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CHRONIC DISEASES RELATED TO AGING AND HEALTH PROMOTION AND DISEASE PREVENTION

Report of the Standing Committee on Health

Joy Smith, M.P.
Chair

MAY 2012

41st PARLIAMENT, 1st SESSION

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

EIGHTH REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied chronic diseases related to aging and health promotion and disease prevention and has agreed to report the following:

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CHRONIC DISEASES RELATED TO AGING AND HEALTH PROMOTION AND DISEASE PREVENTION

INTRODUCTION

From October 2011 until February 2012, the House of Commons Standing Committee on Health heard from witnesses on the issues of chronic diseases related to aging, as well as health promotion and disease prevention. A total of 17 meetings were held during which the Committee heard from government officials as well as witnesses representing health professionals, disease groups, seniors, patient advocates, researchers, private insurance and charitable organizations.

In undertaking this study, the Committee recognized that the administration and delivery of health care services is the responsibility of each province or territory. Guided by the provisions of the *Canada Health Act*, the provinces and territories fund these services with assistance from the federal government in the form of fiscal transfers. Health care services include insured primary health care, such as the services of physicians and other health professionals, care in hospital, home care, and scope of practice.

WHAT THE COMMITTEE HEARD

A. Some Statistics

1. Life Expectancy and Health Status

Life expectancy has reached 80.9 years in this country, according to testimony quoting Statistics Canada data.[1] In addition, almost 90% of Canadians report that they believe their health is good, very good or excellent.[2] In terms of life expectancy, members of the Committee heard that, since the early 1900s, the average lifespan of Canadians has increased by more than 30 years and that 25 of those years are attributed to advances in public health.[3] However, it was also pointed out that the number of years lived in good health peaked in 1996 and has since been declining.[4]

2. Healthy Eating, Obesity and Physical Activity Levels

The Committee heard that the burden of chronic disease is related to the dietary patterns, the rates of overweight and obesity and the levels of physical activity of Canadians. Witnesses stated that healthy eating reduces the risk of developing chronic diseases. It was suggested that 90% of type 2 diabetes, 80% of coronary heart disease, and one third of cancers could be prevented by healthy eating, regular exercise, and by not smoking.[5] Members were also told that as many as 48,000 deaths per year in Canada are related to poor nutrition.[6]

Witnesses spoke of the rising obesity rate, stating that the rate has doubled and in some cases tripled in several countries since 1980.[7] Data was presented for 2007-2008, which indicates that one in four Canadian adults were obese and one quarter of Canadian teenagers were either obese or overweight.[8] Childhood obesity rates have nearly quadrupled in the past three decades,[9] and the rate of obesity among Aboriginal children is significantly higher than it is for other Canadian children.[10] In terms of cost, the Committee was told that health costs related to the chronic diseases most consistently linked to obesity was $4.6 billion in 2008 compared to $3.9 billion in 2000.[11]

Reduced physical activity is also linked to poorer health. The Committee heard that fewer than half of all Canadians are as active as they need to be. Only 7% of Canadian children meet the daily physical activity guidelines and even fewer teenagers meet them.[12] It was told that as many as 25 chronic diseases are directly linked to physical inactivity, and that an inactive person will spend 38% more days in hospital use 5.5% more family physician visits, 13% more specialist services, and 12% more nurse visits compared to an active person.[13]

3. The Aging Demographic

The first of Canada's baby boomers turned 65 years old in 2011, marking the beginning of the anticipated demographic shift which will give rise to an increase in the proportion of Canadians aged 65 years and older. The Committee was told that today, 14% of the population is over 65 years but by 2021, this will rise to 6.7 million people[14] and by 2036, almost 25% of Canadians, or 10 million people, will be seniors.[15] It also heard that in many regions of low population density – that is rural Canada, the senior population is already disproportionately high.[16] Furthermore, by 2041, 4% of the population, or about 1.6 million Canadians, will be over the age of 85 years.[17]

4. The Burden of Chronic Disease

Several witnesses commented on the prevalence of chronic disease, particularly among seniors, and indicated that chronic disease is the major cause of death. Among the most prevalent chronic conditions are cardiovascular disease (heart disease and stroke), cancer, diabetes and respiratory disease. Other common chronic diseases include arthritis, chronic pain and mental health issues such as dementia and depression. Witnesses indicated that between 74% and 90%[18] of seniors suffer from at least one chronic condition, while about one quarter of the senior population is affected by two or more of these conditions.[19] In terms of medications, the Committee was told that 74% of seniors were taking at least one medication[20] while 15% takes five or more medications.[21]

The Committee heard that chronic diseases cost the Canadian economy $190 billion annually,[22] $90 billion of which is attributed to treatment and the remainder to lost productivity.[23] The Committee was told that treatment of chronic diseases consumes 67% of all direct health care costs.[24] Many witnesses stressed that more focus on prevention strategies, coupled with improved diagnosis and management of chronic disease, is needed as Canada heads into the coming years of an aging demographic.[25]

B. Overview of Government Initiatives[26]

The Committee heard that the Govenment of Canada is investing in partnerships to promote the development of conditions for healthy aging. These partnerships address social inclusion, keeping seniors independent, improving their quality of life, helping them understand what they need to do to prevent chronic disease or to delay its onset, and keeping them connected in their communities.[27]

The Committee heard from officials representing the Public Health Agency of Canada (PHAC, the Agency) who outlined the federal initiatives aimed not only at chronic diseases related to aging, but also to health promotion and disease prevention in general. As such, Committee members were told about a variety of initiatives across the lifespan but which also promote healthy aging and address the burden of chronic disease in the elderly. Many of these actions involve partnerships with provincial and territorial governments, non-governmental organizations and business. Officials spoke of the importance of a multi-sectoral, or whole-of-society, approach, not one that is simply restricted to the health sector. The Committee heard that this approach complements the recent United Nations' meeting in September 2011 when Canada joined in the endorsement of the need to include all sectors when designing chronic disease prevention strategies.

1. Federal/Provincial/Territorial Governments Working Together on Healthy Living and Chronic Disease

In 2005, the federal government invested $300 million over five years in the *Integrated Strategy on Healthy Living and Chronic Disease*. In September 2010, these efforts were renewed when Federal, Provincial and Territorial (F/P/T) Ministers of Health endorsed two initiatives:

a) *The Federal/Provincial/Territorial Declaration on Prevention and Promotion*[*] – In 2010, the federal government announced $74.4 million in sustained annual funding in support of the F/P/T *Declaration on Prevention and Promotion.* This Declaration *was* endorsed by all Ministers of Health and Health Promotion/Healthy Living and it outlines a shared vision to work together to make prevention of disease, disability and injury, and health promotion a priority. The Declaration acknowledges that many actions to be taken in order to improve health lie outside of the health sector because many determinants of health lie outside of the health sector. The Declaration also acknowledges the burden of chronic disease that is associated with unhealthy lifestyles;

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* The FPT Declaration on Prevention and Promotion (September 2010) is available at: http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/declaration/pdf/dpp-eng.pdf.

b) *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*.† The framework includes the following three integrated strategies that build on the work of the Pan-Canadian Healthy Living Strategy and the Declaration on Prevention and Promotion:

   i. Making childhood overweight and obesity a collective priority for action for F/P/T Ministers of Health and/or Health Promotion/Healthy Living, who will encourage shared leadership and joint and/or complementary action from government departments and other sectors of Canadian society.

   ii. Coordinating efforts on three key policy priorities:

      - supportive environments: making the social and physical environment where children live, learn and play more supportive of physical activity and healthy eating;

      - early action: identifying the risk of overweight and obesity in children and addressing it early; and

      - nutritious foods: looking at ways to increase the availability and accessibility of nutritious foods and decrease the marketing of foods and beverages high in fat, sugar and/or sodium to children.

   iii. Measuring and reporting on collective progress in reducing childhood overweight and obesity, learning from successful initiatives, and modifying approaches as appropriate.

Committee members heard that the collaborative approach of F/P/T governments involves the formation of partnerships between the federal, provincial and territorial governments. PHAC officials explained that creation of the Agency included the recognition that effective public health strategies require the participation of all jurisdictions. In this regard, the Pan-Canadian Public Health Network (PHN) was created which is governed by a 17-member Council that includes representatives from F/P/T governments. The mandate of the PHN includes: information sharing; providing policy and technical advice to F/P/T Deputy Ministers of Health; and providing support to jurisdictions during public health emergencies.

The collaborative approach of the F/P/T governments includes programs aligned with its three pillars: health promotion, chronic disease prevention and support for early

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† Public Health Agency of Canada, *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*, 2011, http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/framework-cadre/index-eng.php.

detection and management of chronic diseases. Health Canada and its agencies support programs that include disease-specific strategies and frameworks which have been developed through partnerships with governmental and non-governmental stakeholders. They include: cardiovascular (the Canadian Heart Health Strategy), cancer (the Canadian Strategy for Cancer Control implemented through the Canadian Partnership Against Cancer), diabetes (the Canadian Diabetes Strategy), respiratory (the National Lung Health Framework), and mental health (the Framework for a Mental Health Strategy for Canada). Also included is the Enhanced Surveillance of Chronic Diseases program and officials emphasized the need for improved surveillance of chronic disease.

Surveillance falls under PHAC's mandate, and the Agency maintains a number of databases for both communicable and non-communicable conditions. With respect to chronic diseases, the Enhanced Surveillance of Chronic Diseases program initially provided surveillance data for high blood pressure and diabetes under the Canadian Chronic Disease Surveillance System. This program has also provided $15 million over four years for the National Population Health Study of Neurological Conditions. This study will help to improve the quality of surveillance data for conditions such as Alzheimer's disease, Parkinson's disease, epilepsy, neuromuscular disorders, etc. Prevalence, incidence, morbidity and mortality data for chronic conditions including cancer, cardiovascular disease, neurological conditions, arthritis, mental health, diabetes and respiratory diseases are provided through PHAC's *Chronic Disease Infobase* as information becomes available.

The Committee heard that federal investments include the improvement of policy and program decision-making by facilitating access to the best available evidence on chronic disease prevention and health promotion practices. These investments include the Best Practices Portal, a knowledge exchange component and a component to measure uptake in practice activities. The Best Practices Portal is a compendium of community interventions related to chronic disease prevention and health promotion that have been evaluated, shown to be successful, and have the potential to be adapted and replicated by other health practitioners.[28]

With respect to mental health promotion, the Committee heard about federal investment in the Mental Health Commission of Canada (MHCC) which has developed the framework mentioned above and the Canadian Coalition for Seniors' Mental Health (CCSMH), which has developed practice guidelines for practitioners.

International cooperation is also a component of the Agency's integrated approach to chronic disease prevention. In this regard, PHAC officials outlined the Agency's collaboration with the World Health Organization (WHO) in building surveillance capacity in underdeveloped countries. PHAC also works with countries in the Americas, called the CARMEN network, to develop and share case studies having to do with prevention strategies, primarily with respect to obesity. Through the work of the network, prevention discussion is advanced and policy change is facilitated. Finally, PHAC indicated that it works closely with the Pan American Health Organization on the issue of sodium reduction in food.

Finally, PHAC officials spoke of the report entitled *Action Taken and Future Directions 2011*, which was endorsed at the Health Ministers Meeting in November 2011. The report highlights actions that had been taken to advance the framework since September 2010, and makes recommendations and proposed actions that can be taken by Ministers of Health and their governments, as well as other sectors, until the fall of 2012 and beyond.

2. Initiatives in Chronic Disease Prevention and Management

PHAC officials described initiatives that are specific to seniors. The National Seniors Council was created in 2007 to provide advice on emerging issues and opportunities specific to the quality of life and well-being of seniors. It reports to both the Minister of Human Resources and Skills Development and the Minister of Health. Members also heard that Canada participates in a program that was initiated by the WHO called Age-friendly Communities. Under this program, PHAC provides leadership to communities in efforts to enhance or improve the built environment within a community in order to encourage healthy, active living among seniors. Infrastructure such as lighting, width of sidewalks and accessible curbs were cited as examples. The Committee heard that, while over 560 communities across Canada are participating in this initiative, the majority (316 communities) are in Quebec.[29]

The Age-friendly Communities initiative brings older Canadians into the planning and design of their own communities to create healthy, safe, and supportive environments where they can live and thrive. The initiative has resulted in several communities being safer and more accessible to seniors, while also putting older Canadians at the centre of policy discussions about how age-friendly communities are designed.

PHAC officials also mentioned that, outside of the Canadian Diabetes Strategy, the Aboriginal Diabetes Initiative is delivered through Health Canada's First Nations and Inuit Health Branch. This strategy emphasizes prevention strategies as well as improved management of diabetes, much like the Canadian Diabetes Strategy, but it is tailored to be more relevant and effective for the Canadian Aboriginal population.

Finally, members heard that PHAC has developed an assessment tool for Canadians called CANRISK. This questionnaire is designed to improve the identification of individuals at risk of developing diabetes and who would benefit from prevention strategies to delay onset of the disease, or succeed in preventing the disease altogether.

3. Initiatives in Health Promotion

a) Healthy Eating and Health Weights

Witnesses described Canada's food guide which was first introduced in 1942 and was updated most recently in 2007. Health Canada's food guide, entitled *Eating Well with Canada's Food Guide,* was developed using evidence-based nutrition policy and is designed to help Canadians make healthy food choices that will meet their nutrient needs, promote health, and prevent nutritional deficiencies.

With respect to funding initiatives to promote healthy eating and healthy weights, the Committee was told that the federal government invests annually over $112 million to support vulnerable children and their families through various programs such as the *Community Action Program for Children*, the *Canadian Prenatal Nutrition Program*, and the *Aboriginal Head Start Program* in urban and northern communities. The *Canadian Prenatal Nutrition Program* was described as a community-based program delivered by PHAC to help communities promote public health and provide support to improve the health and well-being of pregnant women, new mothers and babies facing challenging life circumstances. Witnesses informed the Committee of the government's *Canadian Gestational Weight Gain Recommendations* which are designed to help health professionals and expectant mothers manage weight gain during pregnancy. Finally, the *Eat Well and Be Active Educational Toolkit* from Health Canada is designed to help educators who teach groups of children and adults about healthy eating and physical activity. Finally, in order to improve access to nutritious, perishable food to help Canadians living in isolated northern communities,the federal government invests $60 million annually to the *Nutrition North Canada Program*.[30]

b) Physical Activity and Injury Prevention

Physical activity and active living are important for maintaining good health. Between 1998 and 2002, physical activity guides were developed by the federal government and the Canadian Society for Exercise Physiology (CSEP) for adults, older adults, children and youth. In January 2011, updates to all four sets of guidelines were released by CSEP.

In March 2011, the federal government announced a $5 million investment over two years in sports and recreation injury prevention through collaboration with non-governmental organizations that focus on major injuries. These include concussions, drowning and fractures incurred during high-participation activities such as hockey, snow sports, cycling and water sports.

4. Federal Investment in Research[31]

Throughout the course of the meetings, members heard about research projects supported by the Canadian Institutes of Health Research (CIHR). CIHR, comprised of 13 virtual institutes, is Canada's granting agency for all types of health research, from biomedical to clinical, to health service delivery. Its annual budget is around $1 billion. Several of these institutes are involved in research in the areas of health promotion and chronic disease prevention and management.

CIHR informed members that it was a founding member of the *Global Alliance for Chronic Diseases*. This international alliance, announced in June 2009, involves the collaboration of six health research agencies around the world which have committed to set priorities for a coordinated research effort focussing on chronic disease. In the interest of advancing this priority, the Committee members were told that CIHR's strategic plan for 2009–2010 to 2013–2014 includes a strategic research priority regarding the burden of chronic disease and mental illness. Within the context of this priority, CIHR notes the need

to enhance patient-oriented care, the pressures placed on the health care system due to the aging population and rising rates of chronic disease, and the importance of leveraging resources by working collaboratively with other departments, agencies and non-governmental organizations to address research needs.

The Committee was told that the federal investment in aging research through CIHR's Institute of Aging was $122 million in 2009–2010. Of this, $44 million were awarded in 2010 to support Canadian diabetes research, and additional funds to support research related to cancer, heart disease, and stroke.[32] Several witnesses mentioned the Canadian Longitudinal Study on Aging (CLSA), one of CIHR's strategic initiatives. The CLSA will follow a cohort of individuals aged 45 years and older for 25 years to help understand the evolution of disease, and the psychological attributes, function, disabilities and psychosocial processes that accompany aging. The Committee heard that, to date, $38 million have been invested through CIHR along with $15 million from provincial and other partners.

The Committee heard that CIHR has been active in promoting research in the areas of health promotion and disease prevention. In addition to ongoing investment in obesity research, CIHR indicated that it funds research into disease prevention through its various institutes, as well as health promotion generally, and more indirectly, on food and nutrition research. In November 2010, CIHR's Institute of Nutrition, Metabolism, and Diabetes held a workshop entitled "Advancing Food and Health Research Priorities in Canada", which aimed to identify gaps in research.

To increase the capacity of Aboriginal communities to act as partners in the creation, oversight and application of research to reduce the health disparities among Aboriginal Peoples, the Committee heard that CIHR has developed the "Pathways to Health Equity for Aboriginal Peoples".

The Committee was also told about the *Canadian Community Health Survey* administered by Statistics Canada which collects information related to health status, health care utilization and social determinants of health of the Canadian population. The survey focused on nutrition in 2004 and it will be repeated in 2015.

Finally, members were told that, in July 2010, the federal government announced an $8.2-million investment over five years in *CIHR Strategic Teams in Applied Injury Research*. Five injury research teams are funded under this investment and will conduct research on childhood injuries.

The Committee heard a range of concerns, as well as a number of suggested approaches, from several witnesses over the course of the Committee meetings. These issues are outlined below.

C. Issues Pertaining to Chronic Diseases Related to Aging

1. Provincial Role in Training, Remuneration and Scopes of Practice of Health Professionals

Some witnesses voiced their strong concern over inadequate training of health professionals to properly identify, treat and manage chronic disease in the elderly. These concerns included not only an inadequate supply of physicians who specialize in the care of the elderly (geriatricians), but also the failure to provide adequate training to general practitioners for the care of elderly patients. For example, members were told that there are only 200 geriatricians in Canada, but that the need is currently for 500-600 and they were cautioned that this need will only increase as the population ages.[33] Similarly, the Committee was told that by 2020, there will be a 35% shortage of respirologists.[34] The suggestion was raised that medical training should focus less on specialties associated with acute care.[35] The salaried remuneration model for geriatricians, as opposed to the fee-for-service model used for most other practitioners, was presented on one hand as a disincentive to enter the specialty,[36] but on the other hand, the Committee heard that evidence suggests a fee-for-service model does not encourage interdisciplinary care or the best care.[37] Witnesses indicated that, in terms of training and continuous education, aging is not sufficiently addressed for physicians and other health professionals.[38]

The Committee heard that improved training of health professionals, particularly in the provision of chronic care for the aged, is being addressed through a five-year initiative in Ontario called the *Associated Medical Services Phoenix Project: A Call to Caring*. The project was described as addressing the need to balance compassion and technical expertise in the provision of patient-centred care.[39] It also heard that this approach, within a health promotion and disease prevention model, has been proposed by the Association of Faculties of Medicine of Canada to address the evolving training needs of future medical practitioners in response to the increasing burden of chronic disease and the aging population. Witnesses commented also on access to primary care and stated that not only is there a shortage of physicians specializing in geriatric care, but also of physicians being trained for general practice. The Committee was told that as many as 6% of Canadians who suffer from at least one chronic disease related to aging do not have access to a primary care physician.[40]

While scope of practice is under provincial jurisdiction, it was raised by pharmacists and paramedics as a way to better utilize health resources. Pharmacists were described as an accessible health care provider in the community. The Committee was told that, as such, they are well suited to provide a “medication management service” through which they assist in chronic disease management by providing comprehensive medication information, monitoring individuals for adverse drug reactions, addressing issues of compliance with medication regimens and communicating with the health providers when identifying problems and proposing alternate therapies. Members were also told that inclusion of pharmacists within a collaborative model of health care, which is discussed in greater detail later on, has the potential to produce a cost saving to the health care

system. As well, pharmacy-based screening programs such as the one in place for blood pressure monitoring in Ontario, can reduce hospital admissions.[41]

Paramedics were described to Committee members as the third largest health care provider group in Canada. The Committee heard that community paramedicine, which would require an increased scope of practice in some cases, permits paramedics to provide non-emergency patient care –both preventative self-care and rehabilitation care, within the community. The argument was presented that effective care transition from hospital back into the home through community paramedicine could reduce readmissions to hospital, which currently stands at 15% within 30 days of discharge. Similarly, community paramedicine was presented as an effective way to divert 911 calls and reduce emergency room visits, as well as a means of keeping elderly patients in their homes, as opposed to a hospital bed, while they wait for long-term care placement.[42]

2. Need for Language, Ethnic and Cultural Sensitivity

The issue of ethnic and cultural sensitivity and the need to provide services in the appropriate language was put forward. While the issue was raised as to whether there is an obligation in Canada to provide health and social services in both officials languages, Committee members also heard that in cases of dementia, which affects one in eleven seniors,[43] a person's capacity for their second language is one of the first things to be lost.[44] Similarly, members were informed about the need for interventions by family or other caregivers when language becomes a barrier.[45]

In terms of demographics of ethnicity, the Committee was told that the urban Canadian population has become progressively more ethnically diverse in the last two decades, and this trend is expected to continue.[46] The Committee was informed that the Chinese community is one of the largest ethnic groups and as such, has served as the first group for which culturally sensitive models of service delivery have been developed. It was explained that it is not so much health care needs that are unique to any particular ethnic group, but rather the manner in which they respond to a particular strategy.[47]

Finally, Committee members heard that the recognition of foreign credentials with respect to health professionals coming to Canada provides an opportunity to broaden Canada's base of health professionals who can also contribute necessary language and cultural knowledge.[48]

3. Managing Those Affected by Chronic Disease

Several witnesses commented on the complexity of managing elderly patients with chronic disease. As indicated earlier, the majority of seniors suffer from at least one chronic condition and take at least one prescription drug, while a significant proportion are affected by several and have been prescribed multiple medications.

The Committee heard from witnesses who spoke about the burden of various chronic conditions. Members were told that there is a strong link between age and type 2 diabetes, and that being 40 years of age or older is a key risk factor to developing the

disease, followed by overweight and a sedentary lifestyle. The Committee was told that the prevalence of diabetes is increasing, affecting 7.6% of the population currently, but expected to rise to 11% of all Canadians by 2020. Factoring in those at risk of developing diabetes means that currently,1 in 4 Canadians is affected and that this is expected to increase to 1 in 3 by 2020. Similarly, there is a significant cost to the health care system. Committee members heard testimony that the current cost is $11.7 billion, and that this is expected to increase along with the condition's prevalence to $16 billion annually. Of particular note is that 80% of this cost is associated with the complications arising from diabetes, namely heart attack and stroke, kidney disease, blindness, amputation, and depression.[49] However, the Committee was told that the aging of the population accounts for an increase of only 1% in the cost of health care services.[50]

The Active Living Coalition for Older Adults has received funding from Health Canada and PHAC to develop information resources to help older adults understand that chronic diseases, including diabetes, are often associated with lifestyle. Information about how seniors can modify their lifestyle is provided by the Coalition to community leaders and offered to older people in their communities.[51]

The Committee heard that cancer, which is now considered a chronic disease due to improvements in treatment and management, is also age-related and increasing in prevalence. It was told that between 2007 and 2031, the number of new cancer cases is expected to increase by 71%. About 30% of deaths are caused by cancer. [52] Funding for the Canadian Partnership Against Cancer, which was created by the Government of Canada in 2007, has been extended another five years from 2012 to 2017. While 50% of patients with cancer will die from the disease, patients and families are often not prepared for end-of-life decisions and conversations. The Committee was told that the Canadian Partnership Against Cancer works with the Quality End-of-Life Care Coalition of Canada's blueprint for action, in order to advance palliative care in the country.[53]

Heart attacks and stroke, or cardiovascular disease, account for slightly less than 30% of deaths overall; however, they are the leading cause of death and disability among Canadians 65 years and older, The Committee heard that age is the single largest predictor of stroke and that probability of stroke begins to rise at age 55 and doubles every decade thereafter. Members were told that, while 50,000 Canadians are hospitalized with stroke each year, five to ten times as many suffer smaller strokes for which medical attention is not sought, even though they produce some level of disability. The Committee was told that the increasing prevalence of obesity and diabetes, combined with the aging population, will contribute to an increase in cardiovascular disease in the years ahead.[54]

Committee members heard that respiratory illnesses also become considerably more prevalent among seniors. Some statistics that were presented included: 80% of lung cancers occur in people over 60 years of age; prevalence of chronic obstructive pulmonary disease (COPD, previously known as emphysema) among people 65-74 years old is triple that for those 35-44 years old; lung diseases currently cost $15 billion annually and this is expected to increase to $27 billion annually by 2020; COPD is a contributing factor in 50% of influenza-related deaths; and the prevalence of lung disease will increase by 33-41% in the next 30 years.[55] To achieve the goal of concerted, coordinated action, the

federal government has partnered with the lung health community in a National Lung Health Framework. Under this framework, an action plan has been developed to improve lung health by focussing on improvements in prevention, diagnosis and treatment. The Committee learned that following an initial strategic assessment of the current state of awareness of lung disease in Canada, it will now undertake targeted actions that are expected to have a significant impact on reducing lung disease.[56]

Witnesses also spoke of the burden of musculoskeletal diseases, including arthritis and osteoporosis. Arthritis was presented as the most frequent cause of disability, affecting one in six Canadians, or 4.5 million people. It affects about 1.7 million seniors. Musculoskeletal diseases are also linked to other chronic diseases. The Committee heard that they can directly impact a person's capacity for physical activity, thereby having a negative effect on overall fitness level, body weight, diabetes and mental health.[57] In addition, the Committee was told that musculoskeletal diseases not only affect individuals, but they also carry significant implications on the collective workforce. This reduced capacity for physical activity and increased mental health risk results in a lower level of productivity and decreased participation in the labour market. This makes musculoskeletal diseases among the most costly diseases in Canada.[58]

Chronic pain was addressed during this study as an issue that should be included when studying chronic diseases related to aging. Members heard that one in five Canadians lives with chronic pain, and this prevalence increases with age. Chronic pain is often under-diagnosed and under-managed. As in the case of musculoskeletal conditions, chronic pain affects many aspects of everyday life. They negatively impact physical activity and social interactions, thereby contributing to lowered fitness levels, increased body weight, increased incidence of diabetes, increased heart disease and stroke, and increased incidence of depression.[59]

The complexity of managing patients with multiple chronic diseases was expressed by several witnesses. The Committee heard that as many as one in four seniors aged 65–79 years has at least four chronic conditions, and this increases to one in three for those aged 80 years and older.[60] It was also noted that these co-occurrences are not necessarily age-related but life-style related, that is, the lack of physical activity and excess weight are associated with increased risk of several chronic conditions including heart disease, diabetes and some cancers.[61] Several factors are responsible for making the effective management of these patients complex. There is the overall diminished capacity to tolerate and respond to drugs with advancing age,[62] the increased probability for adverse reactions to drugs and negative impacts of one drug on another,[63] the increased incidence of over-medication,[64] diminished capacity to articulate symptoms and other concerns when compromised by mental health issues, difficulty in obtaining an overall picture of care when there are multiple caregivers. This is further complicated by a lack of electronic health records, and reduced compliance with treatment regimens due to financial and mobility limitations. Members heard that untangling the symptoms of physical illnesses from those of mental illnesses requires proper training. As a consequence, treatable conditions often go undiagnosed and untreated.[65] The Committee was told that financial limitations not only compromise the patient's capacity for out-of-pocket expenses

associated with their medical and long-term care, but also impact the individual's ability to buy nutritious food, participate in community events and remain physically active.[66]

With respect to the challenge of adverse drug reactions, the Committee heard of the e-therapeutics+ initiative of the Canadian Pharmacists Association. Under this initiative, all Health Canada advisories are posted to disseminate this information to health professionals.[67] The Committee also heard of various initiatives that address the concerns of physical and social participation amongst older Canadians, which are discussed later in this section under "Social Determinants of Health".

4. Increased Focus on Mental Health

Concern for the mental health of Canada's seniors was frequently mentioned throughout this study. Witnesses urged the inclusion of seniors' mental health when considering the issue of chronic diseases.[68] The Committee was told that an individual with mental health issues is not going to take much interest in their other health problems. As such, it heard, there is little need to develop strategies to deal with other physical health concerns if we do not first learn how to address mental health concerns.[69]

Dementia, including Alzheimer's disease and associated conditions, was referred to as the godfather of chronic disease. Members were told that, while dementia in its many forms has a large impact on health care, it has an even larger impact on alternative levels of care.[70] Members heard that currently, 500,000 seniors suffer from dementia and that this is expected to rise to 1.1 million by 2038. In terms of prevalence, this represents an increase from 1.5% to 2.8% of the overall population, although dementia is diagnosed primarily in seniors.[71] Several witnesses emphasized that measurement of dementia's prevalence does not accurately measure its actual impact, as it also adds a significant burden on caregivers in terms of stress, depression and burnout.[72]

Members were told that dementia is the most common reason for transferring patients from acute hospital bed spots to alternate levels of care. It was explained that seniors are generally able to manage their chronic conditions until they are affected by dementia. At that point, self-management is difficult and the individual enters a cycle of hospitalization, stabilization, discharge to home, poor self-management, deterioration in health, and re-admission to hospital. The Committee heard that this cycle often repeats itself unnecessarily as health professionals fail to identify the mental health issue.[73] As a result of this association, many provinces have developed their own Alzheimer's strategy, some under a broader seniors' strategy. The Committee heard that there is ongoing work in jurisdictions across the country in terms of serving people with Alzheimer's and keeping seniors healthy and their minds active.[74]

Depression was frequently mentioned as a significant mental health issue among the elderly. Members were told that as much as 15% of seniors who live in the community suffer from depression.[75] However, the Committee heard that this proportion increases to as high as 80–90% within long-term care facilities. WHO statistics project that, by 2020, depression will rank second with respect to both productive and potential life years lost. Witnesses spoke of the most tragic complication of depression: suicide. The suicide rate

among men aged 90 years and older was stated as being 33.1 per 100,000, almost double the average across all age groups.[76] Risk factors for suicide include the chronic conditions discussed above.

The Committee heard that some work has been done with older adults by creating user-friendly brochures to educate them about depression and other common mental health issues. This initiatve will help to remove the stigma of mental illness, to allow seniors to identify symptoms and to help people feel more comfortable about raising the issue with their physicians and ask for help.[77]

The Committee was told of the Seniors Advisory Committee of the Mental Health Commission of Canada and of its contribution to Commission's Mental Health Strategy, which was subsequently released on 8 May 2012. The Advisory Committee has developed guidelines for comprehensive mental health services for older adults. Members heard that research regarding health service delivery has also focussed on mental health.[78] Research has also been exploring the role of physical activity as well as social participation and their positive effects on mental health.[79]

5. Personal Responsibility and Self Care

Several witnesses commented that chronic disease is not an inevitable consequence of aging.[80] Healthy living, including nutritious diet, active lifestyle and the avoidance of unhealthy or risky behaviours, goes a long way in preventing or delaying the onset of chronic diseases. Witnesses indicated that the majority of seniors are able to remain in their home and maintain a level of independence for most of their life. This includes retaining control over their health care and managing any necessary treatment in consultation with their health care providers.[81]

The Committee heard about initiatives that encourage older Canadians to maintain a physically and socially active lifestyle. As mentioned earlier, Canada participates in the Age-friendly Communities initiative, developed by the WHO. This initiative, which is particularly active within Quebec, provides leadership to communities to improve their suitability to older Canadians for adopting healthy, active lifestyles. Central to this is a focus on social participation. This was described as being essential to an overall sense of belonging and contributing to society, which in turn has a positive effect on overall physical health, reduces depression and helps to slow down cognitive decline.[82] It was also suggested that cognitive stimulation can, in some instances, outperform medication.[83] The Canadian Partnership Against Cancer has also designed an initiative which looks at healthy communities called Coalitions Linking Action and Science for Prevention.[84] Similarly, Canada's Active Living Coalition for Older Adults promotes, through partnerships with national, provincial and local organizations, active lifestyles among seniors as a means to contribute to their overall well-being. This is done through increasing public awareness of the benefits of an active lifestyle, providing resources and social supports to older adults to encourage uptake of healthy lifestyles, and identifying, supporting and sharing research priorities.[85] Finally, the Canadian Chiropractic Association spoke of the *Best Foot Forward* program, a campaign aimed at seniors that provides strategies for preventing falls, along with promoting balance and strength.[86]

In addition to the personal responsibility for adopting healthy, active lifestyles in support of preventing and delaying the onset of chronic conditions, witnesses spoke of the need to promote self-care in the management of health issues. Self-care was described as a means of empowering seniors and their caregivers to be active partners in disease management.[87] It was suggested that there should be public awareness campaigns which promote active self-care to encourage all Canadians and communities to take responsibility for their own health, as well as national guidelines specific to the self-care of various chronic conditions.[88]

In addition to promoting personal responsibility by embracing healthy lifestyles to prevent or delay the onset of chronic disease, and by adopting self-care practices and taking ownership of an individual's health issues, the Committee also heard from the insurance industry that Canadians should take personal responsibility when it comes to coverage for long-term care. They suggested it was the individual's responsibility to plan for this possible eventuality, either through personal savings or private long-term care insurance coverage.[89]

6. Community-based Care

As the Committee heard, the majority of older Canadians live independently in their homes, and want to remain there. It was told that only 7% of Canadians over 65 years of age reside in health care institutions[90] and that between 20 and 30% of long-term care residents do not have to be in those institutions. It was informed that often, they are there because they cannot perform the activities of daily living, but cannot afford assisted living within a seniors' residence.[91] In fact, there is often no compelling reason to send many of our seniors to long-term care in terms of health needs.[92] Witnesses urged improved community-based services, including home care, as a means of reducing hospital and emergency room visits and allowing seniors to remain in their homes and live independently for as long as possible.[93]

In terms of community-based care, the Committee heard that the system needs to be strengthened through improved integration of services and better utilization of the scopes of practice of all health care professionals and home care providers.[94] Witnesses suggested that community-based services could include mobile health clinics, after-hours services, home visits, community outreach programs, paramedicine for non-urgent care, medication management service by pharmacists and mobile emergency nurses to respond to non-urgent calls.[95] Members heard that there are also Scandinavian models of community-based care that Canada could look to for direction.[96]

Several witnesses commented on the need to improve provision of home care services as one element of community-based care. It was pointed out that the need for comprehensive, publicly-funded home care has been highlighted previously, such as in the reports of the Royal Commission on the Future of Health care entitled *Building on Values — The Future of Health care in Canada*[97] and of the Special Senate Committee on Aging entitled *Canada's Aging Population — Seizing the Opportunity*.[98] They noted that the 2004 Health Accord provided for specific focus on home care but indicated that this has not yet been adequately addressed.[99]

Members were told that currently, home care services are focussed on post-hospital recovery as opposed to chronic disease management.[100] They heard that the health care system revolves around acute care within hospitals and clinics and does not extend to continuing care to address quality of life issues for individuals with chronic conditions.[101]

It was suggested that this involves not only regulated health professionals but also better support for informal caregivers. Some witnesses acknowledged the recent federal incentives, including extended employment insurance benefits on compassionate grounds for caregiving purposes, as well as the non-refundable tax credit. Others called for additional caregiver support, such as training and education, which falls under provincial jurisdiction.[102] It was suggested that such training could include patient care issues as well as training to assist caregivers in navigating the health system.[103] As mentioned above, stress, fatigue and burnout of informal caregivers have emerged as concerns when considering the care of those with chronic, as well as terminal, conditions. The Committee heard that extended benefits to caregivers should include mental health supports and providing respite, which also fall under provincial jurisdiction.[104]

With the aging demographics, the need for long-term beds will increase. As discussed, one way to mitigate this is to make better use of home and community care resources, so that those who have been admitted to long-term beds are those who need to be there. Witnesses also commented that this will result in shorter stays for individuals within the long-term care setting. The Committee heard that progress has been made in this regard. Committee members were told that seniors who are transferred to long-term care facilities are spending the last one to two years of their life there.[105] This is shorter than has been the case in decades past when stays averaged 8-10 years. Nevertheless, witnesses emphasized that optimized community-based care could effectively reduce this stay even more[106] and that ultimately, residence in long-term care facilities or nursing homes should be only a few months.[107] Achieving this outcome, however, is inhibited given that long-term care has the lowest proportion of funding of any sector in which health care is provided, the fewest number of researchers interested in the field, and the lowest rates of research funding.[108]

7. Social Determinants of Health

Committee members heard that the onset of chronic illness, in addition to being linked to unhealthy living habits, is also linked to an individual's biological and genetic makeup and social environment. The social environment was described as including social determinants of health, namely income status, education level, housing and social isolation.[109] Witnesses spoke of the important role played by housing and income status as a determinant of a person's health. Committee members heard of the burden of out-of-pocket expenses for care and treatment of chronic conditions[110] for many seniors, and that investment in social housing would have a direct impact on health status.[111] In a broader context, members were told that the health of older adults is being analysed in relation to social inequalities. Research shows that these inequalities become more pronounced as a person ages, such that those individuals at more of a disadvantage with respect to social determinants of health bear an even greater than expected health consequence. This was

referred to as “accumulated disadvantages”.[112] Members were told that, with respect to caring for older persons living with chronic conditions, it is not possible to separate health from social services.[113]

8. An Integrated, Multi-sectoral Approach to Health care

Several witnesses emphasized the need to transform the current acute care model of health service delivery to one which better accommodates the needs of those struggling with chronic conditions, particularly the elderly. Witnesses also talked about the need to expand the scope of primary care beyond simply family practice.[114] It was explained that such a change in policy would require a shift from involving mainly acute disease to including the significant role of chronic disease, and in so doing, needs to move away from institution-based care to a network of health care.[115] They described the integration of a variety of services delivered by a range of sectors within society.[116] Within the health sector, witnesses insisted that silos need to come down so that all health professionals can work collaboratively in the best interest of individuals in need of the complex care required for effective management of chronic conditions.[117] In terms of integrating other sectors, witnesses spoke of the unique needs of the elderly with chronic conditions and urged continuing care services which may not currently be considered as medically necessary.[118]

An inter-disciplinary model of care involving the integration of services provided by a range of health professionals was presented as essential in providing the complex care required for older adults with chronic conditions. The Committee heard that such a model of care would be best suited to support patients as they struggle to manage their own health needs and maintain a good quality of life.[119] Members were told that such a team-based model would have to be patient-focussed and work seamlessly out in the community, as well as within health centres, senior residences and long-term care settings.[120]

Models of integrated care for the elderly have been designed and implemented both within Canada and elsewhere. Committee members heard about two research programs in Quebec, the SIPA (System of Integrated Care for Older Persons with Disabilities)[121] and PRISMA (Program of Research to Integrate the Services for the Maintenance of Autonomy)[122] models of integrated care for the elderly. The SIPA model integrates institution-based and community-based care and has been shown to increase patient satisfaction. The PRISMA model also involves interdisciplinary teams with case managers, and aims to keep people at home longer. The Wagner Chronic Care Model,[123] which has been designed specifically for chronic care, views chronic disease management as part of the health and social care delivery system. In this model, health care is completely integrated within community services and aims to empower patients in terms of decision-making and self-management. Witnesses spoke of patient-centred care and suggested that it could include a funding model in which the money follows the patient.[124] Finally, the Committee was told that this integrated approach to health care is required by 5-8% of the elderly population living in private homes and in the community.[125]

Witnesses suggested that an efficiently integrated system would include utilizing all health professionals to the full scope of their practice.[126] The Committee heard that non-urgent paramedic services, or community paramedicine, could reduce pressure on the acute care system.[127] Paramedics could be integrated into a chronic care model in which they provide post-surgical home care, chronic disease monitoring, routine assessments and health education so that patients are better able to self-manage. The integration of pharmacists within a chronic care model was presented as a valuable addition for monitoring of adverse reactions, providing medication management services and providing health and medication information to patients.[128]

Several witnesses indicated that true inter-disciplinary care will require the development and implementation of information systems, including electronic health records and electronic prescribing systems.[129] The Committee heard that all community health providers should have access to all necessary information regarding any given condition and about any individual in their care.[130] These were presented as essential to increasing efficiencies within the health care system and to improving continuity of care.[131]

The multi-sectoral model incorporates the inter-disciplinary approach, or team-based care, within a broader "whole of society" approach involving a variety of non-health related services. Witnesses commented that many seniors require social services in order to manage their health and live independently. House cleaning, meal preparation, transportation, built infrastructure to encourage and facilitate active living, were some of the examples raised. Witnesses felt that any changes to the way health and social services are provided must not penalize seniors with lower incomes.[132]

The Committee heard that 5% of people currently utilize 50% of the health care resources, primarily those who are elderly with chronic conditions.[133] Further, it was told that home care is 40–75% less costly than institutionalized care.[134] Finally it heard that there are improvements to the quality of care when health providers are integrated and utilized to the full scope of their professions, and that research has suggested that such a system could be established with no additional funds.[135] The Committee was told that the current model does not accommodate the aging population, no matter how much it is massaged or adjusted. In order to be responsive to the needs of Canada's aging population, members heard, there needs to be a fundamental change to clinical and professional practice.[136]

The Committee heard about theTranslating Research in Elder Care Program, or TREC, which is a five-year, $5 million study funded by the CIHR to explore the conditions in nursing homes in three provinces – Alberta, Saskatchewan and Manitoba. TREC analyzes the factors that influence the use of best practices and determines how their use influences resident as well as system outcomes. Resident outcomes include quality of daily life, quality end-of-life and safety issues. System outcomes include support for family and caregivers, improved care practices, and identification of strategies to engage and mobilize front-line staff to work on and improve care practices.[137]

D. Issues Pertaining to Chronic Disease Prevention through Health Promotion

1. Healthy Eating and Healthy Weights for Children

Witnesses commented on the negative health implications associated with sodium and *trans* fat in food. The Committee heard about the *Trans Fat Task Force* which was co-chaired by Health Canada and the Heart and Stroke Foundation of Canada.[138] This task force, created in 2005, was a multi-stakeholder group whose role was to provide recommendations and strategies to the Minister of Health to eliminate or reduce the amount of processed *trans* fat in prepared foods. Its report, "TRANSforming the Food Supply", was submitted to the Minister in June 2006, and made several recommendations in the areas of regulations, incentives and research.

Witnesses informed the Committee that as much as 80% of the foods and beverages marketed to children are unhealthy – either high in fat, sugar or salt, or low in nutrients.[139] The Committee heard that the *Canadian Children's Food and Beverage Advertising Initiative*,[140] which was launched in 2007, encourages the marketing of healthy food choices and discourages the marketing of unhealthy food choices specifically to those under 12 years of age. It is endorsed by 19 food and beverage companies. Additionally, members were made aware of the *Long Live Kids* initiative created by Concerned Children's Advertisers. It encourages healthy eating, active living and improved media literacy among children.

Some witnesses talked about Quebec's *Consumer Protection Act* and that it is the only law in Canada that prohibits advertising directed at children.[141] Quebec has one of the lowest soft drink consumption rates in Canada and the lowest obesity rate among children aged between 6 and 11.[142] Some witnesses recommended adopting Quebec's ban on marketing and advertising of unhealthy food to children,[143] not only in television, but also in other media such as Internet.[144] A few suggested that escalated and sustained action is needed to promote healthy weights for children and youth using a multi-pronged approach.[145]

2. Physical Activity and Youth Injury

Several witnesses commented on the need to encourage and facilitate more physical activity and members were told of some of the initiatives undertaken by various organizations in this regard. ParticipACTION described its *Sports Day in Canada*, which was held in September 2011, to celebrate all sport from grassroots to high-performance levels. Members were also told about ParticipACTION's *Sogo Active* program, a physical activity movement to help young Canadians between the ages of 13 and 19 become more active. The Canadian Association of Occupational Therapists described the active-living guide that it is being developed in collaboration with university researchers.

Physical and Health Education Canada (PHE Canada), in partnership with GoodLife Kids Foundation, discussed its initiative to support schools and communities in developing and delivering after-school programs that emphasize physical activity. PHE

Canada works with educators and professionals to develop the resources, tools, and supports to ensure that every Canadian child acquires the knowledge, skills, and habits to be physically active. The Committee was told that PHE Canada is developing a pilot initiative for children and youth to provide the resources and tools for teachers to assess levels of physical literacy. Finally, the Committee was told that ParticipACTION, in partnership with PHE Canada and other stakeholders, is launching Active Canada 20/20, a national strategy for physical activity.[146]

In terms of provincial strategies, the Committee heard about *Québec en Forme*, which was created in 2002 by the Lucie and André Chagnon Foundation and the Quebec government, to promote healthy living among disadvantaged children aged between 4 and 12 years old. Finally, the Committee heard about the *Toronto Charter For Physical Activity: A Global Call for Action*.[147] The Charter is a call for action and an advocacy tool to create opportunities for physically active lifestyles for all. The four key areas of the Charter are: the implementation of a national policy and action plan, the introduction of policies that support physical activity, the reorientation of services and funding to prioritize physical activity, and the development of partnerships for action.

Some witnesses shared concerns about youth injuries and asked the federal government to assume a more active role. While the recently enacted *Canada Consumer Product Safety Act* was applauded, the establishment of a national strategy for child and youth injuries and injuries across the lifespan was suggested.[148] The pillars of this strategy would be research, public awareness and policy. The Committee was told that resources and funds allocated to health research on injury were small compared to the economic and social burden associated with injury.[149] Moreover, the Committee heard that there would be a high return on investment of effective strategies for injury prevention, namely the lives saved and the reduction of health care costs.[150]

3. Health Promotion and Disease Prevention Investments

The Committee was told that, for the 2011-2012 fiscal year, all levels of government combined allocated 0.9% of total public health spending on health promotion, physical activity and sport.[151] The Committee was informed that increasing this investment to 5% would bring savings to the health care system in the medium term.[152] In this regard, members were told that a recent study in the United States suggested that, within 25 years, investment in prevention would prevent premature deaths due to chronic conditions and reduce overall health care costs.[153] The Committee heard that the federal government should adopt a health promotion and disease prevention vision that engages individuals and community in healthy living activities and provides leadership.[154]

Members were told that persuasive technology on mobile devices has recently emerged as a promising approach to health promotion and disease prevention.[155] The goal is to design technology that can encourage change in human behaviour or attitudes without using coercion or deception. Such technology could reach a large proportion of the population since the penetration rate of mobile devices in Canada was around 70% in 2010.[156]

E. Suggested Areas for Federal Action

Several witnesses acknowledged that the provision of health and social services is primarily the responsibility of the provinces and territories. However, a number of suggestions were made about the actions that could be taken by the federal government in the areas of health promotion, chronic disease prevention and disease management. These are outlined below.

1. Legislation

Some witnesses suggested that the *Canada Health Act* is too restrictive.[157] The Committee heard that the focus should not be limited to acute care but rather, that home care should also be considered as medically necessary under the Act.[158] Similarly, the Committee heard that there should be a statute governing continuing care, a *Long-term Care Act*, which would cover community and residential care and include the same principles as the *Canada Health Act*.‡,[159] Members were told that dedicated resources for home care initiatives would provide Canadians with the option of receiving care in their home, and in doing so, would reduce the reliance on costly acute care services.[160] The Committee was told that a publicly-funded model mandated through federal legislation may be more efficient in terms of health outcomes than a private, for-profit model, or a mixed model of both publicly-financed non-profit and private, for-profit provision of services.[161]

2. Regulation

Members heard that healthy eating habits could be better encouraged if some changes were made to the food labelling regulations. In this regard, testimony was given that front-of-package nutrition labelling should be required. Front-of-package labelling was described as a means to help Canadians make nutritious choices. The "Nutrition Facts table" currently required on pre-packaged food was portrayed as unnecessarily complicated. The Committee was told that concise front-of-package information could be implemented, as it has been in some other jurisdictions. Such labelling would allow consumers to quickly scan food packages for nutrition information, such as whether the salt or fat content of a food is considered low, medium or high.[162]

3. Health Transfers and the Health Accord

Several witnesses who appeared before the Committee drew attention to the anticipated discussions for the renewal of the Health Accord in 2014 as a strategy for addressing age-related chronic disease. Some witnesses suggested that the renewal of the Health Accord in 2014 presents an opportunity for federal leadership by investment in

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‡ The five principles of the *Canada Health Act* are described in articles 8-12 and are: public administration, universality, comprehensiveness, portability and accessibility.

health transfers,[163] particularly in key priority areas, such as home care, pharmacare and continuing care.[164] While the use of a Health Accord to promote accountability, pan-Canadian standards, federal leadership and multijurisdictional coordination was suggested by witnesses, they also specified how the Health Accord could be used to mitigate the impacts of chronic disease related to aging. For example, the Health Accord could encourage a variety of reforms such as: integrated health services that utilize various types of health care providers;[165] technological advances like electronic health records to encourage collaboration among health professionals;[166] primary care reform to include the integration of homecare and community care services;[167] nationally coordinated disease prevention and health promotion strategies;[168] and dedicated funding to stimulate best practices, innovation, and research.[169]

Some witnesses argued that implementing these changes would reorient Canada's current health care system to become more attentive to the changing needs of Canadians and make better use of available health services.[170] As a result, witnesses suggested, the health care system would become more accountable, efficient and cost-effective.[171]

4. Research

The Committee heard from several witnesses representing the research community. Testimony was offered outlining the important research underway as well as on research gaps that need to be filled. Members heard that CIHR's Institute on Aging has incorporated an integrated approach because health policy decisions on re-structuring health service delivery must be evidence-based.[172] Members were told of a number of areas where additional research is required, such as in strategies for extending independent living,[173] the provision of long-term care,[174] the utilization of health professionals to the full scope of their practice,[175] and the integration of health and social services for the elderly.[176] In terms of health promotion and disease prevention, witnesses commented on the need to do more research on how to get people to change habits in favour of healthier lifestyles.[177]

5. National Strategies

Several witnesses described national disease-specific strategies that have been implemented such as the Canadian Stroke Strategy,[178] the National Lung Framework,[179] the Canadian Strategy for Cancer Control implemented through the Canadian Partnership Against Cancer,[180] the Canadian Diabetes Strategy,[181] the Canadian Heart Health Strategy,[182] and the National Pain Strategy, which is expected to be announced soon.[183] The Committee also heard about the National Mental Health Strategy[184] (including a strategy for neurological diseases), which has subsequently been released. While several of these are funded under the F/P/T governments' collaborative approach to chronic disease and healthy living, some witnesses emphasized that for individuals affected by more than one chronic condition, primarily the elderly, management of chronic diseases is more complex than the sum of its parts. As such, the Committee heard, a National Strategy for Healthy Aging should be developed. It heard that a comprehensive pan-Canadian healthy aging strategy should include measures to foster health promotion and early detection of disease, promote health promotion and disease prevention strategies

through healthy lifestyles, support formal and informal caregivers, address the determinants of health, facilitate better access to health services, including appropriate continuing and end-of-life care, and help keep people in their homes longer.[185]

With respect to healthy living, several witnesses suggested areas where the federal government could increase its involvement. These included the development and implementation of a Canadian food and nutrition strategy for a healthy and safe food supply, including food security for all Canadians.[186]

6. Information Sharing and Best Practices

The Committee heard about knowledge translation – the translation of research into practice. Several witnesses commented on the need for the federal government to facilitate knowledge translation by providing a mechanism whereby information, including research results and best practices and innovations across jurisdictions, can be shared across the country.[187] Members heard that the creation of partnerships and national strategies have been useful tools in promoting the sharing of best practices.[188] Witnesses spoke of several successful regional projects and suggested that a robust mechanism is required for sharing these across Canada.[189] Members were told that it is difficult for provinces to make the policy changes needed in order to adapt the health care delivery system for chronic care, but that better sharing of information and best practices could facilitate it. In addition, members were told that CIHR's Institute on Aging has recently introduced a program called "Best Brains." This program brings researchers together with public policy figures in order to provide them with the available research evidence.[190] Finally, the creation of a Centre for Innovation on Aging was described as a means of facilitating the sharing of information and best practices, not only from regions across Canada, but also from jurisdictions globally.[191]

7. Integrated Care Model for Populations under Federal Jurisdiction

Several witnesses identified the groups for which the federal government has a responsibility for the provision of health care and suggested that it lead by example in implementing the changes necessary to transition from the current acute care model to one more responsive to the needs of those affected by chronic conditions.[192] For example, members heard that veterans, First Nations on-reserve, Royal Canadian Mounted Police, and Canadian Forces should be provided with the full continuum of care, including integrated service delivery, to better prevent and manage chronic conditions.[193]

The Committee was told that the Aboriginal population is disproportionately affected by diabetes and chronic respiratory and other conditions, and that an integrated approach in the delivery of health care would be beneficial.[194] However, the approach must be tailored to the population and be culturally sensitive.[195]

8. Healthy Living Strategy for First Nations Communities

In relation to the federal groups, members heard that the federal government should strengthen and maintain its investments in healthy living for First Nation communities, with special attention given to northern and remote communities, since these populations bear the greatest burden of disease. The Committee was also told about the need for a coordinating mechanism for evaluation, synthesis, and mobilization of real-world evidence emerging from community-driven initiatives in local Aboriginal communities.[196]

COMMITTEE OBSERVATIONS AND RECOMMENDATIONS

The Committee agrees that health promotion should begin early in life and must continue throughout a person's lifetime to reduce the risk of chronic disease in later years. Members also understand that, even in later life, health benefits can be garnered by exchanging old habits for healthier lifestyle choices. However, changing habits is no simple task. Members concur that a multi-pronged approach is necessary. While the federal government has a role to play, equally important contributions are to be made by other levels of government, health professionals, active living organizations, the food and fitness industries and individuals.

The Committee acknowledges that while personal responsibility cannot be ignored when it comes to healthy lifestyles, an individual's circumstances can often make it difficult to make the best choices. As such, members applaud PHAC's involvement in supporting projects that reduce health inequities brought about by disadvantages in the social determinants of health.

The Committee understands the concerns raised relating to the health needs of those suffering from chronic disease, particularly in the senior years. It is concerned about the prevalence of mental health issues and supports the efforts of the Mental Health Commission of Canada. The Committee looks forward to further consideration of the recently released Mental Health Strategy. Members encourage the provinces and territories to work closely with the Mental Health Commission to implement the Strategy.

Members agree that the management of elderly individuals who suffer from one or more chronic diseases can become complex and that an interdisciplinary approach to care may be optimal. Such an approach involves reforming the way in which primary care is currently delivered to individuals, particularly the elderly who suffer from chronic disease. It requires the creation of health teams, as well as expanding the scope of practice for some health professionals for better utilization of existing resources. The "whole of society" approach to care may often extend beyond that which has traditionally been labelled as health care services, and also involves domestic cleaning, help with meal preparation, transportation and changes to community infrastructure so as to encourage and facilitate active living. Informal caregiving plays an important role in this and the Committee is sympathetic to the call to provide additional supports such as training, education, mental health supports and respite.

While the Committee is supportive of these approaches, it would also like to emphasize that the role of the federal government should be one that focusses on leadership and collaboration to facilitate and encourage jurisdictions to adopt best practices wherever appropriate. In this respect, the Committee is encouraged by the recently announced health care innovation working group, a provincial and territorial initiative. The Committee agrees that the federal government can play a key role in encouraging the sharing of information and best practices. With respect to those groups for whom the federal government is responsible for health care, the Committee is supportive of the concerns raised by witnesses who suggested that an integrated approach to health care delivery should be implemented.

Therefore, the Committee recommends that:

The Minister of Health continue to engage the provincial and territorial Ministers of Health and Health Promotion/Healthy Living in a discussion about the need to adapt primary health care to a more interdisciplinary and multi-sectoral model;

The Minister of Health continue to engage with provinces and territories to share Best Practices on:

- **scopes of practice of health professionals;**
- **the potential use of health teams;**
- **multi-sectoral approaches to care that involve not only traditional health services, but also those social services necessary to maintain a good quality of life and manage health conditions; and that**

The Government of Canada continue to use integrated multi-sectoral approaches to care where needed and appropriate.

Considerable focus was placed on the research that is underway in Canada pertaining to health promotion, disease prevention and chronic disease management. While many witnesses commended the amount of work underway at the Canadian Institute for Health Information and CIHR, many also identified research gaps that still need to be filled, and called on the federal government to address them. In this regard, the Committee is pleased to see the efforts underway by the CIHR to identify strategic research priorities and commends the CIHR for encouraging research which will: enhance patient-oriented care; identify the pressures on the health care system due to the aging population and rising rates of chronic disease; and address the importance of leveraging resources by working collaboratively with other departments and agencies as well as non-governmental organizations. It suggests that research could also extend to health human resources research, as some witnesses stressed the need to increase the number of people being trained in certain specialties. Finally, witnesses discussed the importance of

translating research results into practice. The Committee agrees that research results need to be made accessible and useful to stakeholders.

Therefore, the Committee recommends that:

The Canadian Institutes of Health Research continue to support research that addresses chronic diseases;

Health Canada continue to work with relevant industry to encourage them to offer healthy choices to Canadians on a voluntary basis; and that

Health Canada continue to promote healthy lifestyle choices for all Canadians with the goal of making the healthy choice an easy choice.

Conclusion

During the course of its study, the Committee heard from various witnesses that healthy lifestyles, even adopted later on in a person's life, have a strong positive impact on the health status and can help to reduce the prevalence of chronic disease. In an effort to encourage Canadians to improve their health status, government officials and various national and local stakeholders informed the Committee of initiatives designed to promote and support healthy living, as well as to reduce the number of people affected by chronic disease. Reducing the burden of chronic disease through the adoption of healthy lifestyles requires primarily engagement by individuals. Nevertheless, initiatives from all levels of government are key to promoting healthy behaviours. Moreover, officials from CIHR and academic researchers presented their findings to the Committee on ways to address the burden of chronic diseases and to help people adopt healthier habits. The Committee encourages those who undertake research on chronic disease and health promotion, and looks forward to the translation of this work into improved health care. Finally, the Committee is confident that the federal government will continue to play a leadership role in encouraging jurisdictions to optimize their approach of promoting healthy living and managing the care of Canadians suffering from chronic diseases.

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1 Public Health Agency of Canada (PHAC), *Evidence*, October 5, 2011

2 PHAC, *Evidence*, December 5, 2011.

3 Canadian Public Health Association (CPHA), *Evidence*, December 7, 2011.

4 YMCA Canada, *Evidence*, December 12, 2011.

5 Ibid.

6 Centre for Science in the Public Interest (CSPI), *Evidence*, February 2, 2012.

7 ParticipACTION, *Evidence*, December 12, 2011; Canadian Institutes of Health Research (CIHR), *Evidence*, December 5, 2011.

8 Canadian Institutes of Health Research (CIHR), *Evidence*, December 5, 2011.

9 YMCA Canada, *Evidence*, December 12, 2011.

10 Martin Cooke, University of Waterloo, *Evidence*, February 9, 2012.

11 Physical and Health Education Canada (PHEC), *Evidence*, December 12, 2011.

12 ParticipACTION, *Evidence*, December 12, 2011.

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14 Canadian Pharmacists Association (CPhA), *Evidence*, October 31, 2011

15 PHAC, *Evidence*, October 5, 2011

16 Mark Rosenberg, Queen's University, *Evidence*, November 28, 2011

17 Margaret McGregor, University of British Columbia, *Evidence*, November 30, 2011

18 Canadian Medical Association (CMA), *Evidence*, October 17, 2011; National Initiative for the Care of the Elderly, *Evidence*, October 31, 2011; and Public Health Agency of Canada, *Evidence*, October 5, 2011

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73 CGS, *Evidence*, October 17, 2011.

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105 Carole Estabrooks, *Evidence*, October 31, 2011; and Baycrest Centre for Geriatric Care, *Evidence*, November 28, 2011.

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111 Fondation Docteur Benoît Deshaies, *Evidence*, November 23, 2011.

112 Canadian Coalition for Senior's Mental Health, *Evidence*, November 16, 2011.

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117 CMA, *Evidence*, October 17, 2011; Canadian Pain Coalition, *Evidence*, October 26, 2011; CPhA, *Evidence*, October 31, 2011; Canadian Health Services Research Foundation, and Elizabeth Badley, *Evidence*, November 2, 2011.

118 Fédération interprofessionnelle de la santé du Québec, *Evidence*, November 16, 2011.

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148 ThinkFirst Canada, *Evidence*, February 7, 2012.

149 Safe Kids Canada, *Evidence*, February 7, 2012.

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153 BC Healthy Living Alliance, *Evidence*, February 9, 2012.

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155 Rita Orji, *Evidence*, February 9, 2012.

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157 François Béland, *Evidence*, November 28, 2011.

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159 Carole Estabrooks and Dorothy Pringle, *Evidence*, October 31, 2011.

160 Canadian Association of Retired Persons, *Evidence*, October 24, 2011.

161 Margaret McGregor, *Evidence*, November 30, 2011.

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163 HSFC, *Evidence*, October 19, 2011 and Canadian Health Services Research Foundation, *Evidence*, November 2, 2011.

164 CPhA, *Evidence*, October 31, 2011.

165 CNA *Evidence*, October 17, 2011; Canadian Association of Retired Persons, *Evidence*, October 24, 2011; Canadian Coalition for Senior's Mental Health, *Evidence*, October 26, 2011/16 November 2011; and Margaret McGregor, *Evidence*, November 30, 2011.

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167 CNA, *Evidence*, October 17, 2011; Canadian Association of Retired Persons, *Evidence*, October 24, 2011; National Initiative for the Care of the Elderly, *Evidence*, October 31, 2011; Fédération interprofessionelle de la santé du Québec, *Evidence*, November 16, 2011; Margaret McGregor, *Evidence*, November 30, 2011.

168 Canadian Association of Retired Persons, *Evidence*, October 24, 2011; CPhA, *Evidence*, October 31, 2011; and Fédération interprofessionelle de la santé du Québec, *Evidence*, November 16, 2011.

169 CMA, *Evidence*, October 17, 2011; HSFC, *Evidence*, October 19, 2011; and Canadian Coalition for Senior's Mental Health, *Evidence*, October 26/November 16, 2011.

170 CNA, *Evidence*, October 17, 2011; Canadian Association of Retired Persons, *Evidence*, October 24, 2011; and Canadian Coalition for Senior's Mental Health, *Evidence*, October 26/November 16, 2011.

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173 Suzanne Garon, *Evidence*, October 31, 2011.

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176 Baycrest Centre for Geriatric Care, *Evidence*, November 28, 2011.

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187 CMA, *Evidence*, October 17, 2011; CLA, *Evidence*, October 19, 2011; Canadian Association of Retired Persons, *Evidence*, October 24, 2011; Canadian Health Services Research Foundation, *Evidence*, November 2, 2011; Baycrest Centre for Geriatric Care, Mark Rosenberg and Francois Béland, *Evidence*, November 28, 2011; and Margaret McGregor, *Evidence*, November 30, 2011.

188 Canadian Partnership Against Cancer and HSFC, *Evidence*, October 19, 2011.

189 CMA, *Evidence*, October 17, 2011; Canadian Association of Retired Persons, *Evidence*, October 24, 2011; Canadian Health Services Research Foundation, *Evidence*, November 2, 2011.

190 CIHR-Institute of Aging, *Evidence*, October 24, 2011.

191 Baycrest Centre for Geriatric Care, *Evidence*, November 28, 2011.

192 CLA, *Evidence*, October 19, 2011.

193 CCA, *Evidence*, October 17, 2011; Fédération des aînées et aînés francophones du Canada, *Evidence*, October 24, 2011; Canadian Health Services Research Foundation, *Evidence*, November 2, 2011; and François Béland, *Evidence*, November 28, 2011.

194 CDA and CLA, *Evidence*, October 19, 2011; Active Living Coalition for Older Adults, *Evidence*, October 24, 2011; and Mark Rosenberg, *Evidence*, November 28, 2011.

195 Canadian Partnership Against Cancer, *Evidence*, October 19, 2011; and François Béland, *Evidence*, November 28, 2011.

196 Chronic Disease Alliance of Canada, *Evidence*, December 7, 2011.

LIST OF RECOMMENDATIONS

APPENDIX A
CHRONIC DISEASES RELATED TO AGING
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Public Health Agency of Canada	2011/10/05	7
Cathy Bennett, Acting Director, Division of Aging and Seniors, Centre for Health Promotion		
Kim Elmslie, Director General, Centre for Chronic Disease Prevention and Control, Health Promotion and Chronic Disease Prevention Branch		
Canadian Chiropractic Association	2011/10/17	8
John Tucker, Director, Government and Interprofessional Relations		
Eleanor White, President		
Canadian Geriatrics Society		
Frank Molnar, Secretary-Treasurer, Member of the Executive		
Canadian Medical Association		
John Haggie, President		
Maura Ricketts, Director, Office of Public Health		
Canadian Nurses Association		
Barb Mildon, President-elect		
Don Wildfong, Nurse Advisor, Policy and Leadership		
Canadian Diabetes Association	2011/10/19	9
Aileen Leo, Associate Director, Public Policy, Government Relations and Public Affairs		
Canadian Lung Association		
Rosario Holmes, Educator, Asthma and Chronic Obstructive Pulmonary Disease, Ontario Lung Association		
Christopher Wilson, Director, Public Affairs and Advocacy, National Office		
Canadian Partnership Against Cancer		
Jessica Hill, Chief Executive Officer		
Leanne Kitchen Clarke, Vice-President, Public Affairs		

Organizations and Individuals	Date	Meeting
Heart and Stroke Foundation of Canada	2011/10/19	9
Manuel Arango, Director, Health Policy		
Mike Sharma, Expert Representative		
Active Living Coalition for Older Adults	2011/10/24	10
Patricia Clark, National Executive Director		
Canadian Association of Retired Persons		
Susan Eng, Vice-President, Advocacy		
Michael Nicin, Government Relations and Policy Development Officer		
Canadian Institutes of Health Research		
Yves Joanette, Scientific Director, Institute of Aging		
Fédération des aînées et aînés francophones du Canada		
Jean-Luc Racine, Executive Director		
Associated Medical Services Inc.	2011/10/26	11
William Shragge, Chief Executive Officer		
Canadian Coalition for Seniors' Mental Health		
Kimberley Wilson, Executive Director		
Canadian Pain Coalition		
Lynn Cooper, President		
Fédération interprofessionnelle de la santé du Québec		
Régine Laurent, President		
Lucie Mercier, Labour Advisor, Sociopolitical Affairs		
As an individual	2011/10/31	12
Carole Estabrooks, Professor, Faculty of Nursing, University of Alberta; Canada Research Chair in Knowledge Translation		
Suzanne Garon, Principal Investigator, Research Centre on Aging, University of Sherbrooke		
Dorothy Pringle, Professor Emeritus, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto		
Canadian Pharmacists Association		
Phil Emberley, Director, Pharmacy Innovation		
Jeff Poston, Executive Director		

Organizations and Individuals	Date	Meeting
National Initiative for the Care of the Elderly	2011/10/31	12
Sandra Hirst, Executive Board Member		
As an individual	2011/11/02	13
Elizabeth Badley, Professor, Dalla Lana School of Public Health, University of Toronto; Senior Scientist, Toronto Western Research Institute, University Health Network		
Canadian Health Services Research Foundation		
Maureen O'Neil, President		
Associated Medical Services Inc.	2011/11/16	14
Jeffrey Turnbull, Member, Board of Directors		
Canadian Coalition for Seniors' Mental Health		
Kimberley Wilson, Executive Director		
Canadian Pain Coalition		
Lynn Cooper, President		
Fédération interprofessionnelle de la santé du Québec		
Régine Laurent, President		
Lucie Mercier, Labour Advisor, Sociopolitical Affairs		
Canadian Life and Health Insurance Association Inc.	2011/11/23	16
Stephen Frank, Vice-President, Policy Development and Health		
Fondation Docteur Benoît Deshaies		
Robert Guimond, Secretary		
As an individual	2011/11/28	17
François Béland, Professor, Department of Health Administration, University of Montreal		
Mark Rosenberg, Professor, Department of Geography and Department of Community Health and Epidemiology, Queen's University		
Baycrest		
William Reichman, President and Chief Executive Officer		
Emergency Medical Services Chiefs of Canada		
Michael Nolan, President		
As an individual	2011/11/30	18
Sylvie Belleville, Director of Research, Research Centre, Institut Universitaire de Gériatrie de Montréal		

Organizations and Individuals	Date	Meeting
As an individual	2011/11/30	18
Margaret McGregor, Clinical Associate Professor, Department of Family Practice, University of British Columbia; Research Associate, UBC Centre for Health Services and Policy Research and Vancouver Coastal Health Centre for Clinical Epidemiology and Evaluation		
Lakehead University		
Michel Bédard, Canada Research Chair in Aging and Health, Department of Health Sciences and Centre for Research on Safe Driving		

APPENDIX B
HEALTH PROMOTION AND DISEASE PREVENTION
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Canadian Institutes of Health Research	2011/12/05	19
Nancy Edwards, Scientific Director, Institute of Population and Public Health		
Philip Sherman, Scientific Director, Institute of Nutrition, Metabolism and Diabetes		
Department of Health		
Hasan Hutchinson, Director General, Office of Nutrition Policy and Promotion		
Catherine MacLeod, Associate Assistant Deputy Minister, Health Products and Food Branch		
Public Health Agency of Canada		
Kim Elmslie, Director General, Centre for Chronic Disease Prevention and Control, Health Promotion and Chronic Disease Prevention Branch		
Canadian Alliance of Community Health Centre Associations	2011/12/07	20
Jane Moloney, Chairperson		
Scott Wolfe, Federal Coordinator		
Canadian Public Health Association		
Ian Culbert, Director, Communications and Development		
Debra Lynkowski, Chief Executive Officer		
Chronic Disease Prevention Alliance of Canada		
Craig Larsen, Executive Director		
Ida Thomas, Chair		
Agence de la santé et des services sociaux de Montréal	2011/12/12	21
Patrick Morency, Public Health Physician, Urban Environment and Health, Direction de santé publique		
ParticipACTION		
Kelly Murumets, President and Chief Executive Officer		

Physical and Health Education Canada	2011/12/12	21
Andrea Grantham, Executive Director and Chief Executive Officer		
Chris Jones, Representative; Senior Leader, Sport Matters		
YMCA Canada		
Scott Haldane, President and Chief Executive Officer		
Centre for Science in the Public Interest	2012/02/02	25
Bill Jeffery, National Coordinator		
Food and Consumer Products of Canada		
Phyllis Tanaka, Vice-President, Scientific and Regulatory Affairs (Food Policy)		
Québec en Forme		
Diane LeMay, Assistant Manager, Partnerships, Knowledge Translation and Innovation		
Manon Paquette, Provincial Nutrition Advisor, Partnerships, Knowledge Translation and Innovation		
Saskatoon Health Region		
Nancy Klebaum, Primary Health Manager		
Donna Nelson, Nutritionist, Food for Thought Program		
Consumer Health Products Canada	2012/02/07	26
Gerry Harrington, Director, Public Affairs		
David Skinner, President		
Safe Kids Canada		
Pamela Fuselli, Executive Director		
ThinkFirst Canada		
Rebecca Nesdale-Tucker, Executive Director		
University of British Columbia		
Paul Kershaw, Professor, Human Early Learning Partnership		
As an individual	2012/02/09	27
Rita Orji, Ph. D. Student, University of Saskatchewan		
BC Healthy Living Alliance		
Cathy Adair, Representative; Vice President, Cancer Control, Canadian Cancer Society, BC and Yukon Division		
Mary Collins, Director of the Secretariat		

Canadian Association of Occupational Therapists 2012/02/09 27

Mary Forhan, Occupational Therapist,
Liaison with the Canadian Obesity Network

Claudia von Zweck, Executive Director

University of Western Ontario

Martin Cooke, Research Partner,
Associate Professor, University of Waterloo

Piotr Wilk, Assistant Professor

APPENDIX C
CHRONIC DISEASES RELATED TO AGING
LIST OF BRIEFS

Organizations and Individuals

Abbott Laboratories Ltd.

Associated Medical Services Inc.

Canadian Association of Retired Persons

Canadian Nurses Association

Emergency Medical Services Chiefs of Canada

Estabrooks, Carole

Parkinson Society Canada

APPENDIX D
HEALTH PROMOTION AND DISEASE PREVENTION
LIST OF BRIEFS

Organizations and Individuals

Canadian Alliance of Community Health Centre Associations

Canadian Association of Occupational Therapists

Canadian Coalition for Public Health in the 21st Century

Canadian Dental Hygienists Association

Canadian Medical Association

Canadian Parks and Recreation Association

Dietitians of Canada

Food and Consumer Products of Canada

ParticipACTION

Saskatoon Health Region

YMCA Canada

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant Minutes of Proceedings for the study of chronic diseases related to aging (Meetings Nos. 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 30, 42, 43, 44 and 45) is tabled.

A copy of the relevant Minutes of Proceedings for the study of health promotion and disease prevention (Meetings Nos. 19, 20, 21, 25, 26, 27, 30, 42, 43, 44 and 45) is tabled.

Respectfully submitted,

Joy Smith, M.P.

Chair

Minority Report: Chronic Diseases Related to Aging and Health Promotion and Disease Prevention

Submitted by:
Libby Davies, NDP, Vancouver East; Djaouida Sellah, NDP, Saint-Bruno-Saint Hubert; Dany Morin, NDP, Chicoutimi-Le Fjord; and Matthew Kellway, NDP, Beaches-East York.

Introduction:

Federal leadership on health care is more important than ever, to renew, invest, and strengthen our public health care system. The Standing Committee on Health's Report on Chronic Diseases Related to Aging and Health Promotion and Diseases Prevention illustrates an important body of research that pursues chronic disease related to aging, and addresses important issues in relation to health promotion and disease prevention. However, the NDP believes that further recommendations are necessary to ensure greater accountability and innovation by the federal government in health promotion and disease prevention. The NDP expresses its disappointment that so little progress has been made by the federal government on these critical issues. The federal government must be a leader in establishing an effective plan that will spur health promotion and disease prevention for the benefit of all Canadians, no matter their age.

Based on the testimony provided to the Standing Committee on Health, the NDP makes recommendations in three key areas: the health accords; health living; and healthy aging.

The Health Accords:

In 2004, the federal, provincial, and territorial First Ministers agreed to a 10-year commitment to institute and achieve a number of priority reforms that would strengthen the Canadian healthcare system. These reforms included a commitment to recognize home and primary care as cost effective means of delivering health care services. The 2004 Health Accord also committed to a pharmaceutical strategy that would provide Canadians with the necessary medication for effective treatment.

New healthcare delivery models such as home care and palliative care have proven to be less expensive than hospital beds, while keeping the patient in a much more familiar environment. In his 2002 report, Roy Romanow, recommended the establishment of a Home Care Transfer, which could be used to establish a national platform for home care services (*Building on Values: The Future of Health Care in Canada,* 2002).

The 2004 Health Accord also included a pharmaceutical strategy aimed at reducing the cost of medications. Unfortunately, this proposal, which is mostly of federal jurisdiction, has gone nowhere. Such a plan would not only save our health care system billions of dollars each year, it would also help Canadians have better access to more effective drugs, especially the 23% of Canadians with chronic illnesses who cannot afford to fill

their prescriptions (Health Council of Canada, *How Do Sicker Canadians with Chronic Disease Rate the Health Care System?,* 2011).

In December 2011, the federal Finance Minister Jim Flaherty announced unilateral cuts to the Canada Health Transfer, without any consultation with provincial and territorial counterparts. The Parliamentary Budget Officer has noted that these cuts will short-change provincial and territorial health budgets by more than $30 billion dollars, forcing the provinces to cut vital services. Premiers have taken a unified stance against this new arrangement, and called for the federal government to initiate discussions on a new Accord.

Recommendation 1: The NDP urges the Minister of Health and the federal government to work with provincial and territorial counterparts to address and follow through on commitments laid out in 2003/4 Health Accords, with particular emphasis on the issues of home care and universal prescription drug coverage, including establishing a comprehensive home care, palliative care, and compassionate care strategy which will save costs in the long-run and improve the health of millions of Canadians. The federal government must work with provincial and territorial counterparts to set out sufficient federal funds that establish measurable health care outcomes.

Recommendation 2: The NDP urges the Minister of Health and the federal government to commit federal funds dedicated to a renewed focus on community-based integrated primary health care, as the key to a more efficient and cost-effective use of health care resources. Reform should include the creation of community-based health care services, delivered by multi-disciplinary health care teams.

Healthy Living:

It is important to examine practices that effectively address chronic disease and encourage healthy living for Canadians in all stages of life. These interventions can range from access to nutritious food, incentives for physical activity, educational campaigns, and eliminating socioeconomic or cultural barriers that may prevent Canadians from accessing care. Of particular note is the lack of Conservative government's lack of leadership on legislative initiatives that promote healthy living, including the regulation of sodium, trans fats, and sugars in prepared foods. It is unacceptable that Canada is falling so far behind on fundamental public health reforms. All of these initiatives must receive stable and adequate federal funding to ensure their effectiveness. The federal government's lead on preventative measures would lower the chronic diseases associated with aging and unhealthy habits.

Recommendation 1: The NDP encourages the Public Health Agency of Canada and Health Canada to engage with their provincial and territorial counterparts to promote ethnic and cultural sensitivity.

Recommendation 2: The NDP urges the Minister of Health and the federal government to implement a National Pain Strategy, built on the Canadian Pain Society's framework

for a National Pain Strategy. This strategy should include provisions for multi-disciplinary health care teams to treat pain; timely pain management; dedicated pain-related research funding; and pain management education for health professionals and the general public.

Recommendation 3: The NDP urges the Minister of Health and the federal government to implement the recommendations laid out the June 2006 report of the *Trans Fat Task Force*, entitled *TRANSforming the Food* Supply, which made several recommendations on the regulation of trans fats, to lower or eliminate the amount of trans fats in prepared foods. Similarly, we urge the Minister to implement the recommendations of the July 2010 report of the *Working Group on Sodium Reduction*, which put forward the *Sodium Reduction Strategy for Canada*, to reduce the sodium intake of Canadians.

Recommendation 4: The NDP urges the Minister of Health and the federal government to work with provincial and territorial counterparts to implement federal legislation similar to Quebec's Consumer Protection Act, which has successfully limited the impact of advertising to children.

Recommendation 5: The NDP encourages all levels of government to commit to increase the total public health spending on health promotion, physical activity, and sport to 5% annually (from current level of 0.9% in 2011-2012 fiscal year).

Recommendation 6: The NDP urges the Health Canada to change food labeling regulations, so that nutritional info appears on the front of the package. The important nutritional information (such as sodium and fat content) should be highly visible.

Recommendation 7: The NDP recommends that the federal government change the Children's Fitness Tax Credit from non-refundable credit to refundable credit. A refundable Fitness Tax Credit should also be established for adults.

Recommendation 8: The NDP urges the Minister of Health and the federal government to recognize the impact that socio-economic factors have on a person's ability to make healthy lifestyle decisions. Access to healthy foods is limited for people affected by poverty or living in remote areas, notably, the First Nations and Inuit communities. Subsidized local fresh produce would improve access to a healthy diet.

Recommendation 9: The NDP urges the Minister of Health and the federal government to reconsider its decision to reduce the funds allotted to the Federal Tobacco Control Strategy as tobacco is the leading cause of preventive diseases, disability and death, costing more than 4 billion in annual health care costs and causing 37, 000 deaths annually.

Recommendation 10: The NDP urges the Minister of Health and the federal government to invest more in healthy living for First Nations communities. Witnesses have made it clear that First Nations constitutes a segment of population that face

increased adverse health outcomes than the average Canadian citizen. First Nations health is a federal responsibility that must be taken seriously.

Healthy Aging:

A National Strategy on Healthy Aging is an important part of the federal government's health promotion and chronic disease prevention initiatives. As witnesses stated, as Canadians age, they are more likely to have complex health care needs, living with more than one chronic condition. A National Strategy on Aging would take a broad perspective, necessary to address the complex health needs of older adults, alongside strategies on home care, long-term care, and palliative care.

Recommendation 1: The NDP urges the Minister of Health and the federal government to work with provincial and territorial counterparts to develop a long-term strategy based on national care standards, affordability, and accessibility. This strategy would assess the need for affordable and accessible long-term care in Canada, and commit funds to meeting this need.

Recommendation 2: The NDP calls on the federal government to establish tax credits and grants for care givers, including: a) increasing the EI Compassionate Care Benefit and changing its current criteria to be allow more care givers to be eligible for this credit, and b); create a refundable tax benefit for the medical expenses incurred by care givers.

Recommendation 3: The NDP encourages the Minister of Health and the federal government to work with territorial and provincial counterparts to develop a National Strategy for Healthy Aging. This strategy should include an emphasis on health promotion and disease prevention through the promotion of healthy lifestyles; support for formal and informal caregivers; address the determinants of health; facilitate better access to health services, and allow people to access care home for longer.

Mental Health

Federal efforts to improve the health of Canadians must include mental health initiatives. Witnesses frequently told the Committee that maintaining one's mental health is a key part of a healthy lifestyle, and that addressing mental health issues can be critical to restoring the overall health of an individual. The Mental Health Commission of Canada recently released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada,* which outlines a framework for all levels of government to work to improve mental health services in Canada.

Recommendation 1: That the Minister of Health and the federal government work with provincial and territorial counterparts to implement the recommendations made by the Mental Health Commission of Canada in their *Mental Health Strategy for Canada* and provide federal funding towards implementation efforts.

Conclusion

The NDP believes that these recommendations will address the concerns expressed by experts in the fields of healthy living and aging. The NDP believes this report adds to the Standing Committee on Health's report on Chronic Diseases Related to Aging and Health Promotion and Disease Prevention; setting out concrete recommendations which will strengthen health care services across Canada and allow Canadians to lead healthier lives for longer. It also demonstrates the role of the federal government to lead the way, to create a more cost-effective public health care system that better serves Canadians throughout their lifetime.

Dissenting Report by the Liberal Party of Canada

Increased longevity and a sharp rise in the incidence of chronic disease have had a significant impact on the delivery of Health Care in Canada, putting increased stress on Medicare. At the same time, Health Promotion and Disease Prevention can have the effect of alleviating that burden. The Committee agreed to the following motions:

- "That the Committee commence a study of Chronic Diseases related to Aging on Wednesday, October 5, 2011, and that the Chair report the Committee's findings to the House."
- "That the Committee undertake a study of health promotion and disease prevention and that it hold four (4) meetings on this study, starting on Wednesday, November 16, 2011."

For 17 meetings, the House of Commons Standing Committee on health heard from witnesses on these issues. The witnesses ranged from health professionals, Non-Governmental Organizations (NGOs), patient advocates, researchers, and officials from the Health Department.

There was a great deal of commonality amongst witnesses about the nature of the problems and solutions; backed by solid data and research relating to chronic disease, health promotion, and disease prevention.

The Liberal Party does not agree that the report, nor the recommendations, adequately reflect the testimony of witnesses.

For this reason the Liberal Party felt it essential to produce this Dissenting Report.

What the Committee heard:

According to Statistics Canada, life expectancy in Canada is 80.9 years. Much of this can be attributed to progressive public health policies, access to Health Care services and new diagnostic and therapeutic technologies. However, this positive trend has begun to decline. Witnesses attributed this decline to smoking, unhealthy eating, lowered physical activity, and obesity, which accounts for 90% of type 2 diabetes, 80% of coronary artery disease and one-third of cancers. The rate of childhood obesity has quadrupled in the past three decades; the rate of childhood obesity is even higher and amongst Aboriginal children.

Witnesses reported that longevity has contributed to a rise in the incidence of cardio-vascular disease, increased rates of injury, chronic pain, dementia and cancer and indicated that 74 to 90% of seniors suffer from at least one chronic condition. They pointed out that given Canadian demographics there was also a need to develop chronic care models that are culturally sensitive to immigrant and refugee groups and to Aboriginal peoples.

Statistics show that 80% of lung cancer occurs in people over 60. Prevalence of chronic obstructive pulmonary disease (COPD), caused by smoking or asthma, among people 65 to 75 is triple that of younger cohorts and costs the Health Care system $15 billion annually.

Witnesses stated that chronic pain has a significant impact on quality of life and productivity, and must be part of any study on chronic diseases. One in five Canadians lives with chronic pain which is often undiagnosed and undermanaged. Arthritis is the most frequent cause of disability, affecting 4.5 million Canadians.

Witnesses and members of the Committee were aware that the Mental Health Commission of Canada (MHCC) would table its report shortly, but many agreed that mental illness is a chronic health condition, particularly high in seniors. Mental illness in this age group is directly related to physical illness. 15% of seniors who live in the community suffer from depression. This can increase to between 80% to 90% in long-term care facilities. World Health Organization (WHO) statistics projected that globally by 2020, depression will rank second to both potential and productive life years lost. Witnesses highlighted the most tragic component of depression: suicide. The suicide rate among men aged 90 years and older is 33 per 100,000 people, which is more than double most other age groups. Chronic disease is one the highest risk factors for suicide in older age groups.

Witnesses stated that dementia was the most common reason for transferring patients to alternative levels of care and that seniors were generally able, with good support systems, to manage their chronic conditions, until affected by dementia.

The Committee was told that financial limitations compromised many chronically ill patients' ability to pay for out of pocket expenses, including drugs, food, and participation in the social life of the community, which can lead to isolation.

Witness comments on measures to promote healthy living:

The Committee heard that chronic diseases cost the Canadian economy $190 billion annually; $90 billion due to Health Care costs, and the remainder due to lost

productivity. Therefore chronic disease is not only a health issue but also an economic one.

Evidence indicates that many chronic diseases may not be a natural component of aging, and could be prevented with good health promotion and disease prevention strategies as well as social policies to alleviate the negative determinants of health, such as poverty, inadequate housing and unhealthy lifestyles.

Overview of current chronic disease care in Canada:

Government's initiatives:

Officials from the Public Health Agency of Canada reported on a variety of initiatives dealing with chronic diseases, health promotion and disease prevention in general; many of these involved partnerships with provincial and territorial governments, NGOs, and private partners. Officials spoke of the importance of a multi-sectoral approach, not just restricted to the Health Care portfolio. Canada endorsed this approach to chronic disease prevention strategies at the recent United Nations meeting, September 2011.

Many initiatives were issue-related dealing with healthy eating and healthy weights, diabetes strategies, age-friendly communities, Aboriginal nutrition, prenatal nutrition programs, child nutrition programs, and physical activity and injury prevention.

In 2010 Federal, Provincial, and Territorial governments declared a shared vision for prevention of disease, disability, and injury with health promotion as a priority. This agreement acknowledged that many determinants of health lie outside of the Health Care sector. A Pan-Canadian Public Health Network was created to share information, provide policy and technical advice to FPT Ministers and support to jurisdictions during public health emergencies.

The *Canadian Best Practices Initiative* responded to the need for sharing data. It includes the *Best Practices Portal* to share knowledge and measure uptake in practice activities as well as provide a compendium of community interventions related to health promotion and disease prevention that have been evaluated.

Current status of federal research:

Much research on chronic diseases is done by the Canadian Institute of Health Research. CIHR is active in health promotion and disease prevention, especially in diabetes, obesity and applied injury research.

The CIHR Institute of Aging and Pathways to a Health Equity for Aboriginal Peoples was recently developed to advance research on health disparities within these particular population groups.

Status of Health Human Resources relating to chronic disease care:

Many witnesses voiced concerns over inadequate training of Health Care professionals to identify, treat, and manage chronic diseases in the elderly and expressed the need for an integrated approach on health human resources. For example, witnesses said there were only 200 geriatricians in Canada whereas the current need requires 500-600, which will only increase as the population ages. It was predicted that by 2020 there would be a 35% shortage of respirologists to deal with COPD and there were insufficient physicians trained for primary care.

Witnesses recommended that the recognition of foreign credentials of Health Care professionals be fast-forwarded to broaden Canada's base of Health Care providers who can also contribute needed cultural and language knowledge.

The way forward:

The Committee heard that individuals need to take some responsibility for adopting healthy, active lifestyles as a way of delaying chronic illness. It was suggested that public awareness campaigns would promote active self-care.

Witnesses mentioned the current model for dealing with chronic illness is no longer cost-effective or appropriate. Many patients with chronic illness, including the elderly, receive care in hospitals and long-term care facilities when a community care based model would improve the quality of life, health outcomes, and the ability of seniors to age in their own homes for as long as possible.

They advised that community-based, patient-centred, primary care models with multi-disciplinary teams integrated with social and housing services would provide the best outcomes.

While government and health care professionals provide the bulk of care, many families are burdened with the responsibility of providing informal care and suffer stress, fatigue, and burnout. Family members need financial and mental health supports and respite. Witnesses felt that the extension of employment insurance benefits for informal caregivers and the non-refundable tax credit do not fully address these problems; instead the tax credit should be refundable to allow low- and modest-income families to benefit.

Social Determinants of Health:

Witnesses reminded the Committee that major determinants of health were related to income status and housing, and that one cannot separate health and social services in providing chronic care.

Healthy Living:

Witnesses commented that the impact of high sodium and trans-fat levels in foods have not been addressed satisfactorily, and reiterated the need for appropriate labeling and regulations to help consumers make informed, healthy choices about the food and beverage products they purchase. As much as 80% of foods and beverages marketed to children are unhealthy; high in fat, sugar, and salt, and low in nutrients. Witnesses also recommended that the federal government re-evaluate food taxation policies to create incentives for consumption of healthy foods and disincentives for unhealthy foods.

They commented that there was a greater need to encourage and facilitate more physical activity and active living to the population in general, but especially to children and seniors. Some witnesses suggested that the *Children's Fitness Tax Credit* should be made refundable and an adult fitness tax credit added. Physical activity not only prevents many chronic diseases, but also prevents injury. They also commented that resources allocated to health research and injury were inadequate given the high cost of the economic and social burden associated with injury.

Finally, the Committee was told that in the last year all levels of government spent only 0.9% of total public health spending on health promotion, physical activity, and sport. Recent studies in the United States showed that within 25 years, investment in prevention would prevent premature deaths and reduce overall Health Care costs and economic loss associated with decreased productivity.

Health Transfers and the Health Accord:

Witnesses stressed the need for a variety of reforms in Health Care that would improve health outcomes, accountability, and cost-effectiveness and be more attentive to the changing needs of Canadians. They felt that the 2004 Health Accord had highlighted some of these innovations and that they were looking forward to a 2014 Health Accord, which would strengthen the transformative changes anticipated in the 2004 Accord.

Recommendations:

Based on what the Committee heard from expert witnesses, department officials and advocates regarding the impact of chronic diseases on human health and productivity;

Based on testimony and long-standing evidence of the cost to the Health Care system of treating chronic diseases;

Based on the evidence that showed many of these diseases to be preventable;

Based on evidence that many chronic diseases have more cost-effective and better quality of life outcomes when managed in the home, in community care models, and outside of hospital; and

Based on evidence that shows the high cost of medications for those who have chronic diseases leads to lack of affordability of, and non-compliance with, treatment and the subsequent exacerbation and worsening of illness;

The Liberal Party recommends:

1. **That a pan-Canadian health promotion and chronic disease prevention strategy that is culturally appropriate and funded to 5% of the overall health budget be implemented with the following elements:**
    a. **A national sodium reduction strategy to lower the daily intake (to below 2,300mg per day), including regulated levels for food industry, and the development and funding of education programs to raise awareness of the dangers of high sodium intake and the existence of lower sodium products;**
    b. **Mandatory regulations of trans-fat levels to 2 grams per every 100 grams of oil or fat;**
    c. **Regulate energy drinks to be sold as a drug under the direct supervision of a pharmacist, as recommended by the federal government's expert panel and prohibit advertising, promotion, and sale of energy drinks to youth under the age of 18;**
    d. **Ban advertising and promotion of unhealthy foods to children under the age of 12, using the Quebec model as a best practice;**
    e. **Examine feasibility of taxation policy on foods high in fat, sodium, and sugar, using the Scandinavian models as a best practice;**
    f. **Adopt a progressive food labeling system to communicate better to consumers the nutritional contents of food;**
    g. **Increase daily physical activity among all youth and children, by investing in community sport infrastructure (including playgrounds), supported by trained coaches and other professionals;**

h. **Reinstate full funding to the Federal Tobacco Control Strategy; and**
i. **Reverse cuts and enhance funding to suicide prevention programs at the Department of National Defence including support for post-traumatic stress disorder; and**
j. **Reinstate full funding to the National Aboriginal Health Organization, Aboriginal Diabetes Initiative, Aboriginal Health Human Resources Initiative, Aboriginal Youth Suicide Prevention Strategy, and the Aboriginal Health Transition Fund.**

2. **Integrate within the *Best Practices Portal*, best practices in primary, patient-centred, multidisciplinary, comprehensive, community and home care models, including housing and social services, which are currently under pilot project status within the 2004 Health Accord. Develop and utilize indicators to measure cost-effectiveness and patient wellness outcomes;**

3. **The federal government return to and implement the following collaborative, cross-jurisdictional objectives agreed to in the 2004 Health Accord;**
    a. **develop a pan-Canadian pharmaceutical strategy that will make medically required therapeutics accessible to all Canadians with chronic and life-threatening diseases. This strategy must also contain a plan of action to anticipate, identify, and manage drug shortages;**
    b. **develop a pan-Canadian Health Human Resources Strategy;**
    c. **develop a pan-Canadian dementia strategy as part of the home and community care reforms agreed to in the 2004 Health Accord.**
4. **That the federal government take a leadership role in developing, with provinces, territories, and other partners, a comprehensive, integrated, National Pain Strategy as tabled by the Canadian Pain Coalition.**

5. **That the federal government implements multidisciplinary, integrated, culturally sensitive, "full continuum" of home and community care service delivery models to manage and prevent chronic diseases within the population cohorts for which the federal government has a direct responsibility: veterans, First Nations, Inuit, and Canadian Armed Forces.**