Prince Edward Island
CANADA

Health and Social Services System

Ministry of Health and Social Services

Annual Report

2003-2004

Annual Report

for the year ending March 31, 2004

Ministry of Health and Social Services

For more information on this report, contact:
PO Box 2000, Charlottetown, PE, Canada, C1A 7N8
Tel: 902 368 4900 Fax: 902 368 4969
or visit our Web site at ***www.gov.pe.ca***

Prince Edward Island
CANADA

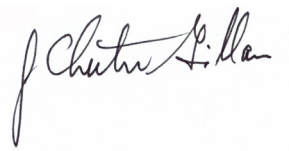
Message from the Minister

To the Honourable J. Leonce 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, 2004.

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 2003-2004 Annual Report for the health and social services system. The outcomes reported here show that we remain committed to the goals and strategies established during the strategic planning process to guide the direction of the system.

I am proud of our many accomplishments in 2003-2004 and would like to highlight some major achievements:

- The five-year strategic plan for the health and social services system continues to support the wellness of Islanders and the sustainability of health care on Prince Edward Island.
- Construction of the new state-of-the-art Prince County Hospital was completed in March of 2004.
- The expansion of the Cancer Treatment Centre was completed in November of 2003.
- Six new family physicians and 11 specialists were recruited in 2003-2004.
- The implementation of the new *Smoke-free Places Act*, effective June 2003, ensures air is smoke-free in public places.
- The new *Child Protection Act,* proclaimed in May 2003, builds on the previous legislation by simplifying the language, establishing a more child/parent sensitive process, being more culturally sensitive, and responding to the need to involve legal processes sensitive to a child's developmental needs.
- The Disability Support Program underwent an extensive evaluation resulting in a change to the age of independence, from 25 years to 18 years, when determining the contribution amount required for people with disabilities over the age of 18 years.

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 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 s 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

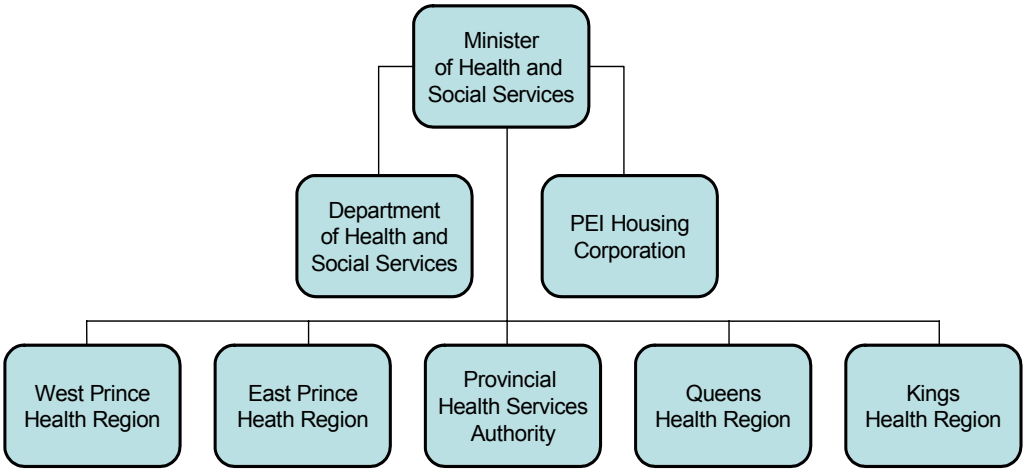
And is also responsible for:

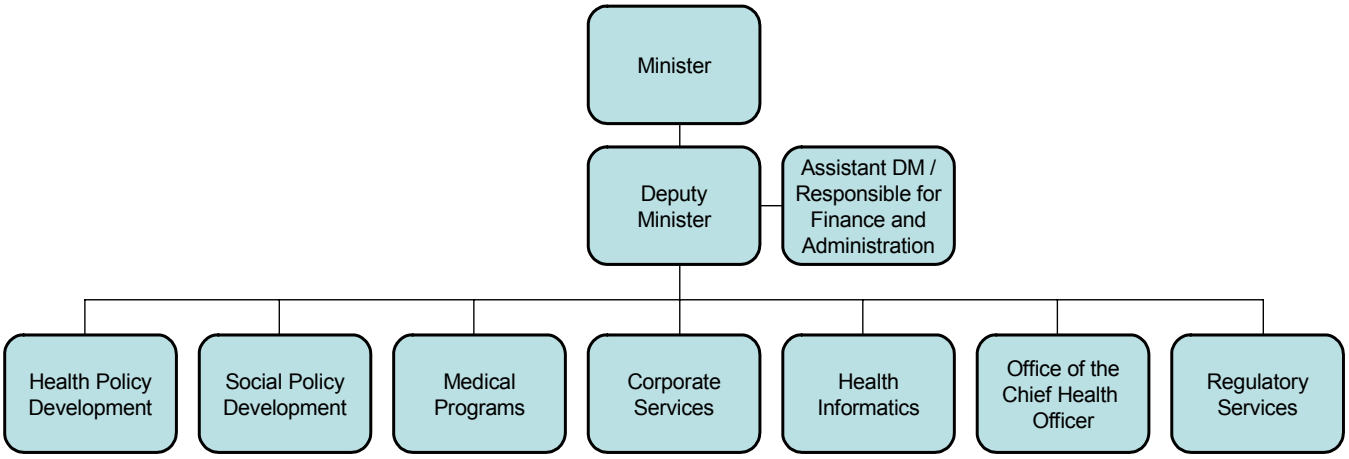
- Quality of health and social services legislation and enforcement of legislation and regulations assigned to the department
- Quality of monitoring health outcomes provincially and regionally within the province
- Client and provider satisfaction
- Exerting influence as appropriate on decisions of 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 March 31, 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

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.

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.

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.

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.

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; and within the corporate information technology (IT) strategy of the provincial health system and provincial government.

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.

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 Stewart
Richard Wightman

Kings Health Region

Michael Gallant, Chair
Marian Trowbridge, Vice Chair
Tom Carver
Sherry Kacsmarik
J. Lloyd Soloman

East Prince Health Region

Dr. Allen MacLean, Chair
Barry Murray, Vice Chair
Alcide Bernard
Doreen Gunn
Melinda Mulligan
Carol Peters
Lorraine Robinson
Gertrude Trainor
Elmer Williams

Queens Health Region

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

as at March 31, 2004

Population by Region, 2003-04

West Prince	14,995	(10.69%)
East Prince	33,872	(24.15%)
Queens	70,228	(50.06%)
Kings	21,185	(15.10%)

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 identifies 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. This section outlines progress on strategies undertaken by the system in 2003-2004 that address these critical issues.

Highlights of the Year

The following are highlights of the ministries achievements in relation to each strategy for the 2003-04 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 enables 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 launched:

Healthy Living Coordinators

Healthy Living coordinators were hired in three of the four regional health authorities in 2003/04. The coordinators help move the strategy forward at the community level.

Healthy Eating Strategy

A partnership of more than 40 government and non-government organizations, the Healthy Eating Strategy was developed and released by the PEI Healthy Eating Alliance to improve current eating behaviours of Island children and youth through nutrition education, promotion and by creating supportive environments. The goals of the strategy are to increase nutrition education and promote healthy eating to students, parents, teachers, and all those who work with children; to increase access to safe and healthy foods in places where children gather; and to increase understanding of how children and youth are currently eating and why, and how best to improve their current eating behaviours through up-to-date quality research. As part of this strategy, a program designed to promote vegetable and fruit consumption was piloted in several schools across the Island. Input is provided in the development of the nutrition component of the Elementary School Health Curriculum. As well, parent information sessions on healthy eating for children were held across the Island in the winter of 2004.

School Healthy Eating Guidelines

Members of the PEI Healthy Eating Alliance worked with the departments of Health and Social Services and Education, school boards and Home and School Associations to develop healthy eating guidelines for Island schools. The best way to encourage healthy eating is to help children develop healthy eating habits when they are young. The alliance provides opportunities to engage parents and school communities to work towards preventing and reducing childhood obesity, which is increasing at alarming rates.

Tobacco Reduction Alliance

The Department of Health and Social Services continues to be an active member in the PEI Tobacco Reduction Alliance (PETRA). The Department of Health and Social Services works 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.

In February 2004, the Students Working In Tobacco Can Help (SWITCH) Clubs organized an awareness raising activity called Death In the Snow. They spray painted outlines of 129 bodies in the snow at various entrances to Charlottetown to represent the number of people in Canada who die each day of tobacco related illnesses.

PEI is a leader in the country in delivering comprehensive support for quitting smoking through the toll-free PEI Quitline. The Smokers' Helpline and the Quit Care Program continue to support Islanders in their efforts to stop smoking.

Stepping Out Program

In 2003, the 12-week community Stepping Out program saw 1,500 Islanders strapping pedometers onto their hips to count the number of steps they took every day. The program continued in 2004 with the launch of the new Stepping Out Dream Team, a group of Stepping Out participants whose progress was profiled in the media and on the PEI Active Living Alliance Web site throughout January and February. In addition, a Stepping Out school pilot project for youth was introduced in several junior and senior high schools provincewide.

Active Healthy School Communities Program

The education sector contributed to the Strategy for Healthy Living by implementing a new Active Healthy School Communities program, beginning in 2003 at East Wiltshire Intermediate and its feeder schools. This new initiative builds on the many programs now in place in our schools to improve eating habits, increase physical activity, and reduce tobacco use. The objective is 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

Cervical Cancer is largely preventable. Studies have shown that about half of the women who develop cancer of the cervix have never had a Pap smear or have not had regular Pap smears. The PEI Pap Screening Program was established in January 2001 to encourage regular Pap screening for cervical cancer. Highlights of the PEI Pap Screening Program's third year include the following:

- PEI's overall two year screening rate for women aged 20 to 69 remains at 58 per cent. The screening rate has been stable over the past nine years.

- The Pap Screening Clinic provided alternative access to screening for 1,174 Island women in 2003, an increase from 993 in 2002. Since its inception on September 12, 2001, 2,600 Island women have been screened by the clinic. Of the women screened by the clinic in 2003, 680 had attended one of 34 scheduled out-reach clinics held throughout the Island.

- PEI's fourth Pap Awareness Week campaign was held October 19 - 26, 2003 to increase awareness that cervical cancer can be prevented by regular Pap tests and to target women aged 50+. The 2003 Pap Awareness Campaign also included a successful collaboration with the Federated Women's Institute of PEI. Four information sessions on Pap screening and issues around hormone replacement therapy were presented by physicians and the program coordinator in each of the health regions.

- A promotional campaign developed in partnership with Island Focus and the Council for the Disabled was held in November 2003 to promote use of a multi-functional examination table purchased in 2002 that could provide medical procedure access to women with physical disabilities and to any individual who requires supportive access. The multi-functional examination table located at the Four Neighborhood Community Health Center is available for use by any family physician, specialist, health professional, and the Pap Screening Clinic.

Smoke-free Places Act

The *Smoke-Free Places Act*, which received Royal Assent in the Fall of 2002, became effective on June 1, 2003. Its purpose is to provide the legislative framework to protect the public and workers from the effects of second-hand smoke by creating smoke-free work and public environments. Smoking is only permitted in workplaces and other public places such as restaurants and bars 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.

West Nile Virus Strategy and Mosquito Surveillance Program

In May 2003, the Department of Health and Social Services tabled the West Nile Virus Strategy. The strategy includes surveillance for West Nile virus in the three Maritime provinces, dead bird surveillance, human surveillance, human testing, a mosquito survey, mosquito control, and public education.

Together with the Department of Environment and Energy, a mosquito technician was hired to conduct a survey of seven sites across PEI during the summer of 2003. The mosquito survey included identification of the species and relative numbers of mosquitoes found, and provided information regarding the patterns of mosquito populations across the province. Of the 34 species of mosquito on PEI, only three are of the Culex species, the usual carriers of West Nile Virus.

Healthy Child Development

A key strategy for improving the health status of Islanders emphasizes that positive early childhood experiences have a long lasting impact on their success in education, and on their ability to form relationships and participate in community life.

Healthy Child Development Strategy

Implementation of the provincial (government and community) five-year PEI Healthy Child Development Strategy is well underway. The objective of this initiative is to improve health outcomes for children prenatal to eight years of age. PEI has established a Premier's Council on Healthy Child Development, a Children's Secretariat and a Children's Working Group to support coordination and implementation within and between government and the community. The action plan for 2003/04 addresses the strategy's three key activities: supporting children and families, building capacity and sustainability, and profiling healthy child development.

Healthy Child Development Conference

Participants from the Children's Working Group, the Understanding the Early Years Advisory Committee and the Understanding the Early Years Community Champions heard keynote speaker Dr. Doug Willms, from New Brunswick speak about research into the nature of children's environments within the family; and in their schools, neighbourhoods, and communities, and how these environments affect a child's cognitive and behavioral development.

Partnerships for Children

The PEI Partnerships for Children initiative provided funding of $110,000 to the Children's Working Group networks for projects that support children and families. The networks support the key areas for action of the PEI Healthy Child Development Strategy.

In 2003/04, Partnerships for Children supported a range of activities, including social marketing and public awareness, skill enhancement and communications within the early childhood education and care sector, programs for children, and workshops for parents and professionals. Initiatives addressed prenatal education, parenting children with exceptional needs, children's mental health, healthy living, family violence prevention, use of car and booster seats, bike helmet safety and parent support.

Children's Think Tank

More than 120 parents, care-givers, educators and representatives from community organizations, business and government gathered for the third annual Children's Think Tank. Participants met to review PEI Healthy Child Development Strategy activities from the past year, to share ideas and to plan methods to address issues affecting children and families.

Measuring and Improving Kids' Environments

Measuring and Improving Kids' Environments (MIKE) is a joint project of the Department of Health and Social Services and the Early Childhood Development Association (ECDA). Consultants quantitatively measure indicators of quality in licensed early childhood centres and support centres to make targeted and measurable improvements to the quality of education and care being offered.

Services for Children

In 2003/04, the health and social services system provided funding for four new full-time speech language pathologist positions across PEI.

In January 2004, PEI launched a universal newborn Auditory Screening Program. All newborns are screened in hospital by nursing staff.

Child Sexual Abuse

The Provincial Child Sexual Abuse Advisory Committee is a collaborative partnership between government and community organizations working together to address child sexual abuse and to promote increased awareness to this issue. The committee was formed in 1991 and continues to promote the needs of child sexual abuse victims, offenders, and their families.

In recognition of Family Violence Prevention Week, held in February 2004, a public information session on protecting children ages 0-18 from sexual abuse was held for parents, care-givers, professionals, and the general public.

Topics discussed included:

- facts about child sexual abuse;
- child sexual development – normal and problem behavior;
- child molesters;
- role of police and child protection – investigation process;
- school's role in educating children about sexual abuse; and
- safety tips.

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 $55 per month per child and is intended to enable children to participate in sporting and cultural activities in their communities.

Supported Adoption Program

PEI is continuing the process of implementing a new Supported Adoption Program 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 perspective adoptive families. Children in permanent care who are adopted have better outcomes than children who remain in long-term foster care.

Creating Positive Outcomes for Children, Families and Staff

The eighth annual Child Welfare Staff Conference was held in the fall of 2003 with more than 120 staff in attendance, including front-line child welfare and resource workers, supervisors and managers; as well as staff of the regional Child and Family Services divisions, including family support workers, group home workers, and youth workers.

Dr. Marion Perpick-Breton was keynote speaker for the conference, her presentation was entitled Creating Positive Outcomes for Children, Families, and Staff. Dr. Perpick-Breton is a child psychiatrist from Toronto who has developed Parenting Capacity Assessment Guidelines, a framework to gather information, make clinical decisions, and determine the best long-term case plan. Her work follows in the footsteps of the late child psychologist Dr. Paul Steinhauer who developed the Centre of Excellence for Child Welfare in Toronto.

Concurrent workshops were designed to complement Dr. Perpick-Breton's presentation. Local social work and early childhood experts presented on topics including self care, high risk youth and child development. During the two-day conference, staff had an opportunity to learn from some of the leading local, regional and national child welfare authorities in Canada. It was also an opportunity for staff to share their experiences and knowledge and to learn from each other.

Immunization Program

The Meningococcal C Vaccination Program commenced in June 2003 for all children at 12 months of age. The meningococcal vaccine was also administered to Grade 9 students during the 2003/04 school year at the same time they received their booster tetanus and diphtheria immunization.

The province discontinued collecting the fee that was charged for routine childhood and school age immunizations. This included routine recommended immunization administered at Public Health Nursing clinics at the ages of two, four, six, 12, 15, and 18 months, four to six years and in Grade 9. The vaccines administered at these ages protect against diphtheria, whooping cough, tetanus, polio, haemophilus influenza B, hepatitis B, chickenpox, measles, mumps and rubella.

Child Protection

The *Child Protection Act* was proclaimed on May 10, 2003 replacing the Family and Child Services Act. The new act does not depart from the previous legislation but builds on it to make the law more relevant and effective in order to meet the challenges of today.

The *Child Protection Act* simplifies language to clarify legal parameters, establishes a more child/parent sensitive process, is more culturally sensitive, and responds to the need to involve legal processes sensitive to a child's sense of time and developmental needs.

Tyne Valley Child and Youth Developmental Health Centre

The new Tyne Valley Child and Youth Developmental Health Centre became part of the provincial health and social services system, focusing on assessment, treatment, case planning and residential support for high-needs children and youth. It is anticipated that the centre will also provide secure assessment provisions, when proclaimed as part of the *Child Protection Act*.

The Tyne Valley Child and Youth Developmental Health Centre will be a parallel program to the Provincial Adolescent Group Home and will provide child care services consistent with their policies and operations.

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

Construction of the new Prince County Hospital was completed in March 2003 and the public had an opportunity to view the new hospital during an open house on March 12th and 13th.

The completion of the new hospital marks a significant milestone for the PEI Health and Social Services System and for the many people who dedicated a great deal of time and energy to the planning and implementation of this facility.

The new Prince County Hospital will be a unique health facility offering state-of-the-art health technologies in an innovative patient-care environment. The Prince County Hospital Foundation led a successful capital equipment campaign, which raised more than $13 million to equip the facility with the latest medical technology. This new hospital will offer 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.

PEI Cancer Treatment Centre

The province's state-of-the-art Cancer Treatment Centre was officially opened in November 2003.

In September 1997, the province announced its commitment to establish enhanced radiation therapy services at the Queen Elizabeth Hospital. The expansion project, which started in 1999, included the addition of a linear accelerator unit to enhance curative oncology treatment services at the hospital. The linear accelerator uses high energy radiation to localize treatment on tumours.

The linear accelerator is also used to treat patients with cancer of the prostate and gynecological cancers. The expansion of the Cancer Treatment Centre means that at least 90 per cent of Island cancer patients can remain in PEI for treatment.

Twenty new employees were hired to operate the Centre, including new positions such as radiation therapists, oncology nurses, electronic engineer, social worker and dietician.

The Cancer Treatment Centre expansion features its own entrance; 35 new and upgraded rooms, including 10 new examination rooms; and designated space for counseling, social work, pastoral care and nutrition services.

Primary Health Care Redesign Initiatives

Primary health care is the first level of care and the initial point of contact for a patient with the health system. The Prince Edward Island Primary Health Care Redesign resulted from a first ministers meeting in September 2000, when the first ministers agreed to make improvements to primary health care to ensure the renewal and continuation of health services. At that time, the first ministers wanted to ensure that Canadians receive the most appropriate care, by the most appropriate provider, in the most appropriate setting. To date, PEI has completed the first year of a five-year plan to develop an integrated primary care system on Prince Edward Island. Initiatives include:

- The PEI Strategy for Healthy Living – A partnership between various government departments and partners to encourage and support Islanders to take measures to address the common risk factors that contribute to chronic disease – tobacco use, unhealthy diet and physical inactivity. The fund supports 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. Regions are registering clients and results will be available in the next fiscal year.

- Family Health Centres – Community-based centres which bring together three or more physicians, registered nurses and other health providers working collaboratively with shared responsibility for patient and client outcomes based on assessed health care needs.

Social Assistance Program

Amendments to the *Social Assistance Act* and new regulations were proclaimed on August 4, 2003. The amendments reflect a change in name for the program from Welfare Assistance to Social Assistance, a clear delegation of authority and duties for the Minister, department and regional authorities, expanded terms of reference for the Social Assistance Appeal Board, provisions for appropriate disclosure of information and protection of privacy, and procedures for cost recovery and the collection of debts.

The Social Assistance policy manual has been revised to reflect these regulatory changes and has now been posted to the government Web site. This makes details of the Social Assistance Program, including eligibility, benefits and services, procedures, expectations and appeal procedures, all readily available to anyone wishing access to that information.

Canada - Prince Edward Island Affordable Housing Agreement

On May 23, 2003 the Canada-Prince Edward Island Affordable Housing Agreement was signed. This $5.5 million initiative will be managed by the Province of PEI to ensure an increase in the supply of affordable housing in the province.

Funding under the agreement will be used for a provincially designed affordable housing program, which will create housing for low to moderate-income households and people with disabilities and special needs. This program will be established by forging new and creative partnerships with community groups, private developers, not-for-profit groups and all levels of government.

Through this agreement, individuals, communities and the private sector have the opportunity to consider construction, acquisition, renovation, rehabilitation, and conversion as affordable housing options. All projects funded will be required to create a minimum of five additional housing units, maintain units at affordable levels for at least ten years and rent only to low to moderate income families. Projects and proposals will be funded based on identified priority needs of families, people with special needs such as survivors of traumatic brain and spinal cord injuries, people experiencing serious and persistent mental illness, and people with disabilities. The home ownership component is delivered in partnership with Habitat for Humanity.

Provincial Addictions Treatment Facility

The Provincial Addictions Treatment Facility provides in-patient residential addiction treatment services to all persons in the province. These programs operate from a disease/abstinence model. Coinciding with treatment programs are one-on-one and group counselling, and educational programs for families of chemically dependent clients. Following treatment, clients are expected to participate in weekly after-care programs. A number of outpatient addiction services are available in all health regions, including outpatient detoxification, smoking cessation, outpatient rehabilitation, individual and group counselling and acupuncture. Youth and family services are available in all regions, including student assistance programs, education programs, assessment and counselling services.

The client-centred community-based mobile program for problem and pathological gamblers and their families continues to be delivered across PEI through the Provincial Addiction Treatment Facility and the health regions. This program is for people who have become harmfully involved in gambling, and for pathological gamblers.

The provincial women's mobile treatment program continues to be available to address the unique treatment needs of women and their families.

Take it Back! - PEI Medicine Cabinet Cleanup Program

The Province of Prince Edward Island, in partnership with the PEI Pharmaceutical Association and Island Waste Management Corporation, established a permanent program that allows Islanders to take unwanted prescription and over-the-counter medications to their local pharmacy at any time for environmentally safe disposal.

Under the new program, pharmacies provincewide serve as free drop-off points, safely storing products that Islanders return to their counters. The pharmacies then deliver the products to one of the Waste Watch drop-off centers, at which time Island Waste Management Corporation arranges for the pharmaceuticals to be disposed of at a licensed hazardous waste disposal facility off-Island. More than 1,300 kilograms (3,000 pounds) of old medications were collected in PEI during the cleanup campaign in 2003/04.

Seniors Advisory Council

The PEI Seniors Advisory Council was created in 1998 to serve in an advisory capacity to government through the Minister Responsible for Seniors and to provide a means of drawing upon the knowledge and experience of seniors of the province. In 2003/04, one of the council's priorities was to improve its visibility and interactivity with Island seniors. To this end, it established a public nomination process through which to fill future vacant positions on the council. Its mandate was also expanded to include conducting public consultations, with two consultations being completed in this fiscal year.

Seniors' Emergency Home Repair Program

In 2003/04, 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 who need specific emergency repairs ensure their homes are safe and secure.

During the 2003/04 year, the program funded 186 repairs at an average cost of $1,079, with priority being given to funding of roofs, furnaces, oil tanks, septic and water systems.

Disability Support Program

The Disability Support Program completed its second year of operation in 2003 with an extensive review and evaluation, including a literature review, program documentation review, focus groups, an administrative data review, expert and key informant interviews, public consultations, file reviews, and a comprehensive telephone survey.

As a result of the evaluation, the age of independence, for which family income is considered, was reduced from 25 years of age to 18. This program change means that parental adjusted net income will not be considered in determining the amount of contribution required for people with disabilities over the age of 18.

Prince Edward Island was the first province in Canada to fully separate the provision of disability-related supports from social assistance programming through the Disability Support Program. There are more than 1,100 individuals and families receiving supports from this program.

A new Web site for the Disability Support Program was also launched on the provincial government Web site. This new Web site includes an Island Focus video, the program brochure and handbook in both English and French, the DSP policy manual and program forms, downloadable versions of the two evaluation reports and a highlights document based on the reports. The Web site can be accessed at ***www.gov.pe.ca/peidsp***

Ministerial Advisory Committee on Disability Issues

In 2003, the Minister Responsible for People with Disabilities announced the establishment of a Ministerial Advisory Committee on Disability Issues. The Advisory Committee was created 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. A public nominations process was created to fill the 12 positions of the newly formed committee and a public call for nominations to fill the positions occurred.

Mental Health Services

In 2003/04, the final stages of the Model for Mental Health Services Delivery for PEI were implemented, including development of a mental health crisis response system for persons in emotional and psychiatric crisis, expansion of outreach services for persons with serious and persistent mental illness, and enhancement of clinical services in community mental health centres. As a result, people in crisis are now usually seen within half an hour of presenting at the emergency department, and are referred to more appropriate supports and services. Also, more than 350 people with serious mental illnesses who previously had been isolated are now receiving needed services.

The Joint Mental Health and Addictions Committee has implemented a number of strategies to improve service for the many people with concurrent mental health and addictions issues. Both mental health and addictions staff now use screening tools to better identify concurrent issues, liaison staff coordinate care between the two services, a treatment group has been designed, and an overall model for the service level integration of addictions and mental health across the Island is being developed.

Family Violence Prevention

In 2003, Executive Council endorsed an interdepartmental working group, the Deputies Coordinating Committee on Family Violence Prevention, to prepare a corporate response to the Five Year Strategy on Family Violence Prevention, and to serve as a corporate liaison with the Premier's Action Committee on Family Violence Prevention.

In December 2003, the Deputies Coordinating Committee requested that a comprehensive overview of current government services, programs, and activities clustered around the forty-one recommendations of the Family Violence Prevention Strategy, be compiled to assist corporate discussions on family violence prevention program priorities and resources. This corporate overview provides a comprehensive profile of departmental priorities across government while recognizing that collaborative partnerships will continue to expand and emerge between government and community. The importance of embedding family violence prevention within government strategic planning and policy was echoed throughout this review exercise.

Highlights of the committees's action items throughout the past year include partnering with the PEI Advisory Council on the Status of Women's Purple Ribbon Campaign, hosting a peace walk in recognition of Verbal Abuse Prevention Week, participating in a two-part Island Focus series on woman abuse protocols and the impact of family violence on children, disseminating information for Family Violence Prevention Week, participating in numerous projects and related initiatives, and partnering with the Office of the Attorney General's Ad Hoc Working Group to review recommendations in response to the Final Report of the Ad Hoc Federal/Provincial Territorial Working Group Reviewing Spousal Abuse Policies and Legislation in preparation of a report to the Attorney General of Prince Edward Island and the Premier's Action Committee on Family Violence Prevention. These activities are in addition to the ongoing public education, awareness, and professional development initiatives.

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 16 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 Ministry of Health and Social Services and a representative from the Acadian and Francophone Affairs division. The FLHSN and its executive committee have met a total of six times in the past year.

The following are activities and projects completed by the FLHSN in 2003/04:

- Published and distributed a French Language Health Services Directory, which included private sector businesses. Almost 2,000 copies of the directory were distributed.

- Initiated and participated in Atlantic, provincial and regional gatherings to represent needs and challenges of the Acadian and Francophone population in the health care area.

- Gathered data on the situation of young Francophones currently studying in the health care field, or who have studied in the health care field in the last five years. This survey will serve as a recruitment tool for the health recruiter.

- Contributed to two projects, one of which was to collect and analyze data on the risk behaviours of students at the Évangéline and François-Buote schools. This data was gathered as part of a study, *Ado, parlons français*! The report will be available very soon. The other project was the *Forum jeunesse*, a forum held in March 2004 in Summerside and Charlottetown. The purpose of this project was to make young people aware of the importance of continuing one's education in French and to promote the health care field as a career choice. The forum reached more than 200 Grade 10 students enroled in French schools and immersion programs.

- Coordinated the submission of projects by the Primary Health Care Transition Fund. This is ongoing. The network itself presented a project to improve access to services in French dealing with communications.

Systemwide French Language Health Services Strategic Plan

Consultations were held throughout the year with employees from the health and social services system and community organizations to develop a five-year strategic plan to improve access to healthcare services in French. The three main areas of intervention are training and retention, communication, and access to services. A draft five-year strategic plan was developed, based on the results from the consultations. The plan will be finalized in 2004/05.

French Language Services Coordinators

In 2003-04, French language services coordinators were hired by both the Provincial Health Services Authority and the Department of Health and Social Services to provide advice and support in the implementation of the French language health services. Kings Health Region conducted a review of the needs within the region. It is anticipated that a French language services coordinator will be hired in Queens Health Region in 2004/05.

Human Resources

As of November 2003, there were 92 employees deemed bilingual according to information in the government's Human Resource Management Information System. This number 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 and addiction counselling, residential care, social services, occupational therapy, medical services, nutrition services, nursing services within hospitals and public dental health.

Human Resources

The human resource planning process, aimed at ensuring an adequate supply and the correct mix of professionals to meet the health needs of Islanders, has resulted in several positive initiatives.

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, which equates to one physician for every 928 people. In 2003 the province had a total of 176 practicing physicians, one physician for every 800 people. In 2003/04, six family physicians and 11 specialists were hired.

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 four-year period from April 2000 to March 2004, a great deal of progress has been made, resulting in 286 one-year Bachelor of Nursing sponsorship agreements; the provision of relocation assistance to 96 off-Island nurses to work in the PEI Health and Social Services System; and reimbursement of the costs of the refresher program for 10 registered nurses.

PEI Nursing Recruitment and Retention Strategy	2000-01	2001-02	2002-03	2003-04
Number of Student Sponsorships (for 3rd and 4th year)*	24	57	78	127
Number of RNs provided with Relocation Assistance	23	21	30	22
Number of RNs provided with Refresher Program Cost Assistance	2	4	2	2
BN Summer Employment Program	28	50	73	77

* *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. Two students were sponsored in 2003/04. The Radiation Therapy Program is jointly delivered by the New Brunswick Community College and the Red River College in Manitoba.

Speech Language Pathologists

Increased awareness of the importance of early intervention has dramatically increased the number of referrals for speech language services. Language and communication skills are one of the measures of readiness to learn and has major effects on success in school. The departments of Health and Social Services and Education have worked together to develop a comprehensive long-term plan for speech. The complement of permanent full time speech language pathologists was increased, with four new permanent full time speech language pathologists in the health regions and one provincial speech language pathologist to expand the Little Expressions Mean a Lot community capacity-building program to a provincewide initiative.

In 2003/04, the Speech Language Pathology Bursary program provided $4,200 toward tuition for one student in her third year of a master's degree program in exchange for commitment of one year of service.

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, 2004 PEI had three students in this program under this initiative, who will graduate in 2005.

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 120 students in 2003/04 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.

Government and UPSE Three-year Collective Agreement

In October 2003, bargaining teams representing the province's five health authorities and the PEI Union of Public Sector Employees signed a three-year collective agreement, giving approximately 1,400 health sector employees a settlement that covers additional pay scale increases, new provisions for part-time or casual employees and an increase in premiums for weekend work.

Health sector employees, including licensed nursing assistants, resident care workers, social workers, social service workers, pharmacists, psychologists, nursing supervisors and a variety of other classifications, received wage adjustments of 3.25 per cent, 3 per cent and 2.75 per cent respectively for the next three years. The agreement is retroactive to April 1, 2003.

The agreement also provides for a supplementary benefits plan for maternity and parental leave, and a change in vacation threshold from six years to five years. The collective agreement was ratified when 90 per cent of the union members voted to accept it.

Licensed Practical Nurses Competency Project

The PEI Licensed Practical Nurses Competency Project was established through a partnership of the Licensed Practical Nurses Association of PEI and the PEI Licensed Practical Nurses Registration Board with support from the PEI Department of Health and Social Services and Human Resources and Skills Development Canada. The partnership engaged Future Learning Inc. of Charlottetown, PEI to conduct the research, which is directed at more effective utilization of licensed practical nurses on PEI.

The project includes three components:

- cataloging the current licensed practical nurses entry - level competencies;
- designing, developing and delivering a licensed practical nurses competency assessment tool; and
- preliminary action plans to support the full utilization of licensed practical nurses in PEI.

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 provincewide approach to health information technology implementation with the development of a provincial information technology infrastructure, the Island Health Information System (IHIS). This system 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:

- Radiology Information System and associated Picture Archive and Communication System (PACS) were implemented provincewide, the first in Canada. This new technology enables X-rays to be electronically captured and distributed between all acute care facilities in PEI, physician offices, emergency rooms and out-of-province facilities. These initiatives are supported by several partnerships, including those with the Queen Elizabeth Hospital Foundation, the Prince County Hospital Foundation, and Health Canada.

Major ongoing projects include the development and implementation of:

- The Integrated Services Management system (ISM) is a multi year, multi phase project that will introduce case management technology to all community-based health and social services within the PEI health system. As of March 2004, the application has gone live for Home Care Services, Public Health Nursing and the Diabetes Program.

- 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.

Prince Edward Island 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 & 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; Dieticians 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 & 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 has set six goals built around areas of our health system that required attention:

1. improve health status;
2. increase personal responsibility for health;
3. improve sustainability is the system;
4. improve public confidence in the system;
5. improve workplace wellness and staff morale; and
6. maintain other results at current levels.

As part of the planning process, indicators were identified to assess progress toward achievement of each goal. Reporting on those indicators is included in the following section of this report.

The most recent data available is reported. Where possible, PEI data was compared to national averages to indicate how we compare to other jurisdictions.

Goal #1
Improve the health status of Islanders

Health status indicators provide us with a comprehensive picture of the overall health of Islanders, and how we compare in terms of life expectancy, disease, health behaviours, and the broad determinants of health. Good results in this area reflect improved health and quality of life, as well as positive effects of the longer term sustainability of the health and social services system.

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 the number of years a person would be expected to live on average, starting at birth, and based on the death rates for a given year. The table below reviews the life expectancy of Islanders as compared to the life expectancy for all of Canada for the 10-year period between 1992 and 2002. The findings are broken down by sex.

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; but these findings reveal several significant trends:

- the life expectancy rates in Prince Edward Island have been similar to the life expectancy rates for all of Canada over the past ten years;

- the life expectancy has been rising for men, while the life expectancy of women on Prince Edward Island has remained steady over the past ten years, fluctuating between 80.1 and 82.6 years. Men have gained 2.2 years between 1992 and 2002; and

- the most recent confirmed data shows that PEI women live on average 5.1 years longer than men in our province. However, the gender gap in life expectancy has been shrinking over the last 10 years – in 1992, the difference was 7.3 years.

While **life expectancy** is the number of years a person would be expected to live, on average; **health adjusted life expectancy (HALE)** is the number of years in perfect health that an individual can expect to live given the current morbidity and mortality conditions. Life expectancy is an indicator of the quantity, rather than quality, of life. For example, a person with a serious debilitating disease living longer may not have the same quality of life as a person in good health living longer. HALE is not only a measure of quantity of life, but also a measure of quality of life. Since level of income is a significant non-medical determinant of health, HALE by income is also reported here.

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

- When life expectancy is health adjusted, the difference for PEI women is about 10 years less and about eight years less for men.

- PEI women have a health adjusted life expectancy that is longer than the Canadian average by about one year. Income had a minimal effect on Island women, especially in the lowest tercile, where the variance from the average was small.

- PEI men have a health adjusted life expectancy that is shorter than the Canadian average by one year. Income had more of an effect on Island men than women, evident in that their shorter life expectancy is distributed more evenly across the three income terciles.

Infant Health

Infant Mortality
Infant mortality is an indicator closely tied to the effectiveness of medical care, preventive care and the attention paid to maternal and child health within our health care system. The rate also reflects social factors in a baby's environment, such as maternal education, smoking and nutritional deprivation. The rates of infant mortality, given as five-year averages below, represent trends in this important indicator of health over the last two decades, from 1982 to 2001.

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, the infant mortality rates for both PEI and Canada have decreased consistently, 35 per cent for Canada and 15 per cent for PEI.

- The rates for Canada and Prince Edward Island are similar, although the five-year averages show a slight increase in the infant mortality rate on Prince Edward Island between 1997 and 2001 as compared to the early 1990s.

Birth Weight
Birth weight is a strong indicator of newborn health and a key factor affecting infant survival, health and development. It is a reliable measure of a newborn's chances of survival and future health.

Low birth weight is a key factor affecting infant survival and risk of disability and diseases such as 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. Low birth weight is reported as the percentage of live births with a birth weight of less than 2,500 grams (just over five pounds).

High birth weight is associated with maternal obesity and gestational diabetes. As well, with high birth weight babies there is a greater potential for complications for mother and baby during delivery. High birth weight rate is the percentage of live births where the baby has a weight greater than 4,000 grams (just under nine pounds).

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*

- Prince Edward Island has consistently had one of the lowest rates of low birth weight in the country for more than a decade. In addition, Prince Edward Island had the smallest proportion of low birth weight babies born in the year 2000, compared to the other Canadian provinces.

- In contrast to the low birth weight data, PEI has a larger proportion of high birth weights compared to the national average. In addition, for the year 2000, PEI had the second largest proportion of high birth weight births compared to the other Canadian provinces.

Self-reported Health

Self-reported health is a general indicator of the overall health status of individuals and reflects how healthy individuals feel they are. It includes features that other measures may miss, such as disease severity, coping skills, psychological attitude and social well-being. Self-reported health data is collected by asking individuals to rate their own health on a five point scale ranging from excellent to poor. Numerous studies have found that self-reported health can predict death rates even when more objective measures are taken into account.

This table reports the percentage 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 total rate for PEI was significantly higher than the Canada rate.
- 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 pose major health problems for the general adult population on Prince Edward Island, including cancer, heart attack, stroke, diabetes, arthritis, and asthma.

Cancer and Cardiovascular Disease

There are many types of cancer, but the most common forms are colorectal, lung, prostate and breast. The following tables examine the five year average incidence rate of these leading cancers, and the estimates for 2004. **Incidence rates** tell us how many newly diagnosed primary cancer cases there have been in a given year.

Average 5-year cancer incidence rate (per 100,000 population) 1996-2000					
		colorectal	lung	prostate*	breast**
PEI	male	68.64	89.14	129.56	
	female	52.32	53.54		108.38
Canada	male	60.84	79.16	116.4	
	female	41.36	42.9		101.68

Source: Statistics Canada, Canadian Cancer Registry, 2003
* *male population only*
** *female population only, although a small number of men each year are diagnosed with breast cancer.*

Estimated cancer incidence rate (per 100,000 population) 2004***					
		colorectal	lung	prostate*	breast**
PEI	male	64.2	89.4	189.5	
	female	51.6	51.8		108.3
Canada	male	62	71.9	121.2	
	female	41	48.4		105.9

Source: Statistics Canada, Canadian Cancer Registry, 2003
* *male population only*
** *female population only, although a small number of men each year are diagnosed with breast cancer.*
*** *2004 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.*

- Incidence rates for all four cancers were higher for PEI than for Canada, for both men and women, and it is estimated these trends will continue through 2004.

- Prostate cancer is the most frequently occurring cancer in men, with a rate of 130 per 100,000 PEI men being diagnosed with prostate cancer each year. Incidence rates are expected to continue to grow in 2004.

- Breast cancer is the most frequently occurring cancer in women, and the rate is expected to remain steady through 2004.

Mortality rates tell us how many people die per year due to a particular disease. The five year average mortality rates offer a picture of how well our system is able to cope with the disease, while it simultaneously indicates the relative severity of cases presenting in our health care system.

Average 5-year mortality rates (per 100,000 population), 1997-2001							
		colorectal cancer	lung cancer	prostate cancer*	breast cancer**	heart attack	stroke
PEI	male	22.74	78.12	30.06		75.98	51.24
	female	12.82	37.7		27.84	44.62	39.64
Canada	male	23.72	67.84	27.36		83.66	40.54
	female	15.24	34.08		25.8	41.34	34.86

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.*

- Heart attack is the leading cause of death for men and women in Canada.

- Lung cancer, then heart attack and stroke are the leading causes of death for men on PEI, while heart attack, followed closely by stroke and lung cancer are the leading causes of death in women on PEI.

- The mortality rate for prostate cancer in men is comparable to that of breast cancer in women, even though the incidence rate is higher. This may be because 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, for lung cancer, Canadian time trends are indicating the gap between men and women is shrinking, as fewer men are dying of lung cancer, and women's rates are increasing.

Chronic Disease

Prevalence of arthritis/rheumatism, asthma, depression and high blood pressure
The prevalence of a disease refers to the total number of cases in a year. Prevalence is reported as the percentage of the population age 12 and over who report that they have been diagnosed by a health professional as having a particular disease in the Canadian Community Health Survey. The following table reports the prevalence of arthritis/rheumatism, asthma, depression and high blood pressure in 2003.

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, and it had a higher rate of prevalence in PEI, at 20 per cent.

- The prevalence of arthritis/rheumatism tends to increase with age - approximately half of those age 65 and older reported having this condition (50 per cent of people age 65 and older on PEI; 47 per cent in Canada).

- For all four conditions, women reported having the particular disease more often than men.

- Arthritis/rheumatism rates, and asthma rates were slightly higher in 2003 than 2001.

- Asthma rates were more prevalent in the younger (age 12 to 19) and the older (age 65 and older) populations on PEI as compared to these same populations in the rest of Canada. The PEI and Canadian rates were similar in the other age groups.

- While there is no data for the total Canadian population in 2003, PEI rates of depression were available. The rate of depression on PEI was less than the Canadian rate in 2001, and has been consistently less prevalent than Canadian averages for the past 10 years.

- High blood pressure is slightly more prevalent on PEI than in Canada, and prevalence tends to increase with age. Of Canadians age 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 prevalence of diabetes gives an idea of the burden of this disease at a given time and is widely used in public health monitoring and planning. The National Diabetes Surveillance System (2003) has estimated that approximately five per cent of all Canadians are affected by diabetes, thereby generating direct costs related to physician and hospital care, prescription drugs, and other costs borne by individuals, and indirect costs including premature death or disability.

This table reports on the prevalence rate of diagnosed diabetes among health service users aged 20 years or over.

Prevalence of diabetes, 1999 / 2000			
	females	*males*	*total*
PEI	4.7%	5.5%	5.1%
Canada	4.9%	5.4%	5.1%

- The diabetes rates for PEI are close to, or the same as, the Canadian rates.
- Diabetes rates increase with age up to age 84. The range is from 0.8 per cent for age group 20-29 years and 15.5 per cent for the 80 to 84 year age group.
- In PEI and in Canada, the diabetes rates are higher for men for all age groups over 40 years.

Incidence of Vaccine Preventable Diseases

A number of diseases can be controlled by adequate immunization programs. Vaccines for those diseases are administered under provincial and territorial immunization programs across Canada. Each province and territory is required to report the occurrence of these diseases. The incidence rate of the six vaccine preventable diseases reported here refers to 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.*

- PEI has had no reported cases of invasive meningococcal disease 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 average incidence rates.

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

Many major illnesses are preventable or manageable, yet many people rely solely on the health system to treat them after they become ill. Acceptance of responsibility for our own health can be increased through 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. Many chronic conditions can be prevented or reduced through modifiable lifestyle factors, early prevention practices, and early detection programs.

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.

Smoking Prevalence

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

Reported smoking rates of current smokers, 1999 to 2003					
	1999	2000	2001	2002	2003
PEI	26%	26%	26%	23%	21%
Canada	25%	24%	22%	21%	21%

Source: Canadian Tobacco Use Monitoring Survey, Household Component, 1999-2003

Reported smoking rates of current and former smokers, 2003		
	current smokers	former smokers
PEI	21%	31%
Canada	21%	26%

Source: Canadian Tobacco Use Monitoring Survey, Household Component, 2003

- In 2003, 21 per cent of Islanders reported being current smokers, the same as the national average. The PEI rate of smoking continues to decrease, from 25.6 per cent reported in 2001 and 26 per cent in 2000.

- Men tend to be smokers more than women. Twenty-five per cent of Island men and 23 per cent of Canadian men were smokers, while the rate of female smokers was the same for Canadian and Island women, at 18 per cent. This was evident across all age groups.

- The majority of men and women age 25 and older are current smokers or have been a smoker at some point in their lives. Of those smoking, the majority have quit.

- The heaviest smokers are men age 25 and older, who smoke on average 19.5 cigarettes a day.

Reported Teen Smoking
The addictive nature of nicotine means that youth smoking is of particular concern. It is estimated that 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, women in this age group have higher smoking rates than men.

Fitness and Nutrition

Reported Physical Activity
Maintaining physical activity is associated with a range of health benefits. For example, many studies have shown that regular physical activity has major heart health benefits, that inactivity is a major risk factor for heart disease, and that physically active individuals are less likely to become depressed.

Physical activity rates are based on information that survey respondents provided about the frequency, duration, and intensity of their participation in leisure-time physical activity over the previous three months. The following table reports the percentage of the population aged 12 and over who reported at the time of the survey a physical activity index of ***"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

- The total PEI rate for "active" was significantly lower than the Canadian rate, and the total PEI "inactive" rate was significantly higher.

- Overall, activity rates have increased, and inactivity rates have decreased, between 2000/01 and 2003.

- In Canada and PEI, both men and women in the 12-19 age group reported the highest rate for being "active".

- In both PEI and Canada, the "inactive" rates increase with age, except for the male age group 65 years and over. This group actually dropped below the "inactive" rates of younger men aged 35 to 64 years.

Reported Body Mass Index (BMI)

Obesity has been identified as a major risk factor contributing to a number of chronic illnesses such as diabetes and heart disease. The effect of excess weight as a risk factor increases with a Body Mass Index (BMI) above the threshold of 25. Body Mass Index is the most common method of determining if an individual's weight is in a healthy range.

Body mass index is based on self-reported height and weight, and calculated as: weight in kilograms divided by height in meters squared. This indicator reports the percentage of the population aged 18 years and over (excluding pregnant women) who reported a body mass index in specified categories, ranging from underweight to obese.

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

- The PEI rate for "acceptable weight" was significantly lower than the Canadian rate. The PEI rates for "overweight" and "obese" were higher than the Canadian rates.

- Across the age groups, men tend to have higher rates of overweight and obesity. In Canada and PEI, women had higher rates in the acceptable weight category.

- In PEI, the age groups with the highest rates of overweight were the 45 to 64 years and 65 years and over age groups. In PEI, the age group with the highest rate of obesity was the 35 to 44 year age group.

Fruit and Vegetable Consumption

Poor dietary habits are linked to some major causes of death, including cancer and coronary heart disease. Five servings of fruit and vegetables per day is the minimum required by the Canada Food Guide. The following table reports the proportion of the population age 12 and older who report consuming fruits and vegetables less than five times a day, and those who report consuming fruit and vegetables five or more times a day in 2003.

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

- Well over half of Islanders, 63.5 per cent of our population 12 years and older, do not eat enough fruit and vegetables. While the rate of Islanders not eating enough fruits and vegetables has decreased since 2001, so has the proportion of the population who consumes fruit and vegetables five or more times per day.

- Islanders age 65 and over have the lowest proportion who do not eat enough fruit and vegetables, and the highest proportion who do eat enough fruit and vegetables.

- Since 2001, the proportion of Islanders in the 12 to 19 age group appear to have made the greatest adjustments in their eating habits: the proportion in this age group who eat less than five servings of fruit and vegetables per day decreased from 71 per cent in 2001 to 60 per cent in 2003, and the proportion who eat five or more servings a day increased from 26 to 31 per cent. In all other age groups, the proportion who ate less than five servings a day remained the same or increased, and the proportion who ate five or more servings a day decreased.

- In all age groups, people who eat enough fruit and vegetables are in the minority.

Early Prevention

Influenza Immunization 65+
Immunization for influenza has been shown to be effective for adults over 65 years of age in preventing the flu.

The following table reports on the percentage of the population 65 years of age and over who reported having a flu shot in the previous 12 months.

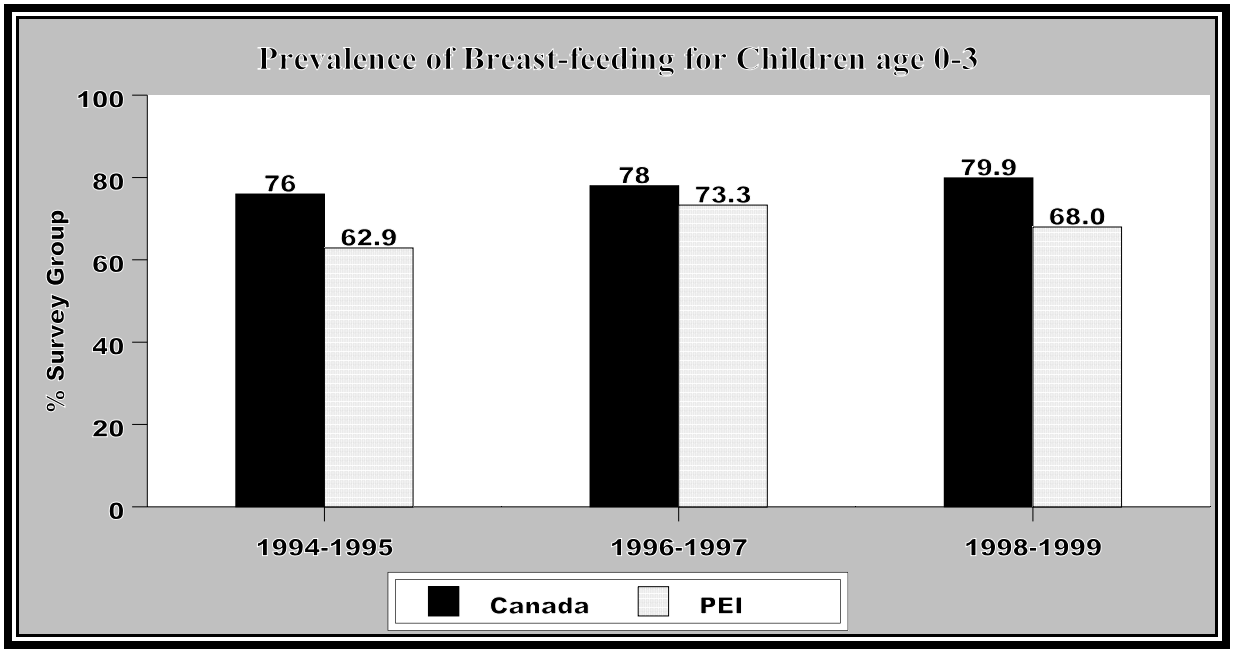
Reported influenza immunization rates, 65+, 2003		
	2000/01	2003
PEI	62.9%	57.8%
Canada	63.0%	62.4%

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

- More than half of Islanders age 65 and older reported being immunized for influenza in 2001 and 2003.
- The PEI rate was similar to the Canadian rate.
- Women reported receiving the flu shot more than men.

Breast-feeding
Breast-feeding is an ideal source of nutrition for babies. Breast milk contains immunoglobulins and antibodies that fight infection and as a result, breast-fed babies have fewer childhood illnesses, including gastrointestinal and respiratory infections, asthma, eczema, and food allergies. Breast milk protects babies from other diseases such as *otitis media*, or middle ear infection. Some research shows that breast-fed children score higher on tests that measure cognitive development.

Prevalence of breast-feeding reports the proportion of children three years of age or younger who are currently or have ever been breast-fed.



Source: NLSCY, Cycles 1 (1994/95), 2 (1996/97) and 3 (1998/99); data from cycle 4 (2000/2001) is not yet available.

- The prevalence of breast-feeding reported among mothers surveyed in PEI was lower than the Canadian average for all three cycles.

- PEI reported the third lowest rate of breast-feeding of all provinces and territories in 1998/99.

However, while PEI numbers are relatively low compared to the Canadian average and most other provinces in Canada, the rate of mothers who are breast-feeding at the time of hospital discharge does indicate a steady increase of approximately two per cent per year. This data is being collected by the PEI Reproductive Care Program and is presented in the chart below.

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

Source: Reproductive Care Program, PEI

Readiness to Learn

These indicators provide information on how "ready" a child is to begin learning at school. The four indicators presented focus on the physical, emotional, and social well-being of children, as well as their language skills, based on data from the National Longitudinal Survey of Children and Youth.

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)

Motor and Social Development

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

- Thirteen per cent were rated as "delayed" in 1998/99 and 15 per cent in 2000/01, which is similar to the average rate for all children across Canada.

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, which is similar to the Canadian average of 14 per cent, and higher than the rate of advanced skills in 1998/99.

- Although the small sample size precluded formal publication of the percentage of PEI children with delayed PPVT-R in 2000/01, a rough per cent might be calculated as somewhere in the environs of 10 per cent. Although this must be interpreted with caution, the rough percentage suggests a rate of delayed PPVT-R lower than the Canadian average of 17 per cent.

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)

Emotional Problems / Anxiety

- Sixteen per cent of Island children between the ages of two and five exhibited high levels of emotional problems and/or anxiety, which is similar to the Canadian average of 18 per cent.

- The rate of children reported in 2000/01 with high emotional problems had increased since the 1998/99 cycle for both PEI and Canada.

- The rate of high emotional problems in Prince Edward Island children between the ages of two and five years of age is the third lowest among Canadian provinces. The lowest rate reported among provinces was 14 per cent.

Hyperactivity - Inattention

- Eleven per cent of Island children aged two to five exhibited high levels of hyperactivity and/or inattention.

- The 2000/01 rate for PEI was lower than the Canadian average of 15 per cent, and the rate had dropped by 3.3 per cent since 1998/99.

- For 2000/01, the young children from the PEI sample had the lowest rate of hyperactivity/inattention among Canadian provinces.

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 of 13 per cent.

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.*

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 of 90 per cent, and similar to rates reported in other provinces.

For the 2000/01 data, researchers at the NLSCY reorganized the way the data would be collected and calculated, using a new tool called Ages and Stages.

- Once again, a great majority of young children on PEI achieved satisfactory score on personal and social behaviour, above the cut off established by Ages and Stages.

- The 2000/01 survey of personal and social behaviour among PEI children indicates a higher rate of positive social and personal behaviour at 93 per cent than the national average of 84 per cent.

- The percentage of Prince Edward Island children demonstrating the positive personal and social behaviour measured here is the highest rate in Canada for 2000/01.

Early Detection

Pap Screening Rates

More than 90 per cent of cervical cancer can be prevented by regular screening with the Pap test. Pap screening rates reflect the percentage of women between 20 and 69 who have participated in a pap screening within a defined period of time.

The PEI Pap Screening Program was established in 2001 to reduce the incidence of, and mortality from, cervical cancer among Island women; to increase accessibility to the service; and to increase the number of women screened.

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

- Each year, approximately 40 per cent of Island women between the ages of 20 and 69 are screened with a Pap. This rate increases to 65 per cent over a three year period.

- 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 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

The most frequently diagnosed cancer for women in Canada continues to be breast cancer, with an estimated 21,200 new cases in 2004[1]. However, mortality rates have declined steadily, from an estimated 32 per cent in 1986 to 25 per cent in 2004. The decline is believed to be due to the benefits of breast cancer screening programs and improved treatments. The breast screening makes early detection of breast cancer available to Island women.

Breast screening numbers and cancer detection rates, 2002 and 2003		
	2002	2003
Number of women screened	8,440	8,271
Rate of cancers detected (per 1,000 screens)	4	7

Source: Mammography Department, QEH and PCH, 2004

- During the years 2002 and 2003, 16,711 women participated in breast screening at the Queen Elizabeth Hospital and Prince County Hospital.

- Fifteen percent of all client visits were women being screened for the first time; 85 per cent had participated in breast screening before and were returning for a subsequent screen.

- The majority of women being screened on PEI are in the target age group: women age 50 to 69.

- At the QEH, the number of women participating for the first time in the screening program decreased with time, while the number of women going for a rescreen increased from 2001 to 2002, and remained steady in 2003.

- The rate of cancer detections has increased to a rate of seven detections per 1000 women screened. This indicates screening has become more sensitive with time, also evident in the fact that almost half (46 per cent) of all newly detected breast cancers at the QEH in 2003 were detected through breast screening, and not because the individuals had symptoms and therefore required a mammogram as a diagnostic procedure. Furthermore, 98 per cent of the screen detected breast cancers were stage 0 or stage 1. There are four stages of breast cancer, stage 0 and 1, where the cancer is contained, and stage 3 and 4 where the cancer has the potential to be more aggressive.

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

The Canadian Community Health Survey offers another source of data for participation in breast screening. These participation rates are based on self-report and tend to be less accurate than the findings from the Breast Screening Programs. However, the CCHS data does allow for comparison to the Canadian average.

- In 2003, 49.3 per cent of Island women between the ages of 50 and 69 reported they received a routine screening mammogram within the last two years. This rate was similar to the Canadian average of 49.1 per cent.

Goal #3:
Improve Sustainability of the System

Several factors are placing increasing pressure on the health and social service system to maintain access, quality, and client satisfaction. These factors include increased demand for new and existing services, rising costs, a declining supply of health professionals, the need to make capital investments in health facilities, and public pressure to make costly new technologies available close to home. We can measure success at improving sustainability by looking at changes in health and social services expenditures, health professionals as a proportion of the population served, and client satisfaction with services.

Health and Social Services Expenditures

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

Source: PEI Department of Health and Social Services, Finance and Administration, 2004

- In 2003/04, total provincial government spending on health and social services was $428.2 million. There was a 39.6 million (10.7 per cent) increase in the health and social services' total system spending from 2001/02 to 2002/03 and an $18 million (4.4 per cent) increase from 2002/03 to 2003/04.

Health and Social Services Costs Per Capita

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

Source: PEI Department of Health and Social Services, Finance and Administration, 2004

- In 2003/04, the average cost per capita for provincial government spending for health and social services on PEI was $3,108, based on a population of 137,781. Approximately three quarters of that cost is related to health care. The total per capita cost increase was $285 (10.5 per cent) from 2001/02 to 2002/03 and $113 (3.8 per cent) from 2002/03 to 2003/04.

Health Professionals

Monitoring the number of health professionals in a population is one indicator of how adequately the population is being served. This indicator is reported as the number of health professional per 100,000 population for 2002.

Health professionals, rate per 100,000 population: 2002		
	Canada	PEI
registered nurses	734	921
licensed practical nurses	191	423
general practitioners / family physicians	96	85
specialist physicians	93	51
pharmacists	84	98
dentists	57	44
physiotherapists	48	38
occupational therapists	31	27
dental hygienists	51	31
chiropractors	20	6
optometrists	11	10
dietitians	23	42

Source: CIHI Health Indicators 2004

- In 2002, PEI had a rate above the national average for registered nurses, licenced practical nurses, pharmacists and dietitians. In fact, the rate of licenced practical nurses in PEI was twice the national average.

- PEI had a rate below the national average for other health professionals, such as physicians, dentists, psychologists, dental hygienists, and optometrists. It is important to note that Islanders go out of province to receive some services from, for example, medical specialists. Therefore, even though number of these health professionals is lower in PEI, Islanders still have access to the services.

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, such as home nursing care, home-based counseling or therapy, personal care, community walk-in clinics. Physicians included family doctors and medical specialists, but excluded services received in a hospital.

The indicators in the table report on the percent of survey respondents, age15 and over, who rated themselves as either "satisfied" or "somewhat satisfied" with the way these 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

- For all services (overall health care services, community-based services, hospital care and physician care) the PEI rates were similar to the Canadian rates.
- 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. 89 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 _____

The delivery of sustainable quality services is largely dependent on a healthy skilled workforce, recruitment, retention, and employee wellness. To achieve this, the health and social services system works to promote a culture of wellness and learning that values personal responsibility, positive personal health practices, safe and positive workplaces, ongoing education, leadership development, and respect and recognition for the contribution employees make to the health and well being of Islanders.

Employee Assistance Program Utilization

The Employee Assistance Program (EAP) aims to contribute to the total health of employees and a productive and satisfied workforce. It provides confidential counseling to employees and group sessions focused on wellness programming in the worksite. EAP confidential counseling utilization rates give an indication of the number of employees with health needs and the willingness of employees to seek the supports they need to ensure their own wellness. This indicator reports on confidential counseling data and is reported as: a) the number of employees in the health regions who use EAP services by year and; b) the breakdown of those who use EAP by age group and years of service. EAP data is available for the whole civil service, but not for the individual departments. Therefore, only the employees of the health regions, and not the employees of the department, are included in the numbers below.

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. About 6 per cent more health region employees used the services of the EAP in 2003/04 than in the previous year.

- For 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 indicated that their problem impacted 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.

- With regard to years of service, those who had worked for 10 to 19 years had the highest participation rate in the EAP program. As well, the 36 to 45 age group used EAP almost twice as much as the 46 to 55 group.

Recruitment and Retention

Physician Recruitment Success

All provinces are experiencing physician shortages, both in family medicine and in specialty areas. Vacancies in the physician complement, regardless of whether they are in family medicine or one of the specialties, impact on services to the general public. Recruitment is an on-going process and there will always be vacancies within the physician complement, whether they are caused by retirement or physicians choosing to leave the system.

Recruitment success reflects the number of positions filled in a given year and serves as a useful indicator to monitor the success of recruitment efforts. Physician complement is the total number of allowable positions for physicians in PEI. The following table reports the number of physician complement positions compared to the number of filled positions for 2003 and 2004.

Physician complement and filled positions, PEI: 2002 and 2004

	as of March 2002		as of March 2004	
Physician practice area	**complement**	**filled***	**complement**	**filled***
Family Practice	75	72.8	80.6	75.6
Specialists	96.1	85.5	111	104.4
TOTALS	171.1	158.3	191.6	180

** Filled positions reflect a full-time equivalent based on both permanent and locum positions.*

Source: PEI Department of Health and Social Services, Medical Programs, 2004

- The physician complement on PEI increased by more than 20 positions since 2002, from 171.1 positions in 2002, to 187.2 positions in 2003 and 191.6 positions in 2004.

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

- More physicians are working on PEI than in 2002 - the number of physicians has increased from 158.3 in 2002 to 180 in 2004. The percentage of positions filled has increased to 94 per cent in 2004. Some of the remaining positions are new, and recruitment is on-going.

- PEI has achieved complement 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, medical oncology and plastic surgery physicians remain below complement.

Nurse Recruitment Success

Registered nurses comprise the largest group of health care providers. Maintaining an adequate supply of nurses involves attracting new nurses and retaining existing nurses. The PEI Nursing Recruitment and Retention Strategy includes several initiatives to a) attract nurses by creating new positions and sponsoring Bachelors of Nursing students, and b) retain nurses through initiatives such as cost assistance to RNs who take refresher courses.

PEI Nursing Recruitment and Retention Strategy		
	2002/03	2003/04
number of student sponsorships (for 3rd and 4th year)	78	127
number of RNs who received relocation funding	30	22
number of RNs receiving Refresher Program Cost Assistance	2	2

Source: Department of Health and Social Services, PEI Nursing and Retention Strategy, 2004

- The PEI Nursing Recruitment and Retention Strategy has helped to relocate 52 nurses to our province.

- Over the past two years, the strategy has sponsored 205 nursing students, a significant number, because sponsored students are required to work in the PEI health system after graduation.

- The province has also sponsored three students in the Radiation Therapy course and two for 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 Protection Act
Child Care Facilities 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 *Child Protection Act* and the *Act to Amend the Child Protection Act* were proclaimed on April 2003, effective May 10, 2003. This legislation replaced and repealed the former *Family and Child Services Act*, with the focus now on protective issues and children in need of protection.

- The *Smoke-free Places Act* and *An Act to Amend the Smoke-free Places Act* came into force on June 1, 2003. This legislation aims to reduce the exposure of workers and members of the public to second hand smoke by prohibiting or restricting smoking in public places and workplaces.

- The amalgamated Kings Health Region and the new Provincial Health Services Authority are added to Schedule C of the *Financial Administration Act* as reporting entities in June 2003.

- The *Chiropractic Act* was proclaimed in July 2003, effective August 31, 2003. This is updated legislation, replacing and repealing an earlier act of the same name.

- The *Social Assistance Act* was proclaimed on July 22, 2003 repealing the former *Welfare Assistance Act*.

- Sections 15, 20 and 21 of the *Licensed Practical Nurses Act* were proclaimed in October 2003 (these sections had been withheld from the earlier proclamation of the remainder of the Act). The sections concern title protection and enforcement of offences under the act.

- *An Act to Amend the Pharmacy Act* was proclaimed upon assent December 16, 2003. These changes redefine "prescription", define the drug schedules as per the National Drug Scheduling System, add a language proficiency requirement, and provide that the minister may authorize persons to give prescriptions.

- *An Act to Amend the Public Health Act* was proclaimed upon assent December 16, 2003. The amendments clarify the process whereby the chief health officer issues quarantine orders, and provides a mechanism for court review of quarantine orders, as well as adding regulation making powers concerning slaughterhouses and other buildings where food for human consumption is prepared.

- The *Denturist Act* was proclaimed, effective March 5, 2003. This is the first legislation for denturists in PEI.

Regulations:

- The Notice of Hearing Regulations and the Transitional Provisions Regulations under the *Family and Child Services Act* were approved for revocation in May 2003.

- The regulations under the *Smoke-free Places Act* were approved and enacted in June 2003.

- Amendments to the regulations under the *Welfare Assistance Act* in June 2003 included changes in the healthy child allowance, child disability benefit and exemption rate adjustments.

- New regulations under the *Social Assistance Act* were approved and enacted in July 2003.

- New regulations were approved in October 2003 and came into force November 1, 2003, replacing and revoking the former Authorization regulations under the *Physiotherapy Act*.

Appendix A
Financial Statements

Major Programs As A Percentage of Total Budget

		2001/02	2002/03	2003/04
Health Care				
	Hospital Services	31.2	31.4	31.6
	Physician Services	11.1	12.2	12.7
	Blood Services	1.0	1.1	1.4
	Ambulance Services	1.0	0.9	1.0
	Home Care	1.8	1.7	1.9
	Continuing Care	10.1	9.8	10.4
	Provincial Pharmacy	4.3	4.2	4.3
	Mental Health	3.3	3.0	3.3
	Public Health Nursing	0.7	0.7	0.8
	Addiction Services	1.6	1.5	1.5
	Dental Public Health	0.6	0.6	0.6
	East Prince Health Facility	5.4	4.1	1.7
	Other Programs	7.2	8.9	8.8
	Total Health Care	**79.3**	**80.1**	**80.0**
Social Services				
	Child & Family Services	16.0	15.6	15.7
	Job Creation	0.6	0.5	0.6
	Social Housing	2.4	2.2	2.1
	Grants - Non Gov't Organizations	1.7	1.6	1.6
	Total Social Services	**20.7**	**19.9**	**20.0**
Total Health & Social Services		**100.0**	**100.0**	**100.0**

Appendix B
Budget Forecast

Budget Estimate

	2003/04
Department of Health and Social Services	
Gross Expenditure	428319300
Gross Revenue	22491100
Net Ministry Expenditure	**$ 405,828,200**