LEGISLATIVE ASSEMBLY
of BRITISH COLUMBIA

Fifth Session, 41st Parliament

REPORT OF PROCEEDINGS
(HANSARD)

COMMITTEE OF SUPPLY, SECTION C

Virtual Meeting
Friday, July 24, 2020
Afternoon Meeting
Issue No. 16

Presiding Officers:

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SPENCER CHANDRA HERBERT,
DEPUTY CHAIR, COMMITTEE OF THE WHOLE

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Her Honour the Honourable Janet Austin, OBC

Fifth Session, 41st Parliament

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Committee of Supply

FRIDAY, JULY 24, 2020

The committee met at 1:31 p.m.

[S. Malcolmson in the chair.]

Committee of Supply

Proceedings in Section C

ESTIMATES: MINISTRY OF HEALTH
(continued)

On Vote 31: ministry operations, $22,042,385,000 *(continued)*.

The Chair: Good afternoon, Members. I call the Committee of Supply, Section C, to order.

I want to recognize that I am in the B.C. Legislature, meeting from the homeland of the Lək̓ʷəŋin̓əŋ-speaking people, Esquimalt and Songhees. Members from the rest of the committee are all over British Columbia, and we recognize and honour all of the First Nations territory on which conduct our work.

We are meeting today to carry on the consideration of the estimates of the very hard-working Ministry of Health. This is our second day, I believe.

Minister, do you have any comments you'd like to make?

Hon. A. Dix: Just briefly, I had promised an answer to the member from Richmond East before the break with respect to alleged abuse reports in the health care system registry in B.C.

Since 2010, there have been 822 alleged abuse reports that have been received from employers, with all reported HCAs immediately removed from the registry. Of those removed, 426 received temporary suspensions, and 396 were terminated by their employers. Of the 396 terminations, 155 HCAs were removed uncontested, and 39 were returned to the registry by mutual agreement between the employer and the union without investigation.

Investigations were initiated for 202. Of the 202 investigations, to date, 197 have been completed, with 33 HCAs deregistered, 109 re-registered with conditions and 55 re-registered without conditions. Currently, there are five active investigations.

The Chair: I now recognize the opposition critic for Health, the member for Kelowna–Lake Country, to either carry on questions or give us a bit of an indication of how you're going to use your time as a caucus.

N. Letnick: Thank you to the minister. A lively morning this morning and, of course, a full day yesterday, and we have this afternoon to look forward to.

We have approximately 25 MLAs from all around British Columbia and political parties that have some questions for the minister — everywhere from five, seven-and-a-half minutes — starting, actually, with the first one from the member for Vancouver-Langara at 15 minutes.

My job is to stay in the background. I will try to quarterback all these wonderful MLAs as they ask questions, most of the time specific around their particular ridings. Sometimes that might leak into provincial matters, but hopefully not too often.

We'll try to keep the questions as succinct as possible, some of which have been received by the minister in advance. Of course, it's up to the minister as to how long he takes to answer them. I have no control over that.

What I do have to say is thank you, again, to the staff at Hansard and everybody else who's running the show. Without any further ado, I will go in the background.

[1:35 p.m.]

M. Lee: I appreciate this opportunity to ask questions to the minister relating to George Pearson Centre.

George Pearson Centre is in the heart of my riding that I represent, in Vancouver-Langara, at 57th and Cambie. As the minister well knows, of course, it's a long-term organization and facility that's been there for many, many years, taking very good care, for the most part, of those who have very complex issues — challenges with mobility and severe disabilities.

There have been, of course, with the previous government and this current government, plans to redevelop the site. That certainly is occurring with Onni, the private developer, as well.

I'd like to ask, first: since the last public update, what is the progress and the status of the redevelopment of the George Pearson Centre, the future home of a community health centre and a potential urgent primary care centre as well?

Hon. A. Dix: Thank you to the member for the question. As he knows, what's in question is a phased development. It has some complexity to it on the site, but it's going to be transformative to the community and transformative to the neighbourhood.

The member will know that the first homes for 44 individuals are under construction now. The proposed completion and in-service date is the spring of 2022. The second-phase homes for 16 individuals are in the planning stage, with a projected completion in the first half of 2024 — subject, obviously, to developer construction schedules. The developer, in that case, is in the process of applying for a rezoning amendment to convert parcel C to a rental building and add market density to other partials. There is a public hearing going on that he will be aware of.

A clinical services plan with respect to the community health centre and the proposed UPCC has been completed, outlining the population needs for the area. Designs have been completed, and we're on the way.

As you know, that model of UPCC and community health centre has proven to be a very successful model, especially in this time of pandemic. I think that not just the site but the community is very, very well-suited in South Vancouver to that development, so we're working hard on it through Vancouver Coastal Health.

M. Lee: I appreciate that response, Minister, and the update.

Certainly, I understand, of course, that in Vancouver South, there's the highest density of seniors and elderly in Vancouver. It's the work that I do as a local MLA, working with seniors and senior-serving organizations with my South Vancouver seniors network and various seniors forums and webinars. There has been, I would say, on the webinars that I host with those who are caregivers, volunteers and leaders in our community who help support seniors, great concern, of course, for care homes and residential centres.

Obviously, we've seen, with George Pearson Centre, before COVID, considerations of the challenges of care in that facility. I've certainly heard from constituents who have family members residing there. As you know, George Pearson Centre doesn't just serve residents who are in Vancouver-Langara. They have long-time residents who are there from, from what I've seen, all over Metro Vancouver.

Some of these family members that I've been speaking with and those who have written letters to the minister and have spoken lately, again, to members of the press and the media talk about the ongoing concerns around inadequate care and poor conditions within the facility. What we've seen, of course — certainly even in COVID-19 situations here and the challenge that it is — is that there have been increasing concerns, raised by residents with disabilities and their families, about the safety and what has been seen to be repeated uses of bullying and conflict with other residents who have substance abuse challenges.

[1:40 p.m.]

This problem has continued to be very difficult for residents with disabilities who have had, of course, for good reason, for their own public health and those of the staff there as well, restrictions on their own freedoms, with a no-visitor policy and other safety precautions that they understood and complied with, while I see, potentially, those who are addicted to drugs not adhering to the same social distancing policies. They continue to see visitors frequent the centre.

We've seen, more recently, incidents that I've become aware of where one resident was smoking narcotics and set off the fire alarm. On another occasion, police had to attend at the centre. Residents have been found smoking crack and other illicit narcotics on the patio outside the facility, with the smoke from these illicit narcotics entering the rooms of residents when their windows are open. Of course, I know the minister appreciates that this would put the health of the residents in danger.

With that long preamble, will George Pearson Centre and Vancouver Coastal Health be provided with the resources needed to adequately manage the needs of those suffering from substance abuse issues at George Pearson Centre?

Hon. A. Dix: Thank you to the member for his question. I know George Pearson quite well from people I used to visit, who, unfortunately, are no longer with us. But I know the centre and admire the people working there very much.

I know the importance of the community of family around the centre to everyone and the challenges the centre sometimes faces, as do all long-term care homes, in dealing with the people living there, the resident community, which, in some cases, can be a mixed community of people with sometimes very different needs and very different circumstances. There are, of course, people at the centre with various cognitive impairments and, also, who are dealing with withdrawal management and other issues related to the other public health emergency, the substance abuse emergency, the overdose crisis that we're facing now in B.C.

A lot of precautions have been taken, and during this COVID period, it has been particularly challenging. There have been and are significant circumstances and physical distancing measures that have been put in place to ensure the people in the George Pearson Centre are kept safe, and staff are certainly fully trained to do it. As the member will know, we have, in general — and this includes George Pearson — dramatically increased staffing levels over the last couple of years in the long-term care centres across the province.

What I would endeavour to do, should the member wish it, is to engage with family members at George Pearson, perhaps with him. Perhaps we could do it, these days, by Zoom, back to back with meeting with the Alliance Française, because I owe the member a meeting, I think, in that regard.

We can have a Zoom meeting and engage with the families to hear their complaints directly, and I'll have people involved from Vancouver Coastal Health there at that time, and we can address what are kind of operational issues, but real issues for families. This might be better suited in that setting than us back and forth in an estimates space. I'd endeavour and commit to do that if that works for the member.

M. Lee: I appreciate the willingness of the minister, knowing how fully occupied he is these days and many months, for good reason, for the province. I appreciate that you recognize, at least within this centre, the concerns that you've seen and some of the letters you've seen and other communications. I would very much appreciate that opportunity to help organize with your staff such a virtual gathering — of course, with sensitivity and privacy considerations in mind — and to help facilitate that type of discussion.

I do think that the concerns, as you know, with long-time residents, those who have been there for some time and family members that…. I know a family where their parents visit every day, and they continue to see the challenges with the care. Recognizing, of course, that the staff are doing as best as they can, but it's a difficult situation. I just appreciate that, Minister, in terms of what you've said.

[1:45 p.m.]

Just to complete, if I may, two other points here. This will give you a sense, of course, of the concerns. That is, of course, appreciating that it is a mixed-use facility, and recognizing the staff focus and priorities dealing with those who have, perhaps, behavioural or temperament issues spurred by substance abuse and addictions. We recognize that that is a consideration, certainly. But those residents who have severe mobility issues or challenges with quadriplegia or ALS or other really complex care management issues are not getting the kind of care that they feel they need, of course, when there are competing priorities, let's say, in terms of the staff time.

One of the other issues, which I alluded to, but just to ask the question: will the Ministry of Health and the minister commit to rehabilitation of those who have substance abuse issues in health care facilities specifically designed and staffed for substance abuse rehabilitation?

Hon. A. Dix: Thank you to the member. It may be possible, certainly, in one of our two remaining legislative weeks. Either next week or the week after, we'll just arrange to add the meeting. I agree we can talk, perhaps, with his constituency staff and with my staff about how best to do that. It may be with a small representative group, which might be the best way to do it so as to maintain privacy.

The member will know that there are 12 people at the centre who are assessed by the VCH overdose outreach team, who access substances. That's a challenge at the centre. The staff is fully qualified to address that.

This is an important centre in B.C. I've met with members on both sides of the House about issues with long-term care as they've developed in different communities and different, specific care homes. This is an important care home with very significant challenges — high levels of staffing and highly trained staff but, also, just people with real challenges who need our support.

I'll just endeavour to do that. What we'll try and do is get together in the next week or so and have Vancouver Coastal Health direct it so people can hear each other. If there are issues that we can deal with immediately or make better, then we can work on that, which I'm happy and committed to do. I think we'll easily be able to find time in one of those two weeks.

M. Lee: Thank you, again, Minister for your willingness to do so. I appreciate that.

Just two other quick points here in the time that I have. In terms of other concerns that we've seen from long-time residents, it's been the continued concerns about the quality of the food. Much has been found to be unappetizing and not healthy for residents.

The question would be: what is being done to ensure the safety and quality of life for the residents with disabilities? Secondly: what is being done to immediately ensure that the meals being provided to residents meet the standards that they should expect?

Hon. A. Dix: An inspection was conducted, I understand, on July 8, 2020, at the site in response to expressions of dissatisfaction with the food at the neighbourhood meeting, which is the one the member may be referring to, on June 26, 2020.

As a result of the complaints, the contractor did change the recipes in consultation with a dietitian. Despite this change, there are ongoing concerns with the taste and visual appearance of the food, I think, at George Pearson.

The menu there is approved by a dietitian. The review of the menu considers issues such as texture, colour, taste, visual appeal, and so on. There was a satisfaction study done in October 2019. I gather the rate of satisfaction was 80 percent in that study. The expectation, the standard, is 85 percent.

We have asked the operator to review the ongoing food complaints and include the residents in the process so that they're fully integrated and, hopefully, start to see the change that they'd like to see. Obviously, this is part of the challenge in every care home in the province. We know this. I know it personally. I know members know it from their families or other families or friends.

Often what happens in care homes, as well, is that there is a supplementing of food and support from families. Desserts and other things are brought in by family visits, which have been severely restricted.

[1:50 p.m.]

This has had, I think, consequences for the quality of life, which are — let's just call them — incalculable for people who live in long-term care.

This is true at George Pearson, as it's true everywhere else. To a degree, the challenge on food is the loss of some of the traditional social supports that many people would expect to give, and it has had a deep impact on their lives.

I regularly call people who send letters to me, about this subject, during the course of the COVID-19 pandemic. Not long ago, a family member called me about their parent and what it meant to them to have tea at three o'clock in their care home. That happens much more inconsistently now than it did before. That may seem trivial to some people, or a small matter, but for them, that person, it was everything. It was something they looked forward to. It was something in their day that was profoundly important to them.

These issues are very important, and everybody — I mean everybody, all 29,000 people living in long-term care in B.C. — is struggling with that right now. It affects people differently, but I fully understand the impact on George Pearson. These are the steps that are being taken, with respect to the food provided by the facility, in order to deal with it.

M. Lee: That's all the time I have. Thank you very much, Minister, for your responses.

C. Oakes: First, I just want to thank the minister for his leadership and for his entire team. On behalf of the constituents of Cariboo North, we certainly appreciate the work and efforts that they have been making.

I want to advocate today, to the minister, for increased supports for seniors in our constituency. Just a little bit of background on the demographic in Quesnel. If you look at the demographic of the 75-plus population, it's forecast to almost double — 91.4 percent — by 2026 and to grow by 156 percent by 2036. I think it's also important to note that it's projected that the cohort of 85-years plus will more than triple by 2036.

Currently there is a waiting list for our complex care and long-term-care facility, which is Dunrovin Park Lodge, of 44 people. We regularly have ten to 15 seniors in our hospital waiting to get into Dunrovin Lodge at any time, and this wait-list can be up to a year.

Our assisted-living facility, which is Maeford, has a current waiting list of 97, with up to a three- to four-year wait for someone newly placed on the list. That is if you can actually…. There are very strict guidelines on how one gets on that particular list.

I just think it's really important…. Based on the significant demographic growth that we are projected to see in Cariboo North for seniors in our region, we need additional both assisted-living beds and complex care/long-term-care facility beds in Quesnel.

To the minister: I'm hoping that you may have an update for me.

Hon. A. Dix: In terms of Quesnel, the member is right that one of the things that Northern Health has tried to do in Quesnel — and, I think, done a better job of in recent years — is on issues around home support. That has been made necessary by the demand, especially the demand at Dunrovin, and the impact of the lack of long-term-care beds, or the lack of a sufficient supply of long-term-care beds, creating ALC bed demands, alternate-level-of-care demand, at Baker Hospital.

As the member knows, just this past week Interior Health — which, I realize, is the other health authority; Quesnel is in Northern Health — is adding 75 long-term-care beds. Certainly, we'll be looking to Northern Health to meet the increasing demand for beds across the region.

[1:55 p.m.]

I think it's fair to say that if you look at a projection — I haven't done it recently; I did at the time that we were working on the urgent primary care centre in Quesnel — of the demand and the growth in the community, in all the communities of the north, of people over 75, clearly we're facing dramatic and significant new demand.

If I recall correctly, the increased number of seniors over 75 is approximately 100 percent, while the overall expectation in the community is to stay relatively stable. So clearly, this is an ongoing need that will require planning. Northern Health understands, I think, the need, for the future of Quesnel, to expand long-term care beds in the community. So we're trying to find a way to do that.

As you know, we have a major project in Quesnel at the hospital, and we're adding primary care network support and urgent primary care support and home support. But inevitably, the share of the population that requires long-term care is a subset of the population for seniors. The population for seniors in a community like Quesnel is growing like this. We can expect very significant change.

The Northern Health Authority is looking seriously at…. Of course, the other part of this that the member will know is the need, ultimately, to replace Dunrovin, if memory serves at least from the last time I toured it. She probably goes there quite regularly and has a sense of the place.

Part of the opportunity in the business planning we're looking at going forward is the need to replace those beds and then, at the time of replacement, add them. That's probably the best plan in Northern Health.

I don't know if Northern Health's best plan for Quesnel is to take the existing facility and to add capacity on site, because there probably wouldn't be a sufficient demand for beds to have a sort of formalized RFP process for 100 beds, which is not what we need, from a private sector proponent. So in that case, probably the process that needs to happen, at Dunrovin, in any event, of improving the existing facility will be the occasion to add the necessary beds.

C. Oakes: My time is up, but I'll quickly put in one more quick question.

I really do appreciate the support that has been made available in Quesnel and appreciate the supports in Interior Health. Our riding does cover a small portion of that as well. So we appreciate that.

The total direct care hours per resident in our long-term-care home of Dunrovin in 2017-2018 was 3.56 hours per resident. For 2018-2019, the care hours per resident is 3.42 hours. I'm just wondering why the decline in care hours per resident. Why has that declined?

Hon. A. Dix: I don't have that answer off the top of my head. But, I say delicately, across Northern Health….

Northern Health is a very different health authority for long-term care than all of the other health authorities. The average in 2017 of funding across health authorities was about 3.06 other than Northern Health, and in Northern Health, it was 3.39. It's partly because it's essentially all health authority owned and operated in Northern Health.

We have increased funding in care hours in Northern Health from an average of 3.39 to an average 3.45. That's across Northern Health. That's the direction, which means there been increased funded hours.

What I'll do is I'll endeavour to get a detailed answer for the member as to what's going on at Dunrovin. That sounds contrary to that.

D. Ashton: Minister, always a pleasure to see you.

Minister, I just want to say thank you to you and especially your staff for being so proactive in taking over the issue that transpired in the Summerland Seniors Village and also with, apparently, the other four entities that are run by an off-shore company. That proactivity is going to make a difference. However, at the current time, there are still issues that are in place at the Summerland Seniors Village.

[2:00 p.m.]

I'd also like to say, through yourself and the ministry, a real shout-out to Susan Brown, the head of Interior Health, who does an exemplary job and is very quick to respond when questions from myself and others come forward. So please give credit where credit is due. Like I said, she is doing an exemplary job.

However, Minister, I would ask if the opportunity would exist for a meeting with yourself and senior staff to discuss the ongoing issues at Summerland Seniors Village. Over the last week, my phone and my emails have been ringing off the hook about ongoing concerns at the facility, not only in the full-time-care side, but also on the assisted living, which I understand Interior Health is not in charge of at this point in time.

Also, Minister, I've had a request for an opportunity for a company, a purveyor of COVID testing equipment. With your direction, I would appreciate where I could go to follow on that request and give the entity an opportunity to get involved in the bid process.

Minister, once again, thank you very much for that proactivity on your behalf and the ministry staff. It is going to make a difference, but let's get through this little rough period first and see if we can all make these homes work a lot better than what they were doing.

Hon. A. Dix: On the issue of PPE, I will have my associate deputy minister, Peter Pokorny, get in touch with you, Member, next week, to engage in that process.

There are, of course, centralized processes of government that are dealing with that as well, but the team led by Mr. Pokorny has done an astonishing job of obtaining PPE. Just to put it in context, while there have been major efforts by the federal government on N95 respirators, 95 percent of the six million we've received have been procured by the provincial government, the Provincial Health Services Authority. Mr. Pokorny will follow up with you, I'm sure.

On the question of Retirement Concepts, as you know, Summerland is one of four facilities that are currently under administration in Victoria, in Nanaimo, in Comox-Courtenay and, of course, in Summerland. Some of the issues are site-specific in all those locations, and we're working through them. Some of those issues go through the organization of Retirement Concepts, which is a major player in long-term care in British Columbia. I won't get into all the debate on that, because people have had it publicly. But we clearly are working to take steps to make the funding of long-term care more accountable to the public.

It is not our preferred solution. In fact, I think that what we've done, putting a facility under administration, has occurred only six times in the history of the act, four of them in the last year. All four are related to Retirement Concepts. One of the previous ones that was done under the previous government was also Retirement Concepts. These are issues we have to resolve. In fairness to them, there have been new managers in place — new management in place — and a new collective agreement, I understand, and other circumstances that are improving the situation of Retirement Concepts. So some of the issues are local, and some are systemic.

I would say that there was a licensing inspection in Summerland on May 6, 2020, which is an independent process even of the administrator. Many of the previous licensing infractions have been addressed. However, there's more work to do. We're clearly not prepared to…. Interior Health is clearly going to continue with the administrator for some time yet.

I would be happy to meet with the member. I think we have a couple weeks left of the session. And do that by Zoom — and with Susan Brown, who's very much seized of this question, and others, as required — to discuss issues that are happening there, because it's important to respond to those issues. I would be, certainly, happy to do that — to hear them. Then you'll know that Susan Brown, because you know that's her approach to these things, will be working at addressing those directly.

D. Ashton: To the minister, thank you, and again to Susan Brown — exemplary on her responses.

D. Davies: Good afternoon, everybody. Good afternoon, Minister. Thanks for taking the time for the questions. I want to thank my colleague, our Health critic, for allowing me a few moments here to ask a question.

[2:05 p.m.]

Minister, I know that we have spoken at length over the past few years. I've sat in numerous meetings with the folks from Northern Rockies regional municipality and their council regarding air ambulance service to the town of Fort Nelson. Of course, Fort Nelson is not necessarily a regional hub, but certainly, many times of the year — especially during the summer, where you've got eight hours of highway up to the Yukon border — if there's a medical emergency, they end up in Fort Nelson, initially.

There is a dire need to have an air ambulance station in the north, in Northern Rockies. There was a contractor that was being used, but his aircraft didn't quite fit the criteria. It wasn't a pressurized cabin. I would hope that there's an opportunity for the ministry to do what's right. I mean, they don't hit every single check box on what's required for a medevac, but these are high-end aircraft that are more than capable of delivering patients as needed.

I just want to highlight one quick point here, and then I'll give the floor to you. I did send you a letter yesterday that you'll have an opportunity to get your eyes on, which outlines some issues. We just had a 65-year-old gentleman that I've got to know in the past few years. He suffered quite a severe series of strokes. He required medical attention that was not fully able to be fulfilled in Fort Nelson. The doctor said that he needed to seek a higher level of medical care within the next few hours or there could be dire consequences. Of course, the medevac could not get there or provide that service to him.

Fortunately, this family did have the ability. They chartered their own aircraft from Fort Nelson for their father to get the needed medical attention. Happy to say that, while there is a long recovery for this gentleman, it is looking much brighter than it would have been had he not been able to look after himself in this issue.

I'm just hoping that the ministry can really take a serious look at how we can provide…. Again, we're not expecting surgeons and such to be working out of Fort Nelson, but access should be no different than a person who lives in Vancouver getting medical access to look after themselves. I'll just kind of leave it with that. Hopefully the minister can work something out with the contractor in Fort Nelson and we never have to worry about this again.

The Chair: Minister, do you have any comments on that? I didn't hear a question there, but maybe you did. Go ahead.

Hon. A. Dix: I did. I think the member was saying: "I've got a problem here, and I want you to do something about it." That was the question, to summarize?

D. Davies: That is correct.

Hon. A. Dix: I never want to summarize the member's question too much, but I think I got the gist of that.

Hey, look, we made a significant increase with improvements — he knows that, in his community of Fort St. John, of course, and in Dawson Creek, for his colleague the member for Peace River South — in ambulance service and in air transport services. One of the changes that was made on April 20, as part of our plan to deal with rural and remote and First Nations areas, was significant enhancement. If the member will look at the *Hansard* yesterday, I won't give him the lengthy response I gave about where those things are and the fact that we're now assessing how we're going to apply and reapply resources.

What I would propose to do is fit in his request and his letter into that discussion, because we've made some temporary allocations of locations of our increase in ambulance and in air ambulance service in the province, based on the specific circumstances of COVID-19.

What COVID-19 tells us is that the closer you are to acute care, which is true not just in times of COVID-19…. In certain circumstances, we can bring people closer to acute care from rural communities. Then, should they require that care — including, say, intubation with respect to COVID-19 — we would be able to give access and get access to that care. Those changes have been brought in with the Premier's announcement April 20. They followed through on the three-year action plan for BCEHS.

I have one other piece of good news for the member. For the first time in a long time, I believe I'll soon be appointing a member of the board of directors of Northern Health from Fort Nelson, which is something I think people from Fort Nelson have been asking me for, for years. That's just a teaser. He's going see that ministerial order soon, and we'll let him know.

[2:10 p.m.]

In terms of what Fort Nelson and…. Often other communities have received lots of representation. We previously had two members from Fort St. John. We're going to have one member from Fort St. John and one member from Fort Nelson, so that will be an interesting change. I think it will bring to Northern Health's attention at the board level, more directly, concerns around maternity and ambulance services and other things that I frequently hear about from the community of Fort Nelson and the hon. member. I thank him for his question, and that's how I'll be responding to his request.

D. Barnett: Thank you to the minister for giving us the opportunity to ask our questions. I thank him and Bonnie Henry.

The first question I have is a little lengthy. It's about the Williams Lake Cariboo Memorial Hospital. I understand that the upgrades have started in the operating room, and soon we will have more specialists. We're going to have orthopedics, and cataract and oncology, and that's wonderful. I know we're moving forward, but my question is: will the full renovation and upgrade that was announced about six times still move forward in 2021?

Hon. A. Dix: Thank you very much to the member.

I don't know if it was…. It hasn't been announced six times by me.

As the member knows, there had been a concept plan produced on the Cariboo Memorial Hospital project around 2014, a master plan around 2011. That concept plan was still in the minister's office. It hadn't been signed off or approved by Treasury Board at that time. So in 2017, we upgraded the concept plan. At the beginning of 2018, we approved the concept plan. In fact, it was my first capital announcement as Minister of Health at that time, so I was particularly happy on that day to be in Williams Lake.

I had visited Williams Lake, as the member would know, during the wildfires in the summer of 2017 and really talked to the extraordinary health care providers who served the community in that time in that emergency. We had made the case for that, so we did that.

Then the business plan was approved, on schedule, a year later, in 2019. The RFQ for proponents on the Cariboo Memorial Hospital is on track. The bid closed July 15. So a week ago, basically. Five proponents responded to the RFQ, and their responses are being reviewed by the evaluation committee.

While that may not seem like great news, it's actually great news, because we were frequently having trouble, in some cases, getting sufficient interest to build hospitals. In this case, five proponents, just as we got five proponents in Fort St. James. It's such exciting news. The RFP will be issued to those five proponents in September, and the selection of the proponent is scheduled, I believe, for January. And then off we go.

D. Barnett: Thank you to the minister. I know we're short of time here, so I'll try to move quickly.

We do have an extreme shortage of family physicians in Williams Lake, and this has been going on for years now. They're working very hard — the community, the doctors — to bring in some new family physicians, and it is a big concern. I get a phone call at least two or three times a week from people that cannot find a family physician, and I know how difficult it is.

I know there's a big shortage of them, but is there anything, Minister, that can be done to help these rural communities obtain more family physicians? We've got specialists, but we need family physicians.

Hon. A. Dix: I think the short answer is yes. First of all, first point, I think Williams Lake and 100 Mile are great places to live, and they, to some degree, sell themselves in terms of the potential for family physicians wanting to live in a great community, both to raise families and to live. I think that, obviously, there's ongoing and great potential there.

[2:15 p.m.]

There's been a significant effort by Interior Health and the whole health system to recruit family doctors to smaller communities. That's done under a number of programs, and the member will be aware of all those. What we're trying to do, as well, is not just have people there temporarily but have people taking up these positions full time.

Part of the way we're doing that is bringing to communities, such as Williams Lake and 100 Mile, primary care networks, which support, in a modern environment, family practice doctors to provide team-based care so that family practice doctors have the supports they need around them to provide care in the modern environment.

This is how young doctors view care. Eighty-five percent of young doctors and resident doctors in the surveys we take want to move away from fee-for-service. Using the mechanisms of primary care networks — and, perhaps, for Williams Lake, an urgent primary care centre — may provide supports to that.

You've always got to be careful, though. In Williams Lake, in particular, we want to work with the current community of doctors. We don't want to bring about changes or to bring things in that will somehow displace so you end up adding someone and then losing someone. But we are going to be advancing the other parts of the primary care community, including nurse practitioners, to support doctors.

In the efforts by Interior Health, Williams Lake is one of the communities in particular that Interior Health focuses on, but over time, less so 100 Mile for whatever reason — both communities.

We'll be working hard on that project, and I'll take the member's representation back to Interior Health as well.

D. Barnett: Thank you, Minister. I have lots more questions, but we're out of time.

D. Clovechok: Thank you, Minister, for this opportunity. The minister will know I've spoken to him various times about this, including the 2019 estimates. The issue is around the Health Connections bus routes that operate between Golden and Cranbrook and also service the residents of the Columbia Valley as well.

The minister will know that the Health Connections route is run in partnership with Kootenay East regional hospital district, the regional district of East Kootenay and B.C. Transit. Those decisions about fares, routes and service levels are made by Interior Health in the town, based on information and planning provided by the municipal systems program of B.C. Transit.

Currently the bus is operating two days a week. Since April 20, those days are Tuesdays and Thursdays. That's been a very positive change, for the most part, because it addresses the issue of clinic closures during statutory holidays, but it's not enough.

Last year in estimates, I asked the minister to consider increasing the services to more than one weekday as well as one day per weekend or once every other weekend. The minister said he would look into it.

My question to the minister. Will the minister today consider increasing the services of the Health Connections bus by at least one weekday and one weekend in the East Kootenays?

Hon. A. Dix: Thank you to the member for his question.

I just want to note to the member for Cariboo-Chilcotin, who might have left us…. I think she was going to ask about operational cuts in home care in 100 Mile. I can tell her that there have been no such cuts, and I'll be responding directly in writing to her request for information about that.

With respect to the bus, I would say that I did listen to the member last year. The change to Tuesday to Thursday really reflected what I learned in that discussion, which is that frequently what was happening with the Monday scheduled day is that all of the statutory holidays would interfere with the travel and make the delivery of health care and people's access to health care worse. So the Tuesday to Thursday is actually the direct result of our discussion in estimates in 2019.

Just to put it in context, there hasn't been too much change on the Columbia Valley section — the Golden-to-Cranbrook ridership, the yellow section — over the last two years. I have looked into that. I'm definitely open to hearing more from the member with this issue. As he can see, last year we made a little bit of progress. The Tuesday-to-Thursday thing reflects that and reflects the commitment of Interior Health and B.C. Transit to work on these questions.

[2:20 p.m.]

On the question of a replacement bus, this is not something that had been brought to their attention before, because I asked them about it this week. That's something that Interior Health and their partners, B.C. Transit and others, will look into.

What I think we want to see, and what I'll review and share with the member…. The substance of that continuing review is about participation on the bus and the potential for increasing services. I would expect to see some increase in participation, in ridership on the bus, because of the change we've made over the course of the year. Obviously, ridership has been way down in recent time because of COVID-19, but that's not a representative period.

D. Clovechok: Thank you to the minister for his support in making those changes. They have been effective, as I mentioned. Hopefully we'll be able to find another spare bus.

My last question, very quickly. Prior to COVID-19, I know I had spoken with the minister on several occasions about the issue between Alberta and British Columbia health care services. I live in a border community, as the minister is well aware. We're still finding those issues of Alberta not accepting British Columbia patients. I did speak directly with Minister Shandro in Alberta about that issue. He was quite surprised to hear about it.

I know that the minister is very well aware of this. I'm just wondering if you could provide any updates as to where that might stand, given that COVID-19 has consumed the majority of your life over the last four months.

Hon. A. Dix: It's an ongoing issue of concern. It's related to the previous question in the sense that I think what we have to try and do — in addition to access to acute care, which continues to be an ongoing problem — is improve the link so that people have access to regular care. Frequently, when we're talking about Alberta, we're talking about access in emergent circumstances. That access is continued, in fairness to people in Alberta, in the region, fairly uninterrupted.

Access to scheduled or elective surgeries was the most significant problem that was being provided. Of course, it's a challenge with the size of the Interior Health Authority. While capacity is there, and has, in fact, been significantly increased in many areas for surgery in Interior Health, often that is far, far away from the communities that he represents, and obviously, other locations are better.

He should know that we have been having regular meetings on these issues with Alberta Health Services. I have spoken to Minister Shandro myself on a number of occasions about these and other issues that are of joint interest. He and I have worked together on a number of issues of joint interest and have a very positive relationship. Our discussions of these issues have been suspended, as he would expect, since March 2020. But we're hoping to pick those meetings up.

What I'll try and do…. I shared with him last time detailed information about transfers, both in the Kootenay area but also in the Peace area — shared information about what's been provided and what hasn't, what we're paying for and what we haven't paid for in recent time — so he has up-to-date information. Obviously, this period won't be representative in that regard because it's the period of COVID-19, unless people are travelling, period.

E. Ross: I'll change my first question to a request, if I may. Nav Canada actually shut down services to the Terrace airport during the COVID crisis, due to manpower and some other issues. I've done some digging, and I found out that they never actually consulted the B.C. government or your ministry. Therefore, from 10 p.m. to 6 a.m. every night, we couldn't get flights out of Terrace — even air ambulance.

What I asked the federal government was: "At least, could you consult with the B.C. government?" Actually, the B.C. government made Terrace a regional centre for COVID cases.

[2:25 p.m.]

My only request, Minister is: could you open up a line of communication with Nav Canada to actually help us continue to be the regional centre for COVID? It kind of contradicted the idea of us being a regional centre.

My real questions are on Mills Memorial Hospital. Is it on schedule? Is it on budget? Can we confirm that the CBA will not apply to this project? And is the ministry expecting a labour shortage, considering the COVID crisis, as well as the labour market being taken up by LNG and LNG initiatives?

Hon. A. Dix: Yes, yes, yes, no, I think, are the answers. I think I got them right, but sometimes when you say something like that, you get the questions in the wrong order. Then you have a problem.

On Nav Canada, I wanted to let the member know that during a phone call with BCEHS on July 20, 2020, Nav Canada announced they are reinstating night service to all affected flight service stations in the province as of August 4, 2020. They're in the process of sending out official notifications to stakeholders.

I agree with him about the concern. In particular, on May 16, there was an issue involving a patient in ambulance traffic that he may know about. We're obviously very concerned about that. We have been, and B.C. Emergency Health Services has been, in touch with Nav Canada and had that confirmation. While that's not tomorrow, it is August 4, and that's positive news given, as he says, the central role that Terrace and health care in Terrace plays in our COVID-19 response in the region.

With respect to Mills Memorial Hospital, we are on track. The project is still within its approved budget. The member will know that the northwest hospital district's contribution, because sometimes the concerns about budget is pressure on the local tax base, in this case, is 25 percent. If he would not tell any of his colleagues who are in communities where they pay 40 percent, I'd really appreciate it. Just don't make them available at all. In particular, don't call the member for Peace River South, or anyone like that. Thank you. So that's some positive news.

Just to say, on the labour shortage question, the proponent we have, with respect to the modified RFP we're doing and engaging in there, hasn't indicated in their presentations any concerns with labour shortages.

J. Thornthwaite: Thank you very much, Minister.

I have one question about seniors. It pertains to a letter that you would've gotten from the residential care family council, pertaining to Evergreen House, which is the long-term care facility on the Lions Gate Hospital campus.

They gave a lengthy letter. I'm not going to go into in any detail. Just to summarize the issues, they call it a special commission report, and they're actually asking for specific action from government to help with the long-term care facilities due to COVID and moving forward.

They're worried about what's going to happen in the fall if there's a second wave and also with the flus; as to what is happening with these plans for changing the resident rooms from four in a room to private rooms; making sure that there's a nurse on every shift; full-time care aides to ensure that the residents are properly cared for in a timely manner with those staffing. We know that during COVID — and it happened at Lynn Valley as well — the family members were left to care for a lot of the residents because there was simply not enough staffing.

Also, the Plexiglas dividers for visitors. Apparently, the families were asked to pay for that. So of course, we are requesting that government pay for the Plexiglas dividers.

And just briefly, also to ensure that when family members have questions of communication issues, including resident calls on the call bells, that they, obviously, be answered in a timely manner.

[2:30 p.m.]

I'm just wondering if the minister has reviewed the letter from this group and if he has a response or if a response is coming.

Hon. A. Dix: As the member will know, I met with the family council some time ago at Evergreen House. We had a little bit of a discussion this morning, in our discussions about seniors care. Obviously, significant steps have been made to increase and improve the quality of care across the system.

The situation at Evergreen House is a situation of some significant number of long-term-care facilities that are health authority–owned and –operated. Historically, they've had higher levels of staffing, and Evergreen has been over the 3.36, but they are older facilities. They're facilities seemingly from another time and not as modern. In the previous couple of decades, there has been relatively little investment in the existing health authority–owned and –operated stock of beds. The focus has been on the addition of private long-term-care beds, public beds that are funded under contract.

What we have, if you look at the stock of beds in health authority–owned and –operated, you'll see the significant share of beds that are no longer or are not single rooms and an older stock. One of the things that I spoke about this morning — and Evergreen is one of the facilities I had in mind — is that, ultimately, what's required at Evergreen is a new facility. That is one of the older facilities in B.C. It's critically important on the North Shore. There are hundreds of beds in the facility. From memory, I think it's close to 300. I've toured the facility more than once myself.

As we build an extraordinary acute care centre at the Lions Gate Hospital, really one of the challenges as Minister of Health is that there's an ongoing acute care crisis in capital in Health. It's why we've been approving — part of this afternoon, we'll be discussing all those projects — acute care projects across the health system. There's also a capital investment question in long-term care, which has been neglected over a period of time. It just has been, and we have to address it now.

I would think that that capital remediation challenge, across the system, is certainly in the billions of dollars, and a project such as Evergreen, in the current concept, would be more expensive than some of the hospital projects we have around B.C. It's a priority, and we're very focused on that.

With respect to the letter from the family council, I'll be happy to…. I'll certainly be reviewing it and responding to it. I will most assuredly copy the member on that response.

J. Thornthwaite: I just have one more follow-up that I'm allowed to do.

Okay, then, Minister. Thank you very much. This letter was dated June 4, so it is definitely pertaining to the issues that occurred with COVID but, moving forward, to all of the changes that need to occur in long-term care and that have been itemized elsewhere, including from the B.C. Liberals.

My final question is: where is the new facility for Evergreen House in the capital projects?

Hon. A. Dix: Those are priorities. I think what I've said is that if you look at the acute care projects in Vancouver Coastal Health, we're doing a significant project at Lions Gate. We're doing the projects around the Pearson site that I just talked to the member for Vancouver-Langara about. We're doing — even though it's a Providence project, it's sort of in the Coastal Health area — the multi-billion-dollar project at St. Paul's. We're doing the Richmond Hospital project. We're doing multiple long-term-care projects, including ones in Richmond that I'll be talking about shortly.

We're certainly focused on building a long-term-care capital plan — that's been missing, in fairness, for decades, well back into the 1990s — to remediate existing long-term-care homes. What I can tell the member is that when I think of that plan and when I think of ensuring that that plan is funded in the province, one of the first priorities I have in my mind — and, I'm sure, in Vancouver Coastal Health's mind — is Evergreen.

J. Isaacs: Good afternoon, everyone. Thank you to the minister and his staff for being here. Thank you to the critic for the opportunity to participate today.

[2:35 p.m.]

There were over 2,000 deaths in Canada in 2018 that have been related to influenza. Of course, as we get older, our immune system weakens, and we are more likely to contract the flu. As the minister knows, influenza is a highly contagious viral infection, and outbreaks often occur in shared spaces. We have seen the impact of COVID outbreaks in long-term-care homes. However, flu outbreaks have been occurring for a number of years. If someone has a compromised health condition or a compromised immune system — like heart and stroke, kidney disease or lung conditions — they are at a much higher risk of influenza-related complications, which includes death.

The B.C. Immunization Council announced in late June that the federal government bought all of the available doses with the intent to distribute to the provinces high-dose flu vaccine. Eight out of 13 provinces already have a high-dose flu vaccine program. As I understand it, 45,000 doses have been allocated to the province of British Columbia — 31,000 for long-term care home residents and 14,500 that would be unaccounted for.

Can the minister advise if he will be accepting the offer of 45,000 doses for high-dose flu vaccine and will that access go to the 31,000 people living in long-term care homes? What are the plans with the remaining 14,500? Does the government plan to provide access for high-dose flu vaccine for people living in long-term care homes in future years? If so, would the government cover the cost of that high-dose flu vaccine?

Hon. A. Dix: As the member will know and as members of the House will know, the onset of respiratory illness season is something that we are preparing for now and that we are highly preoccupied with. That includes long-term care, but it also includes other seniors, other communities and the community at large.

That's for obvious reasons. First of all, influenza itself is a serious challenge every year for the province and for communities across the world. Secondly, because, in the context of COVID, influenza mirrors many of the symptoms that COVID-19 has, the potential for that and even an increase in the common cold will have a significant and disruptive impact on lots of communities of people and workplaces.

We'll be laying out soon a detailed plan for the fall for our response to influenza. I think everyone in B.C.… That plan would come under both my direction and the direction of public health, which is responsible for its implementation to the health authorities. And our deputy minister, Steve Brown, that…. We will be laying that out for the public fairly soon.

The federal government has made an offer with respect to high-dose flu vaccine, and that offer, as one would expect, was accepted. It's a one-year offer, of course. We have to assess, each year, our plans with respect to care. The 31,000 doses, as the member suggests, or approximately that — it will be slightly more than that because there are slightly more than that number of people involved — will go to long-term care.

I would say this. Often the risks of people with respect to flu vaccine are even greater in the community, so it will be important for all of us…. When I announce the program that we'll be going out with, in the fall, I'll be asking all members of the Legislature to join with me in in promoting the influenza shots, flu shots, showing leadership on flu shots, promoting flu shots, telling people why they're important to have this year. As part of a genuine team B.C. effort around that, I think we'll have to work hard to make sure that we increase the level of coverage from the flu shots that we're getting this year, which will include the 45,000 in question.

[2:40 p.m.]

J. Rustad: Two questions that I'll ask as sort of just one monologue here for you to be able respond to.

The first is regarding two capital projects. Fort St. James hospital. I heard you mention that five people — I think it was five — had submitted on the project, which is good. I'm just curious as to the time frame in terms of construction — when you expect that contract to be awarded and when you're expecting shovels to enter the ground.

The second is just the capital project, the health facility or the health clinic in Vanderhoof. You and I have had a conversation about that. I just thought I'd give you an opportunity, on the record, to explain if you're working towards a solution for that clinic. Obviously, it's critical for health care services in Vanderhoof, and with the status of that clinic, action is certainly needed as soon as possible.

The second part of the question, which is a little more complex and a personnel question.… If you need to give it to me in writing, that's fine. Smithers, for many years, has been advertising for a radiologist. A very qualified radiologist from Prince George applied for the job. The folks in Smithers were very excited because of this individual's qualifications, only to find out after this person from Prince George applied that the job posting was pulled. Upon looking into the job posting, apparently it was filled with an individual who is currently still two years away from finishing training in the United States.

The question to the minister on this is: why would that position be filled with an individual who isn't even fully qualified and is several years away from being able to provide services in the Smithers and northwest region when somebody very qualified with many years' experience had applied? The medical team in Smithers was very excited about having her come in as part of the team. Like I say, you may not be able to answer that question right out. If you want to give me that in writing, that's fine. But I thought I should ask those questions.

Hon. A. Dix: I owe the member a phone call. So I'm feeling bad. We'll get to that, one phone call at a time.

I appreciate that. I'll have the discussion on the personnel issue. Obviously, I'll ask Northern Health to look into it, and either the Northern Health president or my team will get back to the member about that question. Usually we don't have extensive discussions of personnel issues, so there are always some privacy considerations involved. But I'll ask, and we'll get some answers.

On the Stuart Lake Hospital — holy mackerel, five proponents. It's exciting. As the member knows, on December 19, the business plan was submitted to me 14 months after the concept plan, which is, if you look back over the last 15 years of projects, a very, very good result. On January 18, the Premier announced the approval of the business plan. The RFQ, the request for qualifications, April 9 — five proponents.

Did I mention there were five proponents? It's so exciting. It closed on June 18. Now the RFP will be issued to the shortlist of proponents in July, in this month. That's all good news. Like many capital projects, while COVID's been going on, because of the energy that Northern Health is putting into this important project, we're zipping along on schedule.

With respect to issues around the primary care update in Vanderhoof, the member will know that we're currently involved intensely in primary care network planning for a number of communities, including Vanderhoof — in fact, an important community. There are two local health areas, community health service areas, involved, Vanderhoof and Vanderhoof rural, which have about 8,600 people combined — 6,000 in Vanderhoof and 2,685 in Vanderhoof rural.

[2:45 p.m.]

The issues that he refers to will be dealt with as the service plan is completed in September. That was delayed somewhat by the onset of the COVID pandemic, but we've taken, obviously, a number of steps in the interim period in terms of virtual access to improve access to care in First Nations and in the community at large. The member will know about that.

We would expect.… The preferred option, as he knows, is the team space at 3299 Hospital Road. It's one of those things. The land is owned by NHA, but the building is owned by Citizens' Services, but that's not really a problem. We're looking at that site for a project, and we're on the road. I think we're going to see action on that fairly soon. Obviously, it has huge support and lots of planning and development, in terms of not just the physical space, but in terms of the services we hope to provide in that region.

I think that, and the work being done in Vanderhoof, and we're looking at other work as well with respect to assisted living, of course, combined with the hospital in Fort St. James, means that the Vanderhoof–Fort St. James corridor there will see, in the coming years, a significant improvement in the quality of care and its ability to attract people to the region to provide the care we need in the future.

J. Rustad: I'm sorry. I may have missed it. I asked about the schedule for awarding of the contract and potential construction date for Fort St. James. I'm not sure if you had that in the answer or not. If you did, I'm sorry I missed it.

Hon. A. Dix: The RFP is going out in July 2020 to the proponents. So we have qualified proponents. At that time, we'll have a detailed schedule for the next phase, which is the RFP phase.

We're moving on and ready to go on that project. It's on time and on schedule. They've met every deadline, and I would expect them to continue to meet the deadlines. In particular, the procurement deadline I would expect to be completed fairly shortly. It will be announced at the RFP process, and obviously there will be a successful proponent, and then we'll be beginning construction, I hope, before the end of 2021.

J. Yap: Good afternoon to the minister. I appreciate the opportunity to participate in estimates of the Ministry of Health.

My question is in regards to a project in my riding, Richmond-Steveston, which I know that the minister is aware of, and that is the Richmond Lions Manor–Bridgeport, also known as the Fentiman project. This is a seniors long-term-care facility. The community has really been hopeful and expecting this project to be developed. Last year in estimates the minister gave us kind of a status update, and I'd like to ask the minister if he could provide us with, again, the most current situation with respect to the Fentiman Place project.

Hon. A. Dix: I wanted to thank the member for the work that he's done, along with other members of the House, on our committee we developed with the seniors advocate, Isobel Mackenzie. I'm very appreciative of that work. He knows, and we all know, both its value and the number of seniors served. I very much appreciate that everyone chose to step up and participate in that in March. I can tell you that the efforts of MLAs have been felt all over the province.

With respect to the Fentiman project, it's a priority. Business planning is underway, which is a good sign. A consultant was hired to update the clinical services plan and functional program to ensure that it aligns with the long-term-care guidelines, which you'd expect, and addresses the lessons from COVID-19 in this part of the development. Following this work, VCH will develop costing and complete the business plan. I expect that the business plan…. I'm told the business plan will be submitted to the Ministry of Health for review and approval in the fall, and then we'll be going forward with the budget.

J. Yap: That's excellent. Thank you, Minister, for that update.

L. Throness: Good afternoon to the minister. I just have two questions. One is from Chilliwack.

[2:50 p.m.]

People from Chilliwack, especially seniors, have to go to Abbotsford to receive injections for macular degeneration. We have two great ophthalmologists in Chilliwack. There's a lot of travel involved. These ophthalmologists could be qualified to do injections here. We're wondering what the benefit is for them to do it in Abbotsford? It's just an extra cost to the ministry and to our seniors. I wonder if the minister could comment on that for me.

Hon. A. Dix: Well, the member will know the issue of the retinal program was one that I asked about extensively as an opposition MLA, so that's a bit of history. It was more than ten years ago, so I can't quite remember what I was saying or whether it was similar to what the member just said. I think I was asking about Vernon at the time, if I'm not mistaken.

In any event, the retinal program is an extraordinarily efficient program. In fact, the number of people who are served in B.C., compared to many other jurisdictions, and the costs which are served, is really extraordinary. It has been the subject of a recent review, as a program. But the purpose of the program is to have the macular degeneration program delivered by 29 retinal specialists. This is what the treatment program is.

One of the challenges with that…. There have been advantages in that, in terms of efficiency and how the program is delivered, which is quite effective. But of course, other people who would like to join the retinal specialists in the group have long argued they've been excluded. There are advantages, though, in terms of quality control in the work that we do in this program, which really affects the lives of thousands and thousands of seniors every year — indeed, tens of thousands.

There are six retinal specialists in Abbotsford. I know that is an inconvenience for people in Chilliwack, just as previously, the lack of retinal specialists in Vernon — where they're centred in Kelowna — was a frustration there. That is the nature of our program. The current retinal specialist program, which was set up, I think, in the years around 2007, 2008, had as its basis, its agreement with retinal specialists, which was designed to ensure quality of care.

It served us well over time, but I take the member's point and concern. But I don't see any changes to the fundamental underlying basis of the program, which is to have it run through those 29 retinal specialists around the province and not to expand out the number of specialists at this time. But I understand the concern and the concerns of the people in Chilliwack. It does seem a bit unfair that there are six in one place and none in the other. That's not an unusual circumstance in the program around the province, but I don't think we're likely to change it any time soon.

In any event, we're certainly reviewing the program now, and we're doing regular quality reviews, given the seriousness of macular degeneration and what's at stake for people in terms of their eyesight. It's a program where quality is also important. That's not a criticism of the ophthalmologists in Chilliwack.

The intention of Minister Abbott, if I remember correctly, who instituted the program, was to ensure quality in the delivery of the macular degeneration injections and that that would be done best by using retinal specialists.

L. Larson: To the minister, just a comment and a question.I'm, as well, in the South Okanagan and have many calls from people who are without a family doctor. I am one of them. I have been without a doctor since the first of March. I have been on the list since then, and I have yet to have a call. So it is very much an issue, and it's something that my office hears about almost weekly, for sure.

My question, though, to you, Minister, is…. We have talked before about Princeton. I'm just wondering whether there has been any work done on capital project or any types of upgrades for the Princeton Hospital. I know that the foundation over there has started to do some fundraising. I just wondered whether or not there was anything on your capital horizon.

Hon. A. Dix: First, on primary care, I'm in the same situation as the member in terms of a family doctor, although I do, because of my diabetes, have an endocrinologist. So I'm well served by the system, but like many people in B.C., the retirement of our long-time family doctor has that impact, and it does on lots of people. So I appreciate that.

[2:55 p.m.]

In the South Okanagan primary care network, so far, which is one of our regional primary care networks, has been, I think, on balance, an extraordinary success. It's focused to date on Summerland and Penticton, as the member knows, but we'll be pursuing opportunities in Oliver, Osoyoos, Keremeos and Princeton. This is a partnership of the division of family practice in Interior Health.

We're in year 2. We're providing approximately $4.4 million in additional annual funding to meet net new primary care services, which is important. The funding amount will increase — that's for the current parts of the primary care network — when we add Oliver, Osoyoos, Princeton and Keremeos as we build out the primary care network shortly.

The SOS, the primary care network, so far has shown ability in Penticton, including the establishment of a brand-new, team-based primary care clinic. That's in Penticton, at Ponderosa, but it shows the effectiveness of this model, which we'll be bringing further south in the Okanagan shortly.

Nine new family physicians, five new nurse practitioners and ten allied health practitioners have been recruited to the region. That approach is going to be applied in the rest of the community shortly. I think the work of people in the community, the priority, the importance of this primary care network and issues around the hospital in Oliver are significant issues, which we're focusing on.

That primary care network is essential and important. With respect to issues in Princeton, they will be, of course, part of that primary care network. We are looking at building out more primary care in Princeton.

In terms of an update around capital projects in Princeton, what I'll do is I'll get some information to the hon. member by the end of next week, just to give her a full update on plans and ideas around Princeton, so she'll be able to have that for her constituents.

L. Throness: I did have one more question for the minister. That was about a personal constituent problem, but it is applicable to other people around the province and to other constituents of mine as well.

My constituent, Angela Hutchinson, has Parkinson's disease and is facing a four-to-five year wait for deep brain stimulation surgery. Four to five years, as you know, is a very long time for persons with Parkinson's. She can get her deep brain stimulation surgery in Saskatchewan with a one-year wait.

"On June 4, I wrote to the ministry just a generic email. It just goes into a black hole. You know, I don't know who to contact or anything. I asked for permission to undertake the surgery in Saskatchewan based on the portability provision of the Canada Health Act. I've received no response."

I'm wondering if I can get a response from you today. Will my constituent get permission to go to Saskatchewan, no doubt at the same price that they're going to pay in B.C., but in one year instead of four to five?

Hon. A. Dix: What I'll endeavour to do is get the member a response to his specific question. I think the issue with respect to deep brain stimulation is one that he's aware that I've taken, I think, some extraordinary action on, supported by Dr. Honey, who's the lead surgeon who provides this surgery in B.C.

We've also added, as he knows, other doctors who are able to do battery replacement, freeing up Dr. Honey to do more surgeries. He'll be aware that in the 2017-18 fiscal year — and really in the fiscal years before that — British Columbia did 32 deep brain stimulation surgeries in the province. In the past year, that number increased to 72, which is, I think he'd agree, an extraordinary increase, especially considering the time it takes to do the surgery. I think that's a significant improvement.

The challenge, as he suggests and many people with Parkinson's disease would say, is the challenge in getting a referral to the surgeon, which would be an issue regardless of what jurisdiction you were going to. You would still need a referral for the surgeon.

I don't have the details in front of me of the case, and it's really not the kind of thing one would discuss publicly in estimates, in any event. But I'd be happy to get back to the member by the end of next week.

[3:00 p.m.]

M. Bernier: Good afternoon, Minister. I let you off the hook last year with my questions, but I know you have them in advance. I know the minister has these. I'm just going to quickly…. For the record, I want to ask him again where we're at — it can be a quick answer of just yes — on moving forward with the Dawson Creek Hospital.

I know the minister…. I want to thank him, because after about ten years of working and advocating for this much-needed hospital, he came to my riding and made the announcement that we were moving forward. The Premier has also referenced it numerous times in his speeches as something that the provincial government is doing. I'm just waiting for that doing to be done.

I'm just curious if the minister can give me an update. I know it was going through a business plan. I know, because of the good relationship I have with not only himself but on the ground here with people, the work behind the scenes that's been going on. Just looking for the quick updates for my constituents.

Hon. A. Dix: I was going to say to the former Health critic that they told me when I became the former Health critic that I couldn't ask questions in estimates anymore. I don't know what the rules are. The standards are clearly declining on the opposition side.

Seriously, it's a huge priority project. We're going to have an announcement very soon. The member knows it's really exciting news. This is transformative news for Dawson Creek, because I believe, as well, in addition to building the hospital, we can take advantage of that to build out our capacity to train the health care workers and health care professionals that we need in the north. I think the health care facilities that were built by the previous government in Fort St. James and all the ones that are being built across the north help us in recruitment. That's an important issue in Dawson Creek and everywhere else.

I want to acknowledge his support, the support, of course, of the mayor, the support of the whole community and the support of the First Nations for this project, of Treaty 8, which has been hugely critical to that consensus.

I want to ask him not to review the *Hansard* of my discussion with the member for Skeena, where I referred to the project. I'm very happy that the community is providing 40 percent of the cost.

It's all good, and we're going forward soon. I'll be telling him before an announcement is made.

M. Morris: Good afternoon, Minister.

We've had excellent service over the past 20 years by the Northern Health bus connections, connecting all the communities in the north here for health services down south. The contract's been in place now…. The last time it was put up for bid was 2006. They're for four-year periods of time, and it's been extended with the same company, now, ever since.

We've got a local transportation company, well equipped to undertake this service. He's been in contact with Northern Health quite a bit over the last year expressing interest in bidding on it. But it wasn't put on B.C. Bid. The contract was direct-awarded to the same company again in March of this year.

This company's asking me to ask you what the province's position is on these contracts. It's a $4 million contract annually, so about $80 million has been expended on the service over the last 20 years or so. I'd just like the minister to comment on how that process works and whether it will ever be out for a bid for other agencies to bid on.

Hon. A. Dix: The member's quite correct. The contract has been in place for 14 years, and probably 20 years from the beginning of the contract. It has not gone out for retendering.

I'll just say delicately that I'm not going to speak to the first 12 years of that. I'll just speak to the more recent period. In 2020, as he'll be aware, with the satisfactory performance of the existing vendor, Northern Health recommended that it be extended another five years. Indeed, it was, as he's aware, in line with a contract provision allowing for a five-year extension. That extension was done to March 31, 2025, and was supported by the Provincial Health Services Authority supply chain, which supported that recommendation.

[3:05 p.m.]

However, following the notice of renewal, there was a complaint issued under the process. I know this won't be necessarily satisfactory to everyone, but Northern Health said to me that while it has been extended in this period…. That's a challenge, I know, for an alternate company in the process. But what I've been assured, and what Northern Health is committed to, is that there will be a retendering in the next round. I admit that that's several years from now, but Northern Health is committed to doing that.

The complaint itself is at stage 2. But part of what I'd say, as well, is the retendering would take place for 2025. It will obviously have to occur in a tendering process well before that. I agree with him that it's good to tender just in general, although sometimes I understand why that wouldn't be the case when Northern Health is satisfied with the contractor. I think, generally, the community is satisfied with the contractor in general — why they might have gone that route.

In any event, it won't go that route the next time. That's obviously a business decision by Northern Health, and a response to a complaint put forward in the process, which is completely fair and legitimate.

M. Stilwell: Thank you to the Health Minister for the opportunity to ask a question.

I'm actually here today to ask questions on behalf of the city of Parksville. The city of Parksville feels like they have been experiencing a significant challenge working with the minister because they have yet to receive the courtesy of a formal response in a bylaw that they submitted in accordance with the provincial regulatory processes prior to the COVID-19 pandemic.

The city, as many communities around the province, is experiencing many problems regarding improperly discarded hypodermic needles, both used and unused. In the efforts to manage the community safety risk in the city, the city abided by the ministry's regulations, and they established some procedures and developed a bylaw. The bylaw was amended based on input that they received from the medical health officer in accordance with the regulation.

However, despite entering into the formal public health bylaw process in what they believe is good faith, and working with the medical officer, the city has been denied that due process and, quite honestly, the courtesy of a formal response from the minister. In fact, the province accidentally notified the newspaper of a neighbouring city that the bylaw was rejected. That occurred on June 2, 2020, and to date, the city still hasn't received any formal decision or reason for that decision from the minister.

Constituents in my riding want to have an answer to the issue. They want to know if the minister rejected the bylaw, and if so, what reasons does he have to support that decision? Further to that, when can the city expect the courtesy of a formal response?

Hon. A. Dix: You can tell Ed, Mayor Mayne, that I'll be giving him a call next week.

M. Stilwell: To add to that, I believe the minister knows that council passed a resolution in the fall of 2019 requesting a meeting with the minister and the medical health officer to find some mutually acceptable solutions to what is a very important community issue. Yet despite many attempts to arrange that meeting by the city staff, the city, again, has not received any response from the minister's office. I recognize that the minister says that he will call Ed next week.

The proposed bylaw seeks to implement the use of retractable needles as a means to reduce community concern about the risks of needle sticks and exposure to the drug residue from used needles. The question now, really, is being raised whether or not the ministry is putting the cost — we do know that retractable needles cost more — ahead of the safety of the citizens. The bylaw also attempts to control the distribution by identifying those individuals who are providing the needles in the community to sort of enhance the accountability for the numbers of used needles being improperly discarded around the community and the volumes of unused needles that are being wasted.

[3:10 p.m.]

We know that the unlimited supply that is given is not actually required because we know that many of the people who are taking them can't even carry the large volume of needles that they're given. Perhaps if an appropriate number of needles were distributed, that could counterbalance the slightly higher per-needle cost that would support the introduction of retractable needles.

That being said, I'm raising this question because wasting hypodermic needles during pandemic times has very serious ramifications for the people of British Columbia, in my belief. We are all watching this race to create a COVID vaccine with hope and with the fear of a second wave. It calls many things into question. When that vaccine will be created, the question is: will there be enough hypodermic needles to vaccinate five million people in B.C.? What is the government doing to build that reserve for the non-drug use of ordinary men, women and children around British Columbia?

We saw the results when the federal government dropped the ball. We saw masks and other health supplies not in rapid supply when we needed it the most. The government has this opportunity now — and, quite honestly, a duty — to make sure that when that vaccine is available to be delivered to the people of British Columbia, as soon as it is developed…. What is their plan to make sure that there are going to be enough needles to go around?

Or will they be misused, and will we continue to see new hypodermic needles thrown away by drug users who, not by any fault of their own, are simply incapable of managing their safe disposal or even keeping track of the unused needles? I want to ensure that this government has a plan so that we have ample supply and to ensure that there will be enough needles in place when the vaccine becomes available. Can the minister tell me what the plan is?

Hon. A. Dix: I think I would say, with respect, the conflation of these two issues is really not one that merits too much discussion.

Dr. Bonnie Henry, who is our provincial health officer, and our team in the Ministry of Health have been involved in multiple pandemics around the world, helping people on multiple continents. Dr. Henry was a leader in the SARS fight in Toronto and helped lead British Columbia and others in the H1N1 issue, which involved very substantial immunization as well, as the member will understand. Preparing for a possible vaccine is something that we give great focus to, both at the provincial and the national levels, and it's a high priority for us.

Obviously, that vaccine doesn't exist yet, but the availability, or putting together a plan for it, is not in any way related to how needles are used or misused by those in the community. This is obviously a high priority for us, as is the development of a plan to address immunization for influenza in the fall, to deal with other immunizations in the system and to deal with medical supplies. I think British Columbia has been a leader in that regard.

With respect to the situation in the community, I would say that it is the same kind of advice that we get from medical health officers that guide these decisions as well. They don't make those decisions frivolously; they take them very seriously. I know that the people of Parksville do as well. I look forward to speaking with Mayor Mayne. Until I make a decision and send a letter out, the decision is effectively not made, although the fact of a recommendation was sent out, I think, and of a briefing note. I want to have that discussion with Mayor Mayne, and we'll follow up subsequently in writing with the reasons for the decision.

M. Stilwell: Minister, thank you for the comprehensive answer. I appreciate that you're taking that time to reach out to Mayor Mayne. I just want to confirm, then, on the record that you're saying a decision has not been made by you at this time and that you are still looking at the issue but will have that discussion next week when you talk to the mayor.

[3:15 p.m.]

Hon. A. Dix: I'm saying that until a decision is communicated formally by me, it hasn't been made.

Of course, the member will know the recommendation and the briefing notes were leaked out — not leaked out but sent out — in response to a media request. It was simply a mistake that was made. That's unfortunate, because that's not the ordinary way we would want to conduct such a thing. I'll be speaking with Mayor Mayne about it personally and then following up in writing with the detailed reasons, which is, I think, the appropriate way to communicate in these matters.

I appreciate the questions from the hon. member.

N. Letnick: Thank you to the minister for his answers so far.

Just to advise that the member for West Vancouver–Capilano is coming up next.

R. Sultan: I return to one of my perennial topics in health budget estimates: British Columbia's cochlear implant program at Children's Hospital and also British Columbia's adult cochlear implant program at Providence Health Care, St. Paul's Hospital. I congratulate the minister and the ministry on the excellence of both programs.

I declare my own conflict of interest, since I myself am rather hearing impaired — a great advantage in politics, somebody once told me — but unfortunately not a candidate for cochlear implants.

Both the adult and the children's programs are important in restoring full capability to qualifying deaf persons, even though not everybody benefits equally from the procedure. I'm sure the minister and the ministry resist any impulses about the lion's share of implant resources to one cohort or the other.

For the adults, the good news is the promise of a $12 million donation to a new B.C. Rotary club hearing and balance centre at the new St. Paul's Hospital, announced by the minister. We all celebrate this landmark development that many, many of us have worked on for many years. St. Paul's hopes the leverage of this donation will create an institution of international recognition, enhancing its already high reputation.

Both our adult and our children's programs are budget-constrained. That's a familiar message. There are more candidates available than surgical resources can handle. I'm most familiar with St. Paul's, currently funded for about 46 implants per year. Excluded is bilateral implantation, meaning in both ears, despite strong clinical evidence of its effectiveness. Similarly rejected on fiscal grounds are asymmetrical hearing-loss candidates, characterized by severe hearing loss in only one ear. Data shows that these candidates would do better if bilateral hearing was restored.

Since cochlear implantation is a relatively new procedure, wait-lists have not been unreasonable. However, as the benefits become more widely known, the expectation is that wait-lists could begin to stretch into one or two years, which would be unfortunate.

My first question, Minister, is: could the minister give us his views on the resource issues and the priority attached to both the adult and the children's cochlear programs?

Hon. A. Dix: We had a good discussion of this last year. I think it shows the commitment of people both at St. Paul's and at Children's Hospital that the number of implants actually is higher than the budgeted number in each year and continues to be higher.

The member will know that both at Children's and at St. Paul's, the cochlear implant was one of the…. It was called non-urgent elective surgery only because we're defining urgent in a different way, but these are obviously important surgeries. Those were cancelled or delayed on March 16 and then relaunched May 18. He'll know that since then, cochlear implants at both St. Paul's and at Children's Hospital have resumed, and that's good news.

[3:20 p.m.]

At Children's, there's no wait-list for cochlear implant surgeries, and two, as they say, have been performed since surgeries resumed there on May 18. That's a significant point, an important point, and I'd refer him to the extensive discussion we had about the children's side of this in yesterday's estimates.

With respect to the demand for surgery at St. Paul's, it is true that average wait times were in months in the early part of the last decade — 20, 24 and 25 months — leading into 2016-17. That situation has improved significantly since then, I should say, in the period before I became Minister of Health and in the period after it, such that we've seen an increase in the number of patients receiving the care.

I'll take his interest in the area and his comments — with respect to, shall we say, other ways that patients can benefit from cochlear implants — to the people of Providence Health Care. Clearly, both on the children's side and on the adult side — this is approximately a $2.6 million program — given its impact on people's lives, it has proven that it's cost-efficient. As we develop our surgical plan and seek to reduce wait times in a number of priority areas, this is one of the areas that we can look at, and I'll take the member's comments as representation to do so.

R. Sultan: The minister has introduced money into the conversation. So let me follow up on that.

The COVID-19 experience is demonstrating that some phases of the cochlear implant preparation may be conducted remotely. As a matter of a fact, I guess this is an illustration that all disasters aren't totally bad, because this is an example of innovation being prompted by necessity.

It may not need face-to-face consultation. "We're seeing improving triage of patients by telephone" — these are the words of my physician down at St. Paul's — "and remote viewing of medical imaging." Now, that's an innovation. This would seem to be an encouraging gain in productivity. However, I am told that the current funding system pays only on the basis of a patient face to face with the surgeon.

Would the ministry consider taking a hard look at the basis of compensation, so that productivity-enhancing remote consultations would not necessarily be discouraged?

Hon. A. Dix: In fact, in this COVID-19 period, there has been a dramatic, almost exponential, increase in the amount of virtual care provided around B.C., including new billing numbers. Its relation to cochlear implants and specialist care is something of interest to us as well. I think what we've seen is not just a cultural change for the health care system but a cultural change for people, many of whom would have balked at the idea of a virtual visit a while ago but are now seeing its utility.

It has utility in people's lives as well. The idea of taking the afternoon off and getting a visit and waiting in a waiting room has been replaced for some people by a more convenient and, maybe, appropriate service. That's not to say there isn't utility in face-to-face meetings with general practitioners and specialists. I think these productivity gains are real.

They present some challenges — as the member will know, from his economics background — to the health care system in terms of overall costs, potentially. We have to work those things through, but new systems have been set up in this period. They've worked quite successfully. I think what we've seen is both a transformation of the population of practitioners and a transformation in the attitudes of patients. That will lead to dramatically increasing use of virtual care in the future. We have more ability to do that.

He'll also know that we've seen the addition of the CST system at St. Paul's Hospital, following Lions Gate, which has made a real contribution to the use of virtual care and has improved the quality of care at St. Paul's and other hospitals where it has been put into place.

R. Sultan: Thank you, Minister. Let me just say…. I think, like virtually all British Columbians, we're very proud of our health care system.

[3:25 p.m.]

S. Sullivan: My question is on St. Paul's Hospital. I note that in 2019 the budget was $1.915 billion but that in 2020 it's $2.083 billion. This is an increase of about 8½ percent. The entire increase is being funded by the province, and the provincial share will increase from $990 million to $1.15 billion, which is a 17 percent increase.

I just wanted to get a confirmation or an assurance from the minister that this project is going ahead as planned and that the targeted completion date is still 2026, within the budget of $2.083 billion.

Hon. A. Dix: I get to talk about St. Paul's. It's fantastic; my afternoon is complete. As members will know, the St. Paul's replacement project has been a long time in the making. Certainly, dozens of announcements, concept plans and business plans — and then back to pre–business plans — characterized the years from to 2002 to 2018. It was an interesting time, but we're on the road now.

As the member will know, the Premier approved the business plan and the budget. As adjusted in the most recent, I think, quarterly report, it's $2.083 billion. The provincial share is $1.158 billion. Providence Health Care will be providing $800 million; the St. Paul's Foundation, $125 million. For that, we are going to get a new, inspiring, transformational hospital in Vancouver that will serve the whole province. It's phenomenal, I think. We're proceeding.

I'm also delighted to say that we're expecting the preferred proponent for the design and build of the hospital to be announced soon. We had multiple bidders, which was very exciting and very positive for the people of Providence Health Care — for their chair, Eric Harris, and for their whole team.

This is an extraordinary venture. While we waited a very, very long time, it was a high priority, the member will know, for me, as Minister of Health, not to make announcements, not to talk about the project, but to deliver the project. We are delivering the project. The indication of the $2.083 billion is a demonstration of the government's commitment to the project and to our partnership with Providence Health Care, a long-term partnership which is continuing.

A new St. Paul's is coming; the project is rolling. A proponent is going to be announced soon. It's in place; I just could talk about it all afternoon.

S. Sullivan: I'd love for you to talk about it all afternoon. It is a very exciting project. I thank you, Minister, for your commitment to this and the fact that you're going full blast on this.

One question is about the involvement of the federal government. I know that the clinical service and research centre is a project where infrastructure dollars are being requested. I know that there have been meetings with the federal government for the past 16 months. I'm just wondering if the minister has any sense of the commitment that the federal government will also put toward this.

Hon. A. Dix: I have no sense of that. I know that the St. Paul's Hospital project also involves a broader project that Providence Health Care is leading, and we're working very closely with them on that. I don't know whether the federal government is prepared to get involved in that, although, of course, they'd always be welcome to, I would say to the hon. member. But I'm very optimistic about the rest of the project as well.

I think for Vancouver, the St. Paul's project…. There are lots of challenges with the development of the project and the move to its new neighbourhood in the False Creek Flats. I think it's going to be, again, transformational and positive for the people living in the neighbourhood, for the economic future of Vancouver and for its potential as a research centre at St. Paul's, in addition to Vancouver General Hospital.

[3:30 p.m.]

I'm very enthusiastic about all of those elements of the project. I don't know about the federal involvement or whether we might expect federal involvement. Providence Health Care may well be reaching out to the federal government on some of its other initiatives, but we're working closely with them on their other initiatives as well.

The very exciting part of this future development, which is going to mean so much to the whole of British Columbia…. While St. Paul's is a Vancouver hospital, I think it's beloved everywhere in the province. I get that everywhere. People from every community in the province have been served by St. Paul's in its more than 100 years of operation. I think the new St. Paul's is going to be part of Vancouver life in the 21st century. All of the facilities that will be built around it will contribute to that as well.

S. Sullivan: Finally, regarding Providence, they're building the first publicly funded dementia village. One in the Comox Valley. Then there's another, 33rd and Heather, which will also require provincial government support.

Can the minister give me any update on this?

Hon. A. Dix: Very excited about the dementia village on Vancouver Island, which I think is transformational. I believe that Providence Health Care is the right proponent for this. This is something I met with them on very early in my time as Minister of Health. As the member will know, I'm a strong supporter of Providence and all of its ventures. That's been reflected in St. Paul's and at Comox.

As we build that long-term care…. I was talking to the member from North Vancouver–Seymour earlier about the need to remediate and rebuild long-term care projects across B.C. — some questions about that — in the public system and in the not-for-profit system of public beds, of which Providence is a key part. Those projects, 33rd and Heather and the other, are key priorities as we seek to take existing long-term care spaces and transform them into the long-term care of the future.

There are going to be some challenges with that. The member will know, as a former mayor of Vancouver, there are things that we can do to make cities more accessible to seniors — long-term care in cities where real estate isn't hugely available, more available. New forms of long-term care and care will need to be developed that work for seniors in community.

Certainly, the 33rd and Heather project is on our radar. The need to use the dementia village model across the system will become, I think, increasingly part of our capital plans for long-term care into the future.

S. Bond: I, like others, want to thank the minister for his tireless efforts during COVID. I also want to thank him for reaching out with very kind words on the passing of my husband recently.

I can certainly speak to the issue of St. Paul's and how people feel about that across the province. I also look forward to debriefing with the minister on behalf of families like mine who lost a loved one during COVID not because they had COVID and the very unique circumstances that families like mine faced.

I know his afternoon would not be complete without a conversation about northern British Columbia and the University Hospital of Northern B.C. I'm hoping that, because time is restricted, and the minister is facing a marathon here…. I don't want to get into a debate again about when the plan or if the plan was on the desk or whatever.

I was very excited yesterday when I listened to the minister's enthusiasm for projects in other parts of the province, and I'm very happy for those cities. But I'm looking forward to a very succinct answer from the minister about when he will be able to be excited about and join us with enthusiasm about improved capacity, the replacement, the issues that he and I have discussed. I think all of us agree that work needs to be done.

I think the other piece that the minister has commented on previously is the issue of cardiac care. I continue to see far too many families and individuals being sent out of our community when, in fact, by adding capacity, we could actually save the system, certainly, resources, but also improve the quality of opportunity for families to be cared for closer to home.

[3:35 p.m.]

Minister, you and I know that it's not a matter of if; it's a matter of when. So my question to the minister, not unsurprisingly, is: when, Minister, will we see added capacity enhancements and, certainly, cardiac care at the University Hospital of Northern B.C.?

Hon. A. Dix: Thanks to the member for her question. I wanted to reach out to her, as well, and hopefully we'll have an opportunity to have that private conversation. In fact, we have a couple of members of the Legislature, recently, who have lost spouses, and those spouses have passed away in acute care.

You know, these circumstances are difficult. They remind us of what our hospitals do. They're for us in moments where we get better. They're also with us in our most difficult moments. So I'd be very interested in having a personal conversation with the member about that and just pass on to her my condolences in that, and for Renée, to her and her whole family, because these are tough moments.

I was reflecting on it. I just want to say this about the member, because I know that it was a very difficult moment and everything else. I understood that the member was on a call four days later about our seniors plan after her husband passed away. I have to say that if that had been me, I would not have been on such a call. So she's tougher than me to have done that. Just to express my extraordinary appreciation for her work on our seniors committee and her willingness to do that. I think that involves an element of trust that, hopefully, we will develop and continue to develop.

I'm not going to give her my long answer on Prince George. What do we need at Prince George, on the capital site? We need a new mental health facility, because the mental health facility — I'm sure she'd agree; I know that she knows the facility better than I do — is from a different time. If we review it from the lens of the present, given the service area it has, the wait times to get into it and the needs for mental health and addictions in the north, it's not at the level we'd expect. We can't replace it immediately, because it takes a while to finish these things, but mental health services have to be part of any plan going forward.

The second thing that has to be part of any plan going forward is new operating rooms. I think the current operating rooms, if I recall…. I mean, the hospital dates from further back than this — there are new parts, and there are some old parts — but the operating rooms, I believe, date from 1978 or earlier. They're simply not up to modern standards. We see this. This affects the ability of the hospital to recruit practitioners, in my view, but, secondly, the quality of care and the quality of service and the types of surgery that can take place there. So we need a new operating room.

Third, we need cardiac care in the north. I think that's just clear. I think these are very difficult moments. Any moment that involves cardiac care is a difficult moment for families. Doing that care closer to home, in the 21st century, in the Northern Health Authority, makes sense to me.

Those are the three elements we'll see, and the member will hear very soon on all these questions.

S. Bond: Thank you very much, Minister. I appreciate that. I also appreciate your kind personal comments.

I would assume…. I'll just say this, and then I have two other things that I want to raise. I don't expect fulsome answers at this moment. I know that I have submitted the questions to the minister. I think yesterday, with the news that the Premier said there may well be an opportunity for a fall election, perhaps I can be thinking that there may well be an announcement about the University Hospital of Northern British Columbia in that time frame. So we'll see what happens.

I will assure the minister that there will not come an estimates time that I won't be here arguing on behalf of my constituents for the very kinds of improvements that he's articulated. He would expect that of me, and certainly my constituents do as well.

Two other issues that I will raise and then allow my colleagues…. I know they have a long list of questions as well.

Obviously, I know that the minister and I and every MLA share concerns about the safety of the workplace for health care professionals. In particular, I've raised with him previously the issue of the pledge that all of us signed to ensure that nurses in…. You know, the pledge was related to nurses, but obviously health care professionals in general. I want to just bring that again to the minister's attention. I have been so grateful, having seen from the inside out, over the last number of months, the incredible work that nurses do, some of the challenges that they face.

[3:40 p.m.]

I want to urge the minister to continue to find ways to provide that safe workplace, looking at the kinds of security issues and all of those things that nurses have raised on a number of occasions. And I did want to speak…. Certainly, I've met with the nurses here in Prince George many times, and I have been touched by how hard they work and also by some of the risks that many of them have faced.

Lastly, of course, the minister would also not be surprised to hear me raise the issue of the importance of automated external defibrillators — having them in public spaces, working in partnership with the Heart and Stroke Foundation to make sure that more and more people have the opportunity to life-saving access to automated external defibrillators.

Those are the other two issues. I have others, but I've already shared them with the minister. I want to thank him again for his personal comments, for his willingness to engage in these discussions, not just today, but in the days ahead. I thank you for the time, and I will listen for the answers, Minister. I look forward to a follow-up conversation on a number of these issues.

Hon. A. Dix: What we'll arrange to do is…. I think we've got two more weeks in the Legislature, interrupted by one, but hopefully we'll have an opportunity in that time. I'll just commit to having a conversation at greater length on some of those issues.

I think one of the issues that the member has raised over the years is the issue of not just having facilities in the north — we're building in Dawson Creek, Fort St. James, Terrace and Quesnel soon — but also the need to have health care professionals and health care workers in the north. I think what we've tried to do, and we've seen some of these changes in recent times, is associated with these new facilities, building out our capacity to train people in the north.

Yesterday the member may have had the occasion to hear my discussion with the member for Kelowna–Lake Country, where we talked about the effectiveness of the distributed model in medical care and the training of doctors — the fact that because of that, doctors stay in regions more. That was an innovation of the previous government, which I had the occasion to applaud yesterday.

We have a very detailed response to the question of safety in the workplace. We've taken a series of initiatives. What I might do, for the benefit of all members, is put a longer response on the record and distribute it to all members, because I think all members would be interested in the response.

We've taken actions step by step at a number of institutions, most prominently the forensic institution in Coquitlam. We're taking steps provincewide to act on a report by Michael Marchbank, who's currently working on surgical issues on behalf of the government, and who the member will be familiar with, which we intend to use to improve levels of safety in hospitals across B.C. That work and that announcement will be coming soon.

As well, I just note the creation of the provincial occupational health and safety organization that was the result of the 2019 round of bargaining. It is an announcement that involves all the partners in health care.

The member will know that certainly nurses — members of the BCNU — but also health care workers are in positions where they often feel that they've received injury in whatever form, intentional or sometimes unintentional. This is particularly true and increasingly true in long-term care, where people are dealing, on occasion, with residents who are struggling with issues of Alzheimer's and dementia. This leads to real challenges for people who are care aides and nurses and LPNs and work in the system.

I have a lengthy series of responses to make, but acting on that report — or acting and following up on initiatives that have taken place in the previous government — we have a new occupational health and safety team. We have multiple sites where the current model to deal with violence and safety in the workplace is being put into place. I agree with her. This is an ongoing issue and struggle, and it's one that continues.

One of the struggles on the acute care side, I think, is we've gone through a period now where we've had relatively, compared to normal, empty hospitals. Hospitals that aren't full, that don't have visitors and have less action and activity. But we've also had a situation where health care workers have been working in the context of anxiety. You see that, and it continues to be the case. There haven't been many cases of COVID-19 in the north, but it's affected health care workers in the north nonetheless.

[3:45 p.m.]

Today, and in the last couple of days, we have, of course, announced ten new cases in the Northern Health Authority, and that causes everyone concern and anxiety, particularly health care workers. So we have to do everything we can to ensure health care workers are safe. We're following up on measures. I don't think our response has been fast enough or perfect. But we are, step by step, taking the steps we need in cooperation with people who work in health care.

I appreciate the member's questions. I will send her a substantial response, which I'll share with other members of the committee as well.

T. Wat: Good afternoon, Minister. I really appreciate the minister taking the whole day to respond to, actually, each and every one of our opposition MLAs. I appreciate your patience. I hope you still have the patience to listen to my question.

It was really a pleasant surprise to see the minister announce the expansion to the Richmond Hospital, the project, even before the business plan was approved. In the announcement in March 2018, the minister — I'm sure you remember — said the business plan would take 12 to 15 months to complete. Now it's more than 27 months. The business plan is still not approved. How much longer will the people of Richmond have to wait for this project to be built?

Can the minister also outline any preliminary budget changes he expects to come from the expansion of this project's size for the new hospital tower?

Hon. A. Dix: I'm sure the member will agree that the people of Richmond have been waiting a lot longer than 27 months for this project. I think it's an exciting project for the future of Richmond.

As the member will know, in March of 2018, we approved the concept plan. We announced the approval of the concept plan for a new tower in Richmond. As we've developed the business plan, we learned, and Vancouver Coastal Health decided, that the order in which things would be built wasn't the right order. You would need an almost immediate new construction project with the opening of the new tower and that we needed to incorporate ICU and emergency and laboratory and new facilities in the tower and increase the size of the project.

What they decided to do, because this would obviously involve an increase in money…. When you approve a concept plan, it means that amount of money is in the capital plan. They came back to us and sought the approval of a new concept plan, which was approved. That process was concurrent with developing a new business plan.

The good news. The member asked a specific question; she'll get a specific answer. We gave people news of the development of the concept plan and all of the new elements that that would incorporate. Obviously, a bigger concept plan. It's my expectation that the business plan will be prepared for September of this year, and I look forward to seeing her — virtually, perhaps, because we're doing these things virtually these days — at the announcement where all the details will be made available.

T. Wat: Minister, can you give us an idea when…? I'm sure the minister remembers that the Premier committed to having the construction start day before 2020. In fact, it was the headline in all the Chinese language media, *Sing Tao* and *Ming Pao*. The community was really excited that, actually, the construction site should have started already.

Now, there is more expansion, which is good news. But when can we see the construction site start? I'm sure the community wants to know the answer.

Hon. A. Dix: Well, the business plan will be approved. What the business plan approval…. You will understand the process. The member is a former minister, so I'm sure she does. Until the concept plan is approved, it's not in any capital plan at all. When the concept plan is approved, it's in the ten-year capital plan of the government. That means there's money attached. You can't approve a concept plan without money attached.

We then upgraded, significantly, the concept plan, so a new amount of money was attached. But when you do a concept plan, the reason why you don't publish the number is that there's a wider range of estimates about what the cost will be. This shows the value of the concept planning process and the business planning process — that we would build the hospital that Richmond needs for the next 40 years and not one that we would immediately have to start working on after the project.

[3:50 p.m.]

So that's what we did. When the business plan is announced in September, the numbers will all go into the budget. Members are familiar with that, as has been the case in Terrace and in Williams Lake and St. Paul's…. The member for Kelowna–Lake Country is looking at me and saying: "He's not going to name all the hospitals now." But as was the case in all of these cases, it will be the case in Richmond.

Then it goes into the three-year capital plan of the government, which appears in the budget document, and significantly more details about the size and scope and particularly budget are available. Obviously, we were delighted about our work with Ms. Meixner and the Richmond Hospital Foundation, which does extraordinary work. I can't believe how positive everyone at the foundation was at our event just recently and about the expansion and scope of the project. I think people in Richmond are inspired by that. I know I am.

I think Richmond Hospital is one of the most important hospitals in the province. It's a place close to my heart, and it's close to my heart because the people of Richmond have come together to so profoundly support this project. The success of the foundation in raising money is an extraordinary thing. And I'm very proud of the work that's been done on the project by Vancouver Coastal Health.

You know what we're going to do? We're going to rock on, and it's going to be fantastic. We'll see you all in September.

The Chair: Just a little status report, a reminder. We're going to break in the area of four o'clock for a Chair change and sanitation protocol.

B. Stewart: Minister, good to talk to you again. I know that your last few months have probably been, I'm sure, busier than you ever imagined.

A little over 16 months ago, we ended up…. Mayor Milsom, from the city of West Kelowna, and myself met in your office about the Westside urgent and primary care centre, which, as you know, has been long since promised by previous governments as well as something that you've looked at.

At the time, you gave some certainty that there was going to be an announcement, which there was in the fall of 2019. Then on January 9, you opened the urgent and primary care in Kelowna-Mission. On February 20, you made a statement that this April — which I know was derailed by all of the other things going on in the Health Ministry — the city of West Kelowna municipal officials would have certainty as to the feasibility of this and whether this project is going ahead or not.

Do you have a comment on that?

Hon. A. Dix: I can't believe that I got a question on Friday afternoon about urgent and primary care centres.

I'm very positive about it and very positive about the work that Interior Health has done with people in Kelowna and West Kelowna and Lake Country. They're doing two things, as you know, in the region. One is the development of a primary care network. That work is happening with the divisions of family practice and people who represent people in West Kelowna and around the region, including Rutland, Lake Country, Kelowna and West Kelowna.

The UPCC in Kelowna is a project that has proved its worth in the COVID time. It's played an essential role, especially considering the events of the last couple of weeks — a particularly essential role in this time. But we are working on a broader primary care network for the whole region. I think we're getting close on West Kelowna. I'm very excited about that. And we have been delayed slightly in what we're doing, by COVID, but not very much.

We're building out a primary care network. We're looking at community health centres in communities such as Lake Country, and we're proceeding there and doing that work. I look forward to being engaged with the mayor and the MLA and yourself, the MLA for Kelowna West — soon to talk about that.

I think West Kelowna is clearly a growing city. There's long been a need for enhanced primary care, but it can't just be one centre or one health authority–run centre. It has to be a primary care network, of which that urgent and primary care centre would be a part.

That's what we're building together in the Central Okanagan. I think we're going to build a network of primary care and team-based care that's going to transform health care in the Central Okanagan. I very much appreciate the work that the member has done and especially, if he'll forgive me, the work of his colleague from Kelowna–Lake Country, who's given a lot of effort and a lot of work with the details of this and how it would work in different communities.

[3:55 p.m.]

We also, of course, as you go north in the Okanagan, have established an urgent and primary care centre in Vernon, which is now at its permanent site. I think what you're seeing develop in the Okanagan, the extraordinary work done with the South Okanagan primary care centre in Penticton…. You can see that the systematic, methodical, step-by-step work of Interior Health in support of this primary care plan is really bearing fruit in the whole region. In West Kelowna, you're going to hear news of that soon. The apple will fall from the tree, and you'll pick it up off the ground.

B. Stewart: I take it by that analogy that I should be able to know sometime in September or October, because the apples will be ready and falling off the trees.

Hon. A. Dix: I like that. I was going to use a wine analogy, but I lost it there.

B. Stewart: No, that's fine. I know that you've told me that it is a priority. Of course, the mayor of Peachland is very concerned. They, a community of almost 6,000 residents, along with the Westside, of over 50,000…. There is a need. And traffic. I don't want to suggest that the one bridge that we have, it does…. It's taxing at this time of year.

I do want to tell you that I had an incident where somebody had to be taken to the urgent and primary care. It worked flawlessly. It was really…. The people there and IHA are to be commended.

On one other matter, if I might ask, you were asked a question by my colleague from Kelowna–Lake Country about the delay in COVID testing in IHA. I had some other comments from constituents in my riding. Certainly, it's been a matter, a topical one, on radio, today and yesterday, and TV. The question really is that people that have been told they need to self-isolate are getting tested, and then they're waiting six or seven or more days to get an answer.

I guess, considering how we ramped up with COVID testing, all of the things of emptying the hospitals, decanting out so that we could use the operating rooms and things like that…. What I can't quite fathom is knowing that this likely second wave is going to come, and we're not really prepared.

I'm wondering. Can you give certainty or some assurance that you're going to look into this and get back to myself and my colleagues in the Central Okanagan about the delays of the testing centre that's right down the street from all three of us?

Hon. A. Dix: I appreciate the question. I would say that I think in the last week Interior Health, in the Kelowna area, did four times as much COVID-19 testing as they'd done in previous weeks. Obviously, there were some delays at some point, but I think the overall response time for most people has been good. I provided those numbers to the member for Kelowna–Lake Country yesterday.

Obviously, when you see a transformation — you go, in a health authority, from two cases to 72 active cases, where we've been in the last number of days — and the anxiety that that produces in the broader population, you're tested for a moment. But I think the people of Interior Health have done a good job in responding. The capacity is there. Yes, sometimes turnaround times can be a problem for individuals. I took seriously the question from the member for Kelowna–Lake Country yesterday.

I think with respect to the capacity for COVID testing provincewide, we're at about 8,000 maximum per day that we could do if we needed to. We need to expand that out to 20,000 by the time of the fall, and it's our expectation that we'll do that.

I also would note that yesterday, particularly in Kelowna, our health care team was out in the community with people from the city and others, engaging in businesses and gatherings around the central part of Kelowna to occasionally write letters but, generally, just engage with people about what needed to happen now.

We have to continue to do this work. COVID-19 is going to be with us for a while. We want to enjoy the summer, but we want to enjoy it safely.

In the case of people awaiting testing, yes, it can be a problem for people, but there is a need right now to self-isolate. I think Dr. Henry had talked about how close to 1,000 cases of contacts, with respect to the Kelowna transmission of COVID-19 around the province, were currently self-isolating.

[4:00 p.m.]

That's obviously a significant problem and shows what can happen, on occasion, when we take our foot off either the gas or the brake. I never get the metaphor straight for cars with respect to COVID-19.

I think these are good lessons, but I think the folks at Interior Health have done a very, very good job. The sheer number of tests that they've done in the last week or so is impressive, and the response times, I think, are back to where they should be today.

The Chair: Thank you, Minister. Thanks to all of the committee members for the cooperation and service expressed here and the dialogue, and to the minister and his team.

We will recess for five minutes. I wish you all safe travels and a good weekend. We'll see you next week.

The committee recessed from 4:01 p.m. to 4:06 p.m.

[S. Chandra Herbert in the chair.]

The Chair: Good afternoon, Members. I see the minister is ready, as usual, and I understand that others will be joining us shortly with more questions.

N. Letnick: Just a segue. We are now entering into one hour of questions from the Third Party House Leader. That will be followed by a wrap-up series of questions by myself, which will take us to 6 p.m. Then, I believe, the minister might have a motion to make at that time.

The Chair: Seeing the Leader of the Third Party, please proceed, Leader. Good to see you.

A. Olsen: It's nice to see you too. It's nice to see all of our colleagues here to witness the last while in these budget debates.

The Minister of Health continues to be a marvel in his ability to simply just have a conversation about the largest, most comprehensive ministry in our government. My hands are raised to him for his obvious…. He's got a good grip on the content here; that's for sure.

I want to go back, I think, a little bit to some of the questions that I've asked the minister in question period, regarding the thousands of my constituents that don't have access to a family doctor yet. I know that there has been a lot of work that's been put into changing the model for how my constituents, and British Columbians across the province, obtain primary health services.

Initially, there was a lot of attention on developing patient care homes and primary care networks. However, as time has passed, it seems the focus has changed slightly toward a different approach: urgent care centres. Perhaps these are just a lot of different names for the same approach, but I'm just wondering if the minister can explain the difference between an urgent and a primary care centre, a patient care home and a primary care network, from his perspective.

The Chair: Minister of Health.

Hon. A. Dix: It's great to see you, hon. Chair, at this time on Friday afternoon. It's our time of day, I think, our time of the week.

[4:10 p.m.]

Thanks to the Leader of the Third Party for his question. I think what I'd like to do, perhaps, is speak about it in the context of his constituency and what he should expect to see in the coming weeks and months.

I think the Victoria area, the capital regional district, is a particular priority in primary care for three sets of reasons:

(1) There are lots of people with chronic disease and lots of our elders, as well, in the Victoria region who depend on health care.

(2) The practitioners in primary care that we've counted on in many communities, in many cases, are retiring. He'll remember the event and the discussions we've had on some of these issues at a public meeting in his riding, which seems like just yesterday, but it was a couple of years ago, I think. Those are significant here.

(3) In some ways, the lack of integration of primary care in the community.

What are we doing here? We're developing on the south Island with the South Island Division of Family Practice, which really includes components in Sidney and Saanich, around the corner through the Western Communities. We're developing primary care networks in those communities, both in the Western Communities and then in Saanich-Sidney. The idea is really to support the activities of existing practitioners to build out team-based care in existing practices, and in fact, to add other health professionals and other health support to existing practices.

We see an example of this with the development of the Sooke clinic, which is an existing private clinic in Sooke, where we've built out both on the capital side and the addition-of-resources side, with new resources to serve more people in an existing site in a team-based setting. That's one.

You see it in the development of the James Bay Urgent and Primary Care Centre, which is an urgent and primary care centre that provides team-based care and urgent care and connects people for longitudinal primary care.

The primary care networks are everywhere. The urgent and primary care centres are spokes in such networks. Then we're also building out other community health centres, which are run by community organizations in many communities. They would include both doctor-led clinics and nurse practitioner–led clinics.

What you're going to see is the development of all of those come together in Victoria to provide an integrated model of primary care to deal with the situations we're facing. I would expect — and he knows, because we've met on this a few times — that the primary care network that serves his constituency, or principally his constituency, the Vancouver Island side of his constituency, will be available to us soon. The Saanich Peninsula PCN will be a partnership of First Nations, which is very important. The South Island–Saanich Peninsula PCN will be part of, of course, the South Island Division of Family Practice in Island Health.

We'll be building out that primary care network together, which is to add resources and link together to those resources in a region. Urgent and primary care centres are one component of that, as are community health centres. Patient medical home is a name we don't use very much anymore, but it means some of the same things and really would mean one of the centres that's linked in the primary care network.

A. Olsen: That's good. I think one of the challenges is that there's been some confusion. There are so many conversations that are going on.

Maybe the final question that I'll ask is…. Maybe the minister can just highlight some of the challenges, just in how different aspects of medical services are remunerated and the challenges with the established practices that are in place. Then, as well, the evolution. I know there are so many conversations going on here that getting a good grip on exactly what's happening…. We've been at this now for the last three years. It seems like it's been going on for a very short time, but over a long period of time.

Maybe just a little bit about the communication and the interactions the ministry has with the division of family practice, Indigenous health services, not-for-profits. We've got a really great not-for-profit in our community called Shoreline Medical. The community is really invested heavily in Shoreline through the relationship that they have with the Saanich Peninsula Hospital and Health Care Foundation.

[4:15 p.m.]

How does the ministry work with Shoreline Medical, as an example, who are doing a lot of the same work to ensure that it's not being duplicated or that we're working together rather than, maybe, in front of or behind each other?

Hon. A. Dix: I think we're well along the road. With respect to, for example, the Saanich Peninsula primary care network. The funding is established. The funding is in place and is flowing. We would expect an announcement soon.

Shoreline and other existing practitioners would be seen as part of that, but it doesn't just include the South Island Division of Family Practice in Island Health. It includes at least four First Nations, as well, who will be part of that effort to expand out not just health care to the whole community but also the specific and important needs of Indigenous health in the member's constituency and in the region.

The member can expect that soon — and the development of new urgent and primary care centres in the capital regional district, the development of new nurse practitioner–led clinics and the development of community health centres. Yes, it's taken longer than we would have wished to develop the centre, because we've decided to take a ground-up approach. That's sometimes the best approach; it's sometimes not the best approach. But what I want to do and what we want to build together is something, ultimately, that will last. Only things that are built from the ground up, I think, can last, where we develop a consensus, even if it takes a long time.

I think there are differing interests sometimes, amongst professions who have worked on their particular model, and the shift to team-based care is culturally a challenge for some people who…. By the way, those that it's a challenge for have been absolutely necessary and remain necessary to the system. We cannot pass that away.

Different interests of different doctors at different times in their careers, many who worked in a fee-for-service arrangement all their lives who are reluctant to see that change, and other young doctors who would like to see a more alternative payment or salaried arrangements.

All of these are in discussion, but I think we're getting there all through the south Island region, with the South Island Division. I think the relationships are excellent. We've just had an announcement in Sooke. I'm expecting more to come in the next few weeks. We'll look forward to fully briefing the member on those as we get closer.

In several cases, what we're waiting for is the money allocation. In this case, the money has been allocated, with respect to the Saanich division. That's incremental funding — incremental for primary care on the Saanich Peninsula, $5.2 million — which is the amount of money that flows. That is a pretty significant addition to primary care just in the Saanich Peninsula part of the South Island Division.

A. Olsen: Thank you to the minister for the response and for providing that clarification. I'll just turn it over to my colleague from Cowichan Valley.

S. Furstenau: I'm delighted to be here, marvelling at the energy and depth of knowledge of our Health Minister, and just want to say how much I appreciated the way he worked with us throughout the lockdown period with COVID-19 and how much I appreciate his willingness to keep us apprised of things, answer all of our questions and really be a shining example of really excellent governance through this very difficult time. I just want to start by really appreciating and acknowledging the minister for that.

Then I'm going to jump right into the questions here. We'll start with COVID and long-term care homes, which clearly was one of the biggest challenges that this province faced and that the minister and Dr. Henry faced. It brought to attention very much across the country the issue of for-profit care homes.

Data from Ontario has shown that there were significantly higher death rates in for-profit long-term care homes from COVID-19 than there were in not-for-profit care homes and municipally run. I'm not sure how that data is in B.C. Maybe the minister can speak to that.

[4:20 p.m.]

Also, to break down some questions here, could the minister just start with telling us how many for-profit, how many not-for-profit and how many public care homes are in operation in British Columbia, and could he explain quickly the difference in operational and administrative structure between these systems?

Hon. A. Dix: With respect to COVID-19 and the for-profit, non-profit question, it should be said that there have been quite a few outbreaks in B.C., and 110 people have died in long-term-care outbreaks in B.C. But I don't think the number of outbreaks represents a sufficient analysis of whether one form of health care is better than another or leaves people more susceptible.

In fact, the largest number of outbreaks amongst the category of outbreaks is in private, not-for-profit facilities. That's because, in those facilities, an outbreak generally occurred because COVID was brought into the facility.

I'll just give you an example. Holy Family, which we talked about with members yesterday, in southeast Vancouver is Providence Health Care. It has a very high staffing ratio. It's in the HEABC agreement. It was basically a single-site provider before the agreement. It's known for the quality of its care and the people who care, its spiritual care, its other supports, its social activities. Yet they had this striking outbreak, as they did at Langley Lodge, which is a not-for-profit; as they did at Royal Arch Masonic, which is a not-for-profit; as they did in Haro Park, which is a not-for-profit; as they did at Lynn Valley Lodge, which is a for-profit provider.

I don't know if there's sufficient information to draw conclusions from that, except that in all the cases, people have worked in an unbelievably dedicated way, under the most difficult imaginable conditions, to do their best in those conditions. The health authority has been there for them.

We've tried not to pit or suggest one group as opposed to another, because I think the evidence shows that if circumstances had been different and COVID had come into a health authority–owned and –operated workplace, for example, as it did in some cases — had come in, in a serious way — the fact that conditions might have been good wouldn't have changed the fact that COVID-19 is a relentless enemy. It has a real impact on people in long-term care, and 22 percent of those who tested positive passed away, which tells you the vulnerability of people in the sector.

I guess, just to generally speak to that subject, that's the evidence — that the largest number of cases and deaths in B.C. was at not-for-profit facilities. But I want to say to everyone who might hear that statement that they should not draw conclusions from that, that there's not enough evidence to draw conclusions from that. It just happened to be the case because four out of the largest five outbreaks were in not-for-profit facilities, and that obviously changes the number. Should there be — we hope not — another outbreak, that would change the numbers again significantly, and more than one institution should….

With respect to long-term care, there are 113 health authority–owned and –operated care homes in B.C.; 110 private, for-profit; 88 private, not-for profit that serve the public system; and 59 private, which are private care homes that don't have public beds. In assisted living, there are eight health authority–owned assisted living; 56 private, for-profit; 73 private, not-for-profit; and 77 private, for a total of 370 care homes in the first category and 214 assisted living in the second category.

S. Furstenau: I guess this is more of a philosophical question for the minister and maybe one that is beyond budget estimates, but we have a publicly funded health care system in British Columbia that has been recognized for its excellent delivery of care to people and patients around the province, and we are very proud in Canada to have a publicly funded health care system.

[4:25 p.m.]

Given that care for seniors is also health care, in many, many cases, what is the minister's view and vision for long-term care for seniors into the future, particularly as we're seeing a demographic shift underway in our country? As we're going to see more and more people needing longer-term care as they age, does it make sense to the minister to have, on the one hand, a publicly funded health care system but to have a seniors care system that has a merger of all of these things that does include for-profit care, with the implications that that may or may not have for COVID but that does have some implications around how we see long-term care for seniors as part of a wider health care system?

Hon. A. Dix: Thanks to the member for her question.

I think we do have to deal with the situation that's in front of us. I talked about the number of facilities. Roughly 9,000 of the 29,000 publicly funded long-term-care beds are health authority–owned and –operated at present, and roughly 20,000 are not-for-profit or for-profit private facilities of some sort that are funded in their public beds — these are all public beds — under per-diem arrangements.

The member and I had an exchange in question period where we discussed the reforms that we'll be bringing in and the process to review those and the work we're going to be doing with the providers over the next number of months to bring a little more stability, standardization and clarity with those contracts, which, of course, makes it easier to ensure and maintain standards.

My approach is the one that the member will know. Clearly, care standards were dramatically low in B.C. when I became Minister of Health. They just were. They were dramatically below the standard the government had set, which was in 2008. They said the standard should be 3.36 per resident-day. It had gone down in the subsequent years. There was an Ombudsperson's report, in which that was the primary recommendation two years later, and it had still not succeeded, to the point that 85 percent of the care homes in B.C. didn't meet the provincial standards when I became Minister of Health.

So what have we done? We've dramatically increased standards. This reflects some the challenges, because the places where they had the lowest-funded care hours tended to be private and not-for-profit, and 75 of them, for example, were under 2.9.

My approach and my belief is that if they're publicly funded beds, they all have to meet and come close to the provincial standard for care hours. That's what we've done. We have this system. It's very challenging to transform it. I'll just speak briefly about that again in a second. So if they're all publicly funded beds, and if, for many people in many communities, they only have a choice of one facility, which might be private for-profit or not-for-profit or public, they should expect a certain standardization in care hours per home. So that's what we've done, and that's important.

Secondly, I believe that the system of subcontracting and the system that had denied workers' rights that was founded in Bills 29 and 94 was wrong for B.C. So we got rid of that, and we restored labour rights to workers. That was a powerful and emotional thing. I know the member had met with members of the HEU and BCGEU and others and understands its importance — to re-engage workers in that system. I think that was fundamentally important.

Thirdly was not to forget that we could spend all of our money in long-term care. We can spend all of it. But it's 30,000 of a much larger subset of a much larger set of seniors who want to, for the most part, stay at home. So we have to invest in home care and home support. We've done two sets of things — significantly increased home care hours and dramatically increased adult day programs for seniors living at home, those hours, in a transformative way, in order to improve resources in the community.

On the south Island and in Metro Vancouver, we brought those services back in to the public health authority and under the direct direction, not by contract, at the public health authority after contracts ended on March 31, 2020, and slightly earlier here with Beacon Services in the south Island, at the end of 2019. So that's a key priority.

The fourth, I think, is that our capital stock, the actual long-term-care homes on the public side, are much more likely to be multi-bedrooms. I think only some 24 percent of them on the public side are multi-bedrooms.

[4:30 p.m.]

We've got a capital deficit problem. We haven't been investing in the capital of health authority–owned and –operated. So while you'd like to build new ones, we have an enormous capital job to address those, and we have to increase the number of beds because there are more seniors in lots of communities in long-term care. My view is to work with all the players in long-term care and not to take an ideological view but a pragmatic view about increasing the options for seniors.

The final thing is the care itself. This is hard to say in these times, because these times are about safety and about not having many visitors and having visitation policies. But we've got to find ways to make life better for people who live in long-term care — not just keep them safer, which takes a lot of effort and a lot of money, but make life better. That's our commitment to do that — really for the system to not be about a race to the bottom on wages and competition between care homes but that the competition should be about the quality of care and seeing that it rise.

I believe, underlying all that we've done — single site and the changes we've made and the investments we've made — is that, which is respecting people who work in long-term care and ensuring everybody has standards. That's the philosophy that I've tried to put in place in my time as Minister of Health.

S. Furstenau: I appreciate the depth and the detail of the minister's answers on this. I'm going to ask one more question on this and then get to a bit more of a specific piece.

With public funds going to care homes, as the minister points out, there are publicly funded beds in all manner of long-term care homes. One of the challenges that he's identified and that has also been identified by the seniors advocate is the oversight of how those funds are being spent. Are the standards being met? Are the care hours being delivered in the way that they need to be?

I guess my question is if the minister could provide some insight into the mechanisms for government oversight for the spending of all public funds that go to any of the care homes to ensure that the direct care hours, the total staff wages and the funds are going to where they should be going to. What capacity does the government have, in cases where that's found not to be the case, to address that issue?

Hon. A. Dix: I think there are two sets of issues. I'll just briefly touch on the first, which is ensuring that standards are high. That's the work of medical health officers. That's the work of health authority boards of directors, supported by us.

The member will know, because she lives on and represents Vancouver Island, that we've had three care homes that have been brought under the administration of Island Health in our time. That's about ensuring the standard of care. It's not the financial question she's raising; it's the standard of care. That part is independent of the other.

In other words, the medical health officer's job is not to address the financial stuff, because there would be some internal conflict in that. So we have different people doing different things. But it's really important.

Unfortunately, only six times in history has that provision ever been used, and four of them involved Retirement Concepts in B.C. right here and right now at this moment. That's unfortunate, and we're working with that company and others to ensure that standards are raised. So there's that set of things.

In terms of the issues raised by the seniors advocate in her report, I think we talked about this in question period. I understand the concerns of the member. I think that what would be useful for everyone is to move towards more consistency amongst health authorities, which makes it easier, in fact, to deal with these contractual arrangements. So that's what we intend to do.

I think in general, our care providers do a very good job, but I think there could be more clarity and more consistency. We're providing more consistency now in the care hours that we provide and that we fund and providing more consistency in the contracts. We'll be working with the sector on this question. That will be useful in terms of allowing us to ensure that people get the care that they need, which is established, on the one hand, by medical health officers and, obviously, on the other hand, by health authorities who are delivering those services.

[4:35 p.m.]

S. Furstenau: On a specific and COVID-related issue, recently there was a change allowing some visitation to long-term-care homes.

Could the minister answer two questions for me? One is: what are the specific parameters for visitation to long-term-care homes right now? Secondly, what can be done if a care home isn't abiding by those parameters — specifically, if they're not allowing the level of visitation that is identified in the provincial parameters — and how to get consistency across all long-term-care homes on that issue?

Hon. A. Dix: The policy changed on June 30. Prior to that, there were visits allowed, for example, in circumstances of palliative care. The member will also know that we made changes — she made representations on this question, as did others — around people with disabilities and their ability to make visits and have their advocates join them for visits, both in long-term care and acute care.

That's what an essential visit is. I use the term "essential" with a capital E, because we are defining what essential visits are. That's laid out in the provincial health administrative health policy that the care homes have to follow and the acute care sector has to follow.

The changes we made on June 30 were to allow, essentially, one designated visitor per resident per care home. We added resources to that to see that enforced. We asked every care home in the province to provide safety plans. I had the number in my head earlier, but a majority of care homes now, about 75 percent of them, have followed safety plans of assisted living. Long-term-care homes have provided the safety plans required, so that number is in the 400 range of the 584 care homes. They have to provide a safety plan that meets those provincial guidelines.

If there are concerns about visits, people should understand that, in fairness to the care homes, some of those concerns are with the limits that myself and Dr. Henry and the ministry and the government have placed on visits. So it's really important that people sometimes not blame the care home operator if they'd like two visitors, and it's just one, or it's one designated visitor, and they'd like to switch them off. Those rules have been set provincially, and we'll be reviewing those rules after the first month of visits.

At the beginning of next month, which is coming upon us sooner than we think, we'll be reviewing that to see if it's possible to make further extensions. And we also provided, of course, and are providing $160 million across the sector for infection control and safety around visitation, which I think is going to be needed. Those controls on visitation are going to be needed certainly for a year into the future.

S. Furstenau: Just to get a little more clarification, with one visitor per resident per care home, is there a limitation as to how many days per month a visitor can come? In the case of one of my constituents, she's been told she's only allowed to visit her mother once every 28 days.

Hon. A. Dix: I don't think those provisions are in the policy. I know that, at present, many care homes are on weekly routines where they're letting people through in their short visits, on 20-minute visits. If the member would make the information available to me, I can look into it.

S. Furstenau: Thank you for that. We will do that.

I'm going to move to a new topic here, which is midwifery. For a lot of parents — and most recently a dear friend of mine — a midwife was the choice for them to have their birth assisted.

In 2016-2017, midwives assisted a total of 10,227 births. That's 23 percent of all births provincially, which is the highest rate in Canada. They lower the costs on the health care system by mitigating the escalation of births. When a midwife is present in care, there are 43 percent fewer Caesarean births, which significantly reduces the cost and time required in surgeries. Throughout this pandemic, the demand for midwives has increased. At-homes births spiked 40 percent in May of this year compared to 2019.

[4:40 p.m.]

In B.C., midwives are the second-lowest paid in Canada. Unlike other primary care providers, midwives pay out of pocket for their health care benefits, parental leave, retirement savings and business costs. Can the minister confirm whether or not midwives received any pandemic pay, like other health care providers did?

Hon. A. Dix: The short answer is no. Midwives, like physicians and optometrists and dentists, were not eligible for the temporary pandemic pay program, which is targeted to front-line salaried public employees in health and community services, which would include all the people who work in private long-term care, for example. They would be considered deemed as public under those circumstances.

The member will know that short-term disability pay is typically a feature of extended health benefits organized by professional associations, whom many negotiated it. That support is part of a master agreement, and these are some of the issues that are being negotiated now.

At the beginning of the public health emergency, it should be said, midwives identified safe practice concerns, and in response, their fee schedule was adapted, enabling people to be compensated for virtual consultations. Midwives have also been provided with PPE, through the regional health authorities, for home births, as with other fee-for-service health practitioners. In-home and clinic-based equipment is still the responsibility of the midwife.

I would say, in addition, that I know the debate about pandemic pay. We had it a little bit earlier with another member, and it's an interesting debate. B.C. has had some of the broadest allocations of pandemic pay, if not the broadest, in the country. It's partly funded through the federal and the provincial governments, and we've had a fairly broad view of it. Inevitably, there are going to be some people — and lots of people, in fact — who feel they merit pandemic pay who didn't receive it, and that's a real challenge in the system. We've seen it. The member will probably ask these questions of other ministers around pandemic pay as well.

With respect to midwives in general, the member will know that we are in the midst of negotiations with midwives. Some of my discussions will be a little bit limited as a result of that. Those negotiations started in March of last year, 2019. They arrived at a tentative agreement in October 2019. That tentative agreement was rejected by the membership, as is their right, so we're back in negotiations, which I think we started in June 2020. I think there are new directions from the association side for that agreement, and we are, as always, hopeful to arrive at a collective agreement as we have with just about everyone else in health care.

S. Furstenau: I recognize that there's some limitations with the negotiations ongoing. Again, I'll come up to sort of a more of a philosophical question about…. How does the minister see the role of midwives in providing primary care? There's an increasing number of family doctors that are not providing obstetric and birth care for patients, and midwives can play a very important role in this.

I guess I'd like to know from the minister what his view on the role that midwives play in primary care and health care is. How does he see a future where we value and retain midwives, given that there is a retention problem for these health care providers?

Hon. A. Dix: I think the retention of midwives is a key element of the discussions. Without speaking of the negotiations, which I'm duty-bound not to speak about so as to not hurt the negotiations, as they say.

I think that outside of a master agreement, we're working with midwives, particularly for rural practitioners, developing a contract template, for example, as an alternative to fee-for-service compensation, which for midwives in rural areas becomes a more difficult proposition, as the member might imagine, in terms of maintaining practice and funding those at a rate that makes the practice sustainable.

[4:45 p.m.]

That's an example of the priority we give to it. I give high priority to midwives. They play a very important role in care in B.C. They have an important role to play. I think the future is bright. We're in negotiations, which obviously creates tensions, and the association is also making its case known publicly, as occasionally happens in contract negotiations in British Columbia.

That is absolutely their right to do, but they should know that I believe that they play a critical role in health care in B.C. I'm a strong supporter of midwives as a profession, and I believe that they're going to play not a lesser role but an increasing role in health care in the coming years.

S. Furstenau: Thank you to the minister for that.

I'm going to shift gear to another area. We hear a lot from constituents who are paramedics and who have been struggling as well. They are considered essential service workers by the province. My understanding is that they were considered essential workers through the COVID-19 pandemic but are feeling less valued than they would like to be. They are feeling that they're not being paid for their full shifts and are having to take on additional costs in their roles.

Can the minister confirm what the mandated minimum wage for a paramedic is and what the average wage is across the industry?

Hon. A. Dix: I take, I would say, a more positive outlook on ambulance paramedics.

First of all, the fact is that we've funded 119 more full-time positions across B.C. in the last two years, under the action plan. We've transformed and shifted, in many rural areas, from part-time to full-time positions that we've added. We have hundreds of positions, in the hundreds, of community paramedicine in B.C. We've improved response times and the number of ambulances, and we've assigned, as the Premier noted, a significant number of new ambulances to support our COVID-19 area, in rural and remote areas.

Finally, we've restored something that had been taken away in 2010, which is the bargaining unit for ambulance paramedics. They were attached to another bargaining unit up to that point, and we created a special bargaining unit for ambulance paramedics. There hadn't been a real, true, negotiated collective agreement in decades, and we negotiated a true collective agreement. The increase in spending since I've become Minister of Health has been approximately 10 percent over two years, which is a pretty significant increase in the spending in the general area. A lot of that spending — most of that spending, as in every area of health care — is on salaries.

With respect to paramedic wage rates, they differ by licence levels, obviously, and whether they're working full-time or on-call. The minimum qualification for a primary care paramedic, working a minimum wage rate, is $27.12. There are some driver-only rates, but generally, a brand-new paramedic will make at least $27 an hour when they're on a call performing paramedic work. There are on-call rates — one that's, of course, noted is the $2 or standby on-call rate — and those are issues that were dealt with in the recent negotiations. Excluding on-call standby shifts and overtime, paramedics earned $36.47 an hour on average in 2019.

That was in advance of the collective agreement that was negotiated. Obviously, the negotiations take place between the Public Sector Employers Council, the Health Employers Association and the employees of BCEHS, who are in their own bargaining unit.

S. Furstenau: Can the minister just give a little bit more information about the on-call rate? I think that's the one that I'm hearing from some of my constituents about. Just give some elaboration on it. When he says that that has been addressed, what is the outcome of that?

Hon. A. Dix: There are some specifics here about how that's dealt with. Yes, there are concerns about that.

[4:50 p.m.]

There is some dispute amongst paramedics as to the direction the government has gone and in what we've done in partnership with them, which is to increase full-time paramedics, to add more full-time paramedics in rural areas and to not have as much support and recognition of on-call paramedics. In the view of some, that's a debate, but there are specific amounts to the collective agreement.

I'm happy to share that information. We'll do so as early as Monday, so that the member can have it. I just want to make sure that the information is exactly right, and I'll share that with the member on Monday.

S. Furstenau: I'm going to jump to my next topic here, which is safe supply and decriminalization of drugs.

As the minister knows — it's very tragic — June 2020 was the deadliest month in B.C.'s history for illicit drug overdoses. There have been hundreds and hundreds of people who have died this year due to drug toxicity. As Dr. Bonnie Henry said, there is widespread global recognition that the failed war on drugs and resulting criminalization and stigmatization of people who use drugs has not reduced drug use but has instead increased drug harms.

Dr. Henry has repeatedly called for a safe, regulated supply of opioids to address this crisis. Could the minister talk about his views on this step of a safe supply of opioids as a way of addressing the overdose crisis in British Columbia?

Hon. A. Dix: Of course, we have, on mental health and addictions issues, an extraordinary cabinet minister in my colleague the Minister of Mental Health and Addictions. I think she did canvass these issues pretty thoroughly. I think it's absolutely fair that I be asked about the issues, too, but I wanted to acknowledge her role and her leadership on this question.

Sometimes people ask me why I don't speak out more. They ask me that question. I say it's because that responsibility is not mine. It's not that I'm not interested in the area, because I am. It's because we have an outstanding Minister of Mental Health and Addictions, who does so.

I think this is an extraordinary set of events — two public health emergencies we're facing. One, the advent of COVID-19, has clearly had a detrimental effect on the other: in June, 175 overdose deaths, and in May, 171 overdose deaths.

The member will know that the Premier has called on the federal government, written to the federal government, to ask for the decriminalization of personal amounts of drugs under the Criminal Code, which is, hopefully, an initiative that the federal government will undertake and that, in any event, is overdue. But we're not waiting for that. We've responded to this impact in terms of the services we provide and the prescribed alternatives that we are providing to people who are dealing with issues of addiction.

We've significantly increased the number of people in opioid agonist programs and iOAT programs in the last number of years, and there's a significant increase in the number of prescribed alternatives. That has real costs, which I should be able to provide to the member, but also significant value. The program and the guidelines were changed — I recall Dr. Henry announcing those changes in March of this year — which has significantly increased access to the prescribed hydromorphone program. I don't have the numbers in front of me, but it went from approximately 600 to approximately 1,800 people, which is a significant increase.

It tells us — in that people that have taken that up

— that the need for prescription alternatives continues to be high and is significant. While the number of overdose deaths has been high, the increase in that access has meant avoided deaths as well. It has been an effective measure that has been helpful. We believe that the federal government should change the law. We're dramatically increasing resources throughout the system, under the direction of my colleague the Minister of Mental Health and Addictions, and are offering prescribed alternatives. Those offers are being made and are making a significant difference.

[4:55 p.m.]

That's some discussion of the issue. I know the member could canvass the issue with the Minister of Mental Health and Addictions, but that certainly reflects my position, in any event.

S. Furstenau: Thanks to the minister for that. I appreciate him elaborating on his position on that.

I have a number of constituents in my riding who have family members and children with cystic fibrosis, which, as the minister knows, impacts thousands of people in this province. There is mental health support needed for people with cystic fibrosis. For several years, a program for standards of care in mental health has been in development, but it would need support from the ministry in order to be fully implemented. Those working on putting this program into place have estimated that it would be $5 million per year in dedicated funding to support this.

Can the minister speak to whether he imagines that there will be dedicated funding for patients with cystic fibrosis under this type of program in the upcoming budget?

Hon. A. Dix: The member will know — and I've talked a little bit about these issues in estimates — that at the end of the last fiscal year, $150,000 in funding was provided to Cystic Fibrosis Canada to support some of their immediate efforts, including efforts in support of the mental health needs of people living with cystic fibrosis.

The member will know, I think, that outcomes for people living with cystic fibrosis have increased. Life expectancies increased dramatically in recent years — something which is a very positive and truly wonderful development. It presents, of course, new problems for people living with cystic fibrosis, but it's an extraordinary development and reflects improvements in care.

I think the program the member is talking about — forgive me; this is from memory — is a proposal that has been made by Cystic Fibrosis Canada to the Provincial Health Services Authority for supports for mental health services and so on. That is being reviewed. As well, I think we need to take the six existing centres which support, at the acute care level, people with cystic fibrosis — two are on Vancouver Island, two are in Metro Vancouver, and then there's Kelowna and the University Hospital in Prince George — which are associated with them and provide supports.

I think what we need to do — and I talked to our colleague earlier — is to ensure that those are fully integrated into primary care networks and that there are more supports in primary care for people with cystic fibrosis. There are ways of doing that. The proposal that has been made by the groups to the Provincial Health Services Authority is being been reviewed and will be involved, like all other items, in the budget process for the coming year. There is an active business plan that's been submitted. The government is looking at that, and the PHSA is looking at that at this time.

S. Furstenau: Thanks to the minister for that. It's helpful to know that that's being reviewed right now.

I'm going to jump over to surgeries, as we have got through this all very quickly within our one hour here. I'm just going to start by asking some figures that the minister, I expect, with his extraordinary capacity, is going to have at his fingertips.

In 2018, the Ministry of Health announced the provincial surgical strategy was $75 million in additional targeted funding in 2018-2019 and $100 million in 2019-2020. They did not have a crystal ball to anticipate COVID-19. I'm aware that that was a bit of an abrupt hit to the planning, and now the minister has committed an extra $250 million in 2020-2021 to perform additional surgeries.

Could the minister, just to get an assessment of where the money is being used, give…? How many total scheduled surgeries were performed in B.C. in 2017-18, 2018-19 and 2019-20?

[5:00 p.m.]

Hon. A. Dix: This is a total of scheduled and unscheduled surgeries, and we can break it down further for the member as well. The number of scheduled and unscheduled surgeries has increased from 318,833 in 2016-17 to 337,063 in total in 2019-20. That's a significant increase and reflects operational investments but also efficiencies that have been developed in the system.

The member will know that we have focused on the increase in some priority areas, including hip-and-knee replacements, where we've gone from 14,378 surgeries to 18,635 surgeries. That's an increase of 29.6 percent from the base to the present. There will be a report of the Canadian Institute for Health Information that comes out at the end of the month which compares us to other jurisdictions, but in general, we were behind in those areas. I think we've done quite well.

Overall, the number of surgeries that we've done in recent years has gone up due to those investments. But if we're going to meet the target of COVID-19, which is a loss of roughly 35,000 surgeries presented in the report earlier this week…. It's publicly available on our site. If we're going to make up that number, we obviously…. If you just keep doing the same number of surgeries with the same number people coming into the system, you're just going to see a net increase in wait times.

We have to meet that challenge. We started to this summer. How are we going to do it? The same way that we reduced wait times for MRI, which is using our system and our operating rooms to the fullest extent possible. The first part is happening right now. There's a summer slowdown every summer, and we're reducing that summer slowdown by 52 percent, which is thousands of surgeries that will be done this summer that weren't done last summer.

Secondly, we're increasing the number of hours in a day that operating rooms are used by one hour, which will, as you can imagine, across a system like ours, significantly increase the number of surgeries.

Three, moving to surgeries on weekends. To do that requires, obviously, new resources, new anesthesiologists, new surgeons, but it is necessary work to reduce wait times.

The details are all contained in the detailed report we prepared on Tuesday, and it's available on the ministry website. I could talk about it literally all day, as the member for Kelowna–Lake Country well knows.

S. Furstenau: I think we're all impressed with the minister's capacity to talk literally all day at a pace that I think his colleagues in the other ministries might find a little daunting. If they want to meet this next year, the bar is very high.

I just have one last area of questions, and I think we're about five minutes out from our full hour here. That's detainment under the Mental Health Act. According to the 2019 Ombudsperson's special report, detention rates under the Mental Health Act increased by 71 percent between 2005 and 2017, to over 20,000 detentions annually. At the same time, voluntary admissions per capita declined, and B.C. apparently has the highest rate of hospitalizations due to mental illness and substance abuse in Canada.

Can the minister provide the number of people detained annually for the last three years, 2017 to 2019, and break this down by demographic, if possible — how many young women, how many Indigenous youth, how many adults — and the primary reasons and diagnoses for detainment under the Mental Health Act?

Hon. A. Dix: I have some information. What I'd suggest to the critic is that if she or her staff would like a fuller briefing on all of the questions related to the Mental Health Act, our Assistant Deputy Minister Teri Collins and others would lead such a briefing next week. I know she has some detailed questions as well.

[5:05 p.m.]

Just to answer for the moment, the most recent information we have is that in '16-17, it was 14,980 individual patients who were involuntarily detained and treated under the B.C. Mental Health Act. In '17-18, that number was 15,711. We don't have the '18-19 data available because of problems related to the data being collected from the Canadian Institute for Health Information. However, those are questions the member or her staff may want to get from staff.

I can give you some information about the number of detainees broken down by demographic: 45.4 percent are women, 12.3 percent are young people aged zero to 18, 7.7 percent are women under the age of 19, 4.6 percent are men under the age of 19, 87.7 percent are aged 19 and above.

We don't have, in my requests for data, data identifying Indigenous clients. That's a question, perhaps, that could be pursued at a briefing.

The reasons for detainment. There really are four: suffer from a mental disorder that seriously impairs their ability to react appropriately to their environment; require psychiatric treatment in or through a designated facility; (3) require care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration; and (4) are not suitable as a voluntary patient.

The common diagnoses treated are severe symptoms of psychosis such as schizophrenia; major mood disorders, often with suicidal ideation, including bipolar disorder; severe eating disorders; severe personality disorders with concurrent mood disorders; and people with concurrent mental health and substance use disorders, such as people with psychosis and concurrent opioid addiction disorder.

There's obviously a lot of work done in this area, and we have people who have a strong understanding of this work. If the member is interested, I'd be happy to arrange that briefing in the coming five days, either for her or, perhaps, for her staff.

S. Furstenau: We have reached the end of our time. I would very much like to pursue this particular issue further with the minister and, in particular, hear from him — not right now because we're going to move you back to the official opposition — his thoughts on the role that preventative mental health care can play and where we can look at mental health care being brought into primary care in this province, avenues for pursuing that.

I just want to thank the minister. I'm delighted if he wants to speak a bit about that right now. Before handing it back over to the critic for the official opposition, I'll just thank the minister for his excellent answers today and all of his hard work through the last few months and over the last three years as well.

Hon. A. Dix: I thank the member for her extraordinary contribution. We've worked together pretty closely for the last little while, in particular, as well, on the seniors initiative, which she, in what must be an impossibly busy time for her, contributed a great deal to. I'm very appreciative of that.

I know that she's in the midst of a leadership race, the Green Party House Leader, the Health critic and probably the critic for four or five other things. She does an amazing job. So I wanted to express my appreciation.

On the mental health question. I didn't want the opportunity to go by to say that we read those numbers out, and we compare them year to year, but you can also look at it another way and look at it as 14,000 to 15,000 individuals who, to reach the criteria of the act, must be suffering terribly. We want to acknowledge that as well.

L. Reid: I am delighted to be back and have a conversation with the minister.

One of the issues that has been raised by a constituent, Mr. Neil McIvor, is about dental care for seniors over the age of 65. The coverage would be for general inspections, for cleanings and for cavities. He believes this would help the general health of British Columbians, especially those who are on limited budgets.

Would the minister kindly respond to Mr. McIvor?

[5:10 p.m.]

Hon. A. Dix: It's true that in Canada, we don't have either a national or a provincial broad dental care program. There are significant dental care programs that are provided, for example, in long-term care and other places.

Dental care is important for young people. The member will know about the healthy kids program and other programs that have been put in place to support young people with their dental care needs, some of which have been significantly advanced in recent times.

For example, not so long ago, there were significant communities in B.C. that had not one dentist that provided such programs. Now, in general, that's not the case. Obviously, supports for people struggling with low incomes get access to some dental care. Although everybody who knows the dental issue understands some of the challenges, and the fees associated with these programs are considerable, in their success.

There are such programs, and there have been and are active proposals for a national dental care program. That would be…. There are some people who argue that that should be, if we're going in the direction of a national program, an even more important priority than PharmaCare. Others suggest long-term care. There are some that have suggested all three, but there's no question of the relationship between dental care and overall health and overall life expectancy and quality of life.

The member will know that in the most significant Harvard study of people without health care coverage in the United States, the first thing that many of them talked about — because many of them in this case were not older or elders but young workers — was dental care. It means for people in the workplace and in life, working in the back of the store or the front of the store and obviously for young people and everyone, important benefits to health.

We look at dental care programs, of course, and their significant importance, although there isn't a plan in B.C. to establish, as of yet, a provincewide dental care program either for seniors or for the whole category of the population, although we've expanded, as the member will know, dental care programs in a number of areas.

L. Reid: Thank you, Minister. I very much appreciate that.

Pansy Choi, manager of Oak Tree House, senior housing in Richmond. In pre-COVID, they would have ten or 15 different visitors each day, support workers visiting from the community. When that ceased to be possible, they went to paying overtime to existing staff.

Any of the programs that the minister mentioned earlier today would allow them to be reimbursed for any of those costs. That is their question. They hope the government and health authority understand the immense pressure they are operating under and additional work put in to deliver the best care they could possibly find for their seniors. Would any of the programs or plans the minister canvassed this morning allow them to be reimbursed for any of those costs?

Hon. A. Dix: I didn't quite understand the question — the work done by the group and the work that they're talking about being reimbursed for. Perhaps, just so that I could properly answer the question, I could get that again from the member.

L. Reid: Through the health authority, this particular care home, which is Oak Tree House senior home in Richmond, would have had ten or 15 visitors each day come to support their seniors, come from the health authority. This was pre-COVID. Post-COVID, those visits to the senior home ceased.

In order to continue to live with those services, they ended up paying overtime to existing staff to deliver those services that had previously been provided by the health authority. It was extremely challenging for them, extremely expensive for them, but they continued to do that work and are continuing to do that work today in terms of providing the best care possible for their population.

They're wondering if any of the programs the minister referenced this morning would indeed allow them to be reimbursed for any of those costs.

Hon. A. Dix: Without all of the details, it's sometimes difficult to pass judgment. The member will recall this from her time as minister in terms of particular casework. The member will know that we provided extraordinary funding to care homes for the three-month period. That was the $26.5 million that I talked about.

[5:15 p.m.]

They can also, if they have identifiable costs, at least contact the health authority. This is not a yes, I should be clear, but contact the health authorities about those legitimate costs, and discuss with them what they are and whether they would be appropriate, or not, for a form of reimbursement. I think that in a general sense, the $26.5 million is intended to cover things like overtime that supports such initiatives. They would be welcome to contact either our staff or the health authorities to discuss that with them.

L. Reid: I thank the minister. I'm more than happy to pass on that direction to Pansy Choi and her staff.

Continuing on. In 2019, 19 percent of B.C.'s population was 65 years of age or older. In 15 years, this is expected to rise to 25 percent. The projected growth rate of seniors who are 75 years or older is 28 percent over the next five years, and that's in the Interior region. The average age of residents in long-term-care facilities is 84 years old.

As B.C.'s senior population grows, it's anticipated that the rates of dementia and chronic disease in the general population will also rise. Long-term-care homes provide professional care services to adults in a supportive and secure environment for people with complex care needs who cannot live safely and independently at home. This includes frail and elderly individuals with chronic conditions, such as those with dementia, as well as adults with complex health needs.

I trust that the minister agrees that the population is becoming more complex, and certainly, the frail elderly are a bigger challenge than we probably anticipated in the past. I wanted to just take a moment to thank the minister for the work that has gone on in terms of supporting this population that's advancing in age and frailty on a go-forward basis. Is there anything new that this population can look forward to?

Hon. A. Dix: Without reliving the highlights of my presentations this morning, I think what they can expect to see in long-term care are improved standards and a workforce whose rights are respected.

Our expectation in long-term care is to continuously improve quality with all providers, whether they be private providers offering public care and public beds or public providers; to increase the quality of care, which is fundamental to the government's approach; increasing care standards; increasing the rights of workers; increasing the rights of residents, who now have rights with respect to consent and choice in long-term care that they have long sought and wished to have.

Beyond that, increasing spaces in assisted living and assisted living hours; significant growth in home care and home support to meet growing demand, which is significant and whose hours are impressive; a system of home support integrated into primary care networks that are hardwired to communities and provide team-based primary care centre services in community; increased community-based services that are provided at home, professional services, and those have increased dramatically; supports for respite care that not only support seniors themselves, but their families.

Investments in hospice care and palliative care are happening across B.C. — which are important not just for seniors, but often for seniors — and are an important means of giving agency at the most difficult time in people's lives, at the end of life, and to give hope to that. And hopefully, in all of this, an increase in adult day programs and community activities.

This is the underlying challenge, I think, in dealing with seniors care. We've made, in the last year — really, the last three years — unprecedented investments in long-term care, which represents a small subset of the seniors that the member is talking about.

We have to remember that our health care system has to be responsive in this time, when one life's expectancy at 65 is 23 or 24, and responsive to the fact that needs will change, that there's a variety of needs, and not to try to respond to that with cookie-cutters. Instead, give, at every possible moment, agency to people in their lives at moments when, perhaps, their health is in decline — occasionally physical, occasionally their mental acuity — but continue to give them agency to live full lives. This is a challenge for us as a society, I believe.

[5:20 p.m.]

We have to become different, make adjustments at the municipal level, at the provincial level and at the federal level, as well as communities. There are going to be more of us who are seniors. Our communities have to better adjust to that, to the many phases of being a senior, which didn't exist, perhaps, in previous generations but exist now. I think these policies attempt to address that. It's not the final answer, but it's a significant answer to how we make things better for seniors, give hope for seniors in the many phases that they're going to interact with the health care system in the coming years.

L. Reid: I thank the minister for the answer.

I continue to believe that any government decisions should be underpinned by the best science of the day. The Canadian Institute for Health Information's new analysis paints an international picture of COVID-19's long-term care impacts — CIHI, dated June 25, 2020, so a very recent article and very recent references.

It makes the case that Canada's older adults are entering nursing homes later in life. As Canada ages and older adults live longer, we have worked towards more capacity for those people to age in community. At the same time, the prevalence of chronic disease, foremost dementia, and the social challenges of living into the 80s, 90s and 100s have increased.

I don't know about the minister, but I certainly sing "happy 100th birthday" to more and more people each year.

The consequences are residents entering nursing homes, coming into their final homes, with much more complex and higher social and medical needs. This has dramatically raised the complexity of care that nursing homes are faced with providing, even compared to the care they required a decade ago.

This is simply to say that the minister's comments are well taken. I think the answer he gave previously certainly covers the necessity for flexibility and the challenges, going forward, of trying to balance and rebalance individual needs. The range of care, indeed, is only going to increase, I would suggest.

Hon. A. Dix: I agree with that. I think, though, that it's also important — and I think the member would agree with this — to flip that over. Too frequently, I think, our debates about seniors and the costs of seniors care…. "Oh my gosh. There's a grey tsunami. Oh my gosh." We're hearing this and something else.

We forget the fact that an extended life expectancy is a good thing and is a positive thing in society. So we have to turn that on its head and value things that maybe we haven't valued enough in the past and value the contributions of seniors and find ways for them to be valued. All of the things we can deem value. Being respected and not being seen as a burden is something that is a preoccupation of many, many of the seniors I know, if not most of the seniors I know.

We also have to turn it on its head and understand the need for care, understand the need for standards but always, always remember that this is an extraordinary development in human history, what we've seen in the postwar years. This increase in life expectancy is a positive thing. It has given people a renewed life, especially, often, after a life of labour.

This presents economic and other challenges that are, of course, unimaginable. The increases, in many communities, in the number of people over 75, to a remarkable degree, while we lose populations under 50 will require a new social understanding and a new social organization.

It's not a bad thing. I'm 56. I'm getting there. I like the fact that life expectancy has increased quite a bit, and I have hopes and aspirations for a few years to come myself. I know everyone else does as well.

I think what we have to do is review seniors care and see it as not just a negative, as not just a struggle but as a means of giving people the liberty and the freedom to achieve their goals, whether they're 84 or four, in our society. If we take that approach, we're going to come to better evidence-based solutions, in my view.

L. Reid: The key message, going forward, from this article is solve the workforce crisis in long-term care. As a first step, and if we do nothing else right now, we must solve the workforce crisis. It is a pivotal challenge.

Workforce reform and redesign will result in an immediate benefit to older Canadians living in nursing homes and is necessary for sustained change. It will also improve, at a minimum, the quality of care so that nursing homes are able to reduce unnecessary transfers to hospital, reduce workforce injury claims and interface more effectively with home and community care.

[5:25 p.m.]

I believe that the minister probably agrees that that is the direction. Certainly, from everything that has been presented in today's and yesterday's debates, it is about how we manage the workforce.

I think, for me, it's about improving the quality of care, the quality of life and the quality of end of life for people living in nursing homes. If the science can assist us in doing that, I know the minister will make good decisions on a go-forward basis.

I want to end this….

The Chair: Sorry, Member. If the minister wanted to respond, he's welcome to. It looks like he's ready.

Hon. A. Dix: I just wanted to thank the member, again, for our debate. We're now in overtime. We did our debate this morning; we've got a little overtime here for everybody.

I wanted to thank her. Of course, I agree that the health human resources question is critical, and it's critical across sectors, not just long-term care but across the continuum of care. It's going to be a struggle for some time to come.

I would like to make an appeal to people, because there are a significant number of jobs upcoming in long-term care. If anybody in the audience, and I don't think it's a big audience, but if anyone in the audience is interested in taking up health care as a profession or becoming a care aide, this is the time to do it. Please, please, please sign up soon, because I'm telling you, it's a fantastic time to be involved in public health.

L. Reid: I believe I, too, will thank the minister for his time in the debate, because I do believe my colleague from Kelowna–Lake Country awaits. Thank you very, very much for your time.

N. Letnick: Thank you to all our colleagues — those that are left in the room. I look around the room, and I think some people have gone home a little early. But we won't start counting, because that'll just take away from my time to ask questions.

The Chair: Of course, we never comment on who's in the room or who's not.

N. Letnick: I know. Riveting questions and even more riveting answers, I'm sure, will attract everyone to watch the rest of this.

We have about a half an hour left. I have about a half an hour's worth of questions. We'll start with chiropractors.

The chiropractors of B.C. have, within their scope of practice, the ability to refer for a diagnostic imaging test, including plain radiographs with X-rays, CT scans, MRIs, as well as to apply X-ray for diagnostic or imaging purposes. However, the Medical Services Plan does not reimburse the imaging tests if referred by a chiropractor. Currently MSP reimbursement policies only allow chiropractors to refer directly to orthopedic surgeons but not to radiologists.

The chiropractors of B.C. must now first send their patients to their family physician for a referral. The patient then makes an appointment and sees the physician for a referral for the X-ray test. Then when the test is ready, the patient makes a second appointment with the physician to receive the test results. The patient returns with the test results to their chiropractor for treatment. Obviously, this is wasteful and causes a delay to treatment with potentially negative clinical impacts for the patient.

Two questions based on this preamble. The BCCA is requesting that the Ministry of Health permit chiropractors to refer for X-ray tests on a time-limited basis until the end of fiscal year 2021. The utilization of X-ray imaging tests would be analyzed and evaluated at the end of this time period.

The first question is: will the minister grant this request?

Hon. A. Dix: I note that, for the member for Kelowna–Lake Country, during my last presentation, my extensive discussion of seniors care, I lost several members of the committee, without commenting on their absence. I'm just saying that was just one speech. But there you go.

The short answer is no. I won't order that at this time. Currently, as you know, it's only the diagnostic orders of physicians, dentists, podiatrists, midwives, nurse practitioners and certain registered nurses that are made payable under MSP.

The Ministry of Health did present the B.C. Chiropractic Association request to the Medical Services Commission to obtain input on whether the commission had an interest in prioritizing MSP spending to include this expansion of current professions who can order insured diagnostic services.

[5:30 p.m.]

The commission at the time — that was at the February 26, 2020 meeting, so it was fairly recent — was not in favour of amending the regulation to enable chiropractors to order diagnostic services. The motion was declined, and they gave reasons for that. It's an issue that can continue to be reviewed, and there may be new evidence to present to the commission, but it wouldn't be my intention at this time to overrule the commission in this regard.

N. Letnick: Thank you to the minister.

In addition, the BCCA is also asking that chiropractors be granted permission to access the provincial e-health viewer, CareConnect, in order to streamline patient flow and minimize wait times for patients.

Without access to the test results, patients have to pay a facility fee to have a copy of imaging and reports made, adding unnecessary costs both to the patient and to the health authority. Alternatively, the patient returns for a second visit to the family physician to obtain the test results, costing the health system unnecessary appointments.

Will the minister grant this request?

Hon. A. Dix: I think this is something that has also been reviewed. The ministry has been meeting with the B.C. Chiropractic Association about that. They have advocated their gaining access to the health authorities' picture archiving and communication system, which is PACS, as the member knows. One of the arguments made by chiropractors is that they have some access in one health authority, Island Health, and no access elsewhere.

It's an issue, of course, that we'll look at. There are pros and cons. Because the pros are relatively short, and the cons are somewhat longer, what I might do is share that information with the member, unless he would like a fuller response now. It's something that is being considered but that has some risks, according to health authorities, in terms of providing access to that information. I'd be happy to share that in a letter with the hon. member so that he can get a full sense of the argument in that regard. We haven't decided to do so, certainly, at this time.

N. Letnick: I appreciate the opportunity of receiving a fulsome discussion through a letter, which I will then share with the authors of the issue. Of course, the BCCA is definitely leading in that.

On the overall issue of chiropractors, can the minister discuss his vision for the role that chiropractors can play in delivering health care services in British Columbia going forward?

Hon. A. Dix: Well, I think that chiropractors, like many health professions, play a critical role in helping a wide variety of patients now. They're part of the health care system generally, part of what we call the private health care system — supported, often, by supplementary benefits. They play a significant role.

I've regularly met with the B.C. Chiropractic Association. In normal years, they come here and present at length about their role. I think chiropractors contribute significantly to the health of their patients, and I suspect they'll continue to do so.

What we're trying to do in general, as the member knows, is to bring in health care professionals more and have them work together more effectively in teams. Chiropractors and others who are generally on the non-MSP-insured side of health care still can play an important role in that. I see the profession as having a bright future. It clearly has a loyal and ongoing market share — even in this room, apparently — and that reflects their values. I think they're going to continue to play a bigger role.

[5:35 p.m.]

They're obviously respected. As we try and bring people together in teams, whether it be through our reforms of colleges, which the member and I are involved in, or others…. I think we want to bring and integrate all health professions as much as possible into team-based care.

That said, we have to take all of that step by step. There is a desire, I think, to add new professions to the health care system and to access the funds of the Medical Services Plan as administered by the Medical Services Commission, and that can be a challenge. But certainly, chiropractors, physiotherapists and many more play central roles in health care, and I see them as continuing to do so in the future, particularly as we have an aging population.

N. Letnick: Thank you to the minister for expanding on his vision and the role of chiropractors moving forward — in particular, on the team-based care piece. I understand that maybe what he's saying is not today, but maybe tomorrow. So we'll see how quickly tomorrow comes for chiropractors.

Another group that is looking to find more active participation in delivering quality health care in British Columbia are physician assistants. Physician assistants contacted me probably the day after I become the hon. Health critic. I'm only honourable because I'm dealing with an hon. Health Minister. He's talking to his colleagues about who uses chiropractors right now. I don't know if it's Stephen Brown or Dr. Henry. But anyway, we'll just leave it at that.

The question is…. Physician assistants, obviously, want to play a greater role in delivering quality health care. Where does the ministry and the minister see them fitting into team-based care?

Hon. A. Dix: The member will know that we've significantly increased the role of nurse practitioners in our health care system. That was an innovation, initially, of Ministers of Health at the time of Mr. Hansen and Mr. Abbott, who brought nurse practitioners, essentially, into the health care system in B.C.

Eleven years later we are, I think, 11th or 12th in Canada in the utilization of nurse practitioners. So we've dramatically changed their role and increased their role and focused on that and the role of other health professionals. Physician assistants, as the member will know, have been reviewed a number of times by the Ministry of Health and have made such proposals in the past, principally under the previous government, which chose not to pursue those initiatives at that time.

Some of the challenges with physician assistants are, of course, that we don't train physician assistants in British Columbia. So at the present time, while we are considering and are open to their proposals, we are focused on expanding the team in health care in new and innovative ways. A signature of that is the growing role in primary care of nurse practitioners. It's not a rejection of the idea of using physician assistants in the future. We've shown, in the period around COVID-19, a willingness to use students and others to perform duties in health care that are significant.

At the moment, we don't have a plan, although we're looking at it. It's one of the issues that is actively considered by the Ministry of Health as we develop team-based care and using physician assistants. But integrating the professions in the health care team that haven't been integrated before is where we're focusing our efforts now. So like previous governments, we're not proceeding at the moment, but it's under active consideration.

N. Letnick: Thank you to the minister for giving some hope to those people that have been working as physician assistants, perhaps in other jurisdictions.

[5:40 p.m.]

In the meantime, "What's needed next?" is the question for physician assistants. I don't believe they are licensed in British Columbia, if I can clarify that with the minister. Are they actually licensed to practise, to work, in British Columbia, and if they're not, what would they require to do so?

Hon. A. Dix: I was just checking on the professional process. They're not licensed in B.C. now, so what you would have to do is probably find a current health care professional college. What would be critical, of course, is a decision to fund the positions, ultimately, because it's not a question of being able to work that's significant. It would be important to them to have that work paid for. So there's that element.

You'd have to have a policy that drove the implementation of physician assistants in the system, and then you'd probably have to have one of the existing colleges take up the regulation and start the regulation of physician assistants in the system. Probably, in that case, the likely model under the current health professional model — there are others to consider, and the member is as expert in this now as I am to provide advice on that — would be the College of Physicians and Surgeons.

The member will know that certified dental assistants, which is a very different category of workers — I'm not comparing them as jobs — don't have their own college but are regulated, I believe, under the College of Dental Surgeons now. That's sometimes an issue for them because it reintroduces into the college framework the hierarchy that exists in workplaces, for example.

You would probably seek out, just if he's asking for technical things…. You'd have to find a college that would take on that work, and then, as well, you'd obviously have to find the means and the policy that would provide funding for those positions in addition to all the other expansion of primary care and other care that we're doing.

N. Letnick: To the minister, I understand through the professional regulations that, from what he said, the College of Physicians and Surgeons might be the correct place for them to speak with to provide them with an opportunity to become regulated in the province of B.C.

Assuming they do, what I also understand from my conversations with them — and I must admit, it's been a year and a half, I think, since I last spoke with them — was that some of them were looking to work in remote parts of the province, paid for by the private sector. It would not require any public dollars. For instance, in an oil rig kind of scenario or maybe an LNG plant or something, where they would be of use in those kinds of industrial settings, is where they actually said they were looking to work — at least to get a foothold in the province to prove out their capacity.

I guess it's more of just a rhetorical piece rather than a question, because I'm not asking the minister if he would approve of them working on an LNG plant. Just so the minister understands, it's not all about them getting public dollars, at least not the ones that I spoke to over a year and a half ago. If he wants to respond, sure.

Hon. A. Dix: I assume what would be required is probably a direction to the college from the ministry, in this case, to consider the issue. I think that's what would be required. It's not something that they would necessarily generate on their own.

I think it's true of many professions that they operate outside of the public system, either in health or elsewhere. But I think if you're going to make the argument that they're essential value, one has to make that argument. But if the argument is that we should just create a whole new regulatory structure for them to be used in only occasional places, I'm not sure that would be the right way to proceed.

I think the right way to proceed in this area, and to consider, would be some form of…. It would require direction. That would cause a lot of time and effort. And to do that in health care when they're talking about people who work with physicians and without a role in the public system, I don't think it would make a great deal of sense. There may be exceptions to that, but I don't think you would develop a whole new regulatory system to deal with those exceptions. We'd have to make the decision that this is where we want to go.

[5:45 p.m.]

I think almost certainly…. This is what we don't have either in B.C.: training within B.C. for physician assistants. There is no training at all here. The member talked about other health professions yesterday coming into the province and the need to train people here. But without that infrastructure in place…. That is an issue, anyway, for the development of physician assistants in Canada, because, essentially, you would be depending on the relatively small number of other institutions that provide such training in other jurisdictions in the country.

N. Letnick: Thank you to the minister. I think this conversation will provide some food for thought for those that are interested in advancing the cause of physician assistants. I really appreciate the conversation.

Moving now to item Z on our list. For those who didn't know, I provided the minister most of the questions in advance a few days ago so that he and his staff would have an opportunity to fly through all these questions as fast as possible. With my colleagues, for sure we have over 100 questions. The minister has done a yeoman's job in answering them. Thank you to the minister for his great capacity to do that.

Z is heart and stroke. What direction will the minister take in coordinating and ensuring that virtual health/telehealth expansion supports rehabilitation from chronic conditions and access to those services by people living in remote and rural locations? That is with a heart and stroke bent.

Hon. A. Dix: I think the member will know, whether you would describe this as a benefit of this period of COVID, we're certainly in a moment where we're dramatically expanding virtual care in the province and, I think, changing the way people view virtual care, in fact, across B.C. I think that's positive news for both practitioners and patients.

We're providing leadership to that. The ministry is delivering a virtual care policy framework that is going to provide direction for the sector. As you know, that included, more recently, billing codes, which aren't directly related to the member's questions but are changes that greatly enhanced virtual care during this time of pandemic.

What I'm talking about are performance standards; physician compensation considerations and policy; appropriate use and guidance around application of virtual care for specific populations; and governance, including reporting and monitoring, which are important considerations. This coordinated approach to virtual care is under the direction of the Provincial Health Services Authority. As well, through the primary care division of the Ministry of Health, we're working with our partners across the health care sector to implement digital supports, which are tools for virtual consultation, secure communications and access in sharing of health information to reduce gaps.

This includes, in particular, consultation with the Rural Coordination Centre of B.C. and the joint standing committee for rural affairs, and, of course, rural doctors, to enhance those very virtual programs.

This is a particularly important part of our work with

Health Canada. It's an area where we work closely with Health Canada, with Canada Health Infoway and other provinces to enhance the technology and, as well — and this was important for the discussion we had yesterday — the privacy and the equity of access and, of course, the evaluation of such care. It's critically important, if we're going to see a growing share of our work done virtually, that that work be evaluated and assessed so that it meets standards and also meets standards of affordability in the system.

There are specific initiatives underway: virtual consultations; home health monitoring, which is critical, in which some corporations such as Telus have played an interesting role; COVID-19 home health monitoring, which is important; developing the virtual health hospital concept, whereby patients who might otherwise have been admitted to hospital are remotely monitored — and this may be important in the fall period, as we try to develop, effectively, a virtual hospital for some people who may feel or be unsafe in hospital; clinician remote access to patient information, which is a critical part of that.

[5:50 p.m.]

In cardiac care, Cardiac Services B.C. provides funding and support to specialty outpatient clinics operated by health authorities. During the initial response, Cardiac Services B.C. worked with clinics to expand virtual health options so that patients could continue to receive care in their homes. CSBC has identified this approach as a practice to be continued during this period of pandemic recovery, as it has been successful in providing access to specialty care.

I just wanted to say, as well, in the area of stroke, to support access during the pandemic, that health authorities identified opportunities to transition some elements of out-patient rehabilitation services to use virtual health technologies. These models of care emerged in both urban and rural settings and will be part, I think, of the ongoing provincial stroke strategy.

I should say that community-based stroke recovery programs offered by the Stroke Recovery Association of B.C., which is a key partner of Stroke Services B.C., transitioned all of their in-person programs to virtual delivery. These programs include exercise programs, peer support, supported conversation groups for people dealing with aphasia, and education. All of that is part of the approach taken. I would say that, certainly, nothing about COVID-19 is desirable, but what's happened in this has advanced virtual care in the province and shown us the way to new models, and shown patients the way to new models, that will help us consistently in the future.

N. Letnick: Thank you to the minister for the response.

A few years ago B.C. became a leader in the country by having billing codes set aside for virtual care. We saw Telus Health, through the Babylon platform, take advantage of that. We saw other companies in our province start to ramp up virtual care and connect physicians to their patients, as well as physicians to new patients, in the case of Telus Health.

We've now seen Maple, a platform that was predominantly in the rest of the country but was charging on a private pay model, come into B.C. using our MSP model. So if you are a patient person in British Columbia and use a platform like Maple, you do not have to pay, as they had in other provinces.

This is all well and good. I've been a strong advocate, as the minister knows, for many years, to increase access to primary health care and other parts of our health care system not only for remote and rural communities but also for people in urban places, like our Chair's city of Vancouver, where someone might not be able to go across the street and see their doctor. They might be at home and not be able to leave their apartment, as an example. Virtual care would allow them to get that important consultation, whether it be physical or mental.

Unfortunately, we have COVID-19. But as the minister says, sometimes these negative impacts on our life and our communities and our world turn out to provide some positives. I think accelerating the adoption of virtual care will definitely be one of those things. When people write books — and I'm sure they're already writing the books — about COVID-19, they'll look at this one piece as a positive.

With that, obviously, there's going to be a cost. The governments, not only this one but previous governments, have been trying to manage costs by, in one part, managing the number of people, for instance, that can go into walk-in clinics during the day, where we saw walk-in clinics close after they've reached their quota.

I assume — and again, I'll clarify with the minister — that this virtual care policy that has been developed will talk specifically about that piece as well. It's what is best for patients and delivery of patient care, but also, what the cost implications are, so that the minister has enough resources in his budget from the Finance Minister to make sure that other parts of his budget aren't compromised. I would imagine, if we are going to offer virtual care — whether by phone or by video, as we are right now — there are going to be more people accessing health care in British Columbia.

It's like highways. If you make the highway bigger, you'll get more people driving their cars. That's not to say it's a bad thing; it's just to say it is what it is. Therefore, there is going to be a cost implication, I would assume.

If the minister would like to make a comment on that, and then I have one final question for the minister.

[5:55 p.m.]

Hon. A. Dix: I thought I heard the member for Kelowna–Lake Country make a case against blacktop there. I'm genuinely concerned about the argument he's making there. I think I heard him say that we shouldn't build more bridges, because the cars will just fill them up.

I've heard that argument being made before. But I do recall it, in B.C. politics, as not being a successful argument. I'll just make that point in passing. But he wasn't asking me about highways, and I understand his point about virtual care.

My consideration, when I engage with people — for example, the people at Telus — on this question, is: I think it's an important need to develop longitudinal care in the province. There is, of course, a need for episodic care — we've seen this a lot during COVID-19 — but we want to connect that care to long-term care in the system.

My challenge to people who want to offer more virtual care is to ensure that that virtual care, which has enormous advantages…. If we'd wanted to go for a doctor's appointment today, we might have missed two or three hours of these rousing estimates, going and driving to the appointment, waiting in line, getting the appointment and coming back, right?

I think there are huge advantages, but my concern with virtual care options, some of them that have been provided in the discussion we have is: how do we integrate that into what we're doing, into team-based care?

It's so that we don't create just more one-off health care — at potentially high costs, as the member suggests — that we integrate it and provide people with the consistent care that they need, not a different doctor every time, and that we don't create, in the virtual care system, some of the elements of the current system that maybe are least effective.

That presents some challenges, but I think, from what the member said and from what we see at this time, that there are enormous opportunities. I'm very optimistic — based both on what some people have done, including Telus in B.C., and on what others have done in other jurisdictions — that this is going to be a moment of change in our primary care system.

N. Letnick: Well, thank you to the minister.

Regarding transportation, I'm very proud to say, we have a six-lane highway going through Kelowna and new intersections at Sexsmith. Four-laning of Highway 33, we have a passing lane going up Walker Hill, we have a new bridge, and the list goes on and on. What we do need — and maybe he can talk to the Minister of Transportation — is to fix the Glenmore intersection at Highway 97 and Beaver Lake Road.

I actually took him in my Smart car to visit people in Lake Country, and we had a chance to see how the lineup was at that intersection.

If there's anything the Minister of Health can do for me today, in one of my last questions, he can really advocate for some blacktop for me there — and some whitetop, because I think it's going to require an overpass. So put some money aside for that, Minister. I know that most of the money is going to Vancouver Island, in Transportation, but send some to the Okanagan too. We can use it. I'll put up a sign. I'll even wear his T-shirt.

The Chair: Member. Member, I'd like to draw you back to Health estimates, please.

N. Letnick: Okay. The last question. Actually, what I'll do — because I'm cognizant of the time and of the need for departures — is just read out the question. If the minister would like to give me a written response later, that's fine.

When it comes to cancer treatment, we all know that the time between diagnosis and treatment is vital in increasing the effectiveness of the treatment. Pre-COVID, B.C. was sending individuals to the United States to receive cancer treatment, CAR T-cell therapy.

Does the minister know how many people have been cut off from this cancer treatment option because of the border closure, or is this deemed essential travel, allowing them still to access care? That's part 1.

Part 2. Can the minister provide the average cost per patient for those that were sent to Washington state for cancer treatment?

The last part. CAR T-cell therapy was pioneered in B.C and is approved for health use by Health Canada, but it can cost three times more if conducted outside of B.C. Has the minister reviewed providing the same here? Again, if the minister wants to send me a written response, that's fine.

Just to say thank you, Mr. Chair, for chairing great meetings.

To the minister and his staff, as usual, an awesome job. I like this — giving you the questions ahead of time. We get through so much more, so much more quickly. I'm sure all my colleagues appreciated getting the minister's answers in a timely manner. Maybe we'll do it again next year.

[6:00 p.m.]

Hon. A. Dix: I did note down the intersection there. I don't recall that on the trip. We saw almost no traffic in Kelowna when I was there on that trip. That was the day we were announcing the urgent and primary care centre.

I'll get the member some specific numbers on that. I suspect that that is essential travel, although that travel may well have been interrupted in these times for the struggles they're having in health care in Washington state. I'll get him that information.

What we're doing in our cancer strategy is trying to repatriate all that. Sometimes it's necessary to find access to care for people in B.C., and we're doing that. That's information that we'll be providing.

My deputy minister, who is here — we want to thank Steve Brown — nodded and said he would be spending the weekend working on that. My associate deputy minister, I think, is going to be working this weekend on something else. Our associate deputy minister Peter Pokorny is here. He and our assistant deputy minister Teri Collins have been here.

I want to thank our provincial health officer, Bonnie Henry, and the many people with the Ministry of Health.

Vote 31: ministry operations, $22,042,385,000 — approved.

Hon. A. Dix: I move that the committee rise, report resolution and completion of the estimates of the Ministry of Health.

Motion approved.

The Chair: Thank you, Members, for a wonderful Health estimates. I wish you the absolute best for your weekend. Safe travels, everyone.

Thank you, everyone. Have a great weekend.

The committee adjourned at 6:02 p.m.

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