of modernization. It is imperative that the federal government support this sector by providing access to existing federal infrastructure funding, and there are many ways this could be administered. We have also noted that Minister McKenna recently spoke about financial support for shovel-ready projects in the post-pandemic stimulus package. These projects, indeed, are shovel ready and we certainly could move forward quickly with federal support.

The other systemic issue that I would like to raise is with regard to health and human resources. This is a challenge that is facing this sector and is ongoing almost at a crisis level across the country. Attracting and retaining individuals for a career in senior care has become increasingly challenging, especially when preparing for the aging demographic transition that we're experiencing right across the country. We're caring for individuals who have multiple and complex conditions much more than we have seen in the past.

We are asking for a health and human resources strategy for the long-term care sector. This is desperately needed and it should focus on the right number, the right mix, the geographic distribution of providers, as well as an appropriate setting for providers to deliver the care in. Through the leadership of the federal government, there must be collaboration with the provinces, the territories and the long-term care sector to develop and implement a pan-Canadian health and human resources strategy.

In closing, there are systematic challenges that the sector has been grappling with for many years, which we have identified. This has been fully exacerbated by the event of COVID-19. We have asked before, and we are asking again, that the federal government provide assistance to the sector to ensure that seniors have the housing and the care they need, not just in a time of crisis, but every day.

I thank you for giving me this opportunity to speak, and I certainly look forward to questions.

● (1650)

The Chair: Thank you.

Dr. Armstrong, you can go ahead. You have 10 minutes, please.

Dr. Pat Armstrong (Distinguished Research Professor of Sociology, York University, As an Individual): Thank you for the opportunity to appear on this critical issue.

In the 1980s, the Ontario Pay Equity Commission asked me to study the health sector to see who would be missing from the legislation, a request that began my research into long-term residential care, or what are most commonly called nursing homes.

Most recently I've been the principal investigator on a 10-year interdisciplinary project, called “Re-imagining Long-Term Residential Care: An international study of promising practices”. This research took international interdisciplinary teams, made up of mainly senior scholars, into nursing homes in six countries: Germany, Norway, Sweden, the U.K., the U.S. and Canada. We observed, interviewed and reflected together on what we saw and heard over the week-long span we spent in each of these homes.

In this, and in a number of other related projects, we've confirmed our central assumptions, assumptions I want to set out here.

First, we need nursing homes now and in the future for those who require 24-hour care. Such care cannot be provided in private homes, not only because many people do not have homes or at least homes suitable for such care, but also because the care required is skilled and demanding. Your grandmother and mine never provided this kind of care, because few people lived into old age and even fewer lived with the kinds of conditions and technologies required today. Of course, it is primarily women, unpaid for the work, who provide care at home now, often to the detriment of their health now and in the future. We need to plan for more, and more accessible nursing homes where 24-hour care is provided.

Second, the conditions of work are the conditions of care. These conditions certainly include adequate staffing in terms of numbers, composition, training and continuity. These conditions also include pay and benefits, especially paid sick leave, and decent terms of employment, such as hours of work and shift length as well as choices about them. The conditions involve equipment that goes well beyond the personal protective equipment that has appropriately received so much attention today. It must include such things as lifts and carts, when we think about the health risk to the residents and staff.

However, the conditions for care include much more than that. Reasonable autonomy, the time to provide the care that training and experience have taught workers to provide, and support for teams are critical conditions. Union protections, especially the right to say no to on-site conditions and to the violence that is far too common, are also essential conditions. Similarly, the physical structure of the home, as we've just heard, and its location shape care.

This is not a complete list of conditions that are necessary for care. We have to take all of them into account in planning for care both during and after the pandemic. Otherwise, we will not have a labour force, as the OECD and the ILO recently made clear in their report in December.

Third, these conditions have to take into account all those who live in, provide paid and unpaid work in, and visit in long-term residential care. Our research clearly shows that it is not only direct nursing care that is critical. While there has been recent media attention on cleaning in pandemic times, there has been virtually no discussion of the laundry and dietary services that are also particularly important now but are always essential to care. Moreover, families do much more than provide the hugs that have received so much media attention. They also fill gaps in other care work, as do the privately paid companions many families provide. Volunteers, too, make critical contributions to the social activities and the physical environment, contributions that are essential to care in long-term residences.

In recent years, this unpaid work of families and volunteers, the paid work of non-staff and the unpaid work of paid staff have all expanded to fill the gaps in care, well before the pandemic. We need to address the gaps in care at the same time as we ensure that everyone who provides care has the training required.

● (1655)

Fourth, this is skilled, gendered work. We've heard a great deal about the heroism of these workers, which may end up like Mother's Day, a one-day recognition. Pay equity legislation grew out of research demonstrating that there is systemic discrimination in the labour force. This discrimination renders invisible and undervalues the skill, effort, responsibility and working conditions involved in women’s work.

This is definitely women’s work, whether carried out by staff, contractors, families or volunteers. More than four out of five of those employed in this sector are women, and a significant proportion are new to the county and/or are racialized. There is a faulty assumption that this is work any woman can do by virtue of being a woman. The value of and the skills involved in the labour may be further undermined by the fact that this is mainly women looking after older women.

I am reminded of an interview I did with a human resources manager of a large home in Norway. I asked her what surprised her when she went into the home after working in a major media corporation and she said, “I couldn't believe how hard these women worked.” When I asked what she would do if she was in charge of the country, she said, “I'd pay these women what we pay the men on the oil rigs, because these women work harder.”

We have to recognize this work. We have to support it as skilled, demanding work that carries considerable responsibility. We have to do so not just now but in the future.

Fifth is that context matters. We talk about promising practices in our research rather than best practices because there are often multiple ways of making care conditions as good as they can be. We can learn from other countries and jurisdictions as we recognize at the same time that what works well in Toronto may not work well in rural Nova Scotia. Nevertheless, we can establish broad principles for setting conditions, and we must do so to protect workers, residents, families and volunteers.

Sixth, the search for profit does not lead to better quality care, greater efficiency or more choice, nor do many of the practices taken from that sector. Indeed, such privatization can lead to the reverse. We have to ensure that our public money goes to care rather than to profit, and to democratic decision-making rather than shareholder decision-making. At the same time, we need standards for all homes and to make sure those standards are practised and enforced.

While there are many other lessons we have learned that would take me well over my 10 minutes, let me end by saying this all leads to the need for federal leadership, as many here have said today. I would argue that it should be through legislation that is similar and parallel to the Canada Health Act, legislation that provides conditional funding based on evidence that principles and criteria are followed.

We have a host of research and commissions that provide enough evidence and advice to move forward quickly. However, in doing so, we need to ensure that the voices of those who live in, provide paid and unpaid work in, and visit long-term residential care are heard. We must ensure that nursing homes are not only safe and accessible, but also organized, funded and designed to make life worth living for all of those who live in, work in and visit long-term residential care.

Thank you. I'd be happy to answer any questions.

● (1700)

The Chair: Thank you.

We'll start our rounds of questions now. We'll do three rounds and start with Ms. Jansen.

I would also like to remind everyone to try to remember that our terms of reference for these meetings are solely to receive evidence relating to the government's response to the COVID-19 pandemic.

Ms. Jansen, please go ahead for six minutes.

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): First, I want to thank everybody for being here.

Pat and Ms. Mackenzie, you both did some amazing work on reports, so I thought I would start with Dr. Armstrong.

In your report about reimagining long-term care.... In our committee we've been hearing from many witnesses and a number of them have made the assertion that public long-term care facilities have performed far better than private during the pandemic. Ms. Langolf suggested in her presentation that phasing out private long-term facilities is the fix we need, whereas I was reading your report, and I thought it revealed that the issue is far more nuanced than just saying if the government were running these facilities this never would have happened.

Clearly, one of the major challenges in the beginning was the scarcity of PPE and the need to ration PPE. In your estimation, what grade would you give the Public Health Agency of Canada on its level of pandemic preparedness, especially with regard to PPE availability and distribution?

Dr. Pat Armstrong: I think it is complicated and I think, as several people have said, we will perhaps not know how complicated until this is all over. Obviously there wasn't enough preparedness in spite of what we saw in the SARS Commission report, which did say we should stockpile for a future pandemic. Although it has to be said that in all the SARS reports, the emphasis was on hospitals, and that has been one of the problems. Not only did we not have enough and the Public Health Agency didn't stockpile enough, but when that equipment was available, it went first to hospitals.

Mrs. Tamara Jansen: You make a number of short-term and long-term recommendations at the end of your report, which I very much appreciated. Of those recommendations, which ones are your top three, the three that would have made the most difference in protecting seniors in long-term care across Canada during this pandemic?

Dr. Pat Armstrong: Staffing and the conditions of work have to be at the top. As we look at what's happening, and as we heard about B.C. in terms of the strategies that were taken early to address this, we see it's about staffing. We've known for a very long time that we need more staff. I can't tell you how many times we've been told there are not enough hands. Perhaps I could say one more thing. I've just been talking with our partner in Norway, and they've had very few deaths in the Norwegian nursing homes. One of the factors there, he said, was that the proportion of their hands-on staff is significantly higher than anywhere else.

Mrs. Tamara Jansen: I understand that here in B.C. staff was basically moved from facility to facility. I thought it was really interesting how staff were using the same equipment as they moved from patient to patient and from facility to facility, because we were obviously rationing PPE. I know in my industry everybody is required, as they come into a vegetable facility, to put on an outfit that they take off at the end. You wonder how much could have been done had we had that sort of PPE available. Maybe Ms. Mackenzie can speak to it.

In regard to “A Billion Reasons to Care”—I love your title there—I was struck by the statistics that you share regarding the difference between for profit and not-for-profit long-term care facilities. As I mentioned, people are making the bold assertion that public facilities are far better than private. Just down the road from me here there's a private care home that actually banned provincial health care workers from being sent to that facility by the local regional health authority, because they were only given two sets of gloves and two masks to use for the month.

Again, how important is the factor of the PPE, as opposed to public or private care? We have some amazing facilities here. Look at the dementia village we have here in Langley. It's an absolutely amazing facility. It's private but a wonderful option for seniors.

● (1705)

Ms. Isobel Mackenzie: When you look at British Columbia so far, there is quite a difference in the probability of an outbreak in a contracted care home versus a health authority owned and operated care home. That is a very clear pattern that's established. I think 8% of the outbreaks are in owned and operated sites, yet owned and operated sites are 37% of the sites. There is quite a difference here.

The PPE issue is, I think, complicated because part of it is the lack of understanding of the appropriate use of PPE. This is something strong clinical leadership can help in a care home setting. It's not clear. When we get all the data and we can sort through all of it and look for the patterns around that strong clinical leadership, for me, one of the litmus tests is when I hear a care home talk about N95 masks and the care home has no outbreak. You don't use an N95 mask in a situation where there is no outbreak.

There is the issue of the supply, writ large, and then the appropriateness of the use of PPE, irrespective of the supply. When we talk about our not being prepared.... I've spent 20 years in delivering both home care and long-term care, and here is my observation: We completely underestimated—for want of a better term—the freak-out factor.

We are accustomed to outbreaks in long-term care. We handle them every year. We had 185 of them last year in British Columbia. We have protocols and we notify, but those are influenza and norovirus. We completely underestimated that, when it was COVID-19, we needed....

This is where I think that, in British Columbia—because we had the first outbreak and perhaps because in the first outbreak the care home wasn't able to respond—public health got in there and saw how quickly it needed to get in there and take control, and then was able to keep doing that. I think that is what has happened in British Columbia. It is public health's going in right away. When I look at what has happened in other parts of the country, that wasn't as quick off the ground, in part because we had the first outbreak here.

Mrs. Tamara Jansen: I'm wondering—

The Chair: Thank you, Ms. Jansen.

We'll go now to Mr. Kelloway, please.

Mr. Kelloway, you have six minutes.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair.

Hello, colleagues.

Before I begin with my line of questioning, I just want to say that it's a real privilege for me to hear from the witnesses today and for all of us to hear from the witnesses today. In my riding of Cape Breton—Canso, we have a large seniors population, and I keep them in mind every day. Throughout this pandemic, I've seen just how much citizens throughout the riding have come together to support seniors in our communities during these challenging times. I want to thank each of you for the work that you're doing in this regard.

My question is for Dr. Armstrong, and this has been referenced. You wrote a report that identified staffing issues, shortages of staffing and low wages for health care workers in long-term care facilities as having contributed to the spread of COVID-19. We know that the spread of the illness, including the common flu, has been noticed very quickly throughout long-term care homes even before COVID-19.

In your research, what solutions have you concluded can address these staffing issues and can prevent the spread of communicable diseases?

Also—I think you've alluded to this—can you talk a little about the best practices that you have been able to identify that long-term health care facility administrators should be aware of?

● (1710)

Dr. Pat Armstrong: Staffing has been identified in report after report, not just in terms of numbers but also in terms of training and distribution.

If we'd had adequate staffing levels to start with, we wouldn't have had the kind of desperation that we've seen. If we'd had full-time jobs, we wouldn't have to be introducing the kinds of practices that were introduced in B.C., because those would already be what was happening in homes. If we had surge capacity within the homes in terms of the labour force and in terms of the physical space, then we wouldn't be having this crisis either, I don't think.

We've known this for a long time, and if we don't learn the lesson from this, then I think we are going to be in worse trouble in the future. This is one of the reasons why we want to talk about the future as well as the present.

We have a lot of evidence that 20 years ago they were saying that 4.1 hours of nursing care per resident per day was essential, and that was before we had residents with the levels of complication that we have now.

Charlene Harrington, who is one of the biggest experts in the U.S. on this issue and who I was talking to this week—she is part of our research team—said that they're now saying that it should be 4.9 hours per resident per day, given the level of acuity that is the case in most homes in Canada. We don't have any province or territory that comes even close to that, and that's in regular times.

Mr. Mike Kelloway: In regular times, absolutely, and that was probably 20 years ago, as you mentioned.

Just to stay with you for a second, many witnesses have come to the committee on various topics regarding COVID, and there seems to be a bit of a common thread around greater federal oversight in a variety of ways. You referenced that here in this session. Can you elaborate a little more as to what that looks like to you?

Dr. Pat Armstrong: In terms of the federal role, I think they need to put in money, but it needs to be money with conditions. I think it could be in a parallel piece of legislation to the Canada Health Act. I don't want to open the Canada Health Act. I think the Canada Health Act is a brilliant piece of legislation, because it sets out the principles while allowing each jurisdiction to adapt those principles within their own jurisdiction so that it gives us both.

The principles are somewhat different, I think, in terms of long-term care, and we have a different kind of labour force. I certainly think it needs to include a national labour force strategy, but that isn't the labour force that's addressed in the Canada Health Act. The principles talk about reasonable compensation, but they don't address some of the other issues that have been raised today and that have been raised over and over again. We have enough information and evidence now that we could set out those principles, especially if we consult the kinds of people we've been hearing should be consulted today.

Mr. Mike Kelloway: Thank you, Dr. Armstrong.

I'll try to get a question in here for Ms. Mackenzie.

A few weeks back, I read that B.C. had announced more supports for seniors and caregivers during COVID-19, in addition to the funding provided by the feds through the local United Way organizations and the new horizons for seniors program we announced in early April. Now that the provincial funding has been out there for about three weeks, maybe close to a month, I'm interested in your perspective. What are you hearing as to how this has benefited seniors and whether it has been difficult for them to access their support?

This could be something I could easily ask people from other provinces as well, in terms of provincial and federal measures, but in this case, with respect to the provincial measures, I'm curious as to what you're hearing on the ground.

● (1715)

Ms. Isobel Mackenzie: The funding that you're speaking of went to the bc211 program over the last seven weeks. That's where I was highlighting those sorts of services. What it showed us was that number one is to make it easy to get the service. That was the beauty of the 211 number. There are not a lot of digits to remember. Number two is to harness the energy and capacity of volunteers who want to help. That was a key part of the program. Get them connected with those seniors and respond quickly to things like “I need groceries”, “I need meals delivered”, “I'm getting lonely” or “I need somebody to talk to.” From the perspective of the issues created by COVID-19, I think that was an effective way. It got out there fast.

I give full credit to the B.C. provincial government for doing that and partnering with the United Way and bc211, which is interlinked with the United Way, a network across the country. I think the federal government signalled that as well with what they did. I think it can be highly effective. It certainly has connected a lot of seniors with services they needed, not medical services but important ones.

Mr. Mike Kelloway: Thank you.

The Chair: We now go to Mr. Thériault for six minutes, please.

[*Translation*]

Mr. Luc Thériault: Thank you, Mr. Chair.

I'd like to thank all the witnesses for their insightful comments. We have to find solutions. My first question is for Mr. Brunet.

Your opening statement was very compelling. You're known for your anything but complacent attitude. It's a quality I appreciate.

On March 13, Quebec was the first to declare a public health emergency, when it had just 17 cases and no deaths. Two months later, the situation is this: the number of cases will surpass 40,000 by tomorrow and more than 3,220 people have died.

Most of the witnesses we've heard from—even some today—have told us that, early on, the weaknesses and vulnerabilities of the health care system exacerbated the rampant spread of the virus. They cited underfunding of the system as the main reason.

Many would prefer to standardize the rules from coast to coast to coast, but health care is the domain of the provinces and Quebec. You had reservations about nationalizing CHSLDs, saying you preferred that Quebec pass legislation requiring a minimum level of care and services in CHSLDs and retirement homes, whether private or public. I'd like you to elaborate on that.

Tell us, if you would, what the parameters or key pillars of that legislation should be.

Mr. Paul G. Brunet: Thank you.

You're right. Over the past 45 years, we've contributed to dozens of parliamentary committees, public consultations and, for the past 35 years, public inquiries, mainly in the area of long-term care. In terms of results, however, things haven't changed.

Long-term care is provided every single day. People need to know that these facilities offer a good standard of living. That means ensuring measures are tailored to the reality on the ground. After 25 years as a health care advocate and given what I've seen, I respectfully submit that it doesn't matter whether an institution is public or private, despite what all the scientific studies say.

I've seen miracles and horror stories in public and private institutions alike. The difference lies in the men and women who run the establishments and their ability to show leadership in bringing together residents, families, unions and health care professionals. When all of them are at the table, the difference is clear. The low number of complaints these establishments receive has shown me that it doesn't matter whether they are public or private; the men and women running them and their ability to work alongside staff are what really matter. That's the empirical evidence I've gathered after being in the field 25 years and seeing hundreds of cases.

That's what I've experienced, what I've witnessed and what I think. Unlike others, I don't claim that it's based on scientific research.

● (1720)

Mr. Luc Thériault: I'm more interested in the bill. In an April 25 interview, you said you had put forward a bill. I'd like to know a bit about the framework and the way it could contribute to the solution, especially in Quebec.

Mr. Paul G. Brunet: We've actually been documenting everything for 20 years: how to run establishments, manage people, supervise staff and so on. Staffing comes up a lot, but supervision is really important. Henry Mintzberg, himself, says that people with little training need supervision in order to do their jobs. Staff members need encouragement, guidance and direction in carrying out their duties.

The idea behind the bill is to introduce a minimum level of care and services, which would be based on the type of establishment where people were admitted. No one could operate a public or private seniors' residence that provided care and services below the prescribed standard. They wouldn't be allowed to; it would be prohibited. What's more, the institution should be subject to oversight.

How many times have we told the government that it's delusional to think everything will be fine if the necessary oversight and checks aren't performed, no matter how many measures it implements in the health care system? People are granted licences to operate these public and private establishments, but terrible things happen and, in some cases, people who don't know what they're doing make their way in.

Mr. Luc Thériault: From the outset, the key has to be adequate funding. Every year that health transfers are cut from 6% to 3%, it results in a huge shortfall. The various networks try to make do with what they have.

The current pandemic is a public health crisis. It has to do with health. Places that provide care are seriously affected. For every $100 the federal government spent on programming to support the economy, it spent just 33¢ on health care to support our so-called guardian angels.

Right there, there's room for improvement.

Mr. Paul G. Brunet: Yes, certainly.

I recently had lunch with former Quebec premier Philippe Couillard. He told me that, after announcing a $20-million investment in his area for CLSCs, CHSLDs and home care services, he then went to a CLSC or a CHSLD and asked whether the money had arrived. He was told that a few thousand dollars had finally arrived on the ground. There's a great deal of bureaucracy, and this issue is even worse at the federal level, unfortunately. As a result of many issues, this money doesn't really benefit the employees on the ground.

Granby zoo employees earn $16 an hour when they first start working. We earn $12 an hour in a number of places. Could we at least be paid the same as the people who take care of animals? Sorry for sounding so silly, but we need to use some shocking examples to make the authorities think.

I understand your perspective, and we have the same issue in Quebec. However, at the federal level, things are even worse, because of the bureaucracy.

Mr. Luc Thériault: You're saying that we must inject money into front-line services rather than trying to set up programs across the country that will inevitably involve an administrative drain. In terms of monitoring, there are already many health department employees who aren't on the front lines and who must be paid.

Mr. Paul G. Brunet: Accreditation Canada conducts monitoring and provides accreditation to care facilities in Quebec and across Canada. However, these people won't eat what we're eating on the ground, won't smell what we're smelling and won't hear what we're hearing. Accreditation Canada doesn't do this.

In 2014, Liberal minister Dominique Vien established certifications for seniors' residences that met the standards. These residences were told that they would be accredited, but that if they failed to comply with the accreditation requirements afterwards, they would be deluding themselves. Lastly, in Quebec, we have departmental visits carried out by volunteers. As a result of former minister Barrette's reform, the opportunity to talk to people in the units has been greatly restricted.

Unfortunately, three things are used to monitor and check what's being done, and this is having very little effect. It's sad, but the system has been bureaucratized and not much has been done to improve the situation on the ground. If we don't eat what we serve people, the reason is that the product isn't good.

● (1725)

Mr. Luc Thériault: How do you think that we could—

[*English*]

The Chair: Mr. Thériault, I think you're done. I lost track of the time, but I think I gave you extra.

[*Translation*]

Mr. Luc Thériault: I found that quite nice, although unusual, Mr. Chair.

[*English*]

The Chair: We'll go to Mr. Davies for six minutes.

Mr. Don Davies: Thank you, Mr. Chair.

Thank you to the witnesses for being here.

Dr. Armstrong, you recently co-authored a report entitled “Re-imagining Long-term Residential Care in the Covid-19 Crisis”. It recommended stopping privatization and ensuring non-profit ownership of long-term care facilities.

Can you outline for us why you made those recommendations?

Dr. Pat Armstrong: I think there's research indicating patterns. Of course, there are some good for-profit homes. There are some bad municipal homes even, or not-for-profit homes, but the pattern is clear that there tends to be lower staffing in for-profit. There tends to be more reliance on part-time and casual employees in for-profit. There are patterns of more ulcers, more transfers to hospitals and more falls. There is a whole host of patterns that are much more common in for-profit homes than in non-profit homes.

I should be clear that we said “non-profit”. That isn't talking about the government taking over all the homes. I'm talking about taking the profit out of care. I don't see any reason to put the money into profit when we're not particularly getting a benefit out of it, and in fact it may be the reverse. Why isn't that money going to care? It's—

Mr. Don Davies: Thank you.

Ms. Mackenzie, I'll turn to you on the same subject. You put out a February 20 report that found that the province's for-profit long-term-care home operators, while making profits, are shortchanging seniors of more than 200,000 funded care hours per year. Your report found that non-profit operators spent $10,000 more per resident per year than for-profit operators and delivered 80,000 additional hours of care beyond what they were funded to provide. It also found that, under the current funding scheme, for-profit operators spent far less on care aides and other front-line staff than their not-for-profit counterparts.

Would you also endorse Dr. Armstrong's view that we should be putting more money into the non-profit sector as opposed to the for-profit private ones?

Ms. Isobel Mackenzie: I think what the report demonstrated was that we don't have the proper financial incentives or oversight. You could argue, Mr. Davies, that, if we get it aligned, then being a for-profit operator will be of marginal value.

I can't speak for Ontario. I know Jodi was talking about the way money is managed. That's not the way it's done here in British Columbia. We give a lump sum payment to a contracted provider, and we come up with that lump sum by saying you should spend this much on this, that and the next thing. They do provide statements that say, “Here is what we spent on this, that and the next thing”, and we look at that, but we don't do anything with it.

The classic example is around wages. In British Columbia, all care-home operators are funded to provide industry-standard wage levels, so they are provided enough to pay care aides at the industry standard. Whatever they pay them less than that, they get to keep. That's the problem.

There are things we could do quickly, and what we could remedy quickly is certainly the money we're giving you to pay wages for—we call them care aides in British Columbia—personal support workers, whatever. You have to pay that, and if you don't pay it, you have to give it back. What we pay you for the nurse, you have to pay, and if you don't, you have to give it back. We take away the incentive, and by that we take away the profit. We take away the motive for making a profit.

There was a very clear pattern. As Pat said, it's a pattern, which means there are exceptions to the pattern, so yes, there will be good performers or, as the economists would say, good actors, in the private field, and there will be bad actors in the not-for-profits.

● (1730)

Mr. Don Davies: I'm sorry, I have limited time, so just quickly, Ms. Mackenzie, you're obviously British Columbia's seniors advocate. I note that Canada does not have a federal or national seniors advocate. Would that be something you'd recommend the federal government to establish?

Ms. Isobel Mackenzie: They can certainly look at it. I think the challenge here that's been identified is a number of these issues are provincial, so what is the role of the federal government around this? Prescriptiveness is going to be limited, but leadership is going to be able to be there. The federal government does give money to provinces and can put strings on that money, so those are levers. They are public policy levers available to the federal government, even within the confines of the Constitution and the BNA Act.

Mr. Don Davies: Thank you. You anticipated where I was going to go, so I'll go back to you, Dr. Armstrong.

There is this question of what the federal role is. Some of us are calling for binding national standards with respect to minimum standards of care, ratios, etc. You've indicated that one particular model is a piece of legislation analogous to the Canada Health Act, but not the Canada Health Act, I understand. What's your view on what the federal government should do in terms of long-term care?

Dr. Pat Armstrong: We set that out in the report, I think, to some extent. It certainly should establish the conditions of work, which would include things like staffing, wages and benefits. Obviously, you don't set out the specifics, but you set out the standards and how you have to, for example, keep to the industry standards in those areas. Minimum staffing levels are absolutely critical and so is some notion about the appropriateness of the staffing levels, even if those are minimum. I always worry that the minimums will become maximums. I think that—

Mr. Don Davies: Dr. Armstrong, could I just interrupt and guide you to one particular aspect? I'm curious about your views on the Canada Health Act, which has five principles, including universal access and public administration. Would you take those concepts and advise that they be applied in terms of long-term care?

Dr. Pat Armstrong: Yes. If we understand access, as it says in the Canada Health Act, there's a broader definition of access of not simply financial, although financial is there, but it also includes actually having the facilities there. We haven't pursued that a lot.

Yes, I would certainly include access, and perhaps uniform terms and conditions, and comprehensive, which is interesting. It's the only place in the Canada Health Act where they get detailed and talk about what should be included. There's a charge for accommodation in every jurisdiction in Canada, so we exclude the food, and in some places the laundry, and we include some of those things that we talked about in terms of a plan in Quebec, because I would argue that food and laundry are absolutely critical to care.

We have to talk about what would be included in those services as well.

The Chair: Thank you, Mr. Davies.

Mr. Don Davies: Thank you.

The Chair: That ends round one. We'll now start round two, with Mr. Jeneroux.

Mr. Jeneroux, please go ahead. You have five minutes.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair.

Thank you to the witnesses for being here today.

I want to talk a bit about some of what Ms. Mackenzie and Ms. Lennox touched on with regard to the degree to which investments will be impacted in the senior and retired population. Obviously the government has come forward with a $300 credit, if you will, but I still get a number of emails on that long-term impact, what it would really mean for these individuals.

Ms. Lennox, since it has been about two hours since your initial presentation, maybe I'll allow you to kick us off and talk about some of that, and then I'll ask Ms. Mackenzie to also provide some feedback.

Maybe we'll start with Ms. Mackenzie, since it looks as though Ms. Lennox might not be there.

● (1735)

Ms. Isobel Mackenzie: Okay. Let me know when her microphone unmutes and I'll stop talking.

That is the other shoe that really hasn't dropped yet. We don't know what the impact is going to be until we see what's really going to happen to the markets over time. You can't really tell now. It's going to be a year from now.

When we look at where seniors are getting their income, among seniors who have income in addition to their basic government pensions, a lot of them are getting dividend income, so what's the impact of that? What is going to be the impact on some private pension plans? Are they going to reduce the pensions because their investments have made them unable to make those payouts? We don't know that yet, but I think we have to remember that this is still coming. You've heard me talk a lot about poverty amongst seniors, but there's also a group of middle-class seniors, and we need them to have an income because they're also paying for a lot of their health care needs.

I agree with Pat. The Canada Health Act is great, and has some challenges.

A lot of health services that probably no one on this Zoom call even thinks about because we can do them all ourselves become health services for people in the community and they have to pay people to help them. They need money to do that, so we can't forget that piece of it. Certainly initiatives around reducing the withdrawal amounts for RRIFs are all helpful for now, and we'll have to wait and see what happens to the markets.

Mr. Matt Jeneroux: Is there anything specific, then?

The Chair: Excuse me, Matt.

Ms. Lennox has been asked to drop and rejoin, so if you want to ask her a question, we'll suspend for a minute or two and let that happen.

Mr. Matt Jeneroux: If it's okay, we can keep going. We don't have to—

The Chair: That's fair enough; as you please.

Go ahead.

Mr. Matt Jeneroux: Ms. Mackenzie, is there any work being done in terms of what that looks like, what the ask will be to help protect these seniors?

I think of the ones who have emailed me. This wasn't part of their plan for retirement.

I'm trying to find what that ask will be. It's fair to say we'll look at what the markets do, but if there's an ask in place, I'd love for us to be able to consider that also as this committee continues.

Ms. Isobel Mackenzie: I think the ask would be to look at the overall economic impact on a group of people who have now lost the ability to in any way change the trajectory of their income. They have retired. They can't add to their savings any longer. They are drawing on their savings.

This is not the finance committee, but I don't know what markets are going to look like in a year from now. They might completely recover. You've heard this: Is it a V-, U- or L-shaped recovery? Those provide very different outcomes and degree of impact.

Making sure that people don't make rash decisions right now is important, and look at measures that allow people to not have to cash in, if they aren't required to, because markets are exceptionally low. Also, allowing for some capacity of capital withdrawals to shore up some expenses during this time might also be helpful. I think there's another side to this, and we'll see what it looks like and where we're at when the markets settle.

The Chair: Thank you, Mr. Jeneroux.

We'll go now to Dr. Powlowski for five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

I read somewhere someone describing a busy neighbourhood bar—although I miss such things—in terms of a place for transmission of communicable disease as being something akin to a wet market in China. There are different kinds of chronic care homes, and I would guess that, depending on the type of home, some have had more problems than others. Probably some homes, in terms of spread of infectious diseases, might also be akin to a wet market in China.

I think Ms. Hall outlined some of those things: a lot of homes where there are four people to a room, narrow halls and one cafeteria. I might add a few other things, such as lower-income residents, more seniors who are more elderly with more chronic care homes, as well as fewer staff, and those are the ones where coronavirus has hit and really spread like wildfire. Am I right or wrong in saying that?

Ms. Hall, maybe I could ask you.

● (1740)

Ms. Jodi Hall: Yes, those are absolutely factors. As I had outlined earlier in terms of the overall condition of the infrastructure in homes, especially older facilities, they were designed for a different generation, a different type of individual who required care. When we look to who we are caring for today, these are people with much more complex conditions than when these homes would have been built 20 to 30 years ago. The room configuration, the overall design and layout of the building, does put people closer together. When we think about things such as isolation and cohort planning, those become very significant factors in the overall prevention efforts against COVID.

We also have to remember that from the beginning of this outbreak to where we are today, we have learned a tremendous amount, especially as it relates to asymptomatic transmission. When we look at the homes that have experienced the most significant outbreaks, that was a critical factor as well, as staff introduced that into the homes and didn't realize the extent of their illness.

Mr. Marcus Powlowski: Ms. Hall, I want to continue on with you, since you work with chronic care homes in general.

On April 13, I think the Public Health Agency of Canada came out with recommendations as to safety standards, public health measures to protect the elderly in chronic care homes. Quebec declared a state of emergency on March 13. Certainly it was mid to late March when we started to really implement those social distancing programs.

Before the Public Health Agency of Canada came out with those standards on April 13, what was in place? Did the provinces have safety measures, and were they being implemented in the homes before April 13?

Ms. Jodi Hall: I think that everyone became extremely aware of the situation in early March. In individual care homes and certainly with colleagues of mine across the country, the discussions were very active and robust as we worked to see what was happening internationally and were starting to see the cases pop up in our own country.

There have been many examples in case studies that we were taking a look at and trying to share amongst ourselves as to the strategies that were needed going forward. We also looked to the provincial governments which were starting to take action. That happened at different rates in different provinces, and that included when access to additional PPE and additional guidance from the provincial public health departments were made available, so there was a bit of a range of time. Early access to appropriate personal protective equipment, better information, key information about asymptomatic transmission, in particular, as the symptom list began to grow were all factors for us.

Mr. Marcus Powlowski: Okay. I want to get one more quick question in.

I think you said that when it came to the worst homes, you couldn't implement the recommendations by the Public Health Agency of Canada to protect the elderly in chronic care homes. Did I hear you right? It was things like requiring isolation when all rooms contained up to four people. Did I hear correctly that some of these recommendations were unrealistic and couldn't be implemented in some homes?

● (1745)

Ms. Jodi Hall: That's correct. Our point was that there was a disconnect between some of the recommendations that were being made when you compared that to the reality on the ground and what could actually be operationalized.

Mr. Marcus Powlowski: Now, did Public Health—

The Chair: Thank you, Doctor.

We go now to Dr. Kitchen.

Dr. Kitchen, go ahead for five minutes, please.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you everybody for being here and for your presentations. It's greatly appreciated.

It was so nice to hear many of you talk about breaking things down with respect to long-term care. I think a lot of Canadians are missing that fact. They lump everything together when they don't understand all the factors. I think, Dr. Armstrong, you said it really clearly when you talked about appropriate training with regard to nursing, cleaning, laundry, diets, volunteers, support staff, families. Those things have to be looked at, so I appreciate that.

Ms. Mackenzie, you mentioned the outpouring of support we've had for seniors because of this crisis. I think it's fantastic that we see that.

I'm wondering if you're hearing that families are also stepping up to help out besides the volunteers who are helping out for other people. Are families stepping up? Do you anticipate that help being there when this crisis is over?

Ms. Isobel Mackenzie: I hope it's there. The short answer is that families are absolutely stepping up. We saw that initially. My office hears from folks all the time about their sons, their daughters, their grandchildren making sure they get the meals, etc. That is the silver lining in all of this. When the chips are down, Canadians have shown overwhelmingly they really care about their seniors. We have to build on that and leverage that now to get the needed improvements that a number of people have spoken about.

I think that we will sustain this. In long-term care certainly we've seen families express both their understanding of why they can't visit and their frustration that they can't visit. I think that's also reassuring in the sense that there are a lot of family members out there visiting their loved ones in care homes. We also hear about how they visit other people in the care homes who don't have family members living in the same city.

I am hoping that we will sustain this when we are through this pandemic. The phrase I use is “my grandmother, my mother, myself”. People can see that they do not want that for their loved ones, they don't want that for themselves, and that if the will is there, the change will happen.

Mr. Robert Kitchen: Thank you for that.

Ms. Hall, you talked about two things that you left us with. One was infrastructure and the other was health and human resources and how challenging that is, in particular when we're dealing with multiple complex situations as we see with seniors. When I did my practice, basically the average lifespan for a male was 78 and for females it was 80, and now we see it is much longer. Now we're seeing issues of dementia. We're seeing Alzheimer's, anxiety, bipolar issues happening more and more as we age.

You covered a lot about the training for people to actually deal with that when you talked about the tight regulations needed to make certain that they're being followed, and they are being followed. I'm just wondering if I could hear your comments. Last week the Minister of Employment, Workforce Development and Disability Inclusion stated that, with respect to providing assistance in long-term care homes during the pandemic, “We may create...some kind of training so that people who aren't in these jobs now—maybe people who are at home and unemployed—can take a shortened version of this training and be able to perform the less complicated tasks that are required at these homes”.

I'm wondering how you see that impacting on all of those aspects that you talked about.

Ms. Jodi Hall: It is critical that we have access to an appropriate workforce. It does give me pause to think about any particular mandate being given to a group who may not necessarily have a desire or an aptitude. Caring for frail elderly is work that requires someone with great compassion and skilful ability. Of course, if there are individuals among the population who are willing and open to receive that training, we would certainly welcome them as members of the workforce. But I would be hesitant to see something that would be a forced program, if I can express it that way.

● (1750)

Mr. Robert Kitchen: That's assuming they had the appropriate training for the level of skill that's needed.

Ms. Jodi Hall: That's correct, yes.

Mr. Robert Kitchen: Ms. Lennox, I'd appreciate your comments.

The Chair: I'm sorry, Dr. Kitchen, your time is up.

Mr. Robert Kitchen: Oh, thank you.

The Chair: It was going so well, I was in a lull, but—

Mr. Robert Kitchen: I was hoping to get Ms. Lennox back into the conversation somehow.

The Chair: Yes. Anyway, thank you.

We go now to Ms. Sidhu.

Ms. Sidhu, you have five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you to all the witnesses for being here with us.

My question is for Ms. Mackenzie.

British Columbia has reported 285 cases in long-term care homes and 74 deaths as a result of COVID-19, but Ontario reported more than 2,000 cases and more than 1,000 deaths from COVID-19 in its long-term care homes.

What is B.C. doing better? What are the best practices so other provinces can follow them?

Ms. Isobel Mackenzie: I've spoken of it and others have as well. I think the reason we are seeing at this moment better outcomes in British Columbia is because of what we learned at the first outbreak at Lynn Valley. I think the approach has been that, first of all, we lowered the barrier to declare an outbreak on one case. The normal outbreak threshold is two cases, one laboratory confirmed. Also, we looked at staff equally as residents. I don't know how many people here have been in practice, but when I was in practice we never looked at staff for influenza swabbing; we looked at residents. That, I think, has helped.

The minute the outbreak is declared, which is one confirmed case, either staff or residents, public health gets in there immediately and gives direction to the care home around all of the things that need to be done. We talk about the cohorting and about these other things.

In British Columbia, 75% of our residents are actually in single rooms. I think that is higher than other provinces. I think that has also helped us manage the best practices that PHAC has recommended, and that any infection control person would recommend.

The recognition of the care staff as the vectors of transmission and the designation to one work site, which was done earlier, has been helpful. If there's one area where we lagged a bit—and I would say everybody did, and Jodi has talked about this—it was the testing of asymptomatic people in an outbreak situation. I think we learned. Early on, we weren't doing that because the evidence at that time was that the test was ineffective if you were asymptomatic. We now know that asymptomatic people can both shed the virus and test positive for the virus. So we have started that best practice as well.

I think it's those things. Certainly, the quick, SWAT-like intervention of public health at the very beginning has been absolutely key to helping us.

Ms. Sonia Sidhu: Thanks for that.

My next question is for Dr. Armstrong.

The Canadian Anti-Fraud Centre put out a bulletin warning Canadians to watch out for scams associated with COVID-19. They warn that fraudsters want to profit from Canadians.

As you know, people of all ages can be victims of fraud, but older people are targeted more than others. What more can be done, working with public health authorities, to cut down or eliminate the spread of misinformation? Have you any thoughts on that?

Dr. Pat Armstrong: Others might be better able to answer that question about fraud and misinformation than I am.

Ms. Sonia Sidhu: Anybody can talk about that. Most times they target seniors. Even though all ages can be victims, seniors are being targeted.

● (1755)

Dr. Pat Armstrong: For sure, there's no question that, as we've heard from a number of people, the older you get, the more vulnerable you can be to a number of these scams, not because you're not smart or capable but because they take advantage of what might be areas where you don't have the expertise, such as me and technology.

Ms. Sonia Sidhu: In your view, how has the pandemic impacted seniors' mental health and well-being?

Dr. Pat Armstrong: In terms of long-term residential care, both those who are inside and those who are outside the home, and Isobel was stressing this, are suffering a great deal from fear and isolation. Even if you're in a long-term care home, you're suffering from isolation.

I want to go back to something that Isobel was saying earlier about long-term care. We seem to see this as the worst option in terms of where people can get care.

I went to a resident council meeting here in Toronto as part of a study we were doing and asked them if there was anything better about being there than at home, and they unanimously said, “Oh, yes.” They said that at the care home they felt safe, but they were talking about safe in terms of getting things such as their insulin. They had company and they had activities. Therefore, we have to think about these places as good places to be when we're responding to this type of issue.

The Chair: Thank you, Ms. Sidhu.

Ms. Sonia Sidhu: Thank you.

The Chair: Monsieur Thériault, we'll go now to you, for two and a half minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Mr. Chair.

Mr. Brunet, in a document signed by your organization and entitled “Other people overlooked during the COVID-19 pandemic,” you referred to people with mental health issues who are hospitalized and housed in a Quebec department of health and social services facility.

Tell us a bit about this issue. What should be done to ensure that these people receive proper health care while being protected from COVID-19?

Mr. Paul G. Brunet: We've received complaints from over 200 user committees in as many health care facilities in Quebec. We're standing up for 300 individual members.

The places that house people with mental health issues are telling us about the significant amount of isolation and the many restrictions. If the premises were better adapted to the needs of these people, they could wander around despite their mental health issues. We're told that these people are victims of the lockdown.

It's sad, because many places, such as the Albert-Prévost mental health hospital and the Louis-H. Lafontaine hospital, are run-down. Imagine that, because of COVID-19, people with mental health issues need to be locked up even more than usual. This has led to a great deal of turmoil, safety issues and physical violence, because a number of people with mental health issues don't understand what's happening.

Mainly, the premises are run-down and they can't accommodate people with serious mental health issues, especially during the current crisis. This has been a major challenge.

Mr. Luc Thériault: CHSLDs have two types of missions, one related to care and one related to the living environment.

Mr. Paul G. Brunet: Yes.

Mr. Luc Thériault: I think that, in the pandemic era, we're falling far short of the mission in relation to the living environment, since we've taken families and caregivers out of these environments.

Starting today, what should be done to try to quickly resolve the situation under the current circumstances?

Mr. Paul G. Brunet: It's difficult, because we're going through a crisis. For over a year, we've been asking the government to participate in recruitment and to show that workers who work with people who are sick and with seniors who need help or assistance are employed in one of the noblest professions in society.

During the current crisis, we've acted as if we had no plan. We asked for help from doctors and the military. We must now resolve the situation by getting more people working and by asking for better supervision for our employees, as I said earlier. This is essential.

I heard my colleague say earlier that her province went all the way to the Supreme Court of Canada to make laundry free for people living in shelters. There's also the whole issue of food.

Significant challenges lie ahead. We've reached out to the different ministers of health and to the Minister of Seniors. On a political level, I understand that challenges lie ahead and that people aren't necessarily prepared to reach out to organizations such as ours. We're very critical, but we also want to—

● (1800)

[*English*]

The Chair: Mr. Brunet, we have to wrap it up.

Mr. Paul G. Brunet: Thank you.

The Chair: Thank you, Mr. Thériault.

We will go now to Mr. Davies for two and a half minutes.

Mr. Don Davies: Thank you.

Ms. Langolf, this morning I participated in a webinar sponsored by the Canadian Federation of Nurses Unions with a number of speakers. One was Dr. Samir Sinha. According to him, long-term care is the largest form of health care in the country that is not covered by the Canada Health Act. I noticed that one of your recommendations was to bring long-term care under the auspices of the Canada Health Act.

Can you tell us why you think that would be a wise course of action?

Ms. Gudrun Langolf: The difficulty we have is that there are 11-plus jurisdictions for health transfers of money and many more differences of quality of care or details of the service provided to citizens because it's left up to the provinces. We're not suggesting that they are negligent. It's just that they have different priorities.

Chances are that unless you provide the guidance with national standards that are clear and understandable across the board, whether you get these services depends on where you live. What happens is that it depends on where you live whether you receive the service, and that should not happen. A Canadian standard ought to be consistent across the country.

Mr. Don Davies: Thank you.

Ms. Lennox, picking up that point, according to TVA Nouvelles almost half of Quebec's residential long-term care facilities have not been inspected for more than three years. A recent CBC News investigation found only nine of Ontario's 626 long-term care facilities received a resident quality inspection in 2019.

You testified that you felt it was the duty of the federal government to make sure it doesn't happen again.

What is your advice to the committee on the proper role of the federal government in addressing long-term care?

Ms. Marissa Lennox: The Canada Health Act is one tool you can use in order to raise standards in long-term care. As Ms. Armstrong also mentioned, the other tool is to stand up its own legislation, similar to the Canada Health Act but specific to long-term institutional care or long-term medical home care.

When you think about the people who are receiving this type of care, though, they are requiring the highest levels of institutional care and long-term care, and it should really be treated no differently as a hospital.

I would suggest that the federal government needs to revisit its funding formula when it comes to providing this type of care, and we need to raise the standards and make sure that they are consistent across the provinces.

The Chair: Thank you, Mr. Davies.

That brings round two to a close. We will start round three with Mr. Webber.

Mr. Webber, you have five minutes.

● (1805)

Mr. Len Webber (Calgary Confederation, CPC): Five minutes is wonderful. Thank you, Mr. Chair.

My first question is for Ms. Lennox.

The Government of Canada has announced that a select group of seniors will receive $500 in a one-time payment. A greater number will receive $300 instead, but most will receive nothing. The Liberal government has suggested seniors do not need special payments for the most part, because their income has not been disrupted in the same way as the income of many other Canadians has.

Can you give us a better idea of the types of increased costs that seniors are facing as a result of this pandemic?

Ms. Marissa Lennox: Sure. A lot of our members have seen an increase in the cost of living, whether that's in dispensing fees for prescription medications or in the delivery of groceries, for example. A lot of seniors over the age of 70 have been told to stay home and so have had to incur those costs. In particular, low-income seniors, who may not have access to family supports or other community supports, are disproportionately impacted by this.

On top of that, we also know that a number of community support programs have shut down. Forty per cent of food banks in Toronto, for example, shut down because of COVID-19 due to physical distancing restrictions and also because of a shortage of volunteers. These are things that seniors depend on, discounted laundry services.... These are some of the ways in which [*Inaudible—Editor*] I would also mention that some of the tax support programs for seniors to file their taxes have also had to close their doors, and seniors are being forced to incur those costs in addition.

Mr. Len Webber: Those are very good points. Can you give us any idea of an average price of these new costs at all? This would give us a better idea of how adequate or inadequate the government assistance is.

Ms. Marissa Lennox: It's difficult to say because on top of that—

The Chair: Ms. Lennox, your sound is very difficult for the translators. Could you speak into your mike if you have one?

Ms. Marissa Lennox: Yes.

The Chair: I'll pause Mr. Webber's time here for a minute.

Ms. Marissa Lennox: I took it out because it kept coming out. Can you hear me now?

The Chair: I can hear you. How are we for interpretation?

Ms. Marissa Lennox: Regarding the costs, it's difficult to say because on top of those out-of-pocket expenses, seniors have also seen significant declines in their retirement savings.

What we know about CARP members is that a majority of them are very concerned about outliving their savings, but when we talk about hard out-of-pocket costs, one of the biggest out-of-pocket expenses is prescription copayments. As you know, many of the provinces have restricted people to a [*Inaudible—Editor*]

The Chair: I'm sorry. You are cutting out a little bit, but if you would speak very slowly and carefully, we'll do the best we can.

Ms. Marissa Lennox: I'm sorry. It could be my Internet connection.

Many provinces and territories have moved to a 30-day supply on prescription medications. Previous to this it was 90 days. The reason for it is supply chain issues and fears of a hoarding mentality at the beginning.

When we have surveyed our members, on average, CARP members take about four prescription medications each, with some taking more than 10. Now that they've been reduced to a 30-day supply, they're having to pay for prescription copayments on each of those medications, and they add up. Depending on where you live in the country, as you know, those copayments and dispensing fees vary.

I don't know if I could give you a hard cost because it really depends. It's very individualized. It would depend on the individual.

Mr. Len Webber: Yes. Do you feel that the government is providing an adequate amount to seniors?

Ms. Marissa Lennox: No, I do not.

Mr. Len Webber: No.

Thank you for that.

I'll turn to Ms. Mackenzie now.

Many people have changed their buying habits as a result of this pandemic, of course, and we see that there is more online buying and curbside pickups. Many of these seniors do not have the technical comfort to shop online. Many others no longer drive, and curbside pickup is a challenge. Of course, family and friends are helping but that will not always be possible.

What is your organization doing, Ms. Mackenzie, to help seniors adjust to this new economy, and how can the government help?

Ms. Isobel Mackenzie: Well, we've encouraged the government around the creation of, what I've talked about already, the bc211 program. In the longer term, of the many, we've talked a lot about long-term care, but the other fault line that's been exposed in all of this is the vulnerability of seniors who are not connected to the Internet perhaps, and therefore are unable to organize those types of deliveries, and who don't have a family network to help them.

Right now, there's an outpouring of volunteers, and some of those volunteers are materializing because they have time. Some of that, I suspect, will dissipate as people return to their paid employment and have less time for volunteer work. I think it is something we need to think about, because there could be another wave. We need to remember that. Certainly here in British Columbia where we're on the downside of the curve, we are expecting potentially another outbreak in the fall. So, what does that look like, and how are we going to make sure that people get the supplies that they need?

I think when the federal government leadership provided some funding to the United Way at the federal level—the province here in British Columbia had already done that—that was helpful as well. It's going to give an opportunity for organizations on the ground to organize in their communities around how they are going to get these seniors the things that they need, remembering that this is time limited to some extent.

● (1810)

Mr. Len Webber: Yes.

The Chair: Thank you, Mr. Webber.

Dr. Jaczek, it's over to you for five minutes, please.

Ms. Helena Jaczek (Markham—Stouffville, Lib.): Thank you very much, Chair.

Thank you to all of our witnesses today. You have valuable insights to help our seniors, particularly those living in long-term care, and obviously you feel very passionate.

I'd like to turn to the question of the physical structure particularly at long-term care homes, retirement homes. Ms. Hall, you referenced this in your remarks, and I understand you've done a number of interviews on that particular subject.

Here in York Region, in our municipal homes, actually, one was redeveloped about 20 years ago. There was sufficient space to have nearly all single rooms and a couple of double rooms particularly for couples who obviously might want to be together in the same facility. In fact, of our two facilities here in York Region, neither has had a COVID-19 outbreak.

I would ask you to talk a little more about the importance of what the government might do to assist in the redevelopment.

Ms. Jodi Hall: Just to restate, the physical infrastructure, when we're talking about something as infectious as COVID-19, is critically important.

The ability to put the recommendations in place from the Public Health Agency of Canada is critical going forward. I think there are many tangible examples of where homes that have a more modern design have had greater success in being able to prevent the spread of COVID. We've noted the narrow hallways and the inability to practise social distancing among the residents, but there are also issues like shared washroom space. Making sure that, in addition to that private room, there's also a washroom space that can be utilized by an individual is important.

There are a number of factors that need to be considered from a standards point of view, and as we think about what role the federal government can play, assisting on some of those structural pieces could be very beneficial.

Ms. Helena Jaczek: Minister McKenna, as I think you alluded to, has made some provision potentially for shovel-ready projects in particular, but there does not seem to be any constraints in what she is proposing that might not be able to assist long-term care. Is that the way you've seen it?

Ms. Jodi Hall: Yes, we certainly took note when she said that. Previously, when the housing dollars were made available federally, there was some sense that perhaps nursing homes or long-term care homes could tap into that line of funding, but that was not the case. We were encouraged when we heard about that shovel-ready project line, because we absolutely have projects that could move forward quickly, especially with the support of the federal government.

Ms. Helena Jaczek: Monsieur Brunet, I believe that in your pre-budget submission of February 2020, you also talked about investing in seniors housing, where care is provided, by using federal infrastructure funding to create some 42,000 new beds and to help rebuild old homes.

I presume you concur that this would be an area that should be pursued.

● (1815)

Mr. Paul G. Brunet: Certainly, I think it makes sense, but it is a challenge. I've seen, in my experience, old premises being held by people, being voluntarily very well tended, places and corridors where it smells good. We're talking about times of peace, not times of crisis. Sometimes the walls, the structure doesn't change the situation of how it is being led and operated, with all due respect. Yes, it certainly helps.

I have seen some places downtown in some villages being destroyed because they were too old and being built elsewhere in the countryside. People were so sad because they wouldn't see anyone walking in the streets. Sometimes you have good points, you want to modernize, but elders in Sainte-Agathe, Quebec are sad because the place they have built is in the woods. They don't see anyone walking around, you know, and elders want to see kids and people walking in the centre of the city.

There is a challenge, but I understand that it should be modernized.

Last summer, or the summer before, Mr. Barrette said that old places could not be air-conditioned. We know they are being air-conditioned when the intention is there, because all administrators, even in old places, have air conditioning in their offices.

The Chair: Thank you, Dr. Jaczek.

Ms. Helena Jaczek: Thank you.

The Chair: Ms. Wong, it's over to you now. Please go ahead for five minutes.

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

First of all, I'd like to thank all the witnesses for their excellent presentations.

I've met some of you before in my former role, and again I thank you very much for doing such a good job. Most of you have already covered a pretty wide range of topics.

Of course, in some of the things, as I've said—

The Chair: I'm sorry, Ms. Wong, could you move your mike a bit higher up, closer to your mouth?

Hon. Alice Wong: Is that better?

The Chair: I think so. Let's try that.

Hon. Alice Wong: Is it better now?

The Chair: A little further down...not so far. Well, a little bit more up....

Put it right next to your mouth, not up by your eyes. That will be good, right there.

Thank you.

Hon. Alice Wong: All right. Can you all hear me now? Okay.

I was thanking everybody for doing such a great job in your research and in your service. As I said, I've worked with some of you before in my former capacity.

I'd like to look more at the federal leadership, how we as a nation should work, not only during these COVID-19 challenges, but also for other jurisdictions as well.

I understand that every year there should be—

The Chair: Sorry, Ms. Wong—

Hon. Alice Wong: I don't know why this is echoing.

The Chair: Yes. Make sure your headset is on properly and the mike is right next to your mouth.

I'm going to pause here. Let's get this sorted out so people can hear you.

Hon. Alice Wong: Is it better now?

The Chair: No, it's very bad sound.

Hon. Alice Wong: How about now?

The Chair: I think that's better. Just say a few words, and we'll see.

Hon. Alice Wong: Testing, testing, one, two, three, four....

The Chair: There is a whole bunch of echo there.

Hon. Alice Wong: Yes, I don't know why it's echoing.

The Chair: Do you have your speakers turned on, or are you using your headset?

● (1820)

Hon. Alice Wong: I'm using my headset.

How about now? Is it better?

The Chair: No, it's not good.

We'll suspend the meeting for a few minutes and get this sorted out.

The meeting is suspended.

● (1820)

_____(Pause)_____

● (1825)

The Chair: We shall now resume the meeting.

Please go ahead.

I'm not sure, but I think you have three minutes left.

Hon. Alice Wong: Okay, sorry about that.

First of all, I'd like to thank all the witnesses. You have covered a very wide range.

One of the things we have been talking about is federal leadership. My understanding is that there should have been many federal, provincial and territorial—what we call FPT—ministers responsible for seniors and looking after these. I don't know whether our current minister has done that. Definitely this is the right time, especially for the long-term care homes and other jurisdictions that are mainly provincial, yet we need to take the lead.

When we talk about seniors in social isolation, we're looking at three different groups of people: those who are in seniors homes, those who are living with their family members, and those who are living by themselves. When we look at their physical and mental needs, I think we should have different reactions.

I'd like to ask if any of our witnesses could shed some light on the different needs of these three different groups.

Maybe I could ask Ms. Mackenzie, then, about the seniors in social isolation, the three different groups.

Ms. Isobel Mackenzie: Thank you, Alice.

You've identified that COVID-19 looks different depending on whether you are living alone, living with somebody or living in long-term care. We need to look at that.

Long-term care is a big focus of COVID, and we've spent a lot of time talking about it. There are definitely changes that need to be made, but we cannot forget the home care piece, what that needs to look like and how robust that needs to be. Then we need to look at the piece that is about the seniors who live alone and how we are going to keep them connected to the non-health services they need, because if we don't, they are going to develop health care needs.

We can step back, maybe not today but in a few weeks or months, and take a look at what really has happened here across a broad spectrum of seniors and their needs and what it is that requires federal leadership in order to effect the kinds of changes that are needed.

That would be a very good way for the federal government to approach it.

Hon. Alice Wong: Just now, our witnesses mentioned a lot about the hardware, what sorts of structures there need to be, redoing some of the seniors homes, and the challenges. At the same time, we are looking at the software part. That's not the only issue now and in the future for our caring for seniors, especially in seniors homes.

We are looking at training as well. Of course, one of the witnesses mentioned that we could have some short-term solutions, but some people don't realize that it is actually skilled work. It's not just anybody who can do it, especially the passion part.

I was able to visit some homes lately, because I was helping a youth group deliver masks to all these different seniors homes in the Lower Mainland. Of course, there is a shortage of PPE and the community is stepping up to help them. Some of them were so passionate that I was almost in tears.

● (1830)

The Chair: I'm sorry. Could we wrap it up, please?

Hon. Alice Wong: My comment is that we should really care for the caregivers as well, those who are informal, who are helping from homes, the relatives and friends, and those who are working in these seniors homes, the front-line people. It is important that we look after them as well. That is the message I want everybody to have in mind—care for the caregivers—and also to share my experiences with them, so thank you very much for allowing me to do that.

I apologize for the inadequacy of my equipment. As Tamara has witnessed, I haven't had any problems except with this committee. There is something against me, it seems.

Thank you very much.

The Chair: Thank you.

We'll go now to Mr. Fisher.

Mr. Fisher, you have five minutes. Please go ahead.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Mr. Chair.

As always, thanks very much to all the witnesses who are here today.

Ms. Hall, yesterday the Prime Minister and the Minister of Seniors announced the tax-free $300 on the OAS and an additional $200 to those who qualify for GIS, positively impacting six million to eight million Canadians, plus previous announcements with regard to funding community organizations.

I am interested in your thoughts on that announcement yesterday as it pertains to seniors.

Ms. Jodi Hall: As has been noted, there definitely are those individuals across the country who will largely benefit from this.

There are questions around the scope of the benefit. Is it sufficient? Does it reach enough seniors who actually have needs? There are questions around those who are in care. Will that be extended to them, and how does that translate?

Of course, I think it's a positive move to be able to support people who have needs that are unique to the COVID outbreak, but there are other questions about whom exactly it applies to. More information would be helpful.

Mr. Darren Fisher: Thank you for that.

Ms. Mackenzie, you had everybody in our committee writing down the freak-out factor and highlighting it when you said that.

I feel that the focus and discussion around long-term care workers and clients became all about PPE and not necessarily about control measures or basic hygiene measures. I thought maybe you could tell us a little about those early days.

Ms. Isobel Mackenzie: Certainly. When we look at Lynn Valley and what happened there, for want of a better term I call it clinical leadership. Strong clinical leadership is needed, particularly now in this environment.

Community care aides are 70% of the care staff in our nursing homes in this country: personal support workers, as you call them in the east, and care aides, as we call them out west. Understanding infection control, understanding how PPE works, understanding the use of N95 masks and aerosolizing procedures was, I think, a piece that was missing.

It weaves through this issue around the care aides in our care homes. This is a place where the federal government could show leadership. I'm struck by the fact that we have national standards—not just standards, but exams—for RNs and LPNs, but we don't have any such national standard for care aides. Part of the way that you make a person feel valued, and part of the way that you attract people to something called a profession, is that you actually provide those standards.

In the 20 years that I worked predominantly with care aides—I worked with nurses and LPNs as well—they craved training. They wanted to be able to take courses. Our system is set up.... It's very frustrating. I could send my nurses on courses and I didn't have to backfill them. It was easy. If I sent my care aides on courses, I had to backfill them. That cost money, so they sort of got left behind in all of it.

I think that is an area: federal leadership around standards, not just around what happens in care homes and care ratios, but around the level of training. I am a big proponent of standardized exams. They have to be practical and written, I do understand that, and they don't tell the whole story. They do not get to the piece around the EQ—emotional quotient—that is needed to be able to provide this kind of care.

Jodi is quite right. The wrong person with the right training is as much a recipe for disaster, in fact I would say more so, than the right person with the wrong training. We have to be careful about that.

Certainly PPE is one example where, if we had better training, more high-level training, more standardized training, we could have.... A lot of concern and anxiety have been created around this. I think when we step back and look at it, we're going to realize that yes, that was important, but really there was this other piece over here. I think that is a key area where the federal government could show leadership as well.

● (1835)

The Chair: Thank you, Mr. Fisher.

Mr. Darren Fisher: Thank you.

The Chair: We go now to Monsieur Desilets.

[*Translation*]

Mr. Desilets, you have two and a half minutes

Mr. Luc Desilets (Rivière-des-Mille-Îles, BQ): Thank you, Mr. Chair.

I want to say good afternoon to all the witnesses and to thank them for responding to our request and sharing their expertise. I'm very pleased.

My questions are for you, Mr. Brunet. You referred to your bill tabled on April 25, which concerns the desired supervision, management and slightly higher levels of oversight. Can you elaborate on this and on how the bill was received?

Mr. Paul G. Brunet: We submitted this bill to the two new ministers, Ms. McCann and Ms. Blais, in January 2019, after they were appointed. We told them not to hold any other political or parliamentary committee meetings because everything was written and documented.

For 30 years, we've known how to treat an elderly person, how to care for a person who is severely paralyzed or who is suffering from various health issues, and how to help a person eat when that person has difficulty swallowing. It's all written down. Now is the time to act.

We've drawn inspiration from these reports, which generally come from the Quebec department of health. We've proposed a basic bill that addresses the minimum level of care and services required. Everything is covered, including laundry, food, menu choices and so on. Now is the time to implement it.

Mr. Luc Desilets: The class action that you're leading refers to the word “abuse.” I want to know your definition of this abuse.

Mr. Paul G. Brunet: The concept of abuse was included in Liberal government legislation a few years ago. It's the same definition that the United Nations uses. It's an act or the omission of an act that should be based on trust and safety for the person on the receiving end, whether it's a statement or an act, and that makes a difference, often negative, between something that's calm, comfortable and safe and something that isn't. The definition is quite broad.

We've used this concept of abuse, which doesn't seem to exist anywhere else in Canada, to make allegations of abuse in the health care system, whether the issue involves food, hygiene care, or basic dental care.

Even before the COVID-19 crisis, we had submitted about 20 grievances against the system that will be subject to a trial. The class action was accepted by the Superior Court. We're waiting for the trial.

● (1840)

Mr. Luc Desilets: Okay.

What about basic care in Quebec residences? In your opinion, do the residences provide this care? Are we still talking about two baths or one bath every two weeks?

Mr. Paul G. Brunet: You know that, since 2003, there have been departmental guidelines. Documents were prepared under the leadership of the former minister of health, Mr. Couillard. However, these rules weren't applied. As I said, everything is documented.

We fought to ensure that people's personal laundry was paid for. We're now fighting to ensure that people who are continent aren't forced to wear a diaper. What a disgrace! We're fighting for this basic care. This isn't a joke.

There are currently some very serious issues, which are the subject of a class action. Basic care is expected. How is laundry done? During the class action, lawyers asked me how clothes are washed. The clothes are washed as they would be in your home, counsel, madam, sir: white separated from colours; delicate clothes in a delicate load. Four lawyers from Fasken Martineau DuMoulin LLP asked me this.

[*English*]

The Chair: Thank you, Mr. Desilets.

[*Translation*]

Mr. Luc Desilets: Thank you.

[*English*]

The Chair: We will go now to Mr. Davies.

Mr. Davies, you have two and a half minutes, please.

Mr. Don Davies: Thank you.

Ms. Hall, I just want to be clear on this. I understand your evidence. Is it your view that the long-term care sector is not entitled to apply for federal infrastructure funding?

Ms. Jodi Hall: Yes, our understanding is that under the existing infrastructure funds through the housing strategy, we are not eligible for applications.

Mr. Don Davies: We've heard evidence, and my research has shown, that there is a critical problem with infrastructure in long-term care homes in this country.

Has the federal government given you any explanation or principled reason why long-term care facilities would not qualify for that funding?

Ms. Jodi Hall: There seemed to be a lack of understanding and perhaps confusion. Some have felt that we were eligible for that, but, in fact, we've determined that we are not, so that was a critical area for us to understand.

It is often cited as well that there is provincial jurisdiction, so that becomes the realm of the provinces. It is important to note that with the aging transition of our population and increasing health system costs on the provincial governments, they have extremely limited resources.

We seem to have fallen into this bit of a grey space, if I can call it that. Certainly we have respect for the federal and provincial responsibilities, but we do see this as an area of shared responsibility, and that's why we're asking for the federal government to come alongside the provinces with this sector to help us address those infrastructure needs.

Mr. Don Davies: The federal government gave several billion dollars to provinces targeted at mental health, which is also administered by the provinces. I remember in 2009, after a recession, the Conservative government at the time made funds available for infrastructure, for recreational facilities like curling rinks and arenas. Certainly there is no constitutional barrier to that.

Ms. Langolf, you had the opportunity to tour senior homes and long-term care facilities in British Columbia when you were president of Cosco. I would also like you to start talking about your views on home care and how this might fit into the equation. What did you notice when you toured those homes? How does home care fit into the equation, in your view?

Ms. Gudrun Langolf: One of the reasons why we're looking at some phasing-out of long-term care, although we can't eliminate it altogether, is that people generally prefer to be in their own homes. I don't think I have to show any studies. That's pretty evident from all kinds of literature that's around.

The Chair: I'm sorry, Ms. Langolf. Could you speak more loudly, please?

Ms. Gudrun Langolf: Sure. I will try to do that.

Obviously, not everyone should be in long-term care facilities. I know that some of them are better than others, and people are more or less comfortable in them, but I think the overwhelming majority of people would prefer not to be there. In order for them not to be there, unless they have really difficult or complicated health issues that require 24-7 care, many of their needs could be met at home, if the home was adapted in a way that was going to be useful in terms of whatever their needs are.

One of the things we see is that there had been a contraction of services for home care. Not everything was covered, and there seemed to be artificial distinctions among housekeeping, meal preparation and administration of medication or therapeutics, as though they are separate. If your home is not a hygienic one, that's not going to be a good situation. I don't know how you can divorce cleaning, cleanliness, laundry services and so on from health conditions in general.

That may seem odd, but I think the services to seniors have to combine or span a whole spectrum of services that perhaps are punctuated by the end station which is, generally speaking, palliative care or a long-term care situation. That's an inevitable process of aging. All of us will face that sooner or later. Hopefully for all of us it will be later, but that's the way it goes.

I think this particular pandemic has given us the opportunity to have a critical look at, and apply some critical thinking towards, the kinds of things that would help make things better. I think that people like Dr. Armstrong and Isobel Mackenzie, and a lot of others, have developed and amassed a great deal of information. Doing more detailed studies, we really prefer not to see that happen. Gathering all that stuff together may be a good idea, and then see how it can be applied in a national way.

Seniors are running out of time. I'm in my seventies. I don't want to wait another 15 years before we tackle this sucker. It has to get fixed. We have to do it. It would be a dumb thing if we did not use this opportunity, as Isobel was mentioning. You have huge numbers of people waking up to the reality of—

● (1845)

The Chair: Ms. Langolf, could you wrap it up, please?

Ms. Gudrun Langolf: Thank you very much. I really appreciate being on this soapbox.

The Chair: Thank you, and we enjoy it as well.

Mr. Don Davies: Thank you.

The Chair: That brings round three to a close. I would like to thank all witnesses for sharing with us their time this afternoon and all of their valuable information. It's most helpful to our work.

Thank you to the members of the committee as well. Also, thank you to everyone for bearing with us through our technical difficulties. Thank you to all our technicians who, day by day, get out there and solve our problems for us.

Thank you all. The meeting is adjourned.