I am proud to say that I am part of a team that has built one of the most influential policy institutes in Canada. I would like to thank Alan and Judy Broadbent for your support over all these years, and Colin Robertson and Tom Barber for your unwavering assistance.

I am also honoured to work with Ken Battle and Michael Mendelson, two of the sharpest policy minds in the country. Going to work every day is both exhilarating – and humbling. Finally, I am sure you share my appreciation of the work of André Picard, who gives us all a public and eloquent voice on issues related to health care, disability and the aging society.

These are obviously big policy areas and we can’t possibly cover all their dimensions in this short time. I hope today to highlight key areas of work in which Caledon has been involved and to identify core challenges that I believe we face in future.

Over the past two decades, Caledon has focused on several aspects of disability including poverty, disability supports and participation in society. Our work will continue to address those issues. We have broadened our scope in recent years to include some distinct, but related, issues around an aging population.

I will discuss disability and the aging society separately. While these areas are linked, they are clearly distinct. The disability community has always warned against confounding disability issues with seniors’ concerns. But there are a few crossover points, especially with respect to community supports.

**Current work**

Close to 4.4 million Canadians – or 14.3 percent of the population – experience some form of disability, though the rate of disability among Aboriginal Canadians is almost three times that level.

There is significant variation in the population of persons with disabilities. Some are born with a disabling condition, such as spina bifida or developmental disability. Others acquire a disability over the course of their lifetime as a result of illness or accident. Still others may experience impairment in function due to the effects of aging.

Some disabilities are stable and predictable. Others are degenerative conditions that tend to get worse over time. Still other conditions are episodic because their symptoms recur and remit. When symptoms recur, they can cause serious impairment. But when they remit, functioning is near normal. Individuals may be able to work, for example, albeit at a slower pace or for fewer hours.
So the term ‘persons with disabilities’ refers to a very diverse group. Despite the variation, they all have three distinct needs.

They require *adequate income* to pay for basics such as food, housing and utilities. They often face *additional costs* associated with disability. Perhaps most important, they seek to be valued as *full citizens* and to participate in all aspects of society.

I first became involved in these issues as a staff person to the House of Commons Committee on the Disabled in 1981, the International Year of Disabled Persons. The Committee’s mandate was to propose recommendations to reduce barriers to participation.

It was the first time in Canada that such an exhaustive inventory had been undertaken on disability. My initial task was to review relevant legislation to find references to moron, idiot, imbecile and feeble-mindedness – unfortunately, terms found all too frequently in our legislation.

The Committee produced the *Obstacles* report, which made recommendations on all major policy issues including human rights, income security, technical aids and communications. The most important result was the inclusion of physical and mental disability as a proscribed ground of discrimination in the newly-introduced *Charter of Rights and Freedoms*. Canada became the first country in the world to provide constitutional protection of disability rights.

Significant progress was made in the country as a result of the *Obstacles* report. But many of the advances assumed the form of improved physical access, including closed captioning for the hearing impaired, ramps on sidewalks, accessible airports and Braille currency.

We have still not done well enough from a policy perspective on developmental disability and mental disability. The other areas that have not seen sufficient advances are income security and disability supports. They are far less black and white than installing a ramp or widening a doorway. Income programs and disability supports need to accommodate highly variable circumstances. Our work at Caledon has focused on those areas that remain problematic.

*a. Income security*

Most Canadians with disabilities live on low incomes. They typically have been underrepresented in the paid labour market. Slightly more than half of workers with disabilities have jobs, compared to 75 percent among workers without disabilities.

Fortunately, in the decade ending in 2008, the bleak picture had started to brightened. The proportion of persons with disabilities who worked at some point had *increased*. Faced with a tighter labour market, employers seemed more inclined to accommodate and hire individuals with disabilities. At the same time, more people with disabilities
were seen as potential employees because, overall, they had improved their educational attainment and skills.

But there are still about one million people with severe disabilities who are not in the workforce. They rely on Canada’s income security system.

The current disability income system can best be described as a ‘patchwork quilt.’ Eligibility for most programs is determined by where and how claimants became disabled and by the nature and severity of their disability.

There is a set of disability income programs whose main purpose is to provide compensation for accident or injury. Another set of programs replaces lost earnings. A third set of programs pays income support for those with few or no earnings.

Social assistance (or welfare), administered by provinces and territories, is the primary source of income for more than 500,000 Canadians with severe disabilities. Because welfare was designed as a last-resort safety net, it virtually guarantees a life of poverty. It never was intended as a lifetime guarantee. If nothing else, social assistance benefits for people with severe disabilities should be bolstered and indexed to ensure that welfare does not equal poverty.

Better still, these individuals should not have to rely on welfare but would qualify for a separate income program, ideally run by the federal government. Caledon proposed this option in a paper A Basic Income Plan for Canadians with Severe Disabilities. Resulting provincial and territorial savings would be reinvested in disability supports.

There is another problem in the income security system regarding sickness and moderate disability. Most income programs expect applicants to be in or out of the labour market – with very few shades of grey. But many conditions, as noted, have periods of remission during which people are able to work. They need interim or periodic financial assistance.

In 2008, Caledon published a study by University of Victoria Professor Michael Prince called Canadians Need a Medium-Term Sickness/Disability Income Benefit. The paper set out three possible options to address this problem, including enhancement of the Employment Insurance sickness benefit.

Caledon was also involved in the design of the Registered Disability Savings Plan (RDSP), which helps parents accumulate a pool of funds on behalf of their children with severe disabilities. The idea had been proposed by Al Etmanski at the Planned Lifetime Advocacy Network (PLAN).

We commissioned two studies to help advance the idea. The first focused on the ‘quantum’ – or parameters of the proposed plan in terms of eligibility and cost. The second study explored potential interactions to ensure that the positive impact of a new savings plan would not be offset through clawbacks to existing programs. The RDSP was announced in the 2007 federal Budget.
In addition to low incomes, persons with disabilities often face another challenge that arises from disability costs, which may be relatively minor or very significant. There are both direct and hidden costs.

Direct costs are readily itemizable and include, for example, technical aids and devices or home modifications. The medical expense tax credit and the disability supports deduction recognize many of these costs. But households must have incomes high enough to afford them in the first place.

Other disability-related expenses are considered hidden because they are more difficult to quantify with precision. They include hiring a trained caregiver rather than a babysitter for a child with a disability or paying higher prices because of fewer shopping options.

The disability tax credit is intended to help offset these additional costs. There have been significant problems with this measure, including the fact that persons with impairment in mental function face serious eligibility barriers.

Caledon had an opportunity to influence this system. The 2003 federal Budget announced the creation of a Technical Advisory Committee on Tax Measures for Persons with Disabilities. I was appointed co-Chair of this Committee. Our mandate was to advise the Ministers of Finance and National Revenue on ways to improve disability tax measures.

While we proposed a range of changes, our basic conclusion was that the tax system generally is an inappropriate vehicle for offsetting disability costs. Current measures basically provide no help to low-income Canadians who most need assistance. We argued that disability supports should be more readily available through provincial/territorial programs.

**ii. Disability supports**

The current system of disability supports defies simple description. These include both equipment and a range of personal services. The supports that may be provided in one jurisdiction may not be available in another. Two people with the same functional ability may be eligible for very different supports depending on their condition.

Over the years, Caledon has argued for increased investment in disability supports. In various papers, we set out several ways to effect such investment, including a federal-provincial/territorial commitment similar to the Early Childhood Development Agreements signed in 2000 and 2003.

Another option is a National Child Benefit-type arrangement in which Ottawa would assume responsibility for income security for persons with disabilities currently on welfare. Under a negotiated agreement, as explained, provinces and territories would direct the resulting savings toward the supply of disability supports.
At the very least, provinces and territories should improve their existing systems of supports. There are substantial changes that can be made, which we discussed in our report *Five-Point Plan for Reforming Disability Supports*. They include:

- enabling access
- clarifying eligibility
- ensuring more effective delivery, including portability of supports
- moving toward a client-centred approach, which can involve individualized funding
- creating an enabling context for participation.

*iii. Participation*

A third area in which we have worked moves beyond the availability of disability supports. Rather, it seeks to change relevant environments to make them more accommodating of disability needs. Disability-sensitive design is helpful not only for persons with disabilities. It makes the world more manageable for everyone.

In fact, far more attention is being paid to the need for accessible environments. The conversation started in the country as a disability-related issue but has since expanded to include the general population. The World Health Organization, for instance, has been spearheading an Age-Friendly Cities initiative in which several Canadian cities now participate.

Accommodation involves more than physical adaptation. Individual needs often can be accommodated through adjustment of rules or procedures.

Accommodation may involve, for example, allowing a friend or assistant to help someone carry out a certain task or participate in an event.

But accommodation goes even beyond these elements to include *a sense of belonging*. André Picard makes this point in his piece on January 30 this past year:

> Real integration requires a lot more than building ramps, adopting human rights legislation and funding programs. Grudging accommodation, with a dash of tokenism, is not enough. If we want people to be healthy – physically, mentally, emotionally – and to reach their full potential, they need to be full citizens.

And herein lies the first major challenge for future work – linked to our values and our humanity.

*Future challenges*

*i. Clarifying our value*
We have not had a *serious* conversation in this country about the notion of citizenship relative to persons with disabilities. We typically talk about citizenship in terms of new Canadians, often in relation to our national symbols and history. But we rarely consider *deep citizenship* – what it means to truly *belong* to a community and a country.

To their credit, disability groups have been speaking the inclusion language for years and have rallied around full citizenship. A conversation about this ideal doesn’t start, in the first instance, with a discussion about income or services. It begins with a focus on belonging.

At the turn of the millennium, I wrote a paper called *Reclaiming Our Humanity*. It was all about what it means to live in a decent, civil society in which every person is deemed worthy of dignity and respect.

Citizenship means that we need to talk – first and foremost – about natural environments and supports. It means ensuring a decent affordable place to live, like the Housing First movement, for example, for people with mental illness and homeless individuals. It means circles of support and informal networks of family members and friends. It means inclusive education. It means access to recreational and cultural opportunities. It means caring communities that provide welcoming public space.

We can *start* by thinking differently about disability and aging. We need to shift our conceptual foundations.

Disability used to be seen as a characteristic or defining feature of an individual. A person *was* disabled or *had* a disability. Appropriate interventions involved treating or fixing the identified impairment.

Over the past few decades, our understanding of disability has moved away from the functional limitation of an individual to more of a social understanding of the person in context. In this social view, persons with disabilities are seen as restricted in their daily activities because of a complex set of factors, pertaining to both the person and the environment.

The implications of this social model of disability are profound. It means that appropriate adjustments to the environment can help overcome serious functional impairments – in which case, these may result in minor or no limitation at all. The social model of disability calls for investments in the modifications and personal supports that can dramatically reduce – if not eliminate – the effects of disability. The problem lies more in physical and attitudinal barriers rather than in the people labelled as ‘less than adequate’ in some way.

Marcia Rioux at York University has helped advance this conceptual shift by arguing for well-being and social justice as the foundational underpinnings of our work. Nobel-prize
winning economist Amartya Sen employs a capability framework that focuses on how to foster *ability*, regardless of age or functional limitation. Traditional policy frameworks typically use problems and deficits as their starting points. A capability framework, by contrast, would ask: What are the strengths and capacities that we need to enhance?

We face similar challenges related to the aging society. By 2036, 23 percent of Canadians will be age 65. If we were to read only the press headlines, we would conclude that the heavy boatload of seniors is about to sink our demographic ship.

Their so-called ‘dependency ratio’ is deadweight on the economy and society. The International Monetary Fund warns that the toll of aging on G20 nations will be 10 times greater than the recent financial crisis – and will be even higher in Canada.

We need to shift this conversation so as not to write off a huge portion of the population as a burden to the economy and society. Thankfully, work under way at the International Federation of Aging and McMaster University, for example, is trying to counter these negative stereotypes.

As if there is not enough to do, several *new* ethical challenges have emerged related to both disability and the aging society. Certain medical advances mean that we can now identify many more potentially disabling conditions *in utero*. If prospective parents subsequently choose to abort their fetus, the disability community argues that these actions effectively devalue all people with disabilities. The message is that *theirs* is not a life worth living.

We face similar challenges at the other end of the life spectrum in determining who will have access to sophisticated medical treatments and who is considered ‘not worth’ the investment. Who will get the expensive liver or stem cell transplants? How will we make good decisions about rationing health care services which, for all intents and purposes, is already happening?

There don’t appear to be any informed, apolitical venues for dispassionate discussion of this issue. It’s not good enough to think that we can debate these questions every so often on the commentary pages of the *Globe and Mail* or *National Post*.

Of course, scientific and technological advances have had a substantially positive impact as well. Mobility and communication devices, for instance, enable independent living. But even here we face ethical challenges – related largely to access.

Those who can afford new technologies are able to purchase them on their own. They can even deduct these costs through the medical expense tax credit or disability supports deduction. Those with modest or low incomes may have access to some technical aids and equipment through provincial/territorial programs or the special assistance budgets of social assistance. But access is by no means guaranteed.
In one study of disability supports, I interviewed an individual who noted that welfare refused to help pay for his sports wheelchair. While the equipment was vital for his health, it was deemed a ‘luxury item’ not essential for his life.

Finally, the aging society will rely increasingly on at-home technologies to monitor bodily functions, such as blood pressure, pulse and glucose levels. They can also be programmed to set off an alarm in case of a serious fall, heart attack or stroke. These are all exciting developments.

I don’t believe we have begun to scratch the surface regarding the social impact of these technologies. While they may enhance independence, could they inadvertently result in greater isolation if fewer personal visits are required? I don’t even think we know the full range of questions to ask — let alone begin to have any satisfying answers. This is definitely a national conversation waiting to happen.

**ii. Bolstering informal supports**

If we start with belonging and citizenship as the conceptual foundations of our work, the second challenge moves us to the next level: informal supports in communities. Informal supports take many different forms but today I will focus on our work related to informal caregivers.

These are the family members and friends who provide an estimated 85 percent of care required by individuals with long-term conditions. Caregivers contribute more than $5 billion of unpaid labour annually to the health care system — though some studies peg this closer to $25 billion.

As a workforce that provides an essential service, caregivers need the same provisions as the workforce in all other fields: money, decent working conditions and training to do a good job.

When it comes to money, most caregivers experience financial stresses that arise from three factors. I called these factors the “three ghosts of poverty” in an op ed published several years ago on Hallowe’en. They are ghosts of poverty because these stresses haunt caregivers throughout their caregiving careers.

The three ghosts relate to the income security of the care receiver, the vulnerable employment status of the caregiver and the cost of health- and disability-related supports. The spectre of poverty is ever-present in a caregiving relationship.

Millions of people with severe disabilities and elderly Canadians live in poverty. Their caregivers often spend much of their own money paying for basic food and rent for the care receiver.

Part of the solution is to shore up the disability and retirement income systems, as we have been trying to do through our work at Caledon. Unless we make significant shifts in
various income programs, the poverty of the care receiver effectively becomes the poverty of the caregiver.

Second, caregivers’ employment status can be jeopardized by the pressures of their caregiving responsibilities. Many caregivers must reduce their hours or leave work altogether in order to carry out their caring role. They put at risk both their current income and future pensions.

The third financial strain derives from additional expenses linked directly to age or disability. More than one-third of caregivers report extra expenses due to their caregiving responsibilities. Two-thirds spend more than $100 per month.

There are several tax credits in place to recognize the additional costs of caregiving. But beware of these tax gifts – what you see is not what you get. This aid is worth only 15 percent of the amounts announced in federal Budgets. The caregiver allowance that was billed as $2,000 when introduced in 2011, for example, is actually worth only $300 – or 15 percent of the “amount.”

Moreover, these amounts are not paid as a direct benefit. They simply allow tax filers to reduce the taxes they owe. Higher-income households enjoy the full value of this tax credit. Modest- and lower-income income households derive little or no benefit from these tax measures.

We have argued that turning these measures into refundable credits would ensure that all households receive some money in respect of their caregiving costs. Both Manitoba and Québec provide a refundable tax credit for caregivers – so there is policy precedence for this approach.

Alternatively, a small direct payment could be made to help offset these additional expenses. The UK and Australia, for example, pay a cash benefit to the family caregiver of persons requiring chronic at-home care with supplements for households that incur especially high costs.

Here at home, Nova Scotia has introduced a $400 per month caregiver allowance. Throughout the country, the federal government pays a Child Disability Benefit, which delivers an annual maximum $2,575 to low-income parents with children with severe disabilities. This amount could be raised and the benefit extended to low-income households caring for adults over age 18 with severe disabilities.

But financial compensation is not enough. A workforce that provides an essential service must also have good working conditions that respond to their needs.

Flexibility at paid employment is one of the most important considerations. The needs of the elderly, in particular, are often unpredictable and require adaptability on the part of the caregiver. The same can be said for someone with an episodic condition, such as multiple sclerosis, where symptoms recur and remit. Some companies are beginning to
recognize that employees may need more than personal or vacation time to deal with caregiving responsibilities.

There are important policy precedents at the international level. As part of its Carer Strategy, the UK introduced wide-ranging employment measures. In 2007, the *Work and Families Act* was amended to allow caregivers the right to request flexible work.

In New Zealand, caregivers who have worked with their employer for at least six months have the right to request flexible arrangements, such as compressed work weeks, flex-time and work from home. These rights do not guarantee that the employer will say yes. But at least they protect the security of employees who ask for flexibility.

Paid leave is another core working condition. In Canada, some practical changes can be made. The current Employment Insurance program includes Compassionate Care Leave. This measure allows up to six weeks’ paid leave to care for a gravely ill relative who is likely to die within 26 weeks.

We are fortunate to have such a measure in place. But the eligibility criteria are too stringent to provide meaningful help to most caregivers. This provision can be expanded to permit leave for other caregiving circumstances, not just terminal illness, and can be extended in terms of the duration of the caregiving period.

Finally, future income can be affected when caregivers must drop out of the workforce due to their caregiving responsibilities. It is essential to find ways of protecting the value of pensions in future.

Several countries, including Australia, the UK and Norway, provide a special pension intended specifically for caregivers. Others make pension contributions on behalf of caregivers so that they are not penalized later in life for lost employment time during their working years.

One possible remedy is to expand the general drop-out or child care drop-out provisions of the Canada Pension Plan. The latter provisions allow workers to discount from the calculation of their pensions the years during which they were caring for a child under age 7. These measures could be expanded to apply not only to child care but also to caregiving responsibilities.

Good working conditions at paid employment must be supplemented by training and support at home. Caregivers need high-quality information about various conditions and advice on how best to handle them. Despite some positive models, there is insufficient training to handle this big responsibility – especially when it comes to mental illness and degenerative disorders, such as dementia.

A significant development in the caregiving field involves the use of social technologies that create networks among caregivers, care receivers and formal services. These networks provide information, emergency intervention and day-to-day assistance with
caregiving tasks. In Canada, Vickie Cammack and colleagues from the PLAN Institute, for example, have established the online Tyze personal networks program.

While wide-ranging measures are required to support informal caregivers, there is little appetite for a national strategy in Canada – at least one coordinated by the federal government. The impetus for anything that resembles a pan-Canadian strategy likely will have to come from the voluntary sector working closely with provinces, territories and the private sector.

iii. Financing formal supports
Finally, we need to move beyond natural environments and informal supports to the third concentric circle in this policy ring: formal community supports. These include home care and long-term care.

As they age, most people would prefer to remain in their own homes for as long as possible. Only a more adequate supply of community supports can make this possible.

Home care is the primary community support. In this context, I am using it to refer to a cluster of services that enable independent living. These include:

- home health care for health-related functions, such as administering medications, changing bandages, cleaning breathing tubes and carrying out dialysis
- attendant care for the personal activities of daily living, such as feeding, bathing and dressing
- homemaker assistance for essential home-related tasks, such as shopping, cooking and cleaning.

These services are in short supply relative to demand. There are simply not enough of them to go around.

Population aging itself does not equate with increased demand. We are a healthier population, overall, than in the past. However, an aging population does mean that more people are living longer with chronic conditions acquired at some point in their lives. Many require some form of medication or health-related supervision on an ongoing basis.

Lack of home care means that many patients cannot be discharged from hospital. An estimated 7,500 Canadians currently live in hospital because they have nowhere to go. At an average $1,500 a day, total costs amount to about $4.1 billion a year – a sum that could help resolve the problem if it were invested in home care.

Many older Canadians eventually require placement in a residential home or long-term care facility if their health-related needs become too great for care at home. There is also a shortage of affordable, long-term care facilities in Canada. Statistics Canada reports that Canadians have a 50 percent chance of needing long-term care by age 75.
The Canadian Life and Health Insurance Association estimate that the cost over the next 35 years of providing care to baby boomers is almost $1.2 trillion (in current dollars). Government programs will likely cover only about half this cost. As a result, Canadians will face a long-term care funding shortfall of close to $590 billion – or about $54,000 for each baby boomer in Canada today.

It is essential to tackle the financing challenge for home care and long-term care. Many would argue against additional funding and would recommend instead that funds be saved through introducing efficiencies and innovation in hospitals and expensive acute care, which consume the lion’s share of provincial/territorial health budgets. I agree. In fact, selected innovations are starting to achieve noteworthy shifts.

There has been modest success, for example, in enhancing the quality of care through improved coordination among parts of the health care system and between hospitals and community care agencies. Significant progress through monitoring technologies and software programs that link, in real time, the formal and informal health providers engaged in caring for a given individual.

Another area that is ripe for innovation involves the reassignment of health-related tasks. With adequate training, many health care functions can be performed in the community by nurse practitioners or physician assistants, personal support workers or care attendants at lower cost than when provided by physicians. It is important to ensure, however, that the workers who carry out these crucial functions are paid a decent living wage. Innovation should not be equated with downward pressure on wages and working conditions.

But health care innovations, while vital, are not sufficient. The community sector is so drastically underfunded right now that it needs a substantial infusion of money to improve the quality and quantity of available supports.

The purpose of new financing options is to generate additional money for the community care sector – not to replace existing forms of financing. While new financing options require substantial study and debate, at the very least Canada should be engaged in this conversation.

Some form of public or social insurance, for example, might be considered for long-term care. Social insurances generally are employed in the event of a shared risk that affects a substantial proportion of the population – in this case, the provision of long-term care for the elderly.

Canada’s social insurance experience is confined to income security programs. But several developed nations, including Germany, Japan, Korea, the Netherlands and Luxembourg, employ a social insurance model to help pay for long-term care.

In Germany, for example, participation in the Long-Term Care Insurance Plan is mandatory. The Plan offers a number of options, which can be adjusted according to
need. Every six months, recipients must choose between cash benefits for individuals who require lighter care or home care services, or in-kind benefits intended for those who require more intensive care in nursing homes. The Long-Term Care Insurance Plan also provides benefits to family caregivers.

Other financing options include some form of individual savings accounts to be used for long-term care. The Canadian Life and Health Insurance Association recommends a form of Registered Education Savings Plan (RESP) for long-term care. Alternatively, these plans could be designed like Tax-Free Savings Accounts.

There may be new financing options that draw from other sectors. Governments sometimes provide tax incentives, such as tax deductions that are higher than the actual contributions, for certain types of investments they seek to encourage. Tax incentives have been employed in the past to incentivize investment in the film industry, various forms of research and multi-unit residential buildings, known as ‘MURBs.’ There could be, for example, a tax break for contributions made to a new Home Care Investment Fund.

Another new fiscal instrument might be developed in support of other discrete areas, such as health technologies. This is a broad umbrella terms that includes technologies for screening, treatment, health monitoring, and information and communications.

There may be a way of raising funds through a designated, short-term Health Technology Bond modelled on the design of the Canada Savings Bond. In order to be attractive, a new bond would need to promise a higher return on investment than current offerings.

Alternatively, Australia employs a form of interest-free loan to assist with the costs of long-term care. There are other important examples of work under way in Canada that are employing some form of financial bond for social purposes.

All these proposed financing options require considerable study to determine their cost implications and administrative viability. For example, earmarked revenues should not be overused. Governments need a robust pool of general revenues in order to meet their wide-ranging responsibilities.

Moreover, most measures that reduce federal income tax also lower provincial/territorial income tax, which is calculated as a percentage of the former. It would be essential to ensure that funds through any new measure would always exceed the sums derived through current arrangements. There must be a net gain to provinces and territories in order to consider any new instruments a viable option.

Finally, the receipt of new funds must come with conditions for accountability. It is not enough to say that more services were delivered in a given period or that additional tests were carried out. In fact, excessive and unnecessary medical procedures actually can harm health.
Bottom line: the purpose of extra dollars is not to embed inertia or reinforce the status quo. Rather, the goal is to foster and drive improvements in health outcomes for a more healthy population.

_All this to say..._
There is a substantial policy agenda with respect to disability and the aging society. Some of the work will involve continued efforts to reform income security, improve disability supports and enhance participation.

But there are several new challenges that have emerged in recent years that relate to informal and formal supports, and more fundamentally, to our values as a society and as human beings.

At the end of the day, the goal of _reclaiming our humanity_ remains as relevant as ever.

_Sherri Torjman_
_October 10, 2012_