

# PRINCE EDWARD ISLAND LEGISLATIVE ASSEMBLY



Speaker: Hon. Kathleen M. Casey

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## Standing Committee on Social Development

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SUBJECT: PRESENTATIONS ON BEHALF OF THE DISABLED AND THE SENIORS

**COMMITTEE:**

Janice Sherry, MLA Summerside-Wilmot (Chair)  
Michael Currie, MLA Georgetown-St. Peters  
Bush Dumville, MLA West Royalty-Springvale, replaces Neil LeClair [afternoon session only]  
Cynthia Dunsford, MLA Stratford-Kinlock  
Sonny Gallant, MLA Evangeline-Miscouche  
Robert Henderson, MLA O'Leary-Inverness  
Neil LeClair, Minister of Agriculture [morning session only]  
Alan McIsaac, MLA Vernon River-Stratford, replaces Paula Biggar, MLA Tyne Valley-Linkletter

**COMMITTEE MEMBERS ABSENT:**

Jim Bagnall, MLA Montague-Kilmuir  
Paula Biggar, MLA Tyne Valley-Linkletter  
Neil LeClair, Minister of Agriculture [afternoon session only]

**GUESTS:**

PEI Disability Alert (Graham Burke, Michael LeClair, Stephen Pate, Kevin Walsh); Salvation Army (Marjorie Montgomery); Seniors' Secretariat (Dr. Albert Adegbembo, Sharon Cameron, Patrick Crawford, Anna Duffy, Bill Fleming, Faye Martin)

**STAFF:**

Melissa Keefe, Committee Clerk

The Committee met at 11:00 a.m.

**Chair (Sherry):** Okay, good morning, everybody, and welcome to the meeting for the Standing Committee on Social Development.

It's a nice, beautiful sunny morning out there and we have a pretty full agenda for today, so I guess I would ask for an adoption of the agenda for today's meeting.

**Ms. Dunsford:** So moved.

**Chair:** Cynthia Dunsford, thank you.

We'll get right down to business. We have a presentation this morning from Mr. Stephen Pate. So without any further ado, we would like to welcome you and we ask you to introduce yourselves for the Hansard. The floor is yours.

**Stephen Pate:** Thank you very much and thank you for inviting me to speak today.

I'm Stephen Pate. I'm a retired business person, a lifelong person with a disability. I had it when I was three, I got polio. I did pretty well with that. Nobody ever - I didn't know I had polio until I got about 50 and then I got post-polio syndrome and I really became disabled when I discovered I could not walk. It was pretty tricky. So that changed my life a little bit.

I retired from work, and I tried to cope with that and I've sort of come back. I've done a lot of advocacy for people with disabilities in my life, from collecting money for the March of Dimes as a child to dropping the puck at hockey games, to helping people get their Canada Pension over the last 10 years, things like that. I did a lot of work with the federal government. I was on the Council of the Disabled for awhile, on the board. I was also on the minister's Advisory Council on Persons with Disabilities for the Minister of

Social Services and Seniors, and for the last two years, I've been working with PEI Disability Alert which I'm the founding director of. So my presentation today is based on my experience over a lifetime, but more specifically over the last 10 years.

So if you would like to turn to the handout that we've given everybody. The basic layout is that we've got a two-page executive summary which we'll go through and I'll just basically read it. Then we can step through the sections. I don't think we're going to read the sections because we have time constraints. There are tables in the back which we might refer to, or you might refer to them on your own, but they're basically backup for some of the statistical data.

It's a very difficult thing to do, but I'm going to try to win your hearts with statistics. Now, I don't know how I do this but I actually can do it, but we have to quote numbers and percentages. I know that's kind of boring, but it does build the point and the case. We try to stay away from anecdotal information because it's not reliable. So we like to rely on things that we can count on. So we'll step into the executive summary.

Poverty negatively impacts the lives of many of the 22,000 Islanders living with disabilities. This number is projected to reach 38,000 by 2024. Statistics Canada has been providing reliable data on the number, severity and needs of persons with disabilities for 20 years. Children represent about 1,000 of those with disabilities, working age adults 12,000, and seniors 9,000, with seniors growing at the fastest rate. Disability is primarily a function of the aging process.

StatsCan classifies disabilities as mild, moderate, severe, and very severe. On PEI, 8,000 people have severe to very severe disabilities requiring assistive devices like wheelchairs, or are bedridden. Seniors are more likely to have severe disabilities.

Our recommendations on employment and income - and we're going to speak on three topics: employment income, housing and disability supports.

Sixty per cent of Islanders with disabilities are not working due to social factors and their disability. Unless they have large savings to rely on, they become poor within a few years of disability. Low income Islanders with disabilities relying on Canada Pension Disability or social assistance are living at 60% of the poverty line or low income cut-off - LICO. I didn't invent that, that's from the federal government, so LICO is the term.

Employment Equity programs have been used in other jurisdictions to assist more of them to re-enter the workforce at their skill level. For those who remain unemployed, the Guaranteed Annual Income model is recommended. We recommend that the Province of Prince Edward Island remove discriminatory barriers to employment for persons with disabilities with new Employment Equity legislation; implement an affirmative action program for the employment of persons with disabilities to be phased in over five years; begin a process of education of the private sector on the benefit of hiring workers with disabilities and use its persuasive power with those private sector employers who deal with the province; remove the restriction to provincially assisted drug plans for persons on CP Disability pension; and implement Guaranteed Annual Income that would see supports for persons of low income up to the statistical poverty line.

Our recommendations on housing.

Housing is the foundation of our living, the safe hearth from which we dispel our dangers. For those with a disability, affordable barrier-free housing is a necessity but one that is not readily available. A recent study showed that the demand for

barrier-free rental accommodations in Queens County was 2.5 times greater than the supply. Those units available cost 60% or more of a disability pension or support. In other words, they're just not affordable.

For homeowners with a disability on PEI, the cost of home adaptations can be as great as \$90,000, but even modest assistance is only available one-third of the time. That basic number is that only one in three people who apply to CMHC can get assistance, and that's based on funding. They just don't have the money.

We recommend the province provide a housing income supplement to maintain housing costs below 35% of income for persons with disabilities; adopt barrier-free building codes to increase the supply of barrier-free accommodations; adopt programs that encourage home sharing for persons with disabilities and seniors living alone; negotiate with the federal government for program increases in CMHC RRAP Disability; and encourage alternative community-based models of home ownership.

Our recommendations on disability supports.

Islanders with disabilities need a variety of supports to maintain inclusion with society and function on a day-to-day basis, namely, technical or assistive devices, daily activity supports, academic and work supports.

The PEI Disability Support Program will provide these types of supports but it is inadequate to the task. It is materially underfunded by government and excludes 9,000 Islanders with disabilities simply because they are seniors, and we define seniors as people that are 65 and older.

It also excludes those who have a mental or learning disability. The unmet needs of Islanders with disabilities has been

determined by studies that the province has agreed with. The program has several policies that are not appropriate in dealing with persons with disabilities and has consistently lost human rights and privacy commissioner complaints.

The province should return the million dollars taken from the Disability Support Program budget in April 2006. This was a pre-election promise. Remove the age restriction and provide assistance for seniors with disabilities, a pre-election promise as well. Provide support for those with learning and mental disabilities; align its support programs to meet the needs identified in legitimate government studies; fund the DSP to a reasonable level required by Islanders with disabilities; design processes that look at the individual; provide an appeals process that is equitable and independent; perform a full and independent review of the department considering its past history of mismanagement.

#### Funding.

Many of the recommendations are cost neutral or positive to the province. Others, such as seniors' coverage, will require new budget allocation that can be met through internal government savings.

So that's a basic summary of what we're going to present today. We're doing pretty good on time, so we'll kind of step through this.

Who are Islanders living with disabilities? We know who they are because Statistics Canada has been studying us for 20 years. The reason I'm bringing up the StatsCan thing is because in a year of meetings with the department I have heard nothing but criticism of Statistics Canada, which I find self-serving and disingenuous, would be my politest way I can put it.

If you are only giving support to 1,000 of

22,000 people, I guess you don't want people to think there's 22,000 people. Right? Must be some other number. Maybe it's only 1,100. But the reality is StatsCan knows what they're doing and the province relies on Stats Canada for transfer payments, health and social service payments, all are based on StatsCan numbers. So I really don't think that we should be trying to second-guess StatsCan and come up with another number.

Just to tell talk about how they developed this, when they do the five-year census, there's a box that says: Do you have a material limitation on daily living? Or words to that effect. It changes every time they do the census. If you tick that box, you get put into a bucket of people that are re-interviewed. When they re-interview, they ask you: How bad is it? You know, is it mild? Is it like hearing you can hear as long as you cup your hand to your ear? Or do you need two hearing aids? That would be very severe. Are you partially blind or totally blind? Are you semi-ambulatory? I'm semi-ambulatory. I can walk around, but I get tired and then I can't go very far. So I have to use a wheelchair.

I have this trick where I use the wheelchair all the time at home. I may just go from room to room in my wheelchair because that saves the energy, so when I come out to a meeting like this I can walk around like everybody else does, but I can't walk around for an hour. So I'm semi-ambulatory. So I would be considered moderate to severe.

Somebody who can't get out of the wheelchair is severe. Somebody who's bedridden most of the time is very severe. Statistics Canada surveys that kind of information, and they also survey: What do you need? Do you have a wheelchair? Yes. Do you have a wheelchair? No. Why don't you have a wheelchair? Can't afford it. Did you get your home modified so you can come in the door with your wheelchair?

Yes, no. Is your bathroom safe? Yes, no. If not, why not?

So they go around this whole grade of questions to determine the severity and type of the disability, the needs that you have with that disability, and whether those needs are met or unmet, and if they're unmet, why not? They want to know why that is. All that data is available to us. Those studies come out every five years, again, and they're based on the census.

So it's based on this PALS data that we know these things. If you go to the back of the submission, the first two tables, tables 2.3-1 and 4.3-1, the first one is adults and children with and without disabilities by sex and age groups in Prince Edward Island. So 2006, and we can also get the 2001 table if you want to compare those numbers back and forth. So we can look at this and see that we have the total population of PEI, and then we have underneath it the persons with disabilities. There's 21,750. Break them down, males and females, by age group. We can get all those numbers: How many people over 75 have a disability? Oh, that's 5,200, 2,000 males and 3,100 females. Then we can analyse that data and then we know why because females have certain problems that males don't have, usually hip problems and things like that, that come earlier for females than males. They actually analyse the data and give us the reasons why in many cases.

On PEI, we're kind of looking at that situation where it's interesting that in society, we focus on children with disabilities, the Easter Seals Campaign. He's so cute, or she's so cute. But there's only 1,000. There's 9,000 seniors, but nobody thinks a senior with a scooter or a walker is cute. You know, they're not photogenic, they don't get on television and raise money. They're just suffering. Nobody thinks that a 42-year old person with cerebral palsy is cute, although he might

have been cute when he was 11. But he's not cute any more. He's an adult. He's probably an annoyance because we don't like people that are different, and that's a societal problem that we'll talk about.

We also get the continuum, on the next table, of severity. So if you go to table 4.3-1, the severity of disability for adults and children with disabilities by sex and age groups, Prince Edward Island, 2006. So then it gives us the whole continuum again by age groups going down the page, and then across the page it's mild, moderate, severe, very severe. Wherever you see a little E, the numbers are - they say - use with caution. So in the case of children, very young children, it's hard to get those numbers really clearly. So they said it's not quite clear but, I mean, it's close enough, and they're using them. Where they don't like the number at all, they won't put a number. So if there's no number in a box, they just can't get any statistical accuracy on it all, and they just don't put it.

The effect of aging on disability is that we become disabled as we age. So in my case I had polio when I was three, but nobody ever thought I was disabled. I played hockey. I played soccer. I played baseball. I went to dances. I started five different businesses. I took one business public on the stock market, which is a pretty tricky feat. It takes a lot of stamina. So nobody would say to me: You have a disability. However, when I couldn't walk, then I knew I had a disability. So that happened when I was 50. It started when I was 47, and by the time I was 50 I had a disability, even though I had polio many years ago, decades before that.

So what they know is that as people get older they tend to develop disabilities. So you can get MS in your 20s but not become disabled until your 40s because it doesn't get severe. You probably are not going to have a stroke when you're 30 but you might when you're 50. You might have a heart

attack when you're 50, not likely at 30. So disabling situations in life usually occur in the 40s, 50s and 60s, and that's why the numbers always skew to the back end of our lives.

If you look at page 7, I sort of broke that down like between 2001 and 2006. Of the groups that we have - the children, 15 and under; working age adults; and 65 and older - the highest growth rate, that is 1,500 people, is in the 65 and older, in seniors. So the growth rate in disabilities is in seniors, and that's why we're facing this bulge that by 2024 we're going to have 38,000 people on PEI with a disability. It's already started. Because we went from 19,000 to 22,000 in five years, simply because the baby boomers are aging. I'm a second-year baby boomer. I was born in 48. So 47, you would have been a first year baby boomer, and people becoming behind me, my friends and the people I work with, they're starting to age and they're starting to have problems.

So I have a bank manager in Montague that I've known for years and years and years. He called me up, he had a stroke. Now he's a person with a disability. He's no longer a bank manager. He's living on his Canada Pension and his RRSP. That's what happens as we age. So as we go through the cycle of the baby boomers aging, we're going to see more and more people becoming disabled.

Now the link between disability and poverty, it's just so obvious it's not funny. If you all stop working, how long could you live on your savings and \$8,000 a year? I mean, you'd have to be pretty smart to downsize your lifestyle and live on even nine or 10,000, and your RRSPs. Your RRSPs just go whump!, especially if you've got to spend \$50,000 to renovate your house so that you can get your wheelchair through the front door so you can go to the bathroom, which you got to do three or four times a day. So you can get to your bed, right?

And you do that, I mean, if you have the savings, and the government can't help you because there's one in three getting help. You just spend your own money and you do it because you have to survive. You don't want to leave your home. Pretty soon you're poor. Within about two years, on average, you're now living below the poverty line. So then the poverty, the LICO, on PEI is around \$17,000 for a single person.

The participation rate for people with disabilities in the labour force is 40% whereas the workforce participation rate for non-disabled people is 70%. So there's that big gulf. Yes, some people with disabilities are working but the ones with severe to very severe, they are not working, and there's reasons why that happens. But they do want to work. We've had programs from the federal government, EAPD, to try and help them to get to work but they've only created what I call sweatshop places, where people work for minimum wage in a sheltered workshop but they're not creating quality jobs that these people are capable of.

One of the problems is lack of education of the public, of the employers, and the other one is this thing that we tend to avoid people who are different. It's a natural human condition and they've actually studied it, and I put the reference in here to the University of British Columbia. We have mechanisms of disease-avoidance that cause us to be prejudiced against individuals with physical disabilities. You may think that's odd, but think about this. The PEI Council of the Disabled has about 18 employees. Only one of them has a physical disability. They're just human. Unless they're forced to do it they won't hire people with disabilities because they feel uncomfortable around them. Governments know that, that it's kind of like something that you have to work on.

So I want to just introduce you to Kevin Walsh over here. Kevin's going to speak to his experience. He has 25 years as a social

worker and as a hospital person at the Community Hospital, and he can talk about discrimination in the workplace because of disability.

**Kevin Walsh:** Thank you, Stephen. Hi. I have one concern. It's employment equity. Mainly, I was working at the Queen Elizabeth Hospital. I retired and now I'm an advocate for disabled people and mainly people with vision problems. But there's one particular case that came to my mind a few years ago and things haven't changed any since.

This young gentleman was fairly smart. He passed grade 12 with honours. He went to UPEI. He passed with honours there. He went to Waterloo. He got his Masters in Social Work. I must say that the provincial government helped him all the way with the Disability Support Program. They were very good to him. However, when he came back to PEI and tried looking for a job he couldn't get one anywhere. He applied all across Canada. Everybody said: Well, you're blind? Yes. Do you have any work experience? No, I just graduated. Sorry, we don't have anything for you right now.

He went to the provincial government. There's just no way. He applied for many different cases, many different job opportunities that were there for people who didn't have a vision problem. But when they found that he (Indistinct) - well, you can't drive, I'm sorry. They didn't really try to do anything for him, except to give him General Welfare Assistance. At the last of it he got fed up and he went to Ontario to stay with his uncle. His mother had just passed away with cancer and he had nobody here, so I lost track of him.

I'm trying to do something to say employment equity, there should be some way that the provincial government could have hired him, given him a job. Could they not switch roles around so that he could

have done counselling? He was well qualified to do counselling. Do something, and somebody else could have done the driving. The jobs could have been switched around a bit, but that's what I mean by employment equity. If there was only some way that the provincial government could help him, help those disabled people to find employment.

Now, I started losing my sight 40 years ago. I was very fortunate then. I went back to university, got trained, and there was no problem for me to get a job. The same thing wouldn't happen today, and I've been told that from many different government officials. You just wouldn't get a job today, and I guess that's my case. I would really like to see some way that we could assist the disabled people so that they could be able to get some type of employment rather than sitting home and drawing General Welfare Assistance.

**Stephen Pate:** Thank you Kevin. Thank you very much.

I brought Kevin because he's a really good illustration of somebody who did have a disability, worked within the system. If you go to the physical medicine department at the QE hospital, down one of the back halls, they have a story in the *Guardian* that was told about Kevin and his career with the government. So he's an exemplary employee. He's not just a hidden employee or somebody that was lost in the shuffle. But he was an exemplary employee that brought honour to the province because of his work and his disability. That is what the government will get if it hires people with disabilities.

In contrast to the provincial situation, the federal government has legislation for employment equity. They force quotas on departments. They actually subsidize, they train, they educate. They help them to break down the barriers. On PEI, 8.5% of the

federal workforce has a disability. It's 5.8 across the whole country. That's 10,000 people in Canada who are working with a disability who wouldn't be working otherwise.

It wasn't easy, because when they brought it in I remember everybody said the world was going to end. Then BCE went to the Supreme Court of Canada because, you see, they're federally regulated so they would fall under the act. They didn't want to fall under the act. So they went to the Supreme Court of Canada because they didn't want to treat their female employees the same as their male employees and they didn't want to hire any people with disabilities and they didn't want to hire visible minorities, and they lost.

Did BCE go bankrupt? Nope, BCE is a very profitable company making, like, lots of money, shares are up. The Government of Canada, did they go bankrupt? Nope. Surpluses up the ying-yang, as we say. Everything is going hunky-dory because they did the right thing at the right time, and this is the right time on PEI when we have this - you're going to have a loss of workers as people retire. Where are you going to get them from? Look at the number of people that have disabilities that you could bring into the government through employment equity.

I did a rough calculation. If you had 8.5% of the provincial workforce, you'd have another 1,000 people with disabilities off welfare roles - which is costing the government money - working, paying taxes, buying things in stores, paying sales taxes, being productive members of society.

And it's the right thing to do. This is the time to do it. It doesn't cost money. The federal government, in all their studies and all of this, have never said: This has cost us N number of hundreds of millions of dollars or more because they know it hasn't caused

them.

Persons with disabilities are very hard-working, loyal employees. They value their employment, and the federal government wouldn't hire 150 of them on PEI if they weren't doing a good job. They're actually higher in PEI than they are in the rest of Canada, by two percentage points. So that's one of our recommendations.

Guaranteed Annual Income. I mean, this has kind of been bandied about for about 30 years. I read an article by Hugh Segal, who is - they call him a Red Tory - he's a Conservative senator, and he said the time is right. I think we have to look at it. Like how many more programs, how many more departments do we need to create, to get people to the poverty level, so they're just at that LICO? Not to make them rich, just to get them to the level where they can afford to pay their rent, buy food, fit clothing.

Like, I do a lot of one-on-one advocacy and I helped a woman with a disability to find an apartment. We went out all over Charlottetown looking for an apartment for her. I think she ended up paying 585. She makes \$825 a month on social assistance. I said: How are you going to live? I'm not going to live. So what do you mean? Where will you get your food? I mean, I go to Superstore and get my food, right? You maybe go to Sobey's or somebody else. She says: I just go to the soup kitchen every day they're open, then I go to the food bank everyday they're open.

That's not a life. That's not dignity. She is a person with a medical problem and a disability together so she's not eating right, she's spending all her time just trying to get food, subsistence food, in this province? I mean, this is a rich place, Canada. We all live well. People buy SUVs that cost \$50,000 while other people grovel in the streets? It's just wrong. It's immoral, and we

have to look at this.

One of the interesting things is they figure if you put in a Guaranteed Annual Income, you save money, because we're spending so much money chasing people on social assistance to see if they're really married, not married, working on the side, doing this, doing that and the other, that a Guaranteed Annual Income thing is like one of those tax things, like your unemployment. You get unemployment - or what do they call it - employment insurance - it's a while since I actually had to do that - and if you make too much, boomp!, they take it off your income tax. They just take it back, claw back, just claw it back. They know that they can implement that at a very low cost per person number. That's what GAI is, it's easy. It's something that can be done. It's humane.

So that's our recommendation for people who can't work because there are some people with disabilities who can't go back to work. If you're bedridden, if you're just surviving it day to day, you're not likely to show up for work and feel good about yourself.

All the other recommendations on employment income are in the thing and we talked about them. There's one little one. Here's how Catch-22 the system can be. If you've worked and you qualify for Canada Pension Disability, it's about 860 a month. If you qualify and if you take it, you can't get financial assistance from social services. But if you have drug problems and need drugs and you're on Canada Pension, then you won't get the drugs. So what they do is they will not apply for Canada Pension. So what we've done is we've offloaded costs from the federal government to the provincial government. Now we've got these people on social assistance so they can get their drugs.

I mean, somebody ought to look at this and go: If they qualify, let them get their Canada

Pension, get the money from Ottawa, and we'll help them with the drugs just as though they were a financial assistance client. It's just kind of like one of those Catch-22 things that you work your way through and there's a bunch of those in the system.

So I'd like to turn it over now to Michael LeClair who's going to talk about housing.

**Michael LeClair:** I'm Michael LeClair.

A few years ago I met a woman who had returned here to Prince Edward Island. She had developed muscular dystrophy, spinal muscular atrophy, at the age of 30 and she moved back here from Portland. Her family had roots here. We have an interesting history that I'm not going to go into in great detail, but it centred around housing, and we eventually got married, and we've been married now for a little over two years.

My little journey with her, experience with her, has really opened my eyes to the plight of people with disabilities that they live with, and particularly, acute disabilities. We have a woman who at the age of 30, just launching a career, discovers she has muscular dystrophy, and by the age of 40 can't walk. By the age of 45 she can't lift up a cup of coffee, so it's a rather severe situation she finds herself in.

My own personal - the thing that I would say most is that what the provincial apparatus does is unload responsibility to caregivers and fails to recognize them. If there's one thing I could say that is profoundly disappointing about the whole experience is the way the provincial apparatus walks away from people with disabilities if they have a caregiver. It's shameful. I can't say it too much.

But anyway, I'd like to talk more about that, actually, because I think there's a vast number of caregivers, primary caregivers,

across Prince Edward Island that are caught in an incredible Catch-22. They provide care for people with disabilities and they're expected to earn an income and provide care and provide home care and do the whole thing. Their income collapses. They go down to where they have no income and the province washes their hands, and I think it's shameful.

When I first met this woman and they launched this Disability Support Program, and she was being sold this program pretty heavily. It was going to be a great program. And she was Miss Pollyanna. Moving back here, it was the land of the Anne of Green Gables. I kind of bit my tongue. I was listening to her. We weren't boyfriend-girlfriend at that point. Eventually she moved in with me because she was homeless. She was living in a room across the river and she had just got her walker. So she moves in with me, and she wasn't in with me three months before the Disability Support Program decided that we were living common-law and that we were married.

I'm a practising Roman Catholic and I found that absolutely offensive, that here I am sharing my home with a woman in a terrible situation in life, and they have the audacity to say that we're now living in common-law and so therefore we're not entitled to this, that, or the other thing.

We had to adapt our home, my home, to accommodate her, re-plumb it, put in a bathroom, put in a ramp and she was (Indistinct). They had OTs over there. They had this, that, and the other thing. The government spent a lot of money saying what she needed and what she didn't need and how the place had to be changed. At the end of the day, after her putting money on her credit card because she wanted to be a helper, they turned to her and said: No, you're not getting the \$2,000 once in a lifetime because you don't own your home.

Imagine.

So I wrote to Jamie Ballem, minister at the time. He kind of laughed at me. He thought it was funny that I lived in a co-op. I'm 56 years old and I'm as much of a citizen of Prince Edward Island as anybody around this table, and I found that absolutely offensive that this is the way we approach this issue of - so I digress.

So I'll get back to housing. Barrier-free housing. One thing that I've come to notice is that there - my wife did a survey about a year ago and she discovered that there's a lot of rental units in the city of Charlottetown. Most of them are not barrier-free. So you have all these people in the countryside that largely can come into Charlottetown because they're in a wheelchair or they're disabled, and there's no housing. Go around town and try to find something, if you're in a wheelchair, to live in. There's a great shortfall.

Our statistics here show that the demand for barrier-free accommodations in Queens County - that's greater Charlottetown - is in the range of 500 units. So where do these people end up? Well, I'll tell you where they end up. One guy, I know he's been the treasurer of the PEI Council for the Disabled for many years. He was in the Kay Reynolds Centre and had some problems out there, so where did he go? Cerebral palsy all his life, he needs a place to live. Where does the guy go? The Queen Elizabeth Hospital for six months. Shuffled here, shuffled there, shuffled someplace else.

Now we have a humongous, a well-funded Disability Support Program. Where were they? Why are we funding them? I ask that question.

See, the problem - and it's not in this recommendation - is that we don't have a program that's based on managing results. It's not saying: Okay, let's look at the

results. What have you achieved? There's no accountability. No one loses a job. No one has to make reports. There's no accountability based in the design of the system. We don't have a results-based system. We pump money in, but we don't say: Council of the Disabled, (Indistinct) case in point - he brought it up - 18, 20 employees. One person disabled. We spend a lot of money, a million dollars a year on employment equity for disabled people. But does anybody around the table - they don't know. Does anybody else know how many people actually got a job after spending a million dollars a year?

They know they don't want to know. They don't want to find out, obviously. So we have to have a system that demands and expects performance: What are you doing?

Okay, rental accommodations. Here in the City of Charlottetown under the barrier-free, we have a lot of rental accommodations in Charlottetown, very few are barrier-free. When I say barrier-free, what do I mean? It's more than a ramp to get into the place. If you're blind as my friend over here, you don't really need a ramp. Maybe you need a ramp, but maybe you need braille included into the design of your accommodation. If you're in a wheelchair, it's nice to get into the apartment, but it's nice to be able to reach the cupboards. It's nice to be able to turn the light switches on. It's nice to be able to use the bathroom. So it's more than just getting into the building, and that's a great misnomer.

Home ownership. On Prince Edward Island we have the largest for disabled people, many disabled people, and it's something that I disputed with my good friend, Stephen Pate, because sometimes I focus too much on the needs of tenants. But we do have more people that are disabled with their own home because people tend to become disabled a little later in life. Up in Mr. LeClair's neck of the woods, a man has a

stroke. He loses his income, and his wife is expected to be now the home care, the health care, the personal care, provider. They don't provide a range of continuing support. They say: Oh, we'll help you on this front.

So the brother comes home and says: My God, you can't live like this. Writes a letter to the *Journal-Pioneer* saying: I can't believe that Prince Edward Island, that likes to present itself as a gentle province, would leave a man and a woman in this kind of a situation. We're spending money. Are we actually getting quality service?

As a caregiver in Prince Edward Island, I have to say, ladies and gentlemen, that we're not. We're not getting the service from our program. Stephen and I spent a year at this or more trying to tell people that it's not about cost containment. It's about trying to meet the basic needs of people that are unable to meet their own basic needs for housing.

Now in terms of housing, I strongly believe that when the Government of Prince Edward Island is in the business of exchanging land for accommodations, providing money, this kind of thing, that they have a quota to say: Listen, if you're going to Mr. Mister, if you're going to get this land, if you're going to build these apartments, or single, whatever you're going to do, you're going to have to have a quota for people that need barrier-free accommodations. It's not good enough just to get the property. We might exchange land in the City of Charlottetown here next in the future, and somebody will trade this land for that land and maybe you'll have enough property to build, I don't know, 300 units. How many of them will be barrier-free? Will the province even ask the question? No. Will they say: Mr. Mister, when you build these units, how many - oh, none. Have you thought about? Well, we're insisting that you build some in order to get the property, in order to get our

participation.

See, currently what we're doing is with the Disability Support Program - which was a very good program in some ways - the problem with the disability program - and it was founded by Baker - is that it had a mindset that they had to contain costs. When you have a mindset that you have to contain costs, then you end up not meeting the real needs of people.

You take my wife's situation when she moved into the house. When they turned her down for the \$2,000 once in a lifetime, what are they actually saying to the woman? You will not be able to get off - when you go to use the washroom, you won't be able to get something that you can actually get off yourself. You'll have to sit there until your husband comes and gets you off. When you want to go into your home, there won't be a ramp to get in the home, because we're concerned about cost containment.

So this system doesn't simply work. Two thousand dollars once in a lifetime. My wife has muscular dystrophy. It's a progressive disorder. Her needs are going to increase. So you give someone \$2,000 once in a lifetime, well, what about in five years' time? So I'll say that.

The whole question of the \$32,000, every year there's people applying to these RRAP programs. This will be the RRAP programs of CMHC. They get turned down. They can't meet all the demand. So where do they go? If you have a spouse today that becomes disabled, what are you going to do? Are you going to say: Too bad, honey, I have to go to work? Are you going to try to care for the person? If you try to care for your spouse you'll be driven into poverty. I assure you, sir and madam, that if you care for your spouse today - so you'll either have to abandon them.

Stephen points out a good thing. Most

people who are married and one of the two partners become disabled, very quickly become divorced. They can't simply handle the situation. I don't think it's just, fair. It's just not simply a good thing to offload provincial responsibility onto the caregiver. My Catch-22 is I have to provide care for my wife, I have to look after the home and I'm expected to make an income. There's only 24 hours in a day. Right now, I sleep 4:00 to 6:00, kind of, and have to kind of run around and try to scratch things together. It simply can't be done. I discovered this myself. I'm saying: Man, there must be a lot of caregivers out there looking after their spouse. How do we do it?

Well, I tell you how we do it. We do it without any support from the Disability Support Program. That's how we do it.

**Stephen Pate:** Can we pass on, Michael?

**Michael LeClair:** Okay.

**Stephen Pate:** Because we're going to run out of time. I know you guys have a short time thing.

I just want to spend a few minutes on the disability supports and then we'll - you can read the material. There's lots of good research there.

The Canadian Council on Social Development studied the unmet needs, and what it basically said was that people who are severely disabled, low income, or those who are seniors, are the most likely to have unmet needs. It's kind of like the worst case scenario. We have a table in the back, Table 1.3, that sort of tells us what that is. So by age group, 39% of working age adults have unmet needs. Twenty-six per cent are seniors. I have to ask myself why that is. Why do the seniors have lower unmet needs? Because some of them are in seniors' homes where their needs are met by the institution. They're not living alone any

more.

If you get totally bedridden and you're 85 years old, your likelihood of staying home is pretty low. So they have migrated into a government institution. But there are a lot of people who are trying to stay in their homes, and we know that it's cheaper to keep people in their homes than to put them in institutions. So what do they need to stay in their homes? They need some supports. Maybe they need adaptation of their home. Maybe they need some home care, maybe some personal care.

Home care is like vacuuming or cleaning. Personal care is: Help me on and off the toilet. It's kind of a very personal thing to think about. When you become really disabled you will probably need somebody to help you get on the toilet to have a bowel movement or to eliminate, and that's very embarrassing, but that's the way it is. They need somebody to help them. Now in Michael's case, he may be that person because he's at home with his wife. But in other cases, it's not that person. It's somebody comes in. Or if the person tries to get on the toilet seat by themselves and falls off, it happens all the time, and they lay there until somebody comes and finds them. It happens all the time.

It's not like: Oh, it happened once last year. It happens all the time. Nobody reports it because how would you like - oh yeah, I'm calling the police because I fell off the toilet. Nobody's going to say that. They just wait till a neighbour comes by or the husband comes home or the spouse comes home or the careworker shows up at noon. They fell off the toilet at 8:30 because they couldn't wait to go to the bathroom.

So it's very difficult, but if we provide the support for the people, they can stay in their homes and they can save the province money. Because if they end up in institutions it's going to cost a lot more.

The Disability Support Program, Michael talked about that a little bit. We know all about it. It's a great program. It's underfunded. It's underfunded and made worse by the million dollar cutback in April of 2006, which the Liberals when in opposition promised they would return and it hasn't come back yet. So we'd like to see that in this budget. It's also underfunded to the point that 9,000 seniors don't even have a hope of applying.

Now if you opened it up to seniors you will not have 9,000 applicants, because we know the number is about 2,200 who have an unmet need. It's between 1,900 and 2,200, based on the national numbers. So we did the economic model on it and we calculated that a year and a half ago it would cost about nine to \$10,000 to add seniors. Because first off, they don't want employment assistance. They don't want education assistance. What do they want? They want assistive devices. They want home care, but home care is already covered for seniors to some extent. So there's an overlap there. People under 65 can't get home care if their life depended on it unless they have a disability, but seniors can get it based on need. So there's some overlap where the programs won't have to duplicate the service.

We know what the needs are because we have the study from 2004 which tells us down to the wheelchair, so if you want to see what those are, Table 1.3 in the back says: Only 6% of the people who need a cane or walking stick don't have one, but there's 44,000 required. But if you go down to expensive things like a motorized wheelchair, 52% of people have an unmet need there and we need 24,000 across the country. You can just extrapolate those numbers to PEI using simple math and you'll find out how many wheelchairs. So I think, I forget, at one point we needed 325 motorized wheelchairs on PEI, and I did the calculation, how many hearing aids, how many wheelchairs. It's not that complicated,

and the calculation was it would add about \$10 million a year to the budget.

So our recommendation is (a) to return the million dollars because we're so - when we thought we had 19,000 Islanders with disabilities, now we know we have 22,000, we were short at 19,000. We got 3,000 more people to look after. We need that million dollars back. We need more than that, but at least we need that. We need the seniors in. It's immoral not to treat our seniors, who are the oldest and the most vulnerable people in our society, not to treat them well. I mean, I think we just have to look inside our hearts and say: Do we want our mothers and fathers to need a wheelchair and not get one when a 25-year old can get a \$10,000 titanium wheelchair for racing?

I mean, what is wrong with the system? The only reason it's there is cost containment. There's no reason to exclude seniors. None of the other programs across Canada do.

There's another small group that we could include and it wouldn't break the bank: Learning and mentally disabled people. There's a very small group. As was explained to me by a psychiatrist, if you have schizophrenia and you need to go to see your psychiatrist, you can't afford to go because you need to pay for a taxi or the bus, but you have no job. You have no money. It's little tiny things like that. I call it walking around money, the ability to go uptown, downtown.

We need to align the program with the real needs that we know about from legitimate studies. We need to fund the program properly, when you should define processes that look at the individual needs and not what the policy manual says. Like, there's some rhetoric in this. This is an individualized program that meets your individualized needs. We don't have time to talk to Graham here, but Graham went in with - an occupational therapist report said

he needed a scooter and he was told he needed an electric wheelchair. He fought for six months to get a scooter and he got a scooter in the end because it was what he needed. So the rhetoric was: We tailor it to you. The actuality was: We think we're saving money by doing this other thing. And they weren't. It was a thousand dollars more for what they wanted to push on him for what he needed from the occupational therapist. That's a bizarre system.

We should have an appeals process that is equitable. You appeal to the person who made the decision in the first place. So it's kind of like the traffic cop stops you for speeding and says: Meet me tomorrow morning in court. You go, what? Yeah, because I'm the judge and the jury. You go to him and he says: Yeah, I remember you. I caught you speeding. Guilty.

What kind of an appeal is that? It's not an appeal. That's like a kangaroo court. It's unbelievable in this day and age that we would have an appeal process that was not independent of the people who make the decision. We can do it because we do it in all kinds of other government programs.

I personally believe that the department is mismanaged and it needs review. Like I went in there in September, I met with the deputy, and I'm thinking: Got to throw her a bone. What am I going to give her? I said: I know what I'm going to give her. Tendering. I said: Do you want to make a million dollars? She said: Sure. I said: Start tendering out of your \$9 million budget. Because they're just giving the business to anybody that comes to them, no price checks, nothing. Buy a wheelchair, it costs \$10,000. Did you ever check that it might cost eight somewhere else? Those things have a 45% margin. We have a tendering act or public procurement act on PEI. Oh, I never thought of that. Never thought of it?

What is that, never thought of it? A senior

civil servant who doesn't know that we have a public procurement act that allows the province to get into ridiculously bad human rights cases that they lose, that cost them a lot of money in the end, privacy commissioner cases that they lose. Do you know how they could have won the privacy commissioner case? Done a review. When the privacy act came in, they just take the act and review it against what they got and say: Ooh, that doesn't look like it will make it. I took one of those and I'm not a lawyer. I just read the act and said: It doesn't seem fair. I'll go in and I'll fight that case. They had a lawyer on their side. I had nobody but me, and I won. That's how silly it was. It was just like walk through.

So I think the department is mismanaged and needs to be - somebody needs to audit the department and look at it and say: What's wrong with this department? Let's fix it. Why is there a department that's serving people that are weak, people that are tired, people that are old, and beats up on them? That doesn't manage the public purse properly? I mean, this is public money that's being mismanaged. It's not their money. It's my money. I pay taxes. It's our money and it should be managed properly.

Where's the money going to come from all this? A lot of these recommendations are self-funding because if you save here, you save there. When I sit back and look at the process, and I say: Well, \$10 million for seniors. Wow, that's kind of like three times what the government lost on Polar Foods. Governments always get into boondoggles because they like to invest in things that seem like they're going to be a good idea but nobody that's investing money would ever do it. I say: Stop investing in bad business. Invest in the people of PEI. Invest in social programs that we need on PEI and fund them properly, but I'll give you a \$50 million solution. Start tendering. The province does not tender any more.

When I was in business in Island Computer from 1985 till 1998, we couldn't get a penny of business from the province of PEI without tendering. Everything was tendered, twice a year. They would have come after us. If they knew the price on a computer went down, they'd come after us and said: We know that price went down. We want you to take your price down. Did we mind it? No. We loved the business. Sixty-six per cent of my business was with the province of PEI. I wasn't complaining. I tendered. I competed with six other people around town, somebody in New Brunswick sometimes. I didn't mind because I knew it was fair. If my price was right, my service was good, I got the business.

In 2004, according to the suppliers guide to goods procurement on Prince Edward Island, they tendered \$25 million. I estimate they bought goods and services, the province of PEI, \$500 million. So there's a big spread here. We've got \$475 million worth of goods and services that might be tendered that might save the province 10 or 20%. That's how you're going to fund social programs. Not going to Ottawa. You're going to do it by managing the money you got.

That's my story, and thanks for the time.

**Chair:** Thank you.

We'll open the floor for 15 minutes for questions and we'll keep it to that 15 minutes because we still have another presentation and I'd like to be wrapped up by 12:30, if at all possible.

So thank you, and - Rob, go ahead.

**Mr. Henderson:** Thanks for your presentation there.

I know I worked with Community Inclusions for a couple of years and working with people with disabilities. I guess, Kevin,

your comments there about the value of people with disabilities as far as their work capabilities and work ethic is definitely there. I know, and probably most people would know them, Darren and Darcy MacDougall. They now work with DVA, but I had hired them as a summer student to be an assistant as an employment counsellor. I don't know if there was thing that they couldn't do. You had to maybe make a few little accommodations, but I mean they were probably fortunate, they had parents that had the wherewithal to drive them to work and drive them to some of the tasks that they had to do, but it certainly worked out well. So I certainly encourage employers to take a look at that.

Then as an employment counsellor with Community Inclusions, I think it's really incumbent upon groups or organizations like Community Inclusions to really show the value that people with disabilities can do a lot of the tasks involved, that just maybe there needs to be a little modification done here and there, and with the supports that Community Inclusions and some of the programs that government provide, it can be quite successful. I think it is important that we challenge these groups to show where the jobs actually were occurred, and I know in Community Inclusions space, I don't think they'd have any problem backing that up with the actual positions.

But to wear the hat simply as a MLA for the area, I know I've encountered this case where, on a number of occasions. There's \$2,000 for a lifetime of modifications to a home, and it has to be your actual home. I have a constituent that got her wheelchair ramp into her home but she's got no modifications to get it into her washroom or through the halls and things like that. Like, it doesn't make any sense. When you do the investigation into that particular issue, well, they've received the \$2,000 for the wheelchair ramp.

So I know another particular case, another constituent, sort of the same thing, that they've got some modifications in their home but they don't have a wheelchair ramp so they can't get out so they have to go to an ambulance if they have to go to a hospital or something if something came up. It's costing government more money just by putting these kinds of restrictions in.

So I think your points are very valid, I guess, and I guess it's incumbent upon us to try to work in trying to accommodate. When you try to do some of those things, we probably can save money. Like your comments about people who wind up in manors when they could be in their own home just because of some little investment that might occur. Once again, it can save money and what it's doing, it's backing the whole system up. We've got people with intellectual disabilities, as an example, in manors where it's costing more money to put them in a manor which is taking away for some senior who could be in those. So I think that's all good to take note of.

The other thing I noticed a lot when I was an employment counsellor, and this is where we get into things - I might have a job for an individual that had, say, an intellectual disability in the people I was working with, but I might have a job opportunity for them. The job opportunity may not be a real high paying position so they find out that: If I take this job, I lose my drug support. Well, in the case of government, we're going to be paying those medications probably forever if they don't work. Would it not make more sense to allow them to work, still get their drug medications, and maybe after a few years they can get up into a wage where we can maybe phase it out over a period of time or something? It may save, once again, government monies in the long run.

So I do think we have to sort of look at those situations and try to make some prudent business decisions where you can save

government money and yet provide a better service for the people with a disability and requiring a service.

So anyway, just a few comments, I guess it's not really a question. But if you have anything to add to that, I'm more than willing to sit in and listen. So thanks for your presentation.

**Guests:** Thank you.

**Chair:** Cynthia.

**Ms. Dunsford:** Just a few quickies here. The building code recommendation and whether or not there are some templates from other jurisdictions that we can go on. So keep that in mind. There's the 8.5% of federal employees with a disability working. Is there a statistic for PEI for provincial?

**Unidentified Speaker:** Five point eight.

**Stephen Pate:** I've asked for two years and nobody will tell me.

**Ms. Dunsford:** We don't know what it is?

**Stephen Pate:** No.

**Ms. Dunsford:** Okay. The other thing I wanted to touch on was knowing that our generation didn't experience inclusion necessarily for people with disabilities all across the board in the school system, and that our children have, do you have some insight as to how that is changing? Because I know there is a difference.

Just knowing my - and I know your kids are the same age as my kids - so what do you see changing as far as the attitude and the perception and how we might see that being as a positive in the future?

**Stephen Pate:** First, I'll answer the (Indistinct) one.

**Ms. Dunsford:** Yes.

**Stephen Pate:** The first one was - remind me.

**Ms. Dunsford:** The building code (Indistinct) jurisdiction.

**Stephen Pate:** In the material it lists cities like Peterborough, Winnipeg, Guelph, Windsor, who have barrier-free codes already.

**Ms. Dunsford:** Okay.

**Stephen Pate:** If you go down to the states, it's like a wave. Most of Texas is barrier-free, Minnesota -

**Ms. Dunsford:** So there's a lot.

**Stephen Pate:** - Portland, Oregon. Vancouver, not by code, just by the fact that - I can't remember his name now because my memory has just gone. But you know the fellow that came here to PEI.

**Unidentified Speaker:** Rick Hansen.

**Ms. Dunsford:** Oh.

**Stephen Pate:** Rick, okay, so that kind of celebrity drove the government of BC to sort of become barrier-free. Now what do they have there? They have a mayor in a wheelchair. He's a quadriplegic. He's in a wheelchair. So there's a tolerance in the community that's created. So I mean, it's happening all over the place.

The thing that everybody gets nervous about when you say you're going to change the building code is this will cause the house to cost more, and the cost is like 2 to 3% of the capital cost. So if you build a \$200,000 house, you might have a five to \$6,000 additional cost for barrier-free. But I mean, things like - you don't need a ramp if you landscape up to the door. You know, you

berm up to the door with landscaping. No ramp required. God gave you the ramp. Just roll it up, put the stones on it, and you got a - almost all front doors are three foot wide now, and a three-foot wide bathroom is a little unusual but it's only four inches wider than normal, so that means you just put up normal. Those grip rails are \$65 to buy. They're \$250 to put them on a retrofit. They're \$65 and \$20 worth of labour to put on during construction because they just put them on instead of the other ones. Instead of towel racks they use these handrails.

So a lot of these things are low cost and the Americans fought through that system because they have the ADA, which we don't have in Canada, which says they had to almost do it. So the cities kind of went ahead because of the ADA and there were committees set up. In Ontario, the Ontario Disability Act created the same thing. Peterborough was the first one to have a committee that said: We're going to make Peterborough accessible, barrier-free. So they had this committee, decided what it would be - commercial, residential - and they just sort of went ahead and did it. Then Windsor and Guelph and Winnipeg. So it's a trend. It's coming. It's not like something new for PEI.

There is an interesting thing. I work with young people constantly because I'm in the music scene and the people that are in music are not my age. They're home watching TV. They're young people, and their acceptance of diversity among young people is amazing. When you think about - I'm a child of the 60s, so all that sort of freedom talk that we had, then we all gave it up, went to work, got a job, raised a family. But now I see with the kids, two generations later, they really do believe in those values. So they try hard to be inclusive. I am optimistic about it. They try, and it's really good to see that.

**Michael LeClair:** On the building code

thing, Cynthia, it's just not having the code. Like, there's codes around. If you want to build a barrier-free home, then this is the code to follow. It's having a program that will supply the barrier-free accommodations that are up to code. So that if, in this case, the provincial government is moving to support the construction of housing, it has an affirmative action program that's based on inclusion.

One part of that inclusion thing is to say: Okay, if we're going to across the board be hiring people next year, let's have an affirmative action program that insists on hiring disabled people. We did it with other minorities. Let's do it with disabled people. It's time for disabled people to be invited to the table, in reality.

The other part of that inclusion, affirmative action program, is that when the government is involved in the provision of housing through social housing projects or trading land or whatever, then it says: Okay, if there is a code, it's a barrier-free code. This is how you go about it and there has to be a certain percentage. Some would argue 100%, okay.

**Unidentified Speaker:** What do you mean?

**Michael LeClair:** But there's an affirmative action, and that you have results management. When you review your project, you say: Okay, what were the results? This is what I find is singular (Indistinct) in terms of how we go forward is that we don't really have a management program that's results-oriented. That says: Okay, how did you do here? You had to have 15 barrier-free homes in West Prince and we gave you some support, did you actually do it? Okay?

I think affirmative action inclusion program has to be multi-faceted. Too often we separate social policy from housing policy. We separate these kind of little silos. I think

we have to begin to integrate things a bit more.

**Stephen Pate:** Following up on what Michael said, think about affirmative action. I hired the first chartered accountant in PEI who was a female, and I'll tell you, she had one heck of a hard time becoming a chartered accountant. They didn't want her to become one. She had trouble getting articulated with a CA firm, and she did. That was in 1986.

My daughter graduated in 2002 from the University of Toronto Law School. She graduated because of quotas - not - she didn't - she got in because of quotas. She graduated because she was sharp. But quotas for females are what run the med schools, the law schools, the accounting - all the professions now realize they have to have so many female engineers, so many female architects. Why? Because 50% of the population are female, and why are they being excluded? The old story was: They can't do the work or they're too short and they're too whatever, which is all bogus. It's against the Constitution, the Charter of rights in Canada, to discriminate on the basis of gender, and in all of them it's against the law to discriminate on the basis of disability.

So we've had quota systems to help women advance into the world that was occupied only by men, and it's great. I just love going to female doctors, female lawyers, because it's a whole different world than it was 20 years ago. That's where we're at with people with disabilities. We need affirmative action. That is, quotas on housing, we need quotas on jobs. Because it isn't going to happen overnight. We waited 20 years after the Constitution and what do we see? You know, the federal government set up quotas and they got action. The province set up no quotas. We got nothing, tokenism.

**Chair:** Okay, we have a couple of more questions.

**Stephen Pate:** Sorry.

**Chair:** Does that answer your question, Cynthia?

**Ms. Dunsford:** Oh yes, definitely.

**Chair:** Okay, Mr. Currie.

**Mr. Currie:** Thank you.

I would like to say hello to Kevin. I met Kevin a long time ago in Summerville, many years ago and I certainly think that he's doing a fantastic job with his life after incurring blindness. I remember when he was working at the shipyard and it changed for him. But I think you have a great asset here, Stephen, with people like Kevin, and I think that he could be a champion for your cause. I know he has done a fantastic job, but I think that to instill, I guess, confidence and determination to a lot of people to overcome barriers is one of Kevin's great assets, and I think he's demonstrated that over his lifetime. I think that he brings out the best in people and I think you should use him more, to not only educate the population but also bureaucrats. He's done a fantastic job and I think you should use him more.

**Kevin Walsh:** Thank you.

**Stephen Pate:** Okay, Kevin, you're signed up.

**Chair:** Is that it, Mr. Currie?

**Mr. Currie:** Yes.

**Chair:** Okay. Alan.

**Mr. McIsaac:** I want to make a couple of comments. First, compliment you on the presentation. I think it's terrific.

One thing I wanted to note was on housing first, and I have a question on page 12. But after I stopped milking cows a few years ago I worked two years in Habitat for Humanity, and the first house we built was for a gentleman who had a handicapped young fellow. It was the first insight, I guess, I had into that type of housing. We had lifts for the young fellow in the washroom and in his bedroom and stuff like that. Habitat is one organization I really appreciate the work they do. I think we could build more of those type houses to fit in there.

On page 12, it said there was a recommendation that "the Province begin a process of education of the private sector on the benefit of hiring workers with disabilities." I know within the civil service, apparently, there is a quota or level of inclusion there and I think that's terrific. But how would we go about that? From personal experience in our family, we are very blessed with good health and things like that. We have a neighbour, however, who's a Special Olympian, and quite honestly, he's the best worker we have ever had on the farm. He is a tireless worker and definitely would put us to shame, kept us going and stuff. But how would we, as a province, do that education bit, to get more people involved in the workforce here, I mean?

**Stephen Pate:** First, you have to do your own bona fides. You have to have an employment equity program and you have to implement it so that that becomes the foundation piece. Then you just do education. Like you get people like that, that are sort of minor celebrities, people that are well known, that have a disability and then are working. Then you talk to them and to their employer. You make little showpieces of them. You have public relations campaigns. You do education on television. You just do things that get people thinking: I could hire a person with a disability.

It's so funny. A person from the Council of

the Disabled came to me in Montague when I was working there in 1982 and started talking about people with disabilities and hiring them. Of course, since I had a kind of a quasi one I'm going: Great idea, who you got? And he said: What do you mean, who you got? I said: Who have you got for me? He said: We don't have anybody. What do you mean you don't have anybody? You were just talking about hiring people with disabilities. We just talk about it.

I said: I'll call - what do they call them - HRDC, which they had a different name then, but you know who they are. So I called them up and they said: Oh no, we don't qualify people by disabilities. That was 20 years ago. Now, they do - 25 years ago - now if call HRDC I can get employees who have disabilities to work for me because it's the federal government. They have to do it because they got employment equity legislation. It's a thing they have to tick off. Do you have a disability? Great. And if you have a disability, you move to the front of the pew in many programs.

Just like if you're a female and you're going into Dal law school, and there's 500 applicants and 200 seats. Guess what? The first 100 approvals are females. You move to the head of the pew because that's the way the system works. It's meant to redress inequity of the past to move things. It's never going to be perfect. There's never going to be 50% of the lawyers female or 50% of the doctors or 50% of anybody, but let's move it up a little bit. The way we do is half of all the entrants coming in, and then HRDC, you can ask for and get people with disabilities as applicants.

That's kind of the process you create is a foundation, do education, work on the system. You're working with HRDC, so the people that the province is hiring to do employment development on PEI are in the cue, that they know. Okay, I have to think about this and I have to try to see if I can get

a job for a person with disability. So it's a whole system. The provincial employment system is like a vast network of NGOs, government people, federal-provincial, working on many problems and we just need to focus them a little bit on this one.

**Mr. Henderson:** Just to add one comment to that too, one of the things that when you have some successes with people with disabilities that are successful in working, they become great role models for other people that think: Maybe I can do it. So I think that's the other point.

**Michael LeClair:** I'd just like to add one small thing to Alan's thing. I think you have the senior secretariat. Government has to provide the leadership. If government says: Okay, we're going to move in this. We're going to have a disability secretariat, and one of the prime things is employment. We're going to provide the leadership for employing people with disabilities. We already know that the minister of technology is always talking about: We're going to have to have a workplace shortage of qualified workers. It seems a shame that we have all these people that are disabled and that need an affirmative action program that would be able to contribute - like, you have your experience. Many people have experiences where disabled workers are loyal, they're punctual, they're hardworking, they're intelligent, and they're just kind of not included.

If the provincial government takes the leadership on this issue and puts quotas in and says: Okay, deputy minister, how did you make out last year with employing people? You employed 73 people, 12 people, how many were disabled? What did you do? How did you follow through on this? So there's a quota. Then from the government, they have to move into the public sector with that leadership saying: This is what we're doing. This is the experience we have. These are role models

we can bring to you, and these are incentives that we can provide you, and this is the stick that we'll use if you don't follow along here, okay?

It's not going to just happen. It has to be something that government has the drive - I believe firmly that if government gets behind this, there'll be cost savings to the government, because you'll be taking people off social welfare policies and other kinds of policies, you'll be taking people off Pharmacare programs, often.

If you're working with the provincial government and receiving a reasonable salary, well, you're not on welfare with the Pharmacard. You know, you're contributing to society. You're feeling better as the disabled person. Your family's feeling better as the disabled person. It's a win, win, win, win. Like, some people talk about the older worker, like myself. I believe there's a great untapped resource on Prince Edward Island and that is people living with disabilities that we haven't really included.

I read the other day a review from CMHC where they're talking about affordable housing in Canada and the crisis there. They never mentioned disabled people. We mention women, we mention immigrants, we mention all kinds of people that maybe have to be invited to the table, but I don't feel that we've been at all fair, as a society. We tend to look at disabled people, even today, with a bias that somehow or another that their disability is a barrier. It's something, they're not quite equal. They're disabled.

I think, you know, like, we've got to get beyond that and realize that a lot of disabled people in this age of information technology can really provide an incredible amount of energy to our society. Unless we have an affirmative action program with meaningful quotas, we'll just be talking. I think that's it, Alan. We have to have the will and behind

that will, we have to have a program.

**Chair:** Okay, we have (Indistinct).

**Stephen Pate:** Can I have one more comment? It just occurred to me. It's quick. Do you know that we have the largest single demographic other than females on PEI?

**Chair:** No.

**Stephen Pate:** Yeah, we are larger than seniors. Seniors are 2% below people with disabilities. So if you do the head count on seniors, it's 18 or 19,000. It's 22,000. So we're the largest minority on PEI, and women aren't a minority, of course, women are the majority. Men are the minority now.

**Chair:** Okay.

**Stephen Pate:** Thank you.

**Chair:** Okay, I would just like to say, thank you very much for coming in.

**Stephen Pate:** Thank you for inviting us, letting us come.

**Chair:** Certainly, your points were well made and I believe that, as a member of this committee and looking around the table, I think that the points were certainly well taken.

I disagree with none of them. I worked with the mentally ill for 15 years before coming to government and we have a very close family friend who is in a wheelchair and spends a good deal of their time at our home. So I'm well aware of the barriers inside our home as well as in the community when I am travelling with them. So you're right, there is a lot of work to be done, and the points certainly did not fall on any deaf ears this morning. I thank you sincerely for coming in.

**Guests:** Thank you very much.

**Chair:** Thank you.

**Guests:** It's our pleasure.

**Chair:** We have one more presenter that would like to come forward.

We'll just take a couple of minutes then, two minutes.

*There was a short recess]*

**Chair:** Okay, guys, can I get the committee to come back into place here for a few minutes?

Certainly sorry for us running a little bit behind schedule, but obviously it was a complex issue and certainly a very detailed presentation by our last presenters. It's always difficult to stop people when they certainly are making good points and have a lot of very important information to share.

However, we do have Miss Montgomery from the Salvation Army in Summerside who has come before the committee this morning. We want to welcome you, and ask you, before you start your presentation, to introduce yourself for the Hansard. We'll give you 15 or 20 minutes and maybe - I don't know how long you figure that your initial presentation is.

**Marjorie Montgomery:** It shouldn't take too long. It's pretty basic.

**Chair:** Okay, then we'll take some time.

**Marjorie Montgomery:** As I've not presented before I wasn't aware of what was needed or what was required, so I did just what I would do for any other organization.

**Chair:** Okay, well, that's great, Marjorie. We'll let you go ahead and then at the end we'll take a few minutes to ask some questions, if anybody has any questions.

**Marjorie Montgomery:** Madam Chair, fellow presenters and concerned individuals and representatives, I'm proud to be here to represent the Salvation Army in Summerside, Prince County.

I am the Community and Family Services Coordinator for that area. Being in that position, I'm well aware of what's going on on the grass roots of that.

I'm not here to condemn the government, but to make you aware of the many social issues facing us as a non-profit organization. I feel a lot of these issues should be supported and addressed by government. I am fully aware we have not reached this point overnight.

I am president of the PEI Food Bank and a representative for the national board. We have two representatives from PEI, but because we are a non-profit, there is no money for us to attend meetings in other provinces. The Upper Room does fund for Mike MacDonald to go. I also sit on the Homeless Initiative of PEI which is a branch of the national.

We in Summerside have no housing for the homelessness while the Charlottetown area has three possibilities. We did have one and due to circumstances, we now have nothing. If a person goes to social service and is not a resident for 30 days in PEI, social service will not help them. If they have no place to stay, they send them to us. Yes, they will pay for a ride for them to go back home.

But a prime example of this: I had a client come into me saying he had been beat up and he looked like he had been beat up. Someone had stolen all his money. He had a job to go to, a full-time job, a commitment. We had a letter saying that he had it, but he had no money. So what we did, we arranged for him to go to MacDonald's Community Care for a week. We paid for that week. He said: I will pay you back. We said: No

commitment. That's not how we work at Salvation Army. A few weeks later in he came with \$120 donation for the Salvation Army. Social service should have been at the table. Social service should have looked after this gentleman. This gentleman was on the street.

A young female was found in the park by a community-minded person. They went to social service with her. The only thing that they would do for her was give her a ticket for home, but not for three days, and they would not provide a place for her to stay. This lady sat across the table from me, had not eaten for a number of days. In fact, I looked at her and I thought: Wow, what's going on here? After talking to her, her head down, shaking, cold - it was in the spring of the year, last year - we arranged for her again to go to MacDonald's Community Care because we have no homeless shelter in Summerside for women, definitely nothing. We sent her to MacDonald's Nursing Home. She came in 48 hours later to get some food to take on the bus and what a difference in this lady. She was warm. She said she couldn't believe how cold she was. She couldn't believe how hungry she was. So she had been fed. Her clothes had been washed. She had been given a lunch box to take on the bus and she went on her way.

When people go to social service they are told they have to have an appointment. Even if it's an emergency they have to wait three or four days. Well, if you went to the hospital and it was an emergency and they told you to wait three or four days, I think we would be burying a lot more people than what we do now. I know I wouldn't want to go somewhere and have an emergency and have them say I have to wait three or four days.

My budget for the year is \$1,000 for room and board. My fiscal year runs from April 1<sup>st</sup>, 2007 to April 30<sup>th</sup>, 2008. At the present time I have more than doubled that budget.

We are a non-profit organization and we depend on the community for our support. We are in a very tight spot. Again, we are asking social service to be more supportive of the clients that enter their doors.

One of the hardest things in my position is when the word comes that someone has committed suicide. You sit and you wait for the name to be released. There is a big void in the Summerside area for the youth between the ages of 14 years and 19-year olds, and especially young offenders that are released. There's no place for them to go to. We have nothing in Summerside or West Prince for these people to go to. We work quite closely with the young offenders. We have them come in. They do a lot of their community hours in our units. They come in, they help us pack groceries, they help us stock shelves, just anything, normal things. There's not a complete contact with the public but they are there with us, and those are the young offenders.

Where do the moms and dads go? What do they do when they've been threatened with bodily harm, with a knife or other objects and the police come and their hands are tied because there's no place again to take these young people? I know from personal experience how the system works. I've had two young grandchildren and the system failed them terribly. If it had not been for the strong family unit that we have and the friends and family around us, I am sure that we would have been burying one of them, if not two. There's people sitting at that table that are aware of those problems. Actually, I have approached that person and said: Do anything for me, I don't care what it is. Just do something for me.

Clients of the Salvation Army in the position of buying groceries or paying rent. Some are in the position of making the decision to buy their prescriptions, oil, or groceries. Today, before I came here, I did a survey. March of 2007, oil was 72.4 cents a litre. So in fact,

that made it \$345.34 for 100 gallons of oil. In December 2007 it was 88.7 cents a litre. That made it 423.10 for 100 gallons. Today, February, it's 93.7 cents a litre. That makes it \$442.73 for 100 gallons of oil.

Electricity in March of 2007 was 10.68 cents. That made it 106.68 for 1,000 kilowatts. In December it was 11.79. That made it 117.90. And in February, today, it's 12.1, which for 1,000 kilowatts is \$120.01, plus your GST.

Just last week I was getting ready to go to work. A quarter to seven the oil man came. He left me a bill before I left the house, \$637.00. I don't clear that in a week. Can you imagine our clients that are living on \$600 a month getting a bill like that? It's happening. It is happening.

We supply about 135 hampers of food per month for the Prince County region. That is us alone. There are other food banks in Prince County that are supplying. We feed somewhere between 1,200 and 1,350 people per month in the soup kitchen. All of this is done with donations from the public and volunteers. Is it not the responsibility of the government to provide the necessities of life for these people? How can people live when they are underfunded by the people that are responsible to look after them? We, as a society of the less fortunate, should be all at the table. Would anyone of us here, as a single adult, be able to live on \$600 per month?

I have a gentleman that comes to my soup kitchen every day. When we're not open - and thank God we're able to open seven days a week now because of a commitment from the United Church - when we're not open, he doesn't get a meal. Yet, he still has time to come and volunteer with us. Many of our people on social services are there not because they want to be but because of life circumstances.

There are four critical areas that need addressing in the Prince County area. First and foremost, we need a shelter for the homelessness. We need a support system for people who want to go back to work, to help get them off social assistance, and a livable social assistance program that does not have them making decisions between buying groceries, paying rent, or medication. A safe place and support for the youth between the ages of 14 and 19.

I understand that there is some discussion about having the young offenders at a place in Summerside. I feel this is an excellent idea and in fact, it would save hundreds of thousands of dollars that could be spent on programs. The location would be excellent for the western and the eastern end of Prince County, that is, the young offenders that is there now.

I thank you for your time and I hope you have gained some insight into the social problems we are facing.

The fourth problem that I want you to look at is the oil situation. On a weekly basis we are probably seeing between three and five people for oil. They have no oil in their tanks. They can't afford to get oil. The oil companies will not deliver less than 100 gallons. If it's an emergency there's a service charge. This is a serious problem at this time. We, as a community, and you, as a government, has to act on this now, not tomorrow, not in the weeks ahead, or not for the fall. It has to be done now. We have children going cold, no food. We need action now on the oil issue immediately.

I thank you.

**Chair:** Thank you.

I think Sonny Gallant, you have a question.

**Mr. Gallant:** Marj, I'd really like to thank you for coming down today. The people that

you're seeing for oil, are these new clients?

**Marjorie Montgomery:** Yes.

**Mr. Gallant:** So over and above -

**Marjorie Montgomery:** I would say 50-50.

**Mr. Gallant:** Okay.

**Marjorie Montgomery:** I think what has happened here, and I'm not positive of this, with the oil issue is there hasn't been an adjustment for social service. Let's face it, if you're paying out \$440 for 100 gallons of oil, and even getting \$1,000 a month for social assistance, and you've got children, you're paying 500 for rent. I mean, you are going through easily 100 gallons of oil in a month. There's just no money.

**Mr. Gallant:** We're hearing that quite a bit from the different groups that the cost of everything hasn't gone up (Indistinct) -

**Marjorie Montgomery:** The cost of flour, I mean, just flour alone is going to increase our cost at the food bank tremendously -

**Mr. Gallant:** Oh yes.

**Marjorie Montgomery:** - because of the bread, cereal, pasta. Like, we're talking about normal, everyday things that we have that we just don't, that we're not -

**Mr. Gallant:** Someone mentioned to me the other day it may inadvertently effect you as well because the big stores will not - they'll only make what they know they're going to sell now because it costs so much.

**Marjorie Montgomery:** Definitely, we'll already seeing it.

**Mr. Gallant:** You're already seeing it?

**Marjorie Montgomery:** We'll already seeing it. Superstore is a great supporter of

the Salvation Army, but where we used to see boxes of bread, we are now maybe seeing five or six loaves. Five or six loaves will do our soup kitchen, but our clients come in every day and sometimes that's the only bread they get in a month is what they get from us.

**Mr. Gallant:** This is a question, I guess. In your letter here where the Nova Scotia government gave the Salvation Army \$200,000 -

**Marjorie Montgomery:** Yes.

**Mr. Gallant:** - could you see, like, if our government was to do something along that, how could we implement that? Like, to trace it? I mean, in 1996 there was a program that came out on oil subsidies -

**Marjorie Montgomery:** Yes, and it was blanket, was it not?

**Mr. Gallant:** Well, I don't know if it went to people that got GST or low income people, but I know people got it that didn't buy oil.

**Marjorie Montgomery:** Yeah.

**Mr. Gallant:** So I mean, if we're going to help people with their oil bill -

**Marjorie Montgomery:** I think it has to be on an individual basis, on a need basis. Now I think that we would have to sit down and have a criteria that they have to come under. I don't think we can do a blanket. I think if we do a blanket we are being remiss with government funds. I think we would have to sit down and have a criteria that says: Okay, you have this amount of money and this is the increase.

What I'm doing with some, I have a garage where I allow them to get \$100 worth of fuel and they go and get the fuel. Because maybe it's only a five-day gap between the time

they've got no oil and they've got money coming in. So we're talking about the working poor here too. This is a major problem with the working poor because the working poor just don't have the money to put out for oil.

I think, first and foremost, we have to have a criteria because we don't want misuse of government funds or anybody's funds. I mean, probably the Salvation Army is the best manager of money that I have ever seen, and I've worked in the business world for years and years and years, I think since I was 18 years old, and I worked on finances for years. They can make a penny go further than anybody I know.

**Mr. Gallant:** Can I ask one more further question? The ice storm, did you deplete some of your inventory? Like, was there a lot of people threw away the food?

**Marjorie Montgomery:** Definitely. We had a large increase on people that lost all their food, couldn't afford to buy any more food, and then on one day alone I think we had three people asking for oil assistance. I had one yesterday. I had one on Thursday that somebody brought in, one of the government agencies brought him in for help. So I'm also seeing the government agency bringing them in because there's a gap there that they're not getting their oil.

But I think, first and foremost, we have to be really careful how we administer this, and we don't want to make it cumbersome in the sense that there's going to be so many i's dotted and t's crossed that we can't work with it. We have to be able to work with it then, now, immediate, emergency.

**Mr. Gallant:** It has to get to the people that need it.

**Marjorie Montgomery:** Yes, and that's number one.

**Mr. Gallant:** I know like in the old rebate, I had a lot of people come to me and say they were paying for the oil and their tenants got the rebate.

**Marjorie Montgomery:** My brother had apartment buildings and he was probably one of them. He had apartment buildings and his tenants were getting the rebate for the oil. I mean, how ironic is that? I mean, he's got, what?, he's got eight units?

**Mr. Gallant:** But that was a federal program.

**Chair:** Yeah.

**Marjorie Montgomery:** They were getting the rebates for oil. So oil is the main thing. Homelessness is another one. Those are the two that are really important.

**Chair:** Okay.

Does that answer your question, Mr. Gallant?

**Mr. Gallant:** Yes.

**Chair:** Mike.

**Mr. Currie:** Marj, thank you for coming down.

I was in the oil business for probably 18 years and I incurred some of the problems you're talking about during the embargo on oil back in the 1970s and stuff where the price went through the roof, but I've always managed to look after them. What I had, I found it was more of a problem of educating the bureaucrats. It doesn't matter what government is in. They seem to have the mentality that they got to teach people skills to individuals that have just had a crisis in their life. Their husband left them, they got the wife and the kids, and they're trying to cope moving into another home and taking on this new challenge in front of them.

They're not focused on penny-pinching oil. What I had done was put them all on automatic.

It was the only way you could run your business and have a level of comfort that clients or customers of yours were not going to go cold and kids weren't going to go cold. I feel bad that that's still instilled within government. I'm not being critical of this government because it happens with all governments. But that mentality has to somehow go away and give these people a hand-up instead of a -

**Marjorie Montgomery:** A hand-out.

**Mr. Currie:** - deal with this. Because you know, to see a house go and freeze and the pipes freeze and then the dollars that are invested after that fact is massive, especially to see kids cold.

But anyway, it can be done and it is done and it takes somebody to go in and say: This is being looked after. The oil companies will insure that it's done on automatic, and these people won't go cold, and then the bureaucrat has to take the time to sit down and budget that amount and allow for the increases. It's very simple and can be done.

**Marjorie Montgomery:** It's not being done right now.

**Mr. Currie:** That's shameful. It doesn't matter - I'm not being critical of the government of the day because it was probably done under our government also, and it just - I know it can be done because it was done. I always (Indistinct) I looked after them that way on automatic.

**Marjorie Montgomery:** Being on the other end of business, I understand where the oil companies are coming from and saying: We cannot deliver oil for less than 100 gallons. Because, let's face it, they do have to make money. But we have an oil company within

our midst that has been extremely good to us - extremely good to us - and has even in an emergency, called them in the morning and they said: Yes, Marj, I'll have the oil there in the afternoon, and don't charge us that emergency charge. So we do have oil companies that have compassion, but they also have to make money. I mean, there's money there and it has to be made, so we understand that.

**Chair:** Any other questions or comments?

**Mr. McIsaac:** I just have one comment. I want to compliment the Salvation Army on the work you do. I'm disappointed the press left as soon as you came on. I don't know why that was. I think your story is just as good a story to report as any. They also give a good plug to the Salvation Army and I'm glad to hear that Superstore and such are supporting you, but it may have helped a little bit more to bring that in too.

I think we'll see what we - I know it's not your issue to make the press and stuff like that, but I think it -

**Marjorie Montgomery:** I just thank you all for having me here today and letting us - I'm not as well polished as some of them, but my heart is in the right place.

**Mr. McIsaac:** For sure.

**Marjorie Montgomery:** Thank you very much.

**Chair:** I think you did a very good job, Marj, and it's certainly that kind of information that needs to come through this committee. In order to make ground we have to have the information from the public, and I don't think any of us differ in the idea that something - there has to be action taken. But it's with this stuff that puts more pressure and helps the cause, so you did an excellent job of your presentation.

**Marjorie Montgomery:** Thank you.

**Chair:** I'm very proud to say that you work with the Salvation Army in Summerside, and thank you so much.

**Marjorie Montgomery:** Thank you.

**Chair:** Okay, this committee is recessed until 1:30 this afternoon.

*[The Committee recessed until 1:30 p.m.]*

**Chair:** Okay everybody, we're back together to start the second portion of our meeting of the Standing Committee on Social Development.

This afternoon our first presenter from Kings Square Housing Corporation did not show up. But we do, this afternoon, have representatives here from the Seniors' Secretariat. On behalf of myself and the committee we would certainly like to welcome you. We would ask you to introduce yourselves by name for the Hansard. The floor is yours.

**Faye Martin:** Okay. Maybe I'll start, and start by thanking you for having us here today.

I'll speak in a moment about the genesis of us being here. It started with a conversation with Melissa, which I'll get to in a moment, but first of all I'd like to introduce my colleagues with me today.

My name is Faye Martin and I'm a director with the Department of Social Services and Seniors. I'm responsible for the Seniors' Secretariat, the drug program, the dental program, and the housing program for the province. Because the subject matter today is seniors, and because seniors are a large part of the client group of all of those areas, I chose to bring the people with me who know most about the programs to answer your questions.

With me is Patrick Crawford, who is our pharmacy consultant for the province, right here; Dr. Albert Adegbenbo, who is with the dental program; Bill Fleming, who's the provincial coordinator for housing. I also have the pleasure of introducing the co-chairs of the Seniors' Secretariat, one of whom is also the deputy minister for the department, Sharon Cameron, who's seated over here, who many of you will know, and a very prominent senior citizen in our province, Anna Duffy, who many of you would have seen on TV last night if you were watching *Compass*.

So I'm very fortunate to have these folks with me today because, collectively, we do have a lot of information about programs that impact upon seniors in this province.

When Melissa called me I think she called in absolute innocence. She just wanted a couple of questions answered. We got talking about the seniors population in the province and I think it became evident to her that there were a lot of issues and challenges around one of our fastest growing populations. We have the third-largest seniors' population in the country. Third, and almost tied for second with Nova Scotia, Saskatchewan having the highest population.

I'm sure we need only think briefly about that statistic to understand the challenges that that brings with it in terms of many of our systems and how our population is structured. We need only to think a short while about that to know that we have a lot of challenges coming our way and they're coming very quickly. We have 20,000 Islanders, approximately, that are age 65 and over. There is a great debate across the country about what age do you have to be to be a senior. It's a bit of a moving target because some groups think that at 60 you're a senior, and some people even think at 55 you're a senior. I don't know how I feel about that because I'm 56, so I'm not sure

yet if I'm ready.

Nevertheless, we have people retiring at much younger ages. We know what we're looking at in terms of workforce challenges with out-migration alone, let alone an aging population. In fact almost 35% of our population is age 50 and over and we have a declining birthrate. So when you put all of that together and do the math and think out there a decade or two or three or four ahead of us, it tells you a little bit about the dramatic changes we're going to see in our population.

So when Melissa and I finished talking, I said: You know what? The Seniors' Secretariat is all about influencing policy, as well as public education and communication, and it would be a great opportunity if we could come and talk to the legislative committee on social policy development rather than just sending a few statistics along. So when I offered that to her she quickly took me up on my offer and we're here today.

I got thinking when I was planning to speak to you that with all of the program areas in the department, as I've already mentioned, that are heavily utilized by seniors and will continue to be even more so, that it made a lot of sense to me to bring along my colleagues that I have with me today. So that's why we're here.

We'd like, each of us, to do a bit of a presentation that will take probably 10 or 15 minutes. I know we have an hour, but I anticipate that you will have questions of us. Because we'll talk about what it is we do, but we also are very anxious to talk about our challenges. Because you folks are the people who will be making decisions around these challenges in the next number of years, and clearly we're up against something that's moving rather quickly towards us. In fact, it's upon us with the aging population.

So I don't know how you - do you save your questions until the end or do you ask them as you go? Okay, so maybe we'll wait, if you don't mind, unless you really need some clarification, maybe hold the questions until the end. I believe we're willing to stay here with you as long as is necessary to answer them. I guess I would say we might not have all the answers and we'll certainly - those questions that we can't answer, we'll get back to you. So if that's okay, if that sort of gives you a backdrop, you know, as to why we're here?

Sharon or Anna, would you like to add anything?

**Anna Duffy:** No, I think you've covered it very well.

As you said, our mandate is to influence policy among government, and it's really important that we have input from seniors from the grassroots' level and that we're able to pass that on to government and government acts on it. So that's one of our principal mandates, is to educate ourselves, too, on the issues concerning seniors so we will be informed of what is available at the present and where the gaps are and how those may be improved.

**Faye Martin:** Sharon.

**Sharon Cameron:** I'd just like to take this opportunity to thank you for putting us on your very busy agenda, and also recognize that this is one of the many challenges that we have ahead of us. So we're just glad to be here to be able to speak to you in person and kind of break it down into the specific issues that we are responsible for. So thank you very much for the opportunity.

**Faye Martin:** Okay.

So maybe I'll just spend a brief moment talking about the Seniors' Secretariat. The Secretariat was created in 2005. Its

predecessor was the Seniors' Advisory Council, and that council recommended a new structure for government. I think it's fair to say that with changes in ministers, in government, and with personnel working for the Seniors' Secretariat that we're really, to be perfectly honest, just getting our feet underneath us. We have, as our mandate, it's a three-pronged mandate at this time that has to do with communication and public education.

Certainly, in terms of a public education piece, we have just launched what we're calling the senior's guide. I think it was probably the latter part of January. We had a fairly high profile public event where we announced far and wide that this document was available. We had 3,500 copies printed. We have none left, and we have a list of people who are interested in receiving copies. So needless to say, this was something that was needed.

It is a document - and I'm thinking that most of you have received copies, and if you haven't we'll have to go - well, I have three with me today, and they're very expensive, because they're the last three of hard copies.

We're receiving some extremely positive feedback on it. We expected that we would be hearing - with the number of phone numbers and contacts that are in here we thought, well, there's got to be quite a few mistakes in there. Phones numbers change. We're hearing very positive feedback. The information is divided into a number of categories: active living, finances, health services, lifelong learning, housing, personal security and legal services, transportation and travel.

So I think in terms of being a service to the public, this is one of a couple of ways that we have been apparently successful, in that - and I'm saying apparently because of the uptake. We also have a toll-free number where seniors can call. The number of the

Seniors' Secretariat itself is published. So we do get a lot of calls every day to answer questions and to answer requests.

Now in terms of the policy influencing piece of the mandate, which is the larger - and I think, probably, if I were to be very frank about it, the most difficult part of the mandate - we have, working as part of the mechanism of the secretariat, an 11-member group that is comprised of representatives from the provincial government and seniors organizations across the province.

As I mentioned before, Anna Duffy is the co-chair and Minister Currie is the other co-chair, replaced by Sharon, should he not be able to be available. Other members of the secretariat include deputy ministers from economic development, from health, from - what's the other department, Sharon, besides ours?

**Sharon Cameron:** Finance.

**Faye Martin:** Provincial Treasury. From the community we have representatives of the PEI Senior Citizens Federation, the Seniors United Network and our Francophone Le Bel Âge Community Group.

They meet regularly to talk about issues that affect seniors in the province with a view to articulating to the deputy ministers present, and the minister, what those issues are and the kinds of things that might happen to address those issues.

We do struggle in terms of finding our way around what processes we are going to use to gather information from the public at large and from the grassroots' seniors population in the province, and we haven't really fine-tuned that yet, but that's something that we're working on, a process that will work better for us in that regard.

I don't really want to spend too much time

on the secretariat. I will certainly answer questions at the end of the presentation.

But the areas that we most often find ourselves talking about are around the programs that have to do with seniors housing, need I say the drug plan. Many of you, all of you, would have been aware of the recent publicity around our drug plan and our seniors' dental plan. So maybe I'll start with Patrick Crawford, if he'd like to start with our drug programs for seniors.

I'm just passing around a bit of a fact sheet on the work of the Seniors' Secretariat.

**Patrick Crawford:** Thank you very much for the opportunity to provide you with some information on our drug programs.

Right now the PEI Drug Programs, they actually consist of 30 drug programs that have been pieced together since the 1960s. The earliest record that we can find anywhere of a drug program, at least in our files, is 1967 when the welfare assistance program was introduced. The reason I say that they're pieced together is because unlike a lot of other provinces, who only have one, maybe two, drug programs that are kind of universal and spread across all of their residents, all of our programs, instead, are targeted, based upon such things as age for our seniors program; disease, such as an HIV Aids program; income, such as a financial assistance program; even where you live, which would be our private nursing home program.

The program that we have that is most commonly used by seniors is our Drug Cost Assistance Plan. Unlike, again, most other provinces, this program is actually universal. Any senior who is 65 years of age or older is eligible for coverage by it. But what they do have to is that they have to pay a co-pay that consists of the first \$11 of the medication cost plus the pharmacy fee. That may not seem like a lot, but if you are getting 10 or

more prescriptions filled in a month and you're low income, that starts to really build up.

Diabetes Control Program is the next biggest one that probably seniors use and, again, it's available to all Islanders diagnosed with diabetes. Again, there are prescription co-pays. For oral medications they would pay \$11 per prescription. For insulin, it's either \$10 per vial or \$20 for a box of cartridges. These co-pays are independent of the seniors' programs. So again, if you've got one or two diabetes medications, those co-pays do start to mount up after a while.

Our Nursing Home Program is available to Islanders who are eligible for a subsidized bed in either a private nursing home or in one of the government manors. All of the government manors in the province right now are actually served by our own government operated pharmacy. It is in the basement of the Sullivan Building. The private nursing homes are all served by retail pharmacies right now. There's no cost to any of these nursing home residents, though, for their medication coverage.

We have a High Costs Drug Program which originally started out as a way to start to provide coverage for the first of our really high cost drugs, which were the MS medications back in the 1990s. Right now we have expanded it out to include medications for the treatment of severe rheumatoid arthritis, cancer, severe Crohn's disease, another cardiac condition called pulmonary hypertension. All of the medications in this program all cost \$20,000 or more per year. Patients that are eligible for this pay an income based portion of the drug cost, and it varies from: for a financial assistance recipient \$2, up to - the cutoff is about \$150,000 of net family income, at which time you would end up paying the full cost of the medication.

We have the Disease Specific Programs which I mentioned. Probably the one that is most used by seniors is the organ transplant program. We are having an increasing number of seniors now that have particularly had kidney and heart transplants. Again, all of the Disease Specific Programs are delivered through our provincial pharmacy, and there is no cost to patients.

For patients who really aren't able to afford the cost of their medications - and that includes seniors who have high co-pays - right now the only real alternative that we have is our financial assistance program, at which time they can go into an income assessment or social services office, have their expenses and their assets and everything all looked at, and they will be given - perhaps would be given some coverage. The coverage is tailored exactly to what they need. Many times, because drug costs are their only problem, they will be given what we call Drugs-Only Financial Assistance Coverage, which is this program here. There's no cost to these patients once they're on the program.

The newest of our programs, the one that really doesn't fit in with drug programs per se, is our Home Oxygen Program that was introduced about four or five years ago. Again, it's available to all Islanders. In this case those that are diagnosed with chronic hypoxemia - which is essentially you just have very low oxygen levels in your blood - this program will provide eligible people with 50% of their approved expenses up to a maximum of \$200 per month. For most people on this program their average cost would be somewhere in the range of about \$300 a month. So they are, in fact, probably paying out about \$150. But there are people that vastly exceed this maximum.

Issues that we have: As Faye has mentioned, we have an increasing number of seniors in our programs. Since 1988-1989 we had just over actually about 9,000 people. This year

we are likely to exceed 16,000 seniors using the program. At the same time, drug costs have been going up. We started off, when I joined the programs, essentially, we were - budget of about \$3.4, and this year we're likely to come pretty cost to about \$12 million for the seniors' program.

The reasons the medications are going up is we have more people using the medications. The medications themselves are more expensive than they used to be. Also, physicians now are relying more on medications therapies than they used to. At one time if you had - a male, let's say, had prostate problems. Well, the only alternative was you either waited it out or you went into the hospital and had surgery. Now we have medications to alleviate the symptoms. So it's that kind of a thing.

Most drug programs across Canada are seeing exactly the same types of increases that we are here, which is in the range right now of about 6 to 7% per year. We are working very hard towards trying to alleviate some of the potential impact of the programs on us. We're trying to take a look at taking our 30 drug programs and harmonizing them down to maybe one or two programs, expanding that coverage to include more Islanders so that we don't just have coverage for seniors and for low-income people and those with specific diseases, but we'll be able to target everyone based upon need, particularly the working poor.

We're looking at expanding the coverage to include more medications. You've all heard the Sutend issue that's been in the media. This is one of the medications that we would like to cover. The issue is we have at least 70 other medications. They're all waiting for coverage, including other cancer medications.

We'd like to be able to provide coverage for new medications much quicker. Currently

the way medications are put onto the formulary is we have national committees that take a look at these medications. They review them. They make recommendations back to us, and then we act on those recommendations. At the moment we have medications that have been waiting in our queue for significant lengths of time and still there's been no decision made on their coverage.

We'd also really like to increase our regional, our provincial-territorial, and our federal, provincial and territorial cooperation with these. Being a small jurisdiction of 140,000 people, we don't have a lot of impact when we go to a pharmaceutical company and say: We really think that we should get a better price for our medications. But by cooperating with other jurisdictions we may be able to get those prices down.

The other one that is quite big with us is catastrophic drug coverage, which really is not just coverage of high cost medications, but it's no one should pay more than, let's say, 5% of their net family income in all of their medical expenses. Through what was called the National Pharmaceutical Strategy we have been working towards that. But due to, really, a lack of support from the federal government, this has completely fallen apart and essentially NPS is now dead, for all intents and purposes.

I think that's all that I have to present. What would you like next?

**Faye Martin:** Thank you, Patrick. I'm sure that's given rise to a lot of questions in your minds, so we'll move ahead so we can get to the questions.

Dr. Albert Adegbembo is our dental consultant for the province and he, I think, has prepared some information for you on seniors dental programming today.

**Dr. Albert Adegbembo:** Thank you for allowing us to come present to you.

Unlike the pharmacy program, we have a level of client for dentistry in the sense that in those days people didn't use to live long and they didn't have teeth. Now they do, and so we are really at the drawing board. What I'm going to presenting will be more philosophical in the sense that I would want you to be able to look at the issues that we have now, look at them within a historical perspective, and then we can then push this forward and see what's likely to be the problem that we're going to be facing in the future.

Now, one of the things that we have is that the rates at which people lose their teeth or complete loss of it, edentulism, has been going down by the years and I will address that in the next few slides. Now most people who have their teeth, they have needs, and people who live in institutions have a higher need. That's based on documented research reports.

The next thing I will go on to describe is the oral health needs in relation to access to care, and then finally I'll talk about the strategies to address oral problems. I'm not going to be talking about the oral health strategies that we have here, but globally. What are other countries, what are other jurisdictions, doing and how do we fit into that?

Now, if we look at the history of dentistry, say 1850-1899, for example, that was when we found the first dental drill. Toothpaste was manufactured in 1880, and we didn't even know what dental disease was until about 1890. That was when we knew that this was a bacterial infection. Now, if you take the cohort that developed around that time - those are people who are over 100 at this point in time - you would quickly realize that they had nothing in terms of care or in terms of management of disease. Also,

those are people who didn't live up to - the average life expectancy at that time was far less than the 80 that we have now. Now, subsequently we have development of local anaesthetic which meant that we can now drill teeth, we can now do things in a more comfortable way, and people are able to receive care.

Now we have next cohort, 1921-1945, for example, who now have enjoyed some benefits of prevention. Fluoridation was first noticed in (Indistinct) in the United States in the 1930s. That's when the research on fluoridation began. Fluoridation in New York started in 1945, in Toronto in 1960, and we had nylon toothbrushes in 1938. So we now have a second group of seniors who now have opportunity to have prevention and who are able to maintain their teeth.

Now, the last group, which is the future cohort of seniors that we'll be having, are people who have had toothpaste, who have had opportunity to receive prevention, and who also have been used to receiving care. They are going to be the next group that we're going to be dealing with. Now, keeping that in mind, let's now look at that's affected the dental health of people.

This graph is based on all the studies that were conducted in Canada up till 2000. I did a study and that study was to take all the studies and look at the ages of people based on where they were born and now compare how many of them didn't have any teeth in their mouths. Now, for those who are born in 1885-1899, all the studies show that people who lived in institutions, for example, only 25% of them would have any teeth in their mouth, 75% didn't have any teeth. Those of them who lived on their own, 70%.

Now, take the next cohort, which is people born 1900-1920. That percentage has dropped. So many more of them are now

having their own teeth. For those who lived in institutions, it was 62% and for those who lived on their own it was 47%. Now, if you take people who were born in 1921-1930, that percentage has dropped considerably to 24%, and that's people who lived on their own.

Now, this information can be looked at, again from another perspective. The United States have been conducting national surveys that are representative of everyone in the United States for quite some time, since the 1950s or 1960s, there about. And they started - the last national survey that they have, which is called the National Health and Nutrition Examinations Surveys, they were conducted in 1988-1999, with a 1994 window, which is the one in blue and, as you will see, the percentage of people who have no teeth is a lot lower than what I showed before. Now, we have 40%, and look at it 10 years after that, we have 31%. So that's a decline of almost 10%, with the next cohort of people who became 75 years old and older. If we look at people who are 65-74 the same thing is noticeable. By the time you get to people who are 20-34 currently, less than 1% of them have no teeth at all.

So we're looking at various cohorts of people moving in time with different numbers of teeth in their mouth. If we go back slightly and look in general right now what you will see would be that on average those who have their own teeth have about 15 teeth in their mouth, 13 are missing. Now, of the 15 teeth that they have, only seven of them would be sound. In other words, there's no disease. Three of them would be decayed - in other words have cavities - and five of them would have been restored because they were decayed.

Now this group would have need for - new, decayed, been restored - replacement of restorations. Mind you, now that we are moving away from amalgam restorations,

which have a longer longevity, to composite resins which have a shorter duration in the longevity in the mouth, it means that there'll be need for more and more replacements over time.

In one study that we have looked at also, if you have a tooth in your mouth - to be specific, for the people who are in nursing home, if you have a tooth in your mouth you have a risk that is 12 times greater than if you didn't have a tooth in your mouth for having the need for care, whatever the need would be. So when we're looking at all the adults now, we're looking at people with teeth and we're looking at problems in times of need. The only thing that predicts one having an increase in the occurrence of root caries - in other words, caries or decay that happens, you know, (Indistinct) the teeth would be that you have a tooth in your mouth. And now we have many people who have teeth in their mouth, so that's going to increase.

We also have people who are living longer. People are living, you know, have various medications. Many of those medications influence the rate of flow of saliva in the mouth. If they don't have saliva in the mouth flowing to clean the mouth, they have a higher tendency to have decayed teeth because the saliva has its own role to play in preventing disease.

So this is the current picture that we have in terms of, first of all, the number of people who have teeth are increasing, and because they have teeth they have a need for care. So what are we going to be able to do? The problem again, I would look at it from, you know - actually, it should be six perspectives when you look at this graph, although (Indistinct) you can only see three. Now there will be people, seniors who are on their own. There are seniors who are living in institutions. And so for each of these three groups you have seniors on their own and seniors living in institutions.

Right now you have people who are insured until retirement. There are not very many but there are a few of them. So those group would have no serious problems. The majority of people have been insured for some time in their working careers and when they retire they lose that insurance. Now, the problem you have now is that if someone loses insurance at 65 - let's even say the government was ready to do something that is not consistent with their previous care - it means that they would have to look for care some place else. Let's say we set up a clinic and we want to provide care for people. We would have to change them from what ordinarily (Indistinct) and they would have to be looking at receiving care from someone else. That's not an ideal situation because you don't have the history, you don't have a history of what the person has been going through before, and the general trust that people have developed with their dentist over time.

Then you have a group of people who have been uninsured all their lives. That's not because (Indistinct), they were not in employments that gave the opportunity, gave them that privilege.

Now, this is not something that is new to us on PEI. It's international, I mean it's everywhere. So people have been looking at this very closely and trying to find out the best ways to handle or manage care for older people as they retire. There are insurance programs that cover people until retirement. General Motors in Ontario, the Oshawa plant, covers them, their workers, until retirement. That plan is there.

In the US the Congress mandated that people who have worn their uniform, in other words military personnel, whatever military service that people have been in, they and their families can be covered by dental insurance and they have the TRICARE retiree dental plan which covers

those people.

The State of Massachusetts also has a plan which extends dental coverage into retirement for their own workers.

The last one that people have talked about and the literature talks about - I'm not sure that it's to the extent that is very common - is an annuity type dental plan, which would mean that you just encourage people to save some money where they're working. That money will be available for them when they retire to draw from when they have a need for care. I'm just saying that maybe if it's made as a trust shelter savings dental plan, that makes it a little more interesting for people to put that money aside for their own care.

Mind you, it's not going to be possible for government to provide the care for all the seniors that we would have in the next few years. Very soon the average age will be about 58 years old. So the average person will be over 50. The median age would be over 50 in Canada. I don't think that's going to be financially possible to do.

So we have to work with the existing infrastructures, particularly the market, to encourage people to use what they have and then the government will now have to catch up for people who fall in between the cracks, as opposed to trying to mop up everybody.

There are other options that other governments are using, looking at providing care for seniors. There are publicly funded dental programs. The first one that is comprehensive, and the only one in North America for that matter, is the Alberta Extended Dental Health Benefit Plan. That program was started in the 1970s and it was essentially a gold card. If you were a senior, go into the dental clinic, receive care, and send the province the bill and they all paid. I mean, the government paid. But after 20 years of the program the only way the

government could sustain the program was actually to reduce the amount of money that it paid to dentists. So if you look at the average cost, which was around \$120, deflated, you know, at consumer price index, Alberta government paid dentists 90% of their level of fees, and by 20 years down the road they were paying them 35%. You can see that it - so that's not really a workable thing.

Now that program has been modified. Right now it's only extended to low-income seniors. They have a cap of \$5,000 for five years. We don't want to start something that you can't really see through in a long time.

In the US the Medicaid covers low-income seniors in some states, not every state. The Europeans are a little better in terms of providing dental care. Likely they've done this through the national health care system. In a place like Germany, UK, and Sweden, they have the covered dental plan for seniors either wholly or in part. Most of these countries cover programs, they provide care for people who live in institutions.

On the Island, Dr. Maze, my predecessor, has started working on this prior to my getting here. He set up the seniors' oral health strategy, which essentially focused on trying to find out what the problem is and trying to, at the same time, educate people on how to maintain their health and increase access.

One of the things that was done at that time was to conduct a survey to assess the needs. As you will see, if you ask Islanders in the past month, one month, how often have you had pain or discomfort in your teeth or gums, about 30% of them will say that they had dental pain or problem within the last one month, sometimes more often. That's one in three, more or less.

Turn the question around: When was the last time you visited a dentist? Thirty-eight per

cent have not visited a dentist in the last five years. (Indistinct) hadn't gone to the dentist within the year. So there's a need, but people can't get here. The question is: Why didn't they go? For the most part it's because they don't have money.

So what we are doing right now is working through the Seniors' Oral Health Council to get an advocacy to bring this to light and also to create brochures, health, and nutrition materials for seniors. We have a Low-Income Adult Seniors' Program. We have a pilot program for seniors and low-income adults and it's means tested. It's not publicized. It's just people come in. Right now the waiting list extends beyond six months. So we need to expand this. But before we do, we also need to be sure that we've done all the groundwork to make sure that we can absorb the need, when it does arise.

Fortunately, at this point in time, dental health has covered all the long-term care facilities in the province. All level four institutions are covered. In the last few weeks, since I've resumed here, I've been working in conjunction with my predecessor to look at options for providing care for low-income adults, including seniors. We are working on that within the ministry and as time goes on we'll be able to bring up more concrete plans as to what will be done.

Thank you.

**Faye Martin:** Thank you, Albert.

I'm still stuck on the electric drill with no local anaesthetic myself. Now that we're really enthusiastically looking forward to our senior years, we'll talk about housing, if Bill would give some information.

**Bill Fleming:** Thank you very much.

The PEI Housing Corporation delivers primarily two programs: subsidized housing

for seniors and subsidized housing for families. While our focus today is on seniors, I wanted to include some information on family housing as well, because there's a strong correlation with regards to similar problems that we're experiencing with the future for family housing, basically the same problems for seniors' housing. So I have included them both in.

PEI Housing owns approximately 350 properties across the province. The value of the properties is about a billion dollars. Through our seniors' housing, they are primarily multi-unit. In fact, all are multi-unit buildings that range from four-unit buildings in some of our smaller areas, such as St. Louis or Souris, to a 96-unit building, which would be our largest building, in Charlottetown at 501 Queen or Spring Park, it's often referred to. So it provides a range. We're in 37 communities across the province.

Our family housing is a little different in that most of those are would-be duplexes type of structure. We do have some larger complexes such as Dresden Court in Charlottetown, that type. That's kind of a snapshot of what our buildings look like.

In terms of programs, we're cost-shared with Canada Mortgage and Housing Corporation. Just a little quick history, I guess. Social housing construction basically started in the 1960s with a cost-shared arrangement that we had with the federal government through Canada Mortgage and Housing. Over the next 25 to 30 years subsequent agreements had been made that allowed a substantial amount of construction to occur in the 1970s and 1980s. Those cost-sharing agreements that we have ranged from the federal government paying 50% of the operational costs to 75%, and in a small number of - we should have more - but in a small number, they paid 100%, the full shot.

But the last agreement that we had was signed in 1989, and in 1994 the federal government made a decision that they would no longer enter into long-term subsidy agreements for social housing. So our last building that we constructed was in 1992 and we've had no construction since then.

In terms of cost, it costs approximately \$9 million per year to operate our buildings. We charge rent. The rent is 25% of an individual's or family's income and, after the rent and approximately \$2 million of subsidy from the federal government, the cost to the province of operating our social housing is about \$3 million a year.

In 2005-2006 we started a capital program where we were able to make some investments in our buildings. After years of not having funds available to properly maintain our buildings, we were able to start investing in our buildings and doing some modernization and improvements. So as a result of that, we were able to convince the federal government to cost-match on a number of our buildings.

But what they didn't do, they wouldn't agree to cost-match on buildings that were the first buildings constructed. It was an agreement that they believed fell outside. Modernization and improvements were not considered to be a part of that agreement, and so we were then left with a dilemma of the buildings that probably most needed the modernization and improvements. We couldn't leverage federal funding to match and so we had to direct as much as we could of our investments into those buildings where we were able to get funding from the federal government. As a result of that, some of our older buildings continued to fall further behind.

Just in terms of the numbers that we serve, we have about 110 seniors' buildings, approximately 1,150 tenants. We're the largest landlord in Prince Edward Island. As

I say, I believe there's 129 buildings. About 110 of those are operational. We do have some buildings that are vacant or near vacant as well. We have waiting lists in certain areas. In Charlottetown and our urban areas we do have waiting lists. I guess it's worthwhile talking a little bit about the process of how we deal with our waiting lists.

Certainly I think one of the concerns that we often hear is from individuals who have been on our waiting list for an extended period of time. In essence, when a senior applies to come into subsidized housing there is an assessment completed by our housing officer, and they will look at a variety of different issues such as the state of their existing housing, the expense of their existing housing in relation to their income, their health, and the physical state of their housing that they're presently in. In essence they will be scored in terms of need for subsidized housing.

So while someone may be applying for social housing, it could very well turn out that because they are not at a high priority, in relation to others that have been assessed, that they would have to wait. In some cases the wait can be long. In some cases it's questionable whether the individual will ever be in a position to enter social housing because in relation to the applications that we're continuing to receive, their priority of need is low or relatively lower. So certainly it's a cause of frustration for a number of our seniors who, understandably I believe, feel that they applied two, three, four years ago and should be allowed entry into our seniors' housing.

Just as - the slide for the Wellington seniors' complex would be a typical building that I'm sure most of you are familiar and aware of in the various communities across the province. In terms of where our buildings are located, we have roughly half of our buildings in the Queens area, about a third in

East Prince, and the rest are proportioned over the rest of the province.

In terms of seniors' waiting, the wait lists, very clearly the vast majority of seniors waiting for placement are in the Queens and East Prince areas. Certainly that's a reflection of something we're seeing, I think, across the board and not just in our program but in many others, the migration of seniors from rural areas to the urban centres in order, for the most part - certainly from what I'm hearing - in order to access services. So it's consistent, certainly in terms of what we're seeing, and our wait lists.

In terms of the state of our buildings, again, we're challenged with the fact that we have old buildings that are both in need of significant regular modernization and repairs, such as reasonably modern windows and doors, roofs that don't leak, siding that needs to be replaced, the standard stuff. But, as well, we're challenged with the fact that the needs of our seniors have changed considerably from the 1960s and 1970s. The request from our seniors are they want larger apartments than what we have available, because the typical apartment would have been probably for a widow who may have been leaving the home and not bringing a lot of furniture with her. Typically again, in the 1960s and 1970s, as opposed to today where we have seniors who are looking at wanting an office for an internet, wanting to have a second bedroom available for their children visiting, those types of things that we just can't accommodate with the buildings that we have today.

We also have bedsitting units which were the bachelor units that would have been extremely small, about the size of a motel room, where the living and bedroom area were combined. We can't give those away, if we had to. We've got vacancies. So we are looking at: Is there anything we can do with trying to convert those units? The cost

is atrocious and in some cases it's next to impossible because some of our buildings have concrete block construction. So to actually try and convert two units into one is prohibitive. So that's a challenge that we're facing. We've estimated that just in bringing our buildings up to date in terms of, again, having reasonably energy efficient windows and doors and the like, we're looking at expenditures of over \$6 million over the next five years.

Just an example, though, of what we have been able to do, this would have been a building in Cardigan two years ago. At that time it consisted of three very small one-bedroom units and a bachelor unit. There were long-term vacancies with that building and we couldn't rent it at all. Because of the fact that it was empty and we were free to do what we wanted inside the building, we converted three one-bedroom units into two two-bedroom units and upgraded the bachelor apartment that was there. The cost of doing that was \$140,000. So when you've got a capital budget of \$660,000, as an example, or a 1.3 million, even with combined, you can't do very many of those within that budget and still try and do the modernizations that you need to do in the rest of the buildings across the province. But that gives a sense, a little bit, of what our buildings look like.

We are certainly doing well in making our buildings more attractive. I think it's fair to state that in certain areas of our province we probably were embarrassed to be the landlord for some of our buildings. We made a lot of progress in bringing them up at least to reasonable standards where people can feel a little prouder about where they're living. There's still a lot of work yet to do.

Again, just touching a bit on family housing to kind of identify that, again, all our agreements that we have with Canada Mortgage and Housing are for senior and

family as well. So for family housing we have 476 units in nine communities that are served kind of at arm's-length through housing authority boards across the province. We have significant waiting lists in Charlottetown and Summerside for family housing and, again, with no new construction for the last 15 years, that's grown year by year.

Through some other programs that we have kind of partnered with the federal government on short-term programs, through an affordable housing program we're able to provide grants to developers to try to reduce their cost of building a building and then being able to charge affordable rent as a result of those. That program's been underway for about three or four years and has been successful in creating about 130 or 140 new units across the province. But again, it's short-term funding and you can't make long-term plans with those.

Our needs for family housing, similarly, are - I think the fact that family housing generally are newer buildings than our seniors' buildings were, in large part that they fared a little better in terms of their condition, but we still have a lot of work to do there. We were successful recently in accessing some funding for the Charlottetown Area Housing Authority to do a lot of upgrading in the units within Charlottetown.

The family dynamics have changed as well, too. In the 1960s and 1970s there was a lot of need for four-bedroom units because of the large family sizes. Those are gone and we actually have, in some cases, difficulty renting them because the family sizes are smaller and the cost of heating the larger houses makes individuals prefer not to have those.

In terms of utilization, again, our seniors are moving, they're coming into our two urban centres. As a result of that, we've got some

underutilized and, in some cases, completely vacant buildings in our rural areas across the province that we need to either find alternate uses for or make decisions to dispose of them. Again, we've got the bedsitter units that we're not able to rent. As we're able to, we're going to try and see if we can convert those to make them rentable.

We're looking at alternate ways that we can provide service rather than building buildings. So we are looking at areas such as a rent supplement where we would provide funding to the senior and the senior would be able to access rents in the regular market. We would assist in trying to bring their rent costs down to the 25% of income levels as one alternative to look at. Again, introducing developer grants to try to promote development of new social housing.

In terms of our future requirements, similar to our other presenters, we recognize we're going to have a significantly larger seniors' population in years to come. The issue with those, though, is that they're going to be coming in with income as opposed to, say, 30 or 40 years ago when, in many cases, they had no income or their only income would have been the old age security and the supplement. So it remains to be seen whether our seniors that are going to be coming in the years to come are going to be okay in terms of accessing rent in the private market. Again, with our changing demographics for our families, we need to look at trying to move towards smaller housing for them.

We also have significant housing issues with regards to persons with disabilities. We have very little accessible housing across the province for: individuals with special needs, particularly individuals intellectually disabled that are living with an adult, an aging adult, parent or caregiver; housing for if there's a family violence, transitional housing; and non-reserve Aboriginal persons.

So that's a snapshot of a fairly broad spectrum of housing challenges that we have ahead of us in years to come. Through a little bit of a technical glitch, the one thing I didn't put on my presentation was our recent program for seniors, our Seniors' Emergency Repair Program, which was introduced last November. That program provides a grant of 50% of the cost of renovations that are considered serious need, as opposed to cosmetic, up to \$1,500 per grant for a senior homeowner with income less than \$30,000 per year.

**Faye Martin:** Thank you, Bill.

Lots of food for thought. Questions?

**Mr. Currie:** I guess, Bill, the seniors' apartments that you have across PEI, what's the liability now for mortgages, total?

**Bill Fleming:** I may have to get that back to you, Mike.

**Mr. Currie:** In the millions?

**Bill Fleming:** I don't have that in front of me. It's more of a finance side than the operational side.

**Mr. Currie:** I appreciate what was done in Cardigan, but for the rest of the members who are here, as the demographics change for a lot of seniors - and their needs today are far greater I think in some ways - like, that complex was empty for a number of years. There was an \$88,000 mortgage on that facility. My wish at the time was to pay out the mortgage and sell it to the private sector who then would probably build to accommodate the needs and make use of the rest of the eight or nine acres. I guess there wasn't a willingness to do that at the time, which was our government, and they decided to do renovations.

I still feel strongly that they should have changed their mind and converted it. I know

there are other similar cases across PEI where that should've been done, or should be done. I just hope that you now look at that seriously because I think the private sector will, in some cases, meet the needs of those seniors that can probably afford to pay, in some cases, and leave some of the building to accommodate some of those that can't pay, and will have a much greater use of the facility and the land that's there and keep the people in our communities instead of, I guess, allowing them to go all to the urban centres. That was my cry at the time.

My second question is on the harmonization of drugs. Bill, is there a way that we can get the doctors to now lobby for whatever new drug comes out and there's a new press release on a new drug? I know you guys are in a difficult bind, and we all see TV and we saw the case of the individual the other night on TV and we all feel for him, but we have to have a way of, if you're adding on, you're taking off. Somewhere along the line there has to be some way of dealing with this that some people, yes, cannot afford and will sacrifice all of their home and their life savings to accommodate a loved one. But we can't, I guess - because every drug company in the world is trying to sell a product. They have all these new drugs. You guys have to decide which one is going to be the one, and the doctors in this province are going to have to somehow agree that that's the best drug for this disease.

**Patrick Crawford:** There's a couple of ways that we deal with new drugs coming onto the market.

The main one is that, as I mentioned in my presentation, we have what we call these common drug review processes. We're either on a national or regional basis. We gather experts together and these are a brain trust that really you cannot find anywhere else in Canada. Just the expertise around the table there makes my pharmacy abilities look pretty pitiful. They're super. They go

through the medications and they, probably right now, are saying no to about 40% of the medications that are coming forward to them. They say no for two reasons. They're either not more effective than or not clinically effective as the medications we have, or they don't have any advantages over medications we already have and they're significantly more expensive. As soon as one of these committees says: No, we don't recommend that you provide coverage for this medication, that's end of the story for us. We, then, don't even look at them again.

The next way that we do is for the medications that are already on the formulary. We have an organization that is known as COMPUS, and it's a big name for the whole thing, and it's the Canadian Optimal Medication Prescribing and Utilization Service. Now you know why we say COMPUS. It's a whole lot easier than that mouthful. What it is, again, it is a group of experts, and the group of experts changes for every category of medications that we look at. They go through all of the available evidence on the use of these medications, plus - because they're experts in it - they also use their own expertise and they then make recommendations back to the participating jurisdictions to say: This is the best way to prescribe this medication. This is the best way for patients to use this medication.

They've done one group of medications now, one that is called the proton pump inhibitors, which are medications like Losec, Nexium, you may have heard about. The little purple pill that you see advertised on television all the time for treatment of heartburn. They've done a big review on that and, as a result of that review, we have actually just recently changed how we cover some of these medications. I can guarantee we're not going to get any push back from the physicians.

The other way that we're looking at trying to get more buy-in from the physicians here on the Island is by reactivating our own pharmacy advisory committee, which was inactivated because we brought in these national drug review committees. But what we're going to really target on with this committee is once a recommendation comes back and says: Yes, cover this medication, this committee's going to take a look at that recommendation and say: Do we really need to cover it for the Island? Exactly what you said: Are there medications that this will replace that we can take off of our formularies? Then once they do that, the next thing they're going to do is they're then going to say to us: We want to put this on a priority list of medications that might be waiting for funding. This is a high priority. We should fund it as soon as possible. Or: No, no, this is a nice one, next time you get the money for it you can look at doing it, but we don't really think it's urgent.

So we are trying to hit kind of the three areas that we're dealing with, with this. It's going to take a little bit of time to get everything all going, but I think within the next few months we'll be pretty close to having everything up and running.

**Mr. Currie:** I guess the point, and I think you're hitting on it, I'm trying to make, especially for the new members here, is that some drug companies will solicit a new drug through their doctors and you guys have already picked a drug to put on the formulary for Islanders. What they're trying to do is get a new drug on the formulary. So what they do is take a patient and say: You go after your government and lobby because this is the one you should have that'll cure your disease. If you guys can get the doctors to agree on what you put on the formulary, then these people here will have no problem.

**Patrick Crawford:** Yes.

**Mr. Currie:** I've experienced that and I know that's how it's done. So, if there's some way to agree to that, you don't have cases as we saw on t.v. last night.

**Patrick Crawford:** Yes. And part of this is using this, with COMPUS -

**Mr. Currie:** The new wonder drug.

**Patrick Crawford:** - it's educating, going back and educating the physicians.

**Mr. Currie:** Thank you.

**Patrick Crawford:** And also with our own pharmacy advisory committee, making sure that we have key physicians that are members of that committee. It's going to be a challenge to pick just the right physician that we want for that, or the right physicians we want for that committee, but I think we're pretty confident we can do that. Because you're right, we do have to get the buy-in from the physicians.

**Mr. Currie:** Because they'll always say: This is another drug that I know that will work but it's not on the formulary so - and it's \$5000 but, God, if you go and chase your politician long enough you'll get that.

Anyway, I hope it's fixed for you guys, for everybody. It pulls on your heartstrings sometimes when these happen. I certainly don't want to see anybody go through that, not having the drugs, nor go through what you guys probably go through.

Thank you.

**Chair:** Thank you, Mike. Sonny.

**Mr. Gallant:** My first question's to Patrick and then my next one's to Bill.

Patrick, you had mentioned we're a small population. Is there much effort into so far buying in with other provinces to buy some

of our medications?

**Patrick Crawford:** We're not doing it right now on a drug program level but we do do it at a hospital level. In fact, the PEI pharmacies are all part of the PEI-New Brunswick hospital buying group. Our own provincial pharmacy, we are part of the Nova Scotia buying group. Now, why we're in the different groups is somewhat historical, but there's also some talk about trying to combine these two groups together.

At a drug program level, going into buying groups is not necessarily the easiest thing to do because it's the pharmacies that buy the medications. All that we do is we pay for them. We may be able to get a deal with a pharmaceutical company behind the scenes for our medication that we're going to cover. But the only way that we really get that deal on it is by having the - or going through a rebate system, where we identify to the pharmaceutical company: We've had - a thousand people have used this medication at \$1 a tablet, and, well, you offered it to us at 50 cents a tablet, so therefore you owe us x amount of money.

We have done that in a couple of things and, in fact, on an Atlantic provinces' basis, I was just on a conference call this morning where we are looking at doing it with two other groups of medications. The problem with the rebate process is it's quite labour intensive, and you have to make sure that when you're doing it you're doing it for enough money to make it worth it. Something that's maybe \$5,000, \$6000, is it worth it? But something that may be 50, 60 or even \$500,000 is well worth our effort to look at.

**Mr. Gallant:** Thank you. My next question - and first of all before I even ask you my question, Bill, I'd like to thank you all for coming in. I know you people have busy schedules as well.

The seniors' units, and one just happens to be in my district, and I'm glad to see Mr. Currie's got fixed up as well in his district. Mine is very nice. It's very new, as well.

You had said they're declining in the rural areas. In your stats, is that because they're not renovated? Like, I know in my short term as an MLA I've had three people not want units because they're not big enough. Not because of where they were. It's because they're outdated. A lot of these units are empty. So if we have a demand - and I'll use my area, Wellington - why don't we focus and repair them and get them rented? We're heating them anyway. Right? I know it costs dollars, but if we're showing the demand is there and the people aren't moving into them because they're not renovated, well, let's take the step and do it.

**Bill Fleming:** I guess the question is renovated or modernized, I guess. Because you can bring them up in terms of making them attractive, but in terms of their functionality, if they're not modern, you still may have spent a lot of money and still not be able to rent them. We've experienced that a little bit in the Souris area specifically as we have a fairly large vacancy problem in Souris that has not gone away despite putting some pretty significant investments into buildings there. We have Rollo Bay, that's a 14-unit building that has two tenants, and we put some good money into trying, again, not modernize, to actually refresh it, I guess, in essence.

So it's a little bit of a chicken and the egg thing, I guess, in term of: Do you make the investment in the hope that the tenants will come? Because, I guess, for areas where we have strong demands, we feel comfortable in putting the investments in those areas initially because we know that the tenants are already living there. We're certainly trying to concentrate on those ones as much as we can.

It's a tough call and particularly, again, with the budget that is relatively compressed compared to what the actual needs are.

**Anna Duffy:** If I may also respond to that, there's another issues that's influencing the vacancies in seniors and that's the lack of provincial public transportation.

In Fort Augustus where I live we have a seniors' home and there's a vacancy in it right now. We only have four units. But it has been modernized and it's in excellent condition. But because the services aren't available there that seniors are seeking - your medical and your groceries and all of the services that seniors require - and the lack of public transportation is, I think, another issue that's causing vacancies in the rural areas. Because those people are moving to the cities because they don't have the services available to them and they don't have the public transportation to bring them to the services.

So that's another issue that's certainly influencing housing in rural areas in Prince Edward Island.

**Bill Fleming:** Let me throw one other example out - I'm sorry - just in Vernon River. We have a six-unit building in Vernon River that was high demand, constantly rented, and the store closed -

**Anna Duffy:** Yes.

**Bill Fleming:** - next door. As soon as the store closed we've had long-term vacancies in that building ever since. I don't think there's any question, we could put as much money as we wanted into that building and it wouldn't matter because the services they're looking for are not around it.

**Chair:** Okay, Sonny.

Robert.

**Mr. Henderson:** Thanks. I guess my question is a little more on this Atlantic formulary, as far as medications are on there.

How close does PEI's, the medications that it covers, in comparison to the other Maritime provinces? If so, if there is quite a discrepancy, why isn't it closer, and if it was closer, would that not alleviate a lot of our problems? Like as an MLA, like, people coming and saying: If I lived in Nova Scotia, or like the fellow the other day: I could live in another province and get that covered.

**Patrick Crawford:** I just went through this with the minister yesterday.

**Faye Martin:** (Indistinct).

**Mr. Henderson:** It's (Indistinct) to hear it then.

**Patrick Crawford:** On one hand, and the way that most formularies are compared, is that people go through them and they count what are called drug identification numbers. So a drug identification number is a unique number assigned by Health Canada. It is for a specific brand of medication, specific dosage form, specific strength. So if there's, like, five strengths of a particular tablet, there'll be five drug identification numbers. If you go on sheer drug identification numbers, we're sitting at about 3,000 right now. The next closest province in Canada to us, which is New Brunswick, is sitting at about 3,500. Then you get Nova Scotia that is sitting at - I haven't done my real close comparison - they're sitting somewhere between 4,000 and 4,500. You then go up to in Ontario which is somewhere between 5,000 and 6,000.

**Mr. Henderson:** Yes.

**Patrick Crawford:** Now, that's on those numbers. But breaking it down, when you

actually look at broad therapeutic categories, and there's a group of medications out there that are called the beta blockers, used for treating high blood pressure, and there are probably 10 or 12 different medications within this group of medications. Well, do you need to cover all 10 or 12 of those? In fact, we don't. I think we only cover six or seven of them. So if you look at the broad therapeutic categories, we actually have coverage that is comparable to most other provinces for the common therapeutic categories: heart medications, asthma medications, that type of thing.

Where we're falling down now on our coverage is in the newer groups of medications, particularly the high cost cancer medications, high cost medications for breathing disorders, high cost medications for rheumatoid arthritis. We're breaking down on those. Why are we behind? Really, it has been the fact that we don't have the money that we have needed to provide coverage for these new medications. My feeling is that we have probably been underfunded consistently since I've been with the drug programs by between \$500,000 and a million dollars a year, depending on the year.

What we're given is we are given status quo or been given status quo. So that's what we spent this year and, if nothing else changes, is what we're going to spend. But we really haven't been given - except for specific groups of medications, MS medications, Alzheimer's medications - we have not been given significant dollars to provide coverage for new medications.

**Mr. Henderson:** But it would certainly seem to me, if we could ever - I know money is obviously the issue - but if we ever get all the three Maritime provinces together, that they could all sort of agree to these are the coverages, then it'd certainly make it a little less complicated, I think, as far as -

**Patrick Crawford:** Well, yeah, and the other thing that's happened is you'll see right now, even in the have-not provinces - for Atlantic provinces, until recently, none of us had universal drug coverage. Well, now that we have petrodollars in two of those provinces, Newfoundland and Nova Scotia, you may notice they've now introduced low-income programs.

Right now it's a matter of a combination of dollars, reorganizing our drug programs so that we can, in fact, spend what dollars we have more efficiently, and also, perhaps, taking a look at it and looking at it that we really need to reserve full coverage for the drug programs for those who need coverage most. For those who are able to pay more of their share of the medications, then perhaps we need to start charging them more. So really introducing some income testing into the drug programs. Now, how we do this, that hasn't been determined because right now there are nine other provinces that all have some form of income testing and every model is different.

**Mr. Henderson:** Okay. Thank you.

**Chair:** Bush.

**Mr. Dumville:** Patrick, how problematic is the physician-pharmaceutical lobby? I mean, you go into your doctor and you see so many free samples around. Here, try this or try that. Is it problematic to you people trying to get a hold on it? Like: My brand is better than your brand and you need this, you gotta have this. So, are they turning the doctors and the general public? Like Minister Currie said here -

**Chair:** Mr. Currie.

**Mr. Dumville:** Minister Currie. That's his name, isn't it? They're using the public to advance their cause.

The other question I have: Is there any

provincial waiting time for somebody that leaves their province and goes to Ontario or Nova Scotia to get drug coverage for a particular drug?

**Patrick Crawford:** Okay. Answer to the first question, the latest statistic that I have seen is that over 40% of all the medical information, all the medication information that physicians get, they get from drug company representatives. In fact, most of that information, it really hasn't - you know, I'm not going to say that it's wrong because it's not wrong, but it doesn't tell the whole story.

A great example is the little purple pill in the US, Nexium. It's essentially, for all intents and purposes, it's exactly the same medication as Losec, which actually has generics available right now. So it has taken the price, compared to Nexium, is about \$2 a tablet, and you take generic Losec or omeprazole and it's now sitting at about 90 cents a tablet. They work exactly the same way but there is nobody out there that is publicizing to the physicians that: Hey, these medications are the same. This one's a whole lot less expensive. Because the drug company that's got Nexium wants to sell lots of it.

So I get probably - or not myself, but our drug programs - we probably get, I'd say, five or six requests a week for coverage of Nexium. We turn them all down and essentially the letter that goes back to the physician essentially states: a proton pump inhibitor is a proton pump inhibitor is a proton pump inhibitor, and you might as well use the least expensive one. That's a real problem.

I forget the second question. Oh, how long.

**Mr. Dumville:** Just curious. Are other provinces, you know, they're seeing in the media and they see that some of our people are maybe leaving here.

**Patrick Crawford:** Coverage in most jurisdictions is tied to Medicare coverage, and if you change provinces from PEI to Nova Scotia today, you have to wait for three months to be eligible for Nova Scotia Medicare, and then you would be eligible for their drug programs.

Now, interestingly enough, that is there, but there's also another end of it that most people don't realize, and that is the drug programs don't follow completely your Medicare coverage. It's eligibility of Medicare coverage, but the day that you leave PEI your drug coverage is terminated. So there's actually a three-month gap between provinces that you have no drug coverage. Is that right? Well, it works out well for the drug programs, but not necessarily well for the patients.

**Mr. Dumville:** Thank you.

**Chair:** Okay. Mike.

**Mr. Currie:** Bill, a couple of questions. We had some people in this morning with issues about disabilities and I noticed in your presentation that there was some there for disabilities. How many units are you possibly doing this year to accommodate those people with disabilities?

**Bill Fleming:** Through that affordable housing program we have an 11-unit building being constructed in Summerside presently, and we're anticipating that there will be 10 to 12 in Charlottetown this year. That one hasn't been completely put together. As we're able to, we're trying to, if not make their units as fully accessible, at least more accessible, in some of the renovations that we're doing to our seniors' buildings.

**Mr. Currie:** Widening of the doors and (Indistinct) -

**Bill Fleming:** Yeah, that type of thing. Still

would not qualify as being fully accessible by any means, but will allow some access.

**Mr. Currie:** That seemed to be a cry from them today, that there was a very large demand and lack of housing that would accommodate those people with disabilities. So maybe if you get a chance you'd pop me an e-mail, or let the committee know, I'm sorry, in regards to how many are being done so we could maybe forward it on to (Indistinct).

**Bill Fleming:** Sure.

**Mr. Currie:** The other one I think Faye addressed. Part of the problem we have with some of the seniors' housing is: When do you become a senior? Some of them, I guess, are leaving early with pensions or whatever, and they do have cars. I noticed in the western part of the province, in Sonny's area, and I think in Pat's districts, that the private sector I think has built senior housing that has a garage and a nice unit on it. People are selling their homes, but they're staying in the community.

I don't know if they're subsidized. If they were, I think that model that they have in Miscouche - Sonny, you know where I mean - and the one in Alberton, they're really nice units. I think if that could be done somehow, with some of these ones that are not being utilized and can accommodate some of them - I know some people don't have cars, but today a lot of the seniors do have cars and they want somewhere that they could - they're still quite mobile and want to stay in the community.

So if that was possible, I'd hope that you'd consider that with some of these ones. Maybe tender that out and ask that that be the model that's followed, to maintain people in the communities (Indistinct) -

**Bill Fleming:** Interestingly - sorry, just to respond - interestingly, in areas such as

Alberton, because seniors are actually coming in with more income now, at 25% of their income, in a number of cases such as Alberton, then the rents that are being charged in the private market, in many cases can be the same as or even possibly lower than what we would be charging as 25% of their income.

So the market actually is kicking in and taking over there, I think, in terms of becoming a competitor to us, which is not a bad thing, for sure. But that is the case, and we know that in Alberton that the buildings that up and the rents that are being charged are very comparable. In some cases are better rents than what we would charge under our rates.

I agree that, yeah, parking is a reflection of the changing need as well, too, from our seniors from before. We actually had some applications from some that are bringing two cars with them and would like to have two spaces available. So it's something we have to build into our future planning, without question.

**Mr. Currie:** Yes. There's no more single bachelor -

**Bill Fleming:** No, there's not.

**Mr. Currie:** - that needs the hotel room and smokes.

**Bill Fleming:** That's for sure.

**Mr. Currie:** There's still a few who smoke.

**Mr. Dumville:** I have an uncle -

**Mr. Currie:** They're only building the new units in Summerside.

**Mr. Dumville:** I have an uncle in that unit you're talking about in Alberton and it's a gorgeous unit.

**Mr. Currie:** Yes, they are.

**Mr. Dumville:** One-car garage and two-bedroom. It's just absolutely beautiful. I think, especially in the west and the rural areas, that the seniors still do need their cars, and even the fact of having those garages in there, they don't have to get out in the winter and be scraping their windshields and falling and breaking a hip or something.

**Bill Fleming:** No question.

**Mr. Currie:** They screen some of them off and they use them for - they sit in them.

**Chair:** In the summertime.

**Mr. Currie:** You've got everything up west. Everything.

**Chair:** Okay, Cynthia.

**Ms. Dunsford:** I just wanted to elaborate on a question that Mike had mentioned when we heard earlier today from Steven Pate and Michael LeClair and others about disability on PEI, and the different programs and supports that is there and what we need.

Mike's point about just how we deal with housing with regards to people with disabilities. Because I think if we're focusing in on seniors' housing here, we know that the majority of people on PEI with disabilities are seniors and we're all getting there very soon.

So I think to think forward when it comes to housing for seniors, I think we have to assume that housing for seniors should be, if not right across the board - like Steven Pate had mentioned, 100% would be ideal - but it's encouraging to hear that you're moving in that direction, and I would encourage you to go even further. Because it's a given. It's not maybe we're going to need that.

It's an economic thing too. If we think

forward and we know that in 10 or 20 years that what we did a couple of decades ago was smart, then we are saving money in the end. It is a given that seniors' housing means housing for people with disabilities. It's pretty well a given.

**Bill Fleming:** Thanks. We've had presentations actually from developers that are fairly - new developers, I guess, coming into the market - that are suggesting that in a lot of ways it costs nothing to build a building -

**Ms. Dunsford:** That's right. It's not that much more expensive.

**Bill Fleming:** - with accessibility. It's simply a matter of where you locate the countertops and -

**Ms. Dunsford:** Doors, hallways.

**Bill Fleming:** - making doorways wider and whatever. It actually costs nothing. So, no question, I think it's the way of the future.

**Chair:** Any other questions?

**Mr. Gallant:** I just had one out of curiosity, Patrick. You'd mentioned about if a physician does a prescription for - a pump is a pump is a pump, you'd said. So does this happen very often? They go outside the realm and prescribe stuff that's not covered under our plans?

**Patrick Crawford:** Yes. We get prescriptions like that just about every day. Either where the evidence - I guess there's two kinds. One is the evidence shows that what they're looking for will do just as well as something else, or what they're trying to do with this medication is absolutely not supported by any medical literature at all. It would be trying to use aspirin to cure cancer typed of some things.

**Mr. Gallant:** In respect to what Mr. Currie

had said, like sometimes physicians are used to promote a drug. Wouldn't that go through you people, as their employer? Wouldn't you people benefit from promoting that drug versus the physician? I mean, they're an employee of our system.

**Patrick Crawford:** Actually, in some jurisdictions there is a program that's called academic detailing.

**Mr. Gallant:** (Indistinct)?

**Patrick Crawford:** Academic detailing. What it is is that they do - what the pharmaceutical reps do to the physicians is called detailing. They give them the details of the new medications. In academic detailing what happens is that either physicians, nurses, pharmacists, or even in some cases other drug company reps, are actually specifically hired to go out and see physicians to actually give them the other side of the story, specifically to give them the other side of the story. The most successful programs right now are in Nova Scotia and in Saskatchewan.

An example of it is the detailers in Nova Scotia went out and one year they did detailing just at the end of summer about flu vaccinations. That every senior or every high-risk person should have a flu vaccination. That year they watched their flu vaccinations go way up, which was a good thing.

At the same time they've gone out and they have done a talk about a medication that's called Plavex that is commonly used. It's a type of a blood thinner. It's commonly used after people have had heart attacks or they've had a heart attack and then they get a stent put in to keep their blood vessels open. There's a lot of controversy about it. If physicians had their way about it, essentially someone would go on this Plavex and they'd stay on it for the rest of their lives when, in fact, the information, the

medical information actually shows, at most, a year that you should be on this medication. So they went out and they have detailed the use of Plavex and they actually started to see the requests that were coming into them did change.

We have looked at doing that. The problem is that it's labour intensive to do. You have to have a good organization to do it. In the past we've actually gone and we've asked the people in Nova Scotia if we can go in with this. But then we actually had a group that fell into our laps that are ex-drug company reps that have launched a private company and they're going out and they're doing the counter-detailing. We've actually gone in on a pilot project with them on detailing how to use proton pump inhibitors. We haven't seen the results of it because they're still in the process of analysing their results. But I expect that we will see some changes in that.

So we're trying it on a small scale. I'd love to be able to expand it out so we actually have a full-time group of physicians and pharmacists and nurses that just do this full time, going from physician office to physician office. But it may not be completely the best use of our dollars to do it that way. It might be easier for us to maybe purchase or go in with another jurisdiction.

**Chair:** Okay. Bush.

**Mr. Dumville:** Patrick, you do have an ally on your side. Some of the insurance companies are refusing the Cadillacs and they force you into generic drug purchases. Because I've had prescriptions written for our family and I've had my insurance company come back and said: You must use generic.

**Patrick Crawford:** They're good on that side, but they're also bad on another side, particularly with the seniors' program.

If a drug is covered, even if you have the best Blue Cross coverage available on PEI, and you're a senior, and that drug is covered by the provincial drug program, Blue Cross will make you use the provincial drug program first. That costs us. The first year that it started to happen it cost us about \$500,000, the first year that we started to see that changing.

So yeah, the insurance company is good and bad. You take the good and the bad, I guess, with them.

**Mr. Dumville:** Now a patient that's been, say, prescribed so many aspirin a day to keep their blood thin -

**Patrick Crawford:** Yeah.

**Mr. Dumville:** - it's not working.

**Patrick Crawford:** Yeah.

**Mr. Dumville:** Then they're prescribed, say, a couple of tablets of Plavex, two tablets a day.

**Patrick Crawford:** Yeah.

**Mr. Dumville:** What are you suggesting? After a year they go back to their doctor and say: Do I need this two tablets, or do I go down to one tablet, or do I come off it altogether?

**Patrick Crawford:** The way that we deal with it with heart attacks, with Plavex, is that we will give you initial coverage for three months after that. That's where the best evidence that shows that it's effective.

If the patient then starts to - either has another heart attack for some reason or starts to exhibit symptoms of angina and chest pains and all that, then all that the physician has to do is come back to us and say: They've been on aspirin, continuous on

aspirin, they've tried this, they didn't have any symptoms, they've gone off of it and now they're having symptoms. Then we will provide them with long-term coverage of Plavex. That's all based, again, upon what we see in the medical literature and what our advisory committees have told us is the best way to use this.

**Mr. Dumville:** Is that the same way for TIAs?

**Patrick Crawford:** Yeah, TIAs, yes. If you have aspirin, you're on aspirin and you're having TIAs, your physician says you're still having them, we will provide long-term coverage for Plavex.

But we want you to use aspirin first. It is pennies a day as opposed to dollars a day. For the greatest majority of people, and I'd say 75%-plus, aspirin works just as well, if not better, than the Plavex. But it's that 25% that it may not work for that we have to take care of. We're not against providing coverage for these medications. We just want to make sure that we're providing it for the right reasons.

**Mr. Dumville:** Thank you.

**Chair:** I just have a couple of comments.

For the 25% that it doesn't work for, and there's a casualty there, is that all right?

**Patrick Crawford:** No, it's not, but -

**Chair:** But?

**Patrick Crawford:** - the realities are -

**Chair:** My grandmother's better than your grandmother?

**Patrick Crawford:** No, no, no. It's a matter that we work with the best information that we have. With a medication like Plavex, we are probably revisiting how we cover this

through our expert advisory committee every three to six months because the information that's coming out on it - we're seeing new studies coming out every three to six months. A new study comes out, we send it to the expert advisory committee. They take a look at it. They may make a recommendation to keep the criteria the same or they may make a recommendation to change the criteria. We actually have a cardiologist on the committee. So he's, you know, for coverage of this medication, but again, under the right conditions. In fact, we have just changed the criteria for the coverage of Plavex based upon the committee recommendations.

**Chair:** So it's three months for Plavex.

**Patrick Crawford:** Three months for post-MI, three months if you have had a bare-metal stent, one year if you have had what's called a drug-eluting stent, and if you've had a TIA while on aspirin, it is life-long coverage.

**Mr. Dumville:** Life-long.

**Patrick Crawford:** Life-long coverage.

**Mr. Dumville:** Do you think possibly some of the physicians would over-prescribe Plavex, like the dose, just for insurance purposes?

**Patrick Crawford:** Yes, yeah. I think - it is impossible for - although I would love it if they could - it is impossible for physicians to keep up with all of the medical literature. I admit it 100%. It's impossible for them to keep up. I can't keep up with it. That's why we have expert advisory committees to help us out with it. And if something's changing every three months, three to six months, you gotta be right on top of using that.

Do we want to cause casualties with this? No. But with the best information you've got to try and make the best decisions you

can, and that's all you can hope for.

**Mr. Dumville:** But stroke therapy is something, like the Chair has said here, it's something you don't fool around with.

**Patrick Crawford:** No. No. That's what the - physicians will, if someone is having TIAs, the first medication that they're going to put someone on - it's just standard therapy - you go on aspirin and you hope that the aspirin is going to work. But there are some physicians out there that as soon as you come in with a TIA you're going to go on a combination of aspirin and Plavex right at the beginning, and to be honest, we still have people that have TIAs, even on that.

**Chair:** Okay.

The other question. I just have a question for Bill. The 11-unit in Summerside area, it's a means - you have to take a means test, right?

**Bill Fleming:** No, their program operates a little differently in that it's under the affordable housing program where we've provided the grant to the developer. So that grant reduces their cost such that they can charge a lower level rent, but that is the set rate, rent rate for that apartment. So it's not based on income.

Now the individuals that could go in and utilize cannot exceed certain levels of income depending on the family size. But there's not a relationship between their income and what rent they pay.

**Chair:** What about the availability for individuals who have a disability and are not under the cutoff for the income?

**Bill Fleming:** It's not good. It's very poor. I think the Council of the Disabled have indicated that they've got waiting lists in the hundreds of individuals looking for accessible housing that are not - certainly the majority, or many of them, would not be

eligible for social programs. Again, I think it's an emerging market the developers and the industry has not caught on to yet.

**Chair:** Because I know I have one couple whose wife had surgery and left her a paraplegic. I mean, he has a good job but the care of her with a young child, where they live is totally not accessible for wheelchair, and they're going to have to split up their family, basically, in order to live. He'd be better off to quit his job and use the system for all her meds. You know what I'm saying? That's how rigid the system is and how the inflexibility impacts on the normal lives of people, right? Because he can't find a place unless he was poor and then he'd be able to get into a place. Then he wouldn't have to worry about her drugs or probably not her care.

**Bill Fleming:** He'd struggle if he was poor as well, too, because again -

**Chair:** Oh, yes, I realize that, but I guess from where he's sitting he's thinking he's almost penalized for -

**Bill Fleming:** Yes.

**Chair:** There's nothing available for them and their young family has to be split up. We can all sit around and go: Oh well. It's not a nice place to be.

**Bill Fleming:** Yes.

**Mr. Gallant:** (Indistinct) somebody had indicated here this morning, as you were already informed, I mean, when someone tells you that if your spouse got in bed, became disabled, you could go from living a very nice lifestyle to poverty within two years, that's scary.

**Bill Fleming:** No question.

**Mr. Gallant:** Maybe we should be looking at taking steps to address that.

**Bill Fleming:** It's a tough one when the exception is the slippery slope, and it gets to then be the judgment call in some cases.

I mean, to the best that you can, certainly you try and address issues as they present themselves, but always with awareness that the decision that you make today needs to be the same decision for anyone else who presents in the same type of circumstances. Suddenly you open your door to a new program that you really don't have any funding for or have really gotten agreement that this is the road that we need to do down or can afford to go down.

But I do recognize, yes, that certainly there are situations that present real challenges.

**Chair:** Deputy minister.

**Sharon Cameron:** First of all, I'd like to say I've been really good here this afternoon. I'd just like that to be recognized. No, I'm kidding.

I wanted to comment, Mr. Gallant, on your comment around all of these emerging issues. I think what we're uncovering here as we go along is that seniors is one area and disabilities is another area that's emerging. I just want you to know that it certainly is on our radar, on all our agendas, and that there are social policy issues that we have to have some very deep and broad discussion about in terms of where we're headed in the future. Because there are also issues around - we discussed this morning - serious situations with families that have children with disabilities and their older parents, and they need to go into a home, but they also have to find accommodations for their children.

So we have a number of emerging issues that we certainly are well aware of. But it's always good to hear from the public too, from their perspective. When you hear a situation like that, some of the other things

that we want to be very cognizant of is not creating situations where we disconnect people from the labour market and actually penalize them. While they'd struggle wherever, but we just don't want to create a further struggle by having them have to disconnect from their communities and their workplace and all those types of things too.

So I just want to thank you for your comments and tell you that we're well aware. What we're going to do about them we're not sure, but we're certainly talking about them, and we'll look forward to more input, too, in helping us carve that out.

**Chair:** Yes, Faye.

**Faye Martin:** I think we're about to wrap up and I just wanted to thank you very much for your time and attention this afternoon.

I think, certainly from our perspective, we wanted to bring you information but we wanted your feedback and we wanted to have the opportunity to put before you - you're the ultimate decision makers that sit in the Legislature - some of the challenges that I know that you're aware of in your respective roles. But collectively, they get larger and they're coming at us faster and we really appreciate your attention and your comments and questions. You've given us some ideas, too, and we'll come back any time you want more information. You can see that we do have some answers, but we have gaps as well, and I think the dialogue is really wonderful and look forward to more of it.

Thank you very much.

**Chair:** Thank you very much. It was wonderful. And I agree, communication is definitely the first step to success.

**Sharon Cameron:** I'd just like to thank these folks here. This is an awesome team, and I just feel very fortunate to be able to

work with them. They work very diligently and they're committed to what they do, and it's great to have the partnership with Anna as well. She brings that community perspective to the work that we do. Just an awesome job. Thank you.

**Chair:** You're not going anywhere. We're not done. We've still got lots of agenda. Did you think I was joking?

**Mr. Currie:** (Indistinct).

**Chair:** We're going to try to go as quickly as we can, just a few items to touch on. I just want to thank them.

Just two minutes, guys.

*[There was a short recess]*

**Chair:** Okay, guys. Okay.

We just have a couple of things to consider. At the bottom, No. 8. Other committee business. I think we can get through this relatively quickly if we're all in agreement, I guess, would be the big thing.

As you know, as the Standing Committee on Social Development, we have the task of the appointments for the Human Rights Commission.

**Mr. Currie:** We do?

**Chair:** Yeah, as a committee.

**Mr. Currie:** Really? (Indistinct).

**Chair:** Always has been, so I'm told.

**Mr. Currie:** This committee appoints people to the human rights?

**Chair:** Yes.

**Mr. Currie:** I never knew that.

**Chair:** So we wondered how we were going to manage that. There was some discussion between myself and Melissa in regards to running an ad in the newspaper to make sure that anybody who has an interest knows that the -

**Some Hon. Members:** (Indistinct).

**Chair:** Everybody's okay with that? Do we have a copy of the ad, Melissa?

**Committee Clerk:** Yes. Well, this is the wording.

**Chair:** Okay. There's the ad, No. 2 on our sheet that was circulated. Is everybody okay with running an ad?

**Mr. Currie:** Yes.

**Chair:** We would run it Wednesday, March 5<sup>th</sup> and Saturday, March 8<sup>th</sup> and then we would -

**Ms. Dunsford:** Just regular committee work for the Human Rights Commission? Is there a specific title?

**Chair:** I believe the Human Rights Commission is going to be in to present to us.

**Committee Clerk:** Yes. They're going to come in next Wednesday so they can give you a little more briefing about what the job would entail.

**Chair:** And all that.

**Ms. Dunsford:** For these two people that are needed.

**Committee Clerk:** Yes. So they'll give us a briefing on that. But we are getting a little short on time so we wanted to make sure that we could put these ads in, have two weeks for people to get in their resumes, and for us to have some time to go through them

and do all that. Because the two people whose terms are finishing, I mean, they'll stay on as long as need be, but their terms are officially over April 11<sup>th</sup>. So we would like to have that report in to the House.

**Chair:** That's all right?

The other part of that business is, of course, we're going to have to write a report, right? So we've got some dates here. I don't believe we have any other presentations past the 5<sup>th</sup> of March.

**Committee Clerk:** No.

**Chair:** So we were looking at starting that report on Friday, March 14<sup>th</sup>, at 1:30 in the afternoon. And then we would go back to it on Tuesday, March 18<sup>th</sup>, in the afternoon. The last meeting before the House resumes would be Thursday, March 27<sup>th</sup> in the afternoon, and we would probably take some time, at that time, to discuss the appointments of the Human Rights Commission, and use the rest of the time to just tidy up and complete the report, if everybody's in agreement with that.

**Ms. Dunsford:** I'm away on the 27<sup>th</sup>, but so be it. The committee can do that without me, I would think.

**Mr. Gallant:** It'll be tough but we'll get her done.

**Ms. Dunsford:** I'll give you my cell if you need to call, you know.

**Chair:** Is everybody in agreement with that?

**Mr. Gallant:** Yes.

**Chair:** Okay.

The other thing we needed to talk about was, as you know, we have certainly requested for the PEI Petroleum Marketers Association to come in and present to the

committee. Melissa could certainly elaborate on that journey, perhaps a little more than even I could, but the bottom line is they've certainly made it clear that as an association they are not interested to come forward and present. I'm going to let Melissa talk a little bit about that, if you don't mind.

**Committee Clerk:** Oh, no.

This was a press release that they sent out. I believe it was sent out end of January. It was covered in the newspapers and whatnot, too. When I spoke to them after we a little more formally invited them, their feeling is basically they've said all they can say. They feel that the presentation that IRAC did kind of covers everything, too. They just feel they have nothing more to contribute. They sent over a copy of the press release for us to go through or for us to have on record as well.

**Mr. Gallant:** Can I ask a question?

**Committee Clerk:** Sure.

**Mr. Gallant:** Why did we want them to come in?

**Chair:** Can I respond?

**Mr. Gallant:** Yeah. You're the chairperson.

**Chair:** I think at first when we asked them we thought that they would perhaps have valuable - to let them have their say and to share any valuable information, to talk about perhaps the service fee that's on the billing. But I think as our work continued on - and it's my feeling that perhaps they're not going to be able to fix the problem for us, and maybe there isn't a need.

**Mr. Gallant:** With all due respect, that's why I asked the question. When we asked them to come in it was eight weeks ago. We've had other presenters since.

**Chair:** We've come way past that.

**Mr. Gallant:** It's basically a dead issue because it's been in the media. They're running a business. They have to do what they have to do. If we are going to continue with the high energy costs and come up with a plan, then so be it. If we're not, then so be that. Because, as I stated before, there is a perception out there that we are doing something, we have a plan, or we're working on a plan.

Now, everybody else understand this or feel this way in this room?

**Chair:** Yes.

**Mr. Gallant:** Because am I the only one that's out in left field? Like, I'm hearing it out there. People think we're coming up with some kind of a plan.

Now, we had a presenter this morning that's telling us it has to happen tomorrow. Well, that's a little urgent. Are we thinking of an oil rebate or something to help the low income people?

**Chair:** I think that we probably can't speculate in committee what the government may be working on, but I think -

**Mr. Currie:** That's a budget issue.

**Chair:** That's right. But I think that we can honestly say, as a committee, that no matter if we had a representative from every oil company come in and sit and present in front of us, it is not going to change the situation that fuel costs are high and there's people in crisis over it.

So that's my feeling. Melissa was asking if we wanted to push it a little. We certainly could push it, but I guess that's when I said: I'll come back to the committee and see how the committee feels. My own personal opinion is I don't think it's going to fix the problem.

**Mr. Gallant:** No. Agreed.

The Committee adjourned

**Melissa Keefe:** If I may? We are going to have the Office of Energy Efficiency in next week. Like the chairman said, I mean, there's not much we can do about oil prices. There's not much you could recommend and you can't really, as a committee, recommend giving a rebate because, as you know, you can't have any recommendations with financial implications. So it's not really a reasonable recommendation.

I think you've heard from a lot of different groups that have some different ideas on things, and hopefully next week the Office of Energy Efficiency will have some more ideas too about moving forward and recommendations you can give.

Certainly, I mean, this committee's work, you'll continue on four years. So if you can't get the oil companies in now, you can keep asking them. You can pursue this after this House goes into session. This doesn't have to be - I mean, we have to submit a report, but we can still continue working. I mean, you could possibly say in the report: We're not done looking at this, we'd like to keep looking into this issue.

I don't think anyone expects you to solve the problem in two months. If they did, it probably would have been solved long ago.

**Chair:** So is everybody okay with just not approaching the oil companies again at this time? Are you good with that?

**Some Hon. Members:** Yes.

**Chair:** All right, so that's it.

**Ms. Dunsford:** Motion to adjourn.

**Chair:** Motion to adjourn.

Thank you for your patience.

