HSE - 20160504 PM 016/ACR/1445

Committee of Supply

ESTIMATES: MINISTRY OF HEALTH
(continued)

The House in Committee of Supply (Section B); R. Chouhan in the chair.

The committee met at 2:48 p.m.

On Vote 29: ministry operations, $17,820,706,000 *(continued).*

J. Darcy: I'd like to begin by canvassing some issues related to health human resources, in particular as they relate to seniors care.

We have, on many occasions and over several years, had discussions with the ministry about health human resource strategies, shortages of various occupations. Certainly, one of the things that has been impressed on the ministry on various occasions is the importance of looking at — very broadly — what shortages we have in health care, not in restricting it to a few specific occupations. Certainly, organizations representing care aides have raised the issue over the years — about shortages of care aides in various areas of the province and the need to address that.

Now, the B.C. Care Providers recently has already spoken out on this issue, very strongly — that the ability to attract qualified care aides to B.C. has increasingly become a challenge, is particularly acute for residential care operators in the Interior and on Vancouver Island. For home support employers, this is a province wide issue with chronic shortages in the north.

[1450]

They have stated that we are simply not training enough care aides to deal with what we've all known for some time, an aging population, and that the lack of care aides in the Interior and Vancouver Island and home support workers in Metro Vancouver is just an early warning signal of what lies ahead. Our workforce is also aging. Daniel Fontaine says

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an aging population, and that the lack of care aides in the Interior, Vancouver Island and home support workers in Metro Vancouver is just an early warning signal of what lies ahead.

Our work force is also aging, Daniel Fontaine says, and it is critical to ensure that we recruit and train enough staff to ensure the adequate levels of seniors care that are needed across the province.

My question is: what is the minister doing to address the shortage of care aides — both those who work in residential care, as well as those would work in home support?

Hon. T. Lake: The training of health care aides is carried out both in the public system and through other providers as well. Currently, there are 41 education providers that offer the health care assistant program; 16 of these are public colleges, there are two school district programs and 23 private colleges. Quite a number of programs around the province.

Where we do see a shortage, we try to bump up the number of seats in that area. Since 2008, we've been providing one-time funding for short-term health education programs to address the immediate needs where we see the need in a community.

For instance, in 2013-14, part of that funding was awarded to Camosun College, here on the island. In 2014-15, there was $356,000 awarded to the great university in Kamloops, Thompson Rivers University — to their health care aide program. I was there for that announcement and saw the great work they're doing. In 2015-16, $153,000 was awarded to the College of New Caledonia for 18 additional health care aides in the Quesnel campus.

What we do is we have a base of 41 providers. Where we see there is a shortage in any particular part of the province, we inject money to boost the programming in that area to meet that demand.

J. Darcy: I'd like to turn to the issue that relates to staffing, human resources, and to continuity of care for seniors. This is an issue that we have also discussed extensively, both in estimates as well as in question period.

[1455]

I want to go back to the Ombudsperson's report on seniors care of several years ago, when she spoke of the significant mass replacements of staff.

> "Mass replacements of staff can occur when facility operators switch from contracting with one private service provider to another. Such turnovers can disrupt the lives of seniors in residential care, especially those whose care needs are complex. Over time, long-term staff acquire specialized knowledge of these needs, so the simultaneous replacement of many employees can make it difficult for the seniors because continuity of care is disrupted, and this is particularly

> can disrupt the lives of seniors in residential care, especially those whose care needs are complex. Over time, long-term staff acquire specialized knowledge of these needs, so the simultaneous replacement of many employees can make it difficult for the seniors because continuity of care is disrupted, and this is particularly the case for residents with dementia.

She also goes on to talk about how incredibly stressful this is for families.

So, this phenomenon, which is…. We're not revisiting legislation now, but we know it is a direct result of Bill 29, going back 13 years. We have more instances of this that occur every year — mass displacements of staff, most recently Wexford Creek in Nanaimo where workers will lose their jobs and where care for seniors will be disrupted. The staff who care for their most intimate care needs will be torn away from them.

Last year in this place we discussed Inglewood, where the contract has been flipped five times, and Laurel Place, and we could go back every year with numerous instances.

My first question on this is whether the Ministry of Health or health authorities are tracing the number of times that services have been contracted out or flipped in residential care.

Hon. T. Lake: The member and I share a concern. I know other members of her team have expressed a concern, and I know that members on our side have expressed concern.

When caregivers are subjected to a change in a contract or for a long-term residential care facility…. People do get very attached, obviously, to the people who care for them every day. It's important to their well-being that there is continuity of care, that there is familiarity, that there is trust. When we do see a change, it can be impactful on residents and their family.

[R. Lee in the chair.]

I want to, again, just acknowledge what the member said — that through 2010, 2012 and 2014 collective bargaining agreements and the Bill 29 settlements, both health employers and unions agreed through negotiations to allow contracting out to continue. I want to stress that this was part of a discussion with the unions, and it was agreed that the ability to contract out would be preserved.

However, the member said it's happening more and more every year. I'm not sure that's the case. We are in discussion with the seniors advocate, asking her to take a look at this particular issue.

What we have done, in the meantime, is develop a policy, which is policy 6k, large scale staff replacements. This is policy that is in the *Home and Community Care Policy Manual* that health authorities have to follow: "Health authorities must ensure that service providers plan and manage the change process for clients when a service provider is planning a large-scale staff replacement."

The requirements are that they ensure maintenance of the quality and safety of the clients' care is the priority through the process; that the client and their families are provided with information about the upcoming change; clients and families should have an opportunity to meet with the service provider, the new staff members, to identify key

concerns, and ensure that the staff replacement does not happen until all clients are informed and have had an opportunity to have their concerns heard.

So we acknowledge the impact this can have on residents and on families. We are working with the seniors advocate to look at making sure that we are tracking how often this is occurring and for what reasons it's occurring and, in the meanwhile, ensuring that the impacts on families and residents is absolutely minimized by health authorities.
[1500]

J. Darcy: To suggest that anyone agrees with contracting out because they have been unsuccessful in achieving protections or guarantees against it is a bit of a stretch. The reality is…. We discussed this very issue last year in this place, as we have in question

anyone agrees with contracting out because they have been unsuccessful in achieving protections or guarantees against it is a bit of a stretch.

The reality is.... We discussed this very issue last year in this place, as we have in question period. The minister said exactly the same thing last year. "We have this policy. This is where you find it." Referring to what the minister just said, he said.... It talks about meeting with family members, providing them with information. It doesn't say anything about changing the practice.

Now, it is true that it is legal to contract out. It is legal to flip contracts. But the minister has levers. The minister has the ability to say.... Because the ministry provides funding to residential care operators through health authorities, the minister certainly has the ability to set policy that says that even in the event of contracting out or contract flipping, there is continuity of staffing and, therefore, continuity of care.

Besides the policy that the minister referred to, which involves meeting with and sharing information, what is the minister prepared to do to actually ensure continuity of care?

Hon. T. Lake: The member refuses to acknowledge that.... Bill 29, and the contract negotiations that occurred, was an agreement. Union members agreed that contracting out would still be allowed to occur. The reason for contracting out is in order to save money. There's another way to save money, and that's to not ask for so much on the other side of the bargain that is created.

This is a two-sided bargain. To suggest afterwards, after unionized members agreed to a certain raise, an increase to allow for savings on the other side, and then after the fact say: "Well, we didn't really mean it. We didn't want that...." Well, okay, give up the other side of the bargain as well. It's just disingenuous to suggest that the government or the contractors should give something up when it was bargained for in good faith by both sides.

What we have said is that we are going to monitor the situation. We have instructed the health authorities to minimize the impact on families in the ways that I just outlined. That's what we are doing. We want to minimize impacts on families while still ensuring that we have a sustainable system of caring for our seniors in residential care. Again, the answer from the member opposite is always: "Just put more money into something." There has to be a way of ensuring that the system is sustainable. That is why the bargain was made — the grand bargain to allow contracting out to continue.

J. Darcy: Well, we're not going to pursue that line of discussion further. I'm actually extremely familiar with what the minister is talking about, and he has it wrong. But that's a discussion for another time.

Let's move on to....

Interjection.

J. Darcy: The minister is laughing, but the impact of contract flipping on seniors care, on their morbidity and their mortality, is well documented.

Let's discuss the issue of staffing level and staffing mix in residential care. One of the issues that has been discussed in question period over a number of days this session is the issue of....

Interjections.

J. Darcy: I'm sorry, hon. Chair. I'm....

The Chair: Minister.
Member.

J. Darcy: Thank you, hon. Chair.

We have spent some considerable time talking in this House during this session about the 3.36 hours of care that is the guideline for care per resident in residential care. My question to the minister has to do with whether or not his ministry has provided any advice, guidance or direction to health authorities beyond the 3.36 hours of discussion starter, which seems to have been in place for some time.
[1505]

It would appear that health authorities have, in some cases, developed their own staffing mix guidelines. For instance, in Island Health, there's a requirement, I understand, that contracted long-term-care providers meet that direct care hour

discussion starter that seems to have been in place for some time. It would appear that health authorities have, in some cases, developed their own staffing mix guidelines.

For instance, in Island Health, there's a requirement, I understand, that contracted long-term-care providers meet that direct care hour accountability for which they are

funded. But there is flexibility in those accountabilities, with the minimum of professional hours being 15 percent. Professions, as defined in the Health Professions Act, can include dieticians, occupational therapists and social workers. It would appear the hours of care per resident can vary depending on the professional percentage.

In Vancouver Coastal Health, I understand they have recently reviewed staffing levels and they're attempting to standardize it with a new model of a mix of 10 percent RNs, 22 LPNs and 68 percent care aides, with maximum number of RNs proportionate to facility size, which I understand was rolled out just last month.

My question is whether or not the ministry is planning to apply some consistency across health authorities, across the province — some consistency between funded residential care facilities. Just further to that, I know an increase in residential care fees back in 2010 2011 was supposed to standardize staffing across the sector. That clearly has not worked. What are the ministry's plans or intentions to standardize care?

Hon. T. Lake: When the changes occurred to client rates in 2010, we committed to ensuring all additional revenue would be invested to improve residential care services. In fact, that is what happened. Over $250 million of incremental revenue between 2010 and 2013 went into increasing staffing levels, increasing staff education and acquiring equipment.

Seniors in residential care obviously do not all have the same care needs. So 3.36 direct care hours is included as a guideline to help planning when health authorities are looking at moving forward and at the needs to help them with budgeting. But it is not a requirement at this time.

The mix of the seniors that are being cared for in the residential care facility will dictate the number of hours. In many of the health-authority-owned-and-operated residential care homes, the needs of the clients are higher. It is not unusual to see a higher number of direct care hours in those HA-owned-and-operated facilities.

In other health care residential care facilities, the needs are at a lower level. The staffing number of direct care hours can be lower, reflecting the lower needs of that population base. It is not a requirement. It's a guideline.

I know that the seniors advocate has been thinking about this. I remember this discussion when she first came on board. She was not at that time a proponent of mandating hours for every resident of residential care services based on a particular number. I know that she has been doing some thinking about that, and her opinions have evolved.

[1510]

I have asked my Parliamentary Secretary for Seniors, the MLA for Abbotsford, to work with the seniors advocate, to work with the community of care providers and with the ministry to look at the number of hours for client care in residential

opinions have evolved. So I have asked my Parliamentary Secretary for Seniors, the MLA for Abbotsford South, to work with the seniors advocate, to work with the community of care providers and with the ministry to look at the number of hours for client care in residential care. I look forward to seeing the results of that work later this year.

J. Darcy: I'd like to move on to staffing shortages in the area of health science professionals…

B. Routley: Thank you to the minister and his staff. I'm happy, because of the shortness of time, to try to lay down a couple of questions and then hear — either in writing or if there is a short comment.

I had a number of surgeons or doctors come into my office to tell me of their concern about cancellations of surgeries in the Cowichan Valley. While I'm sure this may be an issue in other areas as well, they tell me that there is no protected access to surgical beds and that they've had a number of situations where alternative level of care or AAP — assessed and awaiting placement — have ended up with such a large number that it's meant cancelling surgeries.

I'm also told that Victoria has 2.3 beds per 1,000 in population, and the Cowichan Valley has 1.3 beds per 1,000 in population. I don't know why we're the poor cousin over the hill, but that could be…. I do get it. Maybe I'll answer the question somewhat myself. I know, for example, that with a heart surgery I had, I was very appreciative of the highly skilled level of heart surgeons at Jubilee Hospital in Victoria. So there may be reasons to have some specialists in a centralized area. I get that.

The hospital is telling me, the surgeons are telling me, that we have a 15 percent cancellation rate for things like hip surgeries and other kinds of surgeries. So my question is: Is there a plan to either deal with protected access to surgical beds? Or to deal with the problem of not enough….? There's clearly not enough full-time home support or assisted living or complex care in the Cowichan Valley to deal with the problem. It's now becoming a crisis in the Cowichan Valley.

I guess question number one — again, that I'm not going to ask for a fulsome answer right now — is: is there a plan of any kind to deal with this crisis? We're hopeful that you're looking at the opportunity to have some protected access surgical beds, at least, to deal with the crisis that we right now have in a large number of cancellations.

Question number two is about the Cowichan Hospital. I don't know whether you can comment on that. For a number of years, now, the CVRD and all other volunteer groups have been saving towards having a new hospital. I'm told by the doctors that they're hoping to see that in a capital plan for 2016-17, that there have been comments made by VIHA — Island Health — about us, the Cowichan Valley, being somewhat of a priority.

[1845]

I would like to know if the minister can answer on that, whether there is some priority given the situation — a large number of seniors and the large population, a growing population of the Cowichan Valley — and certainly, the dire need and the fact that the hospital

if the minister can answer on that, whether there is some priority given the situation — a large number of seniors and a large population, a growing population of the Cowichan Valley — and certainly the dire need and the fact that the hospital is full to often overcapacity.

The third and last issue that I would like to comment on is the…. I've been meeting with the seniors and their families at Sunridge Place senior care facility. They recently had a dramatic change and did away with half of the LPNs and have gone to care aides. The quality of care has been impacted. Sunridge has 160 seniors in Sunridge Place. Effective March 28, they reduced the number of LPNs from one LPN per 20 to one to 40.

In summary, I would just say this care home with the new owner, which is Carecorp Senior Services…. Its management has reduced everything from food to staff. Now they've got a new in-home pharmacy. There are a number of areas that are impacting seniors. I just want you to be aware that I'm having a large number of constituents come in with concerns, everything from Cowichan….

When we had the Cowichan Lodge, there was a report done that said there needed to be continuity of care. We're not getting continuity of care with all these staff changes. There are complaints from the residents and their families about the quality of care.

I'll leave those three issues with you. If you care to comment now, or if you want to write me, I'm fine with that.

Hon. T. Lake: I'll keep my comments brief.

Hospital congestion in winter is not unusual in flu season. Now, this flu season was a little different than others in that the strain of flu that we experienced this year came a lot later. We did have congestion in a number of hospitals throughout the province, and Cowichan District Hospital was certainly one of them.

The member mentioned that the high percentage of alternative-level-of-care patients waiting for care in the community or placement in residential care was one of the factors. It points to what is often a challenge in health care, and that is flow. If one part of the system clogs up, it backs up through the whole system. If there is nowhere for surgical patients to go after surgery, then surgeries are cancelled.

I believe we have come out of that congestion period, which is good news. But then the question lends itself: "Well, how do we prevent this from happening with another flu season?"

Part of the response is ensuring we have residential care spaces available. Part of the response is looking at the changes that we're making to assisted living to provide more opportunities more assisted living. Part of the answer is looking at the increased supports for keeping seniors in their home longer so that they don't need residential care and so that frees up beds as well.

All hospitals deal with that congestion. Cowichan, I think, this year more than past years experienced it to an acute degree.

In terms of the hospital itself, Vancouver Island Health Authority has rated Cowichan District Hospital as its number one priority. But, of course, it has to fit into the provincial capital plan. I'll just do this very briefly because I know the Speaker is looking at the clock as we all are.

The capital plan over just the last number of years, in terms of completions: Surrey Memorial Hospital; Lions Gate HOpe Centre; Burns Lake Lakes District Hospital Centre; Kelowna General Hospital, Interior Heart and Surgical Centre; Fort St. John Hospital, Prince George B.C. Cancer Centre, Vernon Jubilee Hospital, Polson Tower; Sechelt Hospital expansion, Nanaimo Regional General Hospital expansion.
[1850]

Underway: Vancouver, B.C. Children and Women's; Joseph and Rosalie Segal family health centre at VGH; Queen Charlotte–Haida Gwaii general hospital; Comox Valley and Campbell River on the Island here; Kamloops, clinical services building.

Planning: Royal Columbian Hospital redevelopment, St. Paul's Hospital redevelopment; Royal Inland Hospital patient care tower, Vancouver General Hospital operating rooms.

The list is long, hon. Member. The good news

Comox Valley and Campbell River on the Island here; Kamloops clinical services building.

Planning: Royal Columbian Hospital redevelopment, St. Paul's Hospital redevelopment, Royal Inland Hospital patient care tower, Vancouver General Hospital operating rooms.

So the list is long, hon. Member, and the good news is that VIHA has identified it as their number one priority. Hopefully, as the economy grows and the revenues to government increase, we can continue to increase a record capital program and we can address the issues around Cowichan District Hospital.

In terms of Sunridge Place, if there are concerns about patient care we do encourage families to talk to the provider and, if unsatisfied, talk to the patient care quality office. Health care aids do a very good job and, hopefully, they will prove that in terms of the care that residents are receiving there.

Noting the hour, I move that the committee rise, report progress and seek leave to sit again…

HOUSE BLUES

TUESDAY, MAY 3, 2016

Afternoon Sitting

J. Darcy: The member for Coquitlam-Maillardville is going to take over for discussion about seniors care.

S. Robinson: Thank you for the opportunity to ask the Minister of Health a number of questions around seniors care. I hope that the minister and his staff will bear with me if there is some repeat. I haven't had the opportunity to follow everything that my colleague from New West was doing.

I am focusing strictly on seniors. I do have some high-level questions that relate to the minister's mandate letter, so I thought I would just start there at that high level. Then I have some questions about service plan measures related specifically to seniors, then a couple of questions about the seniors advocate, the doctors' fees as they relate to some of the seniors and some questions about Better at Home. Then I have some other questions that will be coming back up next week.

I'm hoping to get through that over the next hour if that's possible. If not, I guess we'll carry on when I have the opportunity to come back here again.

I'm very interested in points 13 and 14 in the minister's mandate letter — in particular, "undertake a review of dementia care," given that dementia affects mostly a senior population. I want to know where the minister is at with that, what he's learned and what we can expect from this the Ministry of Health regarding dementia care.
[1635]

Hon. T. Lake: The provincial dementia action plan was created in 2012, and some notable achievements in that time were updated HealthLink B.C., SeniorsBC and home and community care websites, as well as print resources with information on brain health, planning for healthy aging, living with dementia.

Also, and the member is probably aware, another $2.7 million was announced for the expansion, continued function of the Alzheimer Society of B.C.'s First Link program. That's on top of the $4 million that was announced a couple of years ago.

We've funded health care professionals in the PIECES training, which is a psychosocial approach to detection and assessment of care planning for people with dementia. As of December of this past year, over 15,000 health care providers had been trained over 226 facilities in the province.

We've implemented the 48/6 model of care for hospitalized seniors. That means that in acute care settings, screening and assessment in six key areas — including cognitive functioning and the development of a personalized care plan in 48 hours — is occurring.

I should mention, too, of course, one that's obvious — and I don't want to overlook — is the formation of the office of the seniors advocate, which is the first of its kind in Canada, and the extensive work that that office has already accomplished.

What we have done is take a look at the 2012 plan, and in response to the need to refresh it, we have provided — or are going to release over the next month — a provincial guide to dementia care in British Columbia. So this is an updated plan. This copy is relatively hot off the press. It is dated May 2016. A draft has gone out to the health authorities. This is just going through final approvals and then will be released in the next month.

[1640]

It, essentially, looks at four different priorities: (1) increase public awareness and early recognition of cognitive changes; (2) support people with dementia to live safely at home for as long possible and support caregivers; (3) improve quality of dementia care and residential care, including palliative and end-of-life care; and (4) increase system supports and adoption of best practices in dementia care.

S. Robinson: So I guess my question was timely. I look forward to seeing what the next phase is, and I'm sure that the minister will fire off a copy as soon as it's publicly released. I appreciate the four areas and look forward to reading what's up next for this action plan.

I was going ask these questions a little bit later, but given that the minister raised them, around First Link, I thought maybe I'd just dive into that, because he raised it. My understanding is that there have been several announcements for First Link over the last number of years. I believe it was 2007. Perhaps the minister can just give me an overview of the funding that First Link has received over time and what the intention is in terms of ongoing funding. Is that going to be a regular funded program, or is it that each year there's a decision made around the table about whether or not to fund this program?

Hon. T. Lake: The Alzheimer Society of B.C. carries out the First Link program. It provides education and services for individuals, families and caregivers that are affected by Alzheimer's, as the member is aware, as well as other forms of dementia. We have provided…. I have to update this because on the weekend we announced another $2.7 million. My note here says $10.7 million, so we can increase that to $13.4 million to fund the First Link program.

There are currently 12,500 people participating in the program. In 2015-16, just under 2,000 people were referred to First Link by a health care provider. There were 1,900 self-referrals. The Alzheimer Society reports that about 50 percent of First Link referrals are made by an individual or a family.

In terms of how we fund it, we work with the Alzheimer Society. We look at…. For instance, the $4 million that was announced two years ago was to expand the

program into more rural areas of the province. Now it is virtually in almost all communities throughout the province.

We have an ongoing dialogue with the Alzheimer Society as to their needs. The $2.7 million that we have provided through year-end funding from 2015-16 will take them through 2017. But it's an ongoing discussion that we have. We want to, with these types of funding commitments, have an ongoing discussion and an evaluation of the program. Everything we've seen from the First Link program to date has been extremely positive. I know from personal conversations with families that have utilized the program that they're extremely grateful for it. It is a vital service to provide them with the supports they need when they're confronting such an impactful disease.

In terms of the funding, it is an ongoing discussion that is carried out on a year-by-year basis, but we want to make sure we're setting the table for at least a year ahead of that so that we're not having an organization fall off the cliff before we get to the next funding opportunity.

S. Robinson: I appreciate that there have been ongoing supports, to date, for this program. I, too, have heard some good things about it.

But I've also worked in the non-profit sector, and I'm sure the minister can appreciate that when you get year-by-year funding, even though it's a year out, it makes it very difficult for any organization to plan, to vision and even to hire staff because you have no idea from one year to the next. I hope that the minister agrees that this isn't the best way to get programs off the ground and operating.

It has been operating for some time, and there's been some good feedback. I'd be interested to hear if there is a vision or a plan or an intention to actually fund the program in a way that allows the organization to carry out its responsibilities and make sure that it has some stable funding going forward.

[1645]

Hon. T. Lake: Well, I think it actually is a good way to get programs off the ground and test them, with year-end funding. But I can see the member's point that once they have reached a level of maturity, a decision needs to be made on sustainability. It is not unusual…. I'm trying to think of an example off the top of my head — staff will be frantically, in the next room, searching for one — in which we have started a program with year-end funding and then we have rolled that into a line item, either through health authorities or through the ministry.

There are opportunities to do that, but I think when we're starting a program and expanding a program throughout the province, the year-end funding model is not necessarily a bad thing. But there does come a point, to the member's point about sustainability of hiring and certainty, where you need to regularize those positions, if you like, and so that is a source of discussion. We are in those discussions with the Alzheimer Society of B.C.

S. Robinson: I'm glad to hear that that is part of the discussion and that the Minister of Health has an appreciation for that kind of programming and the need for certainty and sustainability. I certainly hope that becomes a regular line item, given its importance and its role. We know that there is going to be more demand and more need, and it's going to need to continue to grow.

I will backtrack again, back to the mandate letter. Item 14 in the mandate letter asked the minister to work with his parliamentary secretary and the seniors advocate to provide an update on seniors care improvements in the province. I would be very much interested to find out when there will be an update provided. "To cabinet" is what it says, but I'd be interested in finding out when there will be an update provided to British Columbians.

Hon. T. Lake: Yes, we did answer this question yesterday. We don't discuss what we talk about in cabinet. However, I am happy to share and have shared the fact that our parliamentary secretary, the MLA from Abbotsford, is working alongside our ministry, working with the office of the seniors advocate and with the community that provides many of the services that seniors enjoy in the province of British Columbia on various issues.

Now, the seniors advocate obviously looks at a wide range of issues. The parliamentary secretary is currently reviewing the hours of care and whether there should be a more prescriptive approach to hours of care. There are opposing views on that issue. The seniors advocate has told me that her views have evolved and changed over time.

We want to canvass those views. We want to look at best practices around the country. The parliamentary secretary will report back to me and up to cabinet through me.

But I would say that the office of the seniors advocate is, in fact, doing and reporting to us — and to the public directly, which I think is refreshing — exactly the challenges that we are facing in terms of a demographic that's aging. One of the arguments that I've been making to the federal government is that that needs to be recognized in terms of the Canada health transfer and the participation of the federal government in health care in all provinces.

S. Robinson: I'm sure the Minister of Health can appreciate that when the mandate letter, which is a public document, says that the Minister of Health is to work with his parliamentary secretary and the seniors advocate to provide an update to cabinet, at some point there would be some expectation or some acknowledgment that the public would be very interested, after it got to the cabinet table, to hear what the parliamentary secretary and the seniors advocate have had to say.

So while I appreciate that it's perhaps the first place for that information to go, it needs to go beyond that. I would like to know if there are any plans to take that beyond the cabinet table and out into British Columbia.

Hon. T. Lake: I have made presentations to cabinet committees and to cabinet as outlined in my mandate letter.
[1650]

S. Robinson: While I appreciate the response, it's not quite what I was intending. It sounds a little bit cheeky, but I will move beyond that. While the minister does say he did report to cabinet, I think he knows full well that it's not so much that he reported to cabinet. I think British Columbians would want to know what the update was on seniors care improvements.

I do believe that when something is in the mandate letter, and while the mandate letter says "bring this to cabinet," British Columbians are going to be very curious about what the outcome of that was. It's not "did he bring it to cabinet?" but "what was the content of what he brought to cabinet?" Perhaps the minister is able to answer that question — not that he reported to cabinet, but will there be a time that he anticipates that he'll be able to report out to British Columbians about seniors care improvements?

Hon. T. Lake: Well, we have, as I said, the office of the seniors advocate. Her responsibility includes reporting to British Columbians on the state of seniors care in British Columbia. She is doing that; she will continue to do that. The evidence of the action that government takes will be included in her reporting to the public.

One of the things that we have done in response to the Ombudsperson's report and to one of the seniors advocate's reports is to pass legislation this session that makes changes to assisted living so that people can stay in assisted living longer and don't have to go into residential care when they can stay in place in assisted living. That is something that is in response to the seniors advocate.

We will be in consultation, over the next year, in terms of the regulation with the sector, to ensure that health authorities and the assisted-living and residential care–living sector can plan their development of spaces in assisted living and residential care moving forward. The mandate letter was to make sure that cabinet is informed of the progress we're making. The seniors advocate does a very good job of reporting to the public what the government is doing, and I commend her for the way she's been able to do that.

S. Robinson: Given that the minister keeps deferring to the seniors advocate's reports, why don't I just shift on over to that office? I have a number of questions about that office.

It started back in 2014. I think it came out of some of the private members' bills from this side of the House, so I'm glad to see that government does actually take some advice and recognizes the role for a seniors advocate for the province. That's a good form of compliment, I would say.

At this point, the office has been up and running for a couple of years, so perhaps the minister can…. I know that she reports…. She's not a truly independent office. She's

not an officer of the Legislature. She reports to the Minister of Health. Can the minister tell us what the budget is for this office?
[1655]

Hon. T. Lake: The office of the seniors advocate is allocated through the stewardship and corporate services budget and has a base budget in 2015-16 of $1.6 million; in 2016-17, $1.8 million; and then in 2017-18, $2.06 million.

However, the needs of the office change from year to year, because if they're doing surveys, for instance, they will use a contractor to do those surveys. So there's a discussion at the ministry level. The office of the seniors advocate will say: "We need to do this in the coming year; therefore, we're going to need to have more professional services." Within the ministry, as you can imagine with a ministry this large, there are a lot of professional services that are contracted out for studies, for consultants, things like that. So the office of the seniors advocate will make the ministry aware of their needs.

So in fact, the overall budget for the office of the seniors advocate in 2015-16, with the professional services that they required, was $3.1 million. In 2016-17, it's estimated to be $4.27 million. That should go back down in '17-18 to $2.5 million, because the extensive surveying work that's being done in the '16-17 year will not need to be redone in the following year.

So while the base budget is going up, the amount they actually spend year to year will change, depending on the professional services that they require — to do surveys, particularly.

S. Robinson: I certainly appreciate getting an inside look about how the office operates in terms of its work.

I imagine there's a work plan set out, and that the budget request is based on a work plan. Is that work plan a public document so people can anticipate what's coming up from this office in terms of the kinds of surveys that are going to be happening?
[1700]

Hon. T. Lake: The office of the seniors advocate does notify the public about the kind of work that they are planning to do. This is a very busy office.

Just to recap briefly, *The Journey Begins: Together, We Can Do Better* was October 2014; *Bridging the Gaps,* March 2015; *Placement, Drugs and Therapy,* April 2015. I spend a lot of my weekends reading the office of the seniors advocate reports.

During 2015-16, the OSA released four reports — *Seniors Housing in B.C.: Affordable, Appropriate, Available* in May; the annual report was published in August of 2015; *Caregivers in Distress,*September 2015; *Monitoring Seniors' Services*, 2016. That's the one I was referring to when we talked about how we're doing. That is one of the major reports that provides this information to the public.

Planning, going forward, the residential care facility directory was just released in February; the home support report is coming up very shortly; and later this year, the

resident-on-resident aggression report. Emergency department experience of seniors is coming up this year. A review of PharmaCare is coming up later this year; supplementary benefits later this year; residential care and the residents' voice, in 2017; and transportation, in the spring of 2017.

S. Robinson: That was very helpful in terms of what we can expect to find. I went looking through the website, and I will admit that I didn't dig a whole lot. Generally, it's a pretty easy website to find historical reports. But is this anywhere on the website, where you can see what's coming, what the plan is, so that the public can access the information?

Hon. T. Lake: Not all of that information is currently on the website, but it can be put on there, and we will discuss that with the seniors advocate.

S. Robinson: I appreciate the willingness of the seniors advocate's office to do that, mostly because I think people really want to know. They're very interested in the reports. They've been very robust and very thorough. Anticipating what's coming next I think is helpful for people, and knowing what the plan is over the next couple of years — that if this is the area that she's going to be exploring, then that would be helpful for the public to know. I appreciate the willingness to do that.

I'd like to move off of the seniors advocate. I have a couple of questions around some service plan measures that have to do with people 75 plus that are getting long-term home care and support, and more accountability measures in terms of how we are doing and what the status is.

I'm particularly interested in what targets government has for making sure that the rate of people age 75 plus receiving long-term home care and support is on track. I'd like to hear more about what the minister is doing to monitor that, given that we know that that population bulge has started and that it's going to proceed. I would like to hear more about how that's progressing.

[1705]

Hon. T. Lake: Through to the member, I apologize for the delay. I may need you to refine the question for me. I hope I'm answering it in the way that you framed it, but if I'm not, please let me know.

Home support, including CSIL, which is the community supports for independent living program — if we look at 2013-14, there were 40,374 clients, which was a 23.69 percent increase from 2005 to 2006.

Interjection.

Hon. T. Lake: Sure, yes.

Again, this is all ages now, not just the 75-plus. There are some people, particularly in CSIL, that would be younger.

[1710]

In 2013-14, there were 40,374 clients on home support or CSIL — again, a 23.7 percent increase from 2005 to 2006. In terms of the number of hours, there were 10,970,414 — again, that was 2013-14 — which was just about a 36 percent increase from 2005-2006.

I don't have numbers from '14-15, '15-16, but if I remember correctly from the seniors advocate report, we have seen those numbers drop a little bit in some cases, in some health authorities. Some of that is due to rationalization of services where some home support was overlapping with services that were provided by other services like Better at Home. But the seniors advocate, as mentioned, is doing a comprehensive report on home support later this year.

S. Robinson: It's kind of the ballpark of where I was asking. I'm just interested in finding out how the numbers are changing and what service targets are. If the minister can also add in what the service targets are and whether we are meeting them, exceeding them or falling short.

Hon. T. Lake: Again, I want to make sure I've got the right…. I'll give the answer, and you can tell me if I've got the question correct.

Clients are charged an income-tested fee, so that's a client rate. Well, we can get into a long discussion about the Canadian health care system, but home care is delivered according to need and according to ability to pay. Clients are charged the client rate. In 2016, approximately 68 percent of clients will have a client rate of zero and, therefore, not have to pay any fee to receive home support services.

S. Robinson: I appreciate the information, but I'm interested in the service target area, so service targets. When a work plan is put together, it says, "We want 70 percent of those 75 plus to get care within 30 days" — whatever the service targets are. I'm interested in learning a little bit more about what the service targets are for home support and for long-term support for our most vulnerable population. I picked 75 plus because it is the more vulnerable population, of course. If the minister has those numbers around what expectations are and our ability to deliver.

[1715]

Hon. T. Lake: We don't have service targets for the number of people receiving home supports because it will vary on an individual basis and on a population basis, depending on the health authority. If you look at the demographic in Fraser Health, for instance, it's quite different than it is for Vancouver Island. And each individual is assessed using a RAI, which is a resident assessment instrument. They are assessed by a professional that will look at their needs and determine the level of care that they require at home or whether or not they need to go into complex residential care. That's how individuals are assessed.

In terms of where we're moving…. I think that's what the member is getting at: "Okay, where do you see this moving and what kind of targets do you have?" Our goal

is to keep people in their homes and in community longer rather than relying on the acute care system as much — so not allowing older people to tip over the edge where they end up in the emergency department, end up in an acute care bed waiting for placement in residential care, or in some cases, not even going home at all. That's what we're trying to avoid.

We are going to look at the seniors advocate report on home supports, which she is doing. But we are taking proactive steps to manage and support people in community through a repositioning of health care for older adults project.

This is a prototype project that involves different health authorities. In Interior Health, we've got Kelowna and Kamloops involved. In Vancouver Coastal, we've got North Shore and Vancouver city centre. In Island Health, we've got Cowichan Valley, Comox and Saanich Peninsula. In Northern Health — Prince George, Vanderhoof. In Fraser Health — Langley, Mission and Abbotsford.

Each of these groups are developing resources to support home health delivery of things like palliative care — the development of consult teams and looking at the beds and spaces necessary for palliative care. They're looking at a multidisciplinary geriatric wellness centre. They are developing a similar multidisciplinary geriatric wellness centre at Ponderosa in Kamloops.

They are reaching out into community, proactively, almost in a way that tries to catch people before they tip over and end up in a critical situation. This is prototype work that's being done and is starting to crystalize. As I mentioned, Kamloops and Kelowna are starting their geriatric wellness centres.

We expect this kind of project will be expanded through health authorities once we are able to demonstrate success and learn from each other, because as I said, each of these prototype communities is doing things a little bit differently. We bring all the groups together to discuss the successes — what seems to be working, what other communities can learn from each other. It is an evolution of care.

We've talked a lot about reaching out into community. The changes we've made to the Community Care and Assisted Living Act are part of that. While we don't put targets to it, we look into the future to see how we can change primary and community care to keep people in their home — whether that's an apartment, whether that's their own home or whether that's in assisted living or in residential care.

S. Robinson: I appreciate learning a little bit about the repositioning of care for older adults. But I would imagine that any time you start a new project, you take some baseline data — how else do you know whether or not it's successful? — and that you're going to be measuring some performance indicators, because again: how would you know that you're successful?

I know that the minister, it sounds like, is looking at changing models. You've done that with First Link. You try it out, you measure it, and then you take the measured data and you say, "Has this worked, or hasn't it?" before you actually pour more dollars into it.

[1720]

I would like to know what sort of baseline data the minister is going to be using in order to assess the success of this program.

Hon. T. Lake: In our service plan for 2016-17 through 2018-19, performance measure 3 is: managing chronic disease in the community. The performance measure is the number of people with a chronic disease admitted to hospital per 100,000 people, aged 75 years and older.

This is getting at that idea of not allowing people to tip over and end up in the emergency department. The baseline for 2014-15 is 3,194 people per 100,000, age 75 years and older. The measure for 2016-17 is 3,184; for '17-18, 3,063; and for '18-19, 2,942.

S. Robinson: That's helpful. That was chronic disease that I believe the minister…. What numbers…? I've actually pulled off of a service plan for 2014-15 to 2016-17 item 3, which is the rate of people aged 75 plus receiving long-term home health care and support over per 1,000 people.

This is from 2014-15–2016-17, and there were no actuals for 2014-15. It hadn't identified whether or not the target had been met. Perhaps the minister can go back and let us know how that played out and what it's going to look like going forward.

Hon. T. Lake: I guess I need some clarity. Was the member quoting from the 2014-15 service plan?

Interjection.

Hon. T. Lake: I'm sorry. I don't have that information. What I have is a comparison between the 2015-16 service plan and the 2016-17 service plan. I think the measure that she's talking about, though, probably changed between 2014-15 and '15-16, so I don't have that evolution.

For instance, in terms of seniors care, the changes that we implemented from '15-16 to '16-17 were to provide end-of-life care services, including hospice space expansion, home-based palliative care and clinical guidelines to support those at the end of life with greater choice and access to services. That has been moved to objective 2.2. To improve the home and community care system, including the use of technology — that has been moved to objective 2.2.

[1725]

Then the new objective is the "improved patient health outcomes and reduced hospitalizations for those with mental health and substance-use issues through effective community services."

The GP for Me measure was replaced with the one I just mentioned about the chronic disease management and the reduced rate of hospitalizations.

S. Robinson: If I am to understand correctly, then, this idea of tracking the rate of people aged 75 plus that are receiving long-term home care support — that's no longer part of what's being measured? Is that sort of from year to year that — I'm just generally speaking — you like to track these things?

Hon. T. Lake: It's not that it's not tracked, but the service plan, of course, is an overview and has sort of major objectives. That objective was changed from 2014-15 when the new 2015-16 service plan was composed, but we still track the number of home care hours. I'd mentioned earlier the number of hours that are being given.

I think the realization is that we don't want to put, necessarily, a target and say that we should have more people receiving home care. The objective would be to make sure people aren't ending up in hospital so that individuals are managed, rather than numbers. Through the new prototype community approaches and with the home care report from the seniors advocate, we certainly will continue to track the number of home support hours that are being provided. But to say that we are reaching out for a certain number, I'm not sure is the best objective.

If we're doing our jobs correctly, people will be healthier and not need as many services. If we can proactively reach out to seniors living at home — and community paramedicine is part of that objective — if we can intervene and educate and support, they may not need the level of care that they otherwise would if those things hadn't been done.

S. Robinson: I appreciate the minister and his staff taking the time to answer my questions. I will be back next week with some more questions, and I'm going to take my seat and allow my colleague from New Westminster to continue.

. Darcy: If I just can summarize the minister's answers to some of the questions that I've asked so far. We're talking about health care. The minister has confirmed that the increase in the Health budget is 2.9 percent, 3 percent — roughly, a $522 million increase — and that health care inflation the minister estimated to be approximately 2 percent. He said — and, of course, he's right — that inflation in health care is not the same as a basket of goods, as calculated under the CPI.

The minister has indicated that the aging population accounts for 0.7 percent. CIHI actually says 0.9 percent. But even if we take the minister's figure of 0.7 percent, the aging population…. Sorry, the population increase, the minister referred to as 1.2 percent. That means, even without getting into…. The minister says $160 million for the new nursing positions, from which you would have to deduct various things — I understand — but deducting figures that are not yet known and not yet proven.

We also have an additional $72 million budgeted for PharmaCare. Even without getting into the increased ambulance service and MRIs, it seems to me that the commitments that have been made and the expected increases — because of aging population, because of population increase, because of health inflation — already have eaten up more than the entire budget increase that the minister has projected.

It is very difficult to understand — with those announcements, with those additions and with those costs that the minister has agreed with — how the minister could not be planning to make some significant cuts in various health care programs in order to pay for those expected increases and those new programs. What is the minister planning to cut in order to meet the budget?

Hon. T. Lake: Well, again, the member, I think, is oversimplifying the situation. The member's contention is that nothing will change, that we'll just continue doing what we are doing, just at a higher level in terms of the percentage increases. The reality is: we understand that to have a sustainable health care system, you do have to change things.

[1550]

When Fraser Health, for instance, says, "We've got too many people sitting in what we call alternative level of

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care beds in our health authority; we are going to create 400 new beds in community for complex care patients in residential care, but we're going to close 78 or 80 beds in the acute care system, those alternative level of care beds," that will result in (a) better care, because they're in the appropriate environment, and (b) savings, because each of

those acute beds — the alternative level of care beds in an acute facility — will cost, on average, four times more than a bed in a residential care facility.

The member's contention is that we just keep doing the same thing rather than changing. I know the member has read all of our strategic priorities for the health care system. This team worked extremely hard for over a year when we came into the ministry in June of 2013 to develop the strategic priorities.

Those priorities address the need in an aging population to do things differently, to look after people in their homes longer, to provide help in community — that would be assisted living in residential care — so that we're not as reliant on the high-priced acute care facilities that were really built for a younger population and a style of medicine that was more suited to the 1970s than it is to 2016.

I would contend that by having a 2.95 percent increase in our budget and making the changes in the direction outlined in the strategic priorities for the health care system in British Columbia, we actually will be able to improve care within the budget that we have been allocated.

J. Darcy: Thank you to the minister. I want to turn to commitments that the minister has made in the past and that were set out in mandate letters for the minister in the past and compare some of those past mandate letters with present mandate letters. I think that will….

In addition to the issues that I've raised already today — about programs and funding that the minister has committed to but that it's not clear to me that money exists in the budget to fund — there are a number of other commitments that I would like to understand the status of. This is based on looking at the 2015-2016 mandate letter and going back and examining the mandate letters for the last couple of years preceding it.

For hospice spaces, in 2013, there was a commitment to double the hospice spaces in British Columbia by 2020. In 2014, the commitment changed to "work with Treasury Board and Finance to develop a plan and begin the process of doubling hospice spaces by 2020." Then by 2015, it was simply "provide an update to cabinet" on the plan to double by 2020.

Can the minister please explain what the status is of doubling hospice spaces by 2020, which was the commitment in 2013?

[1555]

Hon. T. Lake: I just want to make the point that the commitment hasn't changed. The mandate letter changes in terms of: "Okay, this is what we said we wanted you to do. Now how are you doing? Report back. Go to Treasury Board to make sure you've got the resources necessary."

The commitment is the same — to double the number of hospice spaces by 2020. These are a combination of health authority beds that would be either in hospitals or

in other forms of tertiary care and then community hospice beds. The number of beds, as a baseline, is 375. We need to get to 750 to meet the commitment by 2020.

Planning is ongoing. At this point, we have 104 beds planned in phase 2. That would be in 2015-16, ’16-17 and ’17-18. Those have been planned. Another 52 beds in phase 3, and that would take us to ’19-20. That’s not the end of 2020, obviously. So there are 219 beds that still need to be filled in that process, and those beds are still being planned.

We’ve got three phases of the plan in place. They’ve been identified — where those will go in terms of which health authority will receive additional beds. But there are still 219 in the planning process to get us to the 750 number that is in the commitment.

J. Darcy: If the minister can please indicate…. The commitment was in 2013 — double the number of hospice beds by 2013. How many of those beds have already been created?

Hon. T. Lake: New beds completed to date total 29. As I mentioned, in phase 2, there are 104. In phase 3, 52. That would bring us up to the 531 mark. So there are 219 beds that are still being planned.

[1600]

J. Darcy: Looking at addiction spaces, in 2013, there was a commitment to significantly increase the number of addiction spaces by 2017. It was reiterated in 2014: deliver by 2017 and, in 2015, provide an update on the status by December 31, 2015.

Can the minister please clarify what was the starting point from which he’s measuring progress? In his update on December 31, 2015, how many addiction spaces had been created? How many will be created in the coming year? Because 2017 is next year.

[R. Chouhan in the chair.]

Hon. T. Lake: The baseline of substance-use beds in the province that the commitment is measured against is 1,104 beds. With the additional 500 beds, then the expected number by the end of 2017 would be 1,604.

To date…. Well, first of all, I should explain that the plan was broken down into three phases, and it was informed by a planning process conducted by the Centre for Addictions Research of B.C. and community consultations. It provided health authorities with estimates of

demand for various types of substance-use services and a description of need by geographic area among subpopulations.

So a three-phased approach, and to date, in planning and implementation, we have 220 beds open in phases 1 and 2. There is still a gap there of 280 beds that need to be planned and implemented by the end of 2017.

[1605]

There's been considerable discussion with the health authorities about what constitutes a bed. Again, the goal was to increase the resources available for substance-use recovery and treatment, and there are different schools of thought on how best to provide that. There has been discussion about mobile withdrawal management spaces and home-based withdrawal management spaces, because not everyone would need an institution-based kind of program.

That is an ongoing discussion with health authorities, and there may be some discussion around the best approach to meet those 280 bed equivalents, if you like, as we approach the phase 3 part of this target.

Again, because I know the member will ask, this is part of the commitment that we have made, that we expect health authorities to be able to manage within their budget. The estimated operating cost for the 500 beds is expected to be in the range of $20 million to $40 million.

So again, in the context of budgets to regional health authorities, which — I don't have the line in front of me — is about $12 billion, we're looking at a relatively small incremental cost for this particular service to patients that would result from savings that accrue to this shift, outlined by the strategic priorities, to have less of a reliance on the higher-cost acute care system.

J. Darcy: So I just want to be clear. The commitment was for 500 new addiction spaces to be delivered by 2017, which is a year away.

The 220 that the minister referred to in planning or implementation — how many of those already exist? How many have actually been created? Not planned for, not implemented — created.

Hon. T. Lake: To date, 144.

J. Darcy: That means that by the end of next fiscal year, the remainder, to take us up to…. That's 356, if I'm doing a quick math — in the next year.

The minister gave a range of cost — $20 million to $40 million. Did I hear that correctly? That's a big range, $20 million to $40 million, especially if we're talking about an additional 356 addiction spaces in order to meet the commitment.

How does the minister expect health authorities to absorb that big of a number in the remaining year of that commitment?

Hon. T. Lake: I stand corrected, hon. Member. There were 76 opened in phase 1; 144 in phase 2; so there's a total of 220 that have been opened. The gap is 280 between now and the end of 2017.

Is it a challenge? Yes. In terms of the cost, I mentioned that the annual operating cost for the extra 500 — so, again, 220 are in place already — is in the range of $20 million to $40 million, on a total budget for health authorities of about $12 billion.

J. Darcy: I neglected, when I asked about hospice spaces…. Can the minister please give the cost of doubling the number of hospice spaces that we talked about previously?

[1610-1615]

Hon. T. Lake: The cost of a hospice bed will vary on a number of things — number one, the type of hospice bed. A stand-alone hospice, for instance, is more expensive than a hospice space that is part of an acute care hospital or part of a residential care hospital. On average, it's estimated that the cost of a hospice space, on a year-to-year basis, is about $300 to $400 per day.

Not all of those beds would be operated every single day of the year, because they wouldn't all be full all year. But within that estimate, the 375 spaces, order of magnitude of costs, our estimated costs…. Again, without the plans in place and seeing what kinds of beds are needed in what community, it's hard to be exact. Again, the estimate would be $20 million to $25 million a year.

J. Darcy: I hesitate to ask some of my remaining questions, because these were the easy ones. Perhaps what I'll do is…. For the times when I'm asking for numbers and it would appear that it will take some considerable time for the answer, the minister could indicate that he would be happy to get back to me and provide the information tomorrow, just so that we can move things along. Would that be acceptable?

[1620]

Interjection.

J. Darcy: Perhaps.

The Chair: Member, continue.

J. Darcy: Well, you know, it would make better viewing for those hundreds of thousands of people who are tuned in to Health estimates and are following this, with rapt attention, from one corner of British Columbia to the other.

How about I put some questions on the record, and the minister could perhaps undertake to provide the information for tomorrow? These are some issues we would like to pursue further. The mental health plan….
[Page 12581]

Hon. T. Lake: To the member: I'm not going to commit to a certain style of answering questions. If you ask the question, I will do my best to answer. If I don't think I can get you the answers within a reasonable period of time, we will provide them to you. But I won't be held to a standard of questions that I don't feel is appropriate. We're here to debate the estimates of the Ministry of Health, and I'm prepared to do that.

J. Darcy: With respect to the minister, we're also here to canvass as many possible issues as we can. If we can expedite this by getting answers and the minister getting back to me, as he often has in the past…. But I guess that's the minister's decision.

Again, in the mandate letters, 2013 refers to "full implementation of the provincial mental health plan"; 2014 refers to the same, "full implementation of the mental health plan *Healthy Minds, Healthy People*"; and 2015 says: "Ensure renewal of the balance of the provincial mental health plan."

Can the minister please provide the figures, either at this time or for tomorrow, about the cost of fully implementing the mental health plan? What of that cost has already been expended, and what is expected over the next budget year?

Hon. T. Lake: The mental health plan — *Healthy Minds, Healthy People* — is a ten-year plan, and the commitment is to renew the last half of that mental health plan. There also is work ongoing with the cabinet working group on mental health. There is no specific dollar attached to the mental health plan. It is embedded in the increases that we see on a year-to-year basis. We currently spend, I believe, $1.42 billion on mental health and substance use per year in the ministry.

Again to the member: this isn't about doing the same things that we've always done. It's about doing things in a different way to achieve better outcomes. A good example of that is the child and youth collaborative, which was to work with health authorities, with primary care physicians. It was a good partnership between the government and the Doctors of B.C. to increase the connectivity of services in child and youth mental health. That is doing something different that doesn't require, necessarily, additional operating dollars on a year-to-year basis.

To the member's contention that each commitment needs to have a line item, my contention is that that would be true if we were doing the same things, but we're not. We're doing things differently. We are making sure that the priorities of the B.C. health care system, as identified in the strategic papers that we have presented, are being met, both by the ministry and by regional health authorities. It's a matter of

doing things differently to get different outcomes within the 3 percent budget increases that are in the three-year budget for the Ministry of Health.

J. Darcy: The minister has spoken on many occasions…. The discussion papers of the ministry certainly speak to the importance of taking pressure off our acute care hospitals so that patients are cared for appropriately in the appropriate place, whether that's residential care, assisted living or in their own homes.

[1625]

Can the minister please set out what the government's commitment is to creating new residential care spaces, new assisted-living spaces and expanded home support, and what are the dollars? How many spaces — residential care — and how many assisted-living? What's the increase in home support that the minister envisions? What's the cost of that over the next year and over the next three years?

Interjection.

J. Darcy: That would be fine. If he has the answer now, that would be great too.

Hon. T. Lake: Just a little bit of context, if I may. The spending on community and residential care currently is $2.92 billion, which, compared to 2001, is a 79 percent increase. That's a reflection of needing to catch up, which we did in the early 2000s, and 6,500 beds have been added in that time.

Now, I don't have in front of me the plans of every health authority in terms of number of beds. We did mention earlier that Fraser Health is looking at 400 additional beds.

Some of that planning will be developed in the consultation process that will take place over the next year with the passage of the Community Care and Assisted Living Act. As the member well knows, this act has been changed so that there's more flexibility to keep people in assisted living rather than having to move on to residential care. That will shift the demand for assisted living and the subsequent demand for residential care.

During that consultation period over the next year, we'll have a better sense of how many new beds in residential care will be required versus assisted living. Currently, health authorities plan using demographics. So if I may…. The majority of people in residential care, for instance, would be older British Columbians. So if we look at the 85-plus age group, that is 2 percent of our population now and will grow to 3 percent of our population by 2025.

We're going from 110,890 British Columbians over 85 to 162,000 in 2025. That's the figure that health authorities use to decide the demand moving forward, but

it will now change because of the changes that we've made to the Community Care and Assisted Living Act.

Hon. Chair, with that, if I might request a health break for a few minutes.

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The Chair: The committee will be in recess for ten minutes.

The committee recessed from 4:30 p.m. to 4:42 p.m.

[R. Chouhan in the chair.]

J. Darcy: I just want to revisit the last question that I asked before the break. I certainly appreciate that the changes to the Community Care and Assisted Living Act will mean that there are a certain number of frail seniors who will be cared for in assisted living, but we're talking about a change from two services to more than two services. We're still not talking about the majority of the frail elderly population in residential care.

I think what the minister essentially said when…. I asked the question about what the plans of the ministry are as far as new residential care beds, new assisted-living beds and increased funding for home support. His answer was that, essentially, it depends. It seems to me that only part of it depends. That part is: what's the potential shift of a certain number of seniors — not the majority, I would estimate — being able to be cared for in assisted living, rather than residential care?

Can the minister please answer the question, which is: what projections does the ministry make about increased numbers of residential care beds, assisted-living beds and increased support for home support?

Hon. T. Lake: Well, I thought I explained extensively how health authorities plan. They base their planning on growth of the population, on the aging of the population. That varies within each health authority. The consultation over the Community Care and Assisted Living Act changes will help to inform and refine those plans. Health authorities know what's coming at them in terms of the aging of the population. They make their plans based on those changes.

Now, however, with the changes that we've made…. They were identified by the seniors advocate in a report that showed that up to 15 percent of people in British Columbia in long-term residential care could still reasonably live in assisted living. That prompted changes to the Community Care and Assisted Living Act to allow that to happen. So that will change the balance.

[1645]

Over the next year, health authorities will be engaged, along with the care providers in that space, to determine what the new demand will be in assisted living versus residential care. It may affect the number of residential care spaces.

I guess I need to make the point that with a regional health authority, we don't have micromanagement from the ministry. We have oversight by the ministry.

The ministry created priority papers, which I mentioned, in February of 2014. There were five major areas: access to primary care; primary and community care, particularly with frail seniors; primary and community care with mental health and substance use; rural health; and access to surgical treatments and procedures. Each health authority has a different way of meeting those major areas of priority that have been identified by the ministry.

The ministry didn't do this in isolation. We did this with extensive consultation with health authorities, with experts in health policy, and using extensive informatics of the B.C. population today and into the future.

Each of those health authorities develop their own plans. We have a leadership council that is comprised of senior ministry officials and the CEOs of each of the regional health authorities. They do an update to the ministry on how those plans are coming. I also meet with the CEOs and chairs of the health authorities on a regular basis.

We did extensive bilateral sessions, one-on-one with the ministry and the chair and the CEO of each health authority, in October of 2015. We set aside the better part of a day to go through, with each health authority, how they were going to meet — and do a check-in on the development of their plans — those five priority areas.

If the member had the opportunity to question the CEO of each regional health authority and the Provincial Health Services Authority in this forum, she would receive more detailed answers in terms of what each of those health authorities are doing to meet those five priority areas.

They have an understanding of what the priorities are. They know what their budget is. It is up to the health authorities, which answer to a board — a publicly appointed board of directors — how they're meeting those priorities. They also need to develop detailed plans and check in with the ministry. We are going through that process with them.

In terms of the individual plans for each health authority, that will vary depending on the health authority. They each have different needs, different challenges. Northern Health is a lot different than Fraser Health in terms of demographics, distances and the types of services that they need to provide.

K. Corrigan: I seek leave to make an introduction.

Leave granted…

K. Corrigan: Well, I'll pull the documents out — that it was mentioned in the platform. That's my understanding, so I will confirm that. Nevertheless, reference to that as being something that has to do with elections and somehow intimating that that's not relevant to what government actually plans to do…. But I'll certainly pull it out and provide it to the minister.

It does concern me, because Burnaby Hospital is very old. I appreciate that the hospital and the hospital staff, who are fantastic…. I've gone there, had my children there, both my parents died in the hospital with great care, and it's served us very well. But to have to put resources — focus hundreds of thousands, perhaps millions, of dollars of resources — to try to prop up a hospital that needs to be rebuilt….

When you talk about the infection control — yes, that was done. But my understanding from talking to people who have worked at the hospital is it took a huge amount of resources that were then taken away from somewhere else.

It's a concern. It is the third-largest city in this province, and we have a hospital that is essentially falling apart, despite the great work of the people that actually work in that hospital — the doctors, the nurses, the support staff and other professionals, and the volunteers.

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I want to ask a specific question about bed closures. Earlier this year, there were several stories in the news about Fraser Valley's plan to close 80 — well, one story says 80; I think another said 95 — beds in Fraser Health Authority.

The report that we had, that the member for New Westminster raised in this House, said over 100 acute care hospital beds were going to be closed. The number that was attributed to Burnaby was 11 — that 11 beds were going to close.

[1710]

The response from the minister on that date, in question period, was essentially that these beds were going to be replaced and then some with community beds. That would include, I'm assuming, long-term-care-facility beds and so on.

My questions are twofold to the minister. Have there been 11 acute care beds closed in Burnaby, or is there a plan to close 11 beds? If it's not 11 beds, how many is it? What beds are being replaced in the city of Burnaby with these other types of resources, like long-term-care-facility beds and so on? What's being added to Burnaby very specifically to address the closure of the 11 beds, if that's the correct number?

Hon. T. Lake: The number is not 95; it's 80. But the member is right in terms of Burnaby General looking at the closure of 11 of what we call alternative level of care

beds. These are people that should be in complex care and residential care rather than in an acute care situation.

There will be 403 new residential care beds in Fraser Health by the end of 2016-17. I don't have the number precisely for Burnaby. I will endeavour to get that number for her and provide it tomorrow…..