



BRITISH
COLUMBIA

Performance Plan
2000/2001

Ministry of Health

And

Ministry Responsible for Seniors

Date: April 2000

Table of Contents

Section 1	Vision Mission Values Environmental Scan
Section 2	Program Objectives and Performance Measures Regional Programs <ul style="list-style-type: none">• Regional Operations• Public & Preventive Health• Adult Mental Health• British Columbia Ambulance Service• Continuing Care Plan Implementation Medical Services Plan Strategic Planning/Pharmacare Corporate Programs Information Management Group Office of the Provincial Health Officer
Section 3	Link to Ministry Strategic Goals Link to Government Priorities
Section 4	Link to Resources
Section 5	Link to other Ministry plans <ul style="list-style-type: none">• Capital• Information Management Resource
Appendix A	Environmental Scan
Appendix B	Ministry Strategic Goals
Appendix C	Capital Plan
Appendix D	IMR Plan

SECTION 1

This Performance Plan is a compilation of the major objectives of Ministry of Health programs. It is not a comprehensive list of all the program objectives to be undertaken during the next year, but it represents issues that are either fundamental to the day-to-day operations of the Ministry or that will take the Ministry towards its vision of the future of health care in British Columbia.

Vision

The British Columbia government's overall vision for health is to ensure a healthy population living in a healthy environment.

The vision encompasses two characteristics:

- The health of all British Columbians will be actively promoted and protected through healthy social, economic and physical environments;
- British Columbians who are sick get the right services, in the right place, at the right time.

Mission

The mission of the Ministry of Health is to support British Columbians in their efforts to maintain and improve their health. The ministry provides strategic direction and leadership of the health care system on behalf of the provincial government. Through a broad range of programs, services and public funding, the ministry is responsible for ensuring the maintenance of high quality, accessible, affordable health care for British Columbians.

Values

Health service planning, management, and delivery is based on principles which are linked to the elements of our mission:

A Health System for British Columbians

Health services should be developed, delivered, and evaluated in collaboration with consumers and health service practitioners and should respect the diversity of all British Columbians.

Health Services should focus on decreasing the disparity in health status among population groups.

Reasonable Access

All British Columbians should have access to the health services they require.

High Quality

Health services should provide the right service at the right time in the right place by the right provider.

Health services should be managed and delivered to provide the best possible health outcomes for British Columbians.

Health services should focus on minimising risks to the health and safety of British Columbians.

Affordable and Sustainable Costs

Health services should be managed and delivered at the lowest cost consistent with quality services.

Environmental Scan

The Ministry performs a regular environmental scan, both to assess the external factors which are likely to have significant impact on the health care sector, and the extent to which the ministry and the sector are equipped to deal with these factors. Because of the range and complexity of the health care environment, the scan is several pages in length and is not contained in the body of this Plan. The most recent scan is attached as Appendix A.

SECTION 2

Program Objectives and Performance Measures

In *Strategic Directions for British Columbia's Health Services System*¹ the Ministry established nine strategic goals, with supporting objectives, which are listed in detail in Appendix B. All Program Objectives are linked to one or more Strategic Goals and the related Objectives.

The Ministry Programs are a snapshot of the Ministry organization as at February 15th, 2000, as follows:

Regional Programs

- Regional Operations
- Public & Preventive Health
- Adult Mental Health
- British Columbia Ambulance Service
- Continuing Care Plan Implementation

Medical Services Plan

Strategic Planning/Pharmacare

Corporate Programs

Information Management Group

Office of the Provincial Health Officer

Each Program section includes a summary of the Key Program Objectives and the performance measures for each objective. Most Program Objectives are supported by Tasks/Activities that have a one-year time-frame; some are marked for a longer period, and some are ongoing activities which will recur every year. Performance indicators are still mostly related to output. The Ministry is moving towards outcome measures and expects to incorporate these to a greater extent with each successive Plan.

The Ministry Annual Report is changing to focus on issues of performance, and it is intended that later versions of the Annual Report will link directly to the performance measures contained in the Performance Plan.

1. The *Strategic Directions* report is available at: <http://www.gov.bc.ca/hlth/>

REGIONAL OPERATIONS

Key Program Objective	Performance Measure	Ministry Goal
Continue to develop accountability and monitoring mechanisms for health authorities, in the areas of acute care, continuing care, mental health and public and preventive health.	<ul style="list-style-type: none"> • Performance measures determined jointly by Ministry and health authority; and, regular reporting to monitor financial, service utilization and outcome data. 	5 & 7
Address the availability and timeliness of cancer care.	<ul style="list-style-type: none"> • Wait time standards established and actual wait times reported for surgical oncology cancer treatment. 	2
Implement an integrated three-year capital planning process for health authorities.	<ul style="list-style-type: none"> • Health authority 2001/02 capital plans are submitted by June 2000 and meet the requirements including completion of a project study for all major projects and program related Treasury Board Minor projects. 	4
Review and assess opportunities for improvements to the Emergency Medical Coverage Program for Northern & Isolation Allowance Communities.	<ul style="list-style-type: none"> • Completion of evaluation of the Emergency Medical Coverage Program and development of Ministry recommendations. 	3
Enhance the provincial wait list strategy.	<ul style="list-style-type: none"> • Wait List Registry is expanded to increase the number of hospitals reporting. 	2
Enhance tertiary services.	<ul style="list-style-type: none"> • Provincial Trauma Strategy is developed and implemented and Cardiac Costing Model is developed and implemented. 	3 & 5
Monitor and promote appropriate utilization of the blood supply.	<ul style="list-style-type: none"> • Percent of hospitals reporting to central transfusion registry and completion of transfusion surveillance pilot project. 	1 & 5

PUBLIC AND PREVENTIVE HEALTH

Key Program Objective	Performance Measure	Ministry Goal
Reduce tobacco use and, in particular, protect young people from tobacco.	<ul style="list-style-type: none"> • Continuation of Contribution Agreement with federal government • Distribution of a retailer toolkit. • Distribution of the Annual Report of the Teen Tobacco Team. • Distribution of the Aboriginal Tobacco Reduction Strategy for consultation. • Distribution of remaining school-based prevention resources 	1
Reduce injury, cardiovascular disease, and skin cancer in British Columbia.	<ul style="list-style-type: none"> • Completed review of emergency department injury surveillance systems and development of a best practices document to prevent sport/recreation injuries. • Development of Cardiovascular Disease Prevention Strategy. • Development of Sun Awareness/Skin Cancer Strategy, Action Plan, and production of Sun Awareness Resource. 	1
Reduce the spread of HIV/AIDS and improve the quality of life for people living with HIV/AIDS and their caregivers.	<ul style="list-style-type: none"> • Implementation of the HIV/AIDS Framework, the Red Road: Provincial Aboriginal HIV/AIDS Strategy and the regional planning process. • Improved access and increased usage of community-based HIV/AIDS services and needle exchange programs • Development of standards and outcomes for HIV/AIDS services • Increased stakeholder involvement and collaboration 	1

Key Program Objective	Performance Measure	Ministry Goal
Protect the health of British Columbians through enhanced immunization reporting and surveillance of diseases, disease patterns, and adverse health effects.	<ul style="list-style-type: none"> • Enhancement of a national and provincial communicable disease database • Participation in implementation of national/provincial diabetes surveillance system 	1
Improve the health status of Aboriginal people in British Columbia.	<ul style="list-style-type: none"> • Development/Implementation of Provincial Aboriginal Health Services Strategy (PAHSS) • Improved relationship between aboriginal communities and health authorities through implementation of the Aboriginal Governors Working Group (AGWG) recommendations. • Devolution of Aboriginal Health Division funding that is consistent both with the goals of PAHSS and with the principles of regionalization. • Options for a relationship between the regional aboriginal health councils and the health authorities, that formalizes aboriginal involvement in the health planning process. • Improved accountability to Aboriginal community for program/services funding 	1

ADULT MENTAL HEALTH

Key Program Objective	Performance Measure	Ministry Goal
Support health authorities' capacity to strengthen mental health services, including those serving rural and remote communities.	<ul style="list-style-type: none"> • Clear policy direction. • Development of best practice resources and tools. 	6
Develop mechanisms for accountability in mental health services.	<ul style="list-style-type: none"> • Performance monitoring framework and baseline report. • Resource utilization management report. 	6 & 9
Support initiatives that strengthen the inclusion and contributions of mental health consumers and their families in service planning and evaluation.	<ul style="list-style-type: none"> • Development of a plan for inter-regional information sharing. • Effective support provided to the Minister's Advisory Council on Mental Health. 	5
Develop strategies with related partners to better serve special needs populations.	<ul style="list-style-type: none"> • Evidence of active inter-sectoral and inter-ministerial committees with work-plans 	6

BC AMBULANCE SERVICE

Key Program Objective	Performance Measure	Ministry Goal
Maximize resource utilization and enhance service availability.	<ul style="list-style-type: none">• Appropriate utilization of ambulance resources and improved response times.	4
Enhance quality of patient care by expanding local access to Paramedic Training Programs.	<ul style="list-style-type: none">• Computers in as many stations as funding allows.	5

CONTINUING CARE PLAN IMPLEMENTATION

Key Program Objective	Performance Measure	Ministry Goal
Develop a comprehensive renewal strategy for continuing care services.	<ul style="list-style-type: none">• Completion of a staged and costed implementation plan for renewing continuing care services	6

MEDICAL SERVICES PLAN

Key Program Objective	Performance Measure	Ministry Goal
Provide a continuum of medical services to meet the diverse needs of BC patients.	<ul style="list-style-type: none"> • Implementation of the Selfcare/Telecare project. • Publication of the Primary Care Demo project final report. 	6
Improve access to necessary medical care for all British Columbians	<ul style="list-style-type: none"> • Implementation of the rural action plan. • Development of a physician resource plan. • Increase in number of Alternative Payment service agreements by at least 15%. 	3
Work towards continuous improvement in medical care	<ul style="list-style-type: none"> • Expanded number of protocols and guidelines. • Increased opportunities for multi-disciplinary delivery of primary care. 	6
Manage and deliver medical services effectively	<ul style="list-style-type: none"> • Completion of agreements with physicians and other health care practitioners that provide cost certainty and effective management mechanisms. • Implementation of utilization measures that contain physician billings within established budgets. 	5, 8

STRATEGIC PLANNING

Key Program Objective	Performance Measure	Ministry Goal
Develop strategic plans, business plans, accountability framework and related performance measures.	<ul style="list-style-type: none"> • Completion of planning cycle. • Completion of ministry performance measures. 	8
Implement an integrated and collaborative planning approach for health human resources.	<ul style="list-style-type: none"> • Completion of an analysis paper for each priority sector. • Completion of a co-ordinated Nursing Strategy to address current and anticipated shortages. The strategy will address: <ul style="list-style-type: none"> - training more nurses - hiring new nurses - retaining existing nurses 	4
Ensure that health authority policies and programs are responsive to women's health needs through support for gender-inclusive regional planning.	<ul style="list-style-type: none"> • Existence of women's health planning in Health Authority Service Plans. Target 25% of HA plans in 2000/2001. 	7
Negotiate and finalize agreements under the BC/Yukon Accord	<ul style="list-style-type: none"> • Reciprocal agreement in place. • Improved access to necessary health services by Northern BC residents. 	1, 2 & 3

PHARMACARE

Key Program Objective	Performance Measure	Ministry Goal
Manage growth of expenditures while maintaining appropriate access and quality of care.	<ul style="list-style-type: none"> • Manage within the budget 	1
Improve utilization initiatives.	<ul style="list-style-type: none"> • Volume of utilization initiatives • Evaluated effective initiatives 	6
Complete follow-up to Auditor General's Report	<ul style="list-style-type: none"> • All recommendations addressed 	8
Improve Administrative and Operational service.	<ul style="list-style-type: none"> • Stakeholder satisfaction levels 	8
Increase communication	<ul style="list-style-type: none"> • Frequency of communication with pharmacists, physicians, drug manufacturers and interested public • Stakeholder satisfaction levels 	5 & 6

CORPORATE PROGRAMS

Key Program Objective	Performance Measure	Ministry Goal
Determine labour settlement costing information requirements.	<ul style="list-style-type: none"> • Changes to the Health Sector Compensation Information System (HSCIS) to improve compliance with reporting requirements. 	5
Perform internal audits to increase accountability in utilization of the health system.	<ul style="list-style-type: none"> • Reduced utilization statistics by patients, practitioners and medical laboratories. 	5 & 8
Evaluate private collection agencies regarding the collection of outstanding MSP Premiums.	<ul style="list-style-type: none"> • Comparison of the Loans Administration Branch (Ministry of Finance) collections and costs to those of private collection agents. 	8
Provide consultation and support to Ministry of Health on privacy and security issues.	<ul style="list-style-type: none"> • Privacy impact statements for all new information systems. 	5
Implement the required amendments to legislation governing the health professions.	<ul style="list-style-type: none"> • Receipt of consultation document in response to the Health Professions Council Legislative Review and completion of Request for Legislation. 	6
Establish career development and succession planning initiatives.	<ul style="list-style-type: none"> • Self-assessment tools developed and career planning education sessions delivered. • Increased representation of youth within the Ministry. 	8
Ensure ministry emergency preparedness by developing, communicating and exercising ministry response, business continuity and recovery plans.	<ul style="list-style-type: none"> • Published plans to which key ministry and other agency staff have been oriented and participated in drills. 	9

INFORMATION MANAGEMENT GROUP

Key Program Objective	Performance Measure	Ministry Goal
Provide access to information systems so that health outcomes will improve.	<ul style="list-style-type: none"> • Hospital Emergency Room access to Pharmanet is established. • Pilot implementation of Pharmanet in selected Physician's offices. • Data availability for evidence-based decision making for health care sector, through HNDData. 	5 & 8
Develop and support an information infrastructure to meet the needs of the healthcare system and improve efficiency.	<ul style="list-style-type: none"> • Improved external access to ministry systems provided through HealthNet Interface (HNI). • More effective compensation information through Health Sector Compensation Information System (HSCIS). • Established business and technical standards for the electronic exchange of lab test data, established common standard for electronic health claims, and creation of a centralized, province-wide registry for provider and facility data 	5 & 8
Provide access to health services information for Health Authorities and the Ministry of Health to improve research and program planning.	<ul style="list-style-type: none"> • Improved external access to ministry systems provided through HealthNet Interface (HNI). • Facilitate evidence-based research, planning and decision making for health care sector by implementing HNDData (Health Data Warehouse). 	5 & 8
Provide the necessary tools to support the infrastructure.	<ul style="list-style-type: none"> • Enhanced security through HNSecure. • Security controls and access kept current. 	5 & 8

OFFICE OF THE PROVINCIAL HEALTH OFFICER

Key Program Objective	Performance Measure	Ministry Goal
Increase awareness and use of the provincial health goals as a means of stimulating action to improve health.	<ul style="list-style-type: none"> • Extent to which the goals are being used within government ministries, based on a review of health goals-related activities. • Extent to which the goals are being used as a tool for health services planning, as measured by a review of health authority service plans. 	1
Increase awareness of the health status of British Columbians, the factors that influence their health, and actions that can be taken to improve health.	<ul style="list-style-type: none"> • Production and uptake of Provincial Health Officer's reports, as measured by requests and media coverage. • Extent to which actions are taken on recommendations made in reports. 	1
Increase access to information and tools for monitoring and reporting on population health, setting targets to improve health, and responding to diseases and health problems.	<ul style="list-style-type: none"> • Adoption and use of a core set of indicators for monitoring population health. 	1
Ensure that Medical Health Officers have regular feedback on the performance of their professional work.	<ul style="list-style-type: none"> • Completion of annual appraisal for each Medical Health Officer. 	6

<p>Maintain inter-ministry and intergovernmental liaison for public health issues.</p>	<ul style="list-style-type: none"> • Production of reports and other products by inter-ministry and intergovernmental committees, e.g., the ACPH Sub-Committee on Intravenous Drug Use is to produce a report and recommendations for F/P/T/DMs by June 2000. • Extent to which B.C. perspective is incorporated into federal/provincial activities and products. • Level of awareness and actions taken within B.C. 	<p>1</p>
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SECTION 3

Link to Ministry Strategic Goals

Program	Ministry Strategic Goal								
	1	2	3	4	5	6	7	8	9
Regional Ops.	√	√	√	√	√		√		
Pub./Prev. Hlth.	√								
Adult Ment. Hlth					√	√			√
BCAS				√	√				
Cont. Care Plan						√			
MSP			√		√	√		√	
Strat. Planning	√	√	√	√			√	√	
Pharmacare	√				√	√		√	
Corp. Prog.					√	√		√	√
IMG					√			√	
Prov. Hlth. Off.	√					√			

Link to Government Priorities

Government Priority	Relevant Ministry Goal Statement	Clarifying Remarks
Education	Goal 4: British Columbia will have an adequate supply of health care services	Ministry Objective 4.1 deals with the planning for, and education of, health service providers.
Health Care	Goals 1 – 9 (see Appendix B)	All Ministry Goals and Objectives deal directly with the provision of health care for the population.

<p>Family and Communities</p>	<p>Goal 1: British Columbians will continue to enjoy the best health status in Canada, and that status will continue to improve.</p>	<p>Ministry Objective 1.4 deals with the use of the Provincial Health Goals to stimulate social, environmental, and economic actions to improve health in the broadest sense. Provincial Health Goal 1 calls for ‘Positive and supportive living and working conditions in all our communities.’</p>
<p>Stronger Economy for B.C.</p>	<p>Goals 1 – 9 (see Appendix B)</p>	<p>Improved health translates to less lost time from work, improved productivity, and a stronger economy. Also, the health care sector is a major employer in the province</p>
<p>Environment</p>	<p>Goal 1: British Columbians will continue to enjoy the best health status in Canada, and that status will continue to improve.</p>	<p>Ministry Objective 1.4 deals with the use of the Provincial Health Goals to stimulate social, environmental, and economic actions to improve health in the broadest sense. Provincial Health Goal 3 calls for ‘A diverse and sustainable physical environment with clean, healthy and safe air, water and land.’</p>

SECTION 4

Link to Resources

PROGRAM¹	PROGRAM MANAGEMENT (\$'000)	SERVICE DELIVERY (\$'000)	FTEs
Regional Programs			
- Regional Operations	9,330	4,481,536	115
- Adult Mental Health	1,819	362,155	25
- Public & Preventive Health	15,998	172,140	117
- BCAS	4,120	140,683	1,693
- Continuing Care Plan Imp. ²	-	-	-
Medical Services Plan	26,060	2,027,064	421
Strategic Planning ³	7,029	-	47
Pharmacare	7,462	653,178	84
Corporate Programs	44,654	-	425
Information Management Group	55,228	-	224
Provincial Health Officer ⁴	638	-	5

Notes:

1. The table does not reflect the Ministry's total budget as shown in the Estimates book. The following programs are not included in the Performance Plan:
 - Minister's Office
 - Communications and Issues Management
 - Vital Statistics (Vital Statistics submits its own Plan)
2. The Continuing Care Plan Implementation budget is included in Regional Operations.
3. The Strategic Planning budget includes \$3.295 million of grants and contributions provided for health research and for Federal/Provincial/Territorial committees.
4. In the Estimates book the Provincial Health Officer budget is included in Public & Preventive Health.

SECTION 5

Link To Other Ministry Plans

Capital Plan

The Ministry has a comprehensive Capital Plan in place, which, at the time of preparation of this document, is under review at Treasury Board and is not available for inclusion. The Table of Contents of the Capital Plan is attached as Appendix C.

Information Management Resource Plan

The Ministry is currently updating a five-year information management resource (IMR) plan, which covers requirements through to 2003. The Table of Contents of the IMR Plan is attached as Appendix D

ENVIRONMENTAL SCAN

2000 to 2003

Table of Contents

DEMOGRAPHICS

POPULATION GROWTH
REGIONAL GROWTH
AGING OF THE POPULATION

HEALTH OF BRITISH COLUMBIANS

HEALTH STATUS
 Self-Rated Health Status
 Morbidity and Mortality

HEALTH EXPENDITURES

PROVINCIAL GOVERNMENT EXPENDITURES
 International Comparisons
 Health Care Expenditures By Province, 1998
FEDERAL GOVERNMENT CONTRIBUTIONS
 Canada Health and Social Transfer
 Federal Cash Transfers to British Columbia

OUTSTANDING AND/OR EMERGING ISSUES

HEALTH SERVICE DELIVERY ISSUES
 Integration
 Waitlists
 Home Care
 Rural Health
 Services to the Mentally Ill
 Relationship with Ministry of Children and Families

BUDGET ISSUES
 Pressures on Pharmacare budget
 Capital equipment funding
 Capital Funding for Facilities
 Technology

HEALTH HUMAN RESOURCES
 Renegotiations of the Master Agreement between Government and the
 BCMA
 Status of Health Sector Collective Bargaining
 Physician Supply
 Nurse Supply

OTHER

Changes to health service delivery for Aboriginal people
Pressures for two-tier system
Increasing public expectations
Recent court rulings
Federal government initiatives

DEMOGRAPHICS

POPULATION GROWTH

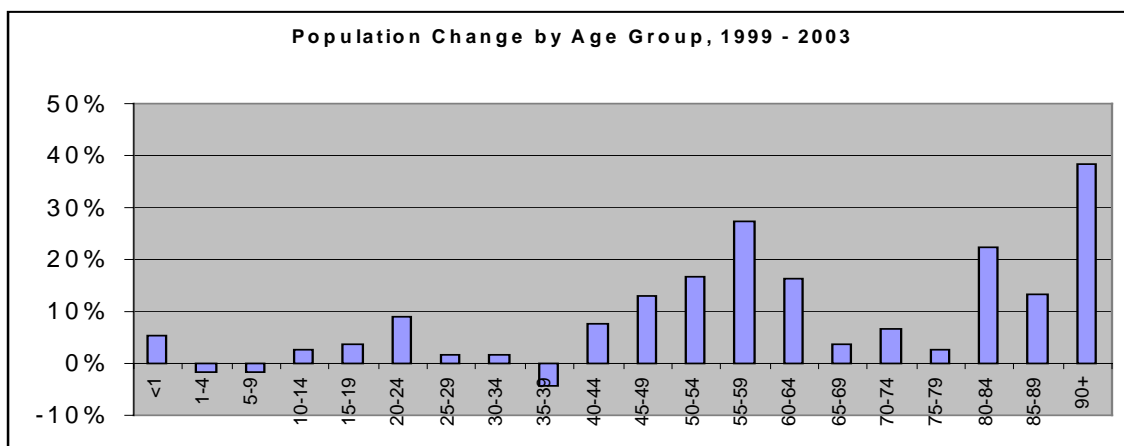
British Columbia's population is expected to increase by 9 percent between 1999 and 2004. This is the same as the rate of increase during the previous five years. The largest component of the projected increase is net international migration to British Columbia which accounts for 52 percent of the increase; net inter-provincial migration and natural increase account for 26 percent and 23 percent respectively.

REGIONAL GROWTH

Although all regional populations will increase over the next five years, the growth rate is expected to vary across regions. Geographic regions of the province in which the population growth is expected to exceed the provincial rate are: Simon Fraser and Coast Garibaldi at 14 percent, South Fraser at 13 percent, Fraser Valley at 12 percent and Okanagan-Similkameen and Thompson at 10 percent.

AGING OF THE POPULATION

The age structure of the British Columbia population is changing. The median age is expected to increase 1.5 years from 36.9 in 1999 to 38.4 in 2003. Between 1999 and 2003, the largest percentage change in population by age group will be in the 90+ age group (38 percent), followed by the 55-59 age group (27 percent) and the 80-84 age group (22 percent).



HEALTH STATUS

The determinants of health do not exist in isolation from one another. Rather, they work together in a complex system. What is clear though, is that people's circumstances affect their health and well-being. For example, research shows that living and working conditions have a greater impact on people's health than health care. Things like housing, income, social support, work stress and education also make a big difference in how long people live, and the quality of their lives.

Self-Rated Health Status

In 1996, 65 percent of British Columbians rated their health as excellent or very good. This is a slight increase from 1994 when 63 percent of the population rated their health as excellent or very good.

The proportion of British Columbians reporting that their activities are limited as a result of a long-term physical or mental condition or other health problem has decreased slightly (22 percent in 1994; 21 percent in 1996). The proportion of the Canadians reporting activity limitation is lower than in British Columbia (percent in 1994; 16 percent in 1996).

Morbidity and Mortality

The major causes of death in British Columbia in 1997 were circulatory diseases (36 percent), cancers (28 percent), respiratory diseases (11 percent) and external causes (8 percent). The causes showing the highest age standardized rates are circulatory diseases (14.71/10,000 population) and cancers (12.92 /10,000 population). The impact of premature deaths is shown by the potential years of life lost rate (PYLLR). Causes showing the highest PYLLR are external causes (14.39 per 1,000 population under age 75) and cancer (12.1 per 1,000 population under age 75).

The major reasons for hospital use in 1997/98 were external causes (20 per cent of inpatient days), circulatory diseases (15 percent of inpatient days), and mental disorders (12 percent of inpatient days). The major reasons for utilization of day care surgery in 1997/98 were digestive system diseases (17 percent of cases), external causes (16 percent of cases) and pregnancy/childbirth (13 percent of cases).

HEALTH EXPENDITURES

PROVINCIAL GOVERNMENT EXPENDITURES

International Comparisons

International and interprovincial comparisons provide benchmarks for appreciating the relative order of magnitude, level and appropriateness of health care expenditures, and some indication of the direction in which these are likely to move.

The basic unit for comparisons is the share of a jurisdiction's recorded economic activity that is devoted to health care: the share of gross domestic product, GDP. Health care's share of GDP depends on the level of health care expenditures and on the level of the GDP.

At the **international** level, Canada ranks among the group of industrialized countries which spent close to 10 percent of GDP on health care during 1997: this group includes Germany (10.4%), Switzerland (10.2%), France (9.9%) and Canada (9.3%). However, instead of being compared with this peer group, Canada is frequently compared with two statistical outliers: the United States, which at 14.0% spends more than any other industrial jurisdiction on health care, and the United Kingdom, which at 6.7%, spends the least on health care among G-7 countries.

Two other units for international comparisons are:

- 1) each country's per capita 1997 health expenditures, converted into U.S. dollars:

United States	\$4,090
Switzerland	\$3,584
Germany	\$2,677
France	\$2,348
Canada	\$1,837
United Kingdom	\$1,457

- 2) and, each country's 1997 per capita health expenditures, converted into purchasing power parity (PPP) U.S. dollars, which basically attempts to describe what each country's expenditures would be, if

they were paying in U.S dollars at the rate which equalizes the prices of an identical basket of goods and services in each country:

United States	\$4,090
Switzerland	\$2,547
Germany	\$2,339
France	\$2,103
Canada	\$2,095
United Kingdom	\$1,347

One important health outcome, possibly related to health care expenditures, is life expectancy at birth. The following table shows how the above-mentioned countries, and Japan, the world leader, fared in 1996:

Life expectancy at birth (in years), 1996

	Females	Males
United States	79.4	72.7
Switzerland	81.9	75.7
Germany	79.9	73.6
France	82.0	74.1
Canada	81.5	75.4
United Kingdom	79.3	74.4
Japan	83.6	77.0

Taken together, these comparisons reveal that Canada is achieving health outcomes comparable to those of other countries which devote a similar share of national resources to health care. The longer-term outlook is that as Canada's GDP per capita increases, the share of resources devoted to health care will increase. The threat in the near-term is that a continuing decline in the value of the Canadian dollar, coupled with declining commodity prices, will lead to a decline in Canada's real per capita GDP, and an increasing health burden associated with high and increasing unemployment. Recent increases in Federal government transfers to the Provinces may help to sustain health care spending at current levels, while a declining economy will lead to a significant increase in the share of GDP devoted to health care, without an improvement in outcomes.

Health Care Expenditures By Province, 1998

British Columbia's Provincial Government spent more per capita on health care than any other province.¹ At \$1,950, British Columbia's Provincial Government spent \$375, or 23.8 per cent more than the Government of Alberta on health care for every person in the province; 13.7 per cent

¹ Source: CIHI, National Health Expenditure Trends, 1975-1998.

more than the Government of Ontario, and 23.6 per cent more than the Government of Quebec.

FEDERAL GOVERNMENT CONTRIBUTIONS

Canada Health and Social Transfer

1998/99 marks a turning point following years of significantly declining Federal Transfer cash payments to British Columbia:

Federal Cash Transfers to British Columbia

Fiscal year		change from previous year	cumulative loss
	\$ billions	\$ millions	\$ millions
1994/95	2.236		
1995/96	2.235	-1	-1
1996/97	1.843	-392	-393
1997/98	1.701	-143	-536
1998/99	1.720	19	-517

Thus, during a period when the population of British Columbia increased from 3.632 million to 4.035 million, the Province had to overcome the challenges of maintaining and improving the health status and the health care of British Columbians, while suddenly being denied hundreds of millions of dollars per year, an amount of the order of one third of total fee-for-service payments to physicians.

OUTSTANDING AND/OR EMERGING ISSUES

HEALTH SERVICE DELIVERY ISSUES

Integration

Increasing the integration and coordination of services is one of the objectives of health care reform. Regionalization and the establishment of health authorities funded on a global budget basis, has established the administrative infrastructure for the development of integrated systems of

care. The next challenge will be to achieve integration at the service delivery level. The Ministry of Health has indicated to health authorities that they are required to increase the integration of services within their service areas, to improve quality and efficiency of care. Challenges to the achievement of this objective include:

- Large investment in information infrastructure needed to support integrated delivery systems
- Payment of physician services remain a responsibility of the MOH, yet physicians are key gatekeepers to most services under the responsibility of health authorities

Development and evaluation of models of service integration is still an evolving field and there are no established “best practices” for health authorities to learn from.

Waitlists

The public views wait times as a serious problem and an indication of inadequate access to health care services. As a result, governments and health authorities are under considerable pressure to reduce waiting times by whatever means possible. However, there is considerable disagreement about the nature and extent of the problem of waiting times, and the evidence does not show a clear solution to the problem, since simply increasing funding often paradoxically results in increasing demand and longer wait lists.

There is, however, a clear need to understand and manage this issue to ensure that those with the greatest need get priority and that wait times are reasonable and do not affect patients' outcomes adversely.

Home Care

The funding, organization and delivery of home care services have become a prominent health policy issue in BC in recent years. A number of emerging issues relating to home care will need to be addressed in the near future:

- Increasing demand for services, resulting from population aging and increased numbers of frail elderly, an emphasis on shifting care from the hospital to the community and technological changes allowing more services to be provided in the community;
- Increasing pressure to provide post-hospitalization home care, which decreases access to those with chronic needs;
- Decreasing access to homemaker services in some jurisdictions, and questions about whether homemaking is an essential component of the home care program;

- Funding for prescription medications required in community settings (which are fully funded in the hospital);
- Policy issues around whether home care provided by family members should be publicly funded; and
- Policy issues around whether home care and continuing care should be covered under the Canada Health Act.

Rural Health

- BC residents living in rural and remote areas face a number of unique challenges in accessing health care, due to factors of population and geography. Many areas have an insufficient population base to support the range of health professional and services that are available in more populated areas. In many areas surface transport is difficult or non-existent because of long travel distances, topography, and hazardous weather conditions.
- The above characteristics of rural and remote areas give rise to the following concerns:
 - Difficulty in recruiting and retaining health professionals, particularly physicians;
 - Lack of community support services in small isolated communities;
 - Costs of travel and accommodation to other special needs associated with obtaining care at geographically distant secondary and tertiary centres.
- Analyses of utilization patterns show that *per capita* expenditure on medical services (i.e. services funded through MSP, including physician services) is less in remote and rural communities. Consumption of acute/rehabilitation hospital days in rural communities is actually higher than the provincial average; rural residents receive a higher proportion of their care in speciality and teaching hospitals.
- The special problems of delivering health care in BC's remote and rural communities has received attention by a number of groups, and a series of programs have been established to address identified problems.
- There is as yet no solution to the issue of distribution and access. and residents of rural and remote areas believe that their health care concerns are not being met. It is also important to note that the health status of remote and rural populations is poorer than that of urban population.

Services to the Mentally III

- BC, with a population of 3.8 million, has on the order of 1 million persons with some form of diagnosable mental illness, including about 100,000 persons with psychotic mental disorders. In 1997/98, of the Ministry's total expenditure of \$6.9 billion, \$1.1 billion was attributable to mental health services, representing 15.8% of total expenditures.
- In 1998, the Ministry of Health released a new Mental Health Plan to reform mental health services. The Plan is focused on a number of critical issues:
 - An emphasis on adults with the most disabling functional impairment due to serious mental illness.
 - An emphasis on early identification and treatment of individuals and related support for their families.
 - Implementation of best practices in mental health care to enable consumers to benefit from the most current knowledge about current knowledge about program and service design that produce positive health outcomes;
 - More responsive services for individuals with multiple problems, who historically have been poorly served by existing services (e.g. people with a mental illness and substance misuse and/or who have been in conflict with the law);
 - A shift in service delivery to better respond to individuals' complex needs through outreach, assertive case management and appropriate medical care in non-hospital settings wherever this is consistent with quality care;
 - Policy development and service planning coordination focused on the biological, psychological and social needs of people with serious mental illness;
 - Integration of forensic psychiatric services with other elements of the mental health system to provide improved community support and assertive case management services to low risk mentally disordered offenders and to reduce the number of people with illness who come into conflict with the law; and
 - Improved policy coordination with other ministries to better address income security, housing, training, employment and other social support needs.

Relationship with Ministry of Children and Families

- Responsibility for children's health care is shared with the Ministry for Children and Families (MCF).
- Most community-based programs and services for children are funded and delivered through MCF, including:
 - children's mental health services
 - early intervention programs,

- prenatal prevention and promotion programs,
 - community support and respite services for children with special medical needs.
- A number of services for children are a joint responsibility. MCF establishes the policy, funding, and delivery framework for the following services which are managed and delivered by health authorities:
 - public health nursing
 - speech and language pathology
 - audiology
 - nutrition and dental health services
 - Medical and hospital services for children are funded through MOH as part of the provincial health care system.
 - Prevention and control of communicable disease, including immunization has also remained an MOH responsibility.
 - There is confusion among the public, service providers, and even Ministry staff about roles and responsibilities in relation to health care for children. Lack of co-ordination at the policy and service delivery level has been identified by the Children's Commissioner and other experts as one particularly important area requiring improvement.

BUDGET ISSUES

Rising input costs will continue to put pressure on health expenditures. Health human resource costs are estimated to represent 80% of expenditures. Therefore, even small increases in wage settlements translate into large expenditure increases. The building of additional beds means increased ongoing operating costs. The planned obsolescence of information technology requires ongoing reinvestment in infrastructure, which although introducing new capabilities, dilutes the advantage of them. For the most part, these expenditure increases do not result in the provision of additional services, and there is no evidence that BC's achieves better outcomes as compared to provinces which spend less.

Pressures on Pharmacare Budget

- Despite the cost saving measures, improvements and evidence based decision making, cost pressures for Pharmacare are expected to continue.

Capital Equipment Funding

- Concerns regarding capital equipment funding include:
 - the lack of sufficient funding for equipment replacement and new technologies;
 - the lack of consistency in annual funding levels for major equipment;
 - the role of the Ministry of Health with respect to equipment grants and equipment planning in a regionalized health care system; and
 - the lack of consensus on how much funding is required for capital.

Capital Funding for Facilities

- Capital for funding of new infrastructure and upgrading existing facilities will be a major cost pressure for years to come.

Technology

Technology continues to have a significant impact on the health care system. This holds not only for new technologies, which may affect service delivery, efficiency and quality of care, but also for the more widespread use of existing technologies. The greater use of, and reliance on, expensive diagnostic equipment such as Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), and automated laboratory testing, will have an effect on costs.

- *Telehealth.* Telecommunications technology is being used increasingly to allow clinicians and patients to interact at distance, to extend consultation among clinicians, and to facilitate distance education for health care providers. Telehealth has the potential to improve access to service, and in some cases may reduce travel costs. To date, few applications have been shown to reduce overall health costs.
- *Information Technology and the Internet.* The more widespread use of computer technology can allow better integration of information, and greater access to information. While this increases consumer awareness and involvement in care, it raises concerns about privacy of records, quality of information, and the hazards of self-diagnosis. Additionally, better management of the health system within a constrained budget increasingly requires managers to make tough funding trade-offs between programs, based on quantified population outcomes. This requires standardization, integration and sophisticated analysis of, and better access to, the large amounts of data captured as a byproduct of clinical and operational functions. The ability to achieve this is diluted by the cost pressures associated with

maintaining the growing portfolio of critical operational, clinical and administrative applications. These are subject to:

- the planned obsolescence of computer technology so that there has to be a continual reinvestment in the basic infrastructure,
 - systemic, world-wide skills shortages leading to the use of contract staff at twice the cost of internal staff,
 - addition of enhancements identified by operational continuous process improvement in response to program cost and efficiency pressures,
 - amortization of previous systems development projects' capital costs.
-
- *Biotechnology.* Biotechnology is the use of living organisms to provide new methods of production, or to make new products. Key issues for the Ministry are pharmaceuticals and vaccines, tissue engineering and xenotransplantation, the human genome project, genetic testing and gene therapy, and the health impact of biotechnical developments in other industries. These technologies can be expected to offer great potential, as well as creating significant ethical concerns and cost pressures.

HEALTH HUMAN RESOURCES

Renegotiations of the Master Agreement between Government and the BCMA

- The government and the BCMA are both seeking financial certainty in the new agreement. Negotiators are examining ways of managing utilization that will ensure the Ministry remains within budget

Status of Health Sector Collective Bargaining

Bargaining units represent a wage and benefit base of over \$3.4 billion. In 1999, negotiations concluded for the 5 master agreements covering over 100,000 employees represented by 11 unions. All agreements in the health sector are for a 3 year term, ending in the Spring 2001.

Settlements were within the 0-0-2 monetary for general wage increases which will impact year 2000. Specific issues were negotiated which impact 1999/2000 including benefit increases, leveling, pay equity, and new nursing positions

Physician Supply

British Columbia has over 7,600 physicians, approaching a near balance of general/family physicians and specialists, with an average population of fewer than one thousand per general practitioner. Although the average of 510 people per physician in 1997 is mostly an abstract concept, since general/family physicians provide most primary medical care, it is useful as a reference point in tracking trends: the comparable figure was 756 in 1968, 610 in 1977, and 524 in 1987. It is clear that the increase in the number of physicians has outpaced the increase in population.

This trend generally means that within each group of physicians, or specialty, each physician is responsible for the care of fewer people, on average. At the same time, the raw numbers alone are not sufficient to understand the simultaneous changes that have occurred in:

- geographic distribution of physicians,
- ratio of general/family practitioners to specialists,
- ratio of female to male physicians,
- age/experience distribution of physicians,
- hours of work per year per physician,
- practice of medicine, specifically changes in diagnostic tests,
- distribution and demographics of the Province's population.

Nurse Supply

- The supply of practicing registered nurses increased 26 percent between 1987 and 1998. However, this increase did not keep pace with the 30 percent increase in the population.
- Recruitment difficulties are reported generally throughout the nursing sector: urban and rural locations, specialty and general duty nursing, and casual and regular employment.
- The past decade saw a shift in employment patterns of nurses. Regular Full-Time employment fell from 54 percent in 1992 to 47 percent in 1998, Regular Part-Time employment increased from 19 percent to 25 percent, and Casual employment increased from 25 percent to 27 percent.
- The nursing workforce is aging. This is particularly manifest in the increase in the numbers of nurses aged 45-54 and the decrease in the nurses under the age of 35. The average age of a nurse in British Columbia is 47.
- An older workforce has implications for the number of nursing hours worked versus the hours paid, due to increased vacation, sick time and long term disability.

OTHER

Changes to health service delivery for Aboriginal people

Aboriginal people have the poorest health status among identified populations in British Columbia. Aboriginal people continue to rank poorly in socio-economic indicators related to poverty, education, housing and incarceration. Demographically, Aboriginal British Columbians are younger (50% under 25), and have a high comparative birth rate. Unless addressed in a strategic manner, with appropriate resourcing, the combination of population trends and indicators point to a continued poor population health status, and higher social and economic costs. Treaty processes are expected to have a significant effect on health service delivery in the coming years. Approximately 70 per cent of BC's First Nations are participating in treaty negotiations. Treaties are expected to provide for a greater measure of local control over community services, including governance and delivery of health care on settlement lands.

Independent of treaty negotiations, the federal government is negotiating agreements to transfer responsibility for administration of MSP premiums and other health-related programs to First Nations. Another significant change at the federal level is the funding cap on First Nations health care (both on reserve services and Non-insured Health Benefits Program). This limit on funding will likely lead to greater pressure on provincial services as the ability of federal services to meet health care needs declines.

While an important undertaking, treaties and federal transfer agreements will primarily impact status Indians living on treaty settlement lands. The majority of Aboriginal people (about 55 per cent) will continue to receive health services through the provincial health system. The health care needs of Aboriginal people have not been well met through this system for the following reasons:

- Poor relationships with public institutions (e.g. justice, education, child welfare and health) have led to distrust and non-participation among Aboriginal people.
- The lack of services that are either physically accessible or culturally sensitive further limit the utility of health services for Aboriginal communities.
- Misunderstandings about services provided to Aboriginal people lead many agencies to assume that such services are beyond their mandate; many Aboriginal people assume that they cannot access certain provincial services for the same reason.

Pressures for Two-Tier System

Public anxiety about the ability of the publicly funded health care system to provide timely access to needed services has led to renewed calls for increased private sector involvement in the delivery of health care. This is especially evident in Alberta. The public debate triggered by the current Alberta proposal focuses on the role and impact of the private sector on the delivery of health care services in Canada and on the long term sustainability of medicare system.

Increasing Public Expectations

Public expectations for health care services have been steadily increasing, and this trend is expected to continue. These increased expectations are the result of a number of factors, including:

- Public awareness of the many factors which affect health, leading to calls for the health care system to cover a wider range goods and services;
- an expanding definition of “health care”, based on medicalization of conditions once considered normal, the increasing prominence of alternative health care professions, and the increasing number of interventions now possible;
- the trend towards professionalization of health-related services once provided by family members;
- greater access to information on treatments;
- increasing media attention to health topics.

Recent Court Rulings

In recent years courts have been more willing to find liability, not just against individuals, but against the bodies seen to be responsible for the “system” in which wrongdoing occurred, and which have the means to provide some real compensation to the victim. This means that organizations that operate or fund health programs are increasingly being found responsible for the actions of individual employees or volunteers, regardless of whether the organization was directly responsible or negligent. In some cases (e.g. historical sexual abuse, Hep C), these judgements are occurring long after the events in question.

Courts have also been more willing to make rulings about the programs that government must provide. Consumers are turning to the courts more frequently to try to force government to provide public funding for certain health-related services. Examples are the rulings on interpretive services for the deaf and the failed attempts to have *in vitro* fertilization covered.

Federal Government Initiatives

In February 1999, the federal, provincial, and territorial governments reached agreement on a “Framework to Improve the Social Union for Canadians”, committing themselves to working more cooperatively and efficiently in the funding and delivery of social programs, including health care. The federal government agreed to respect provincial autonomy in the delivery and organization of health care. In the 1999 federal budget which was labeled the “Health Budget”, the federal government clearly staked out the areas it believes are federal jurisdiction. In addition to increases to the Canada Health and Social Transfers, the federal government committed \$1.4 billion to health research, the development of health information systems, and for enhancing prevention programs. These initiatives may present significant partnership opportunities between federal and provincial governments.

Other national initiatives which will impact on BC’s health care sector include:

- Canadian Contingency Plan for Pandemic Influenza: while immunization is a provincial matter, the federal government has initiated a process to clarify provincial/territorial/federal roles and responsibilities in relation to the projected influenza pandemic.
- Organ and Tissue Donation: development of a national organ and tissue donation strategy
- Reproductive and Genetic Technologies: planned legislation on this topic will impact all provinces by prohibiting a number of practices, and regulating the provision of other procedures, including setting standards for quality of care, reporting requirements, and establishing a licensing regime.

GOAL 1:

British Columbians will continue to enjoy the best health status in Canada, and that status will continue to improve.

OBJECTIVE 1.1:

To reduce the incidence of specific preventable diseases and deaths.

OBJECTIVE 1.2:

To assist individuals, practitioners, and health authorities in planning for and responding to emerging diseases and changes in disease patterns.

OBJECTIVE 1.3:

To reduce inequalities in health status among people in British Columbia – especially aboriginal people and those in geographic regions with lower health status than the general population.

OBJECTIVE 1.4:

Use the provincial health goals to stimulate social, environmental, and economic actions to improve health in the broadest sense.

GOAL 2:

British Columbians will have access to health care services within an acceptable time period.

OBJECTIVE 2.1:

To develop, or reaffirm where now available, guidelines (i.e. minimally acceptable thresholds) for major areas of health services from preventive and primary care through acute and continuing care.

GOAL 3:

British Columbians will have access to health care services within specified geographic distances.

OBJECTIVE 3.1:

To develop, or reaffirm where now available, geographic access guidelines (i.e. minimally acceptable thresholds) for communities throughout the province.

GOAL 4:

British Columbia will have an adequate supply of health care services.

OBJECTIVE 4.1:

To ensure the supply of health care practitioners will be adequate and distributed equitably throughout the province.

OBJECTIVE 4.2:

To ensure that the quantity and distribution of capital resources, including facilities and equipment, is appropriate.

GOAL 5:

The health services system will be organized and managed to ensure the sustainability of Medicare so all parts of the system can provide excellent care in return for the public's investment.

OBJECTIVE 5.1:

To distribute resources appropriately to all areas of the province.

OBJECTIVE 5.2:

To satisfy the public that health care services are receiving sufficient funding, and that the public is receiving good value for these resources.

OBJECTIVE 5.3:

To support an information infrastructure that meets the needs of the evolving regionalized health services system, and the ministry's role within that system.

OBJECTIVE 5.4:

To improve public understanding of how the health services system works, what it costs and how to use it judiciously.

GOAL 6:

The health services system will provide consistently high quality health services that improve health and health outcomes, and satisfy British Columbians' expectations.

OBJECTIVE 6.1:

To provide services which improve health and health care outcomes.

OBJECTIVE 6.2:

To satisfy the needs and expectations of patients and clients.

OBJECTIVE 6.3:

To ensure that self-regulated professions fulfill their obligations to maintain professional standards of performance.

OBJECTIVE 6.4:

To encourage the development of an integrated and comprehensive continuum of care.

GOAL 7:

The regionalized system will be accountable to the Minister of Health, with health authorities operating according to plans approved by the ministry and within the resources allocated to them.

OBJECTIVE 7.1:

To maintain an effective governance process for health authorities.

OBJECTIVE 7.2:

To promote and support a strong planning approach by health authorities.

OBJECTIVE 7.3:

To establish effective partnerships between health authorities and physicians.

GOAL 8:

Programs delivered directly by the ministry will be well managed.

OBJECTIVE 8.1:

To strengthen accountability mechanisms for ministry programs.

GOAL 9:

The working environment within British Columbia's health services system will be informed by a client-centred focus and characterized by a spirit of cooperation and excellence.

OBJECTIVE 9.1:

To ensure that respective roles and responsibilities evolve within a framework of continuous improvement, and providers have clear direction on how to work as a team to deliver high quality health care services.

OBJECTIVE 9.2:

To promote an environment of mutual respect among providers, support staff and patients.

OBJECTIVE 9.3:

To ensure a safe physical environment in the health services system where all who work in the environment are knowledgeable about protecting their own health and safety and contributing to a safe work place.

Ministry of Health Capital Plan

Table of Contents

1. EXECUTIVE SUMMARY

2. LONG TERM CAPITAL PLAN

1) Overview of Agency Programs

Mandate

Strategic Directions for British Columbia's Health Care System:

Regionalized Services

Links Between MOH Programs and Capital Needs

- Organization of Health Care in British Columbia
- Acute Care Facilities
- Tertiary Services
- Alternate Level of Care Patients – 1993/94 to 1997/98
- Continuing Care Facilities
- Mental Health Facilities
- Primary Care
- Academic Space

2) Capital Stock

Health Inventory Assessment

Number and Age of Capital Assets

Expected Facility Life Remaining by Type

- Acute Care
- Continuing Care Facilities

Equipment

- Acute Care Equipment – General
- Radiation Therapy Systems Equipment
- Magnetic Resonance Imaging (MRI)
- Computerized Tomography (CT) Scanners
- Positron Emission Tomography (PET)
- Acute Care/Continuing Care Bed Replacement Program

3) Factors Driving the Need For Capital

Summary of the Factors Driving Need

Maintenance/Repair/Renovation

Replacement

- Acute Care Replacement
- Continuing Care Replacement

Expansion

- 4) **Strategies to Meet Capital Expenditure Limits**
- 5) **Response to 1999/2000 Decision Letter**

3. REQUIREMENTS BY FISCAL YEAR

Ministry of Health IMR Plan

TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
1. INTRODUCTION.....	4
1.1 BACKGROUND	4
1.2 PURPOSE OF THIS PLAN.....	5
1.3 CONTEXT.....	6
1.4 SCOPE.....	6
1.5 AUDIENCE	6
2. BUSINESS PERSPECTIVE	7
2.1 INTRODUCTION	7
2.2 BUSINESS DRIVERS.....	8
2.3 GENERAL HEALTH SYSTEM MODEL	9
2.4 INFORMATION MANAGEMENT FRAMEWORK	10
3. INFORMATION NEEDS.....	13
3.1 INTRODUCTION AND SCOPE	13
3.2 PRINCIPLES	13
3.3 CURRENT STATUS AND ASSESSMENT	13
3.4 FIVE YEAR TARGET	16
4. BUSINESS INFORMATION SYSTEMS.....	18
4.1 INTRODUCTION AND SCOPE	18
4.2 PRINCIPLES	18
4.3 CURRENT STATUS AND ASSESSMENT	18
4.4 FIVE YEAR TARGET	19
5. TECHNOLOGY	22
5.1 INTRODUCTION AND SCOPE	22
5.2 PRINCIPLES	22
5.3 CURRENT STATUS AND ASSESSMENT	22
5.4 FIVE YEAR TARGET	26
6. FIVE-YEAR ACTION PLAN.....	29
6.1 KEY ISSUES	29
6.2 FIVE-YEAR SCHEDULE OF ACTIVITY	30
7. CURRENT FISCAL YEAR SUMMARY OF INITIATIVES	32
7.1 SETTING GOALS, POLICY AND PROVIDING ADVICE	32
7.2 ALLOCATING RESOURCES.....	32
7.3 HEALTH SERVICE PROVISION	32
7.4 PROVIDING PROVINCE-WIDE SUPPORT SERVICES	33
7.5 ESTABLISHING AND ENFORCING STANDARDS AND ACCOUNTABILITY.....	34

8. CONCLUSION	35
APPENDICES.....	36
A1. INVENTORY OF MINISTRY DATA AND INFORMATION	36
A2. INVENTORY OF BUSINESS SYSTEMS	36
A3. INVENTORY OF TECHNOLOGY	37