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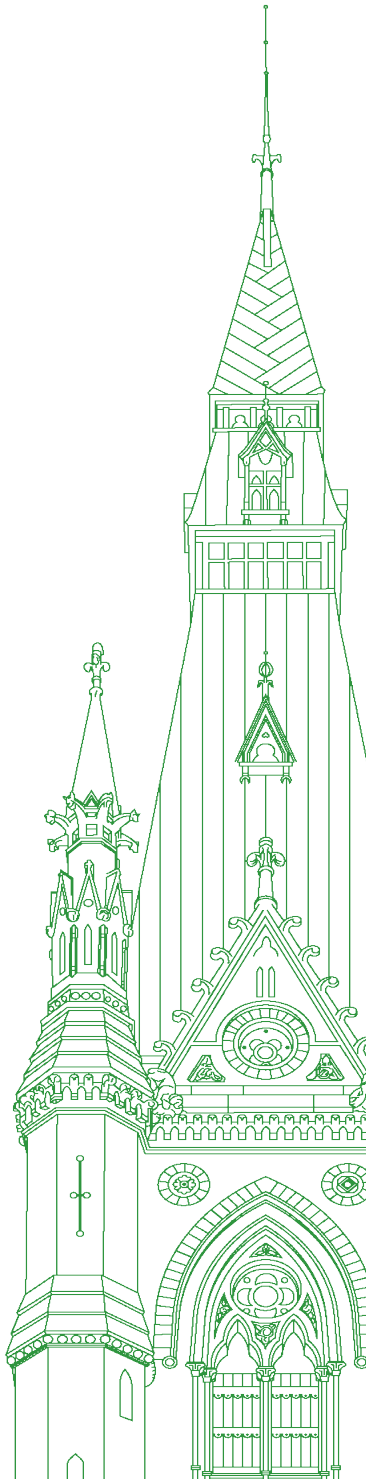

Chair: Mr. Sean Casey

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

Tuesday, June 1, 2021

● (1535)

[*English*]

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

Welcome to meeting number 37 of the House of Commons 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. The webcast will always show the person speaking, rather than the entirety of the 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 of the impact of COVID-19 on seniors.

I'd like to welcome our witnesses to begin our discussion with five minutes of opening remarks, followed by questions. Appearing today, as an individual, is Dr. Veronique Boscart, executive dean, School of Health and Life Sciences at Conestoga College; and from the Centre of Aging, we have Dr. Michelle Porter, professor and director at the University of Manitoba.

For the benefit of our witnesses, I will just make a couple of other comments.

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 you're not speaking, your mike should be on mute.

We're going to start with Dr. Boscart for five minutes, please.

Welcome to the committee. You have the floor.

Dr. Veronique Boscart (Executive Dean, School of Health and Life Sciences, Conestoga College, As an Individual): Thank you.

My name is Dr. Veronique Boscart. I'm going to start off by stating that I am a registered nurse. I've been a registered nurse in long-term care for over 25 years, and I've worked throughout the COVID-19 pandemic on good and bad days.

I'm also in my second five-year term of the CIHR/Schlegel industrial research chair for colleges in seniors care, which means that I hold a national research chair focusing on workforce, staffing and training related to those caring for seniors in our country. Within that portfolio, I conduct pragmatic intervention research to really optimize life and care for seniors and their families both in long-term care as well as in retirement and home care.

I also hold the role of executive director at the Canadian Institute for Seniors Care. With that group, we develop tailored training for the future and existing workforce in seniors care. Most of our work is focused in Ontario.

Last, I'm the executive dean at the School of Health and Life Sciences at Conestoga. There we have focused our strategic mandates on optimizing education and training, as well as innovation in research for our health care providers. We are very committed to raising and bringing into place a generation of health care providers who can recognize and address the needs of our seniors and their care partners in our community.

I want to thank you for the opportunity to speak to you today on the needs of seniors in Canada.

As you're aware, seniors age 65-plus are the fastest-growing population and are more likely to have chronic complex conditions and they [*Technical difficulty—Editor*] support from a health care team [*Technical difficulty—Editor*] communities. The COVID-19 pandemic really highlighted the gaps in our care system, so I think, unfortunately, Canada is the country with the highest mortality rate in long-term care homes. I can personally testify to the detrimental effect that has had not only on our country, but also on our workforce, our families, our loved ones and our communities. Now more than ever is a time to critically reassess the design and the way we provide our services for seniors, as well as how we are educating the future workforce on how we deliver current care practices to our seniors.

There are many reports available on that. I'm happy to provide more detailed information when answering your questions. There's never been a better time than now to really cause a change in our long-term care and health care systems.

I am more than delighted to contribute further, and I pass it back to the chair.

Thank you.

The Chair: Thank you, Dr. Boscart.

Next we are going to hear from Dr. Porter for five minutes, please.

Dr. Porter, you have the floor.

Dr. Michelle Porter (Professor and Director, University of Manitoba, Centre on Aging): Thank you for the invitation to speak today.

I am the director of the Centre on Aging at the University of Manitoba in Winnipeg. Our centre has existed since 1982 and is the focal point for research and knowledge mobilization on aging in Manitoba.

The first issue I would like to discuss is access to information and services specific to the pandemic. One example here includes the fact that most resources, information and booking systems, etc., have relied on web-based systems. Whether it was finding out about where testing locations were or when to get vaccinated, this information is typically provided as a website. In the short term, we need to ensure that access to information is available through the phone as well. Phone numbers need to be highly publicized, through COVID press conferences, for example. If you don't have access to the Internet, how do you find the phone numbers?

We applaud the federal government for providing funding to add a phone line to the Manitoba 211 services. This is a needed service in the short term.

In the long term, we need to find ways so that everyone has access to the Internet. This requires physical infrastructure. It also requires that everyone can afford the equipment and services, regardless of where they live and what their income is. Access to Internet is critical for long-term care as well. In many homes, Wi-Fi did not exist or was not sufficient, so including this in standards for long-term care would be important. Every resident room and common room in a long-term care home should have good Wi-Fi.

Another access issue that has been quite apparent is transportation. Age-friendly transportation and affordable resources are lacking in many locations, particularly intercommunity transportation. This has affected access to COVID testing and vaccinations. If aging in place is a goal for governments, then we have to ensure that communities are age friendly in terms of transportation.

One tragic story in Winnipeg occurred when a family had to pay for a stretcher service to bring their bed-bound father to a vaccination site. An age-friendly community would find ways to ensure that the environment can enable that person to live in a non-institutional setting and still receive services.

Another long-term care issue is related to quality of life. Clearly, there is not enough recreation staff in long-term care. These workers, primarily women, who are key to residents' quality of life, are often only able to find part-time and low-paid positions. We need to ensure that we think beyond the health care aspects of long-term care and provide much more in terms of social care, because these places are people's homes, not hospitals.

Overall, we need to ensure that all workers in long-term care receive the training they need, as well as the respect that they deserve through proper compensation for their vital roles. As we build back, we need to focus on the care economy and ensure that women from all backgrounds are not left behind.

The final issue I would like to introduce is the consequence of sedentariness during the pandemic. Many older people have moved very little for many months. This has implications for risk of falling, health and physical function. Post pandemic, we will need to ensure that programming and services will be available to respond. For example, we know that an individualized approach is critical for falls prevention. However, in Winnipeg, we have lost universal access to adult outpatient therapies because these services are not part of the Canada Health Act. This means there is reliance on private health insurance or paying out of pocket.

Similarly, access to therapy service is not sufficient within long-term care either and residents have experienced a dramatic reduction in their physical activity. Of course, we cannot forget about all of the individuals who will need to recover from COVID. We need targeted federal funds for appropriate therapies and physical activity programming to allow individuals to recover their physical health.

I would like to end by saying that the Government of Canada endorsed the global strategy and action plan on aging and health of the World Health Organization. The year 2020 saw the official launch of the Decade of Healthy Ageing by the WHO. Canada needs to ensure that, coming out of this pandemic, we are ensuring that older people are able to achieve good health in age-friendly environments that are free from ageism.

Thank you.

● (1540)

The Chair: Thank you.

We're now going to rounds of questions, beginning with Ms. Falk, please, for six minutes.

Mrs. Rosemarie Falk (Battlefords—Lloydminster, CPC): Thank you so much, Chair.

I would like to thank both of our witnesses for their time today and for contributing their expertise to our study.

Special thanks to you, Dr. Boscart, for your continued commitment to care for our seniors on the front lines throughout this pandemic.

Tragically, long-term care has been the epicentre of the pandemic. While the problems in long-term care aren't new—we know they're not new—they have been highlighted and heightened during this health crisis. We know the delivery of quality of care for our seniors depends on a skilled workforce.

Dr. Boscart, in the report that you co-authored, "Restoring trust: COVID-19 and the future of long-term care in Canada", it suggests that the priority in addressing long-term care should be to solve the workforce crisis. In fact, it says that if we do nothing else, we need to address staffing.

That report was released in the first wave of COVID, so it was a few waves ago. Would you say that it is still accurate to prioritize the workforce crisis in long-term care? Could you also share with this committee in more detail the existing challenges in the long-term care workforce?

● (1545)

Dr. Veronique Boscart: Yes, absolutely. Thank you, Ms. Falk, for that question.

First of all, I want to accept your thanks. It's a privilege for me to give care to our seniors, and it brings much happiness to me and many others. I see it as a great contribution to our country, to which I am an immigrant, and I feel very fortunate to be able to provide care to its elders.

From a long-term care perspective, indeed staffing is a major challenge, and it is not getting any better. Many nurses and personal support workers, or unregulated care providers and others, have gone through one or two COVID tests themselves—I was one of them—and a lot of us have become sick. In addition to that, a lot of us have not been able to carry on with double shifts and continuous work. Many of my colleagues have worked non-stop since the onset of COVID. At times that starts to weigh, so we are losing staff because they are burnt out.

In addition to that, we also know, and I think my colleague alluded to it, that we work with a workforce in long-term care that is mainly female. The majority of them are unregulated, and we know that those groups of people come from the cohorts or the environments that sometimes struggle with life. Many of them are immigrants. Many of them hold more than one job in order to pay the bills. They cannot take a full-time job in one long-term care home because there are no full-time jobs available. There is full-time work, but there are no full-time positions available.

As a result, they do not have sick leave or benefit plans, or a pension for that matter, and they have to take more than one position in order to meet the ends. [*Technical difficulty—Editor*] who really have to rush from one place to another and are not committed to one specific home. That leads to discontinuation of care, and that always affects the resident and the family negatively. That is one very big problem that we have.

In addition to that, moving into COVID, we also had serious shortages of staff in long-term care. [*Technical difficulty—Editor*] found that even if nursing homes were staffed to the best of their ability with all positions filled, we still would only give 60% of the care that is required to provide quality care. Canada has the lowest staffing recommendations across all of our western countries in mandatory staffing for long-term care homes.

As of today, in long-term care, we are short about 60% of registered nurses, 50% of registered practical nurses and about 20% of personal support workers. It is impossible to provide care if you do not have the people to provide the care. That's a very short, first main problem that I see happening in long-term care.

It's very difficult to attract my colleagues to long-term care, if I cannot guarantee full-time permanent jobs with a pension plan, sick leave or anything else, and where you will always work a double shift. It's very hard to do.

Mrs. Rosemarie Falk: Dr. Porter, do you have anything that you would like to add to that as well?

Dr. Michelle Porter: I would say that the situation is quite similar in Manitoba to what has been described in Ontario.

This issue of part-time work, not being paid well, is clearly not going to entice individuals to come to these positions, particularly not after everything we've seen during the pandemic. Long-term care facilities have been kind of left on their own to fend for themselves and their residents.

A lot more needs to be done in this regard, in terms of ensuring that we have sufficient funding levels to provide the compensation. This is clearly identified in the WHO report. This is an issue across all of long-term care, and also would apply to home care as well. People are just not being paid well enough for the important work that they do.

Mrs. Rosemarie Falk: What would either of you say is the greatest barrier to recruitment, then? Out of everything that was said or listed, what would be the greatest barrier to that recruitment and retention of staff?

● (1550)

The Chair: Answer very briefly, please.

Dr. Veronique Boscart: Pay.

The Chair: That was very succinct. Thank you.

Mrs. Rosemarie Falk: Thank you.

The Chair: Thank you, Ms. Falk.

Next we're going to Ms. Young, please, for six minutes.

Ms. Kate Young (London West, Lib.): Thank you very much, Mr. Chair.

Thank you to our witnesses for being here today. That is a very interesting discussion, of course, about the challenge of retaining nurses.

Sixteen per cent of nurses have said that they'll leave their jobs in the next year, and only one-quarter took time off to look after themselves. I think this speaks to the obvious issue that we have.

You mentioned the excessive shift work that many nurses are taking.

Dr. Boscart, do you have any indication of whether that would be more acute in private versus non-profit homes?

Dr. Veronique Boscart: The answer is probably not. My colleague Dr. Andrew Costa conducted a study to look at care levels and to look at some of the different quality aspects of care in private and not-for-profit nursing homes, and found that it's very similar. It's very difficult to attract staff to these environments, and the ones you have often feel that they're not well prepared; hence, the challenge we have in our educational system to prepare nurses better for what is to come and then provide them with strong orientation so they remain on the job.

Ms. Kate Young: Thus, it's not only pay; it's teaching. It's making sure that they have the skills that they need.

Dr. Veronique Boscart: Yes. Looking across Canada when we do a scan of all nurses—and this is very specific for the bachelor of nursing for registered nurses—we have looked at the content in their curriculum, and I am very happy to see there is still maternal-child education in there and trying to teach nurses how to help moms to breastfeed, which is absolutely necessary.

Ninety per cent of the people in our hospitals and nursing homes are over 85, so they receive additional care. Gerontology is not a mandatory component in our nursing curriculum in Canada, nor is it a specialism or something that people get paid for if they have an additional certification.

I know my colleague Dr. Porter has been a long-standing advocate at the Canadian Association of Gerontology to look at really enhancing the skills of [*Technical difficulty—Editor*], so if we do not prepare specialists, how do we provide excellent care?

Ms. Kate Young: Dr. Porter, could you comment on that?

Dr. Michelle Porter: Just to add to what's been said about the lack of gerontology or geriatric education, I think you will see that this exists in other professions as well, even though they might end up serving primarily an older audience. Even pharmacy programs and rehab programs, many programs out there do not necessarily have that specific training for older people. I think this committee has already heard about the lack of geriatricians in this country compared to pediatricians.

It certainly is an issue. It is challenging, I would say, at the university level when young students are coming in. They're not necessarily anticipating that they're going to work with older people, and that's across all health care professions, but certainly most are going to end up working with older people. We really need to ensure that there are positions out there for people and that they're well paid, as we've already discussed, and that we ensure that gets put into the curriculum of various health care programs, that it's in case studies and some of the interprofessional education that goes on so that teams of health care professionals are able to appropriately serve older people in the community.

Ms. Kate Young: You also, Dr. Porter, mentioned transportation. You said that if aging in place is our goal—and a lot of people now are questioning whether they'd ever want to end up in a long-term care facility—age-friendly communities are important.

What would you think we should do, as a federal government, to further that goal?

Dr. Michelle Porter: Well, the federal government is overseeing the age-friendly communities initiative across the country, although, of course, there's a large provincial jurisdiction over many of the services, which includes transportation. I'm not exactly sure what the role of the federal government is, and this is one of the issues that [*Technical difficulty—Editor*] involved in transportation, which includes municipalities. Municipalities really need support in providing these services, whether they're rural or urban communities. It is not a great scenario and we see stories in the paper where people are not able to get to vaccination sites, which is the main health care issue right now.

We're doing some projects right now in Manitoba. We did get some funding for them, but it all came about a bit too late. I think in general, within health care, there's a concept that someone will set up the appointments and hope that somehow people will figure out how to get to them. However, we've heard over and over again, when we've done consultations across the province, that transportation is a huge barrier for people when getting services, in particular with health care, and in being able to engage in their communities.

● (1555)

The Chair: Thank you, Ms. Young.

Ms. Kate Young: Thank you very much.

[*Translation*]

The Chair: Ms. Chabot, you have the floor for six minutes.

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

I want to thank both witnesses for their presentations. I must admit that several of the points raised resonated with me, since I used to be a nurse. I think that all the provinces are experiencing the realities described in terms of working conditions, compensation, attraction and retention.

In Quebec, we're quite proud of our achievements. At the height of the crisis, 10,000 personal support workers were hired. They're part of the care team for which we ensured increased compensation. It should be noted that labour laws fall under provincial jurisdiction.

This brings me to a question that [*Technical difficulty—Editor*]. Quebec and the other provinces have requested support for health care and social services. They have jurisdiction over service delivery, care organization, labour laws and regulations. The provinces have requested a significant increase in health transfers. As we know, 80% of health care spending is based on the workforce. To provide quality services, workers are needed.

Ms. Porter, do you agree that the federal government should transfer the money needed for health care to the provinces?

[*English*]

Dr. Michelle Porter: More funding is absolutely required across the board, although I'm not going to get into which jurisdiction should be providing those funds. We're all, as individuals, taxpayers and the money has to come from somewhere, but we'll need to see more funding in the system, in addition to the things we've already talked about.

We also know that many surgeries have been delayed. There are a lot of older people who need surgeries going forward, whether for cataracts or knee replacements, and there are even more dire situations right here in Manitoba with heart surgeries and of course with long-term care. I mentioned the therapies that are not necessarily available. Some people can't afford to pay for physical therapy to recover from COVID, for example.

Certainly a lot more funding is needed within the health care system going forward.

[*Translation*]

Ms. Louise Chabot: Ms. Porter, you have conducted several studies and made a number of observations regarding seniors.

In your experience, are there additional costs and expenses associated with illness that may contribute to increased stress and anxiety among seniors aged 65 to 75?

● (1600)

[*English*]

Dr. Michelle Porter: I'm sorry. Was that directed to me?

[*Translation*]

Ms. Louise Chabot: Yes.

[*English*]

Dr. Michelle Porter: Your question was around whether this whole situation has created more problems in terms of anxiety and mental health. Yes, certainly.

I wouldn't say that's across the board. I think it's a bit of a stereotype to think that all older people have fared poorly during the pandemic. I think we have some very resilient older people who have actually done quite well during this. They've had life experience. They've potentially gone through scenarios like this. I know a 96-year-old woman. She's not happy with the situation as it has been, but she has been quite resilient. She's had a lot of struggles in her life.

Certainly, there are older people who have suffered, particularly those who are on low incomes, who are disconnected from their communities or who are living in apartment buildings. They don't feel safe even leaving their rooms.

Yes, dealing with the mental health challenges that the pandemic has posed certainly will be a reality going forward as well.

[*Translation*]

Ms. Louise Chabot: In your opinion, Ms. Porter, are there seniors aged 65 to 74 who spend over 30% of their income on housing?

[*English*]

Dr. Michelle Porter: There are people on the low-income scale who certainly need more support. Any time programs are being designed for older people, I think it would make a lot of sense for those programs to be targeted to those who are in great need.

Again, there's a lot of heterogeneity in the older population in terms of their financial circumstances. There are many older people in that age bracket who are still working, for example, and who are still paying taxes, but there are people who are younger, particularly people who might have faced lifelong health challenges and things, who are not able to work, are in that lower age bracket and might not be very financially well off.

The Chair: Thank you, Dr. Porter.

[*Translation*]

Thank you, Ms. Chabot.

[*English*]

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

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

My first question is for Dr. Porter.

I'm sure you would agree that the treatment of seniors during the pandemic has been pretty horrible and less than adequate. Much of this has had to do with the poor conditions in long-term care centres and generally inadequate programs and systems for seniors.

I would argue that this is a clear indication of an issue of ageism that we certainly have in this country, and I think it's important that we root out these issues to ensure that all seniors can live with dignity and security. Can you tell us more about the role of ageism in the pandemic and how you would suggest creating societies and systems that don't perpetuate ageism?

Dr. Michelle Porter: That's a big topic, but an important one.

We saw right from the very beginning of the pandemic that ageism was seeping in, even by people who weren't likely intending to be ageist. We heard messages such as, “Oh, it's not that serious because it only affects older people.” There, we see the seeping in right away at the beginning, that it really isn't that concerning because it's not affecting everyone in society.

Implicitly, although we might not even realize it, even gerontologists can see it surfacing on occasions, that we have this differential thinking about people by their age. This is something that is pervasive in society, so it's not something that's going to be easily overcome.

I think you're correct in your assertion that in the fact that long-term care did not do well, there is certainly an aspect of ageism and ableism that existed, which was why they were kind of left on their own to try to fend for themselves.

One, we have to have an awareness campaign, to begin with, that this even is an issue, because most people in society realize that there are many forms of discrimination and they realize the harms from those forms of discrimination, but they do not understand [*Technical difficulty—Editor*] as a society. It also has implications for work. We've seen that, in many instances, older people might have lost jobs through the pandemic, and older people will likely have a harder time being hired again because ageism is also pervasive in hiring, training, and even in firing employees.

It is a huge issue for our society and I think it would be worthwhile for Canada, as a country, to join the WHO in combatting ageism. I understand that the National Seniors Council has this as one of its target areas, but I don't think we can underestimate how important this is. I think it also affects our students at the university and the topics they choose to study, because it is not seen as necessarily a good role to be in, in terms of looking after older people. Across the board, we have to try to overcome this.

● (1605)

Ms. Leah Gazan: As we know, during the pandemic, certain groups have been hit harder, and it certainly has shone a light on racial, gender, class and other inequalities that we have in society. These societal inequalities had lethal consequences for groups forced to live in poverty and in vulnerable situations. At the same time, I would argue that, in terms of the wealthy, many people were profiteering off the pandemic and getting richer. I've taken great offence to it.

Can you tell us about the pandemic's uneven effects across all social groups among seniors?

Dr. Michelle Porter: I don't have a lot of specific data that I can cite, but certainly we've seen in Winnipeg where there are lots of individuals who have food insecurity issues. Right now, in this third wave that we're experiencing, they're having to be provided with emergency kits, whereas, as I said, I hear about other older people and they are financially stable and are able to weather this quite well. People are taking up new hobbies. There is a great range of effects of this pandemic on older people.

There's a tendency to think of them as one group and having one effect, but certainly through the various community organizations that are operating within our communities, we hear about these divides, and even just by the fact of where people are living, the physical buildings in which they live. If you're living in a house, you most likely have a much better quality of life because you're able to come and go potentially without any fear that you're going to have a possibility of contracting the virus, as compared to—

Ms. Leah Gazan: Sorry. I have one second left.

Would you say it's difficult to give that assessment because there has really been no race-based data and gender analysis during the pandemic to give a clear response to that, and that it's needed?

Dr. Michelle Porter: Yes, I do, and—

The Chair: Respond briefly, please.

Dr. Michelle Porter: In a lot of aspects of the data, at least that we're receiving here in Manitoba, which I assume is filtering through federally, we might have race-based data, and we might have age-based data, but we don't have a lot of the more fine-tuned data across all individuals. Hopefully, we'll be able to see that as researchers and people will be able to study it.

Ms. Leah Gazan: Thank you so much.

The Chair: Thank you.

Mr. Tochor, you have five minutes, please.

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

I'd like to thank the witnesses for their presentations, for being here today and for the good work they're doing to understand what we're facing with such an important segment of our population.

We touched on aging in place and aging at home or living at home. Just to start off, I believe that after this, once we're on the other side of COVID-19, there's going to be an even larger percentage of seniors who aren't going to want to move into seniors housing. They are going to want to age in place. As much as I think there was probably a large demand before the pandemic, I think that afterwards there are going to be some lingering effects and some fear factors are going to creep into it.

Do you believe that this trend is accurate? Is that going to happen after?

● (1610)

Dr. Michelle Porter: I can answer that if you'd like.

Yes, I absolutely think that. In part, generationally, we see the age cohorts changing. Their lifestyles have been very different from that perspective, I think, even pre-pandemic, yes, in terms of even what families will encourage older people to do in terms of their living environments.

Clearly, that's going to have been affected by the pandemic. We hear in our studies, when people are talking about long-term care, that there is absolutely even more fear than there was in the past. There are going to be people who want to live in their own homes and in their own neighbourhoods. We need to really make sure that we are not just replacing long-term care living with caregivers becoming overburdened and them having to take everything on.

We need to make sure that we have more home care available, as well as a lot more community supports. There's a lot more than just transportation, but that's one that sometimes gets forgotten because when we say “age in place”, I think people think that the person's never going to leave that place. There are many reasons why people want and need to leave the place that they're actually living in.

Mr. Corey Tochor: Thank you.

One the concerns I have is what Canada will look like after this.

I'll carry on with Ms. Porter.

You brought up the delayed surgical care. In general, health care has been delayed for the last 16 months in so many cases. I'm very fearful of the state of finances in provincial capitals across Canada. There's a record amount of debt and the ability for provinces to provide health care going into the future is going to be very challenging.

If there are decisions to be made provincially, I'm concerned about the financial strength of the provinces to meet that challenge. I'm wondering if you have any idea if there's one segment of delayed care that we should be watching afterwards for seniors.

Dr. Michelle Porter: Oh my goodness, in terms of surgeries or therapies, there's a whole host.

If we think from a primary prevention point of view, that was what I was kind of trying to get at in my original statement around the physical therapies and exercise programming. I come from that background in kinesiology. It is a primary prevention means for so many different health conditions but, as I mentioned, many older people live in apartment buildings. They have barely moved at all through these various waves of the pandemic. I think a good place for some money to be spent is on primary prevention for falls and for making sure metabolic health is good. That would be where I would put some money after this pandemic or going out of this pandemic.

Mr. Corey Tochor: That's on the chronic side, but there are going to be emergency needs. I'm wondering if there are any statistics.

I won't say that it's from a reliable source, but there are concerns about delayed cancer diagnoses. We know that with a delayed diagnosis for patients, it's going to be a poorer health outcome. There's cancer and there's hypertension, which is a ticking time bomb out there. It is kind of related to the inactivity of some of our seniors. Is there no research that you know of or no statistics on what we are looking at afterwards?

Dr. Michelle Porter: In terms of one specific medical condition, no. I think it goes across all the cardiovascular...diabetes, cancer and so on. I would imagine there are issues with all of them.

Mr. Corey Tochor: Thank you very much.

The Chair: Thank you, Dr. Porter. Thank you, Mr. Tochor.

Next we have Mr. Long, please, for five minutes.

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

Thank you so much to our witnesses this afternoon. Again, your advocacy is very much appreciated.

I want to touch on isolation and mental health for seniors. Certainly, as politicians during campaigns, we all go door to door and we have one-on-one direct conversations. I would say without question that when I would leave the doors of seniors who were alone, who were isolated, was when I was the most shaken and concerned.

Certainly, as a government, we came forth with some things. We raised the GIS for low-income single seniors. We lowered the age of eligibility from 67 to 65. We're going to now raise the old age pension for those age 75 and older by 10%.

With respect to COVID, however, the pandemic itself has created challenges and exposed increased levels of need for direct government support during crisis for all Canadians but especially for seniors. We want to make sure and recognize the importance of ensuring that seniors are equipped with the mental health supports to combat the social isolation of being away from family and loved ones.

Can you both touch on the issues that have become more pronounced due to the COVID-19 pandemic with respect to mental health and isolation for seniors?

We'll start with you, Ms. Boscart.

● (1615)

Dr. Veronique Boscart: Yes, absolutely. One of the things I think we'll see come out loud and clear after doors open again and people [*Technical difficulty—Editor*] is dementia. I think a lot of that has been hidden. In addition to all of the delayed surgeries that need to happen, I think we'll find a lot of people who now have advanced in their dementia journey a lot faster than we expected. None of those diagnoses or treatments have started in a year and a half right now. I do think that this will be a significant problem.

Building on Dr. Porter's answers, I'll cite two things that really require our close attention and, hopefully, an investment. One is day programming within the community through an equitable, accessible approach where people who live by themselves in the community or with care providers can actually have meaningful activities. This is not only for the seniors, especially for those seniors who live with dementia, but it's also to help the care partners or the family members cope with everything that's going on.

We are expecting that all of these people are going back to work, and their loved ones, older loved ones, may have developed dementia. We know that those numbers are skyrocketing and are probably a lot higher than we think they are—one in 10 by 2036. All of those people will have to be left alone, and people will have to go back to work.

Mr. Wayne Long: Thank you .

Ms. Porter.

Oh, sorry, I thought you had finished.

Dr. Veronique Boscart: No problem.

The second component, and Ms. Porter can talk more about this, is to really get serious about providing financial, mental and health support for the caregivers. They provide the majority of care in our communities. In order for them to balance everything else, they will need support.

Mr. Wayne Long: Ms. Porter, could you give me some comments on that, please?

Dr. Michelle Porter: Absolutely. We certainly hear all the time about how burdened caregivers are, and when we've done consultations around the province of Manitoba, we've certainly heard that there's a lot of need for respite care. There just isn't enough respite care, and one can only imagine how challenging that has been because respite programs were closed during the pandemic.

In looking at the Canadian longitudinal study on aging, some of their data and some of the anxiety and mental health issues, it was actually some of the younger seniors who were experiencing some of the larger challenges. Part of that might be because of caregiving issues.

Caregiving is a huge issue, so on this whole idea of aging in place, we can't just be thinking about the older person. We have to do more to be thinking about the caregivers and coming up with inventive ways that others can help.

We're starting to try to find a home sharing program, where we can have students living with older people in their own homes and taking some of the pressure off of caregivers, not by replacing home care, not by replacing caregivers, but by providing caregivers with some peace of mind, both that there's someone in the home who could be helping the person and that they have someone that they can be talking to on a regular basis.

Mr. Wayne Long: Thank you.

The Chair: Thank you, Mr. Long.

Thank you, Dr. Porter.

[*Translation*]

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

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

My question is for Ms. Porter.

You said that the reality of seniors wasn't necessarily the same across the board, which I found intriguing. I understand that the reality of a 68-year-old senior, a 73-year-old senior or a 77-year-old senior may be different.

In terms of financial health, you said that observations can be made for certain age groups. Statistics show that some seniors decide to continue working between the ages of 65 and 74. In many cases, they do so because they don't have a choice. Their income is too low.

Do you agree with that? Do you have any statistics to share?

● (1620)

[*English*]

Dr. Michelle Porter: I don't have any specific numbers, but I know that the number of older people who are above 65 and are continuing to work is growing. That's a growing segment of the population who is deciding to continue to work. Yes, there are financial reasons for that, but there's a lot of people who do it because they find it very satisfying. It provides a lot of meaning to their life, so they want to continue to work.

There was an article about a 95-year-old lawyer. People are continuing to work. Unfortunately, due to the pandemic, I think we're going to see some people who will have to continue to work longer, particularly those who have put money into their small businesses to keep things going and they've taken from their retirement fund. I think there will be a phenomenon of people working longer in the future.

[*Translation*]

Ms. Louise Chabot: We're finding that family caregivers, both in public facilities for seniors and at home, play an important role. Many people aged 65 and over are family caregivers.

Do these people need to bear an additional financial burden because they're family caregivers?

[*English*]

The Chair: Briefly, please.

Dr. Michelle Porter: Yes, absolutely, they do.

Certainly, as we see more people living into their late eighties and nineties, many of their children who are in their sixties and seventies are potentially still working and also caregiving for their older parents. Yes, there are certainly out-of-pocket costs associated with caregiving.

[*Translation*]

The Chair: Thank you, Ms. Chabot.

[*English*]

Next is Ms. Gazan, please, for two and a half minutes.

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

My question is for Dr. Porter.

You mentioned that it's the UN Decade of Healthy Ageing. You spoke briefly about the World Health Organization's global action plan and strategy on aging and health.

Could you expand on that? Especially as you were speaking about ableism and aging, part of me feels that we need to start looking at what's happening to seniors in this country as a very serious human rights matter that needs to be dealt with.

Dr. Michelle Porter: Absolutely. There certainly are campaigns out there to have a UN charter on human rights for older people. The pandemic has bolstered the advocates for this even further, particularly given what happened in long-term care.

Canada did endorse this global strategy and action plan, but I'm not aware that we actually have a full-fledged plan for what Canada is going to do as a country. We see some things happening, as I mentioned, with the National Seniors Council around ageism, but there are other aspects of how we should be shifting our health care system as well. It's not focusing so much on acute demands and having all of our resources put into hospitals, but thinking about the chronic demands, as well as ensuring that people have good, functional abilities, which is what the definition of health is for the WHO.

We do need to have a concerted action through the federal government as well as all the provincial governments, because there are many things that cross jurisdictions. Municipalities are very involved. An age-friendly environment is a big part of this as well, making sure that our environments enable people to age well and to contribute still to their communities.

We have many older people who make great contributions. One thing that was a surprise to many in the pandemic was that older people weren't able to volunteer anymore. Some organizations, like food banks, relied on older people to keep those food banks going.

There are lots of ways we can work toward this decade of healthy aging as a country.

● (1625)

Ms. Leah Gazan: Thank you so much.

The Chair: Thank you, Ms. Gazan.

Dr. Porter and Dr. Boscart, I want to thank you very much for the work that you do, for your expertise in working with seniors and for being with us to share some snippets of that expertise today. It is extremely interesting and of great value to our study. Thanks again for being with us. We wish you a good day.

We have another panel joining us shortly. We're going to suspend for a few minutes while we do a sound check for them.

● (1625)

_____(Pause)_____

● (1630)

The Chair: I call the meeting to order. Today's meeting is a study of the impact of the COVID-19 pandemic on seniors.

I'd like to make a few comments for the benefit of witnesses.

Before speaking, please wait until I recognize you by name. When you are ready to speak, you can click on the microphone icon to activate your microphone.

Interpretation is available in this video conference. You have the choice at the bottom of your screen of floor, English, or French.

[*Translation*]

When speaking, please speak slowly and clearly. When you aren't speaking, your microphone should be on mute.

I would now like to welcome the witnesses to continue our discussion. They'll have five minutes to give their opening remarks. The members can then ask them questions.

Today we're joined by representatives from the Coalition pour la dignité des aînés: Lise Lapointe, member and president of the Association des retraitées et retraités de l'éducation et des autres services publics du Québec; Pierre Lynch, member and president of the Association québécoise de défense des droits des personnes retraitées et préretraitées; and Rose-Mary Thonney, member and president of the Association québécoise des retraité(e)s des secteurs public et parapublic.

● (1635)

[*English*]

From the Office of the Seniors Advocate of British Columbia, we have Isobel Mackenzie, seniors advocate.

[*Translation*]

We'll start with Ms. Thonney.

Ms. Thonney, I want to welcome you to the committee. You have the floor for five minutes.

Ms. Rose-Mary Thonney (Member and President, Association québécoise des retraité(e)s des secteurs public et parapublic, Coalition pour la dignité des aînés): Good afternoon.

The introductions have already been made, so I won't repeat them. I'm here today on behalf of the Coalition pour la dignité des aînés, a group of six associations representing over 150,000 seniors. My colleagues Lise Lapointe and Pierre Lynch, whose associations have already been mentioned, are here with me. They can answer your questions.

We're here to advocate for the priorities that seniors widely agree on.

The pandemic's toll has been particularly hard on the members of our associations. During this period, a number of them have experienced physical and mental health issues, but also significant financial pressure. The pandemic, coupled with a lack of action prior to this period, has left many seniors in a vulnerable situation.

The lack of health transfers to the provinces has resulted in an under-funded health care system. The impact on seniors' care is felt on a daily basis.

The coalition believes that increased health transfers to the provinces are necessary to improve the living conditions of seniors. Only 25% of the money allocated to long-term care is spent on home support. Only 3% of seniors in Quebec live in long-term care facilities. The rest live at home or in seniors' residences. In Quebec, 18% of seniors live in seniors' residences, compared to 6% in the rest of Canada. Seniors deserve more and better than this.

The past year's crisis has also affected the mental health of seniors. The plight of long-term care facilities and fears about the spread of COVID-19 have isolated the most vulnerable seniors and led to greater anxiety issues. A number of seniors are suffering from real mental health issues. Services are very difficult to access through the public system and very expensive in the private sector.

The coalition is also very concerned about the financial situation of seniors.

In its latest budget, the government announced a 10% increase in old age security benefits starting in summer 2022, along with a one-time cheque for $500 for people aged 75 and over. This isn't enough. It covers only a portion of vulnerable seniors. Nearly four out of ten people aged 65 and over rely on the guaranteed income supplement to make ends meet. These people deserve the same consideration as people aged 75 and over. The increase provided by the government must also be available to people aged 65 and over.

The income of a person aged 65 and over who just receives the old age security pension and the guaranteed income supplement amounts to only $18,000. This amount is well below the adequate income threshold. Moreover, there are people who receive only a pension that doesn't fully meet their needs.

We suggest that you establish a new financial allocation geared directly towards seniors who don't have enough income to live on.

The coalition is also proposing that you improve the medical expense tax credit and lower the eligibility threshold from 3% to 1.5% of the income for people aged 65 and over.

The government must do more to provide a decent income for seniors.

● (1640)

The benefits of these types of measures would be felt across the country and would have a positive impact on both the living conditions of seniors and the economy. Government investments in improving living conditions would be redistributed throughout the Canadian economy and would promote an economic recovery that includes seniors.

As you can see in its document entitled “38 solutions for the dignity of seniors,” the coalition provides many concrete and easy-to-implement proposals.

We're ready, and my colleagues in particular are ready, to answer your questions. Thank you.

The Chair: Thank you, Ms. Thonney.

[*English*]

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

The floor is yours.

Ms. Isobel Mackenzie (Seniors Advocate, Office of the Seniors Advocate of British Columbia): Thank you very much for inviting me to provide my insights on the impact of COVID-19 on seniors. I have to tell you that in my 25-plus years of working with seniors, I can honestly say that nothing has matched this past year for both moments of breathtaking despair and also occasions of spectacular inspiration.

We know that the nation has been focused on seniors in long-term care, and COVID-19 has revealed for all of us to see what life can be like for some who live in nursing homes. Canadians didn't like what they saw and very loudly told their governments that we need to do better. We are starting to see those commitments flow to long-term care from both our federal and provincial governments. That signals a brighter future, hopefully, but a caveat from somebody who's been around for quite a while is that these fiscal commitments need to be followed with expectations, and the expectations need to be able to be measured. Standards are only as good as their monitoring and enforcement.

We also need to remember that the changes are not going to happen overnight, and most importantly, they are not likely to meaningfully affect those who live in long-term care through the pandemic. We need to take stock of both the physical and the psychological damage experienced by current residents that has come from both their being terrified of a deadly virus and their being kept away from their family and friends and their normal routines.

We know that the rate of prescribing antipsychotics increased exponentially over the pandemic here in B.C. We saw an increase of over 10% in the prescription of antipsychotics. That is the highest annual increase that we have ever seen since we've begun measuring this. Here in B.C., we've wiped out all the gains of the past 10 years to reduce their use. We did that in a single year.

There are also going to be emotional scars on family members that may never heal. The pain for some of these family members from forced separation from their loved ones cannot be overstated, and we really do need to reflect on how our actions were inconsistent with our words and devalued the importance of connections with our loved ones in the last years of our life.

Perhaps most important as we focus on the future of long-term care is that we cannot forget that most seniors not only wish to live at home for the entirety of their lives but they do, and I'm following up on much of what Rose-Mary has spoken to very eloquently. Less than 20% of people over 85 live in long-term care in Canada. The vast majority of frail seniors need to be supported in the community, and those living in the community were also profoundly impacted by the pandemic. The rate at which a person is likely to live alone multiplies by a factor of four once you reach your eighties. The important human connections are found less at home than they are at the library, the recreation centre, the seniors centre, the bank or the grocery store. All of these were closed for long periods of time during COVID, and many struggled before COVID to be able to provide these connections. Staying at home was much more likely to mean being alone for those over 65, and it has revealed for us the importance of these community connections going forward.

The virtual connections that kept many of us going proved elusive for some seniors for a variety of reasons. For some, it was too difficult to become tech savvy at this point in their lives during COVID, but for many it was a cost issue. What COVID has highlighted, and Rose-Mary spoke to this, is how many seniors need to use their community supports because they don't have the income they need. A third of our seniors in Canada are living on the guaranteed income supplement, the GIS. In British Columbia, that means less than a minimum wage job. They are really struggling. This pandemic revealed that the $1,000 a year it costs for the Internet is just too much, so many found themselves cut off because they couldn't go to those recreation centres and seniors centres and get the access that they needed.

As we look to the future, we need to make sure that a person who goes into long-term care only does so after all community supports have been exhausted. If we use British Columbia as an example, we have tremendous work to do. In B.C., seven out of 10 admissions to long-term care were people who had no community home supports 90 days prior to their admissions.

We have a long way to go to maximize the potential of our home support and home care program in Canada. This is in part because it's fragmented in our federated model of delivery and looks very different in provinces.

● (1645)

Cost is a big factor. In my province we are subsidizing people in long-term care to the tune of about $60,000 a year, yet we are giving nowhere near that amount of money to assist people to live independently. Many of the costs that some of us don't associate with health care when people are in their forties, fifties and sixties become health care costs for people in their eighties and nineties.

I'll just conclude by saying that balancing the heartache of the past year has been the brilliant display of care, compassion and concern that Canadians have shown for seniors throughout this pandemic. We put up a number on a website for people to call if they wanted to help seniors and it crashed as thousands of British Columbians came forward to help. We saw that across the country, so we're not indifferent to the needs of those who are in the last years of their life. It's quite the opposite.

We need to find a way to harness this tremendous goodwill of Canadians to support aging with dignity. Hearings such as the ones you're holding today are an important first step.

I thank you for inviting me. I look forward to your questions.

The Chair: Thank you, Ms. Mackenzie.

We're going to proceed with those questions forthwith, beginning with Ms. Falk for six minutes, please.

Mrs. Rosemarie Falk: Thank you so much, Chair.

I'd like to thank all of our witnesses for their contributions to this study and making time to come to our committee meeting today.

Seniors living in long-term care have been at the centre of the health crisis and we know that no senior has been immune to the challenges that have been brought on by this pandemic.

My first question is for the Coalition pour la dignité des aînés.

Your organization released 38 recommendations to ensure dignity in living for seniors. How has COVID impacted the priorities and needs of seniors? Would these recommendations have differed before the pandemic?

[*Translation*]

Ms. Lise Lapointe (Member and President, Association des retraitées et retraités de l'éducation et des autres services publics du Québec, Coalition pour la dignité des aînés): Can I answer the question?

The Chair: Yes, absolutely.

Ms. Lise Lapointe: The coalition focused more on short-term and medium-term solutions that would alleviate hardship for our seniors. It took a crisis of this nature to expose many of the shortcomings that already existed but that had hardly been addressed, despite extensive investigations and research into the challenges faced by our seniors.

Abuse is still happening. Some would say that it's organizational abuse. However, the current issue is much bigger than previously suspected. That's why the coalition quickly took steps to ensure that our seniors are given a little more consideration.

It was necessary to send in the army, which reported degrading and disagreeable situations. This gave us a true picture of the situation of seniors living in long-term care facilities in particular, but also in seniors' residences. This is how we were able to elicit responses.

We're asking for better home support. The budgets never meet the needs of the people. Normally, there's a set amount of funding. However, after a while, there's nothing left. The needs that have come up in the past few months are barely or not being met. It's necessary to reinvest in home support.

It's important to consider that seniors play a role in society. Before, we rarely heard about seniors. They weren't necessarily mentioned in policies. The Quebec and federal governments didn't talk about the need to invest more in building repairs or in making sure that air-conditioning systems worked properly during heat waves. These matters weren't part of the discussions or among the issues raised.

A number of issues already existed. However, unfortunately, the situation deteriorated during the pandemic. We hope that the federal and provincial governments will listen to our requests.

The Canadian provinces could also benefit from certain federal measures, given the fact that seniors have a role to play, and it must be a prominent role.

● (1650)

[*English*]

Mrs. Rosemarie Falk: Thank you.

Ms. Mackenzie, I'm wondering if you want to add to that from your perspective. How have seniors' priorities and needs shifted through the pandemic?

Ms. Isobel Mackenzie: It's been over a year now, but in the beginning, as you will recall, there were shelter at home orders, so really it was about getting groceries, medications and meals to seniors. That sort of faded a bit, as what came to the forefront was what was happening in long-term care. That became a continued focus as family members continued to be separated from their loved ones for what will now be over a year. That shifted as well.

I do think the issues around the lack of supports in the community that were there before COVID certainly was revealed more starkly during COVID. I think that's a theme you'll probably hear quite frequently, that these are not problems created by COVID, but these were problems exposed by COVID.

Most of us knew of these problems. I would say for me what was new—or under-appreciated might be a better way of putting it—is the degree to which we heavily marginalize the role that family members play. We saw that in our approach to visits in long-term care. We really have a lot of introspection and soul-searching to do as a clinical community. Basically, we pushed families out of the way and said, "Let us do our job; you're a visitor." Different provinces dealt with it differently over time.

This issue around home care and supporting seniors at home I think is going to become more pronounced because, although the desire was there before, as we experience COVID, there is going to be even greater desire for people to stay at home. We need more federal level, and I don't know if leadership is the right word, but enforced standards and expectations around what people receive in terms of help at home.

● (1655)

Mrs. Rosemarie Falk: Thank you.

The Chair: Thank you, Ms. Falk.

[*Translation*]

Mr. Housefather, you have the floor for six minutes.

Mr. Anthony Housefather (Mount Royal, Lib.): Thank you, Mr. Chair.

I want to thank all the witnesses for their hard work to support our seniors. We're very grateful to them.

[*English*]

I am going to start with Ms. Mackenzie.

During the course of COVID, in my riding, I had numerous long-term care facilities where many, many people died. I had four facilities where over 50 people died. I watched facilities that were not only understaffed but underequipped in the sense that there were four people to a room where there should not be any more than one or two in today's society. I saw very well-meaning but underpaid and understaffed nurses and PABs. I saw families kicked out and caregivers who were meaningful and necessary to the patients kicked out. People died not only of COVID, but of neglect. It was a tragedy.

While this is within provincial jurisdiction, Ms. Mackenzie, you talked about enforceability of national standards and how they could be made meaningful. Could you talk a little more about whether or not you agree that national standards are important in this case and how they could be made meaningful and enforceable?

Thank you.

Ms. Isobel Mackenzie: I do think we need national standards, but as I said, the standards mean nothing if there is not enforcement and monitoring of those standards, so how is that meaningful? They have to be measurable, and there need to be consequences for non-compliance. Whether that is achieved by the mechanism the federal government already uses in health transfers—surgical wait-lists have to be managed a certain way, and provinces are not allowed to extra bill—would lead to financial penalties in the transfer payments from the federal government.

Those are levers that are available for the federal government to use that could push the provinces to demand better accountability from their care homes, whether they're operating them publicly or whether they've contracted with a private operator to operate them. I can't understate the importance of openness and transparency. The public wants this. They will drive this, and if it is known who's meeting standards and who's not, and where the money is going, I think the federal government will have the support of its citizenry.

[*Translation*]

Mr. Anthony Housefather: Thank you, Ms. Mackenzie.

Ms. Lapointe or another witness from the coalition can answer my questions.

I understand that, in Quebec, the issue of federal standards is more sensitive, even though we're working with the province. However, as a member of Parliament from Quebec, I believe that national standards are necessary in this area. I have two questions.

Does your organization agree with the national standards, even if they aren't included in the 38 priorities?

Is the $90 million in funding for home support, as promised in the federal budget, a good step when it comes to your priority of keeping seniors at home for as long as possible?

Ms. Rose-Mary Thonney: Can I ask Mr. Lynch to respond?

Mr. Pierre Lynch (Member and President, Association québécoise de défense des droits des personnes retraitées et préretraitées, Coalition pour la dignité des aînés): Of course.

We've had a hospital-centric health care system for a very long time. It has also long been predicted that more than 20% of the population will be over the age of 65 at some point. The demand for services and care will become quite different. Right now, a generation of seniors, the baby boomers, the people aged 75 and over, have suffered and died as a result of the pandemic in our long-term care facilities. This wouldn't have happened if we had been prepared.

We may have standards across Canada, not just in Quebec, but they mean nothing if no one implements them.

I often visit long-term care facilities because I know people who live in them. I can see that the department visits only every three years. In a public long-term care facility, the visits are more frequent. In a private long-term care facility, where the CISSS or organizations often rent places given the lack of space in public long-term care facilities, the visits are every five years. We may have very strict standards. However, if no one enforces them, the standards won't work.

Certainly, the lesson from the pandemic's first wave is that our long-term care services needed to be just as ready as our acute care services. This wasn't the case in terms of equipment, preparedness, training and the emergency response.

I witnessed the Canadian Armed Forces enter a seniors' residence here in Laval, where I live. At one point, among the 60 or so employees who work in that residence, 40 were sick with COVID-19. It took specialists such as members of the Canadian Armed Forces to go in and get things under control.

We aren't prepared to deal with pandemics. Moreover, this won't be the last pandemic. It's the first, and it's a good warning. We must be better prepared and more proactive.

We're at the vaccination stage. One major issue in Canada is that we rely too much on foreign countries for our expanded immunization program, our vaccines and our biotechnology development. We need to reconsider how we build our industries in Canada and encourage pharmaceutical companies to come back here.

I don't know whether you're aware of this, but right now, we depend on the vaccines that enter the country. If there isn't any vaccine, we don't vaccinate anyone. At the end of the day, I believe that this is about preparedness and thinking outside the box much more than in a traditional manner. Unfortunately, our health care systems are used to thinking inside rather than outside the box.

Thank you.

● (1700)

The Chair: Thank you, Mr. Lynch and Mr. Housefather.

I'll now give the floor to Ms. Chabot for six minutes.

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

I also want to thank Ms. Mackenzie.

I want to acknowledge in particular the Coalition pour la dignité des aînés. In Quebec, the six member groups of this coalition are making a big difference in the lives of our seniors, and their influence extends beyond the people whom they represent.

Thank you for being here.

My first question is for the coalition representatives who want to answer it.

You quite clearly stated what steps the federal government must take with regard to the increase in the old age security pension and the guaranteed income supplement. People must be able to access these benefits at the age of 65, because they already have needs at that age. The Bloc Québécois agrees with this idea.

However, in addition to these enhancements, what concrete and direct steps can we take to improve the financial situation of seniors? Do you have any other examples to share?

Mr. Pierre Lynch: I would like to respond on behalf of the coalition a second time.

Of course, we weren't at all pleased about the lack of consideration given to providing this increase to seniors aged 65 to 75, who need it as much as the others.

A new financial allocation could also be created to improve the living conditions of people with the lowest incomes. Some countries provide insurance for seniors, which may be called different things. As a result of this type of top-up program, people with an income of $18,000 could have a decent net income ranging from $24,000 to $32,000, depending on their city. The situation must be worse in Vancouver and Toronto than it is here. However, I can tell you that the cost of rent has risen dramatically in recent times and that this has negatively affected seniors in many ways. This would be a good first measure to implement.

The next step would be to improve the medical expense tax credits. Seniors are currently the main recipients of health care and they take many drugs. The eligibility threshold should be lowered from 3% to 1.5% for people aged 65 and over. This would provide some relief to the people most in need by ensuring a fairly significant reimbursement.

A number of companies have individual pension plans. Sometimes, for whatever reason, companies go bankrupt or become insolvent. A guarantee fund should be established to ensure that seniors can recover a portion of their pension fund in the event that the company where they worked uses the money for its own survival instead of treating the money as the former employees' retirement fund.

These are the three main measures that I have in mind.

Everyone would need a fairly significant increase in their old age security pension within a short time frame of two to three years. That way, the income of seniors could be increased from $18,000 to $24,000 quite quickly. This is necessary to ensure that these people can have enough money, not only to pay their rent, but to live decently.

● (1705)

Ms. Louise Chabot: Thank you.

My next question concerns health. The whole issue of home support is a hot topic in Quebec. Even before the pandemic, people were asking for proper home support so that they could stay at home.

That said, we shouldn't throw the baby out with the bathwater, should we? Our public facilities house the people who need more care. These facilities will always be needed.

In terms of home support, how could the federal government provide tangible assistance to the provinces?

Ms. Lise Lapointe: Let me respond and also add to Mr. Lynch's response.

Yes, seniors have a standard of living that normally is not acceptable. Many people have complained about the measure announced by the federal government saying that it is discriminatory. Why shouldn't a person under the age of 75 be entitled to the same amount and a substantial increase in their pension income called the old age pension? We get calls from people who complain and are unhappy with the situation. So that needs to be addressed.

Our seniors don't invest in tax havens, that's for sure. It's also a fact that when they receive additional money, they can afford certain activities that they normally can't afford. This generates economic spinoffs, often at the local level. So you can understand that receiving a little bit more money from the federal government would actually allow them to afford cultural activities, transportation, or a little treat in the week or in the month, something that they normally don't get.

With respect to home care, yes, there is progress to be made. For example, to encourage home care, there could be a grant for the renovation of housing that seniors occupy. Of course, there is a program to help people with disabilities or deteriorating physical health adapt their homes to their situation. However, the forms are so complicated to fill out and the wait is so long that people often have to live two or three years in a house that is not adapted to their needs. So they will choose to go to a private seniors' residence or to a residential and long-term care centre, or CHSLD. So that's another measure that the federal government could improve.

On the other hand, on the municipal side, there should also be agreements so that seniors have access to free transportation. This would make it easier for them to get to doctors' appointments and other appointments without the need for a caregiver or companion.

These are some examples of measures that would not cost astronomical amounts of money, but could make life easier for seniors.

● (1710)

The Chair: Thank you, Ms. Lapointe.

[*English*]

Next we have Ms. Gazan, please, for six minutes.

[*Translation*]

Ms. Leah Gazan: Thank you.

My first question is for the Coalition pour la dignité des aînés.

[*English*]

That is where my French will end, because I'm just learning French.

You spoke a lot about financial insecurity among seniors.

One of the things that I tried to champion after being elected was motion 46, for a guaranteed livable income for all, in addition to current and future income supports. One of my focuses, and I guess inspirations, is on much of what you said, that many seniors in Canada live in poverty and current benefits or guaranteed incomes are inadequate and sink seniors into poverty.

Do you believe that a guaranteed livable income—not survival, but livable income—in addition to current and future government programs of support are necessary to ensure that seniors can live in dignity in this country?

I will let one of you answer that.

[*Translation*]

Ms. Rose-Mary Thonney: Mr. Lynch, can you answer?

Mr. Pierre Lynch: Yes, of course.

Yes, such a program could make up for the lack of income, especially for the most vulnerable. About 33% of people currently live on the guaranteed income supplement, or GIS. At some point, they need supplemental income. Recently, my organization did a survey of its members. We found that among our 25,000 members, there were 4,500 caregivers. Do you see the connection?

That means that in our community, almost one in five people support another senior as a caregiver. There are costs associated with that, so they definitely need some supplemental income. Even though inflation is not very high, there is still a 1% to 2% loss in purchasing power from year to year. Unfortunately, the indexed increase in public and even private plans does not make up for this.

So this kind of program could be useful. For that matter, any program that raises the minimum income level for the most vulnerable seniors would be welcome.

[*English*]

Ms. Leah Gazan: Yes, I agree. I think we also need to start talking about the high cost of poverty. When you don't look after seniors by providing things like pharmacare and a good income, it impacts health and it costs in public health. I think there are a lot of cost savings to caring for people and making sure people can live with dignity.

You've written a lot about problems associated with Quebec's public long-term care centres, specifically highlighting the long wait-lists that force many seniors into private long-term care centres where there are lower standards across the board. From the working conditions to salaries, you listed a number of required changes to make sure seniors don't have to age in fear of insecurity and lack of care.

Can you tell us about what improvements to the working conditions of senior care are necessary? As the government develops national standards for long-term care, what standards would you like to see included?

Rose-Mary or Lise.

[*Translation*]

Ms. Rose-Mary Thonney: I will yield the floor to Ms. Lapointe.

● (1715)

Ms. Lise Lapointe: Standards should indeed be set across Canada and should be maintained and monitored by the provinces. These standards should establish a quality that does not currently exist.

The working conditions of people who work with the most vulnerable should be changed. There is a need for more staff, better wages, and more personal support workers—people who provide some support. The presence of family caregivers is also needed. We saw during the pandemic that people [*Technical difficulty—Editor*] who were normally recognized were denied entry, which created isolation.

I would like to add that caregivers and family members have had to deal with grief. It's going to take several years to get over these bereavements, because these people have been cut off from the older person they loved and helped and have not been able to get to their bedside. In some cases, the funeral has not yet taken place. Imagine the lingering loss of that person and the grief that follows.

I do think that working conditions need to be considered in the case of people who care for vulnerable people in residential and long-term care centres, or CHSLDs, hospitals and private seniors' residences, or RPAs. In Quebec, bonuses were given during the COVID-19 pandemic, but if these bonuses disappear, salaries will be even lower. Because the working conditions are so bad, this is not a profession that people want to work in. So they're not going to work in those environments.

People will have to be recruited, trained and, of course, well compensated. There will also have to be managers in every facility. We have heard of cases where managers were not present, often creating negative or disastrous situations. It is important that there be someone in each facility who is in charge, who can give directions, and, to use a familiar phrase, keep an eye on things. This person must also be able to make requests for their facility if necessary.

The Chair: Thank you, Ms. Lapointe.

[*English*]

Thank you, Ms. Gazan.

Ms. Leah Gazan: Thank you so much.

The Chair: Next is Mr. Vis, please, for five minutes.

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

I'll be splitting my time with MP Mazier.

Ms. Mackenzie, thank you so much for appearing before the committee today. A lot of your words really resonated with me as a British Columbian MP.

One thoughtful point that I took from your opening testimony was you said thousands came forward to help seniors. During our committee, we hear a lot about what the government can do and how much more funding would result in better outcomes on *x*, *y* or *z*, but we don't often talk about the role civil society and volunteers can play and want to play in our communities, and some ways that the federal government might be able to help them.

Would you have any recommendations for us about how communities can better engage civil society, those service organizations, people who want to make a difference to help seniors live their best lives, especially those who are in long-term care, or seniors who are not in long-term care and just need assistance?

Ms. Isobel Mackenzie: I think it starts by really understanding and respecting the contributions they can make. If you look at long-term care, we didn't value the contributions that families could make. We didn't turn to families and ask them to help us manage the care for their loved one in long-term care. We shut them out.

When we look at the community, what the pandemic has done—I live in the part of B.C. where we're worried about earthquakes—is that at the end of the day in many types of disasters, the professional help is not what is going to get you through the day and the next day; it's the neighbour across the street, or in the building. Investments need to be made in promoting those relationships and enhancing those networks.

Emergency preparedness for earthquakes, as an example, is something where it ebbs and flows. We get excited about it and we focus on it, and then our attention wanes just like, frankly, preparing for a pandemic. We get excited about it. We pay attention to it, and then our attention wanes and suddenly we find ourselves unprepared for a pandemic.

We need to recognize that there has been lots of tragedy, lots of loss—

● (1720)

Mr. Brad Vis: Thank you. We're so short on time, but thank you so much.

Over to you, Dan.

The Chair: Mr. Mazier.

Mr. Dan Mazier (Dauphin—Swan River—Neepawa, CPC): Thank you, Mr. Chair.

Thank you, Brad, for sharing your time.

Thank you to the witnesses for the great testimony.

I want to bring something to your attention that I believe is important.

Many seniors cannot navigate through confusing government websites. Some do not even have Internet access due to the rural connectivity divide and affordability concerns. Many seniors in my riding rely on physical government offices to get the support they need. However, the government closed the doors to many offices such as Service Canada. This resulted in Canadians phoning government departments and agencies such as Service Canada and the CRA to get the support they needed.

An Order Paper question I submitted revealed that in April 2020 there were nearly six million calls to Service Canada call centres that were unable to even make it to the interactive voice response automated system. The Canadians who did make it through had to wait an average of two hours that month. In January of this year there were over 120,000 calls that hung up while waiting to get hold of the pension call centre. In February, there were over 135,000 and in March there were over 160,000 calls that had to hang up on the same pension call centre.

This question is for Ms. Mackenzie.

Do you believe that this is an issue for seniors, and how do you suggest the government address these accessibility concerns?

Ms. Isobel Mackenzie: I think the issue of how seniors access services, period, is an issue not just for the federal government but also for many private companies. Things are moving online. You have to get your bills electronically, etc. We need to understand that there is a group of people who are going to be left behind as we move toward that digital platform. We certainly saw that in COVID, because they can't navigate the system or they don't have Internet either because they can't afford it or it's not available. We do need to recognize that.

I think issues around overloaded call centres and waiting on the phone for long periods of time plagued everybody, not just people over 65. I think what's important and where the federal government can play a role is to recognize that for whatever necessary services a person might need—utilities, banks, etc.—that are federally regulated, they ensure the ability remains for some people to make connections other than through an online connection. For example, regulating that compulsory paperless isn't legal in federally regulated businesses would be helpful for seniors. They find that frustrating, and it has a whole corollary around fraud abuse as other people have to navigate online platforms for people.

When you look at seniors proportionately, they are less likely to be tech savvy than younger generations. Whether that changes in 30 years with the tech savvy cohort becoming seniors will remain to be seen, but the 85-plus of today, yes, lots can engage in Facebook and online and all the rest of it, but many can't, and we are leaving them behind a bit.

The Chair: Thank you, Ms. Mackenzie.

[*Translation*]

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

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

I want to thank the witnesses wholeheartedly. I think we have the same mission, to improve the lot of those who built our country.

My first question is for Mr. Lynch from the Coalition pour la dignité des aînés.

In the presentations and in the rounds of questioning, there was a lot of talk about financial health, but almost no mention of issues related to mental health, physical health and isolation.

Mr. Lynch, you have a great deal of experience in the area of retiree and pre-retiree rights. I'd like to hear your thoughts on how to combat elder abuse.

The majority of Canadians and Quebeckers believe that elder abuse is hidden and invisible. In reality, elder abuse is present in CHSLDs, as we have seen, and just about everywhere in daily life. It is often family members or caregivers who abuse seniors physically, mentally or financially.

How can we foster safe relationships? How can we prevent violence, including abuse, against older adults? Do you think government investments are a good step in addressing elder abuse? What other ways can the government improve the lot of seniors?

● (1725)

Mr. Pierre Lynch: Thank you for your question.

Personally, I believe that we need to continue the information campaigns for the general public, to raise awareness of the importance of the phenomenon of abuse and maltreatment. It is important to continue these campaigns. These can be televised or not; the important thing is that everyone see them.

Education is also an important component. We talked about the next generations; it's important to educate them, so they know about this phenomenon. I will go even further: we must also educate the cultural communities. In Laval, there are 112 cultural communities. It is important to go to the different cultural communities and to make people aware of the abuse. Very often, elder abuse takes place within families.

More information needs to be provided. The more information people have access to, the more awareness they are going to have about this problem. Then there will be less abuse and mistreatment.

Mr. Stéphane Lauzon: Thank you very much.

Ms. Mackenzie, you talked about aging with dignity. People want to stay at home as long as possible. As you mentioned, the pandemic brought out the desire of seniors to stay at home as long as possible, which is completely understandable. The people who were most vulnerable were those staying in long-term care facilities.

As we know, seniors do not necessarily have the supports they need to stay at home. The government has invested $90 million over three years in the new aging with dignity at home initiative to do just that. As a result, there will be services to assist and support seniors, such as home or lawn care or grocery delivery.

Do you think this is a good initiative? What could be better than investing in organizations that help our seniors?

[*English*]

Ms. Isobel Mackenzie: Yes. I think it is a good investment.

If you visualize this continuum of aging, people don't start out immediately needing total help. It's an incremental process as we age. We need a little help around the house with some housekeeping, some groceries, some meal preparation, and then we start to need some care. It's really at the care-needing level where it is possibly going to tip over into long-term care.

When you ask what more can be done, when we're looking at trying to ensure that people can stay at home and not go into the nursing home, yes, the independent activities of daily living, the IADLs, are important, but it becomes critical to have the care for the activities of daily living as well: the bathing, the feeding, the helping to the toilet, medication management. That's where we're coming up short, in part because, in the federated model, the federal government gives money to the provinces and the provinces decide what the province is going to cover for you. You have a hodgepodge. Some people include housekeeping, some people don't, and also what they charge for it.

In B.C., we charge quite a bit for our public home support. A person living on $28,000 a year, who needs a one-hour daily visit, is going to pay $8,000 a year for their public home support. In Alberta, it's free. In Ontario, it's free. In Quebec, there is a fee for it, but it's rebated a bit through income tax, and it's the same, I think, in Manitoba. It's all over the map. I think there is a role for the federal government to play in saying that, as a Canadian citizen, these are the services you are entitled to receive from your government at home, and this is how much you are expected to pay based on your income. It should be the same, and it's all over the map.

● (1730)

The Chair: Thank you very much, Ms. Mackenzie. That's probably an excellent place to leave it.

We have arrived at the appointed hour. Although we'd love to continue this discussion, we won't have the resources that we need to extend the meeting, so we have to wrap it up.

It has been an excellent and thorough discussion.

[*Translation*]

We greatly appreciate your statements, expertise and work in your respective provinces. Thank you very much for being with us and sharing your testimony with us.

[*English*]

Thank you so much to everyone.

We are now at 6:30, so we'll have to adjourn for the day, but we are very grateful to you for your contribution to the study.

Thanks to everyone.

The meeting is adjourned.