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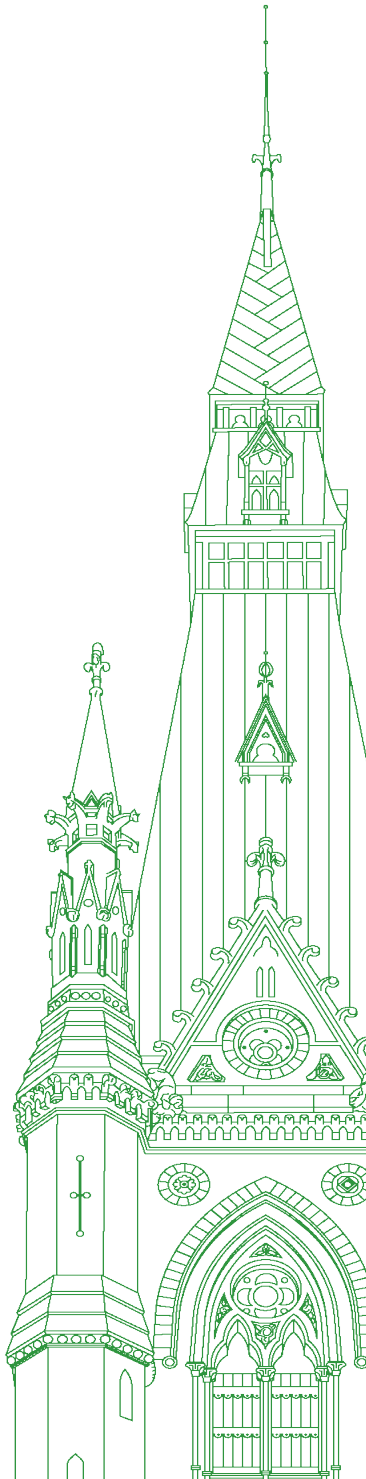

Chair: Mr. Sean Casey

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

Thursday, May 13, 2021

● (1530)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 34 of the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities.

Today's meeting is taking place in a hybrid format, pursuant to the House order of January 25, 2021. The proceedings will be made available via the House of Commons website, and the webcast will always show the person speaking rather than the entire committee.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Tuesday, February 2, 2021, the committee will proceed to its study on the impact of COVID-19 on seniors.

I would like to welcome our witnesses, who will begin our discussion with five minutes of opening remarks. These will be followed by questions.

We have with us today, Laura Tamblyn Watts, president and chief executive officer of CanAge; and Miranda Ferrier, chief executive officer of the Canadian Support Workers Association.

For the benefit of our witnesses, I would like to offer a couple of additional comments.

Interpretation in this video conference is at the bottom of your screen. You have the choice of floor, English or French. When you're speaking, please speak slowly and clearly, and when you're not speaking, your mike should be on mute.

You may notice that with about one minute to go, I will hold up one finger to signal that. I will probably incessantly interrupt you, so please forgive me. I apologize in advance. It's my job to try to keep everything on schedule and ensure that the time is allocated fairly among members.

With that, we're going to start with Ms. Tamblyn Watts.

Welcome, You have the floor for five minutes.

Ms. Laura Tamblyn Watts (President and Chief Executive Officer, CanAge): Thank you for the opportunity to address you today about the pressing issues facing Canadian seniors.

My name is Laura Tamblyn Watts and I'm the president and CEO of CanAge, Canada's national seniors advocacy organization. We are a pan-Canadian non-partisan not-for-profit organization. We work to advance the rights and well-being of Canadians as they age, and ensure that older Canadians live vibrant and connected lives. In the time of COVID-19, however, that has been far from the current reality.

I would like to focus my submission on three specific areas: elder abuse and neglect, long-term care and seniors care reform, and social inclusion.

First is elder abuse and neglect.

I'd like to tell you Mabel's story. When COVID-19 hit, Mabel followed all the rules. She stayed home. She worried. Her adult son lost his job and moved into her house. Soon Mabel was pressured to a make a power of attorney, add him to her bank accounts and eventually put him on as co-owner of her house. Within 12 months, Mabel went from living a safe, socially connected life to living one of fear, abuse and poverty.

Mabel's story is not unique—far from it. Prior to COVID-19, approximately one in five older Canadians experienced abuse and neglect. Since COVID-19, responding organizations, such as Elder Abuse Prevention Ontario and others, are signalling a 250% increase in abuse and neglect of seniors.

We were pleased to see elder abuse mentioned in the budget—along with some other forms of abuse—and the investment, but there is much to be done. We recommend that the government do two things to address this. One, designate on an ongoing basis a similar amount of funding and support for preventing and responding to elder abuse as is given to domestic violence supports. Two, create a pan-Canadian committee on abuse and neglect.

Our second area is long-term and seniors care reform, the one we've been speaking about most during this time of COVID-19.

I want to tell you the story of Stanley. Stanley called me, weeping. He was a resident at a long-term care facility in Ontario. He lived through the first wave and was in a shared room with other sick residents. At one point, he was left alone next to a friend who had passed away from COVID-19, but the remains of the deceased had not been removed.

He was living locked up in a 100 square foot room for months on end. He was not bathed, fed or changed sometimes for days on end. He had not had a breath of fresh air for months. When he called me, he was asking how to get medical assistance in dying, not because of his health status but because life in long-term care during COVID-19 was, in his mind, not worth living any longer.

I cannot emphasize enough the tragedy that has unfolded in long-term care. However, if you ask any experts in the field, they'll tell you that the situation prior to COVID-19 was at the breaking point and that it's only gotten worse.

However, the good news is this: We know exactly what needs to be done. There's very broad expert consensus. We need dedicated long-term care funding, increased staffing, infrastructure development, improved infection control measures and a national adult vaccination strategy.

We need national standards. However, we need to make sure that we are working beyond the accreditation level with provincial and territorial governments to embed standards in regulation, and include innovation, age-tech and digital advances in seniors care as part of that.

We need to fix the buildings. We need to provide transformative investment in long-term care. The outcomes are overwhelmingly worse in older homes, and we know that HVAC systems in many cases, including in Ontario, don't even live up to 1999 standards.

We know—and my colleague will speak more about this—that we need to fix staffing and the conditions of work. The conditions of work are the conditions of care. We need an aging sector health and human resources strategy at the federal level. There should be training incentives and programming, and we should be putting immigration priorities to work.

We know that most people—overwhelmingly, 92% of seniors—will always age at home. We need to do much more by having a federally supported home and community care strategy.

We need a national adult vaccination strategy. Right now only about 3% to 10% of Canadian seniors have the basic vaccines they need. We need to make sure that we are moving forward and building on the successes of the senior-specific flu vaccines for long-term care and COVID.

Last, I want to talk about social inclusion.

I want to tell you about Manon, who is 85 and lives in Nova Scotia. She fell and broke a hip a year ago, which stopped her from driving and getting around. When we talked to Manon, she told us that she had not seen or spoken to anyone in more than a month. She was depressed, disconnected and lonely. This story is really common. A StatsCan report found that 20% of seniors didn't have a single person to reach out to in an emergency.

● (1535)

To conclude, we recommend the following three things: increase investment in community-based programming for seniors, including intergenerational programming and activities; invest in sector supports for digital inclusion and innovation; and last, create a federal office of the seniors advocate to consistently include older people and plan for an aging population.

Thank you. Those are my remarks.

The Chair: Thank you very much, Ms. Tamblyn Watts.

Next we're going to hear from the Canadian Support Workers Association.

Ms. Ferrier, you have the floor for five minutes.

Ms. Miranda Ferrier (Chief Executive Officer, Canadian Support Workers Association): Good afternoon and thank you very much for having me here today.

As was just said, I'm Miranda Ferrier. I'm the CEO of the Canadian Support Workers Association. We represent over 67,000 personal support workers and support workers, which have different names in almost every province, across our wonderful nation.

Seniors and disabled Canadians in Canada have never been at greater risk to their overall safety both financially and societally. These risks are unusual in that they transcend socio-economic and cultural classes. Across Canada our ability to provide care to this demographic has come into question, as the most vulnerable members of our society are made to bear the burden of years of collective mismanagement.

This absence of foresight can best be seen in the inability of our nation to adequately staff personal support workers, who provide the basic needs for these vulnerable Canadians. Personal support workers are often the main point of contact for these individuals and are responsible for their care and emotional and societal supports. However, these relationships are precarious at best and at worst are criminal.

Most of us hope for a long and rich life. However, many of us may think twice about this wish based on the reality of life for thousands of seniors and disabled Canadians in this country who are dependent on personal care. Seniors and disabled Canadians in long-term care and community care often experience traumatic levels of isolation, which quickly erodes independence and quality of life.

As we all journey towards our senior years, our needs will grow more complex and require a robust and stable workforce. Unless we make significant changes and work towards a national standards model, many of us will not have the personal support workers needed to help us participate fully in our lives.

Seniors and disabled Canadians and health care issues are often discussed in tandem, and the reasons are not hard to see. For many seniors and disabled Canadians, it is their own health issues that isolate them, often leading to depression and many other health issues. In other words, as these seniors and disabled Canadians become lonely, their exposure to physical, emotional, verbal, sexual, racial and financial abuses increases greatly.

Of all the possible abuses endured by this vulnerable population, one not often spoken of is financial abuse. Over the last three years, the Canadian Support Workers Association, along with our chapter in Ontario, the Ontario Personal Support Workers Association, has dealt with a growing number of incidents involving the attempted seizure of entire estates by health care workers. Without a professionalized health care workforce, especially in community care, this population is at serious risk of quickly having their financial assets stolen, mortgaged and spent.

I look forward to answering all your questions today. Thank you.

The Chair: Thank you, Ms. Ferrier.

We're going to proceed to rounds of questions now, beginning with the Conservatives.

Go ahead, Ms. Falk, for six minutes.

Mrs. Rosemarie Falk (Battlefords—Lloydminster, CPC): Thank you, Chair, and thank you, Laura and Miranda, for coming today and sharing your wisdom and experience with the committee.

I'm going to start with Miranda.

In advance of Ontario's Personal Support Worker Day, which is next week on May 19, I want first of all to extend my gratitude and thanks to you and through you to support workers across the country for their dedicated and tireless work to care for their patients. Support workers have shown courage and commitment on the front lines throughout the pandemic, and I know that the work support workers does is not easy and takes a certain skill set. It's emotionally, physically and mentally demanding, and has been undoubtedly even more so during this health crisis.

I'm wondering, Miranda, if you could share with the committee the level of professional recognition that support workers have across the country and how this affects the workers and their patients.

● (1540)

Ms. Miranda Ferrier: Absolutely. Thank you very much MP Falk. It's nice to see you.

Personal support workers across our nation are called something different in almost every single province. In Nova Scotia they're referred to as continuing care assistants. In New Brunswick they're PSWs and health care aides. In Saskatchewan they're continuing care assistants. In Ontario we're personal support workers. I'll refer to them as PSWs moving forward.

In every single province we are unregulated. Two provinces do have registries in place for their workers, but they're employer-driven registries, which does nothing for the worker.

One thing the association has been doing on a provincial level in Ontario for over the past 10 years is lobbying quite hard for the regulation of personal support workers. We know that with title protection, regulations, accountability and oversight put in place, our most vulnerable would be much safer. Right now, to be honest, do you know who's knocking at your door? We don't know who is a personal support worker. There's no way, other than with our association, for them to identify themselves as such. That's a huge concern.

The level of abuse in elder care that's happening right now has been happening forever. A personal support worker working in long-term care, home care, a retirement home or wherever can be accused of abuse, be fired from their job, walk down the street and get a job at another long-term care facility, home care company or whatever, because no one's following them in their jobs. That is where elder abuse really starts.

I am happy to announce that the Province of Ontario has put a bill forward to regulate personal support workers in Ontario. It's currently in its public consultation process. It's Bill 283, if anyone's interested, in Ontario. Hopefully it will be an authority that oversees accountability and protections for the public regarding personal support workers.

PSWs, as you know, are unregulated, so we're not taken seriously in the job in a lot of places. We bring a lot to the table. No one else does personal care; only the PSW does.

Mrs. Rosemarie Falk: I have one more quick question for you, Miranda.

In previous meetings at this committee, the Minister of Employment, Workforce Development and Disability Inclusion suggested that the Minister of Seniors and the Minister of Health are working with the sector to standardize credentials for support workers. A follow-up from the department suggested that their work to develop occupational standards was expected to begin this spring.

I'm wondering if the Canadian Support Workers Association has been consulted on occupational standards.

Ms. Miranda Ferrier: No, not at all.

Mrs. Rosemarie Falk: Laura, I'll scoot over to you. Off the top, I want to thank you for the steadfast advocacy you have for an age-inclusive Canada.

In the breadth of CanAge's work, I know that you have valuable insights on a range of issues facing seniors and on the impact that COVID-19 has had on seniors. We know the pandemic has been particularly isolating for seniors and that they have missed out on celebrations, holidays, milestones and even day-to-day contact, like seeing somebody smile, holding a hand or sometimes just sitting beside someone.

I'm wondering if you can share with the committee this afternoon what impact social isolation has had on seniors and the impact that restricted interactions have had during the pandemic.

Ms. Laura Tamblyn Watts: It has been a misery for older people across this country, whether they are the individuals left in their own homes and socially isolated from family, friends, neighbours and faith communities, without exercise and daily connections, or at the most extreme level, those in long-term care like Stanley, whom we spoke about. He was restricted not just to his long-term care facility, but to his room.

Older people are suffering untold amounts of physical deterioration. In long-term and residential care facilities, we've been able to measure it, so we know that their bodies are getting less strong. We also know that cognitive impairment has been significantly affected. People who were more able mentally before are now less able mentally. That can be measured on dementia scales or on other scales for cognitive impairment.

We know that mental health has deteriorated enormously. For some people, particularly those in long-term care, where the average length of stay before a person passes away is 18 months, this has been almost the rest of their lives, so it has been devastating.

● (1545)

The Chair: Thank you, Ms. Tamblyn Watts.

Thank you, Ms. Falk.

Next is Mr. Dong, please, for six minutes.

Mr. Han Dong (Don Valley North, Lib.): Thank you very much, Chair.

Good afternoon to Miranda and Laura.

First of all, I want to say thank you for taking time out of a busy schedule to respond to the invitation of the committee. Also thank you for all your members' hard work during the pandemic. I have six long-term care facilities in my riding of Don Valley North. I have visited them a few times while organizing PPE donations. I've seen first-hand how hard they work. They treat the residents like members of their family. That's the reason most of them are willing to put their safety on the line to provide the support for them. So thank you and, through you, thanks to all your members and your colleagues for doing that.

That being said, reading the most recent report provided by the Canadian military, I got really upset, to be honest, that lives were lost purely due to neglect. I couldn't imagine that this kind of stuff would happen in our country. Also, some of the reports since 2018 have noted that the random checks on long-term care facilities have been suspended, and that kind of feeds into the really terrible picture right now.

I think that's part of the reason we've heard a lot of calls for the federal government's increased involvement in the long-term care sector. We've seen that the throne speech talked about looking at perhaps more severe penalties for perpetrators. We've seen in the budget the $3-billion investment over five years. That leads to a bigger question, which is my first question for both of you.

What's your suggestion for how all levels of government can work together while respecting each other's jurisdiction? I heard my colleague mention occupational standards, which traditionally, I believe, have been a provincial responsibility. Obviously there is a lot of negotiation between the federal government and the province.

What's your vision of how all three levels of government can work together to improve the situation?

Ms. Laura Tamblyn Watts: Of course our division of powers was not meant to promote finger pointing. It was meant to make sure that governments work together. In this particular shared area, we're very pleased to see the federal government reach in with open arms and make profound changes and make significant investments, but we need to do more.

For full disclosure, I am part of the national long-term care standards technical working group, and I know that members will hear from the leaders of those technical working groups next.

From a legal point of view—this is where the lawyer comes out—we feel that it might be very helpful to move forward with standards but then to work collaboratively with our provincial and territorial counterparts to embed those standards in regulation. Our organization, CanAge, would like to see funds tethered to those national standards.

The $3 billion over five years across this country is a good and significant movement and signal about the importance of implementing national standards, but it's not transformative money. We need to make sure that there are specific amounts of money tied to those standards. It will be an agreement between provinces and territories. We hope very strongly that provinces will look at this not as a political football and an opportunity for grandstanding but rather as an opportunity for transformative change for seniors.

Mr. Han Dong: You mean having not a giant envelope but perhaps a specific envelope of funding that targets....

Okay.

Miranda.

Ms. Miranda Ferrier: I would have to agree with Laura. Laura and I are friends outside of this as well, so we see things eye to eye on a lot of different issues, which is great.

I would agree about having the individual envelopes. I think one of the ways we really have to look at this from the federal level looking down into the provinces, especially Ontario, is that one area they just won't touch is ratios in long-term care. This might not play into what you're asking, but I worked as a personal support worker for eight years in long-term care, so my background is all personal support worker, home care, long-term care, hospital. I will tell you that from 2006 forward, I never worked a fully staffed shift. That was starting in 2006 and moving forward. That's scary if you think back that far.

I find that provinces are almost leery of having set ratios. If you have one PSW to eight residents on a floor just to start with and then decrease that as it moves on, that would make such a huge impact. The burnout rates would go down, and you'd actually be able to give the residents better care. I think the federal government could be really influential on the ratios aspect.

● (1550)

Mr. Han Dong: I'll try to get one more question in.

Speaking of the standards, there are two things being considered: the national long-term care services standard and a new national standard focused on operations and infection prevention.

Is there a role for the federal government in ensuring long-term care workers are given adequate training, work conditions and wages?

Ms. Laura Tamblyn Watts: Very briefly, yes. I don't want to speak over Miranda—

Ms. Miranda Ferrier: I was just going to say yes.

Ms. Laura Tamblyn Watts: —but we feel there's an opportunity for incentivized grants; training and education supports; immigration, with the immigration priorities in these areas; and setting out different incentive-based capacity-building programs.

Mr. Han Dong: Miranda.

Ms. Miranda Ferrier: I totally agree. I have nothing to add.

Mr. Han Dong: Great.

The Chair: Thank you, Mr. Dong.

[*Translation*]

Ms. Chabot, you have the floor for six minutes.

Ms. Louise Chabot (Thérèse-De Blainville, BQ): Thank you, Mr. Chair.

Good afternoon.

Thank you, witnesses, for your testimony and opinions. As you know, we're embarking with you today on a study on seniors. All aspects of this study are important, including the financial, social and health aspects.

The consensus around the table is that the pandemic crisis has hit our most vulnerable people, including our seniors, particularly hard.

I listened to Ms. Watts and Ms. Ferrier. My question is for both of them.

You focused heavily on the reality in some provinces. That's fine. However, I want to bring up one point, with regard to national standards. You seem to agree on these standards, which you're focusing on.

In Quebec, personal support worker training is qualifying training and it's considered very important. In terms of staffing ratios, this falls very much under the purview of legislation. It seems far-fetched to try to establish uniform standards in all our care systems and in all the provinces.

Moreover, in Quebec, the National Assembly wasn't really considering national standards, since there are already many established standards. Instead, it focused on the idea that the Canadian provinces need proper funding for the health care system on a permanent, sustainable and structural basis. That's why all the provinces and territories in Canada are calling for a substantial increase in the Canada health transfer to meet their needs.

Do you agree with this demand from the provinces?

Ms. Laura Tamblyn Watts: Thank you for the question, Ms. Chabot.

[*English*]

I think Quebec in many ways has been ahead of other provinces and has better integrated community and long-term care. When it had challenges in the first wave, it took dramatic steps, particularly in hiring over the summer, that have shown leadership.

However, when we're thinking about national standards, we're also thinking about things such as the built environment, HVAC systems, air conditioning systems and how big a space is. For these particular items, we cannot leave people to come up with ideas themselves, in the same way that building codes exist for a reason. It's therefore important that we think about making sure we're levelling up all provinces to have a good understanding that the built environment and standards of care need to have a minimum. This doesn't mean Quebec can't exceed that. We have seen, however, that when health transfers have gone to the provinces untethered—and I'll use the example of home care in 2017—the money has simply disappeared into provincial treasuries and hasn't necessarily been applied for the purposes needed.

I think we are in a transformative step and we can learn from our colleagues in Quebec given how well care has been delivered there in the second and third waves. However, Quebec care is quite different from what we can see sometimes in other jurisdictions. This is a moment of transformative change and we need to make sure that the private, public and not-for-profit homes in all provinces have the information and budgetary knowledge to know what they need to do going forward. It's going to be critically important that we draw out these standards and not restrain innovation but promote it.

● (1555)

Ms. Miranda Ferrier: I definitely agree with Laura.

Congratulations on the great hiring initiative that was done last summer. It actually pushed Ontario to do one as well. Good on you for being the first.

There's a lot more flexibility, it seems, in Quebec than there is in many other provinces in relation to ratios. You guys have really high standards in that way and we all need to learn from that. However, I think that every single province needs to be held to account. We need to know where money goes when it goes to the provinces.

[*Translation*]

Ms. Louise Chabot: Thank you for your responses.

I'll add to what I said.

Even though I think that you know this, I still want to say that, regardless of the province, most health care spending is allocated to staff. In fact, 80% of costs in our health care system, and even in our social services, are staff costs.

You're talking about standards for improving our infrastructure. I don't know whether you share our opinion, but we think that we need workers and staff to support your objectives. For example, air conditioning is part of the debate in Quebec, but that falls under Quebec jurisdiction. These are choices, which are being addressed.

In terms of the ability to properly support the health care system, we can see that the federal government has abandoned the provinces. Funding for the health care system has decreased over time rather than increased to properly meet the needs.

I have a hard time seeing how standards would fix anything when something more fundamental must be fixed.

The Chair: Thank you, Ms. Chabot.

[*English*]

Next is Ms. Gazan, please, for six minutes.

Ms. Leah Gazan (Winnipeg Centre, NDP): Thank you so much.

I'd like to thank both Laura and Miranda for their testimony.

I find it abhorrent how seniors in this country are treated and that so many seniors here live in poverty. It's why I have been pushing for a guaranteed livable basic income. I know the current government has announced increasing OAS rates when seniors are 75, but that's unacceptable to me. It should occur way before then to make sure that all seniors in this country can live in dignity, something that your testimony has clearly confirmed is not happening.

I want you to expand on some of your comments.

My first question is for Laura.

In your testimony, you mentioned the need for a federal seniors advocate. Could you expand on that?

Ms. Laura Tamblyn Watts: As we have seen in comparator countries, having a federal seniors advocate allows a nation to plan. It can make sure that we are thinking about meeting the needs of our aging population and can hold departments to account in making sure that mechanisms and budgets are being allocated appropriately.

We see this in various provinces. In provinces that have seniors advocates, the conditions of care and the supports have improved. Older adults have a voice for well-being and governments have a resource to ensure that they're moving towards an age-inclusive Canada on a social and economic basis.

This is not an expensive proposition, and it is something Canada should have. We have long needed a seniors advocate. We have long needed a national seniors strategy. That's why CanAge wrote “Voices of Canada's Seniors: A Roadmap to an Age-Inclusive Canada”. There is broad agreement that a federal seniors advocate would be a cost-effective small move that would have a large impact.

● (1600)

Ms. Leah Gazan: From the testimony you provided, Laura, it's very clear to me that there needs to be an advocate in place to make sure there is somebody who can fight for seniors who are not being treated with dignity and respect or being provided with the resources they need. Thank you so much for that.

My next question is for you, Miranda.

We know that across sectors, unionized workplaces provide better conditions for workers. For example, in long-term care in Manitoba, and certainly in my riding of Winnipeg Centre, many of the care workers come from racialized communities. Many are from the Filipino community. They provide front-line services and have put their lives on the line, and in fact have lost their lives, caring for others.

Can you speak about how increased unionization for support workers will enable better conditions for them and for seniors in long-term care?

Ms. Miranda Ferrier: Thank you for saying that. We lost a lot of support workers across our nation due to COVID-19. Those workers stepped up to the plate when everyone else stepped back. Thank you for that recognition.

In terms of unionized workplaces, I know that most long-term care facilities across our nation are unionized. It's just the way it rocks and rolls for them in that area. We find it's good but it's also not good. Work needs to be done there as well. If you have a unionized workplace, you have seniority, and the issue with unionized workplaces is the list of seniorities.

For instance, you are a personal support worker who is working in long-term care and you're only part-time casual. You work all the hours they want you to work. You go in all the time. A line finally comes up that you can get a full-time position. But someone who's been there for nine years ahead of you who wants this position, who never takes call-ins, always just works their hours and goes home and never does the extra will get that full-time position. The person with nine years will get a full-time position over the PSW who puts her heart and soul into it.

Seniority has come up as an issue with unionization. But I will say that unionization gives the workers a voice. It gives them that protection, especially against management or administration in long-term care homes where there seems to be a lot of butting heads, shall I say, where management likes to bully the front-line staff. That is an issue. That's where unions do step in. They are excellent for the workers.

Ms. Leah Gazan: I have less than a minute left and I'm very interested in this, but quickly, perhaps I could ask Laura for some more comments around national standards in long-term care. Then I have a last question.

I have about 30 minutes' worth of questions. I'm like, what do I ask?

Go ahead, Laura.

Ms. Laura Tamblyn Watts: We think national standards are not the only solution. They need to be backed by supports embedded in law and money and investment. However, they will provide, I think, a clear minimum set of standards across this country. They help to obviate some of the concerns we have around public versus private long-term care, which is a bigger debate. At least if we could get the care standards up to an equitable level, some of those concerns could be obviated.

Ms. Leah Gazan: Thank you.

The Chair: Thank you, Ms. Gazan.

Next we have Ms. Dancho, please, for five minutes.

Ms. Raquel Dancho (Kildonan—St. Paul, CPC): Thank you, Mr. Chair.

Thank you to the witnesses for their testimony today.

Ms. Watts, I want to pick up on something you shared with my colleague Ms. Falk. She was asking you about the impacts of isolation on seniors. To paraphrase you, you very bluntly said that it has been a misery. Older people are suffering from untold amounts of physical deterioration and cognitive impairment. They're less able mentally. You went on to say that mental health has deteriorated enormously as a result of isolation.

I want you to expand a bit on that in reference to some of the research you did for your pre-budget submission. I'll quote first from your pre-budget submission. You said, “Consequences of isolation, loneliness, and ageism significantly decrease life expectancy, cognitive function, physical well-being, mental health, and quality of life.” You went on to say, “Social isolation can be as harmful to a person's health as smoking, obesity, or hypertension.”

Most of the research, though, was from before the pandemic. Could you elaborate for the committee on how you feel that the research I just mentioned has even been heightened with the tremendous amount of isolation seniors have been experiencing over the past 14 months?

● (1605)

Ms. Laura Tamblyn Watts: Prior to COVID-19, we saw that social isolation could take up to eight years off the life expectancy of an older person. That was prior to COVID-19. We have seen untold levels of social isolation. Active, healthy 75-year-olds now locked in their own homes, unable to see family and friends, have had profound problems with the physical ability to move around. These are people who previously did not have disabilities, whether physical or mental disabilities, but who now are suffering enormously.

We're starting to see some of the research in the community, but we are already seeing some of the research coming out of long-term and residential-type care. The CIHI report did some reviews. Dr. Nathan Stall has done some. Occupational therapy reviews have also been considered. We saw some of the outcomes in the Maples in Winnipeg, which were referred to as well, and across the country. We are able to measure the fact that people are not able to toilet anymore. They're not able to walk as far anymore. They're not able to understand and appreciate or feed themselves. These are real physical and mental engagements. On top of that, the disconnection and the trauma have now pulled people into mental health spheres that we have not ever seen before at the same level.

When it comes to loneliness and self-isolation, up to 15 cigarettes a day was how bad it was prior to COVID-19. Now imagine we are all chain-smoking.

Ms. Raquel Dancho: Wow. That's really incredible and shocking. Those are very disturbing statistics. I appreciate your sharing them with the committee. They are critical for the research that we are doing in this study.

By way of a personal anecdote, I have a very dear mentor who is a friend of mine. Her mother is elderly, lives in a care home and has dementia. She is the one person, even though they have a large family, allowed to go and see her, but when she goes to see her, of course, precautions must be taken. She wears her mask and her shield. Her mother is already quite confused at this stage. She's not even allowed to touch her mother. She's not allowed to help her go to the bathroom, or really provide any of those supports that caregivers are allowed to provide.

When she told me this story, she was very emotional, obviously. As a daughter, she can't even hug her mother. I'm wondering if you have any recommendations, for the next number of years if we have to live with the pandemic, on how we can better support seniors, particularly in that situation, and have their family, perhaps.... I don't know. I'm not a medical expert. I'm not a seniors expert. I'm just wondering what your perspective is. Is there anything more that we could be doing to help women and men in that situation?

Ms. Laura Tamblyn Watts: One of the reasons we put forward the recommendation for a national adult vaccination strategy is that we let epidemics come to seniors every single year in the community and in long-term care, and we do very little about them. It's so simple to vaccinate, but we leave it up to provinces and local health units to order the seniors-specific flu vaccine, the pneumonia vaccine and the shingles vaccine. This time we saw the federal government step up and actually purchase and distribute the seniors-specific flu vaccine to long-term care. That was transformative.

We could take small steps like that on an ongoing basis. Doing that would reduce these yearly epidemics, and hopefully the pandemics, and it would make sure we would never be in some of these circumstances again. That's a very tangible thing to do.

The other piece I would offer is that once people are vaccinated against COVID-19, we need to loosen these restrictions. They are now being stuck because of concern around liability and concern around insurance. Violations of seniors' rights are happening all across this country. There's no reason, if the mom has had two doses of vaccine and precautions are in place, that she shouldn't get a hug and a walk outside.

● (1610)

Ms. Raquel Dancho: Thank you.

The Chair: Thank you, Ms. Dancho.

Next is Mr. Long.

Go ahead, please, for five minutes.

Mr. Wayne Long (Saint John—Rothesay, Lib.): Thank you, Chair, and good afternoon to my colleagues.

Good afternoon to Ms. Tamblyn and Ms. Ferrier. Thank you very much for your presentations. It's great that you're both here.

Ms. Tamblyn, obviously you're right across the Bay of Fundy, as we talked about earlier. I can almost see you on a clear day.

There's no question that this is an incredibly important study.

One of the things that would really break my heart, when I was doing door to door back in 2015 in my first campaign, was seeing seniors in their homes, and how seniors were so vulnerable and were forgotten. You roll that into what's happened during this pandemic with the isolation and just the travesty that it's had on all Canadians, but in particular seniors.

Certainly from our government's standpoint, as MPs, we're always lobbying and making sure we do the right things. It goes without saying that we certainly raised the GIS to 10% for low-income single seniors, and we rolled back the increase in age that the Harper government was going to bring for the age of eligibility for benefits from 67 to 65. I'm thrilled in this budget that we are increasing the OAS for seniors who are 75 years and older. Sure, there are people who would ask, well, why not 65 to 74, but we deem that seniors 75 and up are more vulnerable and have more health care costs. I'm certainly thrilled that our government is moving forward with those initiatives.

I'm in a province that has more people over 55 years of age than under 15. There was a study in 2018 which said that in our country now, one of two Canadians is over 40 years of age. It's a pressing problem, a challenging problem.

I want to talk about home care for seniors, but also kind of roll that into—if I said a NORC, you would know what I mean, obviously—a naturally occurring retirement community. These communities are popping up. These communities are forming, not really even forming deliberately, if you will. They're not designed that way, but over 40% of the people are 55 or older, and so on and so forth.

I read an interesting article the other day that was talking about a concept of needing to get better as government. MP Dong talked about the levels of government and how we need to co-operate better. The article I read basically said that we can do a lot better job of also bringing more services to seniors in these communities. Obviously that rolls into home care, and we're going to talk about specific home care.

I'll start with you, Ms. Tamblyn.

Could you talk about alternative types of care which would bring more care to seniors in their communities?

Ms. Laura Tamblyn Watts: Aging in place and making age-inclusive communities have to be our priority. We will always need long-term care, because as we live longer and are more fragile, there will always be some people who need 24 hours of nursing care. However, about 20% of the people in long-term care could move home if services came to them. Whether those services are shared amongst a community, like a naturally occurring retirement community or not, depends on what the needs are of that community.

Services to people in place are absolutely where we need to focus as a key priority in government.

Mr. Wayne Long: Can you give me any examples of a gold standard, or a community or province that has something that's working?

Ms. Laura Tamblyn Watts: We have NORCs that are very well established in a network across this country. I can provide the committee with more detailed information about an entire association of naturally occurring retirement communities—where they live, how they work, and what the best standards are—as a follow-up piece of information.

Mr. Wayne Long: Thank you.

Ms. Ferrier, could you comment on that?

● (1615)

Ms. Miranda Ferrier: Quickly, I can say that there are many good ways to bring all that seniors need into one community. Home care is easier, believe it or not, to organize at times than long-term care, so it's much more doable.

Mr. Wayne Long: Thank you.

The Chair: Thank you, Mr. Long.

[*Translation*]

Ms. Chabot, you have the floor for two and a half minutes.

Ms. Louise Chabot: Thank you, Mr. Chair.

I want to talk about the financial security of seniors and the direct assistance that they'll need.

Ms. Ferrier, you commented on the federal budget in terms of the increase in the old age security pension. You know that, in Canada, people are eligible for the old age security pension as of the age of 65, regardless of their previous status. That's good.

What do you think about the government's proposal to increase the old age security pension only for seniors aged 75 and over, and only in 2022? Don't you think that this should apply to seniors aged 65 and over?

[*English*]

Ms. Miranda Ferrier: I'm going to have to agree. I do agree that it should start at 65. I have parents who heavily rely upon that.

I think we need to look not just at that. We need to look at what else we can give to seniors. Many seniors struggle with paying for their food. They struggle with paying their rent. They don't have a place to live. They move back in with family. I think we're going to see more struggles if that age is moved up.

[*Translation*]

Ms. Louise Chabot: Ms. Tamblyn Watts, what do you think?

Ms. Laura Tamblyn Watts: Thank you, Ms. Chabot.

[*English*]

We were pleased to see the increase at 75. It was a very long time coming. We think these increases should be broadly brought up to standards with regard to seniors' poverty, and that there needs to be support for those most in need, so a differentiation between what everybody gets and what those who are particularly in need get.

[*Translation*]

Ms. Louise Chabot: Do I have any time left, Mr. Chair?

The Chair: You have 30 seconds left for a brief comment.

Ms. Louise Chabot: I'll make one final comment. I'm trying to understand how the financial vulnerability of seniors is different depending on whether they're 65 or 75.

The Chair: Thank you, Ms. Chabot.

[*English*]

We will go to Ms. Gazan for two and a half minutes.

Ms. Leah Gazan: Thank you so much.

I want to thank Laura and Miranda for speaking about the importance of independence and having the choice to stay at home. I think everybody on this committee would agree that people value their independence, and that when they get to that point in life they would like the option of choosing between long-term care and home. I say that, as well, for members of the disabled community, who should also be granted those life options.

During the second wave, we saw devastating levels of infection and death in long-term care homes, notably in for-profit care homes. In fact, we know, as you know, that 80% of the COVID-19 deaths in Canada have been attributed to long-term care homes. We knew we had problems before the pandemic; we just didn't deal with them. If we had, this wouldn't have happened. I'm just putting that out there. This is not a new problem.

We also saw in long-term care homes that the worst outbreaks were, more often than not, in for-profit care homes. We know that.

My question is for either one of you. Can you speak about why it is important to take profit out of long-term care and how doing that would result, in fact, in better care for seniors across the country and better treatment of workers as well?

Ms. Miranda Ferrier: I don't know if I'm going to give you the answer you want to hear, but I can answer this quite quickly.

Having worked in both for-profit and not-for-profit homes and representing personal support workers in both sectors across our nation, I have to say that both sides have issues. Yes, the for-profit homes definitely had more infections—massively more infections—than the not-for-profit ones did. When it comes to the treatment of staff, when it comes to the treatment of residents, we see issues on both sides of the coin. However, when you talk about supplies, whether they be incontinence products, extra time, extra outings, etc., not-for-profit is the winner of that one.

I think we need to pick good parts from both sides, and then we'll know exactly what we need to do in order to fix our system.

● (1620)

Ms. Leah Gazan: I'll pick up on that, and I appreciate your feedback.

You've indicated there have been issues on both sides, but I would say we have an issue with how we treat seniors in the country, period, on all fronts. Would you agree that this makes it even more critical to put in place national standards and very clear regulations for long-term care homes to ensure that seniors are provided with adequate care?

Ms. Miranda Ferrier: Yes, I agree.

I can hand it over to Laura.

Ms. Laura Tamblyn Watts: I agree as well. In 1987, when we created the Canada Health Act, we only lived until 76.4 years old. We didn't really have long-term care. If we had designed it thinking forward and if we had a seniors advocate telling us we needed to be thinking about these things, we would never have done anything but not-for-profit care. It would have been part of our health act.

We are not there. Fifty per cent of our long-term care is being provided privately, and I don't see a pragmatic way of easily undoing that while trying to meet the needs of a growing and less able population at the end of life. National standards are going to be critical for making sure that we no longer have the problems we have had.

The Chair: Thank you.

Go ahead, Mr. Tochor, for five minutes.

Mr. Corey Tochor (Saskatoon—University, CPC): Thank you very much.

Let's go back a bit. You touched on some of the pressures that seniors are facing, especially with inflation. Unfortunately, everything is costing more and everyone is bracing for what will come after the pandemic, which I fear will put more strain on seniors and our loved ones.

Along that vein of hopefully finding efficiencies within our provision of care, I thought of one of the ideas that came in your written submission for budget 2021. You proposed to create a toll-free national 1-800 line that would help seniors get care and unfortunately bring to light some of the abuses that are taking place out there. It got me thinking about how we make the system more efficient for seniors. Maybe if we could get seniors in contact with people whose role it is to help, we could have better outcomes.

I'd like you to unpack a bit more the idea of a 1-800 number for supports. I can follow up with a second question later, but could it piggyback on the 211 system, which gives citizens access to information on where to find help?

Ms. Laura Tamblyn Watts: The 1-800 number is a simple solution, and it's already being run by the Canadian Anti-Fraud Centre. That existing resource could have its mandate expanded. In fact, the Canadian Anti-Fraud Centre has been quite open to this conversation for some time.

People call when they need to know who to turn to, and there is expertise in each province and territory. If they call from Shediac, they need to know what's happening in New Brunswick. If they call from Kamloops, they need to know what's happening in British Columbia. The systems and frameworks across the country are so diverse, and people are desperate to find regional resources.

We're not suggesting that the federal government do all these things, but a basic 1-800 line staffed with people who can help with navigation would make a huge difference. This has been tried in other jurisdictions, such as Australia, New Zealand and even the United States, and has been a very simple and effective tool. It's not going to solve everything, but it can take some of the desperation away.

Mr. Corey Tochor: Absolutely.

Just to unpack this a bit more, Laura, you talked about Stanley, who got in contact with you. Was it through one of these support lines? How did that conversation reach you?

Ms. Laura Tamblyn Watts: Stanley called us at CanAge. Our phone numbers are available and our email is available.

We have people reaching out to all kinds of services, and 211 is a good service. It's being rolled out across the country now, but it works better in some places than in others. It is another type of resource that can be helpful, but people need to be trained on it because it is for information and referral.

I'll use an example that comes from Ontario. When calls about elder abuse and neglect hit 211, it was flooded, but 211 doesn't have training on this. People were then handed over to the senior safety line. To give you a sense of this, the senior safety line was getting 800 calls every three days during COVID-19, with an 85% drop rate. That means only 15% of the calls were getting through. This was 24 hours a day. Therefore, 211 is a way in, but calls have to go to someone specialized.

We think that 211 and other supports are important points, but a national response line for seniors' inquires, which could be staffed by Service Canada or the Canadian Anti-Fraud Centre, or could be an analogous line with expert resources to help, would be a really useful tool.

● (1625)

Mr. Corey Tochor: Speaking of fraud, I have a couple of questions on how we can reduce it. One proposal was to have a trusted adviser that banks would have to ask for. Along those lines, I brought up some other questions about some of the financial abuse and fraud that unfortunately takes place with other trusted individuals. How would we protect against an effort to reduce fraud that could actually make it more common?

Ms. Laura Tamblyn Watts: One of the key things that can be done by the federal government is to fix the poor wording in subsection 7(3) of PIPEDA, which makes the reporting of financial abuse very, very challenging. Again, if the committee likes, I can provide additional information.

The CSA, IIROC, MFDA and the Canadian Bankers Association are all moving to install trusted contact people as part of the "know your client" principles. That is a good and useful way that the regulatory system is moving forward. What the federal government needs to do is tweak the language in PIPEDA. We've made submissions. It's a very easy fix that would allow reporting to be much more effective for financial institutions.

Mr. Corey Tochor: Absolutely. Could you submit that to the committee?

Thank you again for your submission, and thank you for your public service in helping seniors.

Ms. Laura Tamblyn Watts: Thank you.

The Chair: Thank you, Mr. Tochor.

This is the last question round for this panel.

[*Translation*]

Mr. Lauzon, you have the floor for five minutes.

Mr. Stéphane Lauzon (Argenteuil—La Petite-Nation, Lib.): Thank you, Mr. Chair.

I want to thank Ms. Tamblyn Watts and Ms. Ferrier for being here today and for their testimony, which is very important to this committee.

Ms. Tamblyn Watts, you piqued my interest earlier when you spoke about the importance of organizations that could help seniors.

You know that we invested an additional $20 million in the new horizons for seniors program to establish projects to help seniors. We also budgeted $350 million for non-profit charitable organizations during the pandemic. Moreover, we allocated $109 million to the United Way of Canada, and we gave millions of dollars to food banks.

Do you think that we took the right steps?

What other steps could we take to help Canadian seniors through organizations?

Ms. Laura Tamblyn Watts: Thank you for your question, Mr. Lauzon.

[*English*]

We have taken some steps forward. However, as an example, the money given to domestic violence was $350 million off the bat, followed by another $157 million. When we compare that with the zero dollars for elder abuse and neglect, we see a stark difference between how government responses have been thinking about older people. Again, we think a federal seniors advocate would have supported government in understanding that resources around things like abuse and neglect were going to be critically important.

We do thank the government for its investments. We think the work with United Way was critically important in particular. Where the challenge has ever been with the new horizons for seniors program—I've been very involved with new horizons for more than 20 years—is that they tend to be one year only, with the rare exception of a few multi-year programs, and predominantly pilot-based, with a need to show sustainability. The new horizons for seniors program has been up for review many times. The review process is always the same. Make it more easy for renewable funding and not make it always a one-year program. Elevate that $25,000 to a more meaningful level, or at least allow three-year programming after $75,000, so communities can provide supports. We know that austerity is coming. We know that the first things that get cut are seniors programs. Certainly this is going to be a matter where we need to institutionalize support for seniors and not make just one-time payments.

The last thing I would offer is that it was excellent to see that $500 payment, and again a bit of a support next year as well, to support older people directly for elevated expenses that they have. If you compare that one-time support to ongoing monthly support for children and youth in need, women in need, and others such as CERB, we see that really the answer is more of a universal basic income answer rather than a one-time cost.

Older people have dramatically more expenses in terms of delivery, in terms of transportation, and in terms of different types of medical care during COVID-19. I think it would be helpful to think about how on an ongoing basis older people could be supported with the elevated costs caused by COVID-19.

● (1630)

[*Translation*]

Mr. Stéphane Lauzon: Thank you for your response.

Both witnesses can answer my next question, starting with Ms. Ferrier.

Earlier, you explained why there was a difference and that the pension increase applied only as of age 75.

Do you agree with us that the key is to focus on the most vulnerable people?

We know that half of our seniors, starting at age 75, begin to suffer from a disability. Picture yourself at that age, suffering from a disability, when half of disability cases are considered severe. These people often can't even stay in the same place. In 57% of cases, these people are women. In four out of ten cases, these women are widows. Yet 50% of these people have an annual income of less than $30,000.

That's why a responsible government should take concrete steps to help seniors aged 75 and over.

Based on these statistics, would you say that the government is making a good decision by helping people aged 75 and over, rather than providing less support to everyone, or even providing support to people who are wealthy at the age of 65?

[*English*]

Ms. Miranda Ferrier: I agree with what the government did by only focusing on those who truly need the help. I think that's of great importance.

However, I'm concerned about those who may be just above the threshold of what the government entails as struggling from the age of 65 up. My only concern is what that threshold is going to be and how we can ensure that they're all taken care of at the end of the day.

[*Translation*]

The Chair: Thank you, Mr. Lauzon.

[*English*]

That concludes this panel.

Ms. Tamblyn Watts and Ms. Ferrier, you may have heard at the start that I said this was meeting number 34. I don't think I have ever said this: You made my job easy today. Your answers were concise, but extremely well thought out and informative. We're off to a really good start on this study thanks to you.

Thank you so much for the work that you're doing in support of our seniors and those who care for them, and for your testimony here today. It is greatly appreciated.

[*Translation*]

Ms. Laura Tamblyn Watts: Thank you, everyone.

[*English*]

The Chair: Colleagues, we're going to suspend while we get ready for the second panel.

● (1630)

_____(Pause)_____

● (1635)

The Chair: I call the meeting back to order.

Today's meeting is on our study of the impact of COVID-19 on seniors.

I have a few comments for the benefit of our witnesses. Before speaking, please wait until I recognize you by name. When you're ready to speak, you can click on your microphone icon to activate your mike.

Interpretation is available in this video conference. You have the choice, at the bottom of your screen, of floor, English or French. When speaking, please speak slowly and clearly. When not speaking, your mike should be on mute.

I would like now to offer you a warm welcome to the committee to continue our discussion. You will have five minutes for opening remarks followed by questions.

We have with us today, from Age-Well, Alex Mihailidis, scientific director; and from the National Institute on Ageing, Samir Sinha, director of health policy research.

We'll start with Mr. Mihailidis for five minutes.

Welcome to the committee, sir. You have the floor.

Dr. Alex Mihailidis (Scientific Director, AGE-WELL): Thank you, MP Casey and members of the committee.

My name is Alex Mihailidis, and I am the scientific director and CEO of the Age-Well networks of centres of excellence. I am also a professor at the University of Toronto, having specialized in the area of technology to support older adults for the past 20 years. Age-Well is Canada's technology and aging network.

During this pandemic, we have seen older adults and their caregivers stay resilient, like all Canadians, with the help of technology. All of us are wondering what the world will look like post-pandemic. We can say with certainty that technology will play a much larger role in the lives of older adults and caregivers. With the increase in the use of telehealth, it's not an exaggeration to say that technology is going to help transform the care that older Canadians receive. We anticipate this across all settings, hospital, community, home, and long-term care, where the pandemic has resulted in devastating consequences.

Are older adults receptive to technology? The answer is yes. A poll commissioned in July 2020 by Age-Well shows that COVID-19 has significantly increased the use of many technologies among older Canadians. The poll surveyed over 2,000 Canadians age 50-plus, who are representative of our country's provinces and territories, and used a mix of online and telephone surveys.

More than six out of 10 Canadians age 65-plus agree that technological advancements can help to lessen the impact of COVID-19 on their daily lives. The majority agree that technology can help them maintain relationships, reduce social isolation, pursue hobbies, manage all aspects of health, and stay safe, independent and active as they age.

These trends are driving a multi-trillion dollar age tech market internationally, and Canadians are no different. The majority of those age 50-plus, which includes the future generation of seniors, are willing to pay out of pocket for technology that allows them to stay at home as they age.

Many cutting-edge technologies that benefit older adults are in development, and some are on the market. At Age-Well, the backbone of Canada's age tech sector, research teams and start-ups have over 100 technology-based solutions in the pipeline or that are already making a difference in people's lives, including during the pandemic.

What is age tech? It is anything from glasses on your face, to smart home systems to support aging in place, to mobile health apps and platforms designed to enhance safety and quality of life for residents in long-term care.

I want to emphasize that the timeline for implementing such solutions has moved up dramatically because of COVID-19. People want these technologies now. Even after the pandemic passes, these innovations will be needed to enable people to live longer in their own homes and to ease the increasing pressures on the health care system.

Age-Well is actively working with long-term care providers, such as with the City of Toronto and elsewhere, to determine the technology needs and to implement solutions today.

Here are three ways in which we can accelerate the delivery timeline:

First, the Canadian government needs to increase investment in Canada's age tech start-ups, so that products get into people's hands sooner. Canada's gross domestic expenditures on research and development as a percentage of GDP declined almost 16% over the past 10 years, while other OECD countries grew by approximately 10%. We need to change the storyline in order to continue being an international leader in the age tech space.

Second, we need to accelerate actual access to broadband Internet, which is often a challenge in rural and indigenous communities. In our modern society and in a country like Canada, access needs to be considered a basic right. In long-term care and seniors residences, Wi-Fi must be available.

Finally, supporting clinicians to integrate apps and other new technology into their clinical practices is key for transforming Canada's health care systems. The federal government can play a role in this by earmarking funds for assistive technologies that help with low vision, hearing, cognition and social inclusion, which are critically important for seniors.

As a Canadian organization driving forward Canada's age tech sector, Age-Well will continue to work with key partners in industry, government and community groups to guide and increase the impact of homegrown innovations.

● (1640)

Seniors and caregivers, whose involvement is essential, will be with us every step of the way to ensure that emerging technologies are practical, and will be adopted now and post-pandemic.

Thank you very much for this opportunity to speak with you.

I welcome any questions from the committee.

The Chair: Thank you, Dr. Mihailidis.

Next we have Dr. Sinha for five minutes.

Welcome to the committee.

Dr. Samir Sinha (Director, Health Policy Research, National Institute on Ageing): Thanks, Mr. Casey, and members of the committee.

I'm Dr. Samir Sinha, and I'm the director of health policy research at the National Institute on Ageing.

The NIA is a Ryerson-based think tank focused on addressing the realities of Canada's aging population. Additionally, I serve as the director of geriatrics at Sinai Health and the University Health Network. I was recently appointed as a member of the federal government's National Seniors Council and invited to chair the Health Standards Organization technical committee that has been tasked with developing the new national long-term care services standard for Canada.

First of all, I want to take a moment to acknowledge the 23,253 older Canadians, representing 95% of Canada's deaths thus far from COVID-19, as well as their families.

There's a growing public discourse on the role of governments to address the inadequacies of our supports for older Canadians during the pandemic, including the provision of long-term care, and growing calls for the federal government's greater leadership in these areas. While other countries have acted clearly and decisively to develop stronger systems of long-term care for seniors as they've aged, Canada didn't. This inaction cumulatively helped to sow the seeds of this tragedy we've been witnessing, where 62% of Canada's deaths to date from COVID-19 have occurred in LTC settings, the highest rate of any G20 country.

I publicly noted early on that while LTC homes were becoming the epicentres of Canada's pandemic, there was no national mechanism in place to track these outbreaks in a consistent way. Neither PHAC nor CIHI were doing this. Our NIA, thus, took on the task to systematically collect all the data related to resident and staff cases, and deaths at individual home levels across Canada. Had we not done that, the truth of what happened in long-term care might have remained obscured.

Our highly accurate record, developed with CIHI support, has become the basis of many important studies and analyses. However, my point here is that something important like this should not have been left to the goodwill of provinces or a university research centre, but should have been a clearly enabled function of the federal government's pandemic response. Moving forward, clear protocols and systems need to be in place in future to ensure we're never caught off guard like this again.

PHAC was helpful in coming up with some early guidance to help the provinces and territories look at more standard infection prevention and control measures, and the treatment of COVID-19 cases in long-term care settings. However, it's not clear why the agency could not have been enabled or supported to provide much needed guidance to the provinces and territories to navigate other important challenges, such as addressing the effects of social isolation and resident access to family members.

It was our NIA, on our own initiative, that decided to lead on the creation of national LTC guidance. First, the release of our spring 2020 “Iron Ring” guidance continues to serve as the evidence base around how the provinces and territories should respond to COVID-19 in congregate care settings. We've now updated that three times.

In July 2020, we released our “Finding the Right Balance” guidance document to support the reopening of Canadian long-term care homes to family caregivers and visitors. With the majority of LTC residents and staff being now vaccinated, the lack of guidance being issued, as the CDC has done in the United States, is forcing residents and families in homes across too many parts of the country to remain isolated from each other, producing serious physical and mental health consequences.

Again, the NIA is helping to develop new evidence-based guidance to enable our provinces and territories to safely reopen their homes, but it should be the official government bodies, like PHAC, leading this work.

I'm glad that the federal government is now providing much needed leadership with the creation of new national standards for long-term care. Enabling this with $3 billion will also be helpful to ensure the provision of a more consistent and higher standard of care across Canada. In being asked to chair the HSO's technical committee, I am thrilled to see an unprecedented level of public engagement in this work so far.

In the future, with our NIA research showing that at least 430,000 Canadians have current unmet home care needs, while more than 40,000 are on wait-lists for long-term care homes, even before the pandemic, we need to do more to support Canadians to age well and in their own homes for as long as possible. Our research shows that Canada spends 30% less than the average OECD country on the provision of long-term care, and close to 90% of our public LTC dollars are spent on institutionalizing people rather than caring for them in their own homes where they want to be.

Our NIA's “Pandemic Perspectives” report shows that virtually 100% of older Canadians want to do everything possible to remain in their own homes for as long as possible. Our “Bringing Long-Term Care Home” report shows that this could be done well and for lower costs for many people currently in our long-term care settings. Of course, people have the right to pay privately for their own home care services, but this is not an option for the majority of Canadians who don't have the financial resources to do so.

● (1645)

The recent commitment to increase OAS payments for Canadians 75 and older will enable some to better meet the growing costs associated with aging and aging in place, but we need to think bigger, as other countries have, perhaps by enabling the creation of a national long-term care insurance program or further improvements to the guaranteed income supplement program for lower-income older Canadians.

Where do we go from here? While it's good that most political leaders have agreed that long-term care is broken, we need to ensure that we pair our immediate actions with efforts to determine how best to fix and fund the long-term care system that all Canadians should look forward to as they age. In this regard, I am glad that our NIA has been helping to ensure that we can define the issues properly, ask the right questions and find the right answers and ways of implementing them as quickly as possible.

Much of what we need to do has been well known for years. Luckily it isn't rocket science, but it will take political will and a federal, provincial and territorial coordination of efforts. We thus recommend that the federal government fully support the work ahead that will enable the creation of new national long-term care standards and help its provinces and territories in addressing these issues once and for all.

Thank you very much.

The Chair: Thank you, Dr. Sinha.

We will now proceed to our rounds of questions.

We'll begin with Ms. Falk, please, for six minutes.

Mrs. Rosemarie Falk: Thank you, Chair.

Thank you to both our witnesses for coming today and contributing to this committee study.

With an aging population, we need to ensure there is a better continuum of housing and care needs for seniors in Canada. There seems to be a consensus among older adults and seniors that they would prefer to age in place and live independently as long as possible.

I noted that in the National Institute on Ageing report released last fall, “Pandemic Perspectives”, a significant number of Canadians indicated that COVID-19 changed their opinion on whether they would arrange for themselves a nursing or retirement home. Given what we know, this change of perspective isn't surprising to many of us.

I'm interested to hear your perspective, Dr. Sinha. You yourself said early in the pandemic that if your mother were in long-term care, you would have pulled her out. Do you think that change in perspective is permanent? In addition to improving the standard of care in long-term care homes, which we know will not be an easy task, what do governments need to do to prioritize to respond to that change in perspective?

● (1650)

Dr. Samir Sinha: Thank you very much for that question, Ms. Falk.

The report we put out last fall really spoke about that shifting perspective, where 60% of Canadians said they were reconsidering whether they or a loved one would want to live in a retirement or long-term care home in the future. We followed up that report with another survey in partnership with the CMA. It basically showed that virtually 90% or more of Canadians, and especially close to 100% as they age, now will do everything possible to avoid going into a long-term care home.

Over this pandemic, I think those views have been solidified more than ever. I think the challenge is that now most Canadians are well aware of the shortcomings. They are really looking for change in the sector before they begin to trust it again.

These perspectives are real, and we have to understand them, but I think they can also galvanize an opportunity to not only improve the way we provide long-term care but also think about the value proposition of being able to provide more supports and services to help older Canadians age in the place of their choice, which is often their home. As I mentioned in my opening statement, close to 90% of our publicly funded long-term care dollars are spent on institutionalizing people, whereas if you look at Denmark, for example, they're actually spending two-thirds of their publicly funded long-term care dollars to support people in their own homes. It can often be done cheaper and without worrying about massive infrastructure costs. It can be done in a much more flexible way that can meet people where they're at and when they need it most.

I think there's an opportunity here to re-examine how we provide that care and what the federal government's role can be in something that for now has also always been purely a provincial and territorial jurisdiction. Our federal government currently, in the recent health report, is spending $6 billion to increase the provision of home and community care, and now $3 billion in new dollars on top of $1 billion recently, to try to improve the provision of long-term care across Canada as well.

Mrs. Rosemarie Falk: I think, too, it is so important that seniors have autonomy. In the past it's just been “this is where you go; this is just how the continuum of life goes”, and I think it's so important that different levels of government, where applicable, do what they can so that seniors can still have autonomy and choices in life.

Alex from Age-Well, I'm wondering if you have anything to add to that. What role could the age tech sector play in helping seniors live independently?

Dr. Alex Mihailidis: Thank you very much for that question.

I fully concur with Dr. Sinha's remarks around people wanting to remain in their own homes. Even in our own survey related to that, we found that during the pandemic, only 40% of those who responded to our surveys said they felt comfortable aging in Canada. That number dropped from approximately 60% before the pandemic.

Technology can play significant roles in keeping the autonomy of older people in their homes and communities. For example, we found that the number of older people who are now using social media to reach out to their friends, family and social circles has risen to approximately one-third of those who were surveyed.

We're seeing an increase in the number of older people who are using online tools for even online shopping. We even saw an increase in online dating among seniors with the pandemic as well.

We're starting to see these tools make their way into everyday use.

The one thing to consider, as well, is that it's a new demographic of older people that's coming very quickly with the baby boomers, where technology is mostly already integrated into their daily lives. This expectation is going to continue as they age.

Mrs. Rosemarie Falk: Thank you.

Dr. Sinha, I have one quick question for you.

Given your background in geriatrics, I'm wondering what the solution is for addressing the shortages in geriatrics and also in palliative care. We do know, with the debate on medical assistance in dying in the House not long ago, members of Parliament noted the inadequate manpower that is in those [*Technical difficulty—Editor*].

● (1655)

Dr. Samir Sinha: That's an excellent question.

The Chair: Please be brief, if you can, Doctor. Thank you.

Dr. Samir Sinha: Yes.

Currently we have more older Canadians than younger Canadians, but we have nine times as many pediatricians as we do geriatricians. There are only 305 registered geriatricians in the country. Again, when we talk about palliative care specialists, there are not as many as there need to be. This is where we're calling for a national human resource strategy, or at least targeted investments.

The federal government, for example, could lead to try to promote training. We have more people applying for training positions than there are currently funded, and that's not helping us reach the critical mass we need to meet the needs of an aging population.

Mrs. Rosemarie Falk: Thank you.

The Chair: Thank you.

Ms. Young, you have six minutes, please.

Ms. Kate Young (London West, Lib.): Thank you very much, and thank you to our witnesses today.

Mr. Mihailidis, I want to first comment that my father, who passed away eight years ago, was so engaged with technology. He had his own Facebook page. He used it to communicate with his younger relatives in Scotland and Vancouver. He really took to it. I think there is a sense that older people shy away from it, but I think that's a fallacy in many cases.

I want to talk to you about getting young people engaged in and thinking about this next generation, how they can get into jobs that would support our aging population and what you think the federal government could do to encourage that.

Dr. Alex Mihailidis: That's a great question, Ms. Young. Thank you very much.

I love to hear those kinds of stories, like the one about your father. I hear similar stories everywhere I go. It's wonderful to hear and see the uptake.

You're right. It is a complete myth. The number one consumer group using smart phones in terms of increasing sales are those over 65. Technology is becoming more pervasive.

In terms of getting young people involved, actually, we're not seeing an issue. We're seeing an issue in trying to accommodate the number of young people who wish to get involved in this area.

That's what Age-Well has been doing. Age-Well has a very extensive training program, where we train current masters, Ph.D.s and undergraduate students in the area of age tech. In our first seven years as a network, we have put over 1,000 trainees through that program.

Many of them are not academics anymore. Many of them are doing their own start-up companies. Many of them are working in industry. Many of them are working in policy in government. Age-Well, alone, in the first six years has supported 46 start-up companies in this area, many of which are actually starting to make a little bit of money, which is always wonderful to see.

This is where we need to support things. We need to support the age tech sector to continue to grow. We need to encourage these young Canadians who are coming out of areas such as computer science and artificial intelligence. We are presenting really challenging and interesting problems for them to solve, and that's really what hooks them.

We need the support for our start-ups in the area of age tech, but also the support of well-established industries and companies that realize their number one consumer will become older as well, to help them make that transition into the area to learn about the age tech sector and, more importantly, to learn about seniors themselves.

Ms. Kate Young: Thank you so much.

Dr. Sinha, I've been encouraging my residents to visit longtermcarestandards.ca to share their input on the topic of long-term care standards. As the chair of the technical committee, how will you use this type of information that you'll be getting to come up with ideas for long-term care standards?

Dr. Samir Sinha: This is an important question. It is an important task ahead. My colleague here is also the chair of the sister committee, if you will, which is the CSA committee that will be helping to develop the complementary set of standards. We're both working closely together as chairs and our committees will be working closely together.

One of the key goals that we both set out as chairs is to have deep public engagement. For example, many times when committees like this exist where the work is done, people are not aware of how they can get engaged. Many people have a lot of things to say.

Close to 4,000 people have already completed the initial survey that we put out. This is everything about what they want long-term care to look like and what issues are important to them. We have asked people to comment on the themes on a very broad basis, just so we can start hearing what matters most to Canadians, so that we do come up with standards that actually reflect what Canadians currently want and need and what they think is currently lacking.

This is only a start. We are also planning as chairs to lead the development of town halls and round tables and really do deep public engagement. The public will have an opportunity to do what we call a public review of our draft standards in January 2022, so that we can get more feedback. At the end of the day, when this feedback comes in, we want our committees to see what Canadians want and need.

That's why we're really looking forward to all the input we can get, so that when these standards come out, people can say that they are the standards that they respect and that they want. The standards then can become more broad-based in their use across the country, whether it be for accreditation, funding, enforcement, inspections or even new legislation.

That's what we're hoping to get from the feedback that we're soliciting right now.

● (1700)

Ms. Kate Young: You have a big job ahead of you. You mentioned some other countries that we could learn from regarding long-term care standards. Who has the gold standard in the world?

Dr. Samir Sinha: I would wish to say that I can always point to one country that has it right. I'm particularly a fan of Denmark in the way they have actually thought about an entire continuum of care approach. They're thinking about how they can really focus on wellness and prevention and how they enable technology, as I'm sure my colleague, Alex, can speak about as well. It's also how they think about really supporting people to age in their own homes, where they want to be. They don't have many of the issues that we have.

People say that Denmark is a small country. Sure, it's a small country, but it is a smart country that has really been proactive in how they have approached aging.

In terms of the creation of standards, there are a lot of variable practices around the use of these things. We're going to be studying what's being done around the world, so we can rob and duplicate the best ideas to create standards that will be meaningful for the Canadian paradigm.

Ms. Kate Young: Thank you very much.

The Chair: Thank you, Doctor.

Thank you, Ms. Young.

[*Translation*]

Ms. Chabot, you have the floor for six minutes.

Ms. Louise Chabot: Thank you, Mr. Chair.

I want to thank both witnesses. My first question is for Dr. Sinha.

First, I can understand the desire to study the practices in Denmark, in particular, or in other parts of this region of Europe, where family and social programs are very important issues. In any case, Quebec has drawn heavily from these practices in order to implement a number of social policies, particularly in the area of early childhood education.

I also agree that our seniors, in general, want to grow old in their own homes. This was true before the pandemic, and the pandemic has certainly strengthened that feeling. Obviously, the reason for this is the isolation that they experienced in nursing homes. However, nursing homes and long-term care facilities will always play a role in the organization of services, even though we know that the number of hours of care required for admission has increased dramatically. There must be a balance between the two.

I was troubled by what the Auditor General said in her report regarding the Public Health Agency of Canada. You also released a report on the pandemic, and I wanted to ask you about that. The Auditor General said that, prior to the COVID-19 pandemic, the Public Health Agency of Canada hadn't updated all the pandemic plans or tested plans together with the provinces and territories. The report states that better preparedness could have minimized serious illnesses, overall deaths and social disruption among Canadians as a result of a pandemic.

Are you troubled by this report?

What solutions should we implement to be better prepared? What more proactive measures could have helped lower the high death toll among seniors?

● (1705)

[*English*]

Dr. Samir Sinha: Thank you very much for that question.

This is what we're finding when we look at reports, not only at the federal level but also at the provincial and territorial level. We're seeing from many of these reports that Canada as a whole, and in many of our jurisdictions, was not as well prepared for this pandemic as it could have been. I think partly it may have been that we didn't anticipate, after SARS, for example, that something like this could happen, especially in our long-term care homes. SARS was something that was isolated to certain cities in particular and more to something in hospitals. We've never seen something that's happened on this scale in congregate care settings for older people.

This really reminds us that at all levels of government, whether it was the federal, provincial or even the municipal government levels, for example, there were things that needed to be done. There were things that we needed to anticipate. I think there's a role that all three levels of government could have done better to better prepare themselves for the pandemic.

In partnership with the Canadian Red Cross, the NIA published in December clear guidance, 29 evidence-informed recommendations, that really speak to a public policy, but even a citizen-based level of things we could do as a country to be better prepared to support older Canadians in emergency and disaster response.

Again, what we are seeing is being echoed at many levels, in many reports, that these are things we can do with good-quality planning, with clear pandemic preparedness plans.

As with my comments earlier, as this pandemic was evolving, I think the challenge was when we said that this was a provincial and territorial matter, these issues were all of national significance. I feel that there is a role...that we could have better clarified or made sure that we enabled groups like PHAC or CIHI to have a mandate to say what the guidance is that needs to occur to better support these settings.

There's stuff that could have been done before, that needed to be done during, and hopefully from all of this, we'll learn what all three levels of government should be doing better to avoid the same issues next time.

[*Translation*]

Ms. Louise Chabot: Thank you.

It's nonetheless worrying to see that we weren't able to prevent this. What would you recommend? You spoke about the truth being revealed by your report, but how can we prevent a similar situation from happening again?

We are in the third wave of the pandemic. But it is not the only crisis. We see that the most vulnerable are often victims of such catastrophes. I believe you said it yourself in one of your reports. Whenever there is a catastrophe, such as a flood, it is the most vulnerable that are most at risk. The report states that there was a delay in putting measures in place, and we know that this was a big factor.

I believe your work is national in scope, so what would your recommendations be?

[*English*]

Dr. Samir Sinha: The work of the Canadian Red Cross and the NIA, where we've come up with clear policy recommendations are things that I hope will be reflected in our new national long-term care standards. They will speak to emergency preparedness and pandemic preparedness. This is a mechanism where we can actually come up with national standards. We also have an obligation, as a federal government, to hopefully support the enforcement and the enabling of those standards at a provincial and territorial level.

[*Translation*]

The Chair: Thank you, Ms. Chabot.

[*English*]

Next we have Ms. Gazan for six minutes.

Ms. Leah Gazan: Thank you, Chair.

My first question is for Dr. Sinha.

In the province of Manitoba and much of the western provinces, urban indigenous people, and particularly first nation communities, have had disproportionately high rates of COVID-19. This has also been true for Black communities in Canada.

Can you speak about how the social determinants of health have impacted particularly indigenous and Black seniors during COVID-19, and how the government can implement policies that acknowledge these injustices? I'd also like to include in this group veteran seniors and newcomer seniors.

● (1710)

Dr. Samir Sinha: Many thanks for that question.

When we think about COVID, many people talk about it as being the great equalizer, that it touches everybody, but it touched certain populations, like our BIPOC populations, in particular, more so than others. There are a number of reasons, because it largely comes down to the social determinants of health.

When we look at the issues we have across Canada, we find that many of these communities are more likely to be economically disadvantaged, and they're more likely to represent essential worker populations, where they don't have the space or the ability to isolate in their own homes. They don't necessarily have access to jobs that have paid sick leave readily available to them.

We also know that, especially when you think about BIPOC seniors, for example, they're more likely to be living in intergenerational households and settings. This is why, especially in our indigenous communities in more rural and remote areas, there is a real concerted effort to say, “If COVID comes into our community, especially in homes where we have many people living in intergenerational situations, this can rip through an entire home very quickly.” We're seeing this in regions of Peel, Scarborough and Toronto, and many other urban settings.

The commonality here is poverty. The commonality is not having the mechanisms to allow people to isolate from each other when they need to, and to have access to paid sick leave.

We have to remember that the issues of racism and systemic poverty did not make COVID-19 the great equalizer, but really attacked these communities in particular.

Ms. Leah Gazan: Thank you so much for that.

As I mentioned with our last witnesses, a guaranteed livable basic income, particularly for seniors.... Poverty kills and it costs lives. I really appreciate your comments around that.

My next question is for Dr. Mihailidis. Am I pronouncing your name right?

Dr. Alex Mihailidis: Yes, that's perfect.

Ms. Leah Gazan: Okay. I taught in university for 20 years, and every time a course would start, I would get nervous trying to pronounce names right. My great embarrassment every year was the start of a new course.

Many folks in my riding—you spoke about technology—do not have access to things like computers, cellphones or Internet. You talked about impacts of social isolation, something that has been a deep concern for me in trying to support particularly seniors in our riding through the pandemic, as I can't imagine how lonely one must feel living alone anyway.

Another issue is technological literacy for older adults. One thing I tried to get started in my community is a technology program, and maybe even student jobs. Students would train seniors on how to use technology.

As you indicated, these technologies are critical, especially during the pandemic, for social connections and for updates on pandemic restrictions. Can you speak about how the federal government should address this gap and this critical need for even the health of seniors?

Dr. Alex Mihailidis: Thank you. I really appreciate that question. I also feel your pain at the start of every semester in class at the university.

It does come down to education and developing education programs that can be attainable by anyone, no matter where they live within the country. At Age-Well, for example, we are looking at various models, such as train the trainer models, working with organizations and partners like the Red Cross, which has the capabilities and the expertise in these types of educational models. It's really working with pan-Canadian and international organizations where we can then be developing the curriculum, developing the materials. Really, it becomes a turnkey solution around education and then this can be spread out.

We also strongly believe in education applications within the community itself. For example, Age-Well has supported a couple of projects within indigenous communities. We're taking indigenous youth, who are then working with the seniors in those communities to teach them the literacy skills, and not just teach them the skills but to apply them, for example, in the role of digital storytelling.

These studies have been really fascinating, to see that once you give a purpose to it and connect the community by it, how quickly these skills can be developed and spread across the country.

● (1715)

Ms. Leah Gazan: Thank you so much.

The Chair: Thank you, Ms. Gazan.

Next we will have Mr. Vis, please, for five minutes.

Mr. Brad Vis (Mission—Matsqui—Fraser Canyon, CPC): Thank you, Mr. Chair.

Thank you to both of our witnesses for an excellent time together so far.

Dr. Mihailidis, you mentioned in your three recommendations that there was a 16% decline in R and D investment in Canada. What are the structural issues leading to such a decline and what can we do to improve it?

Dr. Alex Mihailidis: The easy answer obviously is lack of funding that's been provided to our key national funding programs. Those are mainly the tri-agencies, so CIHR, NSERC, and SSHRC for the social sciences. The other issue we're seeing is the increased number of researchers. The number of Ph.D.s we're graduating across Canada has increased, and the number of individuals going into academic positions has increased as well, to the point now where it is becoming quite a crowded marketplace, so to speak. The two simple variables of increased demand and lower supply are causing a lot of these bottlenecks.

The big problem we're going to see, though, with COVID is that because all of the funding resources were directed towards COVID-based solutions and projects, which very much was the right decision to make, the problem is that other areas of research, whether health related or otherwise, are really going to see a gap in funding over the coming years. That's the big worry of the academic community.

Now is the time for increased investment in research in order to not just fund people but to bring us back up to the baseline that we were at several years ago, and to continue to fill the gaps. We're seeing this—

Mr. Brad Vis: Thank you. That's very helpful. I have a short amount of time.

Dr. Sinha, I appreciated some of your earlier testimony. Yesterday I skimmed through one of the NIA reports. In the national seniors strategy, one of the three underlying principles is value for money as it relates to taxpayer expenditures.

You briefly touched upon old age security in your remarks. I'm very interested to hear if any studies have been done on how we distribute the funds that are collected and given to seniors. As you likely know, the minimum threshold for a tax on OAS payments is about $77,000. However, I think you can receive OAS payments up to an income of $130,000, so high-income seniors are receiving OAS benefits from the Government of Canada. Over the course of the pandemic, it's been really clear that seniors on GIS, say, and lower-income seniors have been suffering greatly.

I'm wondering if your organization or any of the research you're doing at Ryerson has discussed the possibility of redistributing the amount of total funds for old age security, but targeting low-income seniors more with existing funds.

Dr. Samir Sinha: That's an excellent question.

There was a bit of eyebrow-raising when we saw the announcement. It's great that we're recognizing that as we age, there are more expenses and that we're thinking about the group of Canadians who are 75 and older. They're more likely to have expenses for things like long-term care and things that challenge their ability to live independently, and we need to recognize that. However, if it had been my decision, I wouldn't have used the old age security mechanism to do that. I would have looked at the guaranteed income supplement.

In our original national seniors strategy, from prior to the 2015 election, we talked about poverty among older seniors and the importance of making sure that our guaranteed income supplement was better and fairer, especially for older women, because they're the ones who are most likely to suffer from late-life poverty. That was certainly a victory, because we saw some increases for single, especially older women as they aged and made improvements there.

As you said, the recent increases to old age security can benefit people with an income of $100,000 or more in older age. However, my bigger concern is the folks who are just making the guaranteed income supplement threshold. We need to think about better ways to support them.

Bridging this to the technology issues, one thing we worked on with Telus, for example, this past year was creating a new smart phone plan for only the 2.2 million seniors who are on the guaranteed income supplement. For only $25 a month, they get a smart phone during the pandemic. By doing that, they can use technology like the COVID Alert app and can participate in telemedicine and Zoom calls. This is, again, a way of thinking about how we bridge access to technology for low-income Canadians, not necessarily those who can afford it. That's where we're trying to challenge barriers with smart policy.

● (1720)

Mr. Brad Vis: Generally—

The Chair: Thank you, Mr. Vis.

Mr. Brad Vis: Thank you both. I really appreciate your testimony.

[*Translation*]

The Chair: Mr. Lauzon, you have five minutes.

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

I would like to thank Dr. Sinha and Dr. Mihailidis for their excellent presentations.

I have a few technology-related questions to start with.

During your presentation, you stressed the importance of the Internet. As you know, our government has made great strides to provide Internet service to all of Canada.

For example, in Quebec, we are working with the province. Currently, 40% of the population in my riding does not have Internet access. However, I can confirm that all residents of Quebec will have Internet access by September 2022, and that they will enjoy a fast connection. This is huge progress.

How will this improve living conditions for people once all Quebeckers are connected in September 2022, compared to how things are currently?

[*English*]

Dr. Alex Mihailidis: Access to something as simple as the Internet can make a huge leap in terms of how older people can be connected not just to information, but more importantly, to their friends, family and health care circles. Again, we've seen during COVID that more older people are getting online in order to access those services.

This is not going to go back to where we were before. This trend of online health care, telehealth and tele-rehab is going to continue to grow. Because of that, the infrastructure needs to be there.

We applaud the efforts of this current federal government to put these points of access in place; however, the questions that we hear all the time from older people are, “Why was this not done five years ago? Why was this not done 10 years ago, when we knew that the role of the information highway was going to be so critical as we move forward?”

It's never really been an issue of technical capabilities. They've always been there. We've seen that in many of our provinces during the pandemic, where for decades, we've fought for telehealth services in the province of Ontario to no avail, then over a weekend it seems, all of a sudden we have telehealth because of the pandemic.

If anything can be taken out of this in a positive light, what we've gone through, it's the fact that it has shown us that we have the capabilities. We have the capabilities here in Canada to do so. Now is the time to really push this initiative forward as quickly as possible.

Mr. Stéphane Lauzon: Thanks for the great answer.

I forgot to tell Mr. Chair that I have to share my time with my colleague, but I have another question.

We have a program we call new horizons. What has been discussed most about this program is related to education, training. Everything is related to devices, like tablets, or the Internet. People want to communicate with their families. Should this program be increased and should we be doing something better for the future to make sure that we support seniors?

● (1725)

Dr. Alex Mihailidis: Absolutely. This program should be increased. It should be considered a basic right of every senior and Canadian from coast to coast to coast. Instead of making it a special project, so to speak, or a special fund, this needs to be a standard part of any budget moving forward.

[*Translation*]

Mr. Stéphane Lauzon: As you know, our government has created, through a technology initiative, a website that is extremely popular, the wellness together Canada site. We weren't expecting it to be so successful. This website is also used by our seniors. It offers services directly online, by telephone or by SMS.

You mentioned earlier that many seniors have telephones and that some of them had downloaded the app onto their telephone.

Is this the sort of tool that we should use more in order to help our seniors with technology?

[*English*]

Dr. Alex Mihailidis: Absolutely. These types of services that can be delivered through off-the-shelf technologies are really critical.

The other important aspect, though, is working with the telecom community and the device manufacturers to ensure that these types of services can work on phones that may be two, three or five years old. That's another trend that we often see among older adults. The phones they use may have been the phone of their grandchild or their son or daughter who passed it on to them. This is the state. Then, all of a sudden, the COVID Alert app does not work on the older version of the phone.

Back compatibility is a big issue. This is something that we need to work on together. This requires bringing industry in, bringing government together, bringing in the manufacturers and designers and bringing the policy and regulatory bodies together as well.

Mr. Stéphane Lauzon: Thank you very much.

The Chair: Thank you, Mr. Lauzon.

[*Translation*]

Ms. Chabot, you have two and a half minutes.

Ms. Louise Chabot: Thank you, Mr. Chair.

My question is technology-related.

Dr. Mihailidis, your presentation and your studies show the importance of continuing with remote diagnostics and medical consultations, which technology makes possible. I agree with you to a certain degree. However, would you agree with me that a balance must be struck?

Spokespersons for the association des médecins omnipracticiens i.e., the association of family doctors, have stated that this tool should be used more. It does not, however, completely replace in-person consultations. What's more, there would have to be excellent Internet service everywhere in the country.

Quebec recently concluded an agreement with the federal government to improve Internet access.

What do you think are the limits of technology in the field of medicine?

[*English*]

Dr. Alex Mihailidis: *Merci* for this very important question. You are absolutely right. Technology is a tool that must be used among many different tools, whether technologically based or not.

Whether it's a smart home system, a sensor that someone is wearing to measure cardiac performance, or even a robot in someone's home—which is coming, if it's not already here—again, these are tools. They're not replacements for the medical profession. They're definitely not replacements for the family caregivers themselves. No way do I imagine it as a replacement. No way do I foresee a robot replacing my friend Dr. Sinha here—though maybe some days he would like to have a robot by his side to assist him—moving forward.

● (1730)

[*Translation*]

Ms. Louise Chabot: What are your thoughts about improving Internet access? It is essential.

[*English*]

Dr. Alex Mihailidis: We absolutely need to have broadband service across the country, coast to coast to coast, for this to happen. It's amazing; once that happens, the floodgates will open in terms of the types of technological solutions we can implement and use to support not only our seniors but also Canadians everywhere.

[*Translation*]

The Chair: Thank you, Ms. Chabot.

[*English*]

Our last couple of questions will come from Ms. Gazan, please.

You have two and a half minutes.

Ms. Leah Gazan: Thank you so much, Mr. Chair.

This question can be for either witness.

The government provided seniors with only a one-time $300 payment to support them during the pandemic. We're now at the two-year mark of this health crisis, and there has been no other support provided. This is deeply concerning for me and my riding. We are the third-poorest riding in the country. We have many seniors, including seniors who are veterans, living in deep, deep levels of poverty.

Do you believe this one-time $300 payment for seniors during the pandemic was sufficient, especially given the fact that we know that seniors experienced an increase in the costs they incurred during the pandemic? If not, what is the alternative?

I'll give you both a chance to answer quickly. I'll start with Mr. Sinha.

Dr. Samir Sinha: This is the challenge, right? I think the initial one-time payment was done at a time when we thought there were just additional costs where, again, someone had to order things online. They had these extra unexpected expenses. They had to take taxis to get to places. These were extra expenses. It was a good investment to be made, because I think it was very useful for many older Canadians in particular.

There's the recent budget announcement of the old age security increase. I believe some of it was to be provided as a lump sum to start and then was theirs ongoing, but I don't know when that will happen. I think we certainly have to look at how people have been affected. Again, these issues didn't last only a few months. These have lasted well over a year now. We have to consider that and how those challenges are affecting older Canadians.

Ms. Leah Gazan: Thank you.

Dr. Alex Mihailidis: I don't have too much more to add to that.

On Dr. Sinha's point, those original decisions were really made without knowing what was coming. Now that we're more educated and we understand the situation and what could happen, obviously new decisions should be made using the best data possible.

Ms. Leah Gazan: I asked that because, as indicated before, this pandemic has certainly highlighted inequalities in a real way. I would argue, certainly during the pandemic, that if we look at groups that have been marginalized even prior to the pandemic, seniors have been horribly marginalized. We need to do better, and I think that needs to happen immediately.

What do you think the next steps should be to ensure that seniors can live in dignity in this country?

The Chair: That is the last question.

Dr. Samir Sinha: To start off, again, I think it's not just seniors in general, but we also need to think about low-income seniors who also are more likely to be racialized or indigenous. This is where, again, if we were to do a limited top-up, I'm thinking about the 2.2 million older Canadians who are principally our guaranteed income supplement recipients, because they're the lowest-income people we can think of.

I think if we're thinking about a financial measure, I would target those who are most vulnerable amongst us, those lower-income people first, because that's an immediate financial relief measure that could be made as one aspect.

The other thing right now is that the number one thing older Canadians want is to get their second dose of vaccine as soon as possible because, again, they're still 90% of the people who are dying today.

Ms. Leah Gazan: Thank you.

The Chair: Thank you very much, Ms. Gazan.

Dr. Mihailidis and Dr. Sinha, thank you for your leadership and for your expertise. We very much appreciate your being with us. It will greatly help our work with this study.

Dr. Mihailidis, if I may say so, thank you for the heroic efforts you took to ensure that the technology would work, and for the enjoyment that I understand you provided to your neighbours. In all seriousness, we very much appreciate your both being with us, and the testimony you have shared with us today.

Colleagues, I'm sure you are aware by now that the budget implementation act has not been referred to the committee, so I wish you an excellent and productive constituency week and look forward to seeing you on May 25 when our witness will be the Minister of Seniors.

Do we have consent to adjourn the meeting?

● (1735)

Mr. Stéphane Lauzon: Yes, sir.

Some hon. members: Agreed.

The Chair: Have a good week, everyone.

The meeting is adjourned.