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Morning Sitting

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TUESDAY, NOVEMBER 5, 2002

The House met at 10:04 a.m.

Prayers.

**Orders of the Day**

[1005]

**Hon. G. Hogg:** I call second reading of Bill 73.

**Second Reading of Bills**

**COMMUNITY CARE AND  
ASSISTED LIVING ACT**

**Hon. K. Whittred:** I am pleased this morning to rise in this chamber and move second reading of the Community Care and Assisted Living Act.

This bill is about protecting the health and safety of persons in care and enabling communities to provide the appropriate services to those who need them. This government is committed to renewing public health care and improving the way care is delivered so that it meets the needs of persons in care. This new legislation is an important element of our new-era commitment to address the needs of B.C.'s growing and rapidly aging population.

This last spring we announced that, working with the private and non-profit sector, an additional 5,000 intermediate and long-term care units will be developed by 2006. This bill will help us achieve that. It also replaces outdated community care facility legislation that was passed more than three decades ago. The old legislation is overly prescriptive and complex and no longer meets the needs of today's child care facilities and people in community care.

This bill also replaces Bill 16, which was introduced last spring, to allow for consultations on how to strengthen protection for residents of community care and children in care.

I want to thank the many people in the sector who participated in the consultation process over the summer. We met with and heard from a wide array of stakeholders, including federal and provincial agencies, advocacy groups, professional associations, health authorities, municipalities, unions and, of course, many individuals.

More than 5,000 agencies and groups were notified by mail of this process, and more than 500 people took part in the 11 community consultation sessions that were held in six communities across the province. Mr. Speaker, 102 written submissions were received. There was, of course, the website available for people to respond via the Internet. By this source we received another 559 responses. I might add, for members who are interested in learning more about the input we received, that a summary of the consultations is posted on the ministry's website.

We undertook the consultation process because we knew there were good ideas out there on how we could improve upon what had been included in Bill 16. I have to say that I am very pleased to see the high level of interest and the constructive suggestions we did receive. We asked for input, we got it, and we have listened. The new bill is proof of that.

Pretty much everyone we spoke to agreed that the old legislation was long overdue for renewal. The old legislation was focused on detailed requirements. The old way of regulating community care was just too complicated, too inflexible and too closed to allow for any kind of innovation. At the same time, the old legislation did not recognize the concept of assisted living, a relatively new housing concept for seniors and persons living with disabilities which has emerged in recent years. Assisted-living residences represent one important component of the rapidly expanding supportive living sector, which is an important element of this government's new-era commitment to meet the needs of B.C.'s growing and aging population and persons living with disabilities.

[1010]

This bill addresses the out-of-date aspects of the old legislation while extending protection to those living in assisted-living residences. It moves regulation of the community care sector from overly detailed rules about procedures in community care to a focus on results.

For the first time, it introduces a legislated framework for assisted-living residences. This bill is based on the belief that it's not the rules that are the most important; it is in fact the people they are supposed to protect. This legislation puts the focus on client care, on care for the vulnerable and dependent, seniors and persons living with disabilities and vulnerable and dependent children.

The bill has two main parts: part 2, which deals with community care facilities and child care facilities, and part 3, which deals with assisted-living residences. Based upon initial feedback we have received from care experts like medical health officers, the B.C. Care Providers Association and the Early Childhood Educators Association of British Columbia, I am confident this new bill will be welcomed by communities, health authorities and health workers working in the field.

I would like to speak for a few moments about the particulars around community care facilities. Part 2 of this act allows for improved protection for community care residents and children in licensed care centres. There are in British Columbia approximately 1,050 licensed adult and child residential facilities with a combined capacity of over 25,000 spaces. There are approximately 4,600 licensed child care facilities with a combined provincial capacity of over 73,000 spaces. Part 2 of this bill is all about improving and modernizing protections for the vulnerable people who are served in these facilities.

This bill provides a clearer focus on persons who are vulnerable and dependent, such as the residents of care facilities and children in licensed care. These are

the people who are vulnerable and dependent, and the facilities that care for them will remain licensed. These facilities will be required to achieve specific outcomes in terms of quality care, whether we're talking about the residents in community care or the care of children in care facilities.

The bill also brings the regulation of private hospitals, which have in the past been dealt with through other legislation, under the same legislation so that all facilities that deal with similar clients will have similar legislation and be regulated by the Community Care Facility Act. The legislation creates a framework that will allow us to develop regulations for all of these facilities that are focused on outcomes, regulations that permit licensees to come up with innovative ways to achieving those outcomes. It clearly distinguishes between facilities that serve vulnerable and dependent people, the facilities regulated by this bill, and those serving more independent clients, facilities that are not covered by this legislation and therefore won't be affected by rules that might not be appropriate for them.

[1015]

Another major aspect of this bill is that it focuses on provincewide, results-based standards. Under the old Community Care Facility Act, regulations were detailed and inflexible. In recent years there had been some change in this. There had been an effort to start moving away and toward regulations that were, in fact, more outcome-based. This new bill will help ensure that this process continues and is in fact accelerated.

In the past, facilities have been forced to spend a great deal of time following detailed rules that have everything to do with process and little to do with results. Health authorities have been forced to monitor and enforce these sorts of intrusive rules rather than keep their focus on what's important, which is in fact the health and safety of the people in care. This bill will allow us to shift the regulations from inflexible and overly prescriptive rules to higher level overall outcome-based standards that are focused on results and that ensure a consistent and high level of care in all licensed facilities.

These regulations will include standards for child care facilities and for the protection of people in residential care. As well, this bill maintains the early childhood educator certification process, the importance of which has been made clear in the feedback we received during the consultations.

The new regulations will be developed over time. This bill will provide an overall structure that allows that process to move forward.

A further major aspect of this bill is that it enhances local authority and streamlines decision-making. It gives local decision-makers more responsibility and flexibility to make sure local needs are met, consistent with provincewide standards.

Local medical health officers will be given increased decision-making authority over community care. They will have primary responsibility for evaluating, reviewing, issuing and enforcing community care

facility licences. By allowing for the creation of provincial standards, the government is putting local decision-makers in a much better position to encourage innovation and new concepts for care and to make sure that this is always consistent with high standards of health and safety protection.

In addition, previous time-consuming processes for suspending or cancelling a licence or for seeking an exemption from one of the regulations will be replaced by streamlined processes to reduce delays and keep the focus on quality care. For example, under the old legislation, when a licensee thinks they have a good reason to do something differently from the letter of the regulation, they must apply for a variance. The application goes to the local medical health officer, who reviews it and decides whether to recommend the variance. The application then goes to a variance committee in Victoria, which reviews it and makes a decision. If the variance application is denied, the licensee can then appeal the decision to the Community Care Facility Appeal Board. All of that process was just to make an exception from the way things are set out in the regulations.

Under our new legislation, this process will be streamlined considerably. An exemption application will simply go to the local medical health officer, who will make a decision. The decision can be appealed to the Community Care Facility Appeal Board, but only if the exemption is approved. This streamlined process will strengthen local authority, ensure more timely decisions, and provide greater consistency and fairness in the way decisions and appeals are handled. It's good for licensees, and it's good for the people the legislation is designed to protect.

[1020]

One of the areas that I am particularly pleased about is the section of the bill that deals with protection for those who report abuse. It improves the protection by adding new provisions for people who feel that they're in a position where they must report an abusive situation. This protection covers employees, residents and family members, who in the past may have believed that complaints about a licensee might result in recriminations to the worker, resident or client. This bill protects against such recriminations, allowing people with concerns to complain in good faith without fear of the consequences. This change is consistent with legislation in other jurisdictions. It's good for employees, and it's good for family members and for the people in care that this new provision is designed to protect.

Now I would like to turn my attention to some remarks specifically around assisted-living residences. Part 3 of this bill provides a new framework for ensuring the health and safety protection of people who live in assisted living. This new framework will help this relatively new and, we hope, rapidly growing sector to thrive and expand in coming years.

Assisted living provides residents with varying degrees of support at a facility where they can live relatively independently. This bill provides protection for the very first time to assisted-living clients, people who

require some supports to continue living independently. To this end we are recommending in this bill a registration-based protection for assisted-living residents. The bill makes a clear distinction between the community care facilities described in part 2, which will continue to be licensed, and assisted-living residences, a new category of residence which must be registered.

An assisted-living residence is a residence where three or more adults who are able to make decisions on their own behalf receive housing. Assisted-living residents will also receive hospitality services such as meals, laundry and housekeeping. In addition to that, they also receive up to two prescribed services, in which regular assistance is provided for various daily living activities. These include things such as the administering of medication, the monitoring of diets, assistance with grooming and personal hygiene, or the maintenance or management of residents' money or property.

A facility that provides three or more prescribed services is considered a community care facility, and it must be licensed. A facility that provides one or two of these prescribed services would be an assisted-living residence and would be registered. With this legislation, all assisted-living residences must be registered.

Now, how is this registration system to work? Well, the registrar will be appointed. An assisted-living registrar will be designated by the minister to register residences, to investigate complaints and to suspend or cancel registrations if the act or regulations are contravened. After the passage of this bill, an interim registrar will be appointed by the minister. The registrar will then lead a consultation process with the industry, including service operators, the health authorities and other interested stakeholders. This process will lead to the establishment of minimum health and safety standards, a process to monitor compliance and a process for following up if standards are not met.

[1025]

The registrar will also work with the industry to identify the process to take when service providers are not complying with industry standards. The registrar may register an assisted-living residence if satisfied it will operate in a manner that does not jeopardize residents' health or safety. The registrar may inspect if there is reason to believe the health or safety of a resident is at risk or if an unregistered assisted-living residence is being operated. The registrar may suspend or cancel a registration if the act or regulations are being contravened. Regulations covering assisted-living residences will cover the prescribed services that are provided; health and safety standards for service delivery; and procedures around registration, fees, and the suspension or cancellation of registration.

Assisted living is a good concept, and government, through this bill, is helping maximize its potential by providing protection to those residents who need it the most. By recognizing assisted-living residences as an important addition to the continuum of care, along with home care and community care, government will

be in a position to provide appropriate support for assisted-living seniors and persons living with disabilities who are living on low or modest incomes. This increases the range of options available to seniors and others in need of assistance who still want to maintain as much independence and to live as independently as possible.

In conclusion, this bill is all about modernizing protections for vulnerable people to make sure that their needs and their health and safety will always be the top priority. By creating a clear focus in community care on people who are vulnerable and dependent, by recognizing the valuable role of assisted living, by focusing on results rather than processes and by encouraging innovation within overall provincial standards, we are improving protection. We are improving health and safety for people who need it.

We are following through on the commitments we made in the throne speech earlier this year and in our *New Era* document. I am very pleased with the improvements we have made to this bill as a result of the consultation that took place over the summer. The result is a balanced bill that maintains protection while making sure that regulation is proportionate to the vulnerability of the people receiving the service. It is legislation that will spur growth of assisted living and help us fulfil our new-era commitments to British Columbians.

**J. Kwan:** The bill that's before us, Bill 73, the Community Care and Assisted Living Act, was preceded by a draft act back in the spring when the minister had created and introduced in this House Bill 16. By way of background, Bill 16, of course, generated a lot of concerns in the community. The concerns related to those who are involved with seniors groups, municipalities and city councils, regional districts, lawyers, unions, community care living officers of B.C. and the Child Care Advocacy Forum.

[1030]

Through the consultation period that the minister had engaged in, they had expressed many concerns. I'm glad that since that time the government has proceeded with a major reworking of the bill. I think we could all agree that the first bill, as it was tabled, had many, many flaws in it.

I'll admit that Bill 73 is an improvement. Having said that, it is not without concerns, and I would like to bring forward some of those concerns. I would also like to just highlight that some of the concerns I bring forward were brought forward from the groups I had mentioned earlier: the seniors groups, the municipalities, city councils, regional districts, lawyers, unions, community care living officers and the Child Care Advocacy Forum. I was hoping — and I think they, too, were hoping — that the government would incorporate their concerns, all of their concerns, into the revamping of Bill 16 and what is now Bill 73.

First of all, let me talk about the biggest issue, really, within Bill 73. The bill itself is called the Community Care and Assisted Living Act. With a title as

such, with a bill that centres around care, one would think the issues around the standards of care would be a major component of the bill. That is not the case.

There's only one line in this legislation about the standards of care. In my opinion and in the opinion of many of the stakeholders that gave me feedback on this bill, standards of care should be the centrepiece of this legislation. What we got instead is one line. The legislation under section 7(1) deals with standards of care. What does it say? Section 7, "Standards to be maintained," 7(1)(b) says that a licensee must "operate the community care facility in a manner that will promote the health, safety and dignity of persons in care."

It's a very nice statement; make no mistake about it. It's all very nice. It's comforting. It's motherhood. Of course care facilities should promote the health, safety and dignity of the person. I think that's without a doubt. They are basic assumptions that one would expect care facilities should be providing. Yet in my view, it's a weak statement in a piece of legislation in which the centrepiece ought to be about standards of care.

Why do I say that? It leaves much to interpretation. It is subject to how people want to interpret what it means to promote health, safety and dignity. It doesn't set standards. What are the minimum standards one would expect? When your loved one is in a care facility, you know that these are the basic minimum standards you can expect and that it is in legislation, stipulated by law, that these are the basic minimum standards my family member — if I have a family member in a care facility — should expect to receive.

In the press release yesterday when Bill 73 was introduced, what did the minister say about standards? "The registrar will work with operators to establish basic health and safety standards." That's what the minister said. I'm a little bit concerned about that statement from the minister. It's true that operators ought to be involved; no doubt about it. Yet so, too, should the clients, their families, the advocates in the field, the front-line workers who do the advocacy work. They, too, should be involved in setting out the standards of care.

[1035]

It's disappointing to see this statement from the minister whose major responsibility, in my view, for this act is to lay out the standards of care. All she could say in the press release yesterday was that the registrar will work it out with the operators. One would have thought the standards-of-care issue is bigger and broader than that and that it would incorporate a wider group of people who would establish what those standards are. One would have thought, after all this consultation and all the work and all the time that has elapsed since spring, that in this legislation itself we would see some of what the standards of care would include. That is not so. It is nowhere in the legislation. We do not see any establishment of the minimum standards in this act.

That concern was raised by many people, one of which is the greater Vancouver regional district, which wrote a letter to the minister with their concerns

around standards of care. Yes, the letter was written as it applied to Bill 16, but given that the bill before us, Bill 73, in my view does not address the issues around standards of care adequately and does not respond to the concerns that have been raised by these individuals, their letter and concerns still stand.

I'd like to share with the minister, in case she didn't get a chance to see the letter from the greater Vancouver regional district regarding the issue of standard of care. In subparagraph 4 of their letter, which is headed, "The need for provincewide standards":

"One of the key changes proposed in the new act is the provision of direct decision-making authority to local medical health officers for various licensing decisions, including greater authority to add terms or conditions to facilitating licenses. We understand the province's desire to provide greater flexibility and efficiency through increased local autonomy, but the delegation of increased responsibility to local health authorities and, functionally, to local governments must be accompanied by appropriate resources from senior governments to support these expanded roles.

"Local health authorities, for example, report that currently case managers are already dealing with an average caseload of 400 people. Furthermore, the objectives of increased efficiency and reduced costs to the consumer and to the aggregate cost of health care service delivery may not be well served by the creation of a patchwork of jurisdictional differences. Differences among local health authorities, perhaps according to bed capacity or other resource constraints, may result in inconsistent approaches used to determine who is admitted to residential care.

"Health care services are now to be unbundled and offered à la carte to facility residents and may differ widely in their availability among them. Service providers are concerned this may result in increased costs to the customer and not necessarily better care."

It's a general statement around the need for province-wide standards and a general concern for the health authorities to provide for a basic minimum standard of care.

One may ask the question: how many beds within a facility? How many staff in order to ensure that there is a minimum standard with a particular facility? Or will that just simply fluctuate from facility to facility, depending on what the resources are in that particular region? That's just one piece of concern around the standard-of-care issue.

I'm sure, though, as the government is fond of saying, that this minister would also say that we'll simply wait for the regulation. "The regulations will come in, and that will establish everything. Don't worry; everything will be fixed."

Well, I don't know about that, especially when you have a major piece of legislation whose centrepiece, in my view, ought to be establishing some standards, yet they're nowhere to be seen.

[1040]

We're debating this in the House now. It will no doubt be passed by the government, with their 76 majority. It will no doubt be passed by government, yet the people who will be impacted will still not know. They will still not know what the ramifications are for

themselves, for their loved ones or for their family members.

The minister talked about the consultation process, and in my view the consultation process, again, was not workable for many people. Why is that, Mr. Speaker? Because the bill itself is a skeleton. Many of the detailed changes that need to be clear and be shared with the community were not. Again, what government often says is, "But the changes will come in regulation," but the regulations have not been shared with the stakeholders. Will the draft regulations be shared for further consultation? That's the one question I have for the minister. If you really want detailed feedback from those who are impacted by the bill, I would assume the minister would do just that: share the draft regulations with the stakeholders and get their feedback before it's finalized. It would be much easier for the public to comment on the government's true intentions if this minister did exactly that.

The issue around the need to see regulations was also highlighted by various stakeholders who have sent letters and expressed concerns to the minister, again from the GVRD. The GVRD raised this issue when Bill 16 was out, and again the comment is applicable for Bill 73. Here's what they had to say around their concerns on regulations in point 2 of their letter:

"Regulations to accompany the new CCF Act. We understand that the province will be undertaking a review of the child care licensing regulations and adult care regulations corresponding to the new CCF Act following enactment of the legislation. The province has indicated that the revised regulations will follow an outcome-based model. Because the regulations will be critical to service providers, consumers, communities and local governments, in understanding the precise impact of the legislation, it would be preferable to have the province delay enactment of the legislation until full consultation and collaboration process with stakeholders can be carried out with respect to both the act and to its accompanying regulations."

The GVRD expressed strong views to the minister around this need. Legislation must come with the regulations so that all those who are impacted and involved with this sector would know what the intentions of government are so that they would know how to respond, how to comment and make constructive criticisms and give advice to the minister so that then we can truly create an act and a set of regulations that would advance into the future in the area of community care and assisted living.

So far, that is not so. Perhaps this is the biggest flaw of all in the government's approach to the revamping of this legislation. It is virtually government by regulation. We've seen it over and over and over again in a variety of legislation. Yesterday we were debating the RTA, Residential Tenancy Act. Time and again, when questions were raised to the minister and the Solicitor General around the intentions of government — what does it really mean? What are the ramifications for both the landlords and the tenants? — the minister's response was consistently that it would be in regulation. Then further than that, arising from the regulation, the

landlords would be able to set out their own tenancy agreement so that, really, at the end of the day, when you pass a piece of legislation, when you debate a piece of legislation, nobody knows what is really behind the words of the legislation, because you can't see the regulations before it and you can't debate it in conjunction.

[1045]

Some have said the legislation is just a skeleton. The meat, if you will, will come later, but without pre-analysis by or input from the opposition or stakeholders. By introducing the act as a new piece of legislation and not simply as a series of amendments to the old legislation, the government clearly signalled that the regulations previously enforced will no longer apply. This model might work for the government, but it creates untold anxiety in the community. The minister claimed to be consultative, but by leaving all the specifics to the regulations, the debate is then internal within government. Some may argue that would render the consultation process simply a farce.

Now, the minister did release a seven-page discussion paper on community care, but it seems to me that it simply served to muddy the waters even more. There was an analysis done by David Schreck on the paper. It's actually a good paper. The Minister of Advanced Education and the minister herself may think that's funny. They might just simply write off people who may have been involved in politics before, who may have a thought or two or comments to contribute. They may just laugh at it and want to mock and trivialize it, but that is not, I think, the approach that government should take. It should look at all the information, evaluate it for its merit to determine whether or not there's merit to the suggestions.

Here's what David Schreck had to say, because I did look at his document, and I thought it was well-thought-out, actually. I did, so I'm going to put it on the record and share with the ministers and the members in this House so they, too, can reflect on the points that were made from this discussion paper. The discussion paper is titled *The Vulnerable as a Business Opportunity* and dated July 22, 2002. I'll just take pieces of it, because it is fairly lengthy — three pages of small print — and highlight the central points. I quote:

"In order to assist the public, a seven-page discussion paper on outcome-based regulations is available on the web-based consultation site. After making an appeal for less regulation so as to help business, it attempts to define outcome-based regulations by way of a couple of examples. It does not take an existing proscriptive or prescriptive regulation and provide an example of how that regulation will be replaced with an outcome-based regulation. However, it does discuss the legal implications of outcome-based regulations.

"It essentially says that outcome-based regulations can pose difficult enforcement problems, but no one should worry about that if the consequences of enforcement are anything short of closing the facility. In the words of the discussion paper on page 4: The legal implications associated with an outcome-base model arise largely where the consequences of provisions are even more severe. This would include provisions which provide for

permanent closure, revocation and refusal of a licence or for prosecution.'

"The discussion paper for community care outcomes may be the first time the Campbell government has come close to specifying what it means by outcomes. It turns out that its concern is for the outcomes for business rather than for the outcomes for residents of facilities.

[1050]

"During legislative debate, the minister mocked the regulation that provides reasonable window space in each resident's bedroom. She claimed that: 'The new provincewide results-based care standards will ensure that health authorities are accountable for a consistent and high-level quality of care for all licensed facilities and that the resources of facilities are devoted to meeting those required outcomes.'

The discussion paper makes it clear that the use of the word "standards" is very important. The discussion paper goes on to say:

"Provisions which provide instruction, education and guidance for achieving desired outcomes constitute a significant component of an outcome-based model, since such a model places a great deal of emphasis on education and providing alternative strategies for achieving outcomes. These types of provisions may not all require the force of law, and some could simply be contained in standards. In other words, standards are those things that government can do nothing about by way of legal enforcement."

There is consensus that the community care legislation was in need of some major updating, but the consensus seems to be that any reworking of the legislation needs to be focused on care and not facilities. That said, this legislation as tabled changes nothing about care. The current act says that you are required to inspect facilities and that these inspections will be done by the ministry.

What does the new act require? You may inspect. This task is devolved to the health authorities by way of the medical health officer — the health authorities who could well be running the community care facility themselves. Just how thoroughly does this government think they will inspect themselves?

This is a submission from David Schreck, and I think the points are good.

It is interesting to see where the minister, this government, has chosen to take us on the issue around inspections. The previous act says you must inspect the facilities. The current act says that you may inspect the facilities.

Why would the government lower the threshold for ensuring and enforcing standards of care within facilities? Why would it do that? What's the purpose behind that? Perhaps more importantly, what would be the outcome of lowering the threshold for enforcement? Would it mean that chances are the facilities would actually provide better care, or would it mean that standards of care would diminish and might or might not be caught in the system to be rectified? Is that a likely outcome?

We see this throughout government as well. Just yesterday in question period with the Minister of Water, Land and Air Protection, the opposition raised the

question: why would government allow a company with a long history of having done damage to the environment to be now no longer enforced and to have automatic right to construction on side streams and riverbeds — construction that would damage our ecosystem? When the company has a demonstrated track record, a long history, of having done damage to our ecosystem and our environment, why would government all of a sudden decide: "Well, gee — no matter; we now have this notion called result-based, performance-based, so this company can do whatever it wants"?

[1055]

It can go ahead and build structures around our riverbeds and our streams and potentially do damage to the ecosystem. There is no longer the requirement from the ministry to produce the reports that say who the violators are within the ministry who do damage to our environment and to make that information public.

If you take that as a scenario, the concept or philosophy behind the government, and transfer that to this issue here, which is the community care and assisted-living care facilities, then you have to ask the question: why would government erode the standard of enforcement for community care facilities? It makes no sense to me. What I think that would jeopardize is.... We'd have problems occur and slip through the cracks because inspections are no longer required. This is, in my view, hugely problematic.

This issue, of course, was raised by many people — not just by David Schreck, not just by the opposition, but by others as well.

From the BCGEU submission to the minister, August 2002, I'm taking two paragraphs from their submission on this issue.

"It is conceivable that an operator could open an unlicensed facility for two persons with no requirement to be inspected. Also, if that unlicensed facility should choose to have two individuals who require a higher level of care, the staffing levels, the qualifications of those caring for the clients and the level of treatment received are not subject to the act. The government is proposing changes to the act that will open the door to making unlicensed facilities acceptable but difficult, if not impossible, to inspect on a regular basis."

That's another opinion from the BCGEU around issues of enforcement relating to the standard of care.

The HEU also provide lots and lots of support in the community in this area. Lots of their front-line workers are there. They, too, made a submission to the minister. It is related to a lot of the concerns, many of which the government, the minister, has not addressed under Bill 73. I'm taking just part of their submission to the minister.

"The recent very comprehensive, large-scale study by the Health Care Financing Administration for the U.S. Congress clearly establishes the relationship between adequate staffing and health outcomes for residents in long-term care facilities. The study identifies two staffing levels: (a) the staffing required to avoid serious harm to residents and (b) the staffing levels required to improve the quality of life for residents.

"Very recently HEU worked with academic researchers in B.C. to develop a database of current staffing levels in all types of long-term care facilities, using the March 2001 essential services information registered at the Labour Relations Board. These researchers found that despite similar funding from government, there were significantly lower staffing levels in for-profit compared to not-for-profit at every level of care and every type of facility. Many of these facilities had staffing ratios that were below the guidelines outlined by the Health Care Financing Administration study for the U.S. Congress.

[1100]

"The new legislation does not require that the health authorities meet provincial standards for staffing and quality care, nor does it require health authorities to report out on quality and consumer protection problems in facilities under their authority. Instead, the language in the proposed legislation states that the provincial director of licensing may require a health authority to provide routine or special reports and may create policies and standards of practice for all community care facilities or a class of community care licensing facilities.

"In other words, there is no reference in the legislation to minimum staffing standards and/or the requirement that the regional authorities monitor resident outcomes for health conditions — i.e., bed sores, the number of falls, dehydration, malnutrition, etc. — that are linked directly to the quality of care they receive.

"In the U.S. and in many other provinces in Canada there is considerably more legislative oversight of long-term care. In Manitoba the provincial licensing legislation includes minimum staffing guidelines. In the U.S. nursing homes are inspected annually by state surveyors. These surveyors issue citations for deficiencies related to the quality of care and health outcomes for residents."

The study cited by the HEU illustrates and heightens the point around the need to set minimum standards and the need to ensure that quality of care is accounted for and legislated in the act. There are a number of factors that involve that: staffing level — no doubt about it — and resources available to the facility — no doubt about it. You also need to make sure in any facility that you actually do an enforcement. You do a check. You do a look-see. Check in to see how the facility is operating, how the residents are being cared for and if, in fact, they are being cared for adequately. But as I mentioned earlier, there is only one sentence in this bill that talks about the standard of care. It doesn't set minimum standards at all. In fact, it further erodes on the inspection side in sort of requiring that inspection must be done. One could now choose to decide whether or not inspections would be done.

Another major flaw in the first incarnation of the bill.... You could call it a flaw or an oversight. It seemed a purposeful change that the definition of community care facility excluded the majority of living conditions that were once under the act. Assisted living did not fall under the definition of care.

Now Bill 73 includes a large new section on assisted living. I'm glad for that. Thank goodness. The minister's major platform in her mandate was to create some 3,500 assisted-living care beds. That she would somehow forget, when Bill 16 was introduced, that that sector of people would have no care at all, no protection at

all by legislation.... It just slipped the mind — forgotten. I'm glad, because the community rose to the task and said: "Good grief. How could this be? You have a brand-new act. You say you're going to do all these new things. You're evicting seniors from intermediate and long-term care facilities, putting them into these supposedly assisted-living care facilities, and many of them don't yet exist." There's no protection whatsoever in the new legislation to address their concerns. How could it be? How could it be that a government could neglect the very people that this minister has been mandated to advocate for and provide protection to? How could it be that she could even introduce a piece of legislation with zero mention of this group of people who are under her area of responsibility? It's shocking — absolutely shocking.

[1105]

After the community had raised concerns with this the government, there is a new section on assisted living in the new bill, Bill 73. The problem is that the bill does not deal with any of the affordability issues on the housing side. There are no restrictions on what can be charged for rent or services for care aides, and there is no prohibition on how often rents or other charges could be raised. Does this mean that the operators of assisted-living facilities can raise the rent as often as they want? Can they raise the rent as much as they want?

The government has decided to separate the assisted-living section from the Residential Tenancy Act. What we now have under Bill 73 is zero protection on affordability, no consumer protection on affordability for those in the assisted-living sector.

Pertinent information that the community has brought forward on the issue around affordability impacting seniors, I think, should be shared in this House. The lower mainland Seniors Housing Information Program Society have produced a position paper on health care and housing for seniors. They only recently produced this — October 2002. In it there is a full section on supported living. Let me just take a few paragraphs from this submission to share the information with this House.

"We're especially concerned that assisted living will include those who need care as high as intermediate care level 2. If this means placing people who are already on residential care wait-lists into new assisted-living units, frail seniors who are not living in a monitored setting and whose needs are not deemed urgent will create a new health care liability. The emphasis is shifting again from addressing the support needs of seniors to providing care for the frail and vulnerable in an effort to reduce costs associated with the delivery of residential care. While we do appreciate the need to deliver care and services efficiently and economically, we believe this new initiative is not well thought out and in time will lead to further shortages of affordable housing for low-income seniors regardless of their care needs.

"We're concerned that assisted living may not be affordable or accessible for many seniors. We understand that the cost of basic publicly funded assisted-living programs will be more than 70 to 75 percent of income. However, there is no guarantee that extra charges won't be

applied for the provision of additional services or supplies. There is no guarantee that seniors on low and fixed incomes will have priority or that housing providers will apply income ceilings. The introduction of income ceilings could create yet another vulnerable group of seniors whose income falls just above the cutoff, and they may be forced into private-pay settings that they could not afford. Furthermore, we're concerned that housing providers, in order to generate higher revenues, may choose or give preference to seniors with higher incomes."

This is the document from the Lower Mainland Seniors Housing Information Program Society. It's an excellent document, actually. It highlights a lot of the issues. I've only just taken a couple of paragraphs from this submission to be shared with this House.

On the issue of affordability, it is a critical question. Many of the seniors are on fixed incomes. They're pensioners. They don't have additional resources. Without consumer protection on affordability, what will happen to them in terms of their safety and security in their old age?

[1110]

By the way, though I suspect this is cross-cultural, it certainly is the way amongst the Chinese community that when you reach your senior years, it's considered that you're in your golden age and that you should have, at that juncture of your life, the benefit to enjoy some of the fruits of the labour of your earlier years. Much value is placed on the seniors, so that in their golden years they don't have to worry about whether or not they have a home. They should not have to worry about whether or not they'll have food on the table. They should definitely not worry about whether or not they could access health care and whether or not they have enough money to buy medicine. Should they need a care facility, they should have access to a care facility.

After all, seniors paid into the system all their lives prior to reaching their golden age. They have paid into the system already, and if they should need assistance from the system, shouldn't the system then be there for them? It's a common belief. It certainly is one that I know many seniors in my own community have, but I don't think that is strictly restricted to my culture. I think it's cross-cultural. I think we all believe that and want to see that.

Yet as we see erosion of programs from government in many, many sectors — in the health care sector, in Pharmacare, MSP premiums, even in the bus passes for seniors — all of those things are costing the seniors more and more money to get the services they need and once enjoyed before the changes. Now, in the situation around intermediate and long-term care, seniors are being evicted from their homes.

Some of them are being taken away from their loved ones, two or three hours away from their loved ones, because there's no facility in their own community. The government has shut them down. This government has closed them down. Cooper Place in my own riding was an intermediate and long-term care facility that was funded by the previous government to have upgrades, renovations to the facility itself. That

project is not proceeding. The government has taken the money back.

[J. Weisbeck in the chair.]

I just wrote a letter. I wasn't able to make it last Friday when there was a rally there, but prior to that, I went down there and met with some of the seniors. One of them who is now gone, evicted from her own home, is 105 years old. She had been there for many, many years. It's the home she knows and the community she knows, where her friends and relatives are, and she's gone. She no longer has a home there, because that facility is being shut down.

That's the reality of it. That's what this government is doing. No one can say: "Well, gee, if you have the resources, you can buy the quality care facilities you need." But you know what? Not every senior is in that privileged position. Many of them are not. This piece of legislation does not give protection around the issue of affordability for those who will now be evicted from their long-term and intermediate care facilities and put into these so-called assisted-living facilities. Many of them would not have consumer protection on affordability.

Another document, from HEU, talks about assisted living, and the document is actually excellent. It is very, very good. It's entitled "Jumping on the Alberta Bandwagon: Does B.C. Need This Kind of Assisted Living?" Let me just put some of that information on the record. The article is written by Wendy Armstrong, the Alberta chapter of the Consumers Association of Canada.

"Many British Columbians are concerned about the provincial government's plan to drastically alter residential care for seniors. In the spring of 2002, Victoria announced the closure of 3,000 beds in traditional long-term care facilities and a concurrent scheme to invest federal housing dollars in assisted-living complexes for seniors. To appease the public's worries and confusion about these moves, some officials have talked soothingly about B.C. emulating the Alberta model.

"Just what is the Alberta model? In the last decade, the province of Alberta was pulled into two different directions. On the one hand, innovators were able to pilot three new public models that yielded many valuable ideas about alternatives to old-style facility care. Unfortunately, these pilot projects were overwhelmed by another, much stronger trend in Alberta: the unravelling of public coverage and the growth of private-pay markets.

[1115]

"Today public coverage of many long-term care services, residential and in-home, has all but disappeared in Alberta. Public access is not far behind. As their loved one's health deteriorates, elderly spouses and adult children now must deal with buying and providing care on their own. Indeed, so much of the burden and cost of care has been off-loaded to families that the Long Term Care Association of Alberta is quietly advising people to purchase private LTC insurance to protect their income and assets.

"If this sounds like American-style health care, it is. And just as the U.S. system is administratively more expensive than Canada's, health authorities in Alberta are

now spending more money administering an increasingly fragmented and privatized system and less money actually funding and delivering health services.

"The dire situation in Alberta did not arise by accident. In 1990 the province simply stopped constructing new nursing homes and auxiliary hospitals, even though Alberta's population was to increase by almost 500,000 over the next decade. Bed shortages led to restricted access for the neediest patients only. Direct care staffing was cut almost in half. Terminally ill cancer patients were moved out of acute care hospitals into LTC facilities, where they were charged per-diem fees. Much-promised home supports for seniors with less serious physical and cognitive impairments failed to materialize and even decreased.

"In 1994 the province began to surreptitiously withdraw funding from the support side of long-term residential care. This was part of a mounting trend by the Klein government to separate the costs of health from the costs of housing. Direct care costs, health care provided by professionals and others, would continue to be publicly funded, but other support and living expenses — housing, cleaning, meals, laundry, monitoring, etc., — would gradually become the personal responsibility of seniors in LTC settings, whether in an auxiliary hospital, assisted living or at home.

"The ever-growing shortfall created by downsizing beds and reducing quality in public LTC created tremendous opportunities for real estate developers. A lucrative private-pay market arose in Alberta, mainly lodges and retirement homes based on the commercialized U.S.-style assisted-living model.

Sound familiar? Let me carry on:

"Assisted living: what does it mean? When assisted living originated in the U.S. in the late 1990s, it represented a new and progressive approach to the needs of special populations with limited abilities. The original assisted-living model calls for a home-like setting that gives residents control over their private space. Residents are helped to maintain their existing capacity for self-care, self-direction and social interactions. In contrast to old-style nursing homes, residents are encouraged to do as much as possible for themselves in an environment of managed risk under the watchful eye of a care organization that coordinates all necessary health and support services.

"This approach to assisted living may include a basic package of meals, housekeeping and help with personal care such as bathing, grooming or transferring. It may also offer the option to purchase individualized services over and above the basics. Naturally, the original philosophy envisions homes and services that are affordable and accessible to seniors in need.

"Since its inception in Oregon, assisted living has branched out into many less-than-authentic directions in the U.S. and Alberta. The term is now applied to housing situations and care models that do not embody the original philosophy. Today assisted living is more likely to refer to multi-unit apartments with varying amounts of on-site personal supports — meals, housekeeping and social activities — and personal care available 24 hours a day, all of which must be purchased by the resident. Regrettably, the original vision has been largely co-opted by commercial operators looking for a high return on investments.

"In Alberta the reality of assisted living is a crisis in access, costs and funding. Let's look at the private and public faces of this kind of care housing today.

"Assisted living for profit. As in the United States, developers and realtors in Alberta promote assisted living as a residential option that falls somewhere between independent living and nursing home care. Private lodges and retirement complexes offer a combination of safe and secure housing, hotel-type services such as regular meals and housekeeping, and nursing care provided by personal care aides, all for a hefty price.

[1120]

"Seniors either buy their own unit as a life lease or they pay rent. The facilities sell a range of services. Some have dining rooms only — no room service; others have 20-bed locked dementia units. Hotel-type services and personal care are purchased in separate units or in tiered packages over and above the basic housing costs. For example, one private facility charges for lunch daily, \$196 a month; dinner daily, \$279 a month; incontinence care, \$150 a month; night checks, \$100 a month; medication assistance, \$150 a month. Assistance getting out of bed, dressed, bathed or taken to meals is usually charged in 15-minute increments at \$20 to \$28 per hour.

"The business of itemizing and tracking these fragmented clusters of services is itself pricey — an administrative cost that is passed on to the consumer. These for-profit facilities operate in a regulatory void, even though many residents are captive and vulnerable consumers due to their emotional, physical and cognitive impairments. If the price of a bath or incontinence care rises too high, they often have nowhere to turn. If a service or building feature goes wrong, they often dare not risk complaining. Opportunities for exploitation abound. One Alberta facility charges residents \$7 for a single wheelchair ride from the front door to their room.

"Alberta pilots a public model. While these private-pay complexes were sprouting on Alberta soil, several innovative models of care were being piloted. The Good Samaritan Society's assisted-living project was based on the original non-profit model in Oregon. Caring partnerships among operators, families and residents were central to the philosophy. The Good Sam model offered basic services — i.e., one meal a day — with opportunities to purchase up. As with the traditional nursing homes, residents were placed by the regional health authority and paid a per-diem fee.

"An evaluation of the project by researchers at the University of Alberta identified a number of benefits and limitations. On the plus side, participants were pleased that the care was indeed enhancing the well-being of residents. On the minus side, major concerns arose about costs and burdens for family members. Expressed in dollars, researchers found families were contributing \$5,800 per resident per year or 41 percent of direct service costs above per-diem expenses. Expressed in time, families were contributing 50 hours per month in direct services out of a total of 95 hours per resident.

"The researchers strongly recommended that policy-makers incorporate informal costs like unpaid caregiving time, out-of-pocket costs and personal costs into their decision-making about assisted living. They were also alarmed about the social and economic well-being of the largely part-time staff.

"By the time the evaluation was completed in 1998, however, the privatization die had been cast. Recommendations were ignored. Instead, the province and the regional health authorities began to see assisted living as an opportunity to shift even more costs to residents, including building costs, drugs and many other services

normally covered in facility settings such as transportation to medical appointments.

"Here's how it works today. Designated assisted living. Existing commercial assisted-living operators and new non-profit operators use their own capital and/or public housing money to build suitable rental units. Owner-operators then set a rental price to recover their investment capital, operating expenses, support services cost and any profit margin.

"The RHA contracts with the operator for control over entry to a number of units and for a specific basket of care services up to \$1,500 per month in Calgary in 2002. Candidates for nursing home care are then placed in these units through the region's single-point-of-entry process — that is, if the person's able and willing to pay the rent.

[1125]

"Rental agreements are between the individual and the owner-operator. Drugs and many other supplies may be privately purchased from retail pharmacists. Families take on a greater role to make up for less monitoring by health professionals. Definite limits exist regarding aging in place. In fact, seniors and their families may need to purchase extra care even for temporary episodes of illness, or else face dislocation.

"Alberta is now talking about shifting even more costs away from the public health care plan. In 1999 the province's long-term care advisory committee suggested that individuals should start paying for personal care provided in any long-term care setting — nursing homes, assisted living and at home. Personal care is usually delivered by a care aide who assists with dressing, bathing, eating, bedtime, housekeeping and monitoring.

"In short, the province seems to be moving towards making seniors pay for anything that is not, narrowly speaking, a direct health care service. Regions will be obligated to pay only for approved services provided by licensed health professionals such as RNs, yet these professionals provide little daily care to at-risk seniors. Only people with very low income would have their personal care covered by the public plan. If this direction is embraced, Alberta's long-term care sector will be more or less reduced to three functions: (1) care by RNs and other professionals, whose work is very limited in long-term care settings; (2) claims adjudication by regional care coordinators — administering the shrunken system; (3) care of the destitute."

There are some myths behind the virtues of privatized care. There are some myths behind the notion of using assisted living as the panacea. Just pausing for one moment from this article, I will share with you the myths that they have highlighted.

Under the previous government there was a continuum of care. For those who needed affordable housing, affordable housing programs were in place, delivered by B.C. Housing — albeit we could do more and albeit the federal government should come back to the table and provide for a national program of affordable housing. That's one thing. Then there were the long-term and intermediate care facilities for those who needed health support, publicly funded and available to anybody who needed that service. That was the spectrum that was in place.

In fact, prior to the election the previous government wanted to extend the long-term and intermediate care facilities. Why is that important? Because it actually allows for a reduced pressure in the hospital set-

ting. Those who are in intensive care units — sometimes costing \$1,500 a day or perhaps even more, depending on the health services you need in a hospital setting — are what we called bed-blockers at that time. That's not necessarily to say that they don't need care, but they don't need intensive care, and they don't need to be in the hospital. They need 24-hour around-the-clock health care support in a home setting. Because there was a lack of long-term and intermediate care facilities, they became bed-blockers, and it cost the health care system more money to actually deal with this group of people.

It was wise for government to devise a plan to expand long-term and intermediate care, and yes — make no mistake about it — long-term and intermediate care facilities are more expensive than just your average housing, than assisted living — no doubt about that. It reduces the cost, though, at the health care end. It was another component in the spectrum, the continuum that needed to be in place.

That's the third piece that was put in place in terms of intermediate care. Then the previous government also put forward supportive living. It's not to say that there's no need for supportive living, but it's an error to say that you will now shut down intermediate care facilities and replace them with assisted living. Assisted living is a further minimized level of care than that of long-term care. Make no mistake about that.

You know what? This could actually escalate as people are being evicted from their long-term and intermediate care facilities, particularly when the assisted-living facilities are not yet fully in place. They are not fully in place. People have nowhere else to go. They go back to their families; they go back to a rental apartment with reduced care. They get sick, and they end up back in the hospital and become bed-blockers once again.

[1130]

It's not good for the family, not good for the individual and not good for our health care system and all British Columbians on the whole. Yet this is the direction in which we're going, Mr. Speaker. The continuum of care that was in place has now been truncated to one answer from this minister. No more affordable housing programs, no more intermediate care and long-term care facilities. One answer only: supportive living. Supportive living is now the flavour of the day. Then, within that spectrum, what can we expect? I anticipate that some of the things that have taken place in Alberta will come to B.C. I don't doubt that for one second. We are already seeing people who have to pay a lot more money to get access to care. We already see that right now across British Columbia.

"The myths behind the Alberta model. These changes in Alberta's health care are predicated on a few widely promoted assumptions, all of which are ideologically biased and factually suspect. They include the following myths. Myth No. 1: people who need long-term care services are sophisticated consumers with lots of money. Fact:

"Few Canadians can be called sophisticated consumers of these kinds of care services and care housing. The need for long-term care services usually arises due to a

major personal crisis such as a stroke or the death of a caregiving spouse. Families are often desperate for help. Even with experience, evaluating complex service options is both difficult and time-consuming. Further, most people over age 65 are not swimming in dollars. The median income for seniors in Alberta was just over \$1,400 per month in 1997.

"The failure of private markets to provide affordable and appropriate rental housing for even independent seniors means that money from the sale of the family home can quickly disappear. Cuts to benefit programs and rising expenses have left many middle-class parents and grandparents struggling to hang onto their lifestyle. The situation of low-income families can be even worse. Loss of projected investment income is another problem for some middle-class households. Grown children are expected to fill the gap by either giving or buying care yet are themselves often struggling to raise families. Many are only one paycheque away from serious financial problems. In the so-called land of plenty, Alberta families have the highest median debt load in Canada.

"Myth No. 2: shifting the costs and burden of care to family members is costless to society.

"In fact, shifting sizeable costs and burdens to the family is expensive on personal and societal levels. The stress of constant caregiving can lead to emotional, financial and health breakdowns. Employers of family caregivers also pay the price in sick-time claims, lower productivity and indirect administrative costs, according to a recent employer benefits plan survey. Caregivers who are forced to drop out of the workforce may become the poor seniors of the next generation.

"Research also shows that when family members are stretched too thin by myriad physical tasks and responsibilities, they cannot provide the emotional support that is the key predicator of health in the elderly. Forcing seniors, who have paid into the public system for years, to give up almost all their income or spend all their savings and assets to obtain care is a grim betrayal of their generation. It could also be viewed as a new kind of inheritance tax.

"Forcing middle-aged children to buy into the high-priced private health insurance market is nothing more than an ill-conceived economic development scheme to prop up the North American insurance industry.

[1135]

"Myth No. 3: private health care markets will provide better service and better value for the money.

"Real competition, affordable prices and quality controls are difficult to achieve in private health care markets due to the nature of the demand and the many opportunities for exploitation — i.e., vulnerable and oftentimes desperate people. Further, a fragmented and privatized system is more costly to run than a public system. As the number of suppliers and payers increase, so do the costs of documenting, monitoring and regulating. Alberta is seemingly sprinting towards a U.S.-style private-pay model of long-term care, despite the fact that the American health care system has administrative costs four times higher than the rest of Canada.

"For example, the administrative costs, tracked by function, of Alberta's health authorities rose from 5.6 percent to 15.2 percent of overall budget between 1997-98 and 1999-2000, more than for any other identified function. Alberta's managers are spending ever-increasing amounts of time, energy and money determining eligibility, evaluating, assessing, documenting, approving, coordinating, billing and collecting, and arranging for even

thinner, tinier units of care from multiple agencies, instead of delivering services themselves. Billing clerks are replacing RNs.

"Beware the Alberta model. Assisted living's promise is in offering seniors the chance to maintain their independence in a personal domestic setting while receiving the care, social contacts and attention they need. Assisted living was conceived as a dignified and responsive model of care for individuals with chronic or declining conditions. But with Alberta's pattern of privatization and its neglect of the progressive public model, assisted living could easily regress to the state of yesterday's unregulated and abysmally staffed nursing homes, just as today's traditional long-term care facilities have deteriorated. There is a very big difference between autonomy and abandonment.

"Organizations and individuals are rightly concerned about the recent proposals for long-term care in B.C. Careful monitoring and much lobbying are needed to avoid jumping on the Alberta bandwagon. The Alberta model is nothing more than a quick trip down a rocky road to U.S.-brand long-term care, fraught with crippling costs, lawsuits for fraud, stories of abuse, underpaid staff and a high toll in family bankruptcies."

I think this article is a worthwhile article for all of us to be aware of the implications, the direction that one could slip into — that British Columbia could slip into. That's on assisted living.

The other issue, of course, is about long-term care, and I talked about the need for long-term care and that full continuum to be in place. As this Liberal government and this minister are shutting down long-term and intermediate care beds, in my view, they're escalating the health care crisis. They're escalating the health care crisis, creating more problems for generations down the road and of course immediately. They are creating stresses, causing harm for those who have lost their homes in a number of ways.

Those who have moved to another community... To you and me, Mr. Speaker, we might think a two-hour drive is not a big deal. But for someone in a care facility who's been moved two or three hours away from their own community, who will likely not get to see their family and friends on a regular basis as they would have had they remained in their own community, what might those impacts be? Studies have been done when a person, especially those who are elderly and frail, has been moved abruptly from their home — what the prognosis is. Studies have been done. They have shown that people die as a result of it. I know some would say: "But they're elderly anyway. They're probably dying already, as it were." I suppose we all are dying; we are all aging. But there's something to be said when you look at a group of people who are faced with that situation, where they've been uprooted from their home suddenly, and all of a sudden within that sector, how quickly their health deteriorated and how quickly their life came to an end.

[1140]

I think that tells you something. It tells you something about such policies and such actions that government is taking today.

On the issue around long-term care, another article. Another research document is entitled "A Dramatic Reversal of Policy on Long Term Care." It is a lengthy document, and I don't intend to read all of it into the record, although I certainly would encourage people to look at it, because the information is valuable. It's valuable, it's well researched, and it goes right to the point of our debate today, broadly speaking, on our overall health and health care system changes.

Let me begin with some of the information.

"The April 23 announcements were a dramatic reversal of the Liberal government's election promise on long-term care. Prior to the election, the Liberals' commitment was to build 5,000 not-for-profit long-term care beds. Shortly after the election, it was simply 5,000 new long-term care beds. The reference to not-for-profits had been removed. Then in the fall it was 1,500 new long-term care beds and 3,500 assisted-living units.

"On April 23, when the regions presented their three-year plan, the numbers changed once again. No new long-term care beds were announced other than one facility in Vanderhoof. Instead, over three years there would be a reduction of 3,111 long-term care beds, an addition of 3,799 assisted-living units and little change in home nursing and home support services."

There's a table in this article that I'd like to share with this House. It's just information on the number of long-term care beds, the number of bed reductions and how many units are being promised in terms of assisted living by 2005. This is done by region. The information is from the announcement that the government made back on April 23, 2002.

Starting with the Vancouver coastal health authority, currently there are 6,922 long-term care beds. By the year 2004-05 the number of beds will be reduced by 573 to a total of 6,349 — an 8.3 percent reduction.

In the Fraser region there are 8,000 long-term care beds currently. By the 2004-05 year it's expected to be reduced by 800 to 7,200 units of long-term care beds — a reduction of 10 percent.

On Vancouver Island 4,960 units of long-term care beds exist right now. A bed reduction of 920 by the year 2004-05 will reduce the number to 4,040 — an 18.5 percent reduction.

In the interior 4,708 beds exist right now. Long-term care beds by 2004-05 will see an 818-bed reduction, bringing us to a total of 3,890 — a 17.4 percent reduction.

In the northern health authority no information was available, but the total for the province looks like this. There are 24,590 long-term care beds currently. By the year 2004-05 we will see a reduction of 3,111 beds, giving us a total of 21,479 beds — a 12.7 percent reduction.

[1145]

That's in an environment, in the context, I must say, where we have an aging population. Keep in mind that people actually are getting older. The baby-boomers are getting older. I hope that many of them will stay in good enough health that they actually will not need intermediate or long-term care facilities, but I anticipate that some will. But what is the trend? Instead of

actually seeing more beds being made available, we're seeing a reduction instead.

I predict — and this is a prediction — that we will see what is known as the bed-blocker phenomenon. As services are not made available for people, as they're not able to access the health services that they need to live comfortably, they'll end up in the hospital. They'll end up in emergency. With that, they will become what are known as bed-blockers. They don't necessarily have to be in intensive care or emergency care, but because the preventative day-to-day support services are not there, people's poor health will escalate to a state where they will need to be in the hospital.

"These broken promises will have very serious implications not only for frail seniors and their families but for anyone trying to access health care services in this province. A shortfall in long-term care beds will intensify the pressure on every other part of the health care system from emergency and acute care to home support, nursing and physician services.

"To understand the full implication of these changes, it's important first to outline why 5,000 new long-term care beds were required and, second, to explain what assisted living is and why it is not necessarily an effective substitute for long-term care. What becomes clear through this analysis is that the Liberal government's continuing care renewal plans are guided almost entirely by the bottom-line monetary considerations and not by the desire to provide our frail seniors with quality care."

The article then goes on to talk about the need for new long-term care beds:

"In 1999 the ministry staff prepared a ten-year plan document for residential care based on current utilization and taking into account population growth and the aging of the population. The document states that an additional 4,495 beds are needed in 2001-02 in order to provide the service required. From 2002-03 to 2009-10, an additional 1,000 to 1,400 beds are required in each year in order to meet the service requirements due to population growth and aging.

"The determination that there is an immediate shortfall of close to 5,000 long-term care beds stems from the fact that there was very little construction of new long-term since the mid-1990s. Over this time period there has been an influx of seniors into the province and an aging of B.C.'s population. As a consequence, access for seniors over 75 to long-term care has actually declined by about 20 percent since the mid-1990s.

"Shortfalls in long-term care beds translate into longer waiting lists for long-term care — the wait-lists increased by 76 percent from 1993 to 1999 — and increased pressure on family caregivers, physicians, home support, nursing care, emergency services and acute care. According to recent projections by the Ministry of Health, about 13 percent of acute care patients are only in acute care because of the lack of long-term, rehabilitation and community services. Acute care is the most expensive part of the system, and the Liberals' election promise to build 5,000 not-for-profit long-term care beds was at least in part designed to reduce this pressure on acute care.

"However, on April 23, instead of announcing 5,000 new beds, the Liberals announced 3,111 bed closures across B.C. To manage the declining number of beds, a new assessment process has been developed, wait-lists closed and access limited to those who qualify under the new rules and require care within three months. The new

rules restrict access to residential care to those people who have been defined through the assessment process as having complex care needs.

[1150]

"Other people, who are not defined as requiring complex care, will have three options. They can remain in their own homes, be assessed for entrance into assisted-living housing or pay for residential care privately. These changes mean in effect that somewhere between 6,000 and 8,000 frail seniors and people with disabilities, who up to now were eligible for entrance into publicly funded long-term care, will not be eligible under the new rules.

"Despite these policy changes, the demand for long-term care will likely grow quite dramatically into the future. Over the next 20 years in B.C. the seniors population over 75 will increase by 27 percent from 1999-2009 and 46 percent from 2009-19. The failure to fund an adequate...of long-term care will in all likelihood generate a crisis in health care that will push many of those who can't afford to pay in the direction of private care. Is this the underlying intent of the policy — to make individuals rather than the government responsible for the cost of long-term care and to support the provision for private for-profit care? If it is, what will happen to the moderate and low-income seniors who are not able to afford to pay for their care privately?

"Assisted living: is it the solution?"

Let me just begin this portion of the documentation, because that is what the government is proposing, and I do want to share information so that people can decide for themselves whether or not the government is heading in the right direction.

"Assisted-living/supportive housing is being presented by the Liberal government as a more positive alternative than institution- — i.e., facility- — based long-term care and the solution to a shortfall in long-term care beds. It is true that assisted living, if it is affordable, can be a very positive alternative for many people with limited care needs. It is not, however, the primary solution to the shortfall in long-term care beds.

"Assisted living is a housing model in which the person lives somewhat independently, usually in a small apartment unit, and is provided with meals, basic housekeeping, social opportunities and some personal health care. It is generally viewed as a positive alternative for people who are able to live somewhat independently, but not appropriate for people with dementia or people who require regular assistance with all or most of the activities of daily living — i.e., toileting, dressing, eating and other activities of daily living.

"Alberta and the United States have moved much more aggressively to an assisted-living model of care and have promoted this model as an effective substitute for long-term care. In 1999 the U.S. Department of Health and Human Services conducted the first survey with a nationally representative sample of assisted-living facilities. Based on an analysis of the survey results, the authors came to three main conclusions: (1) assisted living is a very positive model for seniors with limited care needs; (2)

assisted living is not an effective substitute for residential long-term care, because the staffing levels and staffing mix are not adequate for the care requirements of most residents currently in long-term care; and (3) assisted living is largely unaffordable for moderate and low-income seniors.

"In addition, they found that one out of every four people who moved out of assisted living said they were dissatisfied with the care and the cost. A U.S. General Accounting Office 1999 study of assisted living in four states found that more than one-quarter of the facilities it examined had at least five quality or consumer protection problems, ranging from poor care to inadequate staff to faulty admission and discharge practices.

"In British Columbia the government plans to address the affordability issue by taking advantage of the newly announced joint federal-provincial funding for affordable housing. The new program will be administered by B.C. Housing, and all of the new funding designated for affordable housing will be used to create the 3,500 additional assisted-living units for the frail elderly. Under this housing model of care, the regional health authorities will only be responsible for the costs of direct care staff — non-professional care attendants. All other shelter and supportive service costs — i.e., meals, laundry, housekeeping, maintenance and security, drug, recreation and rehabilitation costs — will be the responsibility of either B.C. Housing or the individual.

[1155]

"If an individual requires additional nursing and personal care, they will have to access that support from the community — i.e., through existing home nursing and home support services. The costs of the direct care portion — i.e., the health authority costs — are assumed to be \$50 to \$75 a day, about half the cost of long-term care. It is on the basis of these lower costs that the government has announced this problem of substitution of long-term care with a housing model of supportive and/or assisted living."

Hon. Speaker, there are a number of serious problems with the substitution of this model that the government has adopted, but noting the time, I move that we adjourn debate. I would also reserve the right, of course, to continue debate when we resume, I presume, after 2 o'clock.

J. Kwan moved adjournment of debate.

Motion approved.

Hon. G. Halsey-Brandt moved adjournment of the House.

**Deputy Speaker:** The House stands adjourned until 2 o'clock this afternoon.

The House adjourned at 11.56 a.m.