MINISTRY OF HEALTH PLANNING

A NEW ERA UPDATE

BRITISH COLUMBIA
Ministry of Health Planning

2001/02
ANNUAL
REPORT

National Library of Canada Cataloguing in Publication Data
British Columbia. Ministry of Health Planning.
Annual report. – 2001/02-

Annual.
"A new era update."
Report year ends Mar. 31.
Continues in part: British Columbia. Ministry of Health and Ministry Responsible for Seniors. ISSN 1499-0350
ISSN 1703-4477 = Annual report - British Columbia. Ministry of Health Planning

1. British Columbia. Ministry of Health Planning - Periodicals. 2. Health planning – British Columbia – Management – Periodicals. 3. Health promotion - British Columbia – Periodicals. 4. Medical policy - British Columbia – Periodicals. I. Title. II. Title: Ministry of Health Planning annual report.

RA185.B7B74 353.6'09711'05 C2002-960151-7

For more information on the British Columbia Ministry of Health Planning, contact:

Communications Branch
PO BOX 9050 Stn Prov Govt
Victoria, BC V8W 9E2
Telephone 250 952-3456

or visit the B.C. Government's Web site at www.gov.bc.ca

Published by the Ministry of Health Planning

INTRODUCTORY NOTE – A YEAR IN TRANSITION

The Government of British Columbia and its ministries are committed to reporting on performance. The *Budget Transparency and Accountability Act* (BTAA), as amended in August 2001, provides the legislative framework for a regular cycle of planning, reporting and accountability. Under the BTAA, ministries are responsible for producing three-year service plans (previously called performance plans), which are updated yearly, and annual service plan reports (formerly called performance reports). The amended BTAA takes effect beginning with the 2002/03 fiscal year. The first three-year service plans, covering the period 2002/03 to 2004/05, were released with the provincial budget on February 19, 2002.

This annual report relates to the previous fiscal year, covering April 1, 2001, to March 31, 2002. This was a transition year, with a new government sworn into office on June 5, 2001. On that day, there was an extensive reorganization of ministries, which were given significant new policy direction and tasked with the responsibility for implementing the government's *New Era* commitments. Later in the year, ministries proceeded through the core services review, which refined the mandates of ministries and identified the strategic shifts required to move government toward its long-term objectives.

This report provides an update on all that activity and also provides a report on performance, approaching the model provided by the BTAA as closely as is possible in the circumstances. An annual report would normally relate back to a preceding plan and report on the results achieved compared with the intentions outlined in that plan. In this case, the preceding plan was produced before the adoption of the significant changes outlined above, and as noted, this ministry has been significantly reorganized, and policies and priorities have changed. This limits the extent to which performance information as described in the previous plan is useful.

Consequently, this report sets out the ministry's redefined role and the services it provides, and — within the context of its goals and objectives as they evolved through the year — describes the achievements of the ministry and the performance targets being used to measure success.

ACCOUNTABILITY STATEMENT

The 2001/02 Ministry of Health Planning Annual Report was prepared under my direction, and I am accountable for the results the ministry achieved since June 5, 2001. This report describes progress made in this first year on the government's *New Era* commitments, which are to be addressed by May 17, 2005.

Honourable Sindi Hawkins
Minister of Health Planning
June 28, 2002

MESSAGE FROM THE MINISTER OF HEALTH PLANNING

I am pleased to present the 2001/02 Annual Report: A New Era Update for the Ministry of Health Planning.

Our government created the Ministry of Health Planning in June 2001 to focus on long-term planning to save and renew our public health care system. In less than a year, the ministry has taken significant steps to address challenges facing B.C.'s health system and to move from an uncoordinated, fragmented system to one that is patient-centred, sustainable and accountable to the public.

We are working closely with health care providers and other partners to act on their ideas for maximizing the value of every health care dollar spent. Last year, the Premier hosted a Dialogue on Health with 140 health professionals, administrators, and other experts to identify new solutions to improve health care. As well, the Legislature's Select Standing Committee on Health held hearings in 10 communities and received 700 submissions from across the province, which were incorporated in its December 2001 report on renewal and reform of health care.

Across Canada, many provinces are facing the challenges of a health care system in need of change. Innovative studies addressing these issues include the Mazankowski Report in Alberta, the Fyke Report in Saskatchewan and the Clair Report in Quebec. The federal government has also initiated the Romanow Commission and the Senate Standing Committee on Health, Science and Technology to evaluate the status of health care in Canada.

Clearly, it is time to move from analysis to action. The ministry set to work immediately planning long-term strategies for health human resources, health infrastructure, information technology, and rural and remote health initiatives.

In December 2001, the Ministry of Health Planning announced an improved governance model that streamlined and reduced the number of health authorities from 52 to six. This has resulted in reduced duplication of services and increased efficiency, and has provided the health authorities with the ability to redirect resources to patient care. The new health authorities have now established three-year health service redesign plans to reform and renew health services for patients in each region. Three-year rolling funding commitments were provided in the budget in 2002 to enable the health authorities to plan ahead and provide the health services that their communities need most.

The Ministry of Health Planning, together with the Ministry of Health Services, also established provincial access standards and guidelines for emergency, acute care and specialty services. These standards and guidelines will ensure patients in every part of the province have access to equitable, high quality health services. Performance agreements were developed to hold health

authorities accountable for delivering quality care. The agreements define expectations and deliverables for patient care in B.C., and the health authorities are expected to meet these targets.

We are also working with health authorities to implement Primary Health Care Renewal that will improve access to primary care services, patient satisfaction and health outcomes. This new model coordinates the services of doctors, nurses and other health care providers to meet patients' unique needs. Over the long-term, Primary Care Health Renewal will enhance access to assessment, treatment and ongoing care.

Other accomplishments this year include implementing a $21-million Nursing Strategy. This strategy is part of the ministry's long-term health human resources plan to provide support and education for nurses, and to improve workplace conditions. Initiatives include training for nurses in rural and remote areas of B.C., specialty certification training, $15 million for the purchase of hospital beds and patient lifts, bursaries for nurses to return to the health system, and funding to help foreign-educated nurses enter the nursing profession in B.C.

The ministry also hired B.C.'s first Chief Nurse Executive in September 2001 to provide leadership and advice on issues related to nursing. The Nursing Strategy is vital for educating, recruiting and retaining the nurses we need to ensure high quality health services for British Columbians.

Our vision for B.C.'s health care system is the provision of high quality public health care services that meet patients' needs, where they live and when they need them. We believe that we can achieve our vision by working with our health care partners to address the challenges we face and develop innovative solutions for building a better health care system for the future.

Honourable Sindi Hawkins
Minister of Health Planning

MESSAGE FROM THE DEPUTY MINISTER

I am pleased to present the 2001/02 Annual Report of the Ministry of Health Planning. The past fiscal year has been a year of transition - and a year of facing challenges, developing innovative solutions, and creating a new vision for B.C.'s health care system. Our health care system faces challenges on a number of fronts, and these are not unique to British Columbia. These include addressing critical skills shortages and staffing levels of health professionals, cost pressures on our health care system, and the increasing demand for health services due to a growing and ageing population. These challenges are being felt in communities and provinces across Canada.

To address these challenges, the former Ministry of Health was reorganized, and a new ministry focusing on health planning was created. The Ministry of Health Planning and the Ministry of Health Services are now working closely on innovative ways to build a sustainable health system for the future. The number of health authorities has been reduced, from 52 to six, to achieve greater efficiency so resources can be redirected to patients. These newly created health authorities have now established three-year health service plans to reform and renew patient services for each region. As well, performance agreements have been established to ensure health authorities are accountable for fulfilling their duties and providing patient care that meets British Columbians' needs. This fundamental restructuring has allowed the creation of organizational structures, which enable us to work closely together with the health authorities to plan the much needed change in our health care system.

As you will see from this report, along with these significant structural changes, there has been an enormous amount of work done and goals accomplished during this year of transition. Our achievements have been focused on the need to ensure all citizens in every part of the province have access to high quality health services across the continuum of care. In addition, we are building a comprehensive culture of accountability for the work we do in government and the work done by our colleagues in the health sector.

Our achievements are due in a large part to the dedication, commitment, and extraordinary contributions of our staff, health authorities and health care partners. Our progress to date has already positioned us to better meet the needs of our citizens in the area of health care.

Penny Ballem, MD
Deputy Minister

TABLE OF CONTENTS

YEAR-AT-A-GLANCE HIGHLIGHTS

SETTING THE CONTEXT FOR CHANGE

2001/02 was a year that signalled the beginning of a new era in the management of B.C.'s public health care system. The stage was set for sweeping changes required to renew the system, and to help British Columbians in their efforts to maintain and improve their health.

Those changes are affecting the way services are delivered in a very real way. It is important for British Columbians to understand reasons for the changes they see taking place in their communities.

In the recent past, our health system has been under constant pressure to treat more people, expand services and increase wages to service providers. New technology, drugs and surgical procedures bring the promise of better health outcomes and fuel increased public demand for services. The government provided more than $1 billion in new funding to the provincial health budget in 2001/02, and yet, there seems to be unlimited demand for more.

British Columbians are asking, "if we're having trouble meeting demands now, how will we afford health care in the future?"

In fact, the problems we face today are not new, and British Columbia is not alone in this struggle. In 2001, the federal government announced a national commission on the future of health care in Canada, headed by Roy Romanow. The commission will make recommendations on how to sustain a publicly funded health system that balances investments in prevention and health maintenance with those directed to care and treatment.

The Romanow Commission is not the first of its kind. Governments have been searching for solutions through a series of health care reviews including: Alberta's Mazankowski Commission, Saskatchewan's Fyke Commission, Quebec's Clair Commission and the federal Kirby Commission.

In British Columbia in 2001, two comprehensive provincial reviews were undertaken, which helped provide the framework for change. The first of these, the Fiscal Review, examined the province's finances. The second, called the Core Services Review, examined all government programs and services.

Throughout the year, consultations on the health system were held. The Premier's Dialogue on Health was a forum which brought together 140 health care professionals, administrators, patients, community leaders, union representatives, other experts from across British Columbia and Canada, and members of Cabinet, to identify solutions for saving and renewing public health care and protecting patient care. The Legislative Assembly Select Standing Committee on Health received 700 submissions and held hearings around the province to involve the public in the discussion.

These reviews and consultations confirmed that B.C.'s health care system is facing a wide array of challenges to its long-term sustainability. Three key issues were identified: growing demands on publicly funded services, structural barriers which impact patient care, and a need for better planning and stronger accountability to patients and taxpayers.

Demands on B.C.'s Publicly Funded Services

British Columbians are among the healthiest people in the world, with relatively high life expectancies – 76.5 years for men and 81.4 years for women. However, as our population ages and grows, it uses health services at increasingly higher rates.

The 'demand' drivers for health services are:

- Population growth
- An aging population
- New technology and drugs
- The patterns of disease

Generally, annual population growth in B.C. is in the range of one per cent, however growth in the 80- to 85-year age group has exceeded six per cent in recent years. Changing demographics will continue to have significant implications for the system, particularly as our baby boomers age.

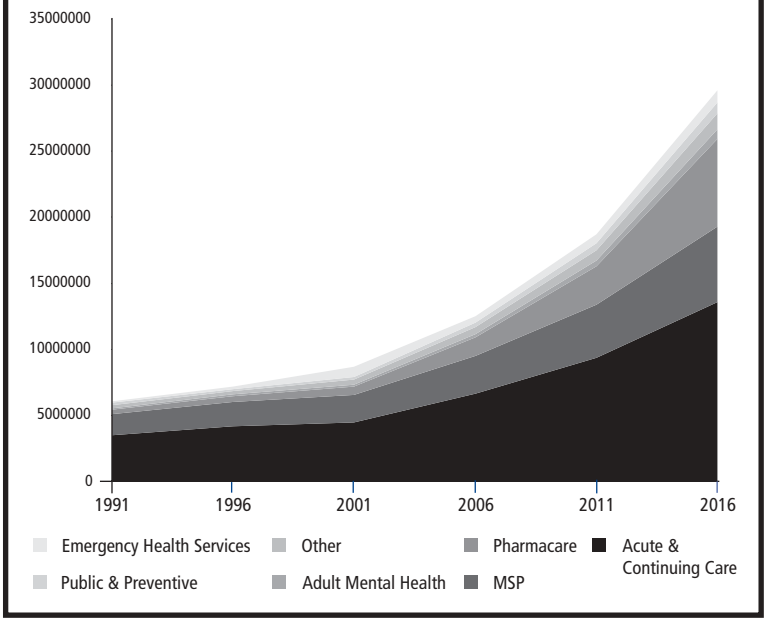
Public expectations are also rising, along with the availability of new technologies and advancements in medical procedures. In many cases, those new technologies allow more services to be delivered safely to more patients. For example, the coronary by-pass surgery rate for seniors has risen 51 per cent in the last 10 years, in part because improvements in this type of surgery have allowed a wider range of patients to benefit from it. New developments in treatments, drugs and diagnostic procedures are typically expensive, and are hitting the market with increasing regularity. The budget for cancer drugs has increased by almost 250 per cent in the last six years. The challenge is to ensure the public system makes the best use of technology, based on patient need and the best evidence about the impact of the technology on patient outcomes.

B.C.'s health care professionals and support workers are among the highest paid in the country. The worldwide shortages of health care professionals will continue to exert pressure on the system. Labour accounts for approximately 80 per cent of health care costs for services delivered in hospitals and through community programs.

Health care costs in B.C. have been growing three times faster than the growth rate of the economy. Pharmacare costs have been rising at a rate of roughly 15 per cent per year in recent years.

The graph shows where the province's health care costs would have been headed without change. B.C.'s health care system, if left to expand according to historical experience and demographic trends, would

B.C. MINISTRY OF HEALTH ACTUAL & PROJECTED EXPENDITURES BY PROGRAM, IN YEAR 2001



have increased at a rate of approximately 6.5 per cent per year.

Structural Barriers

A number of structural barriers must be eliminated and business arrangements improved to support high quality, sustainable patient care.

Emergency wards in acute care hospitals are the safety net for the system but are frequently used where less expensive care could be provided. Services delivered through hospitals are among the most expensive in the system, and are not always the most appropriate care for patients. Prevention initiatives and alternative community services such as hospice have traditionally had difficulty competing with demand for immediate cures. This means missed opportunities for breaking the cycle of over-reliance on hospital care.

Health care professionals require improved access to **patient information** as patients move through different parts of the system. Poor information can lead to gaps, duplication and variation in quality of services provided.

As well, **traditional methods of compensation** may not encourage the most effective system of care. For example, the fee-for-service system for physicians emphasizes the volume of services rather than continuity of care. The ministries are working with physicians to identify better alternatives.

Health authorities provide many of the services British Columbians think of when considering health care: acute care, residential care, mental health and public health services. Previously, 52 independent health authorities provided those services to British Columbians. The result was a cumbersome and inflexible system, difficult to manage, with overlapping responsibilities and minimal accountability to the public. Many regions were simply too small, lacking a sufficient population base to provide a broad range of quality services.

In addition to these structural barriers, **federal contributions** to health spending in B.C. fell significantly behind the increased costs of health care borne by the province.

Need for Better Planning and Accountability

At the provincial level, there was insufficient focus on the critical functions of long-term strategic human resource planning and long-term planning for capital facilities and information technology needs. There was too much emphasis on dollars spent and too little attention paid to whether particular expenditures improved patient care. As well, the accountability relationship between health authorities and government was weak.

Recognizing the problems in such a large and complex system was an important first step towards improving it. The next step was to plan new approaches and start implementing them. The following sections highlight the changes and accomplishments of the past year.

RENEWING HEALTH CARE—A YEAR OF CHANGE

New Roles and Mandates

One of the first tasks to achieve change was to restructure the system—to build a framework to guide and support the envisioned renewal and sustainability of the system.

In June 2001, the former Ministry of Health and Ministry Responsible for Seniors was restructured into two ministries—the Ministry of Health Planning and the Ministry of Health Services—to reflect the priority government places on a planned and accountable system. While both ministries provide overall leadership and direction for the health system, the Ministry of Health Planning was created specifically to address long-term planning for health services.

The Ministry of Health Services is responsible for implementing performance expectations and monitoring results for health authorities, and planning and administering the Medical Services Plan, Pharmacare and the Ambulance Service.

In December 2001, health authorities were reduced from 52 to six, setting the stage for a consolidation of services and the establishment of provincial accountability mechanisms. This includes service standards and performance agreements to be implemented in the 2002/03 fiscal year.

The breakdown of the ministries' and health authorities' mandates and functions is as follows:

Ministry of Health Planning

Mandate to develop and articulate expectations of health system performance and monitor the health of British Columbians.

Functions:

- Report on population health and respond
- Plan
- Develop legislation, policy, standards and other performance management tools

Ministry of Health Services

Mandate to fund, monitor and evaluate health system performance against clearly stated expectations.

Functions:

- Fund and direct health authorities
- Monitor and evaluate health authority performance and respond
- Operate Pharmacare and Medical Services Plan
- Provide emergency services (B.C. Ambulance Service)

Health Authorities

Mandate to effectively and efficiently manage and deliver a range of health services, including acute and hospital care, home and community care, mental health, addictions and public health services.

Functions:

- Deliver and manage patient services
- Develop and report on patient and management outcomes
- Facilitate community input

MINISTRY RESTRUCTURING – REFOCUSING ON PRIORITIES

In January 2002, the Ministry of Health Planning and the Ministry of Health Services announced further structural changes to enable the ministries to refocus on setting overall policy and direction and monitoring performance.

The health planning ministry was created to provide a stronger focus on, and sustained effort toward, long-term planning for health services. There are three divisions under the new ministry structure. The Strategic Change Initiatives Division oversees specific projects designed to improve service quality, access and efficiency—for example, specific primary care projects planned for implementation in 2002/03. The Planning, Policy and Legislation Division works with health care partners in developing long-term plans, standards and a broad accountability framework for the health system. Responsibility for the health and wellness function was realigned with the Office of the Provincial Health Officer and transferred to the Ministry of Health Planning to renew efforts for developing strategies for disease prevention.

The health services ministry was restructured to align its organization with its new mandate, and established review and planning processes for devolving most remaining direct care services to health authorities. For example, Addictions Services will be transferred to the health authorities in 2002/03. The many divisions and programs in the ministry were reconfigured to support core business functions. Some offices were consolidated and some lower priority services were discontinued. The operational functions of Pharmacare and the Medical Services Plan were transferred to the Corporate Services and Financial Accountability Division, while the policy responsibilities were transferred to the newly created Medical and Pharmaceutical Services Division.

These decisions are consistent with the provincial government's priority to target spending on maintaining the delivery of direct patient services. Overall, these strategic shifts will result in reductions of more than 40 per cent in some corporate and program management budgets for both health ministries. The associated savings will help fund patient care.

Health Authority Restructuring—Focusing on Patient Care

As part of its strategic planning role, the Ministry of Health Planning took on the difficult task of restructuring health authorities. The previous regional governance structure was the most complex in Canada. With 52 health authorities, it was difficult to manage and had lost its focus on patient care.

The large number of separate health regions set up artificial barriers. For example, Kelowna and Vernon share many resources such as an airport, university-college, TV station and even a phone book. But they did not share a health region, even though hundreds of people from Vernon are treated at Kelowna General Hospital.

To make operations more efficient and accountable to patients and government, 15 health service delivery areas were established to reflect natural patient referral patterns. Five governing authorities—responsible for planning and co-ordinating services across the 15 health delivery areas—were created. Dividing the province into five geographic health authorities provides enough of a population base and budget in each to offer a full range of services, and provides opportunities for economies of scale.

The ministry also established a Provincial Health Services Authority. This authority coordinates and delivers highly specialized services that can't be offered in all regions. It is also responsible for facilitating the coordination of provincial initiatives, which will improve access to care.

Changing the structure is only the first step. The ministry has also changed how health authorities are funded. Instead of funding for one year, health authorities receive three-year budgets so they can plan ahead. A new population-based funding model was also developed in 2001/02 for implementation in 2002/03. The model takes into account the characteristics of the regions' population and its associated health needs, with the aim of ensuring fairness and transparency.

In March 2002, the health planning minister announced the new community members of the Health Authority Boards. Members were chosen for their leadership skills, decision-making abilities and willingness to be accountable through performance agreements.

The final result is a new structure that is simplified, functional and highly accountable to patients and British Columbians.

New Structure for B.C.'s Health Care System

Leadership Council—Coordinating New Relationships

A Leadership Council was established, with representation from the Chief Executive Officers in health authorities and senior representatives from the health ministries. The council is chaired by the Deputy Minister and provides input on establishing strategies, direction and accountability frameworks.

Bill 29—A Major Tool for Change

In January 2002, the government introduced the *Health and Social Services Delivery Improvement Act* (Bill 29). The Act ensures health authorities have the flexibility to make decisions about services and staff in the best interest of patient care.

RENEWING HEALTH CARE–A YEAR OF CHANGE

National and Provincial Studies on Health Care Issues
(Seaton, Fyke, Clair, Mazankowski, Kirby, Romonow)

REVIEW IN BC

BC GOVERNMENT FISCAL REVIEW
(Comprehensive review of finances)

Premier's Dialogue on Health in Vancouver with professionals

BC Legislative Assembly Select Standing Committee consultations with public

CORE SERVICES REVIEW
(Comprehensive review of all ministry programs and services)

RESTRUCTURING

Creation of Health Planning and Health Services ministries (one to focus on planning: the other on management of operations)

Leadership Council to ensure common strategic approach

Streamlined Regional Health Authorities to focus resources on patient care

PLANNING & REPORTING

Ministry Service Plans with goals, strategies and clear performance measures and targets

Health Authority Performance Contracts to detail patient and management outcomes

Annual Service Plan Reports prepared by both ministries and health authorities showing their performance results

MINISTRY ROLE AND SERVICES

Vision

A health system that ensures high quality public health care services that meet patients' needs where they live and when they need them

WHAT IS THE ROLE OF THE MINISTRY OF HEALTH PLANNING?

Planning for a health system as large as B.C.'s is a complex and challenging task. This $10 billion system has approximately 7,700 physicians, 38,400 nurses (RN, RPN and LPN), 25,000 long-term care beds, and 140 hospitals serving 4 million people across the province. The day-to-day challenges of managing the health care system can focus all attention on immediate pressures. The government has responded with an increased emphasis on long-term planning as an essential element in the development of quality, timely and sustainable health services that meet the diverse needs of patients.

Mandate

The Ministry of Health Planning establishes expectations of health system performance and monitors the health of British Columbians.

The need to focus strong and sustained effort in the area of health planning is particularly important as the pace of change in health services increases. In Canada, we are beginning to see the emergence of services based on genetic technologies and we will need to work with scientists, administrators, providers and the federal government to determine which services should be provided and under what conditions. We see that health care professionals are interested in different types of work arrangements and working to their full abilities. We will have to develop long-term health human resource plans that address these interests.

We also see significant opportunities in the areas of prevention and promotion to reduce disease and disability. Planning the

Mission

To guide and enhance the province's health services in order to ensure British Columbians are supported in their efforts to maintain and improve their health

The priorities of both the Ministry of Health Planning and the Ministry of Health Services are to fulfill the government's New Era vision of saving and renewing public health care and providing high quality health services that meet patients' most essential needs.

system changes needed to shift our focus more fully toward prevention and promotion will be a challenge. We see new technologies developing in many areas such as prescription drugs, diagnostic technologies, and new procedures. We will have to identify the best of these and plan how we can make them available. And finally, we recognize that public concern around access, quality and sustainability demands thoughtful, well-planned responses that allow us to maintain the best of Canadian health care while moving forward in positive ways.

In recognition of the importance of long-term planning and management of the health system, in June 2001 the government created two health ministries: the Ministry of Health Services to direct day-to-day operations; and the Ministry of Health Planning to focus on long-term planning. Planning is a complex set of activities that requires the collaboration of many partners within the health care system. The new Ministry of Health Planning is tasked with leading this process.

The ministry has four major functions in its planning role:

- to assess the health of the British Columbian population and identify their health care needs now and into the future;
- to assess the system's capacity in meeting those needs both in terms of treating illnesses and keeping people healthy;
- to set priorities that focus limited resources on delivering quality patient care; and
- to translate health care needs into a set of directions that will guide operational management and delivery of health services. This set of directions, among other things, will address the issues of planning for health human resources, medical machinery and equipment, and introduction of new services and plans for the development of quality and access standards.

Values

Patient and Consumer Focus
Equity
Access
Effectiveness
Efficiency
Appropriateness
Safety

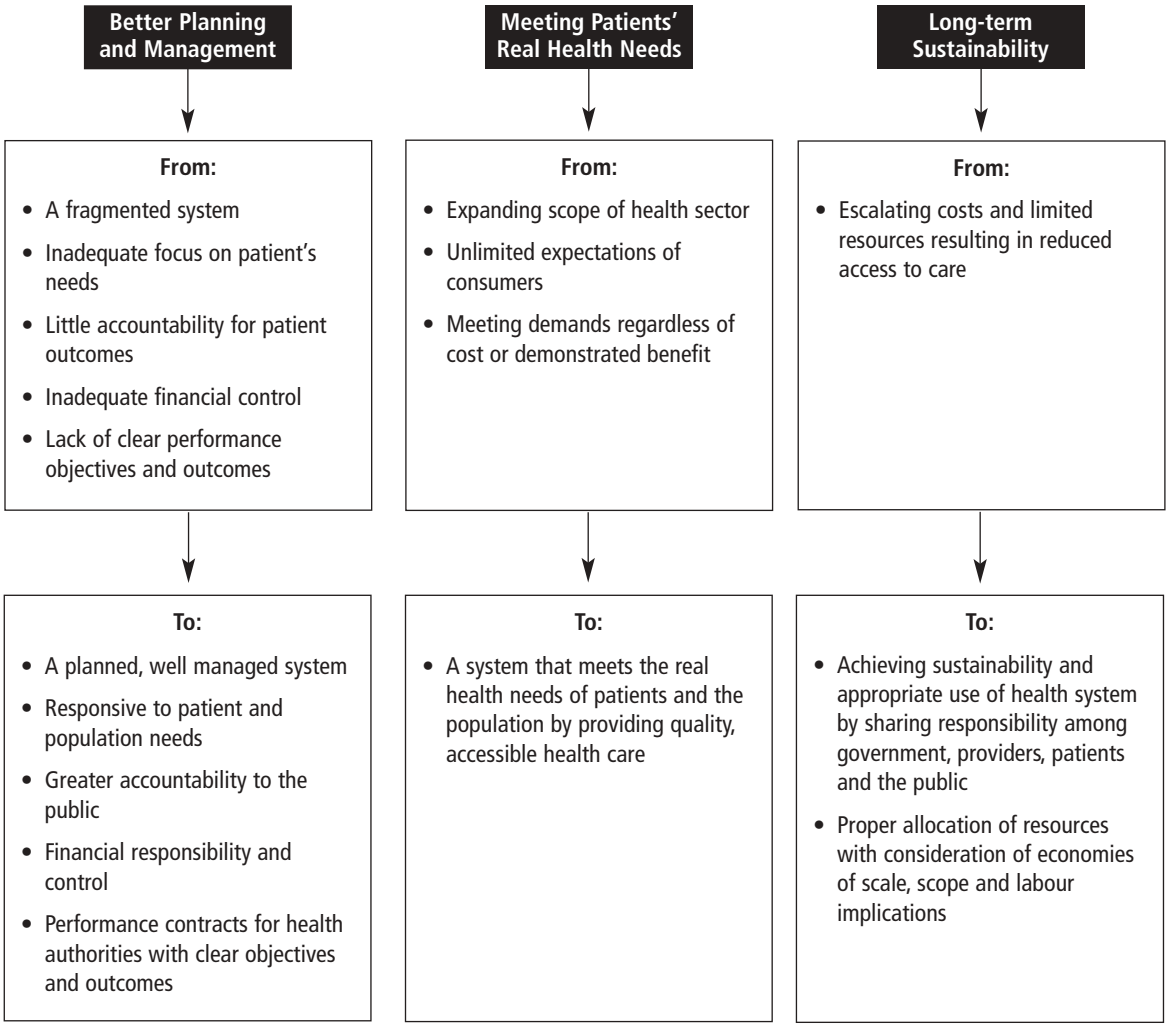
These values reflect our commitment to the five principles of the *Canada Health Act:* public administration, comprehensiveness, universality, portability, and accessibility.

These are not functions that are undertaken in isolation, but require careful consultation with health care partners in the Ministry of Health Services, health authorities, providers, and the public.

STRATEGIC SHIFTS

The provincial government has undertaken three major strategic shifts to ensure high quality patient-centred care, to build a sustainable public health system, and to enhance the health and wellness of British Columbians.

WHAT ARE THE STRATEGIC SHIFTS?



Core Business areas of the Ministry of Health Planning

The Ministry of Health Planning has three core business areas: Office of the Provincial Health Officer and Population Health and Wellness; Strategic Change Initiatives; and Planning, Policy and Legislation

Office of the Provincial Health Officer, and Population Health and Wellness

As detailed in the *Health Act*, the Provincial Health Officer provides independent advice to government on health issues, monitors and reports on the health of British Columbians, identifies the need for legislation or changes in policy or practice, and works with the B.C. Centre for Disease Control and provincial medical health officers to fulfill their legislated mandates. This business area also includes the Population Health and Wellness Division, which develops and evaluates major provincial strategies to improve the health of British Columbians and reduce future demands for health services.

Strategic Change Initiatives

The Strategic Change Initiatives Division oversees projects designed to improve quality, accessibility or efficiency of the health care system. This division works with staff from provincial ministries, health care providers, administrators and researchers, and provides project management expertise

for all areas of the Ministry of Health Services and Ministry of Health Planning.

In addition, the division manages primary health care and rural and remote health strategies, and is the executive sponsor for chronic disease management initiatives.

Planning, Policy and Legislation

The Planning, Policy and Legislation Division works with the Ministry of Health Services, the health authorities and others to develop long-term plans, establish the broad accountability framework for our health system, and develop specific standards for quality and access. There is a major focus on planning health human resources and the accountability framework for the health services system.

In addition, the division is responsible for developing broad health and health services policy, for supporting and encouraging research, and for developing legislation and regulations. The Legislative Services and Self-Regulating Professions unit works to establish and maintain a comprehensive framework to support the health care system overall. A description of the legislative changes undertaken in this year appears in the appendices.

The unit also monitors the activities of self-regulating professions, supports the evaluation of applications by professionals for self-regulation, supports the four appeal boards that ensure fairness in various areas of health care decision-making, and supports the Mental Health Review Panel under the *Mental Health Act.*

The division also coordinates intergovernmental activities and supports a number of federal/provincial/territorial planning and research groups.

WHAT ACTION HAS THE MINISTRY OF HEALTH PLANNING TAKEN?

The first task of the Ministry of Health Planning was to establish its three core business areas as described above. Then the ministry turned its attention to providing leadership and support for major strategic shifts in the health system by adopting formal planning tools, consulting with health care partners, and implementing specific activities.

Adopting formal planning tools

- **Integrated Planning** - The ministries of health are committed to integrated planning at all levels of the health system. The Ministry of Health Planning has the lead in directional planning and shares responsibility for strategic and tactical planning with the Ministry of Health Services and health authorities.
  - Directional planning is long-term planning that looks forward 5 to 10 years and reflects the vision for the entire system. Examples include the overall health system plan and the 10-year human resource plan. The Ministry of Health Planning is responsible for leading this process.
  - Strategic planning flows from the long-term vision. It includes plans such as the three-year service plans that lay out mid-term strategies. The two health ministries both take leadership roles in this process.
  - Tactical planning includes yearly action plans that translate strategic direction into annual project and budget plans. For example, ministries and health authorities produce annual business plans.
- **Population-Based Planning** – The ministry is implementing population-based planning to identify the health needs of diverse communities in B.C. This approach forecasts both the demand and supply of health care services within a geographic area to determine if health service delivery meets the needs of patients. (See topic box on Population-Based Planning.)
- **Monitoring and Assessing** –The Provincial Health Officer (PHO) plays an important role in the planning process by monitoring and reporting on the health of British Columbians. In 2001/02, the PHO provided information on many important health care issues:
  - A Report on the Health of British Columbians, Provincial Health Officer's Annual Report 2000: Drinking Water

Population-Based Planning

What is it?

Population-based planning forecasts both the demand for and supply of health care services within a geographic area to determine if health service delivery meets the needs of patients. This approach places a greater emphasis on examining the types of disease and disability that affect British Columbians.

What are we doing?

The ministry has traditionally planned for service delivery based on historic patterns of service use. In contrast, population-based planning begins with measuring the diseases that affect British Columbians and understanding the progression of diseases. For instance, if we know how many people have diabetes, we can tailor services to their needs as well focus on prevention and earlier intervention for people at risk.

Over the next few years, the Ministry of Health Planning will use a blend of both utilization-based and population-based planning.

What does this mean to you?

Measuring the burden of disease will help to identify the services required. This will lead to less pain and disability, and may help to reduce health care costs.

Quality in British Columbia: The Public Health Perspective, October 2001;

- Health Status of Children and Youth in Care in British Columbia: What do the Mortality Data Show? May 2001;
- Children and Youth in Care: An Epidemiological Review of Mortality, British Columbia, April 1974 to March 2000. (A Technical Report of the Office of the Provincial Health Officer in Cooperation with the Ministry for Children and Families, the B.C. Children's Commission, and the B.C. Vital Statistics Agency, May 2001); and
- Provincial Health Officer's Report on HIV Reportability, February 2002.

- **Project Management System** – The Ministry of Health Planning implemented a new project management system that uses the intranet to allow more effective teamwork across different areas of expertise. This system proved very valuable in supporting the restructuring of both the health authorities and the health ministries.
- **Standard and Guideline Setting –** The Ministry of Health Planning established provincial standards and guidelines to ensure access to high quality patient care. Further work is being done on quality standards in consultation with the Ministry of Health Services and health authorities. By developing these standards and guidelines, the ministry will assist health authorities to plan for the delivery of services and communicate clearly to British Columbians what to expect. (See topic box on Standards Setting.)
- **Accountability Framework** – An important focus of attention has been on the development of an accountability framework for the health services system. The ministry has worked on the accountability provisions related to the newly designed health authorities and with respect to self-regulating colleges and inter-governmental work comparing the accountability approaches of different jurisdictions.

Standard Setting

What is it?

The Ministry of Health Planning, together with the Ministry of Health Services, is establishing provincial standards and guidelines to ensure high quality health care. Standards are benchmarks or targets for acceptable outcomes. These standards will assist health authorities to plan and use evidence-based decision-making to meet the service delivery needs of British Columbians.

What are we doing?

The ministry has prepared acute care access standards that are being used by health authorities in the redesign of hospital services. The standards specify the maximum travel time for accessing emergency services, in-patient services and core specialty services. They also ensure that the majority of British Columbians, in all regions, have reasonable access to these services.

The ministry is developing further provincial standards to ensure high quality patient-centred care for British Columbians. Over the coming year, new standards and guidelines will be developed for mental health, home and community care, surgical services and emergency care.

Health authorities are accountable for meeting standards through their performance agreements with the ministry.

What does this mean to you?

Standards ensure people receive greater consistency of care across the province. Measuring performance against standards allows us to both look for improvements in the quality of care and to be accountable for the services that are provided.

Consulting with health care partners

Planning cannot be accomplished without input from people throughout the health services system. In 2001/02, the ministry participated in a number of consultations.

- **Premier's Dialogue on Health** – The government held a forum in October 2001 with 140 professionals, administrators, and other experts to discuss critical issues impacting the sustainability of B.C.'s health care system. This dialogue sets the stage for ongoing participation of health care partners in addressing challenges and developing solutions for enhancing health services and improving our health care system.

- **Premiers' Conference on Health** – The Ministry of Health Planning provided support for the Premiers' Conference on Health in January 2002. As a follow-up to the Annual Premiers' Conference on Health in August 2001, the Premiers agreed to meet in Vancouver for an extraordinary meeting devoted to health issues. The agreements reached at this conference included:

  - Developing a common drug review process to ensure all Pharmacare programs use the same evidence for listing new drugs;

  - Approving all new drugs on a probationary basis pending an assessment of their effectiveness;

  - Agreeing to fast-track approval of generic drugs; and

  - Agreeing to develop sites of excellence to consolidate low-volume, highly specialized services to improve the quality of the service provided.

- **Leadership Council** – In 2001/02, the ministry established a Leadership Council, with representation from the health ministries and health authorities. The council is designed to ensure a common approach in directing and managing the regionalized health care system.

Renewing Primary Health Care for Patients

What is it?

For most British Columbians, primary health care is the first and most frequent point of contact with the health care system. Whether it's a visit to the family doctor or from a home care worker, a trip to the pharmacist, mental health counsellor or school nurse, primary health care is where new health problems are addressed, and where patients and providers work together to manage ongoing problems.

What are we doing?

There is growing recognition among patients, providers and governments that our current methods of delivering primary health care are failing to keep pace with evolving patient needs.

In B.C., the most common place to receive primary health care is still in a family doctor's office, where the doctor usually works alone and is paid for each service he or she provides. This is much as it was 40 years ago.

But our population and health needs have changed significantly. As a population, we're aging, we don't have strong links between our hospitals, community services and primary health care providers, and our health care resources are limited. General practitioners are trying to find ways to provide full-service family practice.

In B.C., Primary Health Care Renewal is being approached as a health authority level strategy. It typically brings together doctors, nurses, and other health care providers in one location to provide care that is more responsive to patients and better suited to each provider's range of skills. At the same time, it will decrease the need for expensive hospital care.

What does it mean to you?

Over the longer term, Primary Health Care Renewal will result in reliable, appropriate access to assessment, treatment and ongoing care that is based on patient needs, through better coordination of services.

Implementing specific planning activities

In 2001/02, the ministry initiated several planning activities in support of health care goals and long-term planning objectives.

- **Core Review** - The ministry led the core review process to examine the effectiveness and organization of both health ministries. As a result, the ministries were significantly restructured to lay the groundwork for achieving the New Era goals and vision for high quality patient-centred care. The ministry is also supporting the Core Services Review of the Emergency Health Services Commission.
- **Restructuring of Health Authorities** – As part of the restructuring process, the ministry reduced the number of health authorities from 52 to six. This will make operations more efficient and accountable to British Columbians.
- **10-Year Health Human Resource Pla**n - With the Ministry of Skills, Development and Labour, the ministry is developing a 10-year human resource plan to properly provide for training, recruitment and retention of health care professionals in every area of the province. The plan will also address critical skills and staffing levels in under-serviced areas. Working with the Health Human Resources Advisory Committee, composed of health care associations, unions, administrators, educators and health authority representatives, health human resource planning has focused on both long-term planning and on addressing mid-term issues such as recruitment and retention of needed health professionals and developing advice on the numbers and types of seats colleges and universities should be developing to address the demand for health professionals.
- **Service Plans** - The Ministry of Health Planning led the development of service plans for both health ministries. These service plans set out roles, responsibilities, goals and outcomes for the next three fiscal years.

Rural and Remote Health

What is it?

Inequities in terms of resources and access to services are found throughout the province. British Columbians living in more isolated areas encounter considerably more health system barriers than those living in urban centers. This includes long distances separating communities and the lack of specialist medical services outside large urban areas of the province. To change this, the ministry is analyzing where and why gaps in service or access exist, and finding innovative new ways to address this.

What are we doing?

A 10-year human resource plan is being developed with other ministries to provide for the training, recruitment and retention of physicians, nurses, specialists and other health care providers in each area of the province. The plan also addresses critical skills and staffing levels in under-serviced areas.

In conjunction with the Ministry of Advanced Education, A Rural and Remote Training program is being developed, and forgivable student loans will be provided to students attending nursing and medical schools who practice for five years in under-served B.C. communities.

As well, government has announced the development of the BC Life Sciences program at the University of British Columbia's medical school, which will provide opportunities for training and residency positions at University of Northern B.C. and University of Victoria as undergraduates progress through their training.

Another program will be introduced that provides financial and travel assistance to rural/remote health care providers who want to upgrade their training.

A travel assistance program is also administered by the Rural Health Office of the ministry to reduce rural patients' transportation costs to access treatment not available locally.

What does it mean to you?

Through these actions, the Rural Health Office is planning for the provision of more equitable access to health services across the province. These actions will help address critical skills shortages and staffing levels through innovative strategies to educate more doctors, nurses and other health care providers in rural and remote communities.

- **Legislation** – The government introduced the *Health and Social Services Delivery Improvement Act*, which provides health authorities the flexibility to make decisions about services and staff in the best interest of patient care. The ministry also amended the *Medical Practitioners Act*. New legislation is also being developed to amend the *Health Professions Act, Community Care Facility Act* and *Drinking Water Protection Act.*

- **Policy and Research** - The ministry has been engaged in developing policy to guide appropriate and effective involvement of the private sector in the provision of health care services, in development of patient satisfaction tools, and in the development of policies regarding which services should be publicly funded. At the same time, research work in the area of nurse practitioners and work to support making research more accessible to providers has continued.

- **Nursing Strategy** – In 2001, the government allocated $21 million for a new Nursing Strategy and hired B.C.'s first Chief Nurse Executive. The strategy addresses the province's nursing shortage and improves working conditions for nurses in B.C. To link nursing groups more closely with the ministry, a nursing directorate and advisory committee were established. The ministry has already made progress in reducing the shortage, and is developing a long-term plan with several initiatives such as more education seats, incentives for nurses to return to work, and recruitment of foreign-educated nurses. (See topic box on the Nursing Strategy.)

- **Nurse Practitioners** – The government also continues to work with the Registered Nurses' Association of British Columbia towards the recognition of Nurse Practitioners. This includes defining scope of practice, competencies, educational preparation, and the required legislative framework.

Nursing Strategy

What is it?

The Nursing Strategy is a comprehensive approach to address the province's nursing shortage and improve working conditions for nurses in B.C.

What are we doing?

In 2001, the government allocated $21 million for the Nursing Strategy and hired British Columbia's first Chief Nurse Executive. The Chief Nurse Executive has held dialogues with groups of practising and student nurses on the challenges and opportunities with respect to work life issues and avenues for nurses to provide input to system redesign.

The creation of a Nursing Directorate helps to link nursing groups in the province with the Ministry of Health Planning. The Nursing Advisory Committee was also initiated with membership including nurses, employers, unions and professional associations.

Progress has been made in reducing the nursing shortage, providing funds for nursing specialty courses, and finding ways to support new graduates. Work has begun on developing a long-term plan that will identify the number and category of nurses needed in the future. The strategy includes:

- More education seats.
- Initiatives to encourage B.C. nurses who are not working in their profession to return to the health system.
- Recruitment of more foreign-educated nurses.
- New opportunities for nurses to upgrade their skills.
- Funding for new equipment that will help nurses avoid workplace injuries.

What does this mean to you?

Nurses are, and will continue to be, the largest single health care provider group. When we attract and retain skilled nurses, and when we make it easier for people to enter, stay and advance in the nursing profession, we create a stronger health care system in our province.

- **Population Health and Wellness Strategies** – The ministry is developing core public health programs, population health and wellness strategies, and a new *Health Act* as part of its population health and wellness framework. This framework consists of mandatory, ongoing public health programs and minimum service deliverables for health authorities. The population and wellness strategies recommend best practices based on evidence-based research.

- **Chronic Disease Management** – The ministry is developing a Chronic Disease and Injury Prevention Strategy to lower the risk of chronic disease such as diabetes, asthma and lung and heart disease. Together with the Ministry of Health Services, it is also developing a Chronic Disease Management Strategy to improve the treatment and care of people with chronic illnesses. (See topic box on Chronic Disease Management (Prevention).)

- **Primary Health Care Renewal** – The ministry supported the implementation of Primary Health Care Renewal by providing funding in 2001/02 for four additional primary health care organizations in rural areas which follow the primary care renewal model. These organizations typically bring together doctors, nurses, and other health care providers to meet the needs of a community. The objective of providing timely and coordinated care is to decrease the need for preventable hospital care. (See topic box on Primary Health Care Renewal p. 14.)

- **The Rural and Remote Health Initiative** – A new comprehensive policy framework for rural and remote health services is being developed that will strengthen and enhance existing programs and assist health authorities in creating new ways of delivering services to enhance access and availability of health services in rural and remote communities. The policy framework will be completed in 2003/04. (See topic box on Rural and Remote Health p. 15.)

Chronic Disease Management (Prevention)

What is it?

The Chronic Disease and Injury Prevention Strategy uses proven methods to decrease the occurrence and duration of preventable illnesses, such as diabetes and lung and heart disease.

What are we doing?

We are developing a Chronic Disease and Injury Prevention Strategy focusing on five priorities: physical activity, healthy eating, tobacco reduction, alcohol or drug misuse, and preventable injury, especially falls among seniors.

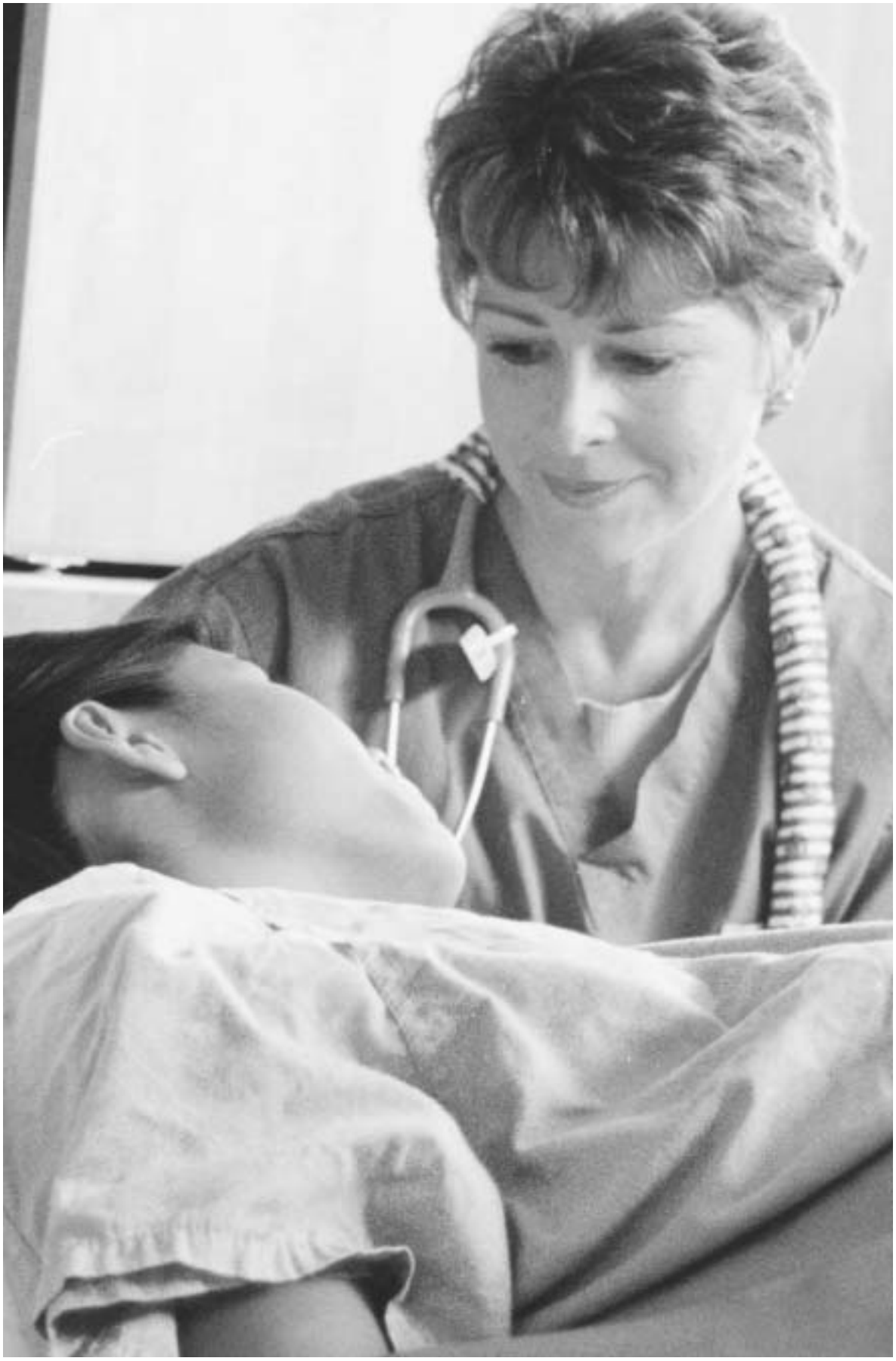
The ministry is working to engage other provincial ministries, health authorities and non-government organizations in action to lower the risk of chronic disease and disability among British Columbians. For example, the ministry is collaborating with the Ministry of Community, Aboriginal and Women's Services and other partners to develop a Sport and Physical Activity Policy for B.C. that targets initiatives for schools and communities.

What does it mean to you?

Over time, the Chronic Disease and Injury Prevention Strategy will help to delay and prevent the occurrence of conditions such as diabetes and heart disease so that fewer people suffer from their consequences.

- **Home and Community Care Plan** – The ministry assisted in the development of the Home and Community Care Plan. The plan is expanding and redesigning the home and community care system to provide services to a greater number of people with functional impairments due to aging, illness or disability.

- **Mental Health Plan** – The ministry worked with the Ministry of Health Services to implement the Mental Health Plan.



UPDATE ON NEW ERA COMMITMENTS

On June 25, 2001, Premier Gordon Campbell sent a letter to each member of the Executive Council providing direction and outlining expectations. The Premier's letter to the Minister of Health Planning itemized the New Era commitments and key projects for which the minister is accountable. The following is the list of New Era commitments and key projects. A detailed description of the ministry's actions and progress on these assignments is contained in the following pages.

NEW ERA PROMISES FOR HEALTH PLANNING

1. Ensure that BC health care is universal, accessible, portable, comprehensive and publicly administered, consistent with the five principles of the *Canada Health Act.*

2. Establish provincial health standards that ensure all citizens in every part of the province are entitled to equitable, reliable, high quality health services.

3. Develop performance measures that are annually audited and publicly reported for each health standard, to ensure provincial and regional health authorities are accountable for fulfilling their duties to provide the prescribed levels of patient care.

4. With Skills Development and Labour, develop a 10-year human resource plan that properly provides for the training, recruitment and retention of physicians, nurses, specialists and other health care providers in every area of the province, and that addresses critical skills and staffing levels in under-serviced areas.

5. With Health Services:

   a. Develop a Hospital Facilities Plan that identifies each health region's key capital requirements and funding priorities.

   b. Develop an Intermediate and Long Term Care Facilities Plan that addresses the needs of our aging population and frees up existing acute care beds.

   c. Develop a Medical Machinery and Equipment Plan that ensures existing medical diagnostic and care equipment is adequately staffed, fully utilized and properly maintained, and that provides for future investments in new equipment and technologies.

   d. Develop a comprehensive Technology Plan to assist health care professionals in delivering faster, more effective treatment to patients through new information technology and telemedicine.

   e. Establish a Rural and Remote Health Initiative to ensure all families get the care they need, where they live and when they need it.

   f. Work with front line health care professionals to act on their ideas for maximizing the value to patients of every health dollar spent.

g. Launch a massive recruitment drive to bring non-practicing registered nurses and licensed practical nurses back into our health care systems.

h. Ensure that appointees to regional health boards are representative of their communities' needs and accountable for their performance in meeting provincial health standards.

i. Work to minimize inter-jurisdictional overlaps that are adding confusion and costs to health care delivery.

j. Work with doctors, pharmacists and others to find a cost-effective alternative to reference based pricing.

6. With Intergovernmental Relations Secretariat (IGR) and Finance, negotiate with the federal government to restore all of the health care funding withdrawn through budget cuts.

7. Increase the number of residency positions in BC hospitals in the next five years.

8. Develop a rural travel assistance program, to reduce rural patients' transportation and lodging costs to receive treatment that is not locally available.

9. With Advanced Education:

   a. Expand training programs for care aides, licensed practical nurses and registered nurses, in collaboration with our universities, colleges and institutions.

   b. Increase the number of medical school graduates over the next five years.

   c. Develop a Rural and Remote Training Program that provides forgivable loans to BC students attending accredited nursing and medical schools who agree to practice in a rural or remote community in BC.

   d. Introduce a Rural and Remote Training Support program that provides financial and travel assistance to health care providers who want to update or upgrade their skills and training.

   e. Provide assistance and opportunities to help nurses develop the specialized skills needed in intensive care units, emergency rooms and operating rooms.

   f. Increase training spaces and recruitment of foreign-trained nurses and physicians.

   g. Establish a "Leading Edge Endowment Fund," cost-shared with the private sector, to establish 20 permanent BC Leadership Chairs in the fields of medical, social, environmental and technological research.

10. Work with health care professionals, caregivers, administrators, community leaders, patient groups and the public to develop a comprehensive 10-year Health Strategy for B.C.

Key Projects for Health Planning

1. Examine the governance structure and make recommendations for alignment of Community Health Council / Community Health Services Society / Regional Health Board responsibilities, including a recommended structure for Vancouver / Richmond Health Board.

2. Develop an accountability framework for Boards and an arms-length appointment process, with identification of clear expectations and performance measures.

3. Develop a transparent population-based funding formula.

4. Review the Medical Services Commission structure and recommend new structures as appropriate.

5. Work with the Agencies, Boards, and Commissions Director on Health Board appointments.

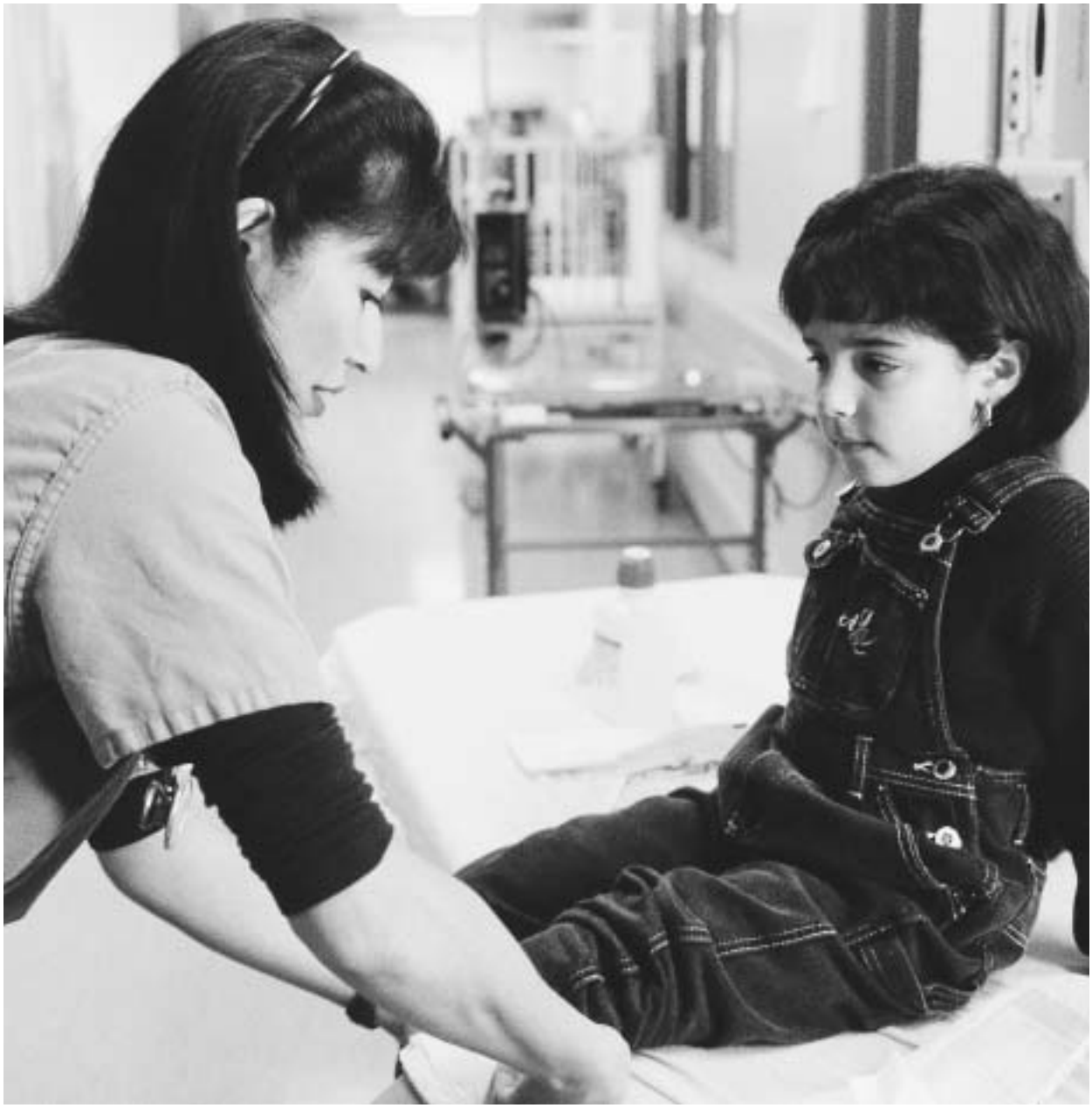
6. Recommend a framework for delivery of provincial programs.

7. Consider the advisability of including Pharmacare, ambulance services and Medical Services Plan in regional authority budgets. Recommend appropriate governance model for licensing functions.

8. Develop a framework for financial and human resource allocation, including capital and equipment.

9. Work with Health Services to develop a planning framework for mental health, intermediate, long term and home care.

10. Act as provincial liaison to the Romanow Commission.



NEW ERA PROMISES

1. Ensure that BC health care is universal, accessible, portable, comprehensive and publicly administered, consistent with the five principles of the Canada Health Act.

The Ministry of Health Planning was created in June 2001 to provide a dedicated focus on the longer term planning and vision necessary to sustain B.C.'s public health care system in the years ahead. The ministry's work is guided by the five principles of the *Canada Health Act*.

British Columbia, like other provinces, reports on an annual basis to the federal government on how we meet the commitments of the *Canada Health Act*. The federal Minister of Health tables these reports with Parliament to ensure public accountability.

2. Establish provincial health standards that ensure all citizens in every part of the province are entitled to equitable, reliable, high quality health services.

Acute Care Access Standards and Guidelines have been prepared to guide health authorities through the re-structuring of hospital services for 2002/05. The standards specify the maximum travel time for accessing emergency, in-patient and specialty services. The ministry is in the planning stages for the development of further provincial standards to ensure high quality health services for B.C. patients.

3. Develop performance measures that are annually audited and publicly reported for each health standard, to ensure provincial and regional health authorities are accountable for fulfilling their duties to provide the prescribed levels of patient care.

Performance agreements have been developed for use between health authorities and the Ministry of Health Services which define expectations and performance deliverables for three fiscal years. For the first time ever health authorities will sign agreements that will hold them accountable for the delivery of patient care, patient outcomes and how health dollars are spent. The agreements also contain major change requirements in areas of service such as Emergency Care, Surgical Services, Home and Community Care, and Mental Health. In addition, a process is underway to also establish core services in Public and Preventive Health.

4. With Skills Development and Labour, develop a 10- year human resource plan that properly provides for the training, recruitment and retention of physicians, nurses, specialists and other health care providers in every area of the province, and that addresses critical skills and staffing levels in under-serviced areas.

The ministry chairs the Health Human Resource Advisory Committee (HHRAC). This committee, through its working groups and formal conferences, addresses issues on education, recruitment, retention and work design. Along with the ministry responsible for skills development and labour, the committee membership includes the health authorities, the Health Employers' Association of B.C., educators, professional associations and unions. The ministry is working closely with planners from each health authority to develop a long-term (10 year) strategic plan for health human resources. Research has begun to analyze current health human resource shortages and long-range system needs, and a model for analyzing supply and demand for health human resource planning has been developed and is now being discussed with key stakeholder organizations involved in health human resources.

5a. Develop a Hospital Facilities Plan that identifies each health region's key capital requirements and funding priorities.

The ministry is developing new capital planning guidelines for health authorities,

and is currently working with the health authorities and Treasury Board Staff to develop long-term strategies for capital planning. The ministry is investigating methods to assess facility stock and the potential need for replacement, similar to the comprehensive inventory of residential care facilities. Additionally, health authorities are in the process of assessing facilities as they redesign health service within their regions to meet the needs of patients.

5b. Develop an Intermediate and Long Term Care Facilities Plan that addresses the needs of our aging population and frees up existing acute care beds.

The ministry, in conjunction with the Ministry of Health Services and the health authorities, is developing an intermediate and long-term care facilities plan. The first step of the facilities plan is an assessment of the physical and functional condition of the 25,400 publicly funded residential care beds. The assessment will be completed by the summer of 2002 and will provide health authorities and the ministry with information on facility condition and the alignment of available bed stock to meet the complex care needs of clients.

This information, together with health authority information on facility specific resources and care delivery, will be used to develop a facilities plan which addresses future residential care capacity requirements to meet the needs of B.C.'s aging population. The plan will include decisions on renovating or replacing beds to meet complex care needs, and converting existing bed stock that cannot accommodate complex care patients or provide appropriate substitute services for acute care.

5c. Develop a Medical Machinery and Equipment Plan that ensures existing medical diagnostic and care equipment is adequately staffed, fully utilized and properly maintained, and that provides for future investments in new equipment and technologies.

The ministry is working with health authority planners on the assessment of the current and future need for medical machinery and equipment. Health authorities are also assessing equipment capacity and needs in relation to their health service redesign plans. Work is also underway to ensure the health system makes the most appropriate use of new technology and medical equipment as it becomes available.

5d. Develop a comprehensive Technology Plan to assist health care professionals in delivering faster, more effective treatment to patients through new information technology and telemedicine.

The Chief Information Officer (CIO) of the health ministries and the CIOs of the health authorities are working together to finalize the strategic plan and develop a tactical plan for health information management and technology (IM/IT) in B.C. The consolidated provincial strategy will provide the health sector with a unified vision and a set of common principles and initiatives.

The CIOs of the health ministries and of the health authorities are also exploring strategies and approaches for establishing electronic health records (EHR) in B.C. The ministry is leading the development of a provider registry system. Once implemented, the system will provide the benefit of consistently identifying health providers, which is a key foundation piece for the EHR.

The ministry is also developing an IM/IT strategic and business plan internally to align its direction with the provincial strategy and contribute to the overall technology plan. The CIO of the health ministries and the CIOs of the health authorities have provided significant input to the Premier's Technology Council. The Health CIOs' recommendations are reflected in the Council's reports.

5e. Establish a Rural and Remote Health Initiative to ensure all families get the care they need, where they live and when they need it.

A project plan has been developed for a policy framework for rural and remote health services that will enhance existing programs and help health authorities create new service delivery models. A stakeholder planning session was held in March 2002, and an analysis report is underway to inventory current health services in rural and remote B.C. and outline existing gaps in service accessibility. Work is also underway on an analysis of access issues relating to special populations and specific health services.

A key outcome of this initiative will be the development of an extensive range of policies and practices related to rural health service planning, roles of nurse practitioners, physician issues in rural and remote areas, and linking primary care with self-care, telehealth services and acute care.

The government has also announced the creation of the BC Life Sciences Centre, which will substantially increase the number of physicians that graduate in B.C. The centre will have a collaborative campus at the University of Northern British Columbia specializing in rural and remote medicine as well as the development of e-health initiatives. In addition, a loan forgiveness program for nursing and medical students willing to work in under-served areas has been established, and $1.2 million has been provided for innovative rural nurse and nurse mentoring strategies to reduce workplace stress, help integrate new nurses and improve the quality of patient care.

5f. Work with front line health care professionals to act on their ideas for maximizing the value to patients of every health dollar spent.

The following mechanisms have been used to incorporate the ideas of front line health professionals in improving patient care:

- The Chief Nurse Executive has met extensively with practicing and student nursing groups around the province. The first stage has been to communicate progress on the Nursing Strategy on work life issues. During this dialogue, front line nurses also shared their ideas for the redesign of health services.
- Similarly, in developing policy around advanced nursing practice, several hundred nurses were interviewed about their ideas for new and advanced roles for practice.
- A standing committee of the Vice-Presidents of Medicine has been

established to provide advice to the Leadership Council on medical issues – another important link to front line health care.

- The government hosted a Dialogue on Health in October 2001, with 140 professionals, administrators, and other experts, to identify new solutions to improve care.

- The Legislature's Select Standing Committee on Health held hearings in 10 communities and received 700 submissions, which are incorporated in its December 2001 report on renewal and reform of health care.

- Policy Rounds, sponsored by the Ministry of Health Planning, provide an opportunity to disseminate research on new and innovative approaches in health services delivery.

5g. Launch a massive recruitment drive to bring non-practicing RNs and LPNs back into our health care systems.

In 2001, government implemented the Nursing Strategy for B.C., which included the creation of a Nursing Directorate to link nursing groups in the province with the Ministry of Health Planning. The Nursing Advisory Committee of B.C. was also initiated in 2001 with membership including nurses, employers, unions and professional associations. Progress has been made in reducing the nursing shortage, providing funds for nursing specialty courses, and finding ways to support new graduates in B.C. Work has begun on developing a long-term plan that will identify the number and category of nurses needed in the future.

Major progress has been made in nurse recruitment, including a $1.1 million initiative targeted at non-practicing RNs and under-employed foreign-educated nurses already living and working in B.C. Almost 400 nurses have now been approved for grants for refresher courses and ESL training. In addition, 48 foreign specialty nurses have been matched to employers through an off-shore recruitment strategy. The ministry has also launched a program to assist nurses to return to practice from workers' compensation or long-term disability.

5h. Ensure that appointees to regional health boards are representative of their communities' needs and accountable for their performance in meeting provincial health standards.

In December 2001, a simpler, more accountable structure for delivering health services was introduced. The new structure includes 15 health service delivery areas governed by five geographic health authorities and one provincial health authority. Health authority board members have been chosen for their leadership skills and decision-making abilities. Community representation was also a key factor and all health authorities have representation from each of the health service delivery areas they govern.

Health authorities are accountable through performance agreements that define expectations and performance deliverables between health authorities and the Ministry of Health Services.

5i. Work to minimize inter-jurisdictional overlaps that are adding confusion and costs to health care delivery.

In December 2001, government announced the existing 52 regional health authorities would be realigned in a new governance structure consisting of 15 health service delivery areas governed by five health authorities and a Provincial Health Services Authority to oversee provincial programs. Creating fewer, more accountable health authorities will minimize the duplication of administrative services that have added confusion and costs to health care delivery. The new model is focused on achieving efficiencies, eliminating administrative duplications, and directing as much money as possible to high-quality patient care.

5j. Work with doctors, pharmacists and others to find a cost effective alternative to reference based pricing.

In November 2001, the Minister of Health Planning appointed a Reference Drug Program Consultation Panel to seek cost-effective alternatives to Pharmacare's Reference Drug Program. Meetings were held in January, February and March 2002, and 46 submissions were made to the panel by various stakeholders and members of the public. The minister will be reviewing the panel's report and preparing recommendations to government.

6. With IGR and Finance, negotiate with the federal government to restore all of the health care funding withdrawn through budget cuts.

In January 2002, the Premier of B.C. hosted an extraordinary meeting of all Canadian premiers to discuss health issues. The ministry worked closely with the Intergovernmental Relations Secretariat (IGR) in preparing for the meeting. At the meeting the premiers confirmed the current level of federal funding contribution is inadequate to sustain quality health care. The issues of inadequate federal funding and the pressures facing provincial health care systems were also raised with the federal government at meetings of the conferences of Federal/Provincial/Territorial (F/P/T) Ministers of Health and F/P/T Deputy Ministers of Health.

7. Increase the number of residency positions in BC hospitals in the next five years.

Following the government's expansion of the University of British Columbia's medical school and establishment of satellite medical schools at the University of Victoria and the University of Northern British Columbia, the ministry is now working with health authorities and the three universities to expand the residency program in B.C. Expanding the program will help alleviate regional shortages by providing a new pool of student doctors who will complete their residency programs in hospitals outside the Lower Mainland.

In addition, the International Medical Graduates program at St. Paul's Hospital has increased its residency positions for foreign educated physicians from four to six.

8. Develop a rural travel assistance program, to reduce rural patients' transportation and lodging costs to receive treatment that is not locally available.

Work has begun to enhance the existing Travel Assistance Program administered by the Ministry of Health Services. The program is a private and public sector corporate partnership program which offers travel discounts to British Columbia residents who must travel within B.C. for non-emergency medical services not available in their own community. The program's administrative system has been automated and streamlined for travel approvals over the phone, and Angel Air has recently been added as a corporate sponsor.

The ministry will continue to develop a rural travel assistance program in conjunction with other initiatives such as the Physician Outreach Program. That program will assist physicians to travel to rural communities to provide services, thus reducing the need for patients to travel.

9a. Expand training programs for care aides, licensed practical nurses and registered nurses, in collaboration with our universities, colleges and institutions.

Government is adding 1,400 new training spaces over three years. In 2001/02, 177 new training spaces were added.

9b. Increase the number of medical school graduates over the next five years.

In March 2002, government announced a $134 million program to expand the

University of British Columbia's (UBC) medical school and establish satellite medical schools at the University of Victoria and the University of Northern British Columbia. This program will almost double the number of undergraduate medical school spaces (from 128 to 224) by 2005, and creates a multi-region and multi-university collaborative teaching model unique in Canada.

9c. Develop a Rural and Remote Training Program that provides forgivable loans to BC students attending accredited nursing and medical schools who agree to practice in a rural or remote community in BC.

A loan forgiveness program for medical and nursing students was established in August 2001. Student loans are forgiven at a rate of 20% per year for each year of service in rural or remote communities of greatest need.

9d. Introduce a Rural and Remote Training Support program that provides financial and travel assistance to health care providers who want to update or upgrade their skills and training.

As part of government's Nursing Strategy, $1.2 million has been provided for innovative rural nurse and nurse mentoring strategies to reduce workplace stress, help integrate new nurses and improve the quality of patient care.

9e. Provide assistance and opportunities to help nurses develop the specialized skills needed in intensive care units, emergency rooms and operating rooms.

Government's Nursing Strategy includes $1.56 million in funding available to health authorities so they can offer nurses skills upgrading and certification in specialty areas. 315 nurses have been approved.

9f. Increase training spaces and recruitment of foreign-trained nurses and physicians.

Under the Nursing Strategy, 48 foreign specialty nurses have been matched to employers through an off-shore recruitment strategy. For physicians, the International Medical Graduates program at St. Paul's Hospital has increased its residency positions for foreign educated physicians from four to six.

9g. Establish a "Leading Edge Endowment Fund," cost-shared with the private sector, to establish 20 permanent BC Leadership Chairs in the fields of medical, social, environmental and technological research.

Government has launched a $45 million Leading Edge Endowment Fund to establish 20 permanent BC Leadership Chairs. The Chairs will be established, based on a cost-sharing partnership with the private sector, at public post-secondary institutions across the province in such fields as medical, social, environmental and technological research.

10. Work with health care professionals, caregivers, administrators, community leaders, patient groups and the public to develop a comprehensive 10-year Health Strategy for B.C.

The ministry has begun work on a Hospital Facilities Plan, an Intermediate and Long-term Facilities Plan, a Medical Machinery and Equipment Plan, a Technology Plan, a Rural and Remote Initiative and a 10-year Human Resource Plan (see individual entries in this report). These plans, along with the completed and ongoing work in developing health standards and performance agreements, will be brought together to form a comprehensive health strategy for B.C.

KEY PROJECTS

1. Examine the governance structure and make recommendations for alignment of Community Health Council / Community Health Services Society / Regional Health Board responsibilities, including a recommended structure for Vancouver / Richmond Health Board.

The ministry examined the governance structure of the health care system and provided recommendations to government. In December 2001, government accepted the recommendations and announced the existing 52 regional health authorities would be realigned in a new governance structure consisting of 15 health service delivery areas governed by five health authorities and a Provincial Health Services Authority (PHSA) to oversee provincial programs. This streamlined model will improve efficiency, strengthen accountability and allow better planning and service coordination for patients.

2. Develop an accountability framework for Boards and an arms-length appointment process, with identification of clear expectations and performance measures.

The ministry has worked with the Board Resourcing and Development Office on health board appointments. The Board Resourcing and Development Office is responsible for establishing guidelines for all provincial appointments to agencies and ensuring that all provincial appointments are made on the basis of merit following an open, transparent and consistent appointment process. This process supports the public interest by putting qualified people in place and giving them the autonomy necessary to properly run the health care system. To support improved accountability, the ministry has developed performance measurements holding health authorities throughout the province accountable not just for how dollars are spent, but in terms of effective delivery of patient care. To ensure accountability, performance agreements between health authorities and the Ministry of Health Services have been developed which define three-year expectations and performance deliverables.

3. Develop a transparent population-based funding formula.

In calculating the 2002/03 grants to health authorities, a population needs-based funding formula was used to equalize the funding allocations between the health authorities. The formula was used for allocations for acute and home and continuing care, and is now being further developed and refined to address questions concerning special costs in urban centres and remote sites. Work is also underway to ensure the model is fully adaptable in relation to funding allocations for mental health services.

4. Review the Medical Services Commission structure and recommend new structures as appropriate.

A review of the Medical Services Commission will be undertaken in 2002.

5. Work with the Agencies, Boards, and Commissions Director on Health Board appointments.

Health authority board members were appointed in March 2002. The ministry worked with the Board Resourcing and Development Office to ensure health authority board members were chosen for their leadership skills and decision-making abilities.

6. Recommend a framework for delivery of provincial programs.

The Provincial Health Services Authority (PHSA), introduced in December 2001, is part of the new governance structure for B.C.'s public health care system. The PHSA oversees the coordination and delivery of provincial programs and highly specialized health care services. The provincial authority will work closely with the five new health authorities and the ministries of health to

ensure these programs are coordinated throughout the province, and that patient access issues are equitably addressed. Performance agreements between the Ministry of Health Services and every health authority, including the PHSA, have been developed to define expectations and performance deliverables for three fiscal years.

7. Consider the advisability of including Pharmacare, ambulance services and Medical Services Plan in regional authority budgets. Recommend appropriate governance model for licensing functions.

A Core Review process has been initiated to examine appropriate governance options for ambulance services and provide recommendations to government. As planning work continues, the advisability of including MSP and Pharmacare in health authority budgets will be assessed.

8. Develop a framework for financial and human resource allocation, including capital and equipment.

The ministry will soon complete work on a health human resource planning framework in collaboration with members of the Health Human Resource Advisory Committee. Work has also begun in consultation with health authorities on the allocation of capital and equipment funding.

9. Work with Health Services to develop a planning framework for mental health, intermediate, long term and home care.

Government has announced a $263 million action plan to revitalize services and facilities for people with mental health problems, and a provincial strategy is under development to redesign the home and community care system. Performance agreements have been developed which define expectations and performance deliverables between health authorities and the Ministry of Health Services for the next three years. These agreements contain specific requirements for both mental health and home and community care services.

10. Act as provincial liaison to the Romanow Commission.

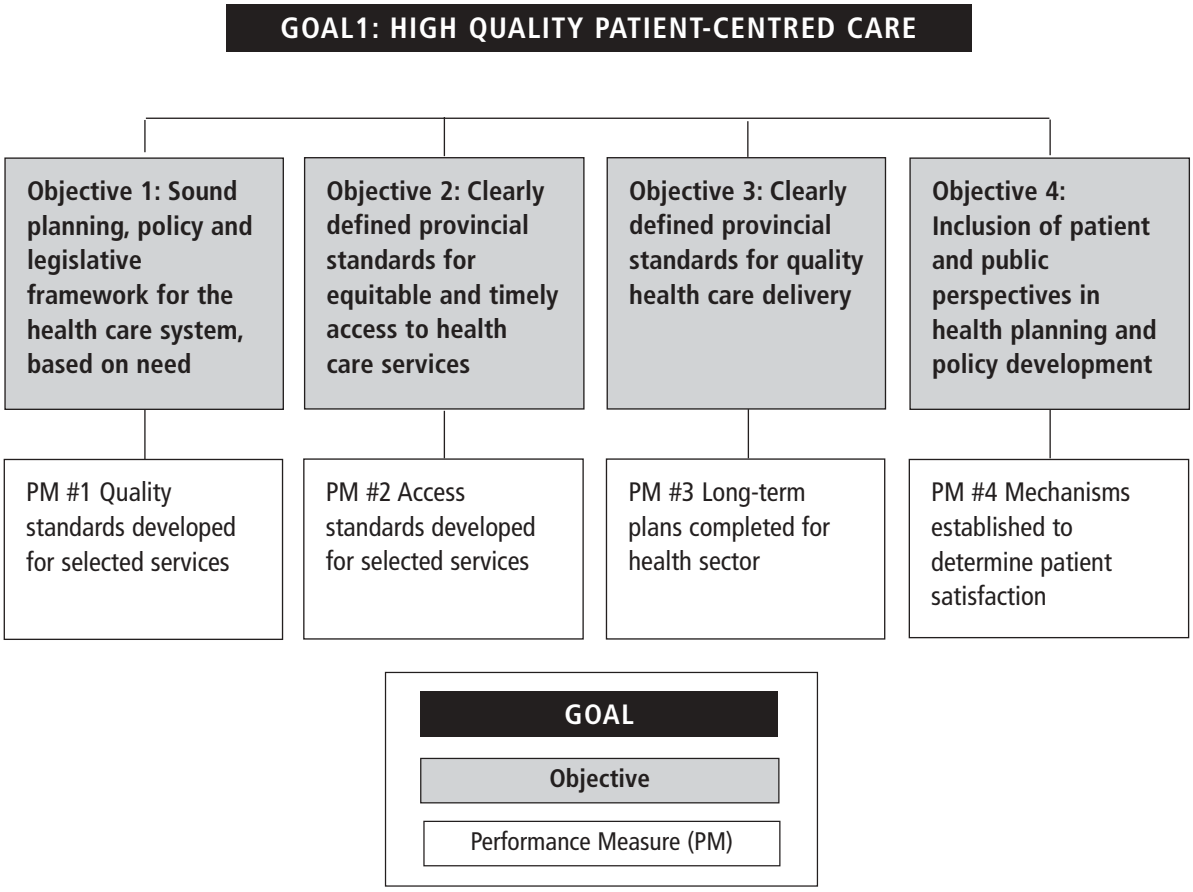
In 2001, the Prime Minister appointed Roy Romanow as a one-man Commission on the Future of Health Care in Canada (Romanow Commission). Romanow was charged with looking at the long-term challenges of maintaining a public universal health care system in Canada. The interim report of the Romanow Commission was released in February 2002. The report, entitled "Shape the Future of Health Care", was intended to be a starting point for discussion. Shortly after releasing the interim report, the commission embarked on a consultation process involving public hearings, expert/stakeholder workshops, partnered policy debates, regional roundtable discussions, and a national stakeholder conference. The Minister of Health Planning presented the B.C. submission to the Romanow Commission when hearings were held in Victoria in February 2002.

PERFORMANCE REPORTING

In February 2002, the Minister of Health Planning tabled the ministry's 2002/03-2004/05 service plan in the Legislature. It includes a set of targets and performance measures that help track progress in meeting the ministry's goals and objectives. This year's annual report provides information on those recent performance measures. These results are intended to serve as background data for next year's 2002/03 annual report when the ministry will begin comparing actual results against targets established in the 2002/03 service plan.

Even though this is the ministry's first year, this year's report shows immediate concrete results for several measures. Others describe significant progress in building new long-term plans, structures and tools for planning and evaluation.

Tracking and reporting how well the health care system is doing in meeting its performance objectives is one of the responsibilities outlined in the *Budget Transparency and Accountability Act*, amended in August 2001. The ministry is committed to ensuring British Columbians get the greatest health benefit possible for every health dollar. Performance measurement is one way to keep track of the quality, accessibility and appropriate delivery of these services. It also helps to monitor the effectiveness of the programs in improving the health and wellness of British Columbians. And finally, the measures help to determine how efficient the health sector is in delivering those services. Knowing how well the ministry is performing in meeting its goals is the first step toward making continuous and meaningful improvements.



PM#1 Quality standards developed for selected services

The development of standards for health services delivery, performance and health care outcomes, will:

- provide a yardstick to measure the delivery of high quality care
- provide a systematic approach to monitoring and evaluation to improve patient outcomes
- establish good, evidence-based parameters and clear expectations for health authorities

The clear articulation of quality standards will allow providers and governors to work towards improvement in patient care, health outcomes, and confidence in health services.

In 2002, the ministry began the process of developing these standards in conjunction with the Ministry of Health Services and health authorities.

PM#2 Access standards developed for selected services

This indicator measures to what extent the ministry has defined a series of access standards for the provision of selected health services. The purpose of provincial standards is to assist Health Authorities in ensuring appropriate patient access to those services within available resources.

In conjunction with the Ministry of Health Services, the Ministry of Health Planning developed provincial standards based on travel time and population for access to emergency, acute inpatient care, and specialty services. These standards are generally applicable outside the major urban areas, but require that larger centres must accommodate inter-regional patient transfers for services that are not available locally.

Access will be ensured according to the following standards:

- Access will be provided to emergency services on a 24-7-52 basis within one hour of travel time or 50 kilometres for 98 per cent of residents within the health authority region and for 95 per cent of residents within the health service delivery area. Emergency services may take the form of a diagnosis and treatment centre, a health centre, a group of practices, or a larger inpatient facility. In remote areas, Red Cross Outpost Hospitals and Federal Nursing Stations may provide these services.

- Access to basic inpatient hospital services will be available within two hours travel time for 98 per cent of residents within the region and for 95 per cent of residents within the health service delivery area.

- Access to core specialty services will be available within four hours travel time for 98 per cent of residents within the region and 95 per cent of the population of each health service delivery area. Core specialty services include general surgery, anaesthesia, psychiatry, internal medicine, obstetrics & gynaecology, and paediatrics. Depending on the catchment population and location, specialty services outside major referral centres may include other specialties such as orthopaedics, urology, ophthalmology, and otolaryngology.

These standards were provided to health authorities to assist their planning for service delivery. Standards will help to ensure British Columbians' access to safe, appropriate, and high quality health care services within a reasonable time and distance. Further information on standards and guidelines for the provision of acute care services will be found on the Ministry of Health Services website.

PM#3 Long-term plans completed for health sector

This measure tracks the development of long-term plans for health human resources, capital resources, and acute, intermediate and long-term care facilities.

The priority is to complete a 10-year human resource plan for 2002/03. Work on capital and facility plans will begin in 2002/03.

For the 2001/02 year, the ministry has:

- completed the initial design of a health human resource plan after consultations with health authorities, educators, the Health Employers Association of B.C. (HEABC), unions, professional associations and other ministries.

- held conferences in October 2001 and March 2002 to identify recruitment, education, retention and work design strategies to address shortages and anticipate future staffing needs for 10 allied health professions.

- implemented the Nursing Strategy for B.C. to help reduce the nursing shortage.

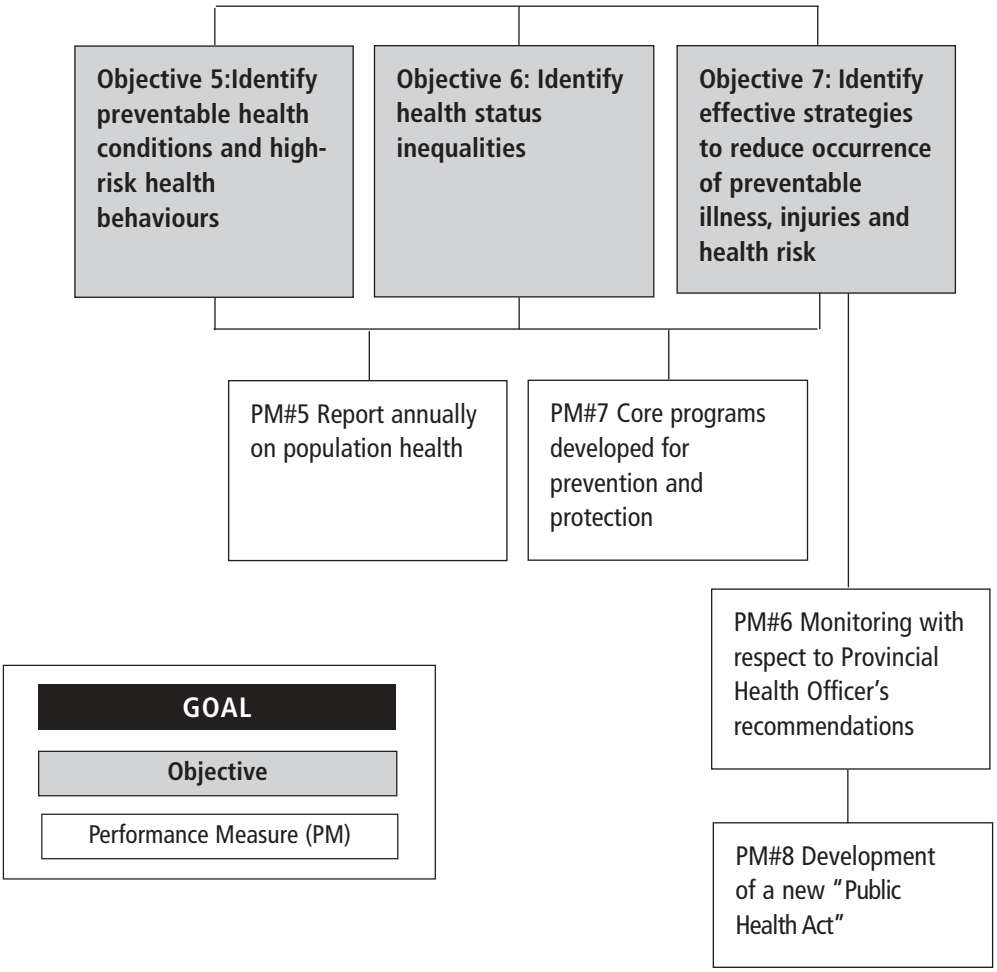
- approved, in collaboration with the Ministry of Advanced Education, new education seats at the UBC School of Medicine, UVIC and UNBC beginning in September 2002, to increase the number of physicians in B.C.

- collaborated with the Ministry of Advanced Education to increase the number of education seats for health sciences programs.

PM#4 Mechanisms established to determine patient satisfaction

This indicator measures the ministry's progress in establishing mechanisms to determine patient satisfaction. The task is to develop the research capacity to monitor the health care system from the perspective of the patients throughout the province. Information on patient satisfaction will support evidence-based decisions underlying policy, planning, and service delivery, and also support accountability, performance measurement, and public consultation.

GOAL 2: IMPROVED HEALTH AND WELLNESS FOR BRITISH COLUMBIANS



PM#5 Report Annually on Population Health Status

This measure monitors the ministry's progress in reporting annually on the health status of the population. Population health information is a good indicator of the effectiveness of provincial health programs and services and supports efforts to improve them.

In 2001/02, the Provincial Health Officer released four reports:

- Health Status of Children and Youth in Care in British Columbia: What Do The Mortality Data Show? (May 2001). This report represents a step forward in British Columbia's ability to measure and monitor the health status of one particularly vulnerable group of children and youth - those who have come into government care. For the first time, death rates for children in care were calculated and compared with those of the general population.
- Detailed statistics on the above issue are contained in a companion report, Children and Youth in Care: An Epidemiological Review of Mortality, British Columbia, April 1974 to March 2000.
- Provincial Health Officer's Annual Report 2000: Drinking Water Quality in British Columbia: The Public Health Perspective (November 2001). This report discusses current drinking water quality issues in British Columbia from a public health perspective.

- Provincial Health Officer's Report on HIV Reportability (February 2002). This report recommends that HIV be added to the list of reportable conditions in Schedule A of the Health Act Communicable Disease Regulation. It also outlines a proposed process for public health involvement if HIV is made reportable.

In 2001/02, the Provincial Health Officer gathered data and other evidence on the health and well-being of Aboriginal peoples in British Columbia, and will release a comprehensive report in the summer of 2002.

PM#6 Monitoring with respect to the Provincial Health Officer's recommendations

This indicator measures to what extent the recommendations by the Provincial Health Officer (PHO) result in action within an appropriate time frame.

The ministry has taken action on two of the PHO reports.

- Provincial Health Officer's Report on HIV Reportability (February 2002): the Ministry of Health Planning has undertaken a focused consultation to hear additional input on certain aspects of the recommendations.

- Provincial Health Officer's Annual Report 2000: Drinking Water Quality in British Columbia: The Public Health Perspective (November 2001). Government is moving in response to the Provincial Health Officer's report and the subsequent Drinking Water Panel Review, established to review the Drinking Water Protection Act and make recommendations.

PM#7 Core programs developed for prevention and protection

This measure assesses the progress in developing core programs that will form the minimum service deliverables that the health authorities are required to provide for patients. Development of core programs will help to ensure consistency in the delivery of fundamental health programs to protect and improve the health of the population.

Work is currently underway in the Ministry of Health Planning to produce a project plan for the development of core public health programs. Consultation with health authorities on the core public health programs will begin in 2002/03 and will result in:

- the development of a list of prioritized core public health programs for protection and prevention in 2002/03;

- the development of program delivery expectations and performance measures in 2003/2004; and

- the incorporation of appropriate programs into a new Public Health Act in 2004/05.

PM#8 Development of a new "Public Health Act"

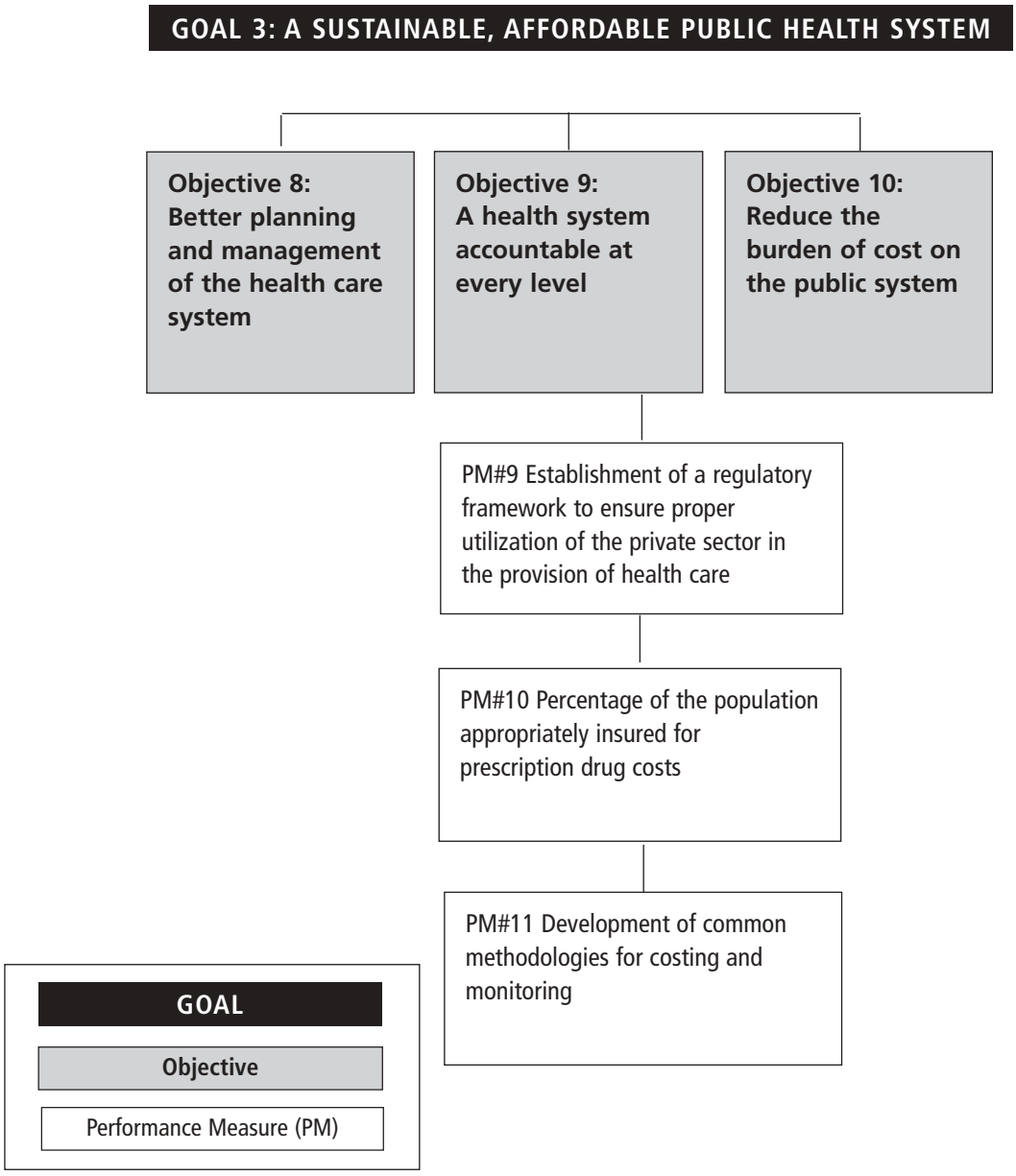
This measure will assess progress in the development of a new "Public Health Act", one of the components of the larger Population Health and Wellness Framework. This act will replace the current *Health Act.*

The intent of the new act is to:

- update the current legislation by eliminating obsolete structures and processes
- redefine roles, responsibilities, powers and authorities
- codify core public health programs.

The Act will specify that health authorities must provide or ensure the provision of a minimum level of core public health programs and services in specified areas. The Act may also authorize the Ministry of Health Planning to develop and publish guidelines that represent the minimum standards for the delivery of these programs and services.

The Provincial Health Officer and Population Health and Wellness have committed to developing the new "Public Health Act" by 2004/05.



PM#9 Establishment of a regulatory framework to ensure appropriate utilization of the private sector in the provision of health care

This measure monitors the progress in establishing a comprehensive policy framework for alternate health service delivery. This framework is intended to give health authorities greater flexibility in determining how publicly funded insured services will be delivered. It will also ensure that quality, safety, and accountability standards are maintained. When adopted, the framework will establish the criteria for contracts or partnerships between the health authorities and private sector providers.

The ministry has begun development on the framework. It will ensure that:

- there is a demonstrated public benefit from private sector partnerships, and
- private sector provision of services is provided within the publicly funded health care system and is consistent with the *Canada Health Act.*

PM#10 Percentage of the population appropriately insured for prescription drug costs

This measure will monitor the percentage of the population that is appropriately insured for prescription drug costs. It is designed to ensure that British Columbians with lower incomes have access to prescription drugs when needed while also ensuring that Pharmacare is sustainable.

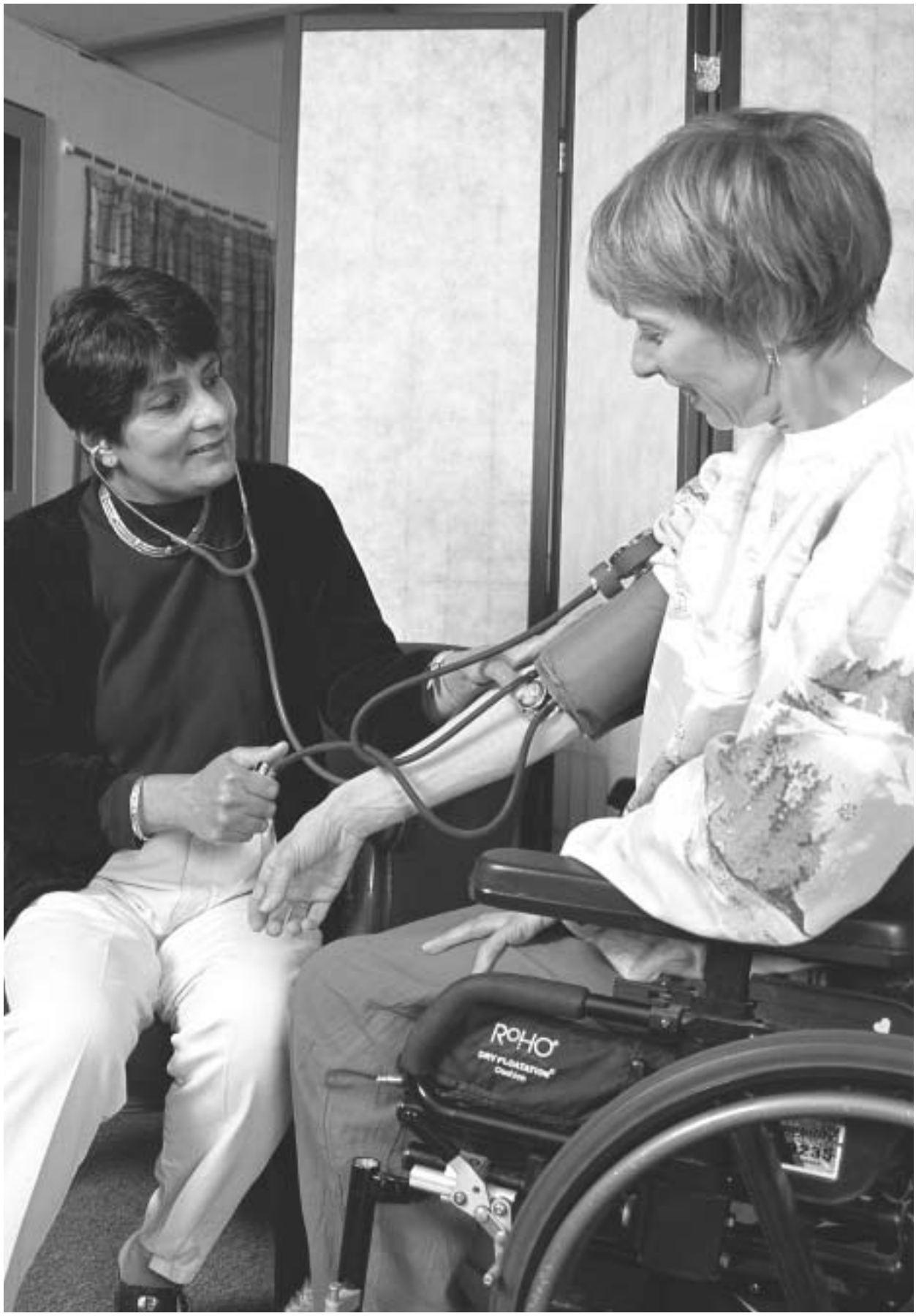
The ministry has begun work on establishing an income-testing mechanism for Pharmacare and research strategies to monitor the eventual health impacts of Pharmacare changes.

PM#11 Development of common methodologies for costing and monitoring

This measure will monitor the progress of the development of common methodologies to determine costs-per-patient for patients in a specific group. The group may be defined by disease, age, geographic location or other characteristics.

Patients usually receive care that is funded through multiple programs. To provide efficient, patient-centred care, especially for those with complex or multiple disorders or illnesses, a clear understanding of cross program costs and measurable outcomes is needed. The goal is to provide key planning tools so the health system can priorize and target the most effective and efficient health interventions. This work will proceed in conjunction with a Health Canada funded study to develop Canadian tools to support evidence-based decision-making.

The ministry has initiated work on estimating the burden of disease, injury and risk using summary measures of population health.


ROHO

REPORT ON RESOURCES

MINISTRY OF HEALTH PLANNING 2001/02 RESOURCE SUMMARY

(Note 1)

	ESTIMATED	OTHER AUTHORIZATIONS	TOTAL	ACTUAL	VARIANCE	NOTE
OPERATING EXPENSES ($000)						
Minister's Office	580	–	580	325	255	2
Planning, Policy and Legislation	1,618	–	1,618	834	784	2
Governance and Accountability	2,600	–	2,600	2,155	445	2
Total	4,798	–	4,798	3,314	1,484	
FULL-TIME EQUIVALENTS (FTEs)						
Total	50	–	50	31	19	2
MINISTRY CAPITAL EXPENDITURES ($000)						
Information Systems			–		–	
Other			–		–	
Total	–	–	–	–	–	
CONSOLIDATED CAPITAL PLAN EXPENDITURES ($000)						
Purpose 1			–		–	
Purpose 2			–		–	
Total	–	–	–	–	–	
OTHER FINANCING TRANSACTIONS (NET DISBURSEMENTS) ($000)						
Purpose 1			–		–	
Purpose 2			–		–	
Total	–	–	–	–	–	

Notes:

1) Estimated budget, other authorizations and actual amounts for 2001/02 as per draft Public Accounts. Figures are unaudited.

2) Recruitment lag and one-time savings account for the variance.

The Ministry of Health Planning was created in June, 2001 to provide a stronger focus and more sustained efforts towards proper long-term planning for B.C.'s health system, and to introduce new measures and expectations that will make the health system more accountable to British Columbians for the quality and effectiveness of the services it provides. The Health Planning ministry will also give health promotion and prevention activities a higher priority both as a means of improving the health and wellness of British Columbians, and as a means of creating a more sustainable system for the future. Having a ministry dedicated to long-term planning, creating a more accountable and sustainable health system, and a healthier population, are key to achieving the government's New Era vision and goals for health. Corporate support services, including financial, information management, human resources, client services and freedom of information and protection of privacy functions, are provided to the ministry by the Ministry of Health Services.

3) The structure of the health ministries has changed significantly since the 2001/02 budget was tabled in the Legislative Assembly on July 30, 2001. By necessity, the public accounts reflect the results of operations against the budget approved by the Legislative Assembly for 2001/02, and those figures are reflected in the ministries' annual reports for the year. For the 2002/03 fiscal year, the budget reflects the new organizational structure and mandate.

APPENDIX 1 – ACTS UNDER THE JURISDICTION OF THE MINISTER OF HEALTH PLANNING

Chiropractors Act

Dentists Act

Emergency Contraceptive Access Act

Health Act, ss. 2 to 7

Health Emergency Act – ss. 6 – 9, and 14(2)(a) and (b)

Health Professions Act

Health Research Foundation Act

Hearing Aid Act

Marriage Act

Medical Practitioners Act

Medicare Protection Act, ss. 3 – 6

Name Act

Nurses (Registered) Act

Optometrists Act

Pharmacists, Pharmacy Operations and Drug Scheduling Act, except Part 8 and ss. 37– 39

Podiatrists Act

Seniors Advisory Council Act

Tobacco Damages and Health Care Costs Recovery Act

Tobacco Sales Act

Vital Statistics Act

Wills Act – Part 2

APPENDIX 2 – PROFESSIONS ADMINISTERED BY THE MINISTER OF HEALTH PLANNING

Acupuncturists

Chiropractors

Dental Hygienists

Dental Technicians

Dentists

Denturists

Emergency Medical Assistants

Hearing Aid Dealers (including audiologists in private practice)

Licensed Practical Nurses

Massage Therapists

Medical Practitioners

Midwives

Naturopaths

Occupational Therapists

Opticians

Optometrists

Pharmacists

Physical Therapists

Podiatrists

Psychologists

Registered Nurses

Registered Psychiatric Nurses

Traditional Chinese Medicine Practitioners

APPENDIX 3 – 2001/02 LEGISLATIVE CHANGES

Four Acts, three administered by the Ministry of Health Services and one administered by the Ministry of Health Planning, were amended or enacted during the 2nd and 3rd Legislative Sessions of the 37th Parliament in 2001 and the first quarter of 2002.

Ministry of Health Services

HEALTH AUTHORITIES AMENDMENT ACT (NO. 2), 2001

(BILL 9, 2nd Session)

This Bill repealed provisions of the *Health Authorities Act* and the *Expropriation Act* that allowed for the mandatory amalgamation of a private corporation with a health authority without compensation.

HEALTH AND SOCIAL SERVICES DELIVERY IMPROVEMENT ACT, 2002

(BILL 29, 2nd Session)

This Bill enabled health employers to deliver cost effective and improved services to the public by

- facilitating implementation of new health authorities restructuring,
- permitting more flexible work arrangements,
- removing excessive layoff and bumping provisions, and
- allowing improved service delivery through open tendering.

MEDICAL SERVICES ARBITRATION ACT, 2002

(BILL 9, 3rd Session)

This Bill cancelled the arbitration between the government and the British Columbia Medical Association and discontinued all further rights and obligations under the arbitration. It also declared as void or amended specific contractual provisions respecting interest arbitration.

Ministry of Health Planning

MISCELLANEOUS STATUTES AMENDMENT ACT, 2001

(BILL 11, 2nd Session)

This Bill repealed certain provisions of the *Medical Practitioners Act* pertaining to the practice of complementary medicine by medical practitioners where those provisions:

- restricted the College's ability to evaluate applicants for admission where the applicant supports the use of complementary medicine;
- limited the circumstances in which an investigation committee could be appointed to examine the skills of knowledge or a practitioner;
- restricted the ability of an inquiry committee in a disciplinary matter to make findings with respect to a practitioner who used complementary medicine.

The Bill also amended the Act to provide that the practice of a non-conventional therapy by a member is not by itself a basis for holding that the member is incompetent or guilty of professional misconduct unless it can be shown that the therapy poses a greater risk to patient health or safety than does prevailing medical practice.

APPENDIX 4 – MINISTRY ORGANIZATIONAL CHART FOR MARCH 2002