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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): I'll call the committee to order.

I want to welcome our witnesses. It's great to have you here today. As you know, we're studying the chronic diseases related to aging. And with our aging demographic in this country, I think it's a very timely presentation. So we very much welcome your input here.

From the Active Living Coalition for Older Adults, we have Patricia Clark, national executive director. Welcome. I'm so glad you're here.

From the Canadian Association of Retired Persons, we have Susan Eng, vice-president of advocacy. It's great to have you on our committee, Susan.

With her, we have Michael Nicin. Michael is a government relations and policy development officer. That's a long title, but an important one. Welcome, Michael.

From the Canadian Institutes of Health Research, we have Yves Joanette, scientific director, Institute of Aging. Welcome. I love your bow tie. You've given us a new level of decorum and whatever, here in this committee.

And we have, from the Fédération des aînées et aînés francophones du Canada, Jean-Luc Racine, executive director. Thank you so much. I have three older adult children who speak impeccable French; unfortunately, their mother still struggles with it. But welcome, and thank you very much.

We will begin with Patricia Clark from Active Living. There will be a ten-minute presentation, Patricia, and then we'll go into the Qs and As.

Go ahead. Thank you.

Ms. Patricia Clark (National Executive Director, Active Living Coalition for Older Adults): Thank you very much. Thank you for the opportunity to speak to you today on what we think is certainly a very important concern for older adults.

I'm here today speaking on behalf of the Active Living Coalition for Older Adults, also known as ALCOA. We have nothing to do with the aluminum company; there's some confusion over that one.

We are a national charitable organization. We were incorporated in 1999. We strive to promote a society in which all older Canadians are leading active lifestyles that contribute to their overall well-being. Our statistics show that approximately 60% of older Canadians are inactive. These inactive older adults are unable to realize the health benefits of active living.

ALCOA is in partnership with its member organizations that include 24 national organizations and 35 local or provincial organizations. Within each of their mandates they support and promote the importance of staying physically active. We encourage older Canadians to maintain and enhance their well-being and independence through a lifestyle that embraces physical activity and active living—hence the name Active Living Coalition.

We have several goals, but some of the goals that apply to this particular session relate to increasing public awareness of the benefits of active healthy living; supporting and encouraging older adults to embrace an active lifestyle by providing resources and social supports; and identifying, supporting, and sharing research priorities.

The membership of ALCOA is very strong from the research perspective. All of the resources and documents we produce are based on the current research and evidence of the day. This discussion today, as Joy Smith was saying, is so vital. As you may know, the statistics show that by 2016—less than five years from now—the number of individuals over the age of 65 will outnumber those under the age of 15. This has never happened before in the demographics in Canada.

We know that the population is aging. With this significant shift in the increase in the demographics of older adults, it is also essential that we shift our thinking to prevention. That's not to say that youth are not equally important and worth our time and energy, but the sheer volume of Canadians in this age group definitely demands significant attention.

All of ALCOA's research is based on the evidence of today. We have created several resources for both older adults and practitioners that relate to a variety of chronic diseases. I have included some of the documents we have produced in the package you have with you.

Many times I do presentations, and when I speak with older adults about chronic diseases I talk about them as the good-news and bad-news story. It's both good news and bad news, because the research shows that for many people, many of these chronic diseases are lifestyle diseases. The bad news is that people have acquired these lifestyle diseases because of the choices they have made. For whatever reason, they've made those choices, whether it's through lack of physical activity, food choices, or choosing to smoke. That's the bad news. The good news is that because these are lifestyle diseases, these and other diseases can be prevented or better managed if the older adult adopts a healthier lifestyle.

Specifically, these diseases include diabetes, cancer, heart disease, and strokes. The research reviews also show us that physical activity can help prevent the onset of or better manage diseases such as Alzheimer's, osteoporosis, and arthritis.

We all talk about this magic pill. The magic pill we need to take to stay healthy is simply to adopt an active healthy lifestyle. Obviously this is a lot easier said than done, based on the statistics of older adults living with chronic diseases. In a recent survey done by the Victorian Order of Nurses, VON—they provide in-home care to elderly people across Canada—their report shows that their clientele have an average of not one, but 3.5 chronic diseases each. So they're not just dealing with diabetes; they may be dealing with hypertension, arthritis, and Alzheimer's—quite a plateful of issues.

● (1535)

ALCOA, along with many other research organizations, have conducted research to better understand the barriers for older adults to adopt a healthier lifestyle. What we have found, unfortunately, over ten years is that the barriers do not appear to have changed. These may or may not be new to you, but some of the barriers include things such as accessibility: the issue of transportation and being able to get to a class, the times that exercise classes might be offered. Is it safe for them to even get to a class or a community centre?

There is the fear of the program and whether they are going to hurt themselves. They are very afraid of falling or taking a class that is inappropriate for their level of ability. Is it suitable for them?

Cost is an issue, whether it's the transportation cost to get there or simply being able to afford to pay for the class. Another barrier is psycho-social support. This has to do with motivation and social interaction. This is very important because of all those other tangible barriers to accessibility. So if transportation, cost, and safety are removed from the equation, if an individual is not motivated to adopt a healthy lifestyle, removal of the barriers is really irrelevant because they won't want to go anyway.

Another key factor that really needs to be addressed first and foremost when we are considering prevention and management of chronic disease is the issue of mental health. From what the research shows, if you do not address mental health as the first concern, there is no need to address the other chronic diseases, because an individual with mental health concerns is not going to have very much interest in their other health concerns. So we need to look at mental health as the first and foremost issue when dealing with either prevention or management of chronic diseases.

In September 2006 a paper was produced for the federal, provincial, and territorial committee of officials for seniors, and it was called “Healthy Aging in Canada: A New Vision, A Vital Investment”. I want to take just a moment to read two paragraphs from this very large document, which I think are critical to our discussion.

> Today, older Canadians are living longer and with fewer disabilities than the generations before them. At the same time, the majority of seniors have at least one chronic disease or condition. Our health care system primarily focuses on cure rather than health promotion and disease prevention. Redirecting attention to the latter is required in order to enable older people to maintain optimal health and quality of life.
>
> The evidence is clear. Older adults can live longer, healthier lives by staying socially connected, increasing their levels of physical activity, eating in a healthy way, taking steps to minimize their risks for falls and refraining from smoking. But there are real environmental, systemic and social barriers to adopting these healthy behaviours. Some relate to inequities as a result of gender, culture, ability, income, geography, ageism and living situations. These barriers and inequities need to be and can be addressed now. Through a combination of political will, public support and personal effort, healthy aging with dignity and vitality is within reach of all Canadians.

The document then goes on to discuss how we can achieve this new vision for healthy aging in Canada by addressing supportive environments, mutual aid, and self-care. It's one very important document that is reinforcing the need for older adults to remain physically active.

In addition to this report, more recently at the 66th session of the United Nations General Assembly, a resolution from the high-level meeting of the General Assembly on the prevention and control of communicable diseases was introduced and adopted on September 16, 2011. So it's really hot off the press a month ago. What is of significance to note is that physical-activity-related solutions are prominent throughout the UN resolution. Out of a very lengthy document, I've taken just a few statements to highlight this point.

● (1540)

They acknowledge the global burden and threat of non-communicable diseases and that it constitutes a major challenge. There is a profound concern that non-communicable diseases are among the leading cause of preventable morbidity and of related disability. We must reduce the risk factors and create health promotion environments. We must engage all sectors of society to generate effective responses for the prevention and control of non-communicable diseases. We must strengthen the capacity of individuals to make healthier choices. And most importantly, prevention must be the cornerstone of the global response to non-communicable diseases.

To inform and educate older adults is the first step to prevention and better management of chronic diseases. Addressing the determinants of health is also critical to develop policies that will provide equitable—

The Chair: Ms. Clark, you're over your time. I've given you quite a bit of extra time. Could you sum up now?

Thank you.

Ms. Patricia Clark: That's not a problem.

We must look at the determinants of health, and I think there is no question that the research and evidence unequivocally confirms the urgency to address the disease prevention and management of older adults. And certainly ALCOA has a reach through our membership and through our partners. We can reach over one million older adults in Canada, and we would like to work with the government.

Thank you very much.

The Chair: Thank you very much.

Ms. Eng.

Ms. Susan Eng (Vice-President, Advocacy, Canadian Association of Retired Persons): Thank you very much, and thank you on behalf of CARP, a national non-profit, non-partisan association of about 350,000 members across the country. We have 50 chapters now across the country. We advocate for public policy changes that improve the quality of life for all Canadians as we age. And health care, of course, for our members and for all Canadians, remains a top priority, but it matters more as we age.

Despite the fact that today's generation of older Canadians are living longer, healthier lives, the likelihood of developing chronic disease increases with age. The prevalence of chronic conditions that particularly affect older Canadians is in fact increasing. The impact of chronic disease on the health care system is expected to increase substantially. The population as a whole is aging, especially as the baby boom generation moves through the senior years.

The real cost drivers in the formal health care system are the escalating costs of treatments as well as of drugs, and also the increased usage by healthy as well as by chronically ill Canadians. But if nothing is changed now in how we deliver health care, the current system may indeed be unsustainable—not, as some would have it, because we are aging, but because of the way we are structured.

The Canadian health care system serves Canadians well for acute care but is not mandated to provide continuing care for those with chronic diseases for which medicine has no cure, by definition. That responsibility, which we would call quality-of-life care, falls to informal caregivers and the home care sector, which is at best a patchwork across the country. So CARP is calling for a three-part approach. First would be a comprehensive home care and caregiver support strategy to deal with people who are now taking on home care and caregiver responsibilities. Second, we have to ensure access to primary care and drug management. And finally, as has already been focused on, would be prevention and health promotion.

Home care was recognized as the next essential service in the Romanow report, which recommended that the massive home care transfers to the provinces be used to support medically necessary home care services and that the federal government provide direct support for informal family caregivers. Despite this and the billions of health transfer dollars since, there is not to this day a comprehensive home care and caregiver support strategy that applies nationally, and there should be.

An estimated 2.7 million Canadians provide the equivalent of $25 billion a year in caring for their loved ones at home. A quarter of those caregivers are seniors themselves. Women are more likely to be caregivers and are more likely to be the ones who have to leave the workforce in order to provide round-the-clock care.

Apart from some modest tax measures, albeit much improved by the recent federal budget, and compassionate leave, there really is no national policy addressing the needs of informal caregivers. Home care services are a provincial jurisdiction, and there are also no national standards of care or certification. Yet the vast majority of Canadians want to stay in their own homes as long as possible, even if they have medical challenges. Not only does this improve their health outcomes, but it keeps them among their family and friends, all of which adds to their quality of life.

This is good social and health policy, but it's also good fiscal policy. A well-integrated and successful home care strategy has the potential of diverting massive amounts of demand from the formal health care system. Home care is 40% to 75% less costly than institutional care.

Finally, not only is a comprehensive home care and caregiver support strategy good public policy, it also makes good political sense. CARP, as some of you might know, polls its members regularly. We have an online newsletter that reaches 85,000 e-mail addresses, and we poll them every two weeks. Some 2,000 to 5,000 members answer our polls, often in the course of a weekend, and we poll them on our various advocacy priorities. Consistently, they rank caregiver support and home care strategy as a top priority. They say that a party stand on caregiver support and home care would change how they would vote. They rated the campaign promises in the recent federal election for us and they especially appreciated the refundable tax credits that were proposed by the opposition. They did, of course, appreciate the increase in caregiver support in the budget, but they appreciated the comprehensive nature of some of the platforms, and they want the new government to improve on even their promise by adopting some of the other recommendations that were on offer.

● (1545)

Just this weekend, some 25,000 members gave us their views about how best to support family caregivers and to improve the availability and professional competence of home care workers. They recommend better pay and accreditation, and help with improving the work of home care workers and financial support for family caregivers, particularly those who are taking on full-time responsibilities.

So CARP recommends that the federal government take the lead in the upcoming negotiations for the new health accords to promote a nationally coordinated home care strategy that ensures national standards of care with stable and sufficient funding, and supports the work of informal caregivers. This support could be accomplished by establishing a new designated federal home care transfer, to guarantee a basic level of home care services to all Canadians wherever they live, explore the feasibility of long-term care insurance, develop and invest in programs that allow more Canadians to age at home, and build upon the recognition in this recent federal campaign of the value provided by informal caregivers by ensuring a three-part strategy. This strategy would ensure that there is targeted financial support, especially for caregivers who provide heavy care, provide workplace protection and work leave, and integrate caregiving with the formal health care system through training, support, information, and respite care.

Access to primary care, especially geriatric care, is a huge concern. In fact, about four million Canadians do not have access to a family doctor. We haven't looked at the numbers precisely, but many of those four million will be seniors. Less than half of seniors with chronic conditions report that their doctors actually review their medications with them or explain the potential side effects. So that is a level of care that is needed, and 6% of those with those chronic conditions particularly focused on aging, such as heart disease, high blood pressure, diabetes, and arthritis, reported not having a doctor at all.

Seniors with chronic conditions who take at least five medications are twice as likely to experience side effects as those taking fewer medications. And here's the kicker. There are approximately 200 geriatricians now practising in Canada, about a quarter of what is needed, according to an estimate by the Canadian Medical Association.

So CARP recommends that the federal government take the lead again in the upcoming health accords to promote universal access to comprehensive primary care by providing incentives for doctors, nurses, and nurse practitioners to practise in under-served communities, to improve drug assessments, to ensure the quality and safety and costs of drugs, especially those taken by seniors, and to promote the study and practice of geriatric medicine.

Prevention is something that has been covered so I won't get into it other than to say that we support the premise that according to the Center for Disease Control, 40% of chronic illnesses are preventable, even among seniors. So we encourage and support the recommendations there. We would add our own including a focus on healthy food strategies, vaccination, and healthy living.

I have one last word that I will leave you with. It is not contained in our formal submission, but I'd like you to listen to it. It comes from the *Los Angeles Times* just this morning.

> What if a new medication for severely ill patients had no role in curing them but made them feel much better despite being sick? Let's say this elixir were found to decrease the pain and nausea of cancer patients, improve the sleep and energy of heart failure patients, prolong the lives of people with kidney failure, drive down health care expenditures and ease the burdens of caregivers.
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> Those are the promises of a fledgling medical specialty called palliative care—not a new drug but a new way of treating patients who are living, often for years, with acute or chronic Illnesses that are life-threatening.
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> If palliative care were a pill, government regulators would very likely approve it for the U.S. market. Federal health care insurance programs would quickly agree to pay physicians and hospitals for treating patients with the new therapy. And patients would make it a blockbuster drug in no time flat.

End-of-life care is part of the quality-of-life care continuum and remains an unmet need in the Canadian health care system.

Thank you for your focus on one of the most important challenges to our quality of life as we age, and for the opportunity to have input to your recommendations.

Thank you.

● (1550)

The Chair: Thank you, Ms. Eng.

We'll now go to the Canadian Institutes of Health Research. Yves Joanette, please.

[*Translation*]

Dr. Yves Joanette (Scientific Director, Institute of Aging, Canadian Institutes of Health Research): Madam Chair, members of the committee, thank you for inviting us to discuss the health care challenge of the growing number of cases of chronic diseases we are seeing in Canada today and, particularly, the link between chronic diseases and our aging population and the even larger aging population we'll have in the years to come.

Canada is an aging country and is already among the oldest in terms of its population.

[*English*]

Life expectancy at birth in Canada is about 81 years old now, a little bit less for males than for females. Our life expectancy in Canada is greater than in the United States by nearly two years. It's greater than in the United Kingdom by a year, more or less similar to Germany and France, but still nearly two years less than in Japan.

At 65 years old, our life expectancy is approximately another 20 years. The most dramatic change is seen among the oldest old. The real achievement, however, will be to transform all these extra years into healthy extra years.

This is not yet the case. The current figures indicate that the proportion of healthy life is about 86.3 and 88.8 respectively for women and men in their lives. Transforming longer life expectancy into healthy life expectancy is one of the contributions of Canadian researchers in the field of aging, supported through the Canadian Institutes of Health Research. In 2009-10 alone, the federal investment in research and aging was $122 million through the CIHR.

The CIHR president, Dr. Alain Beaudet, appeared before you earlier this month and outlined CIHR's strategic plan. I'll remind you that this plan includes a commitment to concentrate efforts in five specific health research priority areas, including the priority areas to promote health and reduce the burden of chronic disease and mental illness, as was said.

CIHR has identified a series of so-called signature initiatives—that's how we call them—that are linked to the five commitment priority areas, many of which relate to chronic diseases and aging. These are large targeted research programs that will leverage several-fold resources from partners in the public and private sectors. They include, for example, inflammation and chronic disease, community-based primary health care—as we heard, it's a challenge—as well as the international collaborative research strategy on Alzheimer's disease.

Above and beyond the CIHR signature initiatives, there's a unique research platform that is supported by CIHR and the government that will contribute to the better understanding of chronic disease and aging. The Canadian longitudinal study on aging, or CLSA, will follow a cohort of Canadians aged 45 and older over the next 25 years. CLSA will advance aging research in Canada and enable researchers to move beyond providing a snapshot of the adult Canadian population towards observing and understanding the evolution of diseases, psychological attributes, function, disabilities, and psychosocial processes that frequently accompany the trajectory of aging. To date a total of $38 million in federal investment in the study is matched by $15 million from the provinces and other partners.

This demographic change has induced profound modifications of the types and patterns of diseases that Canadians have to live with. One of the main characteristics of this change is the increase in the proportion of chronic diseases such as, as we heard, diabetes or pulmonary conditions. Why is it so? Mainly because more acute diseases—infectious diseases, for instance—occurring younger in life have been largely controlled.

The result is that very few seniors in this country do not live with a chronic disease. Over two-thirds of seniors live with one or more chronic diseases. We heard some other figures earlier. If in most cases these conditions are controlled by medication or other health solutions, such as little bit of lifestyle change, it will have a major impact on the health of the aging population.

Let me share with you two dimensions of this new challenge for which research supported by CIHR is ongoing, to provide the necessary knowledge to help you in your decisions. These two dimensions illustrate the complex dynamics between chronic disease and aging. The first has to do with the fact that the presence of chronic disease induces an overall condition of frailty in the elderly, which is highly associated with the loss of autonomy, and which, in turn, can favour the appearance of other health conditions. Frail seniors, as many as 20% of Canadian seniors, are at greater risk for acute and chronic diseases, disability, and death.

Being unable to measure frailty in seniors delays our efforts to prevent these outcomes. A CIHR-funded researcher, Dr. Kenneth Rockwood of Dalhousie University, has developed and tested the seven-point clinical frailty scale as an easy-to-use predictive tool to estimate frailty in seniors. That's only an example.

● (1555)

At the same time, we're beginning to understand as well that some barely detectable chronic health conditions could play a major role in the series of physiological events that can cause other diseases. For example, research is beginning to reveal the role that low-level chronic inflammations could have in the cascade of events that induce Alzheimer's disease.

Again, due to the effort of Canadian basic researchers, whether the process by which our body accumulates amyloid deposits, which is the basis of Alzheimer's disease, could be initiated and sustained by the presence of chronic low-grade inflammation is the subject of a lot of research.

CIHR has a road-map signature initiative that will bring together researchers to build on significant Canadian strengths recognized throughout the world, with the global objective of bridging the silos between research groups working in particular on the chronic disease area, so as to recognize in advance the common pathways and interventions.

The second agent I mentioned of the chronic disease and aging dynamic challenge has to do with the way health services are provided and how health professionals are trained. Health professionals and the health system have largely been constructed on the basis of the acute disease model, as was said before. Of course we still need specialized professionals and acute hospitals to take care of those with acute conditions, but we need to complement this model with professionals who will be able to understand the complexities of the interactions between different chronic conditions. We certainly need a health system that will adapt to better care for those chronic diseases.

According to Dr. Howard Bergman, the Canadian leader in this area, the shift from mainly acute disease to mainly chronic disease means that first we have to increase our emphasis on primary care. Attaining this goal could be helped by the availability of new technologies and information systems allowing all the community health providers to have access to the information regarding the chronic condition of a given individual. Secondly, it also means that our health system should definitely evolve from being institution-based to being a network of health care. We need research on this, including hospitals and nursing homes, but also assisted living, community hospitals, physicians' offices, and so on, research currently being supported by CIHR.

Thirdly, it means as well that health services to individuals with chronic diseases will require physicians who will be better trained to cope with highly complex and intricate health conditions. These physicians will work more and more with the other health professionals to support individuals with chronic conditions to diminish the possible deleterious impact of these conditions on overall frailty—not to mention the impact of the declaration of other diseases like Alzheimer's disease, which I mentioned earlier.

This challenge has to be addressed, because currently seniors with chronic diseases are responsible for an important proportion of our health care. The decisions we have to make about adapting our health services to the elderly with chronic conditions have to rely on evidence coming from research on health services. This is why CIHR is also supporting this type of research, as well as basic clinical and social research. The Institute of Aging has already identified this topic as a priority, and is launching a special program that will support health services and systems for an aging population, a priority for research on aging identified by the seniors themselves across the country through the regional seniors workshop that we hosted some years ago.

We're convinced that research on health systems will provide evidence and knowledge that will help you with the difficult decisions about our health system.

● (1600)

[*Translation*]

I cannot discuss the interactions between chronic diseases and aging today without addressing the matter of prevention, as we saw.

[*English*]

The Chair: Is there a translation problem? You don't have the translation?

Is it better now?

Can you try again?

[*Translation*]

Dr. Yves Joanette: I want to speak briefly about the prevention of these chronic conditions. If it's true that we need to continue the research to understand the impact of chronic diseases on the general condition of fragility and the manifestation of certain diseases, we also need to continue to do research into how our health care system can adapt to this situation. We also need to continue research efforts to reduce the source of chronic diseases, as we heard earlier.

[*English*]

The Chair: Can you wrap up now? You've gone quite a bit over time.

Dr. Yves Joanette: Yes.

On behalf of the Canadian research community on aging, I would like to offer our appreciation for the support the government is providing to sustain the research I've been referring to in my speech. We are ready to move forward in order to provide the objective and demonstrated evidence at all levels to provide you with the evidence you need to make the choices that will make Canada a respected and inspiring world leader in this area.

Thank you so much.

● (1605)

The Chair: Thank you very much.

We're now going to

[*Translation*]

…the *Fédération des aînées et aînés francophones du Canada*.

[*English*]

I'm sorry, my French is not as good as I'd like it to be.

[*Translation*]

Mr. Jean-Luc Racine (Executive Director, Fédération des aînées et aînés francophones du Canada): That's very good. Well done.

I will give my presentation in French. I hope the interpretation is working properly.

On behalf of the president, Mr. Michel Vézina, a resident of Saskatchewan, I would like to thank you this afternoon for your invitation. We are very pleased to present our testimony before the committee.

The *Fédération des aînées et aînés francophones du Canada* has close to 300,000 members. These people pay dues. We are actually a federation of federations. Our member federations include 12 federations of francophone seniors from all provinces and territories in Canada, except Nunavut. Of the 300,000 seniors who are members, approximately 30,000 live in what we call minority communities. So they live outside Quebec. For example, 13,000 members live in Ontario, 2,000 live in Alberta and close to 2,000 live in Manitoba. So there are a lot of francophones living in minority situations.

I want to talk to you today about treating chronic diseases. The angle I will take on the matter will be a little different from the other presentations that you've listened to, although they were very good and they contained good components. I would like to stress the importance of serving the francophone population.

This is a role and responsibility of the federal government under the Official Languages Act. Part VII of the act requires the government to meet the needs of francophones in minority situations. I think we need to give credit where credit is due. The investment of funds through Health Canada into the two organizations, the *Société Santé en français* and the *Consortium national de formation en santé*, for us, marks a unique opportunity to make advances, breakthroughs, to ensure that francophones can receive services in French. But these resources are still limited and the challenges are enormous, especially when it comes to treating chronic diseases.

So today I'd like to talk to you about specific cases, and mainly about the importance of serving the francophone community. Right now, there is a lot of pressure from hospitals with respect to treating chronic diseases. As soon as someone is identified as having a chronic disease, people try to free up the hospital bed and place the person elsewhere as soon as possible. Very often, it is to the detriment of francophones. I'll give you some concrete examples.

You'll recall, about a year and a half ago, a situation that made headlines in the newspapers. The mother of Ms. Lavoie, of Toronto, had Alzheimer's. When a person has this disease, often one of the first faculties to go is the use of the second language. So these people find themselves in a home that provides treatment for chronic diseases. But Ms. Lavoie could not be placed in a home offering services in French. In fact, Toronto has only 17 beds for francophones. At the time, three quarters of the beds were occupied by non-francophones, by anglophones. Ms. Lavoie was required to place her mother in Welland. Surely you know Toronto. Welland is about an hour away by car, when there isn't traffic in Toronto, which is very rare. To visit her mother, who was being treated for chronic diseases, it took her at least two hours of travel time.

Try to imagine the situation and what is involved in placing a person who has lost their second language in a home. It's as if you were placing your mother or father in a home where they only speak Mandarin. It would not be very comforting. This woman experienced the same thing. We are often confronted with cases where seniors are placed in homes that do not offer services in French.

I also want to point out to the committee that when people are sick and vulnerable, they want to receive services in their own language. When people are sick, they want to be sick in French. This is often what we have to face.

● (1610)

When you are vulnerable, you want to be comforted, not fight. When you are in a hospital bed, that isn't the time to fight for your rights. I'll give you another very concrete example to show you how difficult it is.

I'm going to give you the example of my grandfather. Six years ago, my grandfather went to see the doctor. He lives in eastern Ontario, in a community where the population is about 80% francophone. The doctor never asked him if he spoke English. The doctor described his situation to him and told him what to do. Do you know how my grandfather reacted? He said: yes, yes yes. My grandfather doesn't speak English and doesn't understand English. But he was too intimidated and too vulnerable to tell the doctor.

Many years ago, my grandfather and I travelled to western Canada together. I was 12 years old at the time. I would go with him to restaurants so that he could order a hot dog. Imagine. If he had trouble ordering a hot dog in English, understanding the doctors instructions in English would have been a challenge for him.

I could tell you about similar situations. I'll give you an example. I did a national tour of our francophone communities three or four years ago. I was very surprised. I met with francophone seniors who were offended. Their parents had lived their entire lives in French. When the last moments of their lives came, they couldn't be given services in French in the chronic or long-term care homes.

These people wanted to fight. This is why they were in groups for francophone seniors. They fought for that. I met with at least two or three people like that over the course of these encounters.

All that to say that it's important to have chronic care services in French. That's the message I want to pass on.

To conclude, I would like to point out that what's important is the equality of both official languages in Canada. All Canadians need to be able to get services of their choice in both languages. For us, it's essential. Although health care is a provincial responsibility, the federal government has to play an active leadership role in this matter. The provinces are open to it, but the federal government must be very active.

The other important thing is to think in terms of the active offer. It is wishful to think that people are going to demand their services. You can't wait or be passive. Especially when people are in a vulnerable situation, you need to be very active in offering services.

There is another thing to look at. The service criteria is essential. The language of service is essential. I think we need to be proactive and must be able to offer it. It's very important.

The last thing that I would stress is this. When the federal government and all the provinces want to offer services, it is important to continue working with the francophone communities. I think we can help you and support you in that respect. We would be enormously pleased to continue to work toward this.

Thank you very much.

[*English*]

The Chair: Thank you very much.

We'll now go into our Q and A time. We'll have seven-minute rounds, beginning with Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): Thank you, Madam Chair.

First of all, to the witnesses who are here today, thank you so much for coming. I feel that you all presented articulate and well-informed presentations. This, to me, is an indication of how critical an issue this is—chronic care as it affects older Canadians. We expect the CIHR to have great research, and you always do, but for all the organizations that are here, your depth of knowledge about the issue is a good indication of how important it is for your members and those whom you serve.

I've been struck by the commonality of the priorities that people are focused on, not just at this meeting, but at previous meetings we've had as well, whether it's on prevention and health promotion, or whether it's on chronic disease and how we're not really tending to it, because there's been so much focus on acute care.

Ms. Eng, you're correct, the Romanow report did spell out, as the next big priority, the whole issue of home care, and the broader issue of long-term care as well. It dealt extensively with home care, whether it's through the formal system or through supporting families, and it also dealt with access to comprehensive primary care.

Hearing you today, I feel that we have this wealth of information, of research, of experience that's coming from all across the country, and yet we seem to be almost stalled as to where we're going. We've come from the 2004 health accord and we're now moving to the 2014 health accord. As you're addressing these issues for your members, the people whom you serve, when you talk about federal leadership that's required, what are three things that you want to see happen?

Some people have said that we need to have a first ministers conference just on health care that gets us working towards the negotiation of a new accord. But if we're to deal with this issue of chronic disease and we haven't made sufficient progress, despite all of this information, then I think we need to spell out what we mean by federal leadership. One thing might be a transfer involving home care, which is what Mr. Romanow recommended. We've talked a lot about the lack of affordability of drugs. We've talked about the need for comprehensive primary care. Maybe we need to be enhancing community health centres and the federal government should be taking the lead in that. There are any number of things. But I would like to hear you spell out the priorities for federal leadership to get us towards that 2014 accord.

I would ask this of any of the presenters.

● (1615)

The Chair: Ms. Eng.

Ms. Susan Eng: Thank you very much. I could say all of the above; indeed, all of those points are extremely relevant.

We have talked with our membership. We are engaging with them all the time, and we do focus on the fact that lots of work has been done around the country in a patchwork. There are all kinds of pilot projects that are taking place, but what is needed is a comprehensive set of strategies that can only come with a national conversation.

The health accord presents the opportunity for the federal government to set aside money to actually fund these initiatives, but a condition of having that money transferred to the provinces is to set certain national standards, certain national priorities, and to ensure there's accountability for the money being spent. In observing and reviewing the work that has been done according to the existing accords, we find the accountability is lacking.

While there may be projects that are happening—we know a few of them are very promising—we're not certain the knowledge is being shared. A lot of good work and a lot of serious money has been spent, so I think the federal role, and there is definitely a federal role, is to set the large framework. The coordination, the strategy, the accountability is implicitly a federal role.

The provinces, of course, have to deliver. Even in the latest elections this fall, all of them addressed many of these issues in a patchwork. They all had pieces of the puzzle, but none of them had the whole. The single most important message for us is that there be an overall framework.

The second piece, and I want to re-emphasize this because it's important from the point of view of fiscal management, is home care was identified as the next essential service to respond to an impending challenge, which is valid all by itself. But we feel that it's also important because it has the opportunity of restructuring the health care budget for the future. We're worried about its sustainability. We're hearing arguments for private pay, etc., and yet we're not looking at restructuring our actual delivery of those health care dollars and using them more appropriately. The opportunity arises with home care and caregiver support to actually divert a massive amount of demand, and therefore the opportunity to also put our fiscal books in balance.

Those would be our major recommendations for the federal role.

● (1620)

Ms. Libby Davies: Ms. Clark, do you have similar priorities? I mean, how do you look at home care? You could almost see it as prevention, as well, in terms of keeping seniors at home—healthy, active and so on—rather than in an institution. I wonder if you share that as a priority.

Ms. Patricia Clark: Certainly the idea of being able to live in your home as long as possible is what we do push: to remain as independent as long as possible and to have the choice to determine where you want to live and not be forced to live somewhere. The opportunity of being able to stay at home with home care is certainly very important from that perspective. So yes, we would support that, by all means.

We know from the evidence that the one person all older adults will always believe is their doctor; they always go to their doctor for their information to start with. We know that in the medical system now they don't get many hours of prevention within their medical—

The Chair: Ms. Clark, I'm trying to signal that you're over time.

Ms. Patricia Clark: Oh, I'm sorry; I didn't see you.

The Chair: Thank you. Please finish off.

Ms. Patricia Clark: Okay. What I would like to say is I think it would be very helpful if doctors were better informed, to have a system where they could refer so they're not looking at treatment all the time but prevention.

The Chair: Thank you.

Mr. Williamson.

Mr. John Williamson (New Brunswick Southwest, CPC): Thank you.

We've had some good testimony. Thank you for appearing today and presenting your views. I suppose it's left me looking for some answers on where to go next, or where the federal focus ought to be. As an aside, and almost as a joke, I would have to kind of boil down a lot of the testimonies today and elsewhere: I've concluded that if we live long enough, something is going to kill us. By that I mean it seems that, as a country, we've done a relatively good job of curing diseases, and now we're struggling with extending lives and lifestyles in a way that people are happy, or enjoy life to the fullest.

I suppose there's a question I kind of want to drill down on, and I'd be curious to get your answer on. It was touched on by a couple of people, and I'm not sure if it's what you meant when you talked about cure versus disease prevention, and shifting the focus from one to the other. But I can't believe that you would be suggesting that governments or doctors remove the emphasis from curing disease, removing resources, to focus on disease prevention. If you're not, then what would your message be to the federal government, which has under the 2004 health accord increased spending by 6%, and then going forward, at least for two years, increased it by another 6%? Are you suggesting that the federal government mandate to provinces a third of that 6% to disease prevention, or are you suggesting that 6% isn't enough and that more needs to be done? How would you balance that off with other priorities that governments have to face, including managing tax dollars at the end of the day?

Ms. Susan Eng: I would be pleased to answer that.

The importance of the health accords was their focus on five major strategic choices that would in fact improve on the delivery of health care overall. That was the last set of accords. The opportunity now arises to not necessarily add lots more money to the current spending and federal transfers, but to do it more wisely, to be much more targeted so that there is money in fact to do what people need and want, which is to age gracefully at home. If you do that, you have the opportunity to actually bring down your health care budget, because you are at the same time taking them out of institutional care, likely preventing additional conditions worsening and drawing upon the acute care system and so on. So there is an opportunity for cost savings in huge amounts of money. We're not saying take money away from anything. We are saying restructure it so that you're actually getting more value for the dollars that are spent.

In terms of prevention, the opportunity there arises because we know that one of the original promises of medicare was prevention, health promotion—don't get sick, don't get into the formal health care system. The ethic now among Canadians has been to look at healthy aging, and there's an opportunity even as people are already older that they can prevent the onset of chronic disease.

If we put all this there, the chances are that we'll be saving dollars later. Our membership tends to be very cautious of fiscal balance. They will pay dollars, pay taxes for good public services, but they just hate waste in any form whatsoever. So they want to hear sensible solutions that re-manage, restructure how we're spending now $192 billion a year. We're certainly not taking money away from curative efforts. We are looking at using our money more wisely, to prevent having to get into that system.

● (1625)

Dr. Yves Joanette: I totally agree. But in making these decisions together, I think we have to have the evidence to make the right decision. So these decisions have to be evidence-based, not anecdote-based. This is why I think we have mostly all the questions; we don't have all the answers. That's why we need more research, and the kind of research we need is more integrated. That's what the Institute of Aging is trying to do, to put all participants together on these very complex questions.

Also, the second thing is to bring this evidence to public deciders. CIHR has for instance introduced very recently a “Best Brains” program, which offers researchers meetings with public deciders in order to provide them with the evidence in order to do that kind of research. I think that's the kind of action that will help.

Mr. John Williamson: I'm a bit hesitant to go down this path, but I will. I think in the past we've talked about how four million Canadians don't have a family physician. I'd be curious to hear from you and from CARP as well. You talked about evidence. In reallocation of resources, what role does private delivery, for example, play within the medicare system? The evidence would show that Canada is unique in this area. European countries all mix the two. The countries you listed as having higher life expectancies than Canada does—particularly Japan—mix the two. Are there not solutions there as well to encourage...?

I agree with you completely. We need to ask provinces to do more. At the same time, they need to have the resources to do that, and we almost need to treat the provinces as ten laboratories of experimentation that can go out and find best solutions, as opposed to having terms dictated to them by the federal government.

Dr. Yves Joanette: I won't provide you with an orientation, but I can tell you that we have the capacity to do that kind of research, to compare the provinces and compare these systems internationally. And you're right—we have to do that kind of analysis in order to have evidence that one model versus another will be best for the individual, for the society, for the economy, and for the sustainability of these systems. That's exactly the kind of research that is supported.

In fact I must say that Canada is well recognized internationally for its quality of that kind of research. I think we have the capacity to provide this. I don't think we have the ultimate answer yet.

The Chair: Thank you, Mr. Joanette.

We'll now go to Mr. MacAulay.

Hon. Lawrence MacAulay (Cardigan, Lib.): Thank you very much.

Welcome. I'm a substitute on this committee, but I was involved in seniors' issues a number of years ago when I first arrived here.

To ALCOA, how does our health care system adapt, or does it adapt to seniors? Often you'll hear—and this is a bit rash—that when you get to a certain age, there's not quite as much done and this type of thing. You hear this type of complaint pretty often.

Ms. Susan Eng: You're absolutely right. We get complaints from our members all the time on that very issue. Their concern—whether warranted or not, and here's the evidence issue—is that they feel not well treated within the health care system. Already there's a lot of confusion and mystery, and then they think they're not getting the best treatment because they're too old. We've had people say that to us. We have people writing in on that. When you hear the language heads of hospitals and other agencies use in some public pronouncements, they do give you the sense that after a certain age, you're not going to get the best care. We would like to believe that's not the case, but we need it to be proven.

You will find that the efforts now on offer to try to reduce hospital budgets and so on bring situations that are really quite miserable for people. One example is in the alternate level of care. You hear the phrase “bed blockers”. What do you suppose that means? It refers to a person who has fallen, has broken their hip or has had a stroke, and is assessed as not being able to live at home independently. It's not appropriate that they be in an acute-care bed, but that's where they are. They don't have access to long-term care. It could be an issue of language or culture. It could be an issue of cost. It could be an issue of location. But whatever the reason, they are still there. So the hospitals are turning themselves inside out to find a way to get rid of them, not to help them find a place where they're going to rehabilitated or taken care of or find proper home care services or someone to manage their care or anything like that. No, it's to get them out of those beds. It's the attitude rather than the effort. So we do worry about that very thing.

● (1630)

Hon. Lawrence MacAulay: A lot of times you hear that when someone is on a whole lot of medication, perhaps another doctor will take them right off of all the medication and this idea. You'll find there is some medication abuse. There's a problem, of course, with medication abuse and there's also a problem with people needing medication and not being able to get it. There are both.

Mr. Racine, in case I'm cut off, I want to indicate to you that I am sorry, and I understand that does happen, given the language issue. Unfortunately I speak one language only, and if I were put in a situation in which I could not speak to anybody who was caring for me, it would be a pretty horrible situation. And I can get up and walk today.

I'd like you to respond to that.

Ms. Susan Eng: The issue of how people are treated with their medications.... Geriatric medicine doesn't carry a lot of panache. And even though many of the provinces have given extra funding for people who take on older patients, nonetheless, doctors do not encourage it. My own brother is a GP, and he tells me it's not a choice.

So unfortunately the interaction of drugs in an older, smaller body are not well understood by the average practitioner. Therefore, do we hope we're going to get more geriatricians, or do we want to make sure every medical graduate has that understanding of how drugs play with comorbidities within an older body?

We don't have that right now. There is a real fear when people go into hospital that they're not going to be able to tolerate the care they get. And this is the stage we're at because there is a lack of an overall focus on making sure that older people are well treated within our hospital system. What we do have are erstwhile plans to make age-friendly hospitals, for example here in Ottawa. They have to consciously institute a new program to do that. Why? Because it's not happening yet.

Hon. Lawrence MacAulay: Thank you very much.

Dr. Joanette, you touched on that too, and you also touched on health training. I'd like you to elaborate on what additional training we need to make sure our medical people are well trained to take care of the seniors in our institutions, if that's where they are.

Dr. Yves Joanette: Thank you so much.

You've raised a very relevant question, the question of a form of agism vis-à-vis older people. This is one aspect we have to better understand. People like Professor Martine Lagacé here in Ottawa are working on that question.

We also talked about hospitals that are not prepared, so what does that mean? That we need to have all Canadians followed by geriatricians, who are paradoxically in one of the youngest specialties in medicine? It's a very young specialty, so there are not a lot of people, but we won't have all Canadians followed by geriatricians.

As was said, it has to be something that will be integrated in the training and in continuing education. With France and Quebec, CIHR has introduced a program based on the translation of what's called the Cochrane Reviews on best practices, which are evidence-based practices to the physician, in this area among other things. This was available in English and now it's also available in French due to this accord with France.

This is how we can not only train the new, young ones but also provide continuous education and changes of mentality both to the physician and other health professionals, and also try to find the best way to help the system. And the hospitals will take care in an integrated manner of those people coming with lots of little bits and pieces of diseases.

● (1635)

The Chair: Thank you, Mr. MacAulay.

We'll now go to Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you very much, Madam Chair.

Ms. Clark, you've had the misfortune of being cut off a couple of times, so I'm going to start with you.

One thing I've noticed since we've undertaken this study as a committee is that mental illness seems to be a common thread when we're talking about chronic disease. Seniors affected by chronic disease often have to contend with mental illness as well.

I note that you have a pamphlet here in the material you've provided, “Brain Fitness: As Important as Body Fitness”. I wonder if you can speak a bit about brain fitness, as well as what benefits active living could have, not only on cognitive ability but also on the mental health of older Canadians.

Ms. Patricia Clark: I can certainly speak somewhat to that, not to the in-depth research, but the document we have there is something that is quite new in the industry. The simple relationship is that what's good for your body is good for your brain.

That happens because the neuroplasticity in your brain helps you to learn better and retain better. You can learn new things. Just because we get older, it doesn't mean we can't learn new things. That's so very important for older adults because of the obvious concern with Alzheimer's and dementia. If people are able to stay physically active and challenge their brain at the same time, they will be able to improve and maintain their mental capacity, their memory, and also ward off mental illness and Alzheimer's. There is a definite link between physical activity and mental health.

Dr. Yves Joanette: It so happens that as a researcher—I'm a cognitive neuroscientist—this is the kind of question I'm working on. We have this notion of cognitive reserve, or brain reserve, which we can nurture throughout our life. All of this should not start at 65. We should start early with the kind of physical activity that has a direct relationship with brain reserve. CIHR is funding studies by Dr. Louis Bherer, who's showing that physical exercise has a direct impact of the oxygenation of the brain. You have a better reserve to face problems later in life. Having some intellectual activities provides the same benefit. In some countries, you have areas where people do this systematically. Recently I had the chance to be in Shanghai. There are many centres within the city where Chinese people can go to play mahjong, do tai chi, and exercise. They prepare their brains to be stronger.

Mental health is not only cognition. It is also depression and so on. One thing that is important at that point is social isolation. We have to make sure we understand the social insertion and network determinants of mental health and provide evidence to support decisions on the best way to provide these environments where older people will maintain their social participation in our society. That's how you feel happy about living.

Mr. Mark Strahl: Has your organization done specific studies on mental illness in seniors or aged populations? If so, what are some prevention measures that have been identified in those studies?

Dr. Yves Joanette: Yes, the Institute of Aging within CIHR supports that kind of research. We also work with another institute, the Institute of Neurosciences, Mental Health and Addiction. There is a lot of good research done in Canada. One thing we can do is maintain and nurture the social interactions and social support of the family and societal interconnection, along with elders' satisfaction of contributing socially. Isolating older people in an area where they will lose these occasions will not be good.

● (1640)

Mr. Mark Strahl: I want to talk a little bit about home care since it seems to be something that is driving the discussion here today. As far as I know, home care is under the exclusive jurisdiction of the provinces. I would be interested to hear how the federal government would reconcile withholding funds from a province if they didn't go in the direction that the federal government led. You said the federal government should lead. If this is an area of exclusive provincial jurisdiction, why wouldn't the provinces be leading and the federal government doing what it always does, which is to provide financial supports? There has been a 36% increase in health and social transfers since we took office, with the escalator built into the budget. Could I have some comments on that?

Ms. Susan Eng: The way I understand the health accords, but for the fact that the federal and provincial ministers actually agreed on the accord, no federal funds would have flowed from the federal government to the provincial government, since health care is exclusively a provincial jurisdiction. Once you have the accord, you set aside a sum of money according to certain priorities. That's when you have an opportunity as a group to name your priorities and conditions, and to impose accountability.

In the case of home care, you are absolutely right. It is within the provincial jurisdiction to set those parameters and spend those dollars. But as a national organization, we see a terrible patchwork of availability, quality, and access to health care services. You can't give someone three hours when they need 24/7 care. We feel there needs to be a minimum standard across the country.

During the federal election campaign, there was a reference to including home care within the Canada Health Act, which is an important protection for making sure everybody at least gets a basic level of home care services.

There is an opportunity with the health accords, which are outside the scope of the two constitutional jurisdictions sharing this field. They can go some way towards setting standards.

As to the dollars involved, if the federal government—

The Chair: Thank you, Ms. Eng. I'm sorry. Thank you.

We'll now go to our second round.

I want to let you know that I've given all of you extra time. But as much as everyone thinks their question and answer are the most important, my role is to make sure everybody gets an opportunity to ask and answer. I've bent the rules a little to try to get everybody, so don't be personally offended if you're cut off. It has to be done; otherwise you could have the whole hour and a half. Then everybody else would be offended. I just want to clarify that, because some of you get kind of a shocked look on your face when I shut off the mike.

If you watch the mike here, when it turns red it's an indication that your time is up. I try to not cut you off, but I just want to explain that so you understand what it's about.

We're going into five minutes now of Qs and As.

Dr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): My colleague, Mr. Strahl, pointed out that home care comes under provincial jurisdiction. But the aboriginal populations are under the responsibility of the federal government. How do you see home care for aboriginals? Do you have broader information on the situation of our aboriginal seniors? If so, I would very much like to hear it.

Dr. Yves Joanette: I could give you a partial answer but not a full answer. The Canadian Institutes of Health Research comprises 13 institutes, including the Institute of Aging. There is also the Institute of Aboriginal Peoples' Health, which deals with the big challenge of the health of these populations. Right now, discussions are under way between these two institutes to better integrate the health issues of the aboriginal and aging populations and the particular challenges that will arise very soon. It's a concern we have.

For the moment, studies are being done, but not enough. When a gap or a lack of research becomes apparent, the role of the institutes is to support the research in a particular way beyond the good and excellent ideas that Canadian researchers have.

● (1645)

Mr. Dany Morin: Are there any other comments on this matter?

[*English*]

The Chair: Mrs. Clark.

Ms. Patricia Clark: We do some work with aboriginal groups as part of our coalition. We know there is a much higher percentage of diabetes in aboriginal groups, both on reserve and off reserve, than in older adults in Canada. We know that it links back to their lifestyle. There certainly are genetic issues, but looking at type 2 diabetes, we know that lifestyle and the environment they're in need to be addressed in order to help manage and prevent it.

[*Translation*]

Mr. Dany Morin: Mrs. Clark, you think that mental health issues should be considered before physical health concerns. Do you think that the government should have a national action plan for mental health?

[*English*]

Ms. Patricia Clark: I think mental health has to be addressed, and I can see that it's becoming more of an issue. At the preparation for the UN summit, I was sitting in a meeting and they were saying that we have to look at mental health. I don't think it's in isolation. All the issues of chronic disease should not be isolated, because so many of the realities of why people have chronic diseases are based on the same issues. You can easily have one and the other, so I would not want to say that we should just deal with mental health and nothing else. But it needs to be evident that we have to address mental health at the same time, if not before. Otherwise we will not have success from a prevention perspective.

[*Translation*]

Mr. Dany Morin: My next question is for Mr. Racine.

You told us about three specific cases involving francophones. Would you have more general information about the situation of francophone seniors in Canada living outside Quebec?

Mr. Jean-Luc Racine: We have data and the statistical profile. You can find this statistical profile of francophones in Canada if you go to the federation's website. Curiously enough, the health indicators show first that the francophone seniors are much more disadvantaged when it comes to their income than the general population, even in Quebec. Also, studies have been done, and it seems that there are more francophone seniors who are single, separated or who live alone than in the general population. We also have other indications that the education level of the francophone population is lower.

So we know that these francophones are, to some degree, much more at risk. Naturally, there is work to be done in that respect. So we need prevention services, which is what my colleagues have strongly insisted on. I think we must not be afraid of speaking to target clienteles. You just spoke about aboriginals, who are a target clientele under the federal government's responsibility. I think the government must play an important role in this respect.

[*English*]

Mr. Dany Morin: Do I still have some time?

The Chair: We're almost out of time.

Does anyone else want to make a comment on Dr. Morin's question? No?

I'm sorry, our time is up, Doctor.

Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you, Madam Chair.

I'd like to just touch on what we were discussing before with CIHR, on dementia and Alzheimer's. I know this committee has taken an interest in neurological disorders, and a few of the previous speakers have talked about it being a major factor in aging. I think it was estimated that there are 500,000 Canadians who have Alzheimer's. I know one of the mandates that you had for your strategic priorities was cognitive impairment.

What are your findings so far? Is there anything you've identified that can delay onset or that can better equip Canadian seniors to live with this insidious disease?

● (1650)

Dr. Yves Joanette: The international strategy for Alzheimer's disease is called international, but it's not only international: it fosters, of course, Canadian research that is excellent in different areas of the country, because we want to network better in order to get synergy among Montreal, Vancouver, Toronto, Halifax, and all the cities where there is good research on all aspects of Alzheimer's disease.

You're right, it's half a million now. It's going to be 1.2 million in about 10 to 15 years. And to give you figures that are mind-blasting, in about 15 to 20 years the number of people with dementia and Alzheimer's disease in China will equal the population of Canada, around 30 to 35 million people. So this is really a major challenge.

The research is on two fronts, I would say. The first one is to really identify and try to understand what the early markers of Alzheimer's disease are, because at this point there's no curative to offer. So there's lots of research there, and research is at the levels of genomics, biochemistry, and cognitive disorders. There is imaging that can be at the level of these biomarkers, and there are now more and more results that point first to the fact that it's more complex than it appeared to be initially, and that we have to pursue. But I think there's a little bit of light at the end of the tunnel, and we're starting to get some results, although none that are applicable tomorrow morning. Maybe they'll be applicable in five years.

The second front involves trying to strengthen the brain in order to resist the clinical manifestations of Alzheimer's disease for as long as possible. This does not diminish the disease, but makes it shorter. If you can delay by two, three, or even four years by using these lifestyle activities we refer to, then you have a major gain, and this is already available and starting to be implemented.

Mr. Patrick Brown: I read somewhere, was it $8.6 million that Canada through CIHR was investing in Alzheimer's research? Is that allotment part of this international protocol?

Dr. Yves Joanette: CIHR is supporting research-initiated studies to a level.... I can tell you in a minute. Certainly the strategy is $25 million over five years, and we want to partner with other *caritatifs*, with provinces, and also with industry in order to double this money.

Mr. Patrick Brown: There's the partnership with France and Germany and the U.K. Is CIHR doing any independent research aside from that?

Dr. Yves Joanette: Oh, sure. The majority of the research is done in Canada and supported through researchers here. There is some extra money put into a strategy to link internationally, because the question is so complex that we have to learn from others. So there are connections in Europe, connections in Asia, and connections also with the United States. These are the three pods, so to speak, of this international connection at this point, and Canadian researchers are leading in this.

Mr. Patrick Brown: Do you believe that we have adequate resources right now for Canadian seniors who have Alzheimer's in terms of long-term care capacity, of living conditions for seniors? I think of my own riding, Barrie. I know that the wait list is quite long for long-term care. One home, Grove Park Home, has a five-year wait list, and I'm sure that's common.

What types of concerns do any of you have in terms of the wait lists for people who are cognitively impaired and need immediate access to assisted living?

Ms. Susan Eng: From the caregiver perspective it is thought that even people with dementia can age at home. However, the ability to do so requires both the expertise of properly trained home-care workers and adequate training for the family. Those two things in the case of dementia—even if there are no other co-morbidities—create the greatest amount of stress on caregivers and require the greatest amount of expertise among home-care workers, both of which are in short supply.

That is a particular challenge that is over and above helping somebody with kidney disease, for example.

The Chair: Thank you, Ms. Eng.

We'll now have to go to Ms. Quach.

● (1655)

[*Translation*]

Ms. Anne Minh-Thu Quach (Beauharnois—Salaberry, NDP): Thank you, Madam Chair. I would also like to thank the witnesses who gave us the information. I'd especially like to thank Mr. Racine and Dr. Joanette. It is always good and rather nice to hear people speaking French. It's fairly rare here.

My question is for Mr. Racine. You said that it's very difficult for francophones to get care. Can you explain the process that patients need to go through to receive care? Are the steps lengthy? Does anyone help them? What type of person helps them?

Mr. Jean-Luc Racine: There is a process. It starts and often takes place in hospitals. Patients are admitted. In the provinces, it goes through access centres. Placement is more and more centralized. Patients go through access centres, the names of which differ from province to province.

As I explained in my presentation, the system unfortunately is under a lot of pressure. If we speak to social workers in hospitals, they tell us about the pressure they are under to place these patients elsewhere as quickly as possible to free up beds. It's understandable.

We are seeing that taking into account the language needs of patients is something that often becomes insignificant in the process. It's regrettable. Basically that's how we understand the process and it's how it was explained to us.

Ms. Anne Minh-Thu Quach: Which measures do you think would be a priority and should be implemented immediately to improve the situation?

Mr. Jean-Luc Racine: It's an important question. If I had the answer, I would be quick to give it to you.

One thing is for certain, we cannot disregard the problem. The goal of my presentation was to quite simply point out that we must not disregard this aspect of the situation. It's very important. Some measures can be adopted, but all the levels of government must show leadership and accept the fact that this aspect is important. It must be taken into account in the process. It's essential. Leadership does not always come easily.

Some health care facilities are also more sensitive than others when it comes to services provided in the hospitals. A little earlier, we were talking about home care. We don't always have the sensitivity to offer services in French. It works well in some regions, but in others it is very flawed. So it's not an easy situation. It's very complicated. Within the association, we realize that simply trying to find solutions requires a lot of resources.

Dr. Yves Joanette: If I may, your question is quite relevant and poses the issue of language. It's also a marker of culture. So there is the culture and the language. Right now, research is being done on language and culture. For example, in Alberta, Dr. Daniel Lai is working on the issue of Asian immigrant seniors who live in very specific situations in their community in terms of health care for the seniors. I go back to my obsession. I think if we want to find better solutions, they must be based on hard research. We need this hard research. Perhaps we need a co-ordinated national strategy with all the provinces and partners to encourage research on these issues.

Ms. Anne Minh-Thu Quach: My next question is for Mrs. Clark.

You spoke about the importance of social determinants of health. Last week, a symposium in Brazil looked at social determinants and the fact that we are spending 20% of the health budget on them. Could you tell me what type of policies would need to be developed to ensure that the services provided to seniors, especially in the area of chronic diseases, are fair for everyone?

[*English*]

Ms. Patricia Clark: You were talking about 20% of something, and I wasn't sure—20% of...?

[*Translation*]

Ms. Anne Minh-Thu Quach: Twenty per cent of the health budget is set aside for social determinants, including homelessness, unemployment and mental health.

● (1700)

[*English*]

Ms. Patricia Clark: On that, the social determinants of health are really important when we're looking at national policies, be it provincial or federal policies. Just looking at barriers for individuals is not sufficient.

There are eight or ten different factors in the determinants of health that are important to consider when we're looking at policy, and those factors need to be an integral part, whether it be policy at a local level or a provincial level or a national level. There's no point in saying we will implement something—as an example, let's say we're looking at transportation. That's an issue for some older adults, but there are many other issues in addition to transportation. The social determinants of health are critical when looking at policy, that they are included within any framework.

I'm probably not answering your question well enough because I wasn't quite sure what you were asking, but I don't want to ramble on.

The Chair: Thank you so very much.

Now we'll go to Mrs. Block.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair, and thank you to our witnesses for being with us today.

Throughout this study we've heard a lot of things. We know we have an aging population and that we are living longer but not necessarily healthier. We also know it is inevitable that as our population ages some will develop the chronic conditions and diseases we've been talking about.

Following on my colleague's questions, we touched on the important role of the caregiver, which is why the government supports caregivers through a number of tax relief measures, including one that was most recently introduced, which is the $2,000 non-refundable family caregiver tax credit.

We've also recently launched a three-year external research program to fill in important knowledge gaps on key caregiver issues. In 2012 the Government of Canada will also run a national caregiving survey that will refresh the national data to help us better understand the challenges that caregivers face.

What continues to rise to the surface during these discussions is the need for individuals to take or at least increase personal responsibility for their health. It's unfortunate that sometimes we don't do what we should do until we have to—I guess that's human nature.

I do have a couple of questions for Ms. Eng.

In a report issued by CARP in February of this year, members were asked how they could best increase personal responsibility for their health. I think 54% indicated it was adopting a healthy lifestyle. Has CARP followed up on this study? Does a majority of the CARP membership actively pursue a healthy lifestyle? How did they define “healthy lifestyle”, and what kind of guidance does CARP provide in this regard?

Ms. Susan Eng: We certainly encourage healthy aging, in all of its aspects. Through our membership benefits we try to encourage them to join fitness clubs. We get them member discounts, to ensure that people who are in fact selling these kinds of services to help people stay healthy and engaged also provide them with financial incentive to get involved.

In our chapter network across the country, for example, one of them introduced Nordic pole walking in their community. Some have taken advantage of the New Horizons programs and so on, to introduce programs for their local neighbourhood. There certainly is a great deal of support for active aging initiatives.

We have people in our membership who do say that government has a role in supporting and incenting activity, but they certainly take responsibility for their own health themselves. However, when they cannot do so, they do see that government has a role in assisting them and assisting their caregivers and so on.

Now, in terms of bringing forward that aspect of our work, we do encourage it, but it is one of those kinds of priorities where you're encouraging the positive; we concentrate on defending against the negative much more in our advocacy.

We do weigh in favour of providing support for family caregivers to recognize the challenges they have, and they're grateful for the support for family caregivers in the latest budget. But they also say there's a need now to drill down on those who are providing the heaviest level of care so they are able to help with that as well.

● (1705)

The Chair: Mr. Racine, did you want to make a comment?

[*Translation*]

Mr. Jean-Luc Racine: Yes, quickly.

I would simply like to say that I think that to encourage or promote physical activity among seniors, it's good to talk about it and advertise it. But a little structure also needs to be given to help this clientele continue.

We have a big challenge to accept. We are seeing it within our federation. For example, it is much more difficult for the baby boomers who come to join senior citizens clubs. Our challenge will be to put structures in place that will help this upcoming young clientele to continue to be involved and active in the community. We already have very interesting plans in this respect. But these are big challenges for the next few years.

[*English*]

The Chair: I don't think there's enough time, Mrs. Block. I'm sorry about that.

We'll now go to Dr. Sellah.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair.

Thank you to everyone and all our guests here who came to answer our questions wherever possible. I have a question for Ms. Eng.

A survey by your association indicates that some of the priorities of your members were access to doctors and a reduction in wait times. I have two questions for you. The president of the Canadian Medical Association told us when he appeared before our committee that many seniors ended up in long-term care facilities permanently. Now, we all know the repercussions that these long stays have on the health system in general. The reasons for this situation are economic, meaning that these people cannot afford a residence for independent or semi-independent seniors. He told us that the situation was caused by the lack of places administered by the public system in facilities for seniors. Do you think that's a good point of view, particularly when it comes from the president of the Canadian Medical Association?

My second question is what do you think of the effort being made to recognize foreign diplomas? Is this part of the solution? If so, how do you suggest we speed up the process for this human resource that is available and that cost Canada nothing?

I have another question. I'm making the most of it. It's for Mr. Racine. How are your members received when they discuss needs in terms of services in French with the authorities involved?

[*English*]

The Chair: Let's start with Mr. Racine, and then we'll proceed with the other questions.

Mr. Racine, go for broke.

[*Translation*]

Mr. Jean-Luc Racine: We have seen a big improvement over the past ten years, meaning that there is more and more comprehension. It still varies from region to region and province to province, but increasingly we are beginning to understand that these are important elements. But the tangible solutions are often slow in coming. Obviously, a leopard never changes its spots. So things get a little difficult. This is what we're noticing. But the dialogue is more and more interesting. The various communities are open.

I would like to add that Health Canada funds the *Société Santé en français* and the *Consortium national de formation en santé*, which has enabled us to take giant steps in recent years. We are very happy about that.

[*English*]

The Chair: Thank you.

Who would like to go next?

Ms. Eng.

Ms. Susan Eng: I'm not sure that I entirely understood the question. I was trying to listen to both languages, and that was a mistake.

On the issue of foreign credentials, most certainly there is a need to recognize foreign credentials. Foreign-trained professionals provide an opportunity to broaden our base of professional and cultural skills. That is something I have particular knowledge of in my other work with the nursing homes we helped put together in Toronto. There are four locations now, offering service in the Chinese language and also South Asian and Japanese. In fact, in those cases, language was important, but food and cultural behaviour were equally important.

When we talk about foreign-trained doctors, we're not doing them a favour; we are actually bringing their expertise and cultural competencies into our system, which is a major opportunity.

Wait times are an issue the Canadian Medical Association talks about. I'm looking for their solutions. They talk about expanding the numbers of their profession, but I think they need to focus harder on services to seniors and geriatricians, and to put the weight of their organization behind that approach.

The number of people waiting for long-term care is actually criminal. It has been shown that when they are waiting for long-term care they cannot manage at home. There are no options. There isn't enough home care, and they are deteriorating while they wait.

● (1710)

The Chair: Thank you very much.

Dr. Sellah, you have about 20 seconds if you have something else you'd like to make comment on.

[*Translation*]

Mrs. Djaouida Sellah: I'll give up my 20 seconds.

[*English*]

The Chair: Thank you.

We'll now go to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

Ms. Clark, I wanted to ask you a little bit about your organization. Your website indicates that it encourages older Canadians to "maintain and enhance their well-being and independence through a lifestyle that embraces physical activity and active living".

Could you describe how your organization promotes a healthy active lifestyle for seniors? As well, how do you measure your success? How would you measure that?

Ms. Patricia Clark: That's a really good question. I've been asking that, and I've been with ALCOA for four years.

What we do is we take the research of the day, we create resources for older adults, and we disseminate them through our membership. Our role really is to inform and educate and hopefully motivate older adults to make a change in their lifestyle. We do that through brochures and we do it through training seniors to speak to seniors. We really try to get down to the grassroots. We have an older adult speaking to a group of older adults, because we know it's their preference to have information shared that way.

We are by no means a programming organization, but we create resources for the local community leader to create programs in their community. To give you an example of what we're working on now, we have something for diabetes for older adults, getting them to understand how it's a lifestyle disease and how they can make changes in their lifestyle. We'll provide that information to community leaders to offer it within their community. We're hoping to be able to determine the impact of that, when this program goes out, to see what the change has been.

A lot of this information is simply resource-based. The only thing we have is the dissemination and how much we get out there. We don't know what the impact is, but we do know that they're constantly in demand. People do want our information.

Mr. Colin Carrie: So you're saying it is difficult to actually measure what's working and what's not working?

Ms. Patricia Clark: From our capacity, with what we have, yes, it is. We predominantly create resources.

We do get a lot of good feedback from individuals and older adults—i.e., I like this, I would like more, I want to share it with my friends—but we haven't any solid evidence to say what change has happened, except that, as I said, we hope to know from this new document, based on feedback after the courses are over, if they've made a change and how it's affected their lives.

Mr. Colin Carrie: Maybe I can follow up with Dr. Joanette.

Do you have surveillance programs in place to monitor, for example, the chronic conditions specifically related to aging? How would you say the different programs out there are impacting seniors? Are seniors getting the message from different organizations on how they could improve their specific conditions?

Dr. Yves Joanette: The Institute of Aging is not responsible for the delivery of these services. It's there to provide the knowledge that is then implemented. The kind of evidence that is used by ALCOA is based on research that shows, based on hundreds of seniors, that physical activity will have an impact and so on.

Now, the way we do this kind of surveillance is we partner with other agencies in the health portfolio of the government. That's where we have these discussions. Of course, through speaking and exchanges with these other agencies, we have a clearer picture of what's going on.

So we're not monitoring, ourselves, but with StatsCan, with the other agencies, we certainly make sure that we address these gaps and these priorities.

● (1715)

Mr. Colin Carrie: Are there any statistics relating to different chronic diseases and how different chronic diseases may affect the different sexes, male and female, as we get older? Do you have information on that?

Dr. Yves Joanette: That's a good question.

We know that life expectancy is a little bit greater in females than in males—unfortunately for me—but we know that a healthy life expectancy is not that different. The difference is in this period where there's a lack of functionality and good life. This is something we have to understand and address. Currently research is being done to understand why there is this gap between men and women in the portion of life expectancy that is not healthy.

Mr. Colin Carrie: Do I have time for another question?

The Chair: Yes.

Mr. Colin Carrie: The CIHR's Institute of Aging strategic plan for 2007 to 2012 notes the implementation of a Canadian longitudinal study on aging, beginning in 2008. What do you expect we'll find when we take a look at that? Do you have preliminary findings that you might be able to tell us about?

Dr. Yves Joanette: The deployment of this Canadian longitudinal study is, as you can imagine, a long-term thing. It will take about 20 to 40 years. We're at the point now, after three years, of the first re-evaluation of the cohorts, nearly 50,000 people. This is a unique platform Canada has for all the researchers in Canada, which will also attract research from outside of Canada and make Canada recognized as a leader in this area. I think this kind of research will allow us to determine the trajectory and to be able to answer more specifically what these determinants, such as nutrition and so on, are.

The Chair: Thank you, Dr. Joanette.

Thank you, Dr. Carrie.

We'll now go to Mr. Daniel.

Mr. Joe Daniel (Don Valley East, CPC): Thank you, witnesses. Certainly your reports were very interesting to me.

One of the things you've implied is that seniors are treated slightly differently in terms of response times for their treatment. Has anybody actually looked into the cost of all those delays to actually see what the benefit could be if treatment were done more quickly? In other words, what is the cost of a senior getting worse because treatment has been delayed, and what are the costs of all the other things, like keeping them in hospitals and so on?

Ms. Susan Eng: We haven't done the research ourselves. We rely on institutes like CIHI to help us with that kind of research. But certainly it bears doing research to see what the cost is. In individual emotional terms, it's quite obvious. There are both the perceived mistreatment and the real mistreatment. When there is a fear of mistreatment, that probably far exceeds the actual impact. So the neglect and the psychological trauma of feeling that your medical or physical needs are not being met exacerbate the problem.

We do get the concerns. We personally don't have the research showing what the impact of those is. We only have the anecdotes that cause us to point this issue out to the various policy-makers and administrators to make sure they are, first of all, judging whether or not they themselves are making differential choices based on a person's age and whether or not they are communicating their choices well so as to allay the person's fears. That has been our focus, rather than specific research as to whether or not treatment would actually have a negative clinical impact, but I think it stands to reason that it could. I'm not aware of research that has actually looked at that, but perhaps Dr. Joanette might know of some.

Dr. Yves Joanette: There was a very specific study done, the SIPA project, the integrated health system approach to older people, which showed that with this integration of community-based and hospital-based approaches, and with navigator nurses who would help the person and their family, the cost was not necessarily less, but with the same money the impact was much better. So I think that's the kind of impact we could have.

● (1720)

Mr. Joe Daniel: Changing the subject a little bit, when we talk about caregivers and caregiver support, are there proper training courses here that will actually train people to properly handle seniors as they age? I think there are a lot of caregiver-type programs that are around, but I'm not sure they actually address the issue.

Ms. Susan Eng: No, in fact we were partnering with the Yee Hong home to provide some caregiver support seminars. You don't really know what you don't know until you have to confront it. Do you know how to help somebody with a broken hip? Can you change a bed with somebody in it? Do you know how to handle dosing of medications? Most people go through their lives never knowing that or needing to know that, and suddenly they are obliged to take on the care of someone who is, by definition, more frail, and any mistake could be fatal.

What we're calling for, which we don't see a lot of or a systematized delivery of, is caregiver support in the form of training and education and constant support. That, to my knowledge, doesn't truly exist in a formalized way. We are also calling for navigators to help caregivers navigate the health care system. Again, it's a system they didn't need to access for themselves right away. These are ways in which the formal health care system can help us help them by simply providing information and support in training.

Mr. Joe Daniel: Are there any other comments?

Dr. Yves Joanette: The area of Alzheimer's disease is a good example, because there are a number of websites, in French.

[*Translation*]

There is the website www.aidant.ca.

[*English*]

which is a site CIHR supported. It was Francine Ducharme who disseminated this and Dr. Ken Rockwood in Halifax, in English. There is the Canadian Dementia Knowledge Translation Network. This is a website to exchange and offer support to all Canadians in the area of Alzheimer's. So maybe we should take these examples and expand on them.

Mr. Joe Daniel: Madam Eng, when we take a look at the diversity of Canada, we see that we have people from almost every country in the world. Are you finding that there are different sets of diseases that are prevalent in different groups?

Dr. Yves Joanette: There are certainly some genetic predispositions that are associated with some ethnic groups, and these have to be taken into account above and over the linguistic and cultural aspects.

The Chair: Thank you.

Now we'll go to Mr. MacAulay.

Hon. Lawrence MacAulay: Thank you.

There has been some discussion about responsibility and jurisdiction. Of course it is a provincial jurisdiction, but I am one who feels that whoever signs the cheque should have some say. Sometimes that would help a lot.

Ms. Clark, do you feel there are a lot of people in institutions who would not need to be there if there were proper preventative programs in place?

Ms. Patricia Clark: Yes, that's my gut feeling. Many people are there because of lifestyle issues. If they had the opportunity to change those lifestyle issues earlier in life, they wouldn't be where they are today. But that is not an easy thing to do. It's looking at behaviour change.

Hon. Lawrence MacAulay: I agree with you. It's hard to measure success and prevention, because how do you do it? If it didn't happen, you don't have it on the slate and then you can't go to governments and get the money.

Monsieur Joanette, as you indicated, the public deciders need to know. Somehow you're suggesting that there might be enough money around. I never saw anything yet that had enough money. But if it does, great.

A number of years ago I helped put a study together, and one of the most interesting things I got involved with was a doctor in Vancouver in a hospital. They closed a number of beds and they took the funds that they saved and put a program in place in a community where there were a lot of older seniors. In fact, they saved so much money that they could close a number of other beds. That's why I asked the question on prevention.

This doctor was also explaining to me about the drug problem, about his mother who lived in another province. When he was home, he would take her off the medication. All doctors are not perfect. We always believe them, but the fact is that sometimes they overmedicate.

A national home care program is something we need to have. I know it's provincial jurisdiction, but somebody has to be in charge. If there were a program put in place, you would have doctors, lawyers, engineers who would give their time. That's what happened in Victoria, British Columbia. It has to be put together. It would have to be a pilot project. I wanted to hear that here, because you're the people who would be feeding the information to the public deciders. I hope that some programs can be put in place not to cure diseases, but to prevent things like a broken hip. If you fall, somebody should be in who's properly trained, a doctor, who would help them get on their feet. That takes dollars out of government costs. It also gives the quality of life that the senior wants to have. It might not be what you think they should have, and we went through that with my parents. They wanted to be in their home.

You can go on and talk about home repair programs and rails above bathrooms. There are people who are short of money and these people cannot do it. Anyhow, there are many other things I could tell you, but I think you know where I'm going.

● (1725)

Dr. Yves Joanette: First of all, l hope you didn't hear me saying there was too much money for research. I'd need more knowledge if we want to take these evidence-based decisions. But you're right. You're referring to an integrated health systems approach from community to the hospital. We have the proof, the SIPA program of Dr. Béland. Dr. Bergman was one of the first in this field. This program was based on capitation—having the money following the person, not the building, and trying to see that the money is based on knowledge and individual choice, using nurse navigators. We need research to prove that.

The Chair: Ms. Eng.

Ms. Susan Eng: I want to comment on how the health care system can provide that transfer and that connection with the community. We talk about an acute event: a broken hip, a stroke, or a seizure. There is a project happening in Toronto—and I'm sure it's happening elsewhere also—called “virtual ward”. That consists of taking the acute ward, or monitoring the ward after an acute incident, and taking it home.

What do they do? They still discharge you after two or three days, but they follow you home with a case manager. Usually a nurse practitioner will monitor you on a daily basis, check you in, maybe order more tests if necessary, do everything they might do for you while you were in the hospital but in your home. This allows you to stabilize in your own home and look for options for rehabilitation and long-term care in your own home and the opportunity there is to prevent readmission. The value of preventing each readmission was estimated to be $10,000. So there's your opportunity right there to provide a win-win situation.

The Chair: I want to say a special thank you to all our guests. This was a very beneficial and insightful presentation today. This committee has a special interest in taking a very close look at aging and its effects on certain diseases that are so prevalent. So we want to thank you very much. And I thank the committee members for their very good questions.

The committee is dismissed.

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