Prince Edward Island
CANADA

Health and Social Services System

Ministry of Health and Social Services

Annual Report

2004-2005

Annual Report

for the year ending March 31, 2005

Ministry of Health and Social Services

For more information on this report, contact:
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Prince Edward Island
CANADA

Message from the Minister

To the Honourable J. Léonce Bernard
Lieutenant Governor of Prince Edward Island

May It Please Your Honour:

It is my privilege to present the Annual Report of the Ministry of Health and Social Services for the fiscal year ended March 31, 2005.

Respectfully submitted,

J. Chester Gillan
Minister of Health and Social Services

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Deputy Minister's Overview

The Honourable Chester Gillan
Minister of Health and Social Services
Province of Prince Edward Island

Honourable Minister:

It is my pleasure to submit the 2004-2005 Annual Report for the health and social services system.

I am proud of our many accomplishments in 2004-2005 and would like to highlight some major achievements:

- The 2004-2015 **Cancer Control Strategy for Prince Edward Island** offers recommendations regarding issues such as prevention, screening, treatment and palliative care to reach three main goals: reduce cancer incidence, mortality and morbidity in P.E.I.; to enhance the quality of life of cancer patients and families; and to improve the sustainability of the healthcare system.

- The modification of the Children's Dental Care Program has resulted in a more sustainable program while continuing to be one of the most inclusive and extensive programs in Canada.

- The vaccine campaign realized the participation of approximately 7000 Island school students in a research study for a whooping cough vaccine.

- The new **Supported Adoption** program is designed to encourage and secure the adoption of children with special needs who are in the care of the province.

- The new **Prince County Hospital** became fully operational on April 4, 2004.

- The Health Council of Canada's "Best Practice" recognition is a tremendous achievement for the PEI Integrated Palliative Care program.

I am pleased with the progress we have made toward the goals outlined in the strategic plan, and look forward to meeting future challenges as we work together to improve the health of Islanders.

Respectfully submitted,

David B. Riley
Deputy Minister

Ministry's Role and Responsibility _____

Vision

One system of quality services that promotes health and independence through relationships based on trust and shared responsibility.

Mission

The mission of the health and social services system is to promote, protect and improve the health and independence of Islanders.

Principles

Wellness
Our primary focus will be on wellness and children's health.

Sustainability
We will allocate resources appropriately to respond to changing needs and ensure continued access to quality programs and services.

Accountability
We will measure and report on our performance and health outcomes.

Goals

- Improve health status
- Increase personal responsibility for health
- Improve sustainability in the system
- Improve public confidence in the system
- Improve workplace wellness and staff morale
- Maintain other results at current levels

Minister's Role and Responsibilities

The Minister of Health and Social Services is accountable to the Legislature of Prince Edward Island for the quality of the health and social services in the province and its impact on the health and well-being of Islanders. The minister develops systemwide strategies, plans and policy direction in consultation with health authorities*, and carries the interests of the health authorities and citizens to Executive Council and the legislature. The minister allocates resources to health authorities in an equitable manner, and monitors and reports to the public on system performance and results.

The Minister of Health and Social Services is responsible for achieving acceptable results in Prince Edward Island in the following areas:

Jointly with individual citizens, families, communities, health authorities, physicians, other provincial government departments, non-government health care providers and health organizations:

- Health of citizens
- Individual, family and community acceptance of responsibility for health
- Impact of the physical and social environment on health of citizens
- Independence
- Quality of housing in the province
- Quality of public policy affecting health of citizens
- Sustainability of the provincial health and social services system

Jointly with health authorities, physicians and health care providers:

- Quality of services and their impact on citizens
- Cost-effectiveness of health and social services
- Patient, family and client satisfaction
- Equitable access to health care and social services
- Health, safety and dignity of those under care
- Workplace wellness and morale of provincial and health care and social services providers and staff
- Occupational health and safety of staff and volunteers
- Public confidence in the health and social services system

And is also responsible for:

- Quality and performance of provincial and regional health care and social service providers and staff and their conduct of health business
- Physician and health care provider confidence in the PEI Health and Social Services System
- Relations with other governments, stakeholders and agencies
- Quality of monitoring of health outcomes and health and social services system performance
- Condition of health and social services system's facilities and equipment
- Condition of health and social services system's finances
- Compliance with government legislation and regulations
- Enforcement of assigned legislation and regulations
- Such other responsibilities and obligations which are from time to time assigned by the legislature and Executive Council.

** Health authorities include the four regional health authorities and the PHSA*

Deputy Minister's Role and Responsibilities

The role of the Deputy Minister of Health and Social Services is to provide leadership in innovation and continuous improvement across the health and social services system; and to provide specific high quality administration and regulatory services to the health and social services system and to Islanders.

The Deputy Minister of Health and Social Services is responsible for achieving acceptable results in Prince Edward Island in the following areas:

Quality of advice, assistance, information and leadership provided to the minister, and as appropriate, to health authorities and their staff, and public and private health care providers in matters pertaining to:*

- Policy formulation and implementation
- Development and adoption of outcome standards
- Monitoring health outcomes and status
- Frameworks and processes for planning
- Resource allocation
- Capital project planning
- Communications strategies
- Human resource planning and development
- Information technology system planning
- Issues management
- Development and interpretation of legislation, regulations and compliance
- Interacting with other governments
- Dissemination of research knowledge and comparative data
- All areas defined by the Health and Social Services Mission Statement

Quality of administration and operation of direct service in:

- Registration, premium collection, disbursement to providers and other physician payment services
- Out-of-province health service procurement and payment
- Tuberculosis, sexually transmitted disease and communicable disease control
- Ambulance services contracts and associated policies
- Blood services contracts
- Information technology systems
- Adoptions and post-adoption consultation
- Provincial non-government organization (NGO) contracts
- Autism programming
- Health information resources

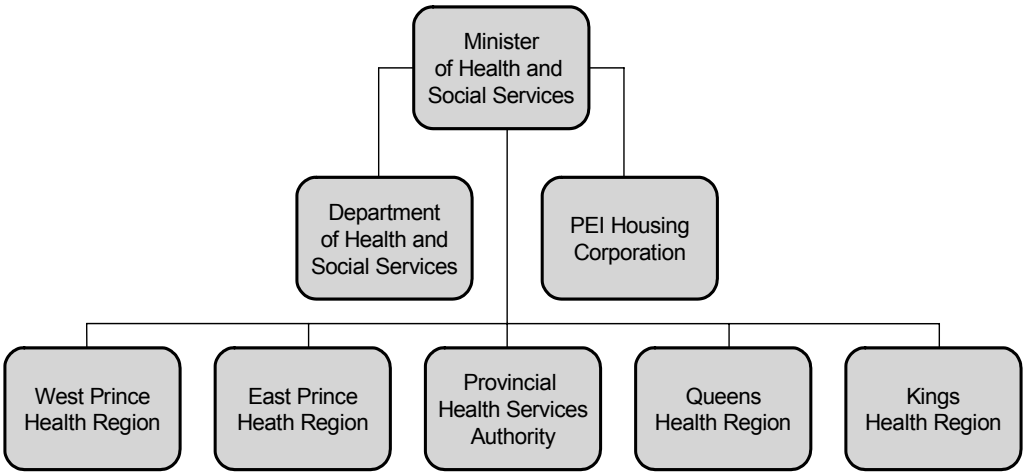
And is also responsible for:

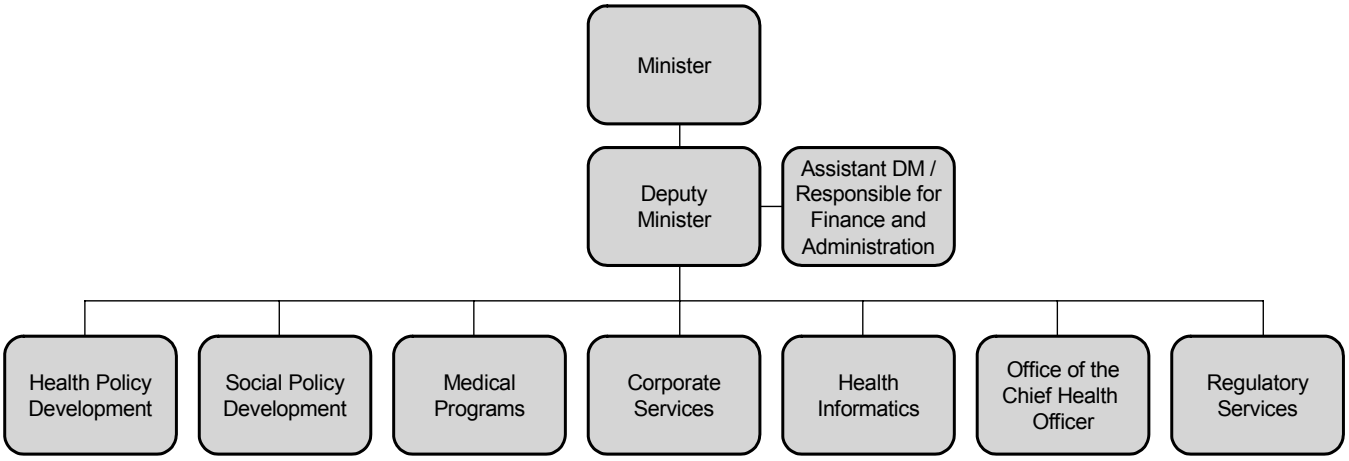
- Quality of health and social services legislation and enforcement of legislation and regulations assigned to the department
- Quality of monitoring health outcomes provincially and regionally within the province
- Client and provider satisfaction
- Exerting influence as appropriate on decisions of other governments, departments and agencies affecting health

- Quality of relationships with other governments, health authorities and their staff, departments, agencies, associations, suppliers and contractors.
- Quality, performance, morale and conduct of staff and their occupational health and safety
- Public confidence in the health and social services system
- Costs and cost-effectiveness
- Condition of department finances and assets
- Departmental adherence to legislation and government policy
- Such other duties and obligations that are from time to time required by the minister

** Quality is defined as reliability, usefulness, quantity, time lines, cost, attitudes, and confidentiality.*

Health and Social Services System Organization Structures





as at April 1, 2004

Department of Health and Social Services

The role of the Department of Health and Social Services is to support the work of the regional health authorities and the Provincial Health Services Authority through leadership in innovation and continuous improvement, and to provide high quality administrative and regulatory services.

Roles of Divisions

Health Policy Development

Responsible for policy direction, program development, evaluation and support in the area of health policy including health promotion and illness prevention, continuing care policy (home care, long term care, palliative care and community care), primary health care policy, dental health policy, nursing policy, chronic disease management, population health and health research. Responsible for policy development in a number of areas including tobacco reduction, the Healthy Eating Strategy, the Healthy Living Strategy, cervical cancer screening, primary health care redesign, diabetes initiatives and maternal/newborn family care.

Social Policy Development

Responsible for policy direction, program development, specialized programs and services and federal/provincial/territorial policy in the areas of child welfare and national child benefit programs, child protection, foster care, adoptions, early childhood development, preschool autism services, youth services, social assistance, employment and employability enhancement, family support and services, family violence prevention, services to persons with disabilities, mental health, addictions, public housing, and emergency health and social services.

Medical Programs

Responsible for the administration of health services as mandated by the *Drug Cost Assistance Act*, *Health Services Payment Act*, *Hospital and Diagnostic Services Insurance Act*, *Hospitals Act*, *Human Tissue Donation Act*, *Medical Act* and the *Public Health Act.* Medical programs and services include the Provincial Medicare Program, physician services, physician consultations and negotiations, physician billing assessment and payment. Has responsibility for ground ambulance, emergency air evacuation, Canadian Blood Services, the Out-of-Province Liaison Program, approvals for health services out of province, physician recruitment, health technology assessment and provincial drug programs.

Corporate Services

Provides advice, assistance and information in the areas of policy development, strategic planning, results measurement, communications, *Freedom of Information and Protection of Privacy Act* policy and administration, intergovernmental and external relations, human resource management, French language services, and legislation.

Health Informatics

Researches, plans, designs, implements and supports information technology and information management solutions for the Prince Edward Island health system in collaboration with the health authorities and department clients within the corporate information technology (IT) strategy of the provincial health system and provincial government.

Office of the Chief Health Officer

Responsible for administration of the *Public Health Act*, supervision of related public health programs, and disease surveillance and control.

Finance and Administration

Overall responsibility for financial and budgetary management, financial planning and analysis, and research and development in financial and policy related areas.

Regulatory Services

Provides regulatory policy, program development, and licensing and monitoring services to ensure compliance with legislated standards and regulations with regard to private sector nursing homes and community care facilities; ground ambulance operators and emergency medical technicians; dietetic services; adult protection; and public guardians.

Assists the Chief Health Officer with the enforcement of regulations covered by the *Public Health Act*. Responsible for the enforcement, promotion and establishment of standards of the *Tobacco Act* and *Smoke -Free Places Act*. Responsible for inspection programs including food safety, rental accommodations, tobacco sales to minors, slaughterhouses, swimming pools, summer trailer courts, tenting and camping areas, and institutional facilities such as day care centres, kindergartens, community care facilities, nursing homes, hospitals and correctional facilities.

Responsible for the collection, registration and maintenance of vital event information including: births, deaths, marriages, adoptions, divorces, stillbirths, change of name, and licencing of clergy to perform marriage ceremonies.

Roles and Responsibilities of Health Authority Boards

Together with the department, the health and social services system includes five health authorities comprised of the four health regions (West Prince Health, East Prince Health, Queens Health, Kings Health) and the Provincial Health Services Authority. Each of the regions is governed by a regional health board of directors who have the mandate to deliver health and social services to the region for which they are responsible, and are accountable to the Minister of Health and Social Services.

The Provincial Health Services Advisory Council provides advice to the CEO of the Provincial Health Services Authority on any matter concerning the institutions, programs or services for which they are responsible.

The role of a health board is to define the strategic plan for the health region within the context of the provincial strategic plan; assess and report on health status and health needs of the population being served; monitor and report on health system performance and impact on health outcomes, fiscal condition, and morale and performance of the CEO and staff; to collaborate with other community agencies which influence determinants of health of their citizens; and to provide advice to the minister on matters pertaining to the health and social services system.

The board of each regional health authority is responsible for achieving acceptable results in their region in the following areas:

Jointly with citizens, families, communities, physicians, other provincial government departments, and non-government health care providers and health and social services organizations, the health authorities work toward:

- Improving the health of citizens of each of the regions
- Fostering individual, family and community acceptance for the health of citizens
- Supporting the independence of citizens with physical, intellectual and financial disabilities
- Improving the quality of housing in each region
- Improving the quality of public policy pertaining to health in each region
- Developing the sustainability of each region's health and social services system

Jointly with physicians and health care providers, the health authorities work toward:

- Ensuring the quality of health and social services, and their impact on citizens
- Ensuring the cost-efficiency of health and social services
- Monitoring patient, family, and client satisfaction
- Ensuring equitable access to health and social services
- Ensuring the health, safety and dignity of citizens under care
- Maintaining public confidence in health care and social services within each region

The health authorities are also responsible for:

- Workplace wellness and the morale of their staff
- High quality and performance of staff as they conduct health authority business

- Workplace health and safety of regional staff and volunteers
- Physician, health care and social services providers' confidence in the healthy authority
- Maintaining good relations with other regional health authorities, the Department of Health and Social Services, stakeholders, and government and non-government agencies both in the province and abroad
- Quality of monitoring of health outcomes and health and social service system performance
- The condition of facilities, equipment, and finances with the health authority
- Compliance with, and enforcement of, government legislation and regulations

Senior and palliative care services, long term and acute care services, and addiction and mental health services are available across Prince Edward Island in numerous facilities and institutions. Services that support children, families and communities are also offered throughout all regions of the Island. The regional health authorities also have internal divisions responsible for human resource initiatives, policy and planning, and finance and information technology.

Health Authorities

West Prince Regional Health Authority
Formed in 1994, is responsible for administering all aspects of health and community services and delivering various programs to the people of West Prince.

East Prince Regional Health Authority
Serves the primary health care and social service needs of individuals, families, and communities from Crapaud to Ellerslie. Determines strategies to improve the health and wellness of citizens in East Prince and promotes appropriate balance between all aspects of care -- including the promotive, preventive, curative, rehabilitative, and supportive aspects of health.

Queens Regional Health Authority
Responsible for planning, integrating and coordinating the delivery of quality health and community services in Queens County. Focuses on promoting health and preventing illness as well as providing programs which treat, manage and support clients throughout their lives.

Kings Regional Health Authority
Responsible for ensuring all services delivered are accessible and adequate by having these services delivered at the local level; ensuring services are efficiently provided and regionally managed; improving the match of services to needs of local residents in the region; monitoring the quality of service delivery; and seeking the advice and opinions of residents on needs and effectiveness of services and programs, thus contributing to a greater sense of community.

Provincial Health Services Authority
Responsible for providing leadership in the delivery of provincial secondary acute and specialized services to improve the health and well being of citizens with a clear focus on quality, access, and improved planning and utilization of these services.

Regional Health Authority Board Members

West Prince Health Region

Ernest Hudson, Chair
Juanita Gaudet, Vice Chair
Barry Clohossy
Brenda Doyle
Maxine Ellis
Donald G. Stewart
Eva Rennie

Queens Health Region

Douglas MacDonald, Chair
William Fitzpatrick, Vice Chair
Kirsten Connor
Cheryl Dalziel
Judy Gillis
Dr. Bob Johnson
Garth McCarville
Dr. Robert Morrison
Helene Garg

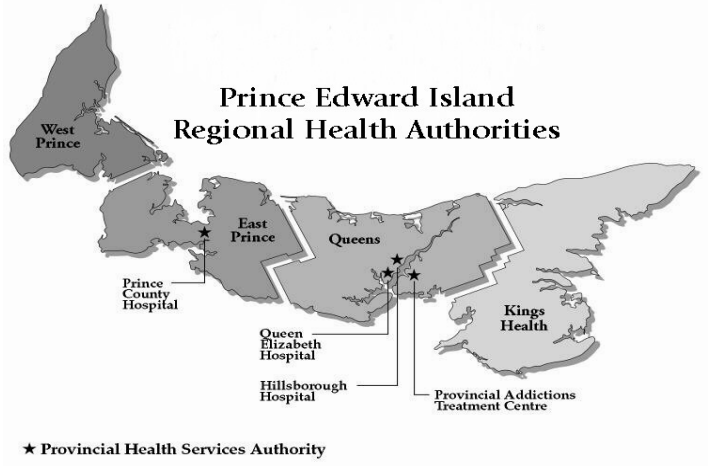
East Prince Health Region

Dr. Allen MacLean, Chair
Alcide Bernard
T. Doreen Gunn
Melinda M. Mulligan
Carol Peters
Lorraine Robinson
Gertrude Trainor
Leonard Russell
1 Vacancy

Kings Health Region

Sherry Kacsmarik, Chair
Marian Trowbridge, Vice Chair
Michael Gallant
Tom Carver
J. Lloyd Soloman
Kevin Brothers
Randy Dingwell

as at March 31, 2005



Population by Region, 2004-05

West Prince	14,945	(10.71%)
East Prince	33,657	(24.13%)
Queens	69,978	(50.17%)
Kings	20,902	(14.99%)

Year in Review

Strategy Implementation

The five-year strategic plan for the health and social services system on Prince Edward Island was established to provide a framework to improve the health of Islanders and the performance of the system over the five-year period from 2001 to 2005.

Based on consultation with providers and the public, the plan identified six critical issues that face the system: public expectations and demand, recruitment and retention of health professionals, appropriate access to primary health care, personal health practices, the aging population and disease prevention.

Six strategies outline the direction the system is taking to improve its desired results. These strategies include Wellness, Healthy Child Development, Access to Services, Human Resources, Health Information Technology and Partnerships to Address the Determinants of Health. The following section highlights the progress achieved by the system in 2004 - 2005, in relation to each strategy and the aforementioned critical issues.

Highlights of the Year

Wellness

Wellness initiatives, which encourage people to reach and maintain their full health potential, have been implemented to focus on disease prevention and improve the health status of Islanders.

Strategy for Healthy Living

The Prince Edward Island Strategy for Healthy Living was launched in June 2003. The strategy continues to enable government, community alliances and non-government organizations (NGOs) to work together to encourage Islanders to address the three common risk factors for chronic disease: healthy eating, active living, and reduction of tobacco use. The development, implementation and evaluation of the strategy is coordinated through a steering committee comprised of provincial government departments of Health and Social Services, Education, Community and Cultural Affairs, and Attorney General, school boards, the regional health authorities, federal and municipal governments, non-government organizations and the PEI Healthy Eating Alliance, the PEI Active Living and the PEI Tobacco Reduction Alliance.

Over this past year, several initiatives that contributed to the overall strategy were undertaken:

Healthy Living Coordinators

Regional Healthy Living Coordinators connected and worked with various partner organizations and members of the community to enhance existing programs, create new initiatives and develop supportive environments for healthy living.

Determinants of Health

The Department was very pleased to have been a major partner in the project *Addressing Inequity and Chronic Disease in Prince Edward Island.* This project, led by the PEI Active Living Alliance, consisted of a series of five forums with the goal to increase stakeholders' understanding of how the social determinants of health impact on chronic disease.

Healthy Eating

The Department of Health and Social Services continued to be actively involved in the implementation of the Healthy Eating Strategy which was developed and released by the PEI Healthy Eating Alliance in 2002 to improve current eating behaviours of Island children and youth through nutrition education, promotion and by creating supportive environments.

Several initiatives were undertaken this past year to increase awareness and knowledge of good nutrition among parents and children:

- A parent information session on media literacy "Growing Up Healthy and Media Wise" was held in January.

- As part of Healthy Eating Week in March, over 400 children and parents participated in a free swim and healthy snacks during a Wintersplash event that was held in each of the four health regions.

- A new Website featuring healthy eating tips, recipes, games and other information for parents and children to encourage healthier food choices was developed.

- A new Speakers Bureau was established to respond to the many calls each year from numerous community groups requesting presentations and displays.

- A resource manual "Healthy Eats Toolkit" and a regular newsletter were developed to inform and assist elementary and consolidated schools in making changes to promote healthy eating.

- The Access to Safe and Healthy Food Working Group continues to administer the Breakfast and Snack Programs in Island Schools. In 2005, there were 43 such programs in operation, up from 18 in 2003.

The PEI Healthy Eating Alliance, departments of Health and Social Services and Education, school boards and Home and School Associations worked together to develop healthy eating policies for Island elementary schools. The Department of Health and Social Services provided funding to the Healthy Eating Alliance to carry out this work. These policies were successfully adopted, marking an important step in creating supportive nutrition environments for Island children to enhance their overall ability to learn and make healthy food choices in schools. Work was initiated to develop similar policies for the intermediate level.

Tobacco Reduction

The Department of Health and Social Services continued to be an active member in the PEI Tobacco Reduction Alliance (PETRA). The Department of Health and Social Services worked collaboratively with others to help non-smokers stay smoke-free, to encourage and help smokers to stop using tobacco, and to promote healthy environments by eliminating exposure to second-hand smoke.

The Students Working In Tobacco Can Help (SWITCH) tobacco prevention clubs in Island high schools organized numerous awareness raising activities in their schools and communities. They held a rally in downtown Charlottetown with the theme, "We Are A Target" and were congratulated for their work by federal Minister Carolyn Bennet, the minister responsible for the Public Health Agency.

PEI continues to be a leader in providing comprehensive support for quitting smoking through the toll free PEI Quitline (1-888-818-6300) and the Quit Care Program at Addiction Services across the province.

Smoking Rates

Reported Smoking Rates of current smokers age 15+, CTUMS 1999 to 2004						
	1999	**2000**	**2001**	**2002**	**2003**	**2004**
PEI	26	26	26	23	21	21
Canada	25	24	22	21	21	20
Canadian Tobacco Use Monitoring Survey (CTUMS) 1999-2004						
PEI has seen a decrease in smoking rates. In 2004, 21% of adults aged 15+ were smokers as compared to 23% in 2002 and 26% in 1999.						
Reported teen smoking rates (age 15-19), CTUMS 1999 to 2004						
	1999	**2000**	**2001**	**2002**	**2003**	**2004**
PEI	28	21	20	19	20	15
Males	na	na	22.2	23	21	#
Females	na	na	18.6	15	18	#
Canada	28	25	22.5	22	18	20
Males	27	23	21.4	21	17	21
Females	29	27	23.6	23	20	19

Canadian Tobacco Use Monitoring Survey (CTUMS) 1999-2004
- high sampling variability

The teen (age15-19) rate of smoking has declined from 28% in 1999 to 15% in 2004. PEI's teen smoking rate is the fourth lowest in the country but slightly higher than the Canadian average for 2003 (20% in PEI as compared to 18% for Canada). For the years where specific data is available 2001-2003, teen girls in PEI have a lower smoking rate than teen boys while the opposite is true in Canada as a whole.

Fewer children are being exposed to second-hand smoke in their homes. The CTUMS data shows a decline in PEI from 27% in 2000 to 18% in 2003 for children aged 0 to 17. For children aged 0 to 11, the decline was even more encouraging, from 25% in 2000 to 16% in 2003.

Stepping Out Program

The PEI Stepping Out program is a pedometer-based program designed to increase the physical activity levels of Islanders. Since 2002, the Department of Health and Social Services provided funding to the PEI Active Living Alliance to offer the Stepping Out program to communities and workplaces across the Island.

During 2004-05, 22 communities, 14 schools, and 6 workplaces offered Stepping Out programs with a total of 1263 residents participating. An evaluation of the 2003-04 program showed a 57% increase in steps per day for those participants who submitted their number of steps for research. There was a 44% increase in physical activity, measured by pedometers, for those students who submitted their steps for research.

Active Healthy School Communities Initiative

The education sector contributed to the Strategy for Healthy Living through the Active Healthy School Communities Initiative. This initiative is intended to build active healthy school communities where students, teachers, parents and communities work together to encourage youth to adopt healthy lifestyles that last a lifetime.

Pap Screening Program

The PEI Pap Screening program was established in January 2001 to reduce the incidence and mortality from cervical cancer through regular Pap screening. Cervical cancer is largely preventable. About half of the women who develop cancer of the cervix have never had a Pap smear or have not had regular Pap smears. PEI's overall two-year screening rate for women aged 20 to 69 remains at 58 per cent.

Highlights of the PEI Pap Screening program's fourth year include the following:

- Public Education and Awareness
  The program held its 5th Pap Awareness Campaign, "Take Action - Regular Pap Tests Prevent Cervical Cancer," in October 2004. This year a new television commercial was produced in collaboration with Nova Scotia and Newfoundland which aired in October 2004 and January 2005. A number of information sessions were also held throughout the year in partnership with community groups.

- Pap Screening Clinic and Out-reach Pap Clinics
  In response to an increasing demand for Pap clinic services, the PEI Pap Clinic continued to hold out-reach Pap clinics in each of the health regions. In 2004, 1500 women attended the Pap clinic in Cornwall or one of the 42 out-reach clinics (an increase from 1,174 in 2003). These clinics have been successful at providing alternative access to under-screened women - 65% of women attending had not had a Pap test within the previous two years.

- Pap Screening Guidelines
  Work has been initiated to develop provincial Pap screening guidelines. It is anticipated that the guidelines will be released in the upcoming year.

Cancer Control Strategy

In October 2004, "Partners Taking Action: A Cancer Control Strategy for Prince Edward Island 2004-2015," was released. The strategy has three main goals: to reduce cancer incidence, mortality and morbidity in P.E.I.; to enhance the quality of life of cancer patients and families; and to improve the sustainability of the healthcare system. The Strategy includes recommendations regarding cancer prevention, screening and diagnosis, treatment and supportive care, palliative and end-of-life care, and survivorship.

The report was developed by an advisory committee comprised of representatives of the Canadian Cancer Society, the Department of Health and Social Services, the Hospice Palliative Care Association, the Cancer Registry, the Cancer Treatment Centre, the Health Research Institute, the Medical Society of P.E.I., the Provincial Health Services Authority and cancer survivors.

P.E.I. Common Health Indicators Report

The P.E.I. Second Report on Common Health Indicators, released in November 2004, is part of the First Ministers' commitment to provide clear reporting on health to Canadians, an initiative that began in 2002. Measuring, tracking and reporting to citizens on health status and the health care system's performance allows Canadians to determine how successful the provinces have been in attaining common goals and objectives, helps those responsible for health care delivery to make more informed choices, promotes the identification and sharing of best practices, and helps Canadians understand how publicly-funded health services are being delivered.

This year's report indicates that Islanders' access to first-contact services such as routine health services, health information and advice, and immediate care for minor health problems are in line with national averages. In addition to providing information regarding access to health care, the report also provides information regarding the quality of services. Satisfaction rates for overall health-care services and physician-care services were higher than the national rate.

A summary of the report is available from the government Web site at *www.gov.pe.ca/health*. The entire report, including many additional indicators and results of other provinces, is available in English at *www.cihi.ca/comparable-indicators*, and in French at *www.icis.ca/indicateurs-comparables*.

Smoke-Free Places Act

June 1, 2004 marked the first anniversary of the implementation of the *Smoke-Free Places Act*. The purpose of this Act is to protect the public and workers from the effects of second-hand smoke by creating smoke-free work and public environments. The *Smoke-Free Places Act* applies to all Island businesses and work places, including taxis and other vehicles used for commercial purposes. Under this Act, smoking is not permitted in workplaces and other public places such as restaurants and bars, except in designated smoking areas that meet requirements outlined in the regulations. Employees are not required to enter a designated smoking room, and food and beverage service is not available in the designated smoking room.

The cooperation from the business community has been tremendous. Most licensed eating establishments opted not to build or renovate smoking rooms, choosing to ban smoking entirely.

West Nile Virus Strategy and Mosquito Surveillance Program

A mosquito sampling program, which monitors the species of mosquitoes most likely to carry West Nile virus, resumed in May 2004.

A mosquito technician was hired to conduct a survey across PEI during the summer of 2004. Areas sampled in 2003 were sampled again, with more traps in Charlottetown, West Prince and rural parts of Queens and Prince Counties. The mosquito survey included identification of the species, their numbers and population patterns across the province.

Public Health Inspectors

In June 2004, Prince Edward Island hosted the 70th annual National Canadian Institute of Public Health Inspectors (CIPHI) Education Conference in Charlottetown. Close to 300 health inspectors, health professionals and associates from across the country participated in the conference. Topics included water quality, tracking food outbreaks, avian flu, BSE in Canada and residential air quality.

CIPHI is the only professional association for public health inspectors in Canada. CIPHI works to protect the health of all Canadians on environmental issues while promoting the science of environmental health and the profession. Environmental Health Officers are certified by the Board of Certification of the CIPHI. This certification process guarantees that the highest standards for entry into the profession are met. CIPHI also provides ongoing opportunities for professional development.

Prince Edward Island Environmental Health Officers inspect restaurants, child care facilities, nursing homes, community care facilities, swimming pools, tattoo parlours and slaughterhouses. Additionally, Environmental Health staff are responsible for enforcement of the *Tobacco sales to Minors Act* and the *Smoke Free Places Act*. These professionals work diligently in the prevention of illness and disease through education of the public on issues of safety such as food safety, safe drinking water and indoor air quality, and enforcement of numerous acts and regulations.

Healthy Child Development

Positive experiences in early childhood have a lasting impact on education and the ability to form relationships and participate in community life.

Healthy Child Development Strategy

Implementation of the PEI Healthy Child Development Strategy continues. Focusing on children from the prenatal stages to the early school years, the Strategy aims to improve outcomes for children in the areas of safety and security, good health, success at learning and community belonging and responsibility.

A Premier's Council on Healthy Child Development, a Children's Secretariat and a Children's Working Group continue to support coordination and implementation within and between government and the community. The action plan for 2004/05 addressed the Strategy's three key activities: supporting children and families, building capacity and sustainability, and profiling healthy child development.

Partnerships for Children

The PEI Partnerships for Children initiative provides funding to the Children's Working Group networks for projects which support children and families. The networks support the key areas for action of the PEI Healthy Child Development Strategy.

In 2004/05, Partnerships for Children supported a range of activities which addressed prenatal care, healthy eating and physical activity, children with exceptional needs, children's mental health, healthy living, family violence prevention, use of car and booster seats, family literacy, bike helmet safety and parent support.

Children's Think Tank

More than 100 parents, care-givers, educators and representatives from community organizations, business and government gathered for the Premier's Council on Healthy Child Development's Fourth Annual Children's Think Tank. Each year, participants meet to review Healthy Child Development Strategy activities from the previous year, to share ideas and to prioritize actions to address issues affecting children and families.

Measuring and Improving Kids' Environments

The Measuring and Improving Kids' Environments (MIKE) program continues to utilize an on-site consultation process to provide training, resources and support to licensed early childhood development programs. Through MIKE, licensed early learning and child programs are supported in their efforts to make targeted and measurable improvements to the quality of education and care being offered. MIKE is a joint project of the Department of Health and Social Services and the Early Childhood Development Association (ECDA).

During Early Childhood Care and Education Week in November, early childhood educators met at the second annual Share and Tell Celebration to discuss ways to improve the quality of the services they provide in their day care centres. The Share and Tell Celebration, which is hosted by the MIKE program, provides early childhood educators from across the province with the

opportunity to discuss current strategies and practices, to share ideas, and to reflect on program improvements underway in their centres.

Strategies discussed in detail included project-based learning, which provides for child-directed learning opportunities; the development and implementation of story sacks to foster language and pre-literacy skills; and inclusive education practices.

Speech and Language Initiative

May is Speech and Hearing Month in Prince Edward Island and across North America. The PEI Speech and Hearing Association, which represents speech language pathologists and audiologists in the province, celebrated its 25th anniversary in 2004. In Canada, it is estimated that one in ten people has a speech, language or hearing problem.

As part of Speech and Hearing Month in May, the Little Expressions Provincial Speech and Language Initiative provided all family physicians and pediatricians province-wide with a desktop reference guide of speech and language guidelines.

Little Expressions also partnered with the PEI Speech and Hearing Association to provide fact sheets to all early childhood educators and family resource centers across the province. The fact sheets contain information regarding developmental guidelines, the referral process and practical tips to support a child's speech and language development.

All people in a child's life can play an important role in promoting good speech and language development. Babies learn to talk by listening to others around them, so diagnosing hearing problems as early as possible is crucial for their speech and language development. The Prince County Hospital and the Queen Elizabeth Hospital are playing a pivotal role in early intervention by providing infant hearing screening to all newborns.

Children's Dental Care Program

A modification to the Children's Dental Care program, effective November 2004, resulted in a more sustainable program without diminishing the program's status as one of the most inclusive and extensive programs in Canada.

The modification ensures that children in the most financially vulnerable families are still able to get the dental services they require. The program had to be modified to strengthen its sustainability, balanced with the need to ensure that this would not be done at the expense of Island children. Dentists are as committed as government to protecting the children in the most financially vulnerable families.

The preventive portion of the program remains the same - all preventive treatments are free of charge for all Island children at dental public health clinics province-wide. The only modification is that in addition to the registration fee, families choosing to participate in the program will now be responsible for a payment directly to their dentist amounting to 20 per cent of the Children's Dental Care program rates for treatment services. As in the past, registered families will receive diagnostic services free of charge.

At the time of its inception in 1971, dental decay rates on P.E.I. were high, while access to dentists was extremely limited. Very few dentists in public health served the entire province, so many families had to travel significant distances to access dental care. Through this program, this situation has improved to the point where decay rates in Prince Edward Island are the lowest in the country.

National Child Benefit Reinvestment

Funding from the National Child Benefit Reinvestment Fund is invested in child, family, youth and community services, and programs such as child care, children's mental health and increasing the healthy child allowance. The allowance is currently $76 per month per child and is intended to enable children to participate in sporting and cultural activities in their communities.

Foster Family Fall College

Foster families play a vital role in the care of Island children and youth. Children may need to be removed from their homes if their health and well-being are in jeopardy. When children enter foster care, it is usually with the intention that the arrangement will be short-term, pending permanent placement with a family or return to their own home, if at all possible. This is very a traumatic time, especially for children and youth. Foster families provide a loving and emotionally supportive environment for them in this time of crisis. In Prince Edward Island, 144 families have opened their homes to children in need of a safe place to stay.

Potential foster families undergo an extensive screening, assessment and pre-service training program before they can become approved foster care givers. Approved foster families provide service through annual contracted agreements between them, the pertinent health region CEO, and the Director of Child Welfare.

Every year foster families participate in a Fall College, which provides them with an opportunity to refresh their skills and learn about the latest resources available to them. This year, the Parent Resources for Information, Development, and Education (PRIDE) foster care training program was introduced at the college.

Immunization Program

In the fall of 2004, approximately 7000 students in grades 3 to 9, 11, and 12 participated in a research study for a whooping cough vaccine. Most grade 10 students were not eligible to participate in the study as a booster containing this whooping cough vaccine was provided to grade 9 students in 2003.

Whooping cough is an illness which can be severe, particularly in young children, and can affect children, adolescents, or adults of any age. The old whooping cough vaccine used prior to 1997 in Prince Edward Island did not provide 100 per cent protection against whooping cough and resulted in a number of reactions. In 1997, a new whooping cough vaccine became available for children under 7 years of age with fewer and less severe reactions being noted.

Outbreaks of whooping cough occurred in PEI in 1993, 1996 and 2003. With the introduction of the new vaccine in 1997, there has been fewer cases of whooping cough among children under seven years of age. This is a wonderful opportunity to do a catch-up vaccination campaign for school-aged children and should reduce the incidence of whooping cough province-wide. The booster vaccine containing the whooping cough protection also contains protection against tetanus and diphtheria.

The intent of the study was to record the number and types of reactions in school children who had not received a whooping cough booster in a number of years. Each child was given a digital thermometer, a ruler, and diaries in which to record their reactions to the needle. They were also able to record their information on a special Website. The information was then sent to the IWK Health Centre in Halifax for interpretation.

Supported Adoption Program

PEI implemented a new Supported Adoption program in February 2005. It is designed to encourage and secure the adoption of children with special needs who are in the care of the province. The supports under this program will create more opportunities for children to be permanently adopted by their foster care-givers or other prospective adoptive families. Children in permanent care who are adopted have better outcomes than children who remain in long-term foster care. Six adoptions have been approved for supports under this new program since February.

Access to Services

The success of improving access to services relies on our ability as a health system to embrace innovation in service delivery to increase the impact of our services on the health and well being of citizens and to improve the quality of those services.

Prince County Hospital

The new Prince County Hospital became fully operational on April 4, 2004. This facility is approximately 30 per cent larger than the original Prince County Hospital with a wide range of inpatient, outpatient and community based health and wellness services. The new hospital includes more specialty services and has increased emphasis on the delivery of ambulatory care services.

The new Prince County Hospital is a unique health facility offering state-of-the-art health technologies in an innovative patient-care environment. This new hospital offers new diagnostic imaging equipment, new cardiac monitors, new sterilizing equipment, a considerable amount of new lab equipment, new food preparation and serving equipment and a new patient television system.

Primary Health Care Redesign Initiatives

Primary health care is the first level of care and the initial point of contact for an individual with the health system. The Prince Edward Island Primary Health Care Redesign resulted from a First Ministers meeting in September 2000. PEI is in its last year of federal funding for the Redesign initiatives. Initiatives include:

- The PEI Strategy for Healthy Living - A Wellness initiative which partners various government departments, community groups and non-government organizations to encourage and support Islanders to address common risk factors that contribute to chronic disease: tobacco use, unhealthy diet and physical inactivity. The initiative supports the work of the regional Healthy Living Coordinators.

- Integrated Palliative Care - A program designed to enhance client and family options for palliative care through appropriate access to trained, qualified health care teams in every care setting - home, hospital, and long term care. Through the initiative, resource teams and home care support has been enhanced for palliative care clients and their families, and partnerships with community agencies have been improved.

- Family Health Centres - Community-based centres which bring together physicians, registered nurses and other health providers working collaboratively with shared responsibility for patient and client outcomes based on assessed health care needs. A defined set of services are provided with an emphasis on diagnosis and treatment, health promotion, illness prevention, and chronic disease management. Through the initiative, family health centres have been established which are based on the interdisciplinary collaborative practice model.

Palliative Care Program

The Health Council of Canada has identified the Prince Edward Island Integrated Palliative Care program as one of six "Best Practices" from across Canada. The "Best Practices" are described in videos released in support of the Council's first report, entitled Health Care Renewal in Canada: Accelerating Change, which was issued in January 2005.

The "Best Practice" recognition is a tremendous achievement for the PEI Integrated Palliative Care program. The team approach of this program is the key to its success and, most importantly, provides individuals with personalized, top-quality palliative care in any setting, including the comfort of their homes.

Home Oxygen Program

The Home Oxygen program began accepting applications in October 2004. The program provides approved patients with financial assistance for the purchase of home oxygen and related equipment and supplies, as well as, financial assistance for the cost of equipment maintenance. This program provides up to 50 per cent of eligible home oxygen expenses to a maximum of $200 each month.

Canada - Prince Edward Island Affordable Housing Agreement

In 2003, the Canada-Prince Edward Island Affordable Housing Agreement was signed. This $5.5 million initiative is managed by the Province of PEI to ensure an increase in the supply of affordable housing in the province.

There are approximately 600 families on a waiting list for affordable housing across the province. Over the next four years, the Canada-PEI Affordable Housing Agreement will work towards creating an additional 120 affordable housing units to help meet the needs of Islanders.

New Affordable Housing in Charlottetown

A new 12-unit affordable housing complex in Charlottetown was announced in March 2005. The project will provide 12 three-bedroom housing units which will be rented at affordable rents for ten years. Funding of $290,400 was provided under the Canada-P.E.I. Affordable Housing Agreement.

Habitat for Humanity Affordable Housing

Habitat for Humanity completed two new homes, one in Montague and one in Stratford, which will provide Island families with the ability to own homes with mortgages at rates that are affordable for them and their families. The Canada-P.E.I. Affordable Housing Agreement contributed land valued at $26,500 to these projects.

This partnership with the Kings and Queens branches of Habitat for Humanity, clearly demonstrates how governments can work innovatively and effectively with community groups to access home ownership.

Abe Zakem House

Twenty-two affordable housing units for low to moderate income Islanders were built in Charlottetown thanks to the combined efforts of the Government of Canada, the Province of Prince Edward Island, the Kiwanis Club and the City of Charlottetown.

Abe Zakem House, named after Kiwanis charter member Abe Zakem, is located on the corner of Water Street and Weymouth Street on land made available by the city. The Canada-P.E.I. Affordable Housing Agreement contributed $566,000 to the project, while the Kiwanis Club provided $250,000. The balance of funding was provided through a CMHC insured mortgage loan. In return, the Kiwanis Club will rent the units at affordable rates for 10 years to low to moderate income Islanders.

New Affordable Housing in Wellington

Housing, consisting of eight one-bedroom and six two-bedroom apartment units, will be available to rent at affordable levels for a minimum period of 10 years in Wellington. La Cooperative d'hébergement le Belle Age L'tee, the group responsible for this new development will receive $350,000 under the Canada-P.E.I. Affordable Housing Program Agreement along with $195,000 from the Province.

This project will provide 14 families and individuals in the Wellington area with safe, affordable housing, which will improve the quality of their lives significantly.

Souris Group Home

The Souris Group Home Association is a non-profit corporation providing a community based living option to adults with a wide range of developmental disabilities and support needs. The MacIntyre House, a new seven-bed facility in Souris, will serve as a home for persons with mental and physical disabilities. The facility, a former RCMP quarters, was transferred through the National Homelessness Initiative's Surplus Federal Real Property for Homelessness Initiative and also received funding under the Canada-PEI Affordable Housing Agreement.

This new development will allow the Souris Group Home Association to continue to provide affordable supportive housing in a home environment designed for life skill training and a more independent lifestyle to the residents.

Seniors' Emergency Home Repair Program

The Seniors' Emergency Home Repair Program was designed and implemented to provide assistance for low and moderate income seniors for emergency repairs to one of the major components of the physical structure. Many Island seniors want to live in their own homes and be close to their families and friends, feeling most comfortable in their home communities. This program helps Island seniors in need of specific emergency home repair, ensure that their homes are safe and secure.

During the 2004/05 year, the program funded 188 repairs at an average cost of $1,062, with priority being given to funding of roofs, furnaces, oil tanks, septic and water systems.

Disability Support Program

The Disability Support Program has been in operation since October 2001. Prince Edward Island was the first jurisdiction in Canada to fully separate the provision of disability-related supports from income support programming through the Disability Support Program. There are more than 1,200 individuals and families receiving supports from this program.

Ministerial Advisory Committee on Disability Issues

In June 2004, 12 members were appointed to the Ministerial Advisory Committee on Disabilities after a public call for nominations. The Advisory Committee became fully operational and developed a work plan. The committee's purpose is to serve in an advisory capacity to government through the Minister Responsible for People with Disabilities. The three primary functions of the committee are to convey knowledge and research in order to enhance the Minister's understanding regarding persons with disabilities, to provide advice to government as it establishes priorities, develops policies and implements programs, and to establish and maintain ongoing consultation with the disability community.

Labour Market Agreement for Persons with Disabilities

On April 7th 2004, Prince Edward Island signed the Canada-Prince Edward Island Labour Market Agreement for Persons with Disabilities. This is a two year agreement with the Government of Canada. Under this agreement the federal government agreed to cost share up to 50 per cent of the cost of programs and services, meeting the objective of the agreement, up to a

maximum of $1.3 million per fiscal year. The objectives of the agreement are to improve the employment situation of people with disabilities.

Remicade and Embrel Program

The Remicade and Embrel Program, begun in the fall of 2004, provides financial assistance to qualified patients using Remicade for the treatment of severe rheumatoid arthritis, severe Crohn's disease, or fistulizing Crohn's disease, and qualified patients using Embrel for the treatment of severe rheumatoid arthritis.

Central Line Dialysis Pilot Project

Prince Edward Island is participating in a pilot project to offer central venous catheter hemodialysis, also known as central line dialysis. The treatment is available from the existing satellite dialysis clinic, located in East Prince.

Many diseases contribute to kidney failure, but the most common causes are diabetes and high blood pressure. Dialysis is required when kidneys become permanently impaired and can no longer function normally to maintain life. Dialysis cleans the blood of wastes and removes excess fluid.

There are two ways to deliver hemodialysis - peripheral vascular access and central venous catheter access. Peripheral vascular access is the preferred method, and the majority of hemodialysis patients on PEI undergo this type of treatment. For some people, though, this method is not a viable option, and central line dialysis is required. For this reason, this pilot project provides a valuable service to those Islanders.

Family Violence Prevention

Family violence prevention remains a long term endeavour. Sustainable collaborative partnerships among and between government and community organizations are essential to the promotion of safer homes and safer communities.

Throughout the past year, the Premier's Action Committee on Family Violence Prevention has continued to work in partnership with others to enhance family violence prevention initiatives and to increase public education and awareness. Priority areas for action include childhood exposure to domestic violence, measuring outcomes, and improving interagency response to high risk domestic violence cases.

Throughout the past year, the Queens Region High Risk Domestic Violence Working Group was implemented with the goal of enhancing protective services to high risk families. Staff surveys among frontline service providers guide the direction of the working group. Quarterly workshops have been initiated to increase networking capacity across sectors while providing ongoing educational training and awareness sessions for those working directly with children and families.

A report entitled "Police Response to Domestic Violence: A Provincial Overview" was commissioned by the PEI Association of Chiefs of Police and authored by the provincial Family Violence Consultant. This report measures quantitative and qualitative outcomes of all domestic violence reported to law enforcement agencies across PEI for the year 2002. The findings of this report indicate that fifty percent of calls to police for domestic violence involve children, and frequently, very young children. This report will serve to influence policy development across sectors including justice, education, health, and community-based organizations working in family violence prevention. The report will also serve to support the five year provincial strategy on Family Violence Prevention and has been recognized internationally with a presentation of findings recently presented at the first World Conference on Family Violence Prevention held in Banff, Alberta.

Ongoing public education and collaborative partnerships with a community development lens continues to be the strategic direction of the Premier's Action Committee on Family Violence Prevention. The past year has witnessed a blossoming of partnerships with the Federation of Canadian Municipalities, the Atlantic Mayor's Congress, and municipal governments throughout the province and across the country.

Requests for presentations on family violence and the impact on children continue to dominate with increasing linkages being fostered within varied sectors including faith communities, corporate sectors, community organizations, and those providing services to children and families, including for example, professional development presentations to all school bus drivers within the Eastern School District.

French Language Services

Opportunities to obtain health and social services in French has been identified as a high priority by the Acadian and Francophone community. Accordingly, the Department of Health and Social Services has worked towards the implementation of the *French Language Services Act*.

French Language Health Services Network

The PEI French Language Health Services Network (FLHSN) was established in November 2002 by the Minister responsible for Acadian and Francophone Affairs and the Minister of Health and Social Services, who agreed that the most appropriate means for the health system to prepare for the proclamation of the *French Language Services Act* was to create a joint government-community network dedicated to the task of proposing practical solutions for the delivery of French-language health and social services in PEI. This network will ensure the sharing of information between the health system and the Acadian and Francophone community.

The FLHSN brings together key provincial players in the area of health and social services, as well as from the Acadian and Francophone community. The network, comprised of 17 members, includes representatives from the public, the Société Saint-Thomas-d'Aquin, the Acadian Communities Advisory Committee, the regional health authorities, the Provincial Health Services Authority, a representative from the Department of Health and Social Services and a representative from the Acadian and Francophone Affairs division.

The following activities and projects were completed by the FLHSN:

- Various networking and awareness building activities were initiated to promote understanding and awareness of the needs and challenges facing the Acadian and Francophone community in obtaining French services. As a result of this work, improvements in communications and the production of publications in French has been realized.

- A project entitled *Setting the Stage, an Action Plan for the Delivery of Primary Health Care Services in French* was undertaken. This important project is the provincial component of a national project seeking to outline a national strategy for French language primary care delivery. This project will be completed by March 2006.

French Language Health Services Consultations

A number of information and awareness sessions were held on the importance of access to services in French and Acadian and Francophone community's needs. In addition, consultations were held throughout the year with employees from the health system and community organizations in order to gather information to improve access to healthcare services in French. The three main areas of proposed intervention are: training/retention; communications; and access points/organization of services.

French Language Services Coordinators

The Provincial Health Services Authority (PHSA) and the Department of Health and Social Services each hired a French Language Services Coordinator to provide advice and support in the implementation of French-language health services. The Coordinator for the Department transferred to Queens Health Region and a new incumbent was hired at the Department. The PHSA Coordinator position was vacated and remained vacant as of the end of March 2005. In 2005, Kings Health Region entered into an agreement with Queens Health Region which resulted in the sharing of the Queens Health Region's French Language Services Coordinator.

Human Resources

As of March 31, 2005 a total of 124 employees have been identified as bilingual, representing 3.1% of all staff in the health and social services system, this count does not include casual or contractual employees. The following health services are available to the Acadian and Francophone community in certain regions: public health, speech therapy, home care, mental health/addiction counselling, residential care, social services, occupational therapy, medical services, nutrition services, nursing services within hospitals and public dental health.

Needs Assessment – Kings Health Region

In May 2004, the Kings Health Region prepared a report entitled the French Language Health Needs Assessment. This report analyzed three issues: the need for French language health services; how to best meet the need for French language services, and the experiences of managers, staff and members of the Acadian and Francophone community in the provision of health services offered by the region. One of the key recommendations in the report, securing a French Language Services Coordinator for the Region, was implemented in 2005.

Human Resources

A number of human resource planning initiatives intended to ensure an adequate supply and the correct mix of professionals to meet the health needs of Islanders, have been undertaken.

Recruitment and Retention

Government is committed to maintaining an adequate supply of health professionals in Prince Edward Island. A number of initiatives have been implemented to meet this challenge. Active recruitment was carried out throughout the year for a variety of health professionals and additional initiatives were implemented to deal with some of the more difficult to fill positions.

Physician Recruitment Strategy

In February 2000, government implemented the four-year, $4.2 million dollar Physician Recruitment Strategy to address serious challenges in physician resources. The strategy included funding for family practice and specialist training, new medical school seats, medical trainee sponsorships, student loan assistance, location grants, relocation cost assistance, locum support, continuing medical education, hiring a recruitment officer, enhancing recruitment resources and incentives to attract international medical graduates.

In the early 1990s, there were about 140 physicians practicing in the province. In 2004 the province had a total of 183.3 practicing physicians, up from 176 physicians in 2003.

Physician's Master Agreement

The enhancement of physician services has been a significant priority of government. The Master Agreement, effective April 1, 2004 until March 31, 2007, ensures PEI remains competitive with other jurisdictions so that Islanders can continue to access a quality health care system.

Government and the physician community collaborated significantly to bring this process to a satisfactory conclusion. The issue of recruitment and retention remains a significant focus for the government. Many advancements have been made and this agreement will continue to support government's priority in this area.

The new Master Agreement provides for economic increases of 2 per cent in the first year, 2.5 per cent in the second year, and 3 per cent in the final year. Also, government will invest an additional $2.1 million, to be implemented over three years, to address areas which will make the health system more competitive so that it can maintain services and increase the success of recruitment and retention efforts for physicians.

Medical Education Program

The Medical Education Program is administered under the Department of Health and Social Services which works closely with Dalhousie Medical School in Halifax to provide training opportunities. Residents in medical schools across Canada are also welcomed by available teaching physicians.

Residents are doctors enrolled in postgraduate training after receiving their medical degrees. A residency is an apprenticeship, a time during which doctors take their theoretical skills and apply them, practicing their clinical skills. Family practice residents apprentice for two years while residents in other specialities spend from four to seven years acquiring their expertise.

Medical residents spend time with preceptors - qualified doctors who mentor them. Working with medical residents is beneficial for both the apprentice and the preceptor since such teaching opportunities are one of the most rewarding aspects of medical practice. Teaching helps demonstrate pride in one's craft, helps sustain the discipline as a whole, and aids in recruitment efforts.

Medical residencies are also opportunities to show what the Island has to offer. Encouraging residents to complete clinical rotations on Prince Edward Island provides the Island with an opportunity to have an influence on the resident's choice of where they would like to practice medicine.

Health Education Training Study

The Atlantic Health Human Resources Association, acting on behalf of Atlantic Ministers responsible for Health and Post-Secondary Education, announced in May 2004 that it has signed a contract with MedEmerg International Inc., to conduct a study in the four Atlantic provinces to assess human resource requirements in occupations in the health care sector in Atlantic Canada.

P.E.I. has been, and continues to be, committed to maintaining an adequate supply of health professionals in the province. An extensive study was completed in December 2001 on the supply and demand of health professionals in the province. The Health Education Training Study is a wonderful next step. Training is not available on P.E.I. for the majority of health professions, so it is crucial for P.E.I. to partner in regional initiatives which address the education requirements for its health human resources.

The one-year study builds on work previously done by each Atlantic province to determine health human resources needs. Based on this earlier work, a profile of regional requirements for major health occupations, now and in the future, will be developed. Also, a re-usable, scenario-based education and training planning tool will be employed to assist the four provinces in determining what type and how many education and training programs will be needed to meet future demand for health occupations in the region.

This project will help us better predict Atlantic Canada's future health education and training needs, so that we can prepare the right number and mix of health professionals.

PEI Nursing Recruitment and Retention Strategy

Registered nurses comprise the largest group of health care professionals. Maintaining an adequate supply of nurses involves attracting new nurses and retaining existing nurses. The PEI Nursing Recruitment and Retention Strategy contains several initiatives, including the Bachelor of Nursing sponsorship program, which provides financial assistance to third and fourth-year nursing students who agree to work in the province upon graduation, the Summer Student Employment Program, refresher program cost assistance, established funding for clinical education resources, more resources into recruiting student nurses and nurses living away, and funding to help with relocation costs for nurses who move to the province.

Over the five-year period from April 2000 to March 2005, a great deal of progress has been made, resulting in 364 one-year Bachelor of Nursing sponsorship agreements; the provision of relocation assistance to 136 off-Island nurses to work in the PEI Health and Social Services System; and reimbursement of the costs of the refresher program for 13 registered nurses.

PEI Nursing Recruitment and Retention Strategy	2001-02	2002-03	2003-04	2004-05
Number of Student Sponsorships (for 3rd and 4th year)*	57	78	127	77
Number of RNs provided with Relocation Assistance	21	30	22	40
Number of RNs provided with Refresher Program Cost Assistance	4	2	2	3
BN Summer Employment Program	50	73	77	78

* *The number of student sponsorships represents the total number of years of return-in-service agreements.*

Radiation Therapists

A sponsorship program was put in place for Islanders to receive radiation therapy training. One sponsorship agreement was in place in the 2004-05 fiscal year and a three year return-in-service agreement has been signed.

Medical Laboratory Technologists Seats

In 2003, the PEI and New Brunswick provincial governments entered a three-year agreement which provides qualified Islanders guaranteed access to three seats each year in the Medical Laboratory Technology diploma program at the Community College in Saint John, New Brunswick. Medical laboratory technologists provide laboratory testing related to the diagnosis, treatment and monitoring of disease. A two-year return-in-service agreement will ensure students have a job in the health profession on PEI when they complete the training. As of March 31, 2005 PEI had six students in this program under this initiative: three in first year and three in second year.

Health Care Futures

In an effort to encourage more youth to consider careers in the health sector, the Health Care Futures - Public Sector initiative provided employment to 103 students in 2004/05 in a variety of settings including hospitals, government long-term care facilities and community care. In addition, the Health Care Futures - Private Sector program provided 50 per cent cost sharing on the salary costs of students hired by the owners of private nursing homes and community care facilities.

Health Information Technology

Services provided to Islanders are improved by providing quality information to health care providers. Accurate and reliable health information helps Islanders take more control over, and improve, their health.

The health and social services system has a standard province-wide approach to health information technology implementation with the development of a provincial information technology infrastructure, the Island Health Information System (IHIS). This is a fully integrated information resource supporting the delivery of health and social services in PEI.

The following activities and projects were completed in the last two-year period, and they support the development of IHIS as a robust information resource:

- The Integrated Services Management system (ISM) is multi faceted system that has introduced case management technology to all community-based health and social services within the PEI health system. This system provides technology services to all community health and social services-based programs across PEI.

Major ongoing projects include the development and implementation of:

- The Pharmacy Network Project will create a repository containing prescription information collected from both physicians and retail pharmacies for all individuals receiving prescriptions in PEI. It will involve modifying the existing system and the retail Pharmacy systems to capture the required information. The system will be accessed by all retail and institutional pharmacy sites, emergency departments and physician sites. Ultimately, this will result in reduced health risks to the PEI public.

- Work is underway in collaboration with Canada Health Infoway to work on the development of the Electronic Health Record. There is also activity underway with Health Infostructure Atlantic to further the development of an Electronic Health Record within Atlantic Canada. The major focuses of these activities include the overall Electronic Health Record, Health Surveillance and Telehealth activities. An Electronic Health Record allows the most up-to-date information to be stored and accessed at any time by those required to provide health services to patients.

Partnerships to Address the Determinants of Health __

The development and strengthening of partnerships is key to ensuring that the health and social services system achieves positive impacts on the health and well-being of Islanders.

The Department of Health and Social Services is proud of the partnerships it is able to foster. The positive results noted in this annual report could only be accomplished with the help of our many partners.

Healthy Living Strategy partners include:

The Prince Edward Island Tobacco Reduction Alliance; the PEI Active Living Alliance; the PEI Healthy Eating Alliance; the provincial departments of Health and Social Services, Education, Community and Cultural Affairs, and the Office of the Attorney General; the regional health authorities; the Canadian Diabetes Association; the Canadian Cancer Society, PEI Division; the Heart and Stroke Foundation of PEI; the Western School Board and Eastern School District; the PEI Federation of Municipalities; the PEI Recreation Facilities Association; and other community-based groups.

P. E. I. Tobacco Reduction Alliance partners include:

The Canadian Cancer Society, PEI Division; the PEI Lung Association; the provincial departments of Education, and Health and Social Services; the Early Childhood Development Association of PEI; the Evangeline Community Health Centre; the regional health authorities; the Federation of PEI Municipalities; Health Canada; the Heart and Stroke Foundation of PEI; Holland College; the Medical Society of PEI; the PEI Home and School Association; the Eastern School District and the Western School Board.

Active Living Alliance partners include:

The departments of Health and Social Services and Community and Cultural Affairs, the PEI Recreation and Sports Association for the Physically Challenged; the PEI School Athletics Association; the PEI Lung Association; the PEI Physical Education Association; the PEI Senior Citizens Federation; the PEI Special Olympics; the RCMP; Scouts Canada (P.E.I. Council); Sport PEI; the Arthritis Society; the Women's Institute, and the Worker's Compensation Board.

Autism Strategy partners include:

The Provincial Autism Committee, which includes parents; staff of the regional health authorities, the departments of Health and Social Services and Education, and representatives from pediatrics, mental health, school boards, the PEI Autism Society, PEI Association for Community Living and other community-based organizations.

Healthy Child Development partners include:

Core staff in the Department of Health and Social Services; representatives from the provincial departments of Education, Community and Cultural Affairs, Development and Technology and the Office of the Attorney General; members of the Premier's Council on Healthy Child Development; and community representatives, including the Early Childhood Development Association, Family Resource Centers, Literacy Alliance, Breast Feeding Coalition, Children's Mental Health Coalition, Women's Network, Association for Community living, Premiers Action Council on Family Violence, the RCMP, the University of Prince Edward Island and Health Canada.

Healthy Eating Alliance partners include:

The provincial departments of Health and Social Services, Education, Agriculture and Community and Cultural Affairs; and community representatives including the University of Prince Edward Island; Cancer Society; school boards; the Home and School Federation; health regions; Medical Society of PEI; Association of Nurses of PEI; Queen Elizabeth Hospital; Heart and Stroke Foundation; PEI School Milk Foundation; Dietitians of PEI; PEI Active Living Alliance; CBC; Canadian Red Cross; School Breakfast Programs; PEI Home Economics Association; Chartwells International; and parents.

Provincial Child Sexual Abuse Advisory Committee partners include:

The provincial departments of Health and Social Services, Education, and Office of the Attorney General; Eastern School District; Adult Survivors; PEI Rape and Sexual Assault Crisis Centre; RCMP; Summerside Police Service; regional health authorities; Community Legal Information Association; Mi'kmaq Family Resource Centre.

Premier's Action Committee on Family Violence partners include:

The provincial departments of Health and Social Services, Education, Office of the Attorney General, Development and Technology, Community and Cultural Affairs, and Provincial Treasury; PEI Teachers' Federation; PEI Nurses Association; PEI Aboriginal Women's Association; PEI Medical Society; PEI Seniors' Federation; PEI Chiefs of Police Association; RCMP; Transition House Association; PEI Rape and Sexual Assault Crisis Centre; Community Legal Information Association; L'Association des Femmes Acadiennes; Eastern PEI Family Violence Prevention; PEI Advisory Council on the Status of Women; clergy; East Prince Women's Information Centre; Women's Institute; and Big Brothers/Big Sisters Association.

PEI Cancer Control Strategy Advisory Committee partners include:

The provincial department of Health and Social Services; PEI Health Research Institute; Canadian Cancer Society, PEI Division; cancer survivors; Hospice Palliative Care Association of PEI; PEI Cancer Registry; PEI Cancer Treatment Centre; PEI Medical Society; and Provincial Health Services Authority.

PEI Pap Screening Advisory Committee partners include:

The provincial department of Health and Social Services; Canadian Cancer Society, PEI Division; PEI Medical Society; Women's Network of PEI; and Queen Elizabeth Hospital Cytology Laboratory.

Results Achieved

In its five-year strategic plan, the Department of Health and Social Services set six goals to improve health system performance and results. They are as follows:

1. Improve the health status of Islanders
2. Increase personal responsibility for health
3. Improve sustainability of the system
4. Improve public confidence in the system
5. Improve workplace wellness and staff morale
6. Maintain other results at current levels

In order to measure progress in relation to each goal, indicators were identified. This section reports on results in relation to those indicators.

This report uses the most recent available data. Where possible, PEI results are compared to similar Canadian data to illustrate how our province is doing within a national context.

Goal #1: Improve the health status of Islanders

Health status indicators are used to provide a snap shot of our health as Islanders. Specific indicators include life expectancy, infant health, self-reported health, major health concerns, and chronic and preventable diseases.

Length and Quality of Life on the Island

Life Expectancy and Health Adjusted Life Expectancy

Life expectancy is a widely-used indicator of overall population health. Life expectancy is defined as the number of years that a person could expect to live on average, based on the mortality rates of the population in a given year. The table below outlines life expectancy by gender, for Islanders compared with all Canadians for 1992 and 2002.

Life expectancy in years, 1992 and 2002						
	1992			2002		
	men	women	both sexes	men	women	both sexes
PEI	74	81.3	77.5	76.2	81.3	78.8
Canada	74.8	81.2	78	77.2	82.1	79.7

Source: Statistics Canada, Vital Statistics, Birth and Death Databases

Life expectancy is an average and does not reflect individual health circumstances. Nevertheless, these findings reveal several trends:

- Life expectancy rates in Prince Edward Island have been similar to Canadian rates over the past ten years.

- Women live on average 5.1 years longer than men in this province.

- The gender gap is shrinking. Male life expectancy improved by 2.2 years between 1992 and 2002. Female life expectancy remained steady during that period.

Health Adjusted Life Expectancy (HALE): Whereas life expectancy is an indicator of the quantity of life, health adjusted life expectancy (HALE) reflects quality as well as quantity of life. HALE is the number of years in perfect health that an individual can expect to live given the current morbidity and mortality conditions. Since level of income is a significant non-medical determinant of health, the health adjusted life expectancy rate is reported by income.

Life expectancy and health adjusted life expectancy rates, by sex, 2001

		life expectancy	health adjusted life expectancy			
			all income groups	*income tercile 1 (lowest)*	*income tercile 2 (middle)*	*income tercile 3 (highest)*
PEI	**males**	75.2 yrs	67.3 yrs	65.2 yrs	67.5 yrs	69.5 yrs
	females	82.0 yrs	71.7 yrs	71.8 yrs	70.5 yrs	72.5 yrs
Canada	**males**	76.9 yrs	68.3 yrs	65.8 yrs	68.6 yrs	70.5 yrs
	females	82.0 yrs	70.8 yrs	69.1 yrs	70.8 yrs	72.3 yrs

Source: Statistics Canada, Vital Statistics, Birth and Death Databases; National Population Health Survey

- The health adjusted life expectancy rate for PEI women is about 10 years less than life expectancy. For PEI men, the HALE is about eight years less.

- PEI women have a health adjusted life expectancy which is above the Canadian average by about one year. For Island women, income had little effect on HALE.

- PEI men have a health adjusted life expectancy which is shorter than the Canadian average by one year. For men, health adjusted life expectancy was highest for the third of the population with the highest income and lowest for the third of the population with the lowest incomes.

Infant Health

Infant Mortality
The rate of infant mortality is affected by a variety of factors, including quality of maternal and childcare services provided by the health system and health care providers, as well as social factors such as maternal education, smoking and nutritional deprivation. Rates of infant mortality for PEI and Canada, presented as five-year averages for the period from 1982 to 2001, are outlined in the table below.

Infant mortality; five year average rates for the past two decades, 1982 to 2001				
	1982-1986	1987-1991	1992-1996	1997-2001
PEI	7.02	6.56	5.3	5.94
Canada	8.3	6.96	6.08	5.32

Source: Statistics Canada, Vital Statistics, Birth and Death Database

- Over the past two decades, infant mortality rates have decreased by 15 percent for PEI and 35 percent for Canada.

- While infant mortality rates are similar for Canada and Prince Edward Island, the PEI rate has shown a slight increase between the periods 1992-96 and 1997-2001.

Birth Weight
Birth weight is a reliable predictor of a newborn's chances of survival and future health. Both low birth weight and high birth weight are associated with a variety of health risks.

Low birth weight is associated with decreased chances of infant survival and increased risk of disease and disability, with examples including cerebral palsy, visual problems, learning disabilities and respiratory problems. Appropriate medical care and a healthy life style for the mother can improve the chances that the baby will have a healthy birth weight.

The low birth weight rate is the proportion of babies born with a birth weight of less than 2,500 grams (just over five pounds) in relation to the total number of live births in a given year, stated as a percentage.

High birth weight is associated with maternal obesity and gestational diabetes. High birth weight poses increased risk for complications during delivery for mother and baby.

The high birth weight rate is the proportion of babies born with weights greater than 4,000 grams (just under nine pounds) in relation to the total number of live births in a given year, stated as a percentage.

Low and high birth weight rates, 1998 to 2001				
	1998	1999	2000	2001
Low Birth Weight Rate				
PEI	4.9%	5.3%	4.3%	4%
Canada	5.7%	5.6%	5.6%	5.5%
High Birth Weight Rate*				
PEI	17.3%	17.1%	19.9%	
Canada	12.8%	13.1%	13.8%	

Source: Vital Statistics, Birth Database
* *Data not available for 2001*

- The low birth weight rate on PEI has improved over time and is consistently lower than the Canadian rate. In the year 2000, Prince Edward Island had a smaller proportion of low birth weight babies than any other Canadian province.

- The rate of high birth weight babies born in PEI during the years 1998-2000 was higher than the Canadian average at that time. In the year 2000, PEI had the second highest rate of high birth weight births when compared with other Canadian provinces.

Self-reported Health

Self-reported health is based on the response provided by individuals in the Canadian Community Health Survey when asked to rate their own health. Self-reported health reflects how healthy individuals feel they are, and is a general indicator of the overall health status of individuals. This indicator includes features that other measures may miss, such as disease severity, coping skills, psychological attitude and social well-being. Numerous studies have found that self-reported health can predict death rates even when more objective measures are taken into account. The table below presents the proportion of the population aged 12 and older who reported that their health was "very good" or "excellent" in 2001 and 2003.

Self-reported health, the proportion of the population who reported "very good" or "excellent" health, by age group, 2000/01 and 2003				
Age Group	**PEI**		**CANADA**	
	2000/01	**2003**	**2000/01**	**2003**
total 12 yrs +	64.4%	64.9%	61.4%	58.4%
12-19 yrs	67.8%	62.8%	70.8%	66.9%
20-34 yrs	75.1%	74.8%	73.0%	68.7%
35-44 yrs	71.2%	73.7%	66.7%	63.6%
45-64 yrs	58.0%	61.6%	55.8%	53.4%
65 yrs +	47.3%	46.7%	36.5%	36.6%

Source: Statistics Canada, Canadian Community Health Survey, 2000/2001 and 2003

- The proportion of PEI respondents who reported very good or excellent health was higher than the Canadian average.

- In PEI and Canada, the 20 to 34 year age group reported the highest rate of "very good" or excellent" health in both years.

- In PEI, for almost all age groups, men reported higher rates of "very good" or excellent" health than women.

Major Health Concerns

Several acute and chronic conditions including cancer, heart attack, stroke, diabetes, arthritis and asthma, pose major health problems for the general adult population of Prince Edward Island.

Cancer and Cardiovascular Disease

There are many types of cancer, but the most common forms are colorectal, lung, prostate and breast. The following table outlines the estimated incidence rate of these leading cancers for 2005. Incidence rates are based on the number of newly diagnosed primary cancer cases in a given year per 100,000 population.

Estimated cancer incidence rate (per 100,000 population) 2005***					
		colorectal	lung	prostate*	breast**
PEI	male	65	86	179	
	female	59	50		98
Canada	male	62	71	121	
	female	41	49		106

Source: Statistics Canada, Canadian Cancer Registry, 2005
** male population only*
*** female population only, although a small number of men each year are diagnosed with breast cancer.*
**** 2005 age-standardized rates are estimates produced by Health Canada through extrapolation (f) of cancer incidence data from the National Cancer Incidence Reporting System (NCIRS, 1969-1991) and the Canadian Cancer Registry.*

- For both men and women, incidence rates for three of the four cancers listed were higher for PEI than Canada.

- Prostate cancer is the most frequently occurring cancer in men, with an estimated incidence rate for 2005 of 179 per 100,000.

- Breast cancer is the most frequently occurring cancer in women. The incidence rate is expected to remain steady through 2005.

The tables below present the mortality rates associated with the most common forms of cancer, as well as heart attack and stroke. Mortality rates are based on the number of people who die each year as a result of a particular cause or condition per 100,000 population.

Estimated Age-Standardized Mortality Rates (per 100,000 population) for Major Cancer Sites, 2005***					
		colorectal cancer	lung cancer	prostate cancer*	breast cancer**
PEI	male	31	80	34	
	female	22	50		28
Canada	male	27	63	26	
	female	17	40		24

Source: Statistics Canada, Vital Statistics, Death Database
** male population only*
*** female population only, although a small number of men each year are diagnosed with breast cancer.*
**** 2005 age-standardized rates are estimates produced by Health Canada through extrapolation (f) of cancer incidence data from the National Cancer Incidence Reporting System (NCIRS, 1969-1991) and the Canadian Cancer Registry.*

Age-Standardized Mortality Rates (per 100,000 population) for Heart Attack and Stroke, 2005***		
	30-Day Acute Myocardial Infarction In-Hospital Mortality Rate 2000-2001 to 2002-2003	30-Day Stroke In-Hospital Mortality Rate 2000.2001 to 2002.2003
PEI	13	20.3
Canada	11.4	18.6

- Heart attack is the leading cause of death for men and women in Canada.
- The leading causes of death for men on PEI are lung cancer, heart attack and stroke.
- Heart attack, followed closely by stroke and lung cancer, are the leading causes of death in PEI women.
- The mortality rate for prostate cancer in men is comparable to that of breast cancer in women, even though the incidence rate for prostate cancer is higher. Prostate cancer is relatively slow-growing and many men diagnosed with it die of other causes first.
- Men have higher mortality rates for all leading causes of death than women. However, in the case of lung cancer, Canadian time trends show that male mortality rates for this condition are on the decline while the female mortality rate is on the increase.

Chronic Disease

Prevalence of arthritis/rheumatism, asthma, depression and high blood pressure
The following table reports the prevalence of arthritis/rheumatism, asthma, depression and high blood pressure as found in the 2003 Canadian Community Health Survey. In this table, the prevalence rate for a disease is the percentage of the population aged 12 and over who reported in the Survey that they were diagnosed with a particular disease by a health professional.

Rate of prevalence of chronic disease, 2003				
	arthritis / rheumatism*	**asthma**	**depression****	**high blood pressure**
PEI	20.2	9.1	5.4	15.2
Canada	16.8	8.4		14.4

Source: Statistics Canada, Canadian Community Health Survey, 2003
** Arthritis/rheumatism includes rheumatoid arthritis and osteoporosis, but excludes fibromyalgia.*
*** Depression refers to the proportion of the population age 12 and over who, based on responses to the short form Composite International Diagnostic Interview, had a probability of 0.9 or greater of having experienced a major depressive episode in the past 12 months. This data is not available for Canada.*

- Arthritis/rheumatism was the most prevalent chronic condition in both PEI and Canada. The prevalence rate on PEI, at 20%, is higher than the Canadian rate.
- The prevalence of arthritis/rheumatism tends to increase with age, with approximately half of Islanders aged 65 and older reporting that they have this condition.
- Prevalence rates for arthritis/rheumatism and asthma were slightly higher in 2003 than 2001.
- Prevalence rates are higher for women than men for the four chronic conditions listed above.
- Compared to Canada, asthma was more prevalent in the younger (age 12 to 19) and the older (age 65 and older) age groups on PEI. Rates for other age groups were similar.
- The rate for depression on PEI was less than the Canadian rate in 2001, and has been consistently less than Canadian rates for the past 10 years.
- High blood pressure is slightly more prevalent on PEI than in Canada. Of Canadians aged 65 and over, 43 per cent reported having high blood pressure, while 42 per cent of Islanders reported having the disease.

Prevalence of Diabetes
The following table reports the prevalence of diabetes for the province of PEI and for Canada as determined through the Canadian Community Health Survey of 2003.

Prevalence of diabetes, 2003			
	females	*males*	*total*
PEI	3.7%	6.5%	5.1%
Canada	4.3%	4.9%	4.6%

Source: Statistics Canada, Canadian Community Health Survey, 2003

- Prevalence rates for PEI females is slightly less than the Canadian average, while the rate for PEI males is higher.

- Prevalence of diabetes increases with age. On PEI, 0.3% of young people aged 12-19 years had diabetes compared with 13.5 per cent of people aged 65 and over.

- For both PEI and in Canada, prevalence of diabetes is highest for men over age 40.

Incidence of Vaccine Preventable Diseases

A number of diseases can be controlled by immunization programs. The table below reports the incidence rates for six vaccine preventable diseases. Incidence rates are the number of new cases in a given year per 100,000 population.

Notifiable diseases, rate per 100,000						
		1998	**1999**	**2000**	**2001**	**2002***
invasive meningococcal	**PEI**	2.61	0	0	0	0
	Canada	1.3	1.6	1.69	2.45	1.31
haemophilus influenzae b (invasive) (HIB)	**PEI**	0	0	0	0	0
	Canada	0.8	0.77	0.5	0.97	0.92
measles	**PEI**	0	0	0	0	0
	Canada	0.04	0.1	0.67	0.13	0.03
tuberculosis**	**PEI**	1.5	1.5	1.4	2.2	0.7
	Canada	5.9	5.9	5.5	5.5	5.2
pertussis***	**PEI**	15.34	7.26	7.95		
	Canada	29.08	19.98	16.09		
hepatitis C***	**PEI**	43.1	18.87	7.95		
	Canada	75.21	63.58	61.05		

Source: Health Canada, Notifiable Disease Reporting System
* *2002 numbers are preliminary numbers.*
** *TB Source: Canadian Tuberculosis Reporting System (CTBRS).*
*** *No data currently available for 2001 and 2002.*

- There have been no reported cases of invasive meningococcal disease on PEI since 1999, invasive haemophilius influlenza B since 1995, or the measles since 1997. Immunization is now available for all three diseases, with the most recent addition of the invasive menningococcal vaccine in 2003.

- The incidence of pertussis, or whopping cough, and hepatitis C are declining in PEI and Canada. The PEI rates are well below Canadian rates.

Goal #2: Increase our acceptance of responsibility for our own health

Many diseases are preventable, or have complications, which can be lessened through healthy lifestyle choices, early prevention, and early detection. Increased prevalence, and or severity, of disease imposes a burden on individuals and their families, and contributes to increased costs for health care service delivery systems. The health system can help people accept responsibility for their own health by providing educational programs, disease prevention and management programs, increased access to primary health services, increased access to health information and partnerships to address determinants of health.

Lifestyles, Risk Factors and Health

Smoking

Tobacco use is the leading cause of preventable illness and death in Canada. Health Canada estimates that smoking is responsible for more than 45,000 deaths per year.

This table reports the percentage of the population over age 15 who reported they were current or former smokers in the Canadian Tobacco Use Monitoring Survey, 2003.

Reported smoking rates of current smokers (aged 15+), 1999 to 2004						
	1999	2000	2001	2002	2003	2004
PEI	26%	26%	26%	23%	21%	21%
Canada	25%	24%	22%	21%	21%	20%

Source: Canadian Tobacco Use Monitoring Survey, Household Component, 1999-2004

Reported rates of current and former smokers (aged 15+), 2004		
	current smokers	former smokers
PEI	21%	33%
Canada	20%	26%

Source: Canadian Tobacco Use Monitoring Survey, Household Component, 2004

- In 2004, 21% of Islanders reported being current smokers - a decrease from 26% in 1999.
- A greater proportion of men smoke than women. 25% of Island men and 22% of Canadian men were smokers. 18% of Island women were smokers while the Canadian female rate was 17%.
- Men aged 25 and older tend to be the heaviest smokers, consuming 18.6 cigarettes a day on average.

Teen Smoking

Youth smoking is a concern since nicotine is an addictive substance and approximately eight out of every 10 people who try smoking become habitual smokers.

The following table reports the percentage of the population aged 12 - 19 (inclusive) who reported at the time of the survey that they were ***current smokers*** (current includes daily and occasional smokers) or ***daily smokers***.

Reported teenage smoking rates, 2000/01 and 2003				
	2000/01		2003	
	current smoker (includes daily and occasional smoker)	*daily smoker*	*current smoker (includes daily and occasional smoker)*	*daily smoker*
PEI	14.8%	10.9 [E]%	11.4 [E]%	10.1 [E]%
Canada	18.7%	12.9%	14.8%	9.1%

Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003
E - Data should be interpreted with caution. Refers to data with a coefficient of variation (CV) from 16.6% to 33.3%.

- The PEI rates for current smoker and daily smoker were similar to the Canadian rates.
- Teenage smoking rates have declined since 2000/01, in both Canada and PEI.
- In PEI and Canada, for this age group, a higher proportion of females smoke than males.

Fitness and Nutrition

Reported Physical Activity

Regular physical activity provides many well documented physical and mental health benefits. On the other hand, physical inactivity is a risk factor for a variety of serious illnesses, including heart disease and diabetes. The following table provides a summary of activity rates for males and females in PEI and Canada obtained through the 2003 Canadian Community Health Survey. Survey respondents were asked about the frequency, duration, and intensity of their participation in leisure-time physical activity during the previous three months. The following table presents the percentage of the population aged 12 and over who rated their physical activity as either ***"active"*** or ***"inactive"***.

Reported physical activity rates, 2000/01 and 2003					
		2000/01		2003	
		active	*inactive*	*active*	*inactive*
PEI	**total**	19.6%	52.0%	22.0%	53.2%
	males	21.6%	48.2%	25.4%	50.4%
	females	17.7%	55.7%	18.7%	55.8%
Canada	**total**	21.0%	49.1%	26.1%	46.9%
	males	23.7%	44.2%	29.8%	43.5%
	females	18.4%	53.8%	22.7%	50.2%

Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003

- On average, Islanders are less likely to be active and more likely to be inactive than other Canadians.
- Activity rates are improving among Islanders and Canadians.
- Males and Females aged 12-19 report the highest rates of physical activity.

Reported Body Mass Index (BMI)

Obesity is a risk factor for a number of serious illnesses, such as diabetes and heart disease.

Body Mass Index (BMI) is used as a measure to determine appropriateness of weight in relation to overall body size. This measure is calculated by dividing weight in kilograms by height in meters squared.

Obesity is defined as a Body Mass Index above the threshold of 25.

The table below presents self reported rates of Islanders and Canadians who are underweight, normal weight, overweight or obese according to an estimate of BMI obtained through the 2003 Canadian Community Health Survey.

Self Reported BMI rates, 2003				
	underweight	*normal weight*	*overweight*	*obese*
PEI	1.7%	37.1%	37.1%	20.6%
Canada	2.6%	46.7%	33.3%	14.9%

Source: Statistics Canada, Canadian Community Health Survey, 2003

- Compared to the Canadian average, a smaller proportion of Islanders are normal weight and a larger proportion are overweight or obese.

Diet: Fruit and Vegetable Consumption

Diet and health are closely connected. Poor dietary habits are linked to a number of serious illnesses, including cancer and heart disease. Adequate fruit and vegetable consumption is a basic component of a healthy diet. The Canada Food Guide recommends a minimum of five servings of fruit and vegetables per day. Average daily fruit and vegetable consumption is used as an indicator of the dietary habits of the population.

The following table presents self reported rates of fruit and vegetable consumption for the population aged 12 and older.

Self Reported fruit and vegetable consumption rates, 2000/01 and 2003				
	2000/01		2003	
	Less than five times per day	5 or more times per day	Less than five times per day	5 or more times per day
PEI	64.5%	34.2%	63.5%	29.3%
Canada	61.8%	37.2%	55.2%	38.9%

Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003

- In 2003, 63.5 per cent of Islanders did not eat an adequate amount of fruit and vegetables.

Early Prevention

Influenza Immunization: Adults Aged Sixty-Five and Older
Influenza can pose a serious health risk for many people, including those aged sixty-five and over. Immunization is effective in preventing the flu. Immunization for those most at risk for complications associated with influenza, including adults aged sixty-five and older, is an important prevention measure.

The following table presents the percentage of the population 65 years of age and over who reported having a flu shot in the 12 months prior to the survey.

Reported influenza immunization rates, 65+, 2003		
	2000/01	2003
PEI	62.9%	57.8%
Canada	63.0%	62.4%

Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003

- While over half of Islanders age 65 and older reported being immunized for influenza in 2001 and 2003, the rate of immunization decreased during that time period.

Children and Second-Hand Smoke
Exposure to environmental tobacco smoke (second-hand smoke) is harmful to children, and is associated with respiratory illness, sudden infant death syndrom (SIDS) and ear infections. Children are especially vulnerable to the effects of second hand smoke because their bodies are still developing, their breathing rates are higher than adults, and they have little control over their indoor air environments. The following table reports the percentage of children regularly exposed at home to Environmental Tobacco Smoke.

Exposure of children at home to Environmental Tobacco Smoke, 2004			
	% Children Age 0-11	% Children Age 12-17	% Children Age 0-17
PEI	13%	18%	15%
Canada	12%	19%	15%

Source: Canadian Tobacco Use Monitoring Survey, 2004

- PEI rates are similar to national averages.

- Exposure to second hand smoke has been dropping in PEI and Canada since 1999.

Breast-feeding

Breast-feeding is an ideal source of nutrition for babies. More than just a food source, breast milk contains immunoglobulins and antibodies which provides the baby with protection against disease. Breast-fed babies have fewer childhood illnesses, such as gastrointestinal and respiratory infections, asthma, eczema, food allergies, and middle ear infections than other babies. There is evidence as well that breast feeding may contribute to cognitive development.

The table below reports the percentage of females aged 15 to 55 who had a baby in the previous five years and who breast-fed exclusively for at least four months.

Mothers who Breast-fed for at Least Four Months, 2003	
	2003
PEI	34.9%
Canada	38.4%

Source: Canadian Community Health Survey (CCHS), 2003

- The PEI rate of 34.9% ranks fifth lowest amongst provinces and territories for 2003.

- There are signs of improvement on PEI. The table below shows that breast feeding rates at time of hospital discharge have been increasing steadily over the past few years.

Breast-feeding rates (at hospital discharge) on PEI					
	1998	**1999**	**2000**	**2001**	**2002**
PEI	59.3%	61.7%	62.3%	64.1%	61.8%

Source: Reproductive Care Program, PEI

Readiness to Learn

School readiness is influenced by a variety of factors, including:

- motor and social development
- language skills
- emotional health
- social behavior

The following indicators, derived from the National Longitudinal Survey of Children and Youth, reflect the "readiness" of Island children to begin learning at school.

Language Skills

- When tested in 2000/01, the vast majority of Island children from the age group sample had average receptive or hearing vocabulary skills.

- In 2000/01, 15 per cent of children from the PEI sample displayed advanced skills. This was similar to the Canadian average of 14 per cent, and higher than the rate of advanced skills in 1998/99.

Motor and Social Development

- The vast majority of Island children in this age group had average scores for motor and social development in both survey cycles.

- A similar proportion of Island children aged zero to three years had an advanced level of motor and social development compared to the Canadian average.

Percentage of children who had average scores in motor and social development, and language skills.			
		1998/1999	2000/01
motor and social skills (age 0-3)	PEI	68.6%	66.5%
	Canada	71.1%	72.6%
language skills (age 4-5)	PEI	81%	75.4%
	Canada	70.8%	68.8%

Source: NLSCY, Cycle 3 (1998/1999) and Cycle 4 (2000/2001)

Emotional Problems / Anxiety

- 16.1 per cent of Island children between the ages of two and five exhibited high levels of emotional problems and/or anxiety. This is similar to the Canadian average of 17.8 per cent.

- The rate of children with high levels of emotional problems increased between 1998/99 and 2000-01.

Percentage of children who exhibited high levels of emotional health problems, Ages 2-5.			
		1998/1999	2000/2001
emotional problems / anxiety	PEI	14%	16.1%
	Canada	13.8%	17.8%
hyperactivity / inattention	PEI	14.1%	10.8%
	Canada	12.2%	15.1%
physical aggression	PEI	15.1%	11%
	Canada	13.5%	12.6%

Source: NLSCY, Cycle 3 (1998/1999) and Cycle 4 (2000/2001)

Hyperactivity - Inattention

- 10.8 per cent of Island children aged two to five exhibited high levels of hyperactivity and/or inattention.
- The 2000/01 PEI rate was lower than the Canadian rate. In fact, PEI had the lowest rate of hyperactivity / inattention of any Canadian province.

Physical Aggression / Conduct Disorder

- Eleven per cent of Island children between the ages of two and five years exhibited high levels of physical aggression, opposition and/or conduct disorder.

- This rate is similar to the Canadian average.

Personal-Social Behaviour

- In 1998/99, 93 per cent of Island children aged two to five years exhibited satisfactory levels of prosocial behaviour.

- This rate was similar to the Canadian average and similar to rates reported in other provinces.

Percentage of children who exhibited satisfactory social behaviour*, ages 2-5.			
		1998/1999	2000/2001
Prosocial Behaviour	**PEI**	93%	
	Canada	89.8%	
Personal and Social Behaviour	**PEI**		93.2%
	Canada		84%

Source: NLSCY, Cycle 3 (1998/1999) and Cycle 4 (2000/2001)

* *Social Knowledge and Competence indicators provide information on the rates of children age 2 to 5 who exhibit what NLSCY researchers termed "prosocial behaviour" in previous reporting cycles. In the 2000/01 data, the term "prosocial behaviour" was replaced by an assessment of "personal-social behaviour," using a new tool called the Ages and Stages Questionnaire.*

For the 2000/01 data, researchers at the NLSCY reorganized data collection and calculation processes, using a new tool called Ages and Stages.

- Most young Island children achieved satisfactory scores on personal and social behaviours.

- The 2000/01 survey of personal and social behavior among PEI children indicated a higher rate of positive social and personal behaviour than the national average. In fact, PEI scored higher in this area than any other Canadian province.

Early Detection

Pap Screening Rates

More than 90 per cent of cervical cancer can be prevented by regular screening with the Pap test. The PEI Pap Screening Program was established in 2001. Program objectives included: reduction of incidence and mortality from cervical cancer among Island women; increased accessibility to the service; and increased number of women screened.

Pap screening rates are the percentage of women between 20 and 69 who participated in a pap screening program within a defined period of time.

PEI Pap screening rates, by age group, 2001-2003			
	screening period		
age group	one year (2003)	two years (2002-2003)	three years (2001-2003)
20 to 34	44%	62%	69%
35 to 49	39%	59%	67%
50 to 69	37%	52%	57%
total 20 to 69	40%	58%	65%

Source: PEI Pap Screening Program, 2003 Report

- Approximately 40 per cent of Island women between the ages of 20 and 69 are screened with a Pap annually. Over a three year period, 65 per cent of Island women undergo a Pap screening.

- Participation in Pap screening decreases with age, regardless of the screening interval, with the highest participation rate for women in their reproductive years.

The Canadian Community Health Survey also provides information on Pap screening rates. These participation rates are based on self-reported data and tend to be less accurate than the findings from the PEI Pap Screening Program. However, the CCHS data does allow for comparison to the Canadian average.

- In 2003, 81 per cent of Island women reported that they had a Pap screen within the past three years. This was up from 2000/01, and was above the Canadian average of 74 per cent.

Mammography Rates

Breast cancer continues to be the most frequently diagnosed form of cancer for women in Canada. In 2004, there were approximately 21,200 new cases diagnosed[1]. Mortality rates have declined from an estimated 32 per cent in 1986 to 25 per cent in 2004. Improved breast cancer screening programs and treatments have contributed to the decrease.

The 2003 Canadian Community Health Survey reported that 49.3 per cent of Island women between the ages of 50 and 69 reported receiving a routine screening mammogram within the last two years. This rate was similar to the Canadian average of 49.1 per cent.

[1] Canadian Cancer Statistics, 2002, National Cancer Institute of Canada

Goal #3:
Improve sustainability of the system

Several factors pose challenges to the long term sustainability of the health and social services system, including increased demand for new and existing services, rising costs, supply of health professionals, requirements for capital investments in aging health facilities, and public pressure to make costly new technologies available close to home.

The following sustainability indicators are being monitored: Health and Social Services expenditures; health and social services system costs per capita; supply of health professionals; and patient satisfaction.

Health and Social Services Expenditures

PEI Health and Social Services System program expenditures (in current dollars), 2001/02 to 2004/05				
	2001/02	2002/03	2003/04	2004/05
health care expenditures	$294.0 M	$328.6 M	$342.8 M	$345.7 M
social services expenditures	$76.6 M	$81.6 M	$84.4 M	$84.9 M
total system expenditures	$370.6 M	$410.2 M	$428.2 M	$430.6 M

Source: PEI Department of Health and Social Services, Finance and Administration, 2005

- In 2004/05, the provincial government spent $430.6 million on delivery of health and social services.
- Between 2001-02 and 2004-05, total system spending increased by $60 million (16%).

Health and Social Services Costs Per Capita

PEI Health and Social Services System costs per capita (in current dollars): 2001/02 to 2004/05				
	2001/02	2002/03	2003/04	2004/05
health care cost per capita	$2,150	$2,399	$2,488	$2,510
social services costs per capita	$560	$596	$620	$616
total system costs per capita	$2,710	$2,995	$3,108	$3,126

Source: PEI Department of Health and Social Services, Finance and Administration, 2005

- In 2004-05, average cost per capita for provincial government spending for health and social services on PEI was $3,126.
- Between 2000-01 and 2004-05, per capita cost increased by $416 (15 per cent).

Health Professionals

The number of health professionals per population of 100,000 is an indicator used provincially and nationally to monitor and compare trends.

Health professionals, number per 100,000 population: 2002-2003				
	2002		2003	
	Canada	PEI	Canada	PEI
registered nurses	734	921	760	994
licensed practical nurses	191	423	199	448
general practitioners / family physicians	96	85	97	88
specialist physicians	93	51	91	54
pharmacists	84	98	87	108
dentists	57	44	58	44
physiotherapists	48	38	49	38
occupational therapists	31	27	33	25
dental hygienists	51	31	53	49
chiropractors	20	6	21	6
optometrists	11	10	12	11
dietitians	23	42	24	44

Source: CIHI Health Indicators 2004

- In 2002 and 2003, the number of registered nurses, licenced practical nurses, pharmacists and dietitians per 100,000 population on PEI was above comparable national rates. In fact, the PEI rate for licenced practical nurses was twice the national rate.

- PEI had a rate below the national average for other health professionals, such as physicians, dentists, dental hygienists, and optometrists. It is important to note, however, that Islanders receive some services, such as medical specialist consults, out of province. Thus, while the number per 100,000 of some health professionals may be lower on PEI than elsewhere, Islanders may still have appropriate access to these services, but on an out of province basis.

Patient Satisfaction

Reported patient satisfaction with overall health care services, community-based care services, hospital care and physician care were measured in the Canadian Community Health Survey in 2003.

Community-based care includes any health care received outside of a hospital or doctor's office. Examples include home nursing care, home-based counseling or therapy, personal care, and community walk-in clinics. For the purpose of this survey, physicians included family doctors and medical specialists, but excluded services received in a hospital.

The table reports the percent of survey respondents, aged15 and over, who rated themselves as either "satisfied" or "somewhat satisfied" with the way services were provided in the previous 12 months.

Proportion who reported they were "satisfied" or "somewhat satisfied" with health services, 2003				
	overall health care services received	community-based care services received	hospital care	physician care
PEI	88.3%	88.4%	85%	94.2%
Canada	85.3%	82.9%	82.3%	91.8%

Source: Canadian Community Health Survey, 2003

- The majority of Islanders and Canadians were satisfied with the various health services they had received.

- PEI's results included a very small sample and were flagged to be interpreted with caution.

Goal #4:
Increase public confidence in the system

Public confidence in the health and social services system is essential to advance system goals and strategies. Public confidence can be measured by a public rating of the quality of services received. Perceptions of service quality were measured through the Canadian Community Health Survey.

The table below reports the percentage of the population rating any health care service, community-based services, hospital care and physician care as "excellent" or "good." Community based care services include home nursing care, home based counseling or therapy, personal care and community walk-in clinics.

Proportion of the population who rated the quality of health care services received as "excellent" or "good", age 15 and over: 2003				
	any health care service	**community-based services**	**hospital care**	**physician care**
PEI	88.6%	87.2%	86.2%	94.6%
Canada	86.8%	79.6%	83.9%	91.9%

Source: Canadian Community Health Survey, 2003

- Islanders and Canadians generally responded positively about the quality of care they received, 88.6 per cent rated the quality of health care service on PEI as excellent or good.

- In all four areas of health service, the PEI rate was above the Canadian rate.

Goal #5:
Improve workplace wellness and staff morale

Long term quality and sustainability of the health and social service delivery system requires a sufficient supply of skilled health human resources. A variety of efforts directed toward recruitment, retention and employee wellness have been undertaken at all levels of the system.

Permanent Employees in the Health and Social Services System, March 2003 to March 2005			
	Number as of March, 2003	*Number as of March, 2004*	*Number as of March 2005*
Department	159	167	165
Health Regions	3615	3792	3887
Total	3774	3959	4052
Rate of increase over prior year	--	4.9%	2.3%

Source: DHSS Human Resources, 2005

Employee Sick Hours

Sick leave usage is related to a variety of factors. For instance, collective agreements (articles utilize sick leave balances for medical appointment and addictions treatment), organizational culture and staffing issues can all contribute to increases or decreases in the usage of sick time. The following table presents sick leave utilization in the Health Authorities between 2003/04 and 2004/05.

Sick Leave Utilization in the Health Authorities* , 2003/04 to 2004/05		
	2003-2004	**2004-2005**
Total Hours	7405727	7616696
Total Sick Hours	288032	300019
Sick hours as a percentage of total hours	3.9%	3.9%
Average number of sick days per year used per FTE**	10.2	10.2

Source: Department of Health and Social Services, Human Resources
** Excludes the Department of Health and Social Services*
*** FTE is "full time equivalent" and refers to full-time hours which is 1950 hours per year.*

- The average number of sick days between the 2003-2004 and 2004-2005 fiscal years remained constant at 10.2. This average is in line with national averages.

Workers Compensation Board Claims

Workers Compensation Board Claims, 2001/02 to 2004/05				
	2001/2002	2002/2003	2003/2004	2004/2005
Claims Filed	500	452	401	374
Time Loss Claims	196	162	142	115
Days Lost	4187.8	3571.9	3404.2	2510.2

Source: Workers Compensation Board, PEI

- The number of claims filed and the number of days lost have both decreased over the last four years.
- The number of days lost decreased 40 percent between the periods 2001-02 and 2004-05.

Employee Assistance Program Utilization

The Employee Assistance Program (EAP) provides confidential counseling to employees and group sessions focused on wellness programming in the worksite. EAP counseling utilization rates provide an indication of employee health needs and willingness to seek helpful supports.

Employee Assistance Program utilization rates, Health Regions, 2002/03 and 2003/04			
Age & Years of Service Breakdown		2002/03	2003/04
Age groups	36-45 years old	40.1%	37.6%
	46-55 years old	23.9%	22.1%
Years of service	6-10 years	26.5%	23.3%
	11-19 years	41.2%	34.0%
	20+ years	14.5%	11.2%

Source: Employee Assistance Program, 2004

- In 2002/03, 578 health region employees used the Employee Assistance Program and in 2003/04, 614 used the services - an increase of about 6 per cent.
- In both years, the top three presenting problems were marital/partner issues, job conflict and anxiety.
- Each year, over one quarter of those using EAP services indicated that their presenting problem affected the quality or quantity of their work; close to 20 per cent indicated that their problem led to job conflict; and close to 20 per cent indicated that their problem resulted in absenteeism.
- Most Program users were aged 36-55 years, with the highest proportion aged 36-45 years.

Recruitment and Retention

Attrition Rates
For the twelve month period ending December 4, 2004, the rate of attrition for the health and social services system was approximately 4.4%. In summary, 180 non-casual employees exited the system during that one year period for the following reasons: resignation (43%); retirement (28%); term positions ended (12%); deceased (5%); dismissal (2%); and other reasons (9%).

Physician Recruitment Success
All provinces are experiencing physician shortages in both family medicine and specialty areas. Vacancies in the physician complement, whether in family medicine or a specialty area, affects services to the general public. The province is responding to the issue of physician shortages and vacancies in the physician complement through ongoing recruitment efforts.

The following table reports on the total physician complement and number of positions filled within that complement for 2003 and 2005. The Physician complement is the total number of allowable positions for physicians in PEI.

Physician complement and filled positions, PEI: 2003 and 2005				
	as of March 2003		as of March 2005	
Physician practice area	**complement**	**filled***	**complement**	**filled***
Family Practice	81	77.3	82.6	79.6
Specialists	106.5	104.4	110.1	100.2
TOTALS	187.5	181.7	192.7	179.8
** Filled positions reflect a full-time equivalent based on both permanent and locum positions.*				

Source: PEI Department of Health and Social Services, Medical Programs, 2005

- The physician complement on PEI increased by more than 21 positions since 2002, from 171.1 positions in 2002, to 187.5 positions in 2003, 191.6 positions in 2004, and 192.7 in 2005.

- The province has, since 2002, increased the number of physicians required for internal medicine, emergency medicine, psychiatry, physical medicine and family medicine.

- More physicians are working on PEI than in 2002. The number of FTE physician positions filled has increased from 158.3 in 2002 to 180 in 2005. Some of the currently unfilled positions are new and recruitment is on-going.

- PEI has achieved complement, since 2004, in the majority of physician practice areas, and experienced an increase in Emergency Room, Ophthalmology, and Physical Medicine physicians. Family Practice, Anesthesia, Internal Medicine, Psychiatry and Plastic Surgery physicians remain below complement.

Nurse Recruitment

Registered nurses comprise the largest group of health care providers on PEI. The PEI Nursing Recruitment and Retention Strategy provided a variety of strategies to ensure an adequate supply of nurses over the long term. These strategies included 3rd and 4th year student sponsorships, relocation assistance, Refresher Program Cost Assistance and Summer Employment. The following table reports on participation and uptake in these strategies.

PEI Nursing Recruitment and Retention Strategy			
	2002/03	**2003/04**	**2004/05**
Number of student sponsorships (for 3rd and 4th year)	78	127	77
Number of RNs who received relocation funding	30	22	40
Number of RNs receiving Refresher Program Cost Assistance	2	2	3
Bachelor of Nursing Summer Employment Program	73	77	78

Source: Department of Health and Social Services, PEI Nursing and Retention Strategy, 2005

- The PEI Nursing Recruitment and Retention Strategy has in the past helped to relocate dozens of nurses to the province.

- The strategy has sponsored 282 nursing students. Sponsored students are required to work in the PEI health system after graduation.

- In addition to the Nursing Recruitment and Retention Strategy, the province has also sponsored students in the Radiation Therapy course and the Speech and Language Pathology Masters Program.

Legislative Responsibilities

Legislation administered by the health and social services system for which the Minister of Health and Social Services is responsible:

Adoption Act
Adult Protection Act
Change of Name Act
Child Care Facilities Act
Child Protection Act
Chiropractic Act
Community Care Facilities and Nursing Homes Act
Consent to Treatment and Health Care Directives Act
Dental Profession Act
Denturists Act
Dietitians Act
Dispensing Opticians Act
Donation of Food Act
Drug Cost Assistance Act
Family and Child Services Act
Health and Community Services Act
Health Services Payment Act
Hospital and Diagnostic Services Insurance Act
Hospitals Act
Housing Corporation Act
Human Tissue Donation Act
Licensed Practical Nurses Act
Marriage Act
Medical Act
Mental Health Act
Nurses Act
Occupational Therapists Act
Optometry Act
Pharmacy Act
Physiotherapy Act
Premarital Health Examination Act
Provincial Health Number Act
Psychologists Act
Public Health Act
Rehabilitation of Disabled Persons Act
Smoke-Free Places Act
Social Assistance Act
Social Work Act
Tobacco Sales to Minors Act
Vital Statistics Act
White Cane Act

NOTE:
There are two other statutes that are private member's bills, not in the province's official consolidation, but are considered to be within the responsibility of the Health and Social Services Ministry:

Dental Technicians Association Act
Funeral Directors and Embalmers Act

Legislative Changes

Acts

- The *Act to Amend the Adoption Act* received Royal Assent on May 2, 2004. This legislation replaced a process that had been available under the now-repealed *Family and Child Services Act*, for the Director of Child Welfare to be able to enter into agreements for custody with parents wanting to place a child for adoption or to place a child while they contemplate adoption. Although a similar agreement exists under the *Child Protection Act*, it is in a child protective context only, and is therefore not appropriate for parents considering this option who are not involved in a child protection situation. The *Act to Amend the Adoption Act* came into force September 14, 2004.

- The *Act to Amend the Pharmaceutical Information Act* received Royal Assent on May 20, 2004. The amendment was required to correspond with changes to the *Pharmacy Act* and recognize additional persons who may be authorized to prescribe drugs; it also provided for paramountcy over the *FOIPP* legislation in the event of a conflict; further, it clarifies provisions concerning disclosure of program information to researcher applicants (Act and amendment not yet in force).

- On September 29, 2004, section 2(3) of the *Smoke-free Places Act* came into force, thus removing the exception (from the application of the Act) for correctional facilities.

- The *Act to Amend the Tobacco Sales to Minors Act* received Royal Assent on December 16, 2004. The changes add further definitions, delete references to "vendors", further clarify the ban on selling tobacco to those under 19, makes exception if tobacco is for use in Aboriginal practices or ceremonies, lists designated places where tobacco cannot be sold, bans tobacco vending machines and self-serve displays, adjusts the fine structure, amends the regulation-making power, provides for pharmacies and stores containing pharmacies to be added to the list of designated places, and makes consequential amendments to the *Health Tax Act*.

- The *Registered Nurses Act* received Royal Assent in December 2004. This is new, updated legislation regulating the practice of registered nursing; it also introduces a new category of nursing for PEI - nurse practitioner.

- *An Act to Amend the Occupational Therapists Act* was assented to in December 2004. The changes update the legislation governing occupational therapy, including recognition of current concepts such as continuing competencies, and further support labour mobility for these practitioners.

Regulations:

- The regulations under the *Vital Statistics Act* were amended to allow for a fee for "rushed" service under the Act. The change came into force May 1, 2004.

- The regulations under the *Change of Name Act* were amended to increase the processing fee from $160 to $185 - the increase was necessary due to an increase in the cost to register documents at the Registry Office. The change became effective May 15, 2004.

- Amendments to the regulations under the *Drug Cost Assistance Act* effective June 1, 2004 increased the co-pay requirement by $1.

- Changes were made to the Slaughter House Regulations under the *Public Health Act* to update terminology concerning the slaughter business and specifically to reflect an increased awareness of, and the hygienic precautions to be taken concerning bovine diseases (BSE). The amendments came into force May 22, 2004.

- Amendments were made to the registration and licensing requirements of emergency medical technicians (EMT's) in the Emergency Medical Services Regulations under the *Public Health Act.* These changes included moving from 2 levels of licenses to 3; and some changes to the equipment requirements for ambulances. All sections but s.6 came into force December 25, 2004, and section 6 concerning the new license levels, came into force April 1, 2005, to coincide with a new licensing term.

- Changes were made to the regulations under the *Licensed Practical Nurses Act* , including housekeeping changes, and an amendment to the requirements for program instructor. These changes became effective February 26, 2005.

Appendix A
Financial Statements

Major Programs As A Percentage of Total Budget

		2002/03	2003/04	2004/05
Health Care				
	Hospital Services	31.4	31.6	32.2
	Physician Services	12.2	12.7	13.2
	Blood Services	1.1	1.4	1.3
	Ambulance Services	0.9	1.0	1.1
	Home Care	1.7	1.9	2.0
	Continuing Care	9.8	10.4	10.7
	Provincial Pharmacy	4.2	4.3	4.6
	Mental Health	3.0	3.3	3.5
	Public Health Nursing	0.7	0.8	0.9
	Addiction Services	1.5	1.5	1.5
	Dental Public Health	0.6	0.6	0.6
	East Prince Health Facility	4.1	1.7	0.0
	Other Programs	8.9	8.8	10.8
	Total Health Care	**80.1**	**80.0**	**82.4**
Social Services				
	Child & Family Services	15.6	15.7	13.9
	Job Creation	0.5	0.6	0.3
	Social Housing	2.2	2.1	2.1
	Grants - Non Gov't Organizations	1.6	1.6	1.3
	Total Social Services	**19.9**	**20.0**	**17.6**
Total Health & Social Services		**100.0**	**100.0**	**100**

Appendix B
Budget Estimate

Budget Estimate

	2005/2006
Department of Health and Social Services	
Gross Expenditure	$445,278,000.00
Gross Revenue	$23,076,600.00
Net Ministry Expenditure	**$422,201,400.00**