TRANSCRIPT OF THE OPEN CABINET MEETING

MONDAY, APRIL 22, 2002

Province of British Columbia

EXECUTIVE COUNCIL

Premier and President of the Executive Council	Hon. Gordon Campbell
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Minister of Energy and Mines	Hon. Richard Neufeld
Minister of Finance	Hon. Gary Collins
Minister of Forests	Hon. Michael de Jong
Minister of Health Planning	Hon. Sindi Hawkins
Minister of Health Services	Hon. Colin Hansen
Minister of State for Mental Health	Hon. Gulzar S, Cheema
Minister of State for Intermediate, Long Term and Home Care	Hon. Katherine Whittred
Minister of Human Resources	Hon. Murray Coell
Minister of Management Services	Hon. Sandy Santori
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Minister of Skills Development and Labour	Hon. Graham P. Bruce
Minister of Sustainable Resource Management	Hon. Stan Hagen
Minister of Transportation	Hon. Judith Reid
Minister of Water, Land and Air Protection	Hon. Joyce Murray

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The cabinet met at 9:04 a.m.

Premier's Opening Remarks

Hon. G. Campbell: I call the meeting to order.

We do have a number of items on the agenda today that touch on health care and one, specifically, that touches on economic measures for first nations. I want to start today by saying that we will have, tomorrow, a major presentation from the regional health authorities across the province to the people of the province about how we hope we're going to be able to move forward to improve health care services for patients. Today in cabinet we have a number of issues to deal with including future standards that we intend to set. For the first time in the province, standards for health care for people across the province are going to be set. There will be some discussion about home and community care services that are clearly essential, the ambulance service, etc.

[9:05]

I want to start and take us back almost a year now before we get started, because I think it is critical that we put this all in context. I don't think there was anyone a year ago who said: "Boy, the health care system is working exactly the way we want it to." In fact, I think one of the most interesting things about the health discussions we've had so far is that while some people are moving to try and improve the system, there are an awful lot of voices that say: "Don't make any changes."

No change is not an option. Our health costs in British Columbia have gone up by almost 25 percent in just two years. There is an incredible jump in the costs of health care. We have an aging population. We have increasing costs of technologies. We have increasing costs of pharmaceutical care. We had a system last year, frankly, that was in disrepair. As many people said prior to last year's election, it took ten years to get the system to where it was, and it's going to take a long time to improve it. I do think we've made some major strides forward, and I want to highlight some of those as we start today.

First, last year we discovered in June when we came in as government that there was a significant supply-and-demand problem. There was a problem with human resources. There was a problem with hospital facilities. There was a problem with intermediate and long-term and home care. There was a problem with medical machinery and equipment. Ultimately, there was the most significant problem, and that was the problem we had with patient care.

Previously, government, in trying to respond to the issues of patient care, had decided all they needed to do was more of the same, and more of the same meant more problems. We do have to try and change the way we've done things, and that's exactly what the four health ministers that were appointed last June have been trying to do.

There was a management problem. As incredible as it is for us to believe, there wasn't one senior ministry official responsible for health planning - not one. Out of a $9.3 billion budget, not one person was responsible for health planning: planning our human resource needs, planning for the physical needs of our health facilities. As a result, a decade of problem identification, I think, had sat there with no responses and no solutions.

Fifty-two health regions, as you know, community health councils, community health service societies…. We have taken a number of steps to try and meet these. Over this next week, we're going to see some more steps taken to try and put in place a framework for health care that puts the patient at the centre of the agenda, so we meet patients' needs regardless of where they live in the province.

I don't think we should be under any illusions about the difficulty of this challenge, because it is big. As I've said before, British Columbia is larger than England, France and Germany combined. There are four million people that live here. At least half of them are spread out over a vast, diverse area with, in some cases, very thin populations.

The challenge of bringing together our caregivers with the people who need that care is a challenge that I think we should recognize is taking place in British Columbia, but it is taking place across the country as well. I hope that over these next few days, people understand this challenge is one that is always going to be ongoing and one we're trying to meet.

As has been pointed out previously, there had been a lot of words said about health care but not much action behind it. The mental health plan that was put in place was announced with no resources behind it at all. I think the cabinet ministers we have - the Minister of Health Services, the Minister of Health Planning, Katherine with the home care and long-term care, and Gulzar with mental health care - have actually brought focus to what we're trying to do.

I want to first of all say that I think this challenge they faced with is one we're going to keep on facing. The solution will not be there on Friday. It's not going to be there a month from Friday or a year from Friday. We're all going to have to work through this together. I think one of the critical things is to recognize that there have been some significant changes: significant human resource changes, significant resources put into nurse training and licensed practical nurse training.

For the first time I'm aware of in the province, we have a special bursary in place that allows for people who decide they're going to graduate from either medical school, nursing school or health profession training and go and work in rural or remote areas. They get 20 percent of their student loans actually reduced. Over a period of five years, their entire student loan can be forgiven.

We have a $263 million plan to revitalize mental health care. You know, this is not news. For ten years we've been told we do not have a mental health care system in the province that meets the needs of people who are mentally ill; yet for some reason, for an awfully long time, there was no action with regard to that. I think Gulzar has put together a sensible and achievable plan for us to start to meet the needs of people with mental illnesses.

[9:10]

Katherine has been working very hard as Minister of State for Intermediate, Long Term and Home Care to develop our plan to create 5,000 new home care beds and new community spaces over the next five years. She's going to outline some of that today.

The interesting thing, as we look to the future, is that we've now approved the plan not just to increase the number of medical practitioners - doctors - that graduate from 128 to 224 or something like that, but we're also going to try to deliver those new medical education services in a different way than has happened anywhere else in the country.

The new campus at UNBC and the new campus at UVic are both aimed at meeting specific needs. We know in an aging population…. When it comes, for example, to the University of Victoria, we've set goals for them in terms of geriatric medicine and at the University of Northern British Columbia with regard to the development of rural and remote medical practices across this province. All of those things are steps, I believe, in a direction that's critical for us to move forward.

One of the most critical recommendations that's been made for over a decade now was the recommendation that we try and move decision-making out of the political arena and into the arena of professional decision-making at the local level, which we define as regional health authorities. There's probably no single more difficult transition that we're going to have to make.

I want to remind people that as we go through this over the next number of days, there are a number of areas where accountability is built into the system. The first area is that the Minister of Health Services obviously will be holding health authorities to account for the delivery of services. We will be holding them to account for meeting the standards that Sindi's going to be laying out for us today.

Since I was elected in 1994, the Health Committee of this Legislature had not met. We said quite clearly when we ran for office that the Health Committee would be playing an important role in looking at this. They will have a critical accountability function in reviewing health authority plans and their performance. Again, following the introduction of the plans this year, next year those authorities will be before our Health Committee of the Legislature - an all-party committee should all parties decide to participate. I can tell you that will be an opportunity to look at standards, at what's happening, at where things are working well and where things are not working quite as well as we'd like, and to try and improve them.

I think one of the important things for us to remember is one of the hallmarks that people have said, and consistently say, is: "Why can't you politicians think long term instead of short term?" Many times I ask myself the same question. The fact is that what we are trying to do is set out three-year plans. Those three-year plans are going to improve as we go through the next three years. Again, I don't think we should pretend they are going to solve every problem in the system. I don't believe they will, but what we have to do is recognize that those three-year plans can be improved from one year to the next. We can improve on our goals. We can look at the results we're getting. We can challenge ourselves and our authorities as to whether or not we are delivering to the people of the province the care they need in the communities that they're living in.

I think that's going to be a critical shift that we have to take as we move forward: to look at this on a long-term basis as opposed to a short-term basis. There will still be daily problems. There will still

be daily situations, I'm sure, where every one of our ministers is going to work like crazy to try and make sure that patients' needs are met in a specific community in a specific way.

We have taken resources from the ministry. We've significantly added resources. It is interesting to listen to the comments from some people that suggest this is about cutting. This is not about cutting. This is about changing the way we deliver health care. We have added $1.1 billion to the health care budget in the last year. We've done that because we recognize the importance of human resources. We recognize the importance of doctors, nurses, physiotherapists and health care workers. We want to be sure those front-line workers are liberated to deliver the care they need to in facilities across this province.

Problems have been identified for a long time. I know what we're trying to do is start to deliver some solutions that meet those problems, that change the results we get out of the health care system, that re-establish a sense of confidence of the public in the health care system. I think we should have no illusions.

[9:15]

There will be people whose only health care system is the status quo. Their only health care system is the system we had a year ago or two years ago. I certainly didn't seek office on the basis that we would maintain the status quo and maintain what we had a year ago or two years ago. In fact, I think we can do much, much better than that.

Today we're going to hear from Sindi with regard to standards and guidelines. We're going to hear from Colin. We're going to hear an overview of some of the health authority issues that we're dealing with. We're going to hear from Katherine on a community care strategy for the province. We're going to get an update from Colin on the ambulance service. Following that, we're going to hear from Geoff on the economic measures for first nations.

This will be an important week. I do encourage those who are watching the television to pay careful attention to what takes place - to engage in this discussion. There are clearly very few services that are more important to Canadians than quality health care, and there are very few services that provide us with a challenge that is as great and as important as the health care system.

We're going to move through this together. I'm sure we're all going to learn as we go through it. I think one of the things that is clear is that when you have a service that consumes more than 40 percent of your provincial budget, we'd better all be paying attention to it as we move forward.

With those opening comments, I'm going to ask Sindi to take us through the issue of future standards. Again, I should point out that this is the first time I'm aware of that the province has even endeavoured to create specific standards for across the province. If you don't have standards and you don't have goals, it's hard to tell whether you're reaching the destination. This is an important step.

Sindi.

For Decision: Future Standards and Guidelines for Patient Services

Hon. S. Hawkins: Thanks, Premier.

Today I want to talk about quality patient-centred care and how we can improve care by using standards and guidelines. I'll be reinforcing a lot of points that you made.

As you know, Colin and I in the Ministry of Health Services and the Ministry of Health Planning have been working closely together in the past year to find solutions to the problems and challenges that we've been facing in our health care system today.

One of the solutions is to make our health care system more accountable for its performance. We can do this by setting standards, by measuring performance and by monitoring patient outcomes. Certainly, this will allow us to set targets to achieve those good patient outcomes that we're looking for.

Today I'll be asking for cabinet's approval in principle to develop further provincial standards and guidelines in the areas of mental health, home and community care, surgical services and emergency care.

As you know, our new-era vision is for high-quality public health care services that meet all patients' needs where they live and when they need it. I think it would be a bit of a stretch to say that the system we've inherited focuses on patients and currently works in a way that puts patients' needs first.

I know many of you have had conversations. We've done consultations. We've had forums with the public and patients. We all know that they're demanding better management of our health care system and more accountability for patients' outcomes and the public's investment. Certainly, in our conversations we have heard the need for sustainability. The public and the patients want a health care system that will be there to meet their health needs today, tomorrow and into the future. That's why we as government made a commitment to find ways to save and renew our public health care system in B.C.

We decided as a government that we were going to keep focused on patients. Keeping that in mind, we set three goals for our public health care system.

The first goal is to offer high-quality, patient-centred care. This simply means that patients will receive appropriate, effective, quality care at the right time in the right setting. More importantly, I think this means that health services are well planned, well managed and delivered around the needs of the patient, not around the needs of the providers, the policy-makers and certainly not the managers and administrators. Our principle of putting patients first is at the centre of all our considerations as we move forward.

Our second goal is to improve the health and wellness of citizens. As you probably all know, B.C. has one of the healthiest populations in the world. But we know we can do better, and we must do better. We want to make sure that British Columbians are provided with access to health services when they're sick. Again, more importantly, we want our citizens to stay healthy. We want to make sure they stay out of the health care system in the first place. If we give our citizens proper information, we believe they can make wise personal choices to safeguard their own health and wellness and therefore maintain and improve their quality of life.

[9:20]

We are working in the ministry on strategies for disease prevention and chronic disease management. In diabetes, for example, we know we can reduce the risk of dialysis, the rates of kidney failure, admissions to hospital for diabetic coma, and we can certainly reduce the incidence of devastating vision loss if we have good management of the disease before patients get serious complications. Chronic disease management strategy certainly will decrease patient complications, and it will save precious health resources.

I know that around this table we all know how important it is, and we all share a responsibility for those broader determinants of health. We take that responsibility very seriously. We all know that factors such as a thriving economy, a healthy and safe environment, a sound education system and an investment in early childhood development go a long way to improving the health and wellness of all our citizens.

Third, our goal is to provide a sustainable, affordable health care system. I think that's the key to the future of public health care, because unless we can renew our health care system now in a way that's affordable, we won't be able to meet our first two goals. I don't think we can even hope to have a system that focuses on patients or a system that ensures quality health care services when and where people need them if we don't start today, if we don't start to find ways to ensure the sustainability of health care.

I don't think it comes as a surprise to anyone that we've been facing some critical challenges in health care today. We have a so-called health care system that's not really working as a system. It's fragmented. It's been built up over the years in sort of a patchwork of services, and more often than not I think the system lacks a focus on patients. It lacks a focus on health planning, and certainly it lacks any real accountability for patient outcomes. As the Premier mentioned, if we had decided to leave the system just the way it was, if we had accepted the status quo, we would find that patients would continue to fall through the cracks and the system wouldn't by any measure meet the future needs of our citizens.

I think all of us have examples, and we're all too well aware of where patients have suffered, especially at a time when they needed the health care system the most. They suffered either because of a difficulty in recruiting and retaining professionals in rural areas where there is a high burnout rate or because of unacceptable gaps in continuous 24-hour call when it was needed or

because some health professionals were facing a very significant challenge in trying to maintain their level of professional skills so they could provide the safe, quality patient services that they wanted to.

We know the system definitely isn't working for patients when we see a child in the north who has to wait three days to get a broken arm fixed because there is no one to cover that service or when we see that a critical emergency room in a major city is forced to close because we literally can't move staff across the street to provide care to those patients. I think the public and patients have made it clear to us that they won't accept the status quo. They want us to face the challenges, and they want us to address the challenges head-on.

I think we've listened, and we have taken action in the process of our restructuring to date. We responded in several ways. Firstly, in December we reduced the administrative layers in health care by streamlining the health authorities. We went from 52 to six. Secondly, we gave the health authorities three-year budgets. We protected funding so that they could plan for the future, and we asked the health authorities to drill down and find efficiencies and find administrative savings, and every dollar they find is going to be targeted right back to patient care.

Next, we did deliver some managerial flexibility, because health authorities told us there was too much rigidity in the system - again, the example of the emergency room having to close. They told us they needed that flexibility in order to focus services to meet patient needs. Throughout this restructuring health authorities and government recognized that decisions have to be made in a rational, coordinated way to make sure that we are delivering high-quality, patient-centred care, and that's why we are setting standards and guidelines and introducing those into our health care system.

You know, we want our health authorities to be creative and innovative and adaptive as they plan and provide for health services for patients across the province, but at the same time we want to be able to and make sure that we protect our citizens' access to health services by providing health authorities with broad but meaningful standards.

[9:25]

As part of our new-era vision we did commit to establishing provincial health standards, and I think standards are a key component of our restructuring of public health care. We need them to help health authorities meet our expectations of appropriate access to equitable, reliable, high-quality health services for patients across the province.

My ministry, Health Planning, is responsible for developing that broad accountability framework for the health care system. I'm responsible to make sure we have the tools or those specific standards for outcomes and performance that the Ministry of Health Services, Colin's ministry, will use to help us achieve the goals and targets we've set for patient care across the province.

We've already developed the provincial standards and guidelines for access to acute health care service, and we delivered them to the health authorities to use as a requirement. These are standards they must meet as they do their planning and redesigning of acute care health services in their respective regions. Any changes to how acute care services are provided in any region have to meet these provincial standards for access to acute care. I'm going to review those access standards for you, but first I want to brief you on what we mean by standards and guidelines, the principles on which these standards were developed and the factors we considered in developing them.

We can define standards as yardsticks or measures that we use to direct our health authorities on how to deliver quality care. Standards are minimum requirements. They have to be met. Some examples of standards you might already know include licensing requirements for health professionals and facility operators. We have standards for safe use of equipment and drugs, and we have standards for water and food safety. Those are recognized standards.

Now, examples of standards in the areas of expected performance levels and health service provision are hard to find, or they don't exist. That's our challenge.

As the Premier mentioned, public health service has developed over the last 40 years. It's grown incrementally with little or no regard to its performance in relation to patient outcomes. We now spend 41 percent of our provincial budget - that's $10.4 billion - on health care. That's $1.1 billion more than we spent last year. For all that spending, you should be surprised that we really don't have very much solid information to tell us if we're actually achieving good patient results.

We intend to get that information. We need to evaluate our health system performance by developing these standards in the areas of performance levels and health service delivery so we can monitor and measure patient outcomes. These standards are intended to establish parameters and clear expectations for our health authorities.

We need to have the standards because we want to improve and protect access to quality care for patients within the resources that we've allocated to our health authorities. Standards will help our health authorities make good, evidence-based decisions by giving them better information to use in their planning process as they move forward.

By determining and communicating those clear expectations to health authorities, we believe the use of standards and guidelines will improve accountability and results. This in turn will, I think, help to increase public confidence in the health care system because we know that is a concern. It will certainly help us meet our new-era goals that we have set for public health care in B.C.

When we were developing these standards, my ministry considered several key issues around acute care services. We looked at the principles for quality patient care. We did an analysis of current patient care in B.C., and we looked to other provinces and countries to see what they were doing insofar as developing standards and guidelines.

In developing provincial standards, we started by anchoring them in three principles we believe will ensure quality patient care. These are the principles of accessibility, safety, and sustainability and appropriateness. Accessibility means that health care services need to be provided to community residents in the right place, at the right time and in the right way. As you know, accessibility is one of the key principles of the Canada Health Act. Safety means that health services should be safe and effective. Safety requires that we have competent professionals who are available when they're needed.

[9:30]

Lastly, again, is the issue of sustainability and appropriateness. In order to maintain a high level of quality of patient care in a health care system, it must be sustainable. It must be able to deliver affordable health services in an appropriate manner; treatment must be provided to patients when necessary, delivered in the right manner in the right setting by the right provider. Certainly, the system should be efficient by using appropriate resources such as staff time, tests, equipment and facilities to achieve the best possible outcomes for patients.

We're striving for continuity of patient care. We've seen too often that patients fall between the cracks, and we want to make sure there's a smooth transition from hospital to home to community care. In order to do that, we need to encourage and build strong links and service agreements between agencies, organizations and service provider networks in the community. If we can do this - if we can provide that continuity of care between hospital and home and residential care, adult care, Meals on Wheels programs, mental health, public health care and preventative programs - I think we go a long way toward maintaining and strengthening health care for patients.

In the analysis of current patient care that we did in B.C., we recognized that patient needs and the quality of acute care services are closely linked to four factors: population and demographics; professional competence; critical mass of health care providers and resources for service delivery; and, lastly, distance and geography. We took all those factors into account, and we also recognized that health needs are closely linked to population size, since the incidence and prevalence of disease and disability are generally proportional to the number of people in a community. From a mix of population and demographics we can predict expected patient workload - for example, the greater the population, the higher the utilization of health services; therefore the greater the need, you can say, for resource requirements such as facilities, staff and equipment.

In order to maintain professional skills, our health care providers need to have regular practice. We all recognize the importance of that. That is to say, they need to see certain types of disease often enough to get familiar with the signs and symptoms and be able to give appropriate service and treatment. For example, they need to see enough patients in order to safely deliver babies, give proper diagnoses, do surgery or give an anaesthetic. Health care providers, then, require a certain population size to keep that level of professional competence.

In some cases professionals might require a relatively low volume of patients to keep quality high, but in most cases - for treating more complex or unusual conditions and maintaining the kinds of skills required for that safe, effective treatment - you more likely require a higher volume of patient

caseload. I want to say that this is an issue of quality and safety, not of cost. There's greater efficiency, continuity, quality and safety when services are concentrated.

Again, we've seen way too often how difficult it is for smaller populations to support specialty services because the capacity or the volume of patients is just not there. We've seen smaller communities across the province that are able to recruit health professionals. I mean, we have a beautiful province, and those areas are attractive, but then retention becomes a huge issue when patient volumes aren't realized, when those professionals can't maintain skills, when they don't have enough patients to see. We all know of communities where health providers go in and out. It's almost like a turnstile. You don't get that continuity of care. There are gaps in service, and that is not good-quality patient care.

Therefore, in order to offer and operate services successfully, there have to be sufficient staff resources or critical mass - that's what we mean by critical mass - of health care providers. The concept of having a critical mass of health care providers is to provide that continuous coverage. It's an issue of sustainability and safety. As I mentioned before, continuous coverage is attractive for retention and recruitment. It prevents burnout of our providers, disruption of service, and it prevents the gaps in care that we see when we have a solo practitioner who goes to a community and then leaves it.

[9:35]

For example, medical services on an ongoing basis - on a 24-7-52 basis. We know we have to plan for a group of doctors rather than a single practitioner. That's to ensure we have that continuous supply and that there's safe, effective care. This demonstrates, then, to us that we have to act responsibly now to stabilize services and to concentrate them where it makes sense to do so. We're doing that because we want to improve care to patients, and we want to make sure that they get quality care.

Distance and geography is another factor which we took into consideration. We believe that small communities which are located a significant distance from larger centres, despite that lack of critical mass, should have the resources they need to provide patients with that basic range of health services. In those cases, quality and cost considerations are balanced against how easy it is to access health care, so when we look at the geography of the province, we're looking at reliability of road or air travel. That is a critical consideration of what services are required. For example, are there road closures? Are there bad driving or flying conditions?

We've done that assessment of how emergency transportation might be delayed or might not be able to get into a community because of the frequency of bad driving or flying conditions. We collected the data. It gives us a realistic assessment of the risk of inadequate access to health care. Before the final decision is made of what health services are provided, that assessment is done, and we see what kind of health services we need to maintain in a community. Again, we look at differences across the province, so a smaller centre with fewer or a different mix of practitioners may be needed to be considered in certain cases, such as the kinds of services that are available in Dease Lake or in Atlin, in remote areas or in nursing stations in very isolated first nations communities. We want to make sure that we maintain a basic range of services for those patients.

Finally, we also looked at other provinces and other countries to see what they were doing, to look at their ideas in how they were approaching accountability in health care, as we developed our province's standards and guidelines. We couldn't find very many. We actually went to New Zealand - we didn't go to New Zealand; I wish I had - and looked at what they were doing, because it really provided the only immediately available comparison standards. New Zealand is often compared to British Columbia because it has similar geography and demography. We learned that the government there had set national standards for access to two things: emergency services and acute in-patient services.

We went forward and developed provincial standards that the health authorities must meet as minimum requirements for patient access to acute health care. These standards are based on time of travel and on populations. According to the standards that were approved by cabinet, access will be provided in the following way. Emergency services on a 24-7-52 basis will be provided within one hour of travel time or 50 kilometres for 98 percent of residents within the health authority region. For basic in-patient hospital services, access will be provided within two hours of travel time or 100 kilometres for 98 percent of residents within a health authority region and for 95 percent of residents within the health service delivery area. For those core specialty services, those high-level, high-cost, low-volume services like cancer care and cardiac surgery, access will be provided

or guaranteed within four hours of travel time or 250 kilometres for 98 percent of patients within the health authority region and 95 percent of residents in the health service delivery area.

These standards are consistent with the only known international standards, and those are the standards that were set in New Zealand. In New Zealand it's interesting that they provide for emergency services within one hour for 90 percent of their population and acute in-patient services within one and a half hours for 90 percent of their population.

Now, I think it's important to note that all the health authorities are already meeting the provincial standards we set for patient access to acute care services. In setting these standards, we wanted to make sure that there would be no diminished access as a result of health care restructuring. They are required to meet these standards, and they are doing that.

[9:40]

Again, as a comparison, we looked across the country and compared access to health care across Canada. We found that health care in B.C. is comparable to access in the rest of Canada. A 1993 study found that 98.9 percent of residents in British Columbia lived within 50 kilometres of the nearest acute care hospital. As a whole British Columbia residents lived closer to a hospital, when compared to residents in all other provinces except Ontario.

We also provided and developed some guidelines for the health authorities to use. I guess guidelines can best be described as recommendations for best approaches to providing various health care services. They're basically used to guide health authorities in the direction that change should be going, but guidelines don't establish absolute requirements that have to be met. The reason for this is, again, that we recognize there are differences across the province in different regions and communities. In other words, we have a very diverse province, and one size doesn't fit all - or, as Bill says, one shoe doesn't fit all.

We did look at factors like geography or remoteness. We know that a single fair standard might be difficult to develop, implement and monitor in various parts of the province, so we are making some guidelines or recommendations only. We'll leave it up to the health authorities to decide how they're going to use them and what kind of solutions they come up with to meet patients' needs, given the different circumstances in communities around the province.

We did develop provincial guidelines around acute care physician services and hospital-based services. For acute care physician services, the guideline is one family doctor or general practitioner for every thousand people in a rural community. That's the rule of thumb. Therefore, a town or area of 5,000 people might support up to five physicians. Again, we're doing that because we want to make sure there's that continuity of care and there's coverage and access to safe, appropriate, quality health care services. For hospital-based services, the guideline is one local bed for every thousand people in smaller communities, so a town of 25,000 people may support up to 25 acute care hospital beds.

The recommended physician and hospital bed numbers in relation to a population base do support that critical mass and efficiency concept that allows professionals to maintain their skills, as I mentioned. It'll help decrease burnout and staff turnover, it supports retention and recruitment, and, at the end of the day, it'll help us ensure that patients are getting quality and appropriate care.

I think it's important to say again that in some of those sparsely populated areas where we don't have a lot of people, and they're further away from services, guidelines can't always be followed, due to those small populations and the distance. In those cases, standards do take precedence over the guidelines to make sure that patients have appropriate access to a basic range of services.

One of our goals is to have the health authorities become as self-sufficient as they can and to provide as full a range of health services as their population base will support - from acute care to subspecialty and specialty care, to home care, to community care, public and preventive health care and mental health. We want them to move towards this self-sufficiency. I think the standards and guidelines we set will direct them, help them and influence their decisions.

For example, the access standards, which I just mentioned that we set, specifically direct that the health authorities restructure their acute care services in a way that ensures timely access to emergency care, hospital beds and core specialty services because we want patients to have accessible, safe, sustainable and appropriate health care. The health authorities have already

been using the provincial access standards and guidelines as they redesign their acute care services in their regions.

The health authority performance contracts, which we've laid out and Colin is enforcing, require that changes be made to improve services in four major areas of health service over the next three years. These are in the areas of mental health, home and continuing care, surgical services and emergency care. In order to make improvements in those areas, I think it's important to say, we need to set some clear standards so that we let patients know the services they can expect.

[9:45]

For example, in the area of acute care we'll be working with health authorities to establish standards for access to elective surgery, because I think we all know that wait times and wait-lists are concerning to all of us. These are the issues we all want to work towards resolving. Developing those provincial standards in those four areas is going to be very important work for my ministry in the year ahead.

I am asking cabinet for approval in principle to develop provincial standards. I'm doing this because I think we should know that we're doing something new. We're forging into an area that has not been explored very much before. It's not been done anywhere else in Canada. We're breaking new ground by setting standards and performance measures for our health care system and actually expecting results for the money we invest in our public health care system.

I think it's really important - forward planning for health care service delivery - and I think, Premier, that B.C. will show leadership in setting quality controls and setting appropriate expectations for how the system can meet patient needs. Setting these standards will, I think, go a long way to help us determine whether our public health care system is measuring up. I think it'll help us decide where we need to do better, as you say. Most importantly, I think it's a way of demonstrating our accountability to the public and to patients.

Thank you.

Hon. G. Campbell: Thanks, Sindi.

Any questions?

I think the critical thing is that as we try and develop these standards, they've always got to be based on what's best for patients. I think that too often there's a significant amount of political discussion that takes place. One of the things we want to try and do as we develop standards and guidelines is develop them on the basis of what are best practices, and we want to have the decisions that are made driven by professional judgment and professional standards as opposed to what the political debate may be about.

These are four areas, again, where I think if we look back over the last two decades, we will see that there's been a lot of lip service given to community care, to home care and to mental health services. I think it's critical that we develop those standards if for no other reason than we can see if we're making progress with the decisions we make. I think that as we develop the standards, they should not just be done in terms of the profession, but we should be communicating them to the public so the public can have a sense of what we're trying to accomplish and what they can expect as well, which creates another layer of accountability.

We said last year, when we had this little campaign - you might remember this - that we would ensure that appointees to regional health boards were representatives of their communities' needs and were held accountable for their performance. It's very difficult to hold people to account if you don't have standards and guidelines you're holding them to account to. I think these are important steps we've taken. It takes some time to get there, but….

If there are no questions and no…. Sorry - Judith and then Greg.

Hon. J. Reid: Sindi, I just want to get confirmation from you that in trying to go forward with this plan, there wasn't - in the past - the information available for decision-making for, say, the costs of operations or even tracking patient outcomes so that we would know how certain treatments and certain ways were providing certain outcomes. That body of information isn't there and accessible in order to develop these plans. We have to work and get some of that information so we can make these decisions and formulate these plans.

Hon. S. Hawkins: Well, there is a lot of data, and there is a lot of information, but it's never been put together in a way that makes sense or sets a standard. I think Health has been one of the biggest offenders of sucking in a lot of money but not really showing results.

In the past we measured inputs rather than outcomes. If we set up a program, if more patients subscribed to it, we just assumed that it must be a good program and need more money. You know, people lobbied for programs or recruited specialties without really looking at whether a community could sustain that service, whether there was enough of a critical mass to provide a continuity of care.

We're trying to put that information in a way that makes sense. We set a measurement, and there's a standard for communities to meet across the province so that we can show that the investment we're putting into a program or a facility or a service actually results in good patient outcomes. We're looking for those good patient outcomes. We might invest in something and find it's not doing anything or it's actually making patients worse, but we need to know that as well.

Hon. J. Reid: Thank you.

[9:50]

Hon. G. Campbell: One of the big issues, Judith, that the Premiers identified at both of the Premiers' conferences was the lack of evidence, for example, with regard to Pharmacare. Yes, you can approve a drug, but is it actually delivering the service that you thought it was going to? Is it as efficacious as they expected it to be? There were approval processes they went through. The drug was approved for use, and then it was sort of left there, and there was no gathering of information to say whether or not it was actually meeting the goals that had been set for it when it was approved initially.

I think the other thing that's clear, and I've had some discussions with some of the health authority chairs…. I don't think there's one chair of one health authority that doesn't say that we have not taken advantage of the technologies that are available for us to coordinate information, to look at outcomes. There's lots of information in the system, but I think Health is probably one of the most retrograde in terms of the equipment they have available to them to deliver information that's usable and makes a difference.

We're already applying some new technologies. B.C. Bedline has been a very successful technological tool for physicians, for nurses, for caregivers across the province to focus…. Instead of spending hours on the phone to try and find out where a bed is, they can go to the website and find out right away. The telehealth program that we have in place has already dealt with, I think, 17 severe cases and saved substantial money at the same time. When I say saved substantial money, it's allowed those dollars to be used for other places for patient care, at the same time giving better quality care for people in the province.

I think it's fair to say there was not a culture of measurement and accountability in the health care system. I think we found that out last June, when Colin was asked to take on this task, and he went and found out that at that point they were already estimating they were going to be $400 million over budget. We have a lot of work to do to provide both the equipment and the facilities that people need so that we can get the measures and we can also drill down into them so that we take advantage of all of the information that's available in the authorities. Right now that's not there.

Greg.

Hon. G. Halsey-Brandt: Thank you, Premier.

Sindi, I appreciate the sort of context you're setting out - the geography, the number of physicians, population base and all that sort of thing - but I guess I get a lot of questions as consumers. The issues are around wait-lists perhaps for community care, surgical care or emergency wards - when you have to go to one, it's full and you've got to be diverted to somewhere else. I take it, then, that what's coming back as a result of this is what is an acceptable standard for a wait-list or an emergency room or how you get moved from one emergency room to another. Could you give me some idea of the process and the time line in terms of when you'd be coming back with those standards?

Hon. S. Hawkins: Right. You're absolutely right. That is the kind of stuff we're looking at in setting standards for those four areas. What are appropriate times, say, for orthopedic surgery? We have patients, and many of them are elderly, waiting for hip replacements. Some of them can't get in to

see a specialist for a year, and then they wait on top of that. We want to consult with the experts. We're going to go to the professionals, and we're going to talk to orthopedic surgeons and say: "Okay, what is an acceptable period of time for a patient to see a specialist and then have their surgery, get their rehab and get the services they need in the community?"

Those are the kinds of standards that we will set. Again, they have to be measurable. They have to be reasonable. We're not going to set standards that the health authorities can never achieve. We don't want to set them so high that we're never going to meet them, so we're going to be working with our health authorities, as well, to see what is reasonable. You have to start somewhere. We're going to develop these over the course of the year, because we have set targets for how we can improve service in these four areas over the next three years. We've certainly set targets in the performance contracts and with respect to our ministries, so we will be developing these in the next year and providing them to the health authorities to use over the course of the next three years.

Hon. G. Halsey-Brandt: Thank you.

Hon. G. Campbell: Other questions? So the recommendation is that we approve the development of standards in, specifically, mental health, home and community care, surgical services and emergency care. They'll be developed over the next year and provided to health authorities as part of their ongoing planning process. They will be plugged into the next generation of three-year revolving plans, if you want. All in favour?

Some Voices: Yes.

Hon. G. Campbell: Okay.

Thank you very much, Sindi.

The next item on the agenda is an overview of the health authority sector from Colin.

Colin?

[9:55]

For Information: Overview of Health Authority Sector

Hon. C. Hansen: Great. Thank you. Thank you very much, Premier.

We often, when we're talking about health care, refer to the health care system. Sindi was talking about this earlier: the fact that it's not a system at all. If we look around at the way health care gets delivered, it's disjointed. It has been built over a number of decades through a process of incrementalism. There has been no planning, as Sindi mentioned.

There has been no effort to look forward and try to anticipate the needs of British Columbians, and largely, over the last decade, it has been driven by the crisis of the day. Whatever seemed to appear on the front page of the newspaper or on the 6 o'clock TV news was what got addressed the following day by the Ministry of Health in years gone by. This so-called system, as we refer to it, is ineffective. It's inefficient, and fundamentally it's unsustainable if we try to go forward without making some pretty significant changes.

We have certainly recognized that need for change after ten years of a lack of planning, really, and a lack of action when it comes to trying to deal with some of the fundamental problems. When we went into the election - actually, we were in the middle of that election a year ago today - we put forward 42 commitments in our New Era document, 42 commitments around health care alone. We have already acted upon over half of those, and the other ones are certainly in our sights to be accomplished in the time frames that we committed to.

The other thing that has happened over the last decade or so is just the number of different reports and studies that have been done around health care. If you go back to 1991, that was when the Seaton commission brought down their report in this province. In there, they identified some of the fundamental structural problems with health care. Many of the very profound recommendations that they had made then were never acted upon by the previous government.

Since that time, there has been a whole series of different reports and studies and hearings that have been held around the province. When we were still in opposition, we undertook what we called the dialogue on health care where we went out to 24 different communities to get that input

from community leaders, from front-line workers and from individual patients who really had had differing experiences with the health care system.

Last fall, as was mentioned earlier, I think, our own legislative Select Standing Committee on Health actually met for the first time since 1993. Not only did they meet, they went out and around the province to hold hearings to get input from British Columbians. They produced a very thoughtful report in terms of how we move forward.

There have been other reports. The B.C. Medical Association, for example, put out a document called Turning the Tide. Then they supplemented that, and I guess it would have been last May that they came out with Part II of II: A New Course for Health Care, which again had some very thoughtful suggestions. Some of the changes we're going to see coming forward this week reflect the specific recommendations that were brought forward by the BCMA in those Turning the Tide documents.

If you look at other provinces, we've had the Fyke commission in Saskatchewan. We've had the Clair commission in Quebec. There's been the Mazankowski commission that was in Alberta. Federally, we've had the Kirby senate committee that's been looking at health care. We've got the Romanow commission, which is now in the middle of its process. There has been extensive consultation. There have been extensive hearings across Canada and throughout this province and extensive dialogue with community leaders and front-line workers, sometimes on a one-to-one-basis and sometimes in the context of hearings.

What I'm starting to hear increasingly is people throughout the province saying: "We've talked about this for ten years. We know there's a problem. Get on and fix it." I think British Columbia is going to be the first province in Canada to take some pretty decisive leadership, some strong leadership, in addressing those fundamental problems and getting on with that action.

You know, our hospitals in British Columbia are not being used effectively. In many cases, you see the occupancy rates - the average number of beds that are used in a hospital at any one time…. Those occupancy rates in many hospitals are quite low, especially if you look at that those individuals who have to be in an acute care hospital make up only a portion of those that are actually in the hospital. Often those acute care beds are being filled up with patients who should be in some other kind of care in that community, but that other kind of care doesn't exist.

[10:00]

Sometimes, as well, we look at specialists. I know Sindi was talking about this earlier. In many parts of British Columbia, you have specialists who are sole specialists in that community, and they're trying to meet the community's needs on a 24-hours-a-day, seven-days-a-week basis. We see specialists that get burned out. We see many rural physicians that get burned out because we haven't organized the way care gets delivered in a way that actually allows them to have a sustainable lifestyle. Those who really suffer as a result of that are the patients who can't get access to care; or they're being seen by a physician or a specialist who has been up for 24 hours without proper sleep; or they have a specialist who doesn't have an adequate number of surgeries they're doing in a year to really keep their skills current during that period of time.

If you look around some of the residential care facilities - and I know Katherine is going to be talking about this in a moment - of all of the long-term care facilities and community care residential programs, we've got a lot of very old facilities that really don't meet the needs of a modern health care system. We have to look at a process of renewing that residential stock that we have in the province. Katherine will outline that in a moment.

The other thing that we really lack, in many cases, is adequate coordination between the hospitals and community care. In many hospitals around the province we wind up with sometimes 20 percent, or even higher, of patients who should not be in acute care. In many of the larger lower mainland hospitals we run 15 percent what they call ALC, alternate level care - patients who should be in some alternate type of care, not in acute care. We need better coordination between the hospitals and community care throughout the province.

We've already taken some action to deal with this. As Sindi was talking about earlier, we went from 52 health authorities in the province to six. That allows us to streamline administration, to come up with that critical mass of population so that we could better deliver on the needs within a region instead of having patients who constantly have to be sent out of a region to get care.

By coordinating resources on a regional basis, we're going to be able to deliver better care for people living in that area. A lot of that is around human resources. How do we make the best use of nurses at a time when we have a nursing shortage? How do we make the best use of doctors - family doctors as well as specialists - in a region so that people can get access to care in the timely fashion that Sindi was outlining earlier?

We have to make better use of facilities. We've got to make the best use of equipment we have in this province. I think the other point that sort of underlines all of this is the need to make the best use of budget. We've got to live within our financial means and still deliver on good patient care throughout the province.

I think the end result of this…. I was actually asked a question by one of the reporters as I was coming into the session this morning about whether there would be more air ambulances added as a result of some of these changes. One of things I would like to see come out of these changes is that we end up relying on the air ambulance system less. We want the air ambulance system to be there for us, and it will be there for us when we need it in communities throughout British Columbia. But too often today, we are exporting patients out of a region to the lower mainland or even other provinces to get access to the care they need when in fact, properly organized, we should be delivering that kind of care within that region. That's part of the goal that will come out of this health authority redesign.

This is not incrementalism anymore. This is not about the use of any one facility. This is about a framework that sort of takes the whole health care system and makes it a system for the first time in this province. Part of that is the standards - and Sindi outlined that earlier today - that we have to build on to make sure they're consistent in any community throughout British Columbia. We have to make sure there's an equitable funding formula in the province.

In the past what was happening was they took last year's budget and tried to see whether there was any more money they could throw at the problem. The budget that any particular region got was based on last year's numbers plus maybe a little bit of tweaking here and there. We saw parts of the province that were growing significantly, and yet the changes in the health budget for those regions didn't reflect their population growth. I will talk about that more because it's not just about population growth. It's also about demographics and other things.

We have to make sure we renew primary health care. There is so much more that can be done at the primary health care level. That's the point at which the individual accesses the health care system. Usually it's the doctor's office, in the province. There is so much more that we can be doing at that level of care to keep people out of acute care and to make sure that we prevent or manage disease before it becomes complicated and in need of acute care settings.

[10:05]

Katherine is going to be talking about the home and community care which is so vital in this whole continuum of care to make sure that it works for patients. A couple of weeks ago Gulzar outlined all of the changes to the mental health plan. It's a $263 million plan to make sure that those who are suffering from mental health challenges get better care, better access to community supports so that they can be cared for - again, without putting unnecessary pressures on our acute care system.

Another element that's so vital to this continuum of care is the ambulance service. Later this morning I'm going to be outlining some changes to the ambulance service that will make sure that element is properly recognized.

The other area is around accountability. I will be outlining for you some of the instructions that we've given to the health authorities to guide their planning process. This whole new-era framework for renewal of health care comes together to really enable the health authorities to begin a process of redesign so we can ensure that the health care system is renewed and that it's there for patients when they need it, where they live.

I want to take just a minute to talk about the population needs-based funding model. As I mentioned earlier, the old system was based on historical funding. It wasn't recognizing changes in population, high-growth areas or demographic changes. This new population needs-based funding model that was developed by the Ministry of Health Planning under Sindi's direction is, first of all, fair. It's equitable, because I think we want to be able to demonstrate to British Columbians in every part of the province that they're getting a fair allocation of the health dollar.

We could double the health budget tomorrow to $20 billion, and we still could not do everything that people would like to see done. We wouldn't be able to do everything that's possible in health care. Given our financial means, we have to be able to demonstrate that those dollars are allocated fairly throughout the province. This funding formula does that. Most importantly, it has to be transparent so people can see that fairness that comes into play.

Yes, it does deal with the population growth, but it goes beyond that. It's not just as simple as counting the number of people living in a region and dividing up the pie.

It takes into consideration age and gender. Clearly, older individuals have much higher health care demands than younger populations.

It takes into consideration aboriginal populations. They do have significantly higher health care needs, because their outcomes are significantly lower than the rest of the population. That's something that we have to take action to do something about.

It takes into consideration socioeconomic status of individuals living in that region.

It looks at rural populations as opposed to urban populations, because rural populations do have higher health care costs than urban centres.

It takes into consideration the complexity of care that is needed in the province.

We also have to factor in the cost of teaching. Many of the lower mainland hospitals now have a significant component of academic teaching for new doctors, new nurses and other health care professionals. That does add to cost.

I guess the good news is that Prince George, for example, will wind up with a teaching component as a result of the new programs at UNBC. UVic will also have a component of that, which will enhance some of the teaching components they already have in the capital region. Indeed, there are opportunities for teaching throughout the province in other areas, as well, that we'll be looking at.

This delivers on one of our new-era commitments. We said - and I can quote directly from the document the Premier was showing us earlier - that commitment is to fund health regions at a level necessary to meet the needs of the people who live there. That is a significant change from the practice we had before.

This formula is going to be adjusted annually as we learn from experience. It's also going to be expanded in the future to include mental health programs as well as public health. I think public health is a very important component to make sure that we deliver on good preventative programs. There is funding in the budget today, but it's not as sensitive to population demographics as it should be. We'll be doing that in the future.

Primary health care renewal is going to be vitally important, as I mentioned earlier. We want to take full advantage of the federal funding that has been put in place to strengthen primary health care. Primary health care, as I mentioned earlier, is the patient's first point of contact with the health care system. We want to strengthen full-service primary care by encouraging more family practice in the province and the development of teams of health professionals who can work with our family doctors to ensure that a full range of services is provided to their patients.

[10:10]

We want to ensure there is a focus on prevention strategies at the primary care level and, as Sindi was talking about earlier, chronic disease management to ensure that individuals get the care they need before they get to that critical stage where they're in need of hospitalization. Just as an example, there's no reason why an individual with asthma should wind up in an emergency room in British Columbia. With proper management and proper use of their medications, we can ensure that they can stay out of hospital in most cases. We can significantly decrease the pressures on emergency rooms through that kind of primary care management. Over the next four years we will be spending $74 million throughout the province on primary care renewal. I think that's going to be significant in helping to make sure that communities get the primary care services they need.

Another one of the key new-era commitments was to provide for three-year rolling funding. In the past what was happening was health authorities were simply getting one-year budgets at a time. If you go back two years, the health authorities didn't even get their budgets until six and a half

months after the start of the fiscal year. You can't do planning in that time frame. You can't do proper planning in the time frame of a year, never mind five and a half months.

This year not only did we roll out three-and-a-half-year funding, but we also made a commitment that that would be renewed every year. They got that funding announcement prior to the start of the fiscal year, and it's the first time in this province that's ever happened, so they can make the proper planning.

There is a slide I want to show to you here, which shows that the health authority budgets across the province went up 7.4 percent. We've heard a lot in the media and from some of the groups that have been engaged in protests around the province that somehow there are these health care cuts. Well, as the Premier mentioned, we've increased the overall budget of the health spending for the province by $1.1 billion this year, and every one of the health authorities has received an increase in their budgets from what was there last year. But we can't continue at that rate. That rate of growth is simply unsustainable.

We've seen double-digit inflation in the cost of health care over the last number of years, and we simply don't have the financial means to do that, so we have to get it under control. First of all, throwing more money at the problem is not the answer. You know, if you looked at all the additional money that's been put into health care budgets over the last ten years, if you went out and asked British Columbians, "Is the health care system better as a result of that ten years of increased funding?" they will say no, that they feel the health care system is actually less capable of meeting their needs than it was ten years ago. It's not just about money. It's about making sure the system works in a coordinated way.

The health authorities are undertaking what is really groundbreaking work to redesign health care delivery to get the most out of every single dollar that's spent. We have challenged them to take a strategic approach to health care planning and to make sure that we use all of our assets, especially our health care professionals, to get the best outcomes possible.

In spite of this $1.1 billion increase to the health spending of the province, there are still significant cost pressures. If we did nothing in terms of changing the way the health care system works, in addition to the $1.1 billion that we've put into the system, they would need an additional $567 million over the next three years to deal with those rising cost pressures. The health authorities have come back with their plans for redesign, which will be outlined tomorrow. What's interesting is how they have dealt with those future cost pressures. The instructions we gave to the health authorities were that, first of all, they had to look at new sources of revenue, sources that were totally consistent with the Canada Health Act, because we're not going to be operating outside of the Canada Health Act in this province.

We have told them, secondly, to look at improvements in administrative procedures and support services so that we can make, first of all, the budget savings around administrative and support services. Thirdly, we asked them to look at best practices. By best practices, it was: how do you change the way health care is delivered, looking at models from other provinces or other parts of the world that actually wind up delivering better patient care and at the same time more effective patient care? That's a win-win all around.

Just to give you some of the examples: appropriate levels of care for patients recovering from major illness or from surgery. They don't need to be in a very expensive acute care bed. The duplication of diagnostic services. You know, we often hear British Columbians telling us about the number of different blood tests they get from the time they've gone to their doctor's office until they finally get the surgery they need. They can wind up going through three, four, five different blood tests. Many of those blood tests are not necessary if they are properly coordinated in the system. We look at consolidating surgical services so that we can actually get better care and better outcomes. Those are best practices.

[10:15]

The health authorities, in looking at best practices when dealing with cost pressures, have come up with $165 million in savings, and that will lead to better patient outcomes. When you add all that up, we still wind up with the need for service changes in the province, and those service changes amount to $150 million out of that $567 million total of future cost pressures.

I want to just re-emphasize: this is not about reducing budgets. There will not be a health authority budget in this province that will be reduced either this year or last year or in the three years to

come. What we have said to them is that they have to manage their rising cost pressures, and that's what this $567 million is.

I also want to emphasize that what is driving the redesign of the health care system in the province that will be outlined tomorrow is all about how to deliver better quality care and safer care, as Sindi was outlining earlier. The fact that we have budget pressures to deal with is secondary. Obviously, we have to deal with all of them, but we're not going to do it in a framework that in any way compromises quality of care or the safety of patients in this province.

The health authorities, over these last months, have put in countless hours. There has been a huge amount of work done in analysis, in looking at experiences in other jurisdictions and sharing experiences throughout the province in terms of what some health authorities have done that has resulted in best practice guidelines or best practice directions. I'm sure the amount of paper that has been generated by the health authorities and the ministry over these last months is propping up the pulp and paper industry, Mike, so that may be some solace here.

I have read a lot of that material, and the thoughtfulness and the detailed analysis has been very, very well done by some very excellent, thoughtful professionals that we have working in the health authorities and working at the Ministry of Health Services.

The evaluation that's been done of the health authority plans has been asking some of these fundamental questions. First of all, does the plan improve the use of resources for patient care? Is access improved or at least assured for all British Columbians? Is service prioritized for those most at risk? Are the Canada Health Act principles assured? Because we are not going to be working outside of the Canada Health Act. Are sectors and services planned and integrated in a way that actually makes the system work as a system? Are all of the risks identified?

They've gone through this checklist in looking at all of the health authority plans, and that has been very detailed. On the whole, all of these plans meet the standards that we have set for the health authorities. We will be continuing to work with them to support the work that's done at the health authority level as they proceed with implementing those plans.

These redesigned health authority plans are a first for B.C. patients. In fact, they are a first for anywhere in Canada - this kind of a strategic and thoughtful redesign of how the health system works. It's a health system that will be responsive to patient needs. It promotes strong leadership. It holds people accountable for results. It is focused on planning for the future, which is so vitally important. The funding is based on the needs of the people who live in the region. I would argue that these changes are long overdue, and it's high time that we get on with it.

The plans will be announced tomorrow by the health authorities at a press conference held in Vancouver. It will not be a big blueprint for this change. This is the start of a process of change. It's going to be fairly significant in terms of the redesign, particularly as to how one accesses acute care emergency service in this province. We want to make sure they're stable and assured. But there's more work to be done, so this is the start of a process that will lead over time to a much better, much more dependable health care system.

Tomorrow the first phase begins. We will be hosting this press conference at which each of the health authorities will outline their changes to meet the needs of the residents that live in their regions. Quite frankly, I think it's an exciting time. I've had lots of health care professionals in this province express frustration to me about the rigidity of the system, the fact that they recognize the status quo doesn't work, that they can't get care in a timely fashion for patients that they're trying to care for. This redesign of the health care system will be exciting for those who recognize that the status quo isn't acceptable, and look forward to change that will actually improve patient care in British Columbia.

I'm looking forward to it tomorrow, and I'm sure all British Columbians are. Thank you.

Hon. G. Campbell: Thanks for that, Colin.

Are there questions from anyone? Judith.

[10:20]

Hon. J. Reid: Colin, are you saying that any savings a health region finds stay in that health region to be used for patient care and that they get to make the decisions on how they're going to use those dollars?

Hon. C. Hansen: That's exactly it. One of the regions, for example, is looking at their administrative costs. For the first time we can actually measure administrative costs on a consistent basis across the province, which we couldn't do before. One of the regions has actually taken on a challenge that they want to have the lowest administrative costs as a percentage of their budget compared to any of the other health regions.

I think this gives us an opportunity to encourage innovation in health care but, at the same time, to identify success so that when one health authority has success in delivering better patient care more cost-effectively, first of all, they can redirect those dollars to other health care needs in their region, and we can also identify those successes so we can duplicate those in other regions and learn from them.

Hon. G. Campbell: Thanks.

I'd just like to say a couple of things. First, the work that's been done by the ministry in giving up a lot of that planning function to the authority level has been very important. I do think it's important to note, though, that while Colin pointed out that over the last few months there have been reams and reams of paper generated, it's really over the last few years that an awful lot of these ideas have been out there. One of the things Colin's done that's been important is that he's given our professionals permission to actually recommend how we can do better. That's a big difference from what took place before.

We talk about wanting to identify risks of change if we move in a new direction. There is one great big risk we sometimes forget, and that's the risk of not changing. The risk of not changing - that costs were going to continue to rise at a totally unsustainable rate…. To put this in context again, a 20 percent increase in health care funding over the last three years, at a time when our economy was growing at maybe 3 percent or 4 percent over the same period of time….

Clearly, there were big risks in leaving things the way they were - not the least of which was that patients weren't getting the care they needed, not the least of which was that as you went around the province, you couldn't find a critical mass of caregivers together so they could have professional lives as well as personal lives. We all went through those challenges in 1997, 1998, 1999. Rural communities were raising the issues of the quality of care they were getting. The status quo was clearly not something that was going to work.

As Colin mentioned earlier, as well, a lot of this has been identified for a long time. The confusion that was taking place with 52 health authorities, community health councils, community health service societies…. I had a physician from Nanaimo the other day congratulating me, saying it was the first time he actually got an answer to a question in a timely way that made a difference to him in what he was trying to do. He happened to be an emergency physician.

The critical thing is to know that the staffs of the authorities and of the ministry have really worked very, very hard to try and bring us to this first step, which will be laid out for the public tomorrow. I do think all of us should remember it's a first step. It's not the end of the journey. We'll be laying out three-year objectives - three-year plans, not three-week plans. It's going to take time. It's going to take effort. It's going to take commitment from them to accomplish their goals.

Colin, I do think that you made really significant progress, and I want to say thank you for that. That's great.

The next item is the home and community care strategy for the province. Again, home and community care is something that's been identified for some time as one of the major challenges in terms of delivering acute care services and one of the major challenges in terms of the backups that we feel from the acute care facilities right down through to the community. Katherine's going to take us through that.

For Decision: A Home and Community Care Strategy for the Province

Hon. K. Whittred: Thank you, Premier.

Both Sindi and Colin have alluded to the fact that previously our health care system has, in fact, not been a system but a series of fragmented programs. I'm going to try to illustrate today how home and community care will become part of a very connected and integrated system of care.

[10:25]

Home and community care was first introduced in British Columbia in 1978. It was then called the long-term care program. Quite honestly, it's not changed very much since then. It's sort of interesting. As I observe many of the facilities in the program - many of them that were built back in those days - one of the main criteria around them was the parking lot. They were required to have a certain number of parking spaces for their residents. Today that seems somehow quite out of place when we think about the people that we are caring for in our residential care homes.

We know that the changes we make in home and community care services can have a very profound and positive effect on the services that are delivered across the health system. Colin, I think, alluded to a couple of those that I'll just serve as examples: alternate-level-of-care patients that frequently are inappropriately using acute care beds when they should more appropriately be cared for in the community system. And post-surgical care, of course, calls out for home nursing. These are the kinds of services that home and community care delivers.

This plan is consistent with the government's new-era commitments - commitments that reflect the public's desire to ensure that we have home and community care services that meet the needs of all British Columbians. The new-era commitments, which we made over a year ago, in this area were to develop an intermediate- and long-term care facilities plan that addresses the needs of our aging population and frees up existing acute care beds, to develop 5,000 new intermediate- and long-term care spaces by the year 2006, and to improve and expand home care and palliative care services.

Now, exactly what are home and community care services? Well, they consist of a range of services in health care and support services that often take place in the home. These might be nursing services; they might be rehabilitation services, support for activities of daily living, adult day programs where clients are transported from their home to a day centre; or they might be palliative care services. Also, they are community-based services such as short-stay assessment centres, where clients might be assessed to determine the treatment that they need, or, of course, residential and hospice care. The people that are served in this system span the broad range of needs from acute, chronic, palliative and rehabilitative health needs.

Now, if you just direct your attention to the slide, I think it demonstrates clearly where the resources in this program go. The program served slightly more than 118,000 clients in this last year, for a very significant budget of over $1.5 billion. You will see that the residential care portion of the program consumes 72 percent of the resources but serves 30 percent of the clients, while the home care portion uses 28 percent of the resources but serves 70 percent of the clients.

Home and community care services are provided to all people who are adults. However, 76 percent of the clients, in fact, are seniors. Out of the total seniors population about 17 percent or, in fact, 17 out of every 100 seniors will access some form of home and community care. Today's senior population represents 13 percent of the population, and this is expected to grow to 21 percent over the next 25 years. Significantly, the fastest-growing cohort of that group is the population over 85 years. I heard a song on the radio yesterday as I was in the car, the old Beatles song: "Will you still need me, will you still feed me when I'm 64?" I thought, more appropriately, today we might ask: "Will you still feed me when I'm 84 or perhaps 94?"

Hon. G. Campbell: I'm closer to 64 than I want to admit.

[10:30]

Hon. K. Whittred: Over the short term - that is, in the next four or five years - we will see an additional increase of 1,625 clients per year needing service in this sector. That is a net increase of 6,500 people by the year 2006.

The visual on the screen clearly shows that it is residential care that is the major driver of this budget. Contrary to popular belief, clients receiving services at home are not just those that require a low level of service. In fact, a significant number of persons with very complex care needs are being cared for at home. In fact, 23 percent are assessed at the very highest levels of care. Unfortunately, the corollary is also true, where 27 percent of clients in residential care are assessed as having low care needs. What this really means is that with the right supports, those individuals could be cared for at home.

Wait-lists are another issue that comes up around community care. The wait-list for residential beds has often been characterized as an expression of the demand for residential care service. However, a large number of clients are on a facility wait-list in anticipation of the day when they might require care and their health might deteriorate. In reality, facility admission is frequently

triggered more by social isolation and a lack of safe, affordable housing rather than a requirement for round-the-clock nursing care or medical supervision. International, provincial and local studies all indicate that 25 to 50 percent of people on facility wait-lists or in institutions could live in the community, either in their own home or in supportive living, with appropriate and adequate supports.

Now, there will always be a need for residential care facilities. However, admitting a person to a facility should be the last resort used only when the person has very complex care needs and other community-based options have been exhausted. The cost of residential care is high, almost $48,000 per year per bed in operating costs, while the cost of an alternative basket of services delivered in the community is between 50 and 75 percent of the cost of residential care. Thus, every dollar we spend on one client inappropriately placed in a facility could support up to two clients in the community. This is why it is so important to ensure that residential care facilities are targeted only to those clients with the most complex care needs and, at the same time, to expand the array of services that will enable people to remain in their own homes.

Too often by default, not by design, acute care is used as a substitute for home care rather than the other way around. These are actually the people that Colin was referring to when he talked about the ALC patients. Also, congestion in emergency departments and lengthy wait times for admission to acute care have all been attributed, in part, to the inability to move patients who no longer require acute care to more appropriate services. Our failure to provide appropriate care solutions for these people will result in the continued unnecessary use of emergency and acute resources. The steps we take now to make our system sustainable will lay the foundation for future delivery.

[10:35]

Seniors have told us over and over again that they want to remain independent for as long as possible. They want a choice in the type of care they receive and where they receive it. Quality of life is very important to them. They are looking to government to provide a broader range of options than is currently available, options that will promote independence and quality of life. To do this, we have to create continuum-of-care options that support client independence and quality of life. We have to create a system where we ensure that facility care is there for people who truly need it, people with very complex care needs, and we have to ensure appropriate utilization of the continuum of resources.

Lack of funding is often cited as the reason why we cannot create the options that are desired. However, when we look at how we currently use our resources, it's clear we could do things differently and get a better result. This will mean shifting some of our investment in facility care to create more appropriate services that support clients to remain independent in their own homes. My goal is to have a home and community care system that will provide services to a greater number of people, be more responsive and appropriate in meeting the needs of the people it serves and, at the same time, be more cost-effective and accountable.

The really good news there is that as we move along the continuum of care that you see reflected on the screen, not only do the clients get the benefit of the best practice in the system, but it also means that we are able to deliver that service in a more cost-effective manner.

Shifting to sustainability will require moving from a reliance on facility care. Facility care must be there for people with complex care needs, and that care must meet the needs of this higher-acuity population. Colin, in his remarks, alluded to the fact that many of our long-term care facilities were built many, many years ago - many of them 30 years ago - and they are no longer appropriate either to support independence and quality of life or to support the higher-level-of-acuity patients that we have in the most complex care situations.

It's becoming increasingly obvious that what we need to do is move and shift from dependence on those resources to a variety of other things. We need to move to an array of community-based affordable housing options like supportive housing and assisted living.

The diagram on the screen shows you how a health authority could reinvest funding from an existing facility to create an array of innovative contemporary care options that support independence while maintaining complex care clients in residential care. You see on the screen that you could move from this facility which previously served 205 people to one that will serve 247 people, which is a net increase of 20 percent. You will note that a much wider variety of programs are offered.

The other happy news, of course, with that kind of scenario is that in addition to serving more people, the clients in the system are actually cared for in a much more appropriate manner.

Recently - and some of you will certainly have noted this in your communities - there has been some anxiety around announcements that residential care facilities are going to be phased out or whatever. I want to make it very clear to all of you and to the public, to our seniors and to their families that a facility will not be closed until the health authority has addressed the concerns of the residents and their families and there is an alternative plan in place. No resident will be moved unnecessarily. Where a client must be moved, the appropriate placement will be found in consultation with the client and their family, and families will be actively involved in the planning process.

After a very close review of the health authority plans, I am recommending today that we require health authorities to submit transition plans for implementing the new era for home and community care. This will give the assurance that the needs of British Columbians will be respected throughout that transition. That is the recommendation that we will be discussing a bit later.

[10:40]

Residential facility care will be focused on those with the most complex care needs. This means we need to have alternatives for those with less complex needs who could be supported in the community if the right services were available.

Earlier I described an array of services that would meet a variety of needs, and I said that facility admission is frequently triggered more by social isolation and a lack of affordable housing than a requirement for nursing care or medical supervision. Therefore, I have worked with the Hon. George Abbott, the Minister of Community, Aboriginal and Women's Services, to develop a new program for 3,500 supportive living units for home and community care clients, which I will describe in more detail in a moment. These will form part of the 5,000 new care spaces. The remaining 1,500 new replacement beds will be developed to accommodate complex care clients.

This will ensure that our residential care facilities are there for people who truly need 24-7 health care. To achieve this, residential care access policy will be revised. This will result in moving from a wait-list that is based on chronology to one that is based on need. Criteria for assessing complex care needs have been developed to assist case managers. This policy change will be implemented early this fiscal year.

In addition to making this work more smoothly, a new client assessment and classification system is being developed. Using our resources properly requires ensuring that we do the best possible job of assessing our clients' needs and matching the most appropriate service to those needs.

Health authorities will, as one of their priorities over the next three years, be implementing a new, internationally recognized assessment and classification system. That simply means the nomenclature that we give to describing people who are in long-term care. We presently say that you are in intermediate care, and you have several levels, or you are in extended care. This system is simply moving to refining that process and making it equitable and fair across the system.

The client access and information project will provide health authorities with state-of-the-art tools for determining client needs for home care and residential care. These tools are currently being tested in the Vancouver coastal health authority and the Vancouver Island health authority. The Premier mentioned earlier in his remarks about how in B.C. we have been very backward and behind many other jurisdictions in our use of technological tools. This is an example of how we're going to, over the next few years, make technology work for us in a very positive way.

I indicated earlier that 27 percent of our residential facility clients might have been cared for in the community if adequate supports had been available for them at the time they were in fact admitted to the facility. For a number of these clients, supportive living is truly the missing link in the care continuum.

Supportive living consists of three components. Supportive living is an independent housing unit. People are living in their own home. Supportive living has support services attached to it. These might be meals, housekeeping, laundry, recreational activities, and monitoring and emergency response systems. Supportive living also includes personal care services which assist a person with the activities of daily living such as mobilization, bathing, dressing, grooming, nutrition and keeping their medications organized.

I've got to tell you a story about a woman I met. She was 103 years old, and she had gone into a supportive living facility in a wheelchair. Several months later after participating in the wellness program and the workout program, this lady was walking on her own, not with a walker or a cane. She was actually walking on her own. That is an illustration of how the right kind of environment can have very, very nice outcomes. This kind of supportive living is truly the preferred alternative for the majority of seniors.

[10:45]

The Premier, the Hon. George Abbott, Mr. Shayne Ramsay, who is the CEO of B.C. Housing, and I are very pleased to announce this day a new program called supportive living B.C. This program is a partnership where the Ministry of Health Services establishes the provincial framework and program criteria, and B.C. Housing provides the housing funding. Private housing providers from both the non-profit and for-profit sectors operate the housing, and health authorities provide the health care services and case-manage clients into supportive living.

The housing component of this program consists of a mix of options under a public-private partnership model. It will consist of 1,500 new supportive living housing units developed by non-profit agencies. It will consist of converting 1,000 existing social housing units or residential beds to supportive housing, and it will consist of 1,000 private market-rent supplements for new or existing supportive housing units.

New builds and conversions will utilize funding from the recently signed Canada-B.C. affordable housing agreement. Of the $88.7 million in federal contributions, $62.5 million is targeted toward new and converted units. Federal grants together with mandatory equity contributions from sponsors, municipalities and the community will reduce capital and operating costs.

Now on the screen, you see the new logo for this new program. I'm very proud to say I think we're going to be seeing this logo over the next several years as we deliver on our commitment to provide the 5,000 beds. You'll see that the program is called supportive living B.C., a housing for health partnership.

The rent supplement component of the program provides for private sector participation and gives health authorities flexible and cost-effective options in the private sector where sufficient stock is already available. The intent is to ensure that supportive living is attractive and affordable as a housing option and that it supports client choice and independence. No client will be forced to move into a residential care facility simply because they cannot find affordable housing and care in the community.

Finally, I have commissioned an end-of-life care strategy to look at ways to better use our limited resources to support choice and dignity for people at the end of life. It is being developed in collaboration with palliative and hospice experts, health authorities and health care professionals, and it will provide the framework for health authorities to develop a continuum of community-based, hospice- and hospital-based approaches to caring for people at the end of life.

Funding these new services will require the reallocation of existing resources, and this will come primarily from decommissioning the obsolete facilities we have already mentioned. People who have those, of course, will have an option of participating in the rebuilds or the renewal portion of the assisted living program. This will be done in order to fund complex care beds, new community programs and supportive and assisted living.

This shift is consistent with what seniors and their families frequently ask for - namely, that they want responsive and accessible services that will allow them to remain in their homes. In addition, the literature supports that clients experience a higher quality of life in their own home or in a supportive living environment.

[10:50]

In addition to the actions I have outlined, the Ministry of Health Services is implementing a wide variety of other legislative, regulatory and policy changes to support greater flexibility in service delivery and to provide the health authorities with better planning and management tools. This will include removing policy barriers that hamper health authorities' ability to make change.

As part of this initiative, steps will be taken to ensure that supportive living is treated as housing rather than a facility. Through BCBC's health services group, a complete inventory has been taken of all residential care facilities. This information is made available to the health authorities to help

them in planning their current and future needs. In consultation with the health authorities, a new information management system will be designed and implemented to ensure that we have the best possible information for planning and monitoring of services. Through the three-year deregulation project, regulatory and policy changes will be identified to reduce unnecessary regulatory burden while always focusing on health and safety as the primary objective.

The changes I have described are significant, but achieving sustainability across the system means we have to let go of the old, outmoded ways of doing things in favour of approaches that balance the desire of our clients to maintain independence and dignity with the resources available. The results will be worth it. Clients will have a comprehensive assessment of their needs and be matched to the services that are most appropriate to serve those needs. Residential care facilities will be there for people who need the 24-hour nursing care. Health authorities will offer an array of creative, contemporary services that support independence and choice, and British Columbians will have access to supportive living options in communities throughout the province. Our progress will be monitored and our course adjusted as required. The steps we take today will lay the foundation for the future.

Now I ask my colleagues to make a decision on the plan I mentioned earlier - that the health authorities must submit comprehensive transition plans for implementing the new-era commitments for home and community care. Thank you.

Hon. G. Campbell: Okay.

Bill.

Hon. B. Barisoff: Thank you, Premier.

Minister Thorpe couldn't be here today. He asked me to ask you a question, Katherine. He's actually with the federal minister of trade in India trying to bring opportunities back here to British Columbia.

One of the questions he was concerned about was the high percentage of seniors in the Summerland area and what role communities and volunteers could play in providing some of these services.

Hon. K. Whittred: Thank you, Bill. That's a really good question, because communities and volunteers play a very, very central role in the whole delivery of service in the community care sector. Historically, the vast majority of our long-term care facilities have been provided by community organizations, organizations like the Kiwanians or the Salvation Army. Many churches, for example, have been involved, and they fundraise. They partner with either the private sector, in some cases, or the government to provide service, and I would expect that that will continue.

Also, in the Summerland area there are some excellent programs that seniors do volunteer to help with. I'm very pleased to say that the seniors counselling program, which there was some controversy about, is being continued in that area. I'm really pleased that the local health authority has picked that up and is working to continue the program.

[10:55]

Hon. B. Barisoff: Katherine, what role could the city councils and others play in making things happen in their communities? Are there any things they can add to the mix, particularly in areas where there is a high concentration of seniors, to make the facilities that are needed in those areas?

Hon. K. Whittred: Well, certainly. We certainly expect that city councils, the communities, are going to come to the table as full partners in the efforts to create new options for home and community care. Many communities have programs where they reduce the development costs, for example, for seniors facilities. They may give breaks on the land. They might give long-term leases. There are a number of things. I have been in communication with municipalities on these issues, and we will be continuing that dialogue, because we're looking for full partnerships in creating these assisted-living projects. It's my hope that we will have some really innovative partnerships develop that will be between the community, the non-profit society and B.C. Housing pulling the whole project together.

Hon. G. Campbell: Thanks.

I've got Greg, Linda and then Mike.

Hon. G. Halsey-Brandt: Thank you very much for that announcement, Katherine. Obviously, it's very good news, and I know some groups in my community are going to be excited about that.

The question, I guess, is just in terms of accessing the funding in the program. Does the health region do an analysis, for example, of existing beds in the community and level of care in the community and then come up with some recommendations about how many and what type in each community? Or can groups later today or tomorrow approach the health region with their proposal and their partners to access some of these plans? They're going to be starting to call, I know, after you've made this announcement. Where do I go with them? Who do they apply to? What's that rollout mechanism?

Hon. K. Whittred: Well, that, also, is a very good question. Shayne Ramsay from B.C. Housing will be coming out with the details around the actual rollout of the program. Essentially, the responsibility for determining the need is the health region's. We've provided them with a number of tools, which I've outlined in my presentation, to assist them in being able to determine what their needs will be. So the health regions are the ones that know what their needs are. They will determine that, and then it will be their job to put out requests for proposals. Then community groups can, of course, respond.

On the other part of your question, I see absolutely no reason, though, why community groups cannot be very proactive. Many community groups are very knowledgable about the needs of their community, and I hope they will be actively involved in that process.

Hon. G. Halsey-Brandt: Rather than wait, particularly for the regional health authority, if some community groups have done some research and they feel there are some gaps in the provision of care, they could make a proposal to a health authority. Then they could react to that proposal….

Hon. K. Whittred: They could certainly, I think, get a dialogue going - yes.

Hon. G. Halsey-Brandt: Right. Thank you very much.

Hon. G. Campbell: Linda.

Hon. L. Reid: Thanks, Premier.

Katherine, I want to extend my sincere appreciation. I think this is an area of government that has long neglected seniors. To have you focusing directly on long-term care, looking out for seniors and providing some choice in dependence is fabulous. I think it's absolutely fabulous.

I have, as you know, a strong commitment to Rotary, Lions, Kiwanis - all the folks who continued over the years to go ahead and build facilities when I think there was very little government support. Can I take from your remarks that that partnership will not just be continued but absolutely acknowledged as those folks having formed really, really helpful partnerships with the seniors across this province?

Hon. K. Whittred: Well, yes. We are committed not only today but in our new-era document. One of the things we ran on was to re-establish our link and our partnerships with the non-profit societies. This was a relationship that we felt was very badly damaged with the previous government and one that needed to be rebuilt. A very primary focus of what I do is to rebuild those relationships. I'm looking for all of the community organizations to be very active partners in this ongoing project to serve the seniors of our community.

Hon. L. Reid: Katherine, you mentioned the end-of-life strategy. When will it be made public?

[11:00]

Hon. K. Whittred: The end-of-life strategy…. The discussion paper should be released within a few weeks. It's been a little bit slower than I'd hoped, but I understand it's in its final stages of being readied for public discussion. It will then be available for discussion. We hope to finalize the strategy next fall.

Hon. L. Reid: So individuals interested in hospice care - they too would fall under the B.C. Housing partnership?

Hon. K. Whittred: That is correct. That would be part of the project. The process would be the same as I described to Greg.

Hon. L. Reid: Thank you.

Hon. G. Campbell: Mike.

Hon. M. de Jong: Thanks, Katherine.

I was listening and trying to put myself in the position of an elderly person who's left their home or maybe their farm. They're in a condo now. Maybe their husband or wife passed away recently. They've generally enjoyed pretty good health, but they're getting on to 80 years of age, and they're having some problems. Even the condo is getting to be a bit much for them, and they are having to think about making other arrangements.

They are in their living room this morning watching this meeting. This new logo flashes up on the screen, and the minister responsible for that aspect of public policy that is of paramount concern says: "I have a new program. I have a new logo. It's all about partnerships in supportive living."

The question that person is probably asking is: "What does it mean for me, as I have to think about making some decisions moving forward?" In general terms, what does it mean for that individual? Who do they begin to interact with as they move forward? Is it the regional authority? You alluded to an assessment process. At the end of the day, it's that individual we are trying to service better. What does this mean for them?

Hon. K. Whittred: For that individual, Mike…. That, too, is a very good question. It speaks to how someone actually becomes part of the system.

That individual you speak of is reaching a stage where she can no longer manage in her own apartment. A number of things could happen. Her family, for example, could request that she be assessed by a case manager. That is the way that you enter the system. If that happened, that request could come from the individual herself, a family member or her doctor. The assessment would take place. Someone would come to her home, talk to her and spend some length of time.

What they're really doing is assessing how well that person functions in their own space. Can the person cook their own meals, or are they prone to leaving the stove on? These are the kinds of functional questions that are often the kinds of things that they would look for. It's not just a matter of health.

The person you speak of would be assessed, and an assessment level would be given. The assessment level might say, "We think, Mrs. Jones, that you're functioning at what we now call an intermediate level 1," which means that the person would probably benefit from being in an assisted-living type of environment. Then, of course, the mechanisms would be put in place, if she wishes, to go into that kind of environment.

Alternatively, they may decide she can be maintained with community programs that are in place in the community. The whole idea is that they would look at her individual needs and suggest the most appropriate kind of supports for her to access.

Hon. M. de Jong: As we move forward, her range of options presumably would increase as this becomes more fully implemented?

[11:05]

Hon. K. Whittred: That is correct.

There are other options that are increasingly becoming available and being used. One is to take advantage of where seniors tend to cluster. The example that you've given…. This lady may in fact live in an apartment block where there are many other seniors. This gives an opportunity for the health region, if they note that there are many clients in that building who need some level of care, to go there and say, "We're going to put cluster care into this building" - meaning that they put in on-site home support. They take it to the client rather than the client having to move to a supportive-living environment. That's what I mean by providing an array of services and attempting to meet the clients' needs, to give them the kind of service they really require.

Hon. M. de Jong: Thanks.

Hon. G. Campbell: Sandy and then Joyce.

Hon. S. Santori: Thank you, Premier.

With respect to some of the facilities that have been identified that are no longer meeting the needs of the residents and will phase out over a period of time, do you know what the opportunity might be for other non-profit societies - or the private sector, for that matter - to take advantage of those facilities to convert them into other means of providing care for seniors?

If it's deemed not to be feasible for the public sector, for the health care system, to make the changes to that facility, how are we going to dispose of those facilities? Will we make them available either to non-profits or to the private sector for conversion and private use or non-profit use?

Hon. K. Whittred: Actually, Sandy, because of the history of long-term care, most of those facilities are the property of either non-profit societies or private enterprises. That is because long-term care historically has been a blending of largely non-profit and public service providers. Until very recently there were not very many public long-term care centres. They were all largely non-profit or denominational. I think it is certainly our hope…. One of the reasons that we've included the conversion part in the housing plan is to enable those organizations to come up with plans to convert these very old and increasingly obsolete facilities into something that is more timely and useful for this day and time. That opportunity will certainly be available to them.

Hon. G. Campbell: Joyce.

Hon. J. Murray: Thanks, Premier.

Katherine, when you described the partnership - and that was about supportive living - it was more about housing. That's my understanding. That's kind of a subset of the overall strategy. Could you talk a bit more about the framework in your strategy to support people to live in their homes? I know that in New Westminster there is a high population of seniors, and many would like to stay in their homes. You've said the objective is to enable people to do that and provide them with appropriate support. Is it as defined - how we will identify the supports needed and provide a framework for providing that support for people in their homes?

Hon. K. Whittred: Yes. I've spoken, in the presentation I made, about having to shift resources away from primarily having those resources in residential care and moving to community-based services. The concept of supportive living can be offered in someone's own home as well as in a home they would move to. Supportive living means that you offer supports to the individual, really, to enable them to continue to live there.

Let's take an example of someone who perhaps is no longer able to bathe themselves. Of course, bathing is a very important function. Everybody has to be clean. If home support can go in once a week and offer that person a full bathing program…. Or sometimes in some health authorities they actually transport the patient from the home to another site. Many of the long-term care facilities actually have outpatients that come in for bathing programs that are offered by different groups in the community. That's an example of how we would offer a support in the home for someone who needs that service. It's the goal, of course, to target the services to the individual needs of the clients.

[11:10]

Hon. G. Campbell: I think the critical component of the recommendation we're dealing with today is that the health authorities come back with comprehensive transition plans. It helps to answer a lot of the questions that have been asked around the cabinet table.

Let me just say, in terms of supportive living B.C. and what's taking place there, that first of all, I think we have to get our vocabularies correct. In fact, there are a lot of people who would hear "residential living" and think we meant they were living in their residence. Personally, I think we should change that to "institutional living," because what we're really doing is saying that we want to take those institutional care facilities and try to maximize their benefits across the population.

I'm sure every one of us has a story of someone who did something like break their hip, end up in a hospital and never got out of the hospital - never found a way that they could move away from that environment of dependency. We watch deterioration in those situations.

One of the things that we're trying to do is shift some of the burden, if you want, from institutional care back to the communities where I think people clearly want it. This is the strategy, if I'm right, Katherine, about creating independence for people for as long as they can be independent, providing support for as long as support meets their needs. Only when we've gone through that continuum of care do we say: "Unfortunately, now we have to give you institutional care." This is what we have called in the past residential care.

It seems to me this goes back to one of the fundamentals, which is: what do people want? What is in the best interests of patients? I can't recall the last time I met with someone - you know, they were getting closer to the end; they were getting more and more dependent on other supports - who felt that they wanted to spend the last few months or last few years of their life in a hospital. What they want to do is spend as much of their life as they can at home, in their community, in their neighbourhood. The hospital or institution is the last place they want to go.

What Katherine has done with George is work with resources from B.C. Housing. There'll be $16.7 million a year which will be contributed to the housing units; this is about housing. The health authorities will have resources that they can use to help provide for health supports through this supportive living. There are 2,500 units that are being proposed - 1,500 new ones and 1,000 conversions. The federal government is contributing up to $25,000 a unit to try and help make sure that those are provided for people.

Already within the health authority budgets there are budgets for support services for supportive seniors. Those dollars are in those budgets now. What we're trying to do is optimize the resources that we have across the system. We're trying to make sure that we create a new vehicle - which, frankly, hasn't been there and which was almost always the last thing to be thought of in terms of what we had to provide - in the hopes that we can provide not just a higher quality of service and a higher quality of life to people, but you actually can provide substantially more effective use of your tax dollars when you do that.

Katherine, I think the focus that you're asking the health authorities to give to this is an important part of setting some standards for ourselves and moving forward and making sure we're delivering to the people in the province who need those supports.

Are there any further questions?

So that request is granted, if you want, and we will be requiring health authorities to submit comprehensive transition plans.

One other thing that is important, which I want to underline for everyone around the table, is that no one will be removed or facilities closed down without full and detailed consultation. In fact, one of the proposals in terms of transition plans is individualized transition plans if they're needed for patients in communities across the province. I'm sure we'll hear more about that as we go through, but this is a step in the right direction.

The next item on the agenda is an update on the B.C. Ambulance Service. Colin.

For Information: Update on the B.C. Ambulance Service

Hon. C. Hansen: Thank you, Premier.

Just before I start into the ambulance discussion, if I could just reflect on the last agenda item very briefly. I don't want to leave the impression that the health authorities have not been looking at transition in these areas. They have done extensive work. A lot of the announcements that are going to come out tomorrow are not things that are going to happen overnight. They are things that will happen over a two-, three-year and sometimes even a longer time frame, but at least we'll start to get some certainty around where delivery of community care is going in the regions around the province.

So there's been a lot of work done on transitioning already. Certainly, this decision by cabinet will underscore that and allow us to make sure that there are transitioning plans that are consistent from one corner of the province to the other.

[11:15]

With regard to the ambulance service, we have talked about acute care, we've talked about primary care, and we've talked about community care. The mental health plan and mental health

services throughout the province were outlined at a previous cabinet meeting. One of the areas that we have not touched upon, which is absolutely vital in terms of the continuity of service to British Columbians and health, is around the ambulance service.

The ambulance service today gets about 420,000 calls a year, which come into the three dispatch centres located in Kamloops, Victoria and Vancouver. I think, largely, the ambulance service has been taken for granted. They've somewhat been operating in isolation over the last number of years. We see lots of examples of stovepipe in health care, where acute care doesn't necessarily talk to community care. But the ambulance service has always been out there on its own and, even in the current model, is not integrated into the workings of the health authorities.

I would say that the ambulance service has not been properly connected into the health care delivery system. In spite of that, I see the ambulance service as somewhat like the Energizer Bunny. They keep going and going, and they're always there for you. You can make that call, and the ambulance is going to arrive and be there when you need them.

What is really important is that we make sure that the ambulance service is integrated into everything else that we do in health care in a way which provides seamless care when you need it. This became particularly obvious - that it was not as integrated as it should be - as we were going through and evaluating all the plans of the health authorities. Not only were the facilities not linked to each other in the communities, but what's vital to make sure that the facilities can interrelate - people can get access to the right care they need in an emergency situation…. We have to make sure that the ambulance service is there for them at those times.

There's been a fair amount of work done on that, particularly as the health authority plans have come together and been evaluated. One of the things I am pleased to advise today is that we are going to be spending, in this fiscal year, an additional $30 million on ambulance service in the province, and $20 million of that is going to be reallocated from within the ministry. These are moneys that we had put aside to facilitate the redesign process. An additional $10 million is going to be put forward by the health authorities themselves to make sure that their local needs are met, but it's going to be done in an integrated way for the first time to make sure that it's consistent throughout the province.

One of the things that came up this morning in some of the news reports was that somehow we had eliminated 300 ambulance attendants over the last year. That's not true. We did, at the time of unveiling our service plans for the ministry in September, talk about 37 positions that were over and above what we were obligated to provide in the province. We had proposed in that core service plan to reduce paramedics in the province by 37, to the level that we were obligated to in our contracts. We are not going to be proceeding, at this time, with the elimination of those 37 positions - which would have been done through attrition. Certainly, the staffing levels within the ambulance service will be maintained as we go through this redesign process.

There will be a big emphasis on training. In this current fiscal year 1,300 paramedics will be trained to a paramedic 1 level. In previous years we typically train about 350 ambulance attendants a year. This year 1,300 will be brought up to that paramedic 1 level. That's particularly in the rural areas, where in many cases we wind up with some ambulance attendants in the province that have very basic training or sometimes no specialized medical training at all.

As a result of being brought up to the paramedic 1 level, the ambulance attendants will be able to deal immediately, to intervene in the case of chest pains or heart attacks. For the first time, we will have defibrillators in every single ambulance in the province. That was not the case up till now.

They will be able to intervene in the case of diabetes. Earlier Sindi was talking about some of the acute conditions that can develop as a result of diabetes. They will be able to manage those at the time the ambulance arrives, while in transit back to an emergency care centre.

Somebody with asthma will be able to be stabilized by a paramedic 1. They'll be able to deal with drug overdoses, which unfortunately happen all too often in British Columbia. They will have that level of training. There's a whole series of things they will be able to deal with in a very competent way as a result of this training.

[11:20]

In addition, we're going to be expanding critical care training for many of the paramedics in British Columbia to allow them to transport patients who are in need of either trauma care or intensive care. This will be initially in the central interior but will be expanded to other areas.

What we see when we monitor MSP billings is that too often we wind up taking doctors away from a community to ride with patients as they're going to another community, and then the doctors have to find their way back. It deprives those communities of their physician coverage during that period of time. Upgrading the skills of some of the paramedics is going to allow us to meet that need through many parts of the province.

The training that they're going to get is the same training that the air ambulance paramedics have now to be able to transport patients. We will be able to do this for our road ambulances as well.

I'll give you a couple of examples as to how this $30 million of additional money is going to be spent. Right now patients in acute care waiting for transfers to a more appropriate facility can wait up to five days. You can wind up with somebody who's gone through surgery and could easily convalesce in their own community hospital, but the ambulance service can often take up to five days until that patient can be moved. That ties up that acute care bed and deprives somebody else, who needs to get into that bed, of access to it. At the same time, it denies access to their family members, because in some cases they might be miles away. The new ambulance service policy will see patients returned to their local facilities within 24 hours of being determined medically fit for transfer.

Another area that the $30 million will benefit comes out of the closure last fall of the St. Paul's emergency room. Many of you know how upset I was about that. I thought it was totally unacceptable that a major emergency room in this province got shut down because of the pressures. It was shut down from a Wednesday afternoon, I think, until the following morning. On the Friday of that week Sindi and I went to St. Paul's, and we met with the emergency room doctors and some of the nurses that were trying to cope with that situation. Out of that came a whole bunch of suggestions which we are proceeding to implement.

They talked about the need for better coordination among hospitals in the lower mainland so that when one's under pressure, the other can pick up some of the slack. We talked about the need to have a better flow of patients who no longer need to be in acute care. Their problem on that occasion was that they had 34 patients in the emergency room waiting to be admitted to the hospital, but the beds weren't available in the hospital because there were too many patients who needed to be somewhere else. Better coordination there is being implemented.

The other thing that has been put in place is something called the B.C. Bedline, which actually allows for computer tracking of available beds so that doctors don't have to spend hours and hours on the phone trying to find where a bed is available.

What has come out of that is a lot of work being done by emergency room physicians and administrators on the lower mainland. They have developed what's called an emergency department management plan. The ambulance service has a critical role to play to make sure that, first of all, patients wind up at the emergency room that is best able to deal with them. If it's an absolutely critical emergency, they go to the closest hospital, but if it's another condition, then they can go to the hospital that is best able to deal with them. Also, it's to facilitate the transfer of patients to a more appropriate facility, to free up those acute care beds so that we get the flow-through in the emergency rooms that we need. That will be an important development.

In summary, there is $30 million of additional funding to the ambulance service. Ambulances, in the way they operate, will be integrated into the health authority plan so that there is that continuity of care. They can respond to emergencies in the timely way that they're proud to deliver, they can facilitate patient transfers to more appropriate facilities when that's necessary, and we can ease the emergency room congestion that we see in lower mainland hospitals.

As I mentioned earlier, we've got 1,300 rural paramedics who are going to be trained to the paramedic 1 level. I think the bottom line is that we want to make sure that, like the rest of the health care system, the ambulance service is going to be there for us and our families when we need it. I think that's good news.

Hon. G. Campbell: Thanks, Colin.

We've got Bill and then Sandy and then Rick.

Hon. B. Barisoff: Thank you, Premier.

This is another one of the questions that Rick had with his concerns about the south Okanagan. In fact, both Rick and I have talked to you a number of times about the ambulance service in the

south Okanagan. One of my concerns, though, Colin, is: how do we convey the message - particularly in our areas, where there's a high percentage of seniors - that the ambulance drivers actually have those abilities to look after them? They know that they come, and they're there and whatever else. I think the big concern with a lot of the seniors is: do they have the ability to do all the different steps that need to be done?

[11:25]

I'm just wondering: is there a way that we can get a message out to all the seniors in British Columbia, particularly in rural areas where they automatically assume that they're less trained or whatever? If they knew in their own heart of hearts that the person that was coming to pick them up or whatever had a certain expertise of training, is there a way of conveying that message to them?

Hon. C. Hansen: We will certainly do our best to get that message out. I think the 1,300 paramedics that we trained up to the paramedic 1 level are going to be an important step in ensuring that they get the care they need when they need it. This is a big change.

Right now there are a lot of ambulance attendants that do not have any specialized medical training. This will ensure they get that training, and when that ambulance arrives to take care of anyone, whether it's a senior or anybody else, those ambulance attendants are going to have a level of training necessary to ensure that care is started.

Hon. B. Barisoff: In the different communities though, Colin, is there a way that we could actually - use Osoyoos as an example of saying, "Okay, in Osoyoos we have four ambulance attendants, and they're all at level whatever" - just put an ad in a paper every year or make sure the community councils or whatever are understanding of the fact that they portray that message that this is the level that we're at or that the minimum level we're at is going to be this in British Columbia? Is that possible?

Hon. C. Hansen: Yes, there are certainly some opportunities around messaging. You know, we're very reluctant to spend scarce health dollars on advertising, because we want to make sure they're spent on patient care, but as we find opportunities to get that message out, we'll certainly pursue it. It's a message I will take back both to the ambulance service and to the health authorities.

Hon. G. Campbell: Sometimes we forget that we actually have an excellent ambulance service in British Columbia already. I can tell you, when I did the dialogue for health care back in the year 2000, I think it was - a year and a half ago, I guess - one of the things that rural community ambulance attendants were constantly saying was that they needed that upgrading, that level. I don't candidly think that a lot of people know what paramedic 1 training means. Probably you didn't even until Colin told you today. Just to announce that is one thing, but I think if the ambulance service is there saying, "Yes, we're getting the training we need; we've got the support we need to provide you with the front-line service that you need," that is what this is.

This is one of the things that I think people in urban areas forget: the ambulance service is the front door to the health care system. We have to make sure that we're providing that where we have these vastly dispersed populations. The training and bringing 1,300 additional ambulance paramedics up to paramedic 1 is a huge step to actually creating that confidence. I can tell you that the ambulance service itself will tell people in communities how important that is to them because it's something they've been asking for, for some time.

Sandy and then Richard.

Hon. S. Santori: Thank you, Premier.

I must say the increased training is very welcome and critical to rural B.C., so thank you, Colin.

One question that I do have, and I think it's a concern that's been shared by many rural communities over the past several years, is the determining of staffing for ambulance service in rural communities as based on the number of calls they receive in a given year. Therefore, X number of staff are hired.

My question now is: with the standards that have been established whereby response to a hospital or to an emergency ward is within 60 minutes of an emergency facility, is there going to be a change towards response time to an accident as opposed to the number of calls in the year?

If that shift does not take place somewhat, it's going to be very difficult for us to meet the standards in those communities where they did have emergency wards in the past and that may not have them now. The old formula was not conducive to having an ambulance at the scene within five minutes. The staffing just wasn't there.

My question is: are we going to look at a different way of determining what the staffing levels will be with more onus on response time as opposed to the number of calls they get in a period of a year?

Hon. C. Hansen: We actually carefully monitor that now. It's not just the number of calls; it is very much around response time. It's also around the kind of transportation that's necessary. About a third of the calls that the ambulance service gets are when they don't wind up transporting a patient. They get called out, but when they get there, they find out there's not a need.

[11:30]

There's actually only 6.3 percent of all of the calls that come into the ambulance service that result in a lights-and-siren transportation of a patient back to an emergency care facility. That is carefully monitored. As we go through these changes, we'll be looking at the calls, we'll be looking at the acuity of the calls, and we'll be looking at the response times. We can make adjustments quite quickly in staffing levels to make sure those community needs get met.

Hon. S. Santori: One more question, if I may - or a suggestion. With the increased training now that's going to take place - and I don't mean to get into the nuts and bolts of ambulance service - right now in rural B.C. if there's someone on call and one person on full-time, the person on call has to report to the ambulance building to come with his or her partner to the scene. Can we at least look at the person on call being dispatched immediately to the scene, who may be there in most cases quicker than the ambulance but at least have the expertise with this new training to be able to deal with the patient in a quicker way, even though that patient may in fact not be in the ambulance yet? It's just a suggestion to report to the scene rather than to have to go to the building and then to the scene.

Hon. C. Hansen: Certainly, I know that they factor that into response times when there is a call-out that's involved. Often, what happens with the call-out is a backup, so you wind up with…. Sometimes an ambulance crew goes out, and they'll call in other part-time ambulance attendants to make sure that there's that backup support should there be another call. Certainly, the specific item that you mentioned, I will take back and discuss with the ambulance group.

Hon. G. Campbell: Richard and then Lynn.

Hon. R. Neufeld: Thank you, Colin, for bringing us up to date on this. I appreciate it very much. Sandy asked some of the questions I was going to ask around how we do it in rural areas. I just wonder what the percentage of paramedics is that are part-time. Is that usually larger in the rural areas than it is in the urban centres?

Hon. C. Hansen: There are actually about 3,200 ambulance attendants in the province. About 2,000 of them are part-time and 1,200 full-time. Yes, there is a higher percentage of full-time staff in urban areas because of the call volumes and the demands that are there. There is a formula - I guess is the right way to describe it - which determines the appropriate mix of full-time and part-time based on the community needs, so a lot depends on the size of the communities. The other big advantage that we've got with the part-time paramedics is that it gives us the flexibility that if there are increases in demands on the ambulance service, they can respond quite quickly to that by increasing the hours of the part-time attendants.

Hon. R. Neufeld: I have one other question after this too.

What we find in rural B.C., at least where I come from, is that the part-time people are not people that usually spend much time in the area. You find ambulances actually not being familiar with a rural setting that is huge in nature and trying to get to Mile 101 and Blueberry and actually going in two different directions although it's the same place. Those kinds of things are what happen when you use part-timers that come and go on a regular basis. I don't think there's anything you can do about it, but it's something that you should keep in mind.

The other question I have is on the new policy of returning patients to, I guess, where they live. Does that cover air ambulance? Coming, again, from a rural area where you have air ambulance transport to Vancouver for special treatment, which is what we normally do, what happens is they get released and they're on their own to get home. They can't buy a cheap ticket, because they

don't know when they're getting released, and sometimes they're not in really good shape to come home all on their own. Does that mean that the air ambulance policy is going to return these people within a 24-hour time frame? I assume you were talking more about wheels.

Hon. C. Hansen: Actually no, it would involve some air ambulance, because if you wind up with somebody, say, who's had a hip replacement, and that surgery…. Say they've come from the Peace down to the lower mainland to have that procedure done. They may be ready to go back to, let's say, the Dawson Creek Hospital to convalesce, but they're still not well enough to go home because they need the 24-hour nursing. The air ambulance would be engaged, in that case, to bring them back.

[11:35]

Our goal is to make sure that you get more surgery done on a regional basis so that patients don't have to go to the lower mainland to get the care they need. With the redesign and the consolidation of specialist services, you'll see more services being provided on a regional basis rather than relying on sending patients to the lower mainland. When you wind up with patients who don't require air ambulance - either they have to travel long distances to get access to care, or they have to travel long distances to get back after they've been discharged - we will be putting in place our travel assistance program which we have made a commitment to in the campaign, and we will be rolling that out. It won't be this coming year but, hopefully, as soon as possible to make sure that some of those other travel needs of northern British Columbians can be met.

Hon. R. Neufeld: Thank you.

Hon. G. Campbell: Lynn?

Hon. L. Stephens: Thank you.

Richard asked part of the question I wanted to talk about, and that was the air ambulance. Because of the regionalization, what role will the air ambulance play now, and how will it change from what we currently experience? Are you going to be increasing air ambulance service? On the use of helicopters, I'm not sure whether or not there are a lot of them in British Columbia, if any, but I do know some of them participate in organ delivery. What's the role for the air ambulance in the province?

Hon. C. Hansen: The air ambulance service right now does use helicopters out of many of the centres. We've got a very good air ambulance service. We certainly have the capacity to expand the air ambulance service as it is required, but one of the things we hope will come out of the redesign is less reliance on flying patients out of a region.

One case I was told about a couple of years ago was a patient who was in a northern hospital in an intensive care bed, and simply because they couldn't get an ICU nurse for the weekend, they had to medevac the patient to the lower mainland. That's a waste of taxpayers' money. It's bad patient care.

That's part of the kind of flexibility we built into the system, and it's part of the redesign that's going to make sure we have the best use of our nurses and other health professionals to meet those needs. Out of this redesign plan, I would expect that we will not see a significant increase in air ambulance. In fact, we may actually see a decrease by providing the proper access to care on a regional basis.

Hon. L. Stephens: Thanks.

Hon. G. Campbell: Any other questions? Thank you, Colin.

The next item on the agenda is the economic measures for first nations. Geoff.

For Decision: Economic Measures for First Nations

Hon. G. Plant: Thanks, Premier.

We're going to change gears from health care to the economy. I'm here asking for cabinet approval for the business plan for the first nations economic measures fund, which has been provided for in the February budget. It's $10 million a year for each of the next three years to be used to support economic development projects involving first nations.

Why do we need this fund? Well, anyone who casts their eye over the economy of British Columbia will see that first nations are not adequately integrated into our economic mainstream. They don't share as they ought to in the fruits of economic activity, and there are some reasons for this that are unique to aboriginal communities.

They include challenges around access to appropriate education and training, and sometimes the training is very specific. It is training not just in learning how to do something like operate a drilling rig or carry on forest harvesting activity but also in the sense of knowing how to prepare the business plan or the forest licence application or the document you need to get in the door here in the provincial government to get access to the resources.

This fund has been established to rectify, to the extent we can, some of those challenges. It's very consistent with and builds on new-era commitments. We knew we would have these challenges and these opportunities if we were elected into government. What we're doing here links very strongly not just to our general commitment to revitalize the economy but more narrowly, of course, to our commitment to increase access to Crown lands and resources for all citizens and also to our goal to expedite interim measures agreements as a vehicle to building some measure of economic certainty in the province - also, in some way, I think, assisting the treaty process as another aspect of building strong relationships.

[11:40]

What you have in front of you, as part of your material, is the actual business plan for how we intend to, over time, disburse these funds. I'm just going to provide a very high-level overview of that plan here now.

There are really four themes. The starting point is to say that what we're doing here is focusing on developing capacity within first nations communities in order that aboriginal people in those communities will be better positioned to participate effectively in key sectors of the economy. Really, this is not just about increasing economic opportunities for aboriginal people but, through that, increasing economic opportunities for all British Columbians.

There are four themes, if you will. The first is the idea of focus. The focus here is, at the high level, on our strategic provincial interest in economic development but also, at the local level, to look for and explore and exploit locally based initiatives.

The second theme is the idea of participants - who is involved in this. The participants will include first nations, the provincial and federal governments and also the private sector. I'll have more to say about that in a minute.

The third theme is the idea or theme of accountability - that is, that we want to be accountable. My ministry, as the lead on this, wants to be accountable to you as we develop proposals and projects. The idea is that accountability is a theme that will pervade the operation of this fund from start to finish, right from the beginning of selecting projects to the evaluation of various proposals through to implementation and then, of course, into the fourth theme, which is the theme of outcomes. We're not going to just spend this money and hope that something happens. We intend to define outcomes and to measure them.

With respect to that first theme, the theme of focus, I just want to point out that, as I've already said, we are going to use this fund to engage in key provincial economic sectors like oil and gas, tourism, aquaculture, forestry, including the Olympic bid. We think there are opportunities here to engage first nations through these dollars in a way that will contribute to the Olympic bid but also to look at the local level for specific initiatives that arise in particular communities that will serve the needs of those communities.

A key focus of our initiatives, or the goal for spending these dollars in each of these areas, will be training - training to reduce obstacles to existing employment, training to help aboriginal communities prepare for work in emerging sectors and industries. To give you an example - because this is not brand-new; government has been doing this in a less coordinated way than we intend to do - one of the projects that has existed is something called the petroleum employment training project. That has as its focus the training of young aboriginal citizens in the Doig River and Blueberry River Indian bands so that they can take entry-level positions in the oil and gas industry in northeastern British Columbia.

Again, the point here is, of course, not to subsidize participation in a particular economic sector but to recognize that there are unique obstacles to access to participation in those sectors, obstacles

that are unique to aboriginal communities. A program like this petroleum employment training project is intended to speak to and respond to those unique challenges and hopefully, through that, provide greater aboriginal employment within the oil and gas industry.

[11:45]

I talked about the theme of participation - that is, identifying the participants. The first leg of this is first nations. I want to make it clear that all first nations in British Columbia are eligible for funds here. You don't have to be in the B.C. Treaty Commission process.

The second leg to this is the participation of government. Of course, the provincial government participation consists of the $10 million a year for three years that I'm here to talk about. I should also point out that when I first met with Robert Nault, the federal Minister of Indian Affairs and Northern Development, shortly after the last election, he expressed to me his commitment to using these kinds of dollars federally and provincially to lever economic opportunities for first nations. In fact, this provincial fund will be matched by $11 million in federal funding.

The third leg is the private sector leg. First of all, I want to point out that industry has stated its support for the use of economic measures. We've heard from the Council of Forest Industries, the Canadian Association of Petroleum Producers and the Cattlemen's Association about their support for the idea that government should work with industry and first nations on industry training and employment initiatives. That's what this fund is intended to do. Those are the three participants in the funds here.

When we turn to the theme of accountability, I want to stress, first of all, that we are taking a business approach to this. This is fundamentally about economic measures as opposed to social service measures. The fund is about expanding first nations abilities, business skills and knowledge, and employment opportunities and, hopefully, about ultimately increasing investment opportunities for first nations and all British Columbians. We will, of course, work closely with Minister Thorpe to ensure that the programs or the projects that are supported by this fund do not create business subsidies.

We intend to take a sound business approach to managing the fund. That includes tying accountability to results. Each agreement entered into under this fund will include performance targets, cost justifications and payment schedules that will be tied to results and to deliverables. There will be evaluation frameworks developed so that we can see how well we're doing in meeting our objectives. We'll conduct random audits. I will be reporting to you and my ministry will be reporting to Treasury Board annually on our successes and those projects that have not been so successful, if we have some of those - and another report, again, at the end of three years.

The second leg of accountability is the assessment criteria. These are stated in some detail in the plan you have in your documents. We will be assessing the viability of project proposals against a number of criteria. Some examples include asking the questions of whether the proposal will promote economic growth, whether it has a strong business case, whether and how it will facilitate first nations participation in the economy and also whether the proposal will contain what are called quid pro quo provisions. That is, if we are in a situation where we are using public dollars to try to create a good working relationship with a first nation, we think we should be getting some assurances from the first nation that they will not be litigating or engaging in other tactics that might obstruct economic development. We are also, of course, going to be testing proposals against the extent to which we have been able to secure funding from other partners, including the federal government and the private sector. We will also be looking to ensure that any project proposals do not duplicate existing government programs.

[11:50]

The third leg of accountability is the decision-making process. That's also set out in your material. The proposals will be developed by ministries, and the framework of the business plan you have is the framework that will be used to assess the merits of the proposals. Any proposal that is for a project of under $1 million that meets the tests of the business plan will be considered by the deputy ministers' committee on natural resources and the economy, so it won't come directly here.

If you approve the business plan, then we'll roll this out, and the particular review mechanism will have the deputy ministers' committee there for proposals under $1 million, which I suspect will be the vast majority of proposals. Any proposals for projects over $1 million will go to Treasury Board.

The fourth theme is the theme of outcomes. I've really already touched on this in general terms. The whole point of the business plan and the criteria is to be sure that when proposals come forward, they are assessed according to what we think they can produce by way of outcomes. We are going to test the projects against those outcomes to make sure they achieve them.

That is a broad overview, if you will, of the business plan that's in your document. I think this does offer a great opportunity to reach out into first nations communities, working as partners with them, with the federal government and with the private sector, to explore opportunities to enhance first nations access to the economy and through that build stronger relationships with first nations and meet our goals - the goals stated in the New Era document - for first nations.

Thank you for the opportunity to provide that overview.

Hon. G. Campbell: Thanks, Geoff.

Questions - Stan, Sindi.

Hon. S. Hagen: Thank you, Premier.

I want to applaud Geoff on this. I think it's a very thoughtful, very focused plan, and I can tell you, as I travel around the province and meet with first nations people wherever they are, most of them really want to enter the economic mainstream of British Columbia. I think the plan that Geoff has here will provide those opportunities to do that, and I look forward to working with Geoff through Land and Water British Columbia to build those stronger relationships that we're going to need and that will help move us down the road, even toward treaty resolution. This is, I think, a tremendous opportunity.

One of the industries you didn't mention that is working very closely with first nations is the aquaculture industry. I think they've done just a great job in what they've done. I think this will provide the opportunities for first nations people. I think it will help build much stronger relationships between the government of British Columbia and first nations people, so I congratulate you.

Hon. G. Campbell: Thanks, Stan.

Sindi.

Hon. S. Hawkins: Thanks, Geoff. I also want to support you in this initiative. I think it's a great way to promote cooperation and build those partnerships that we need to with first nations. I think a lot of industries, especially in my community, are going to welcome this. I know they've been really proactive in trying to build those partnerships and promote economic development in first nations communities around my area. I think it is good news for people who do business in B.C., who live in B.C., because we're trying to move toward creating that stability and certainty.

My question to you is…. I know the treaty negotiations office is going to be managing this. Does this mean that applicants have to be in the treaty process, then, to apply for these funds?

Hon. G. Plant: Well, I think the proposals can come to the treaty negotiations office unsolicited from first nations, but I suspect that we will also be able to identify across government areas that we already know where there are opportunities. I think, as we have developed the business plan for the fund, that we in my ministry have worked quite closely with some of those ministries already, including Stan's ministry, certainly Dick Neufeld's, the tourism people and Mike de Jong's ministry as well as John van Dongen's.

[11:55]

It doesn't end there. Many of the line ministries in the resource part of government have already worked over the years to establish relationships with first nations. They know where the obstacles and the opportunities are. I think this fund has been something that many folks in government have been waiting for as an opportunity to move forward in a disciplined, coordinated and organized way.

As first nations and businesses, for that matter, see opportunities here, then I would welcome them contacting government directly. We'll certainly look at them to see if they meet the project criteria and if they are worth pursuing.

Hon. G. Campbell: Let me answer directly. No, you do not have to be in the treaty process to be part of this program.

Hon. G. Plant: Oh, I'm sorry. I missed that. I thought I said it already.

Hon. G. Campbell: You did mention it.

You do not have to be; first nations won't have to be. This really reinforces some of the other steps that Geoff has already taken to build the new relationships with first nations. For example, Richard and I had a meeting with first nations with regard to the energy sector and creating opportunities. Building new relationships is really what this is aimed at doing, as well as enhancing capacity. We said we'd do that.

It does complement the federal jurisdiction, as well, where they are also looking for ways we can build that capacity and start to build those relationships. It's with all first nations. It's with all ministries. As we did last year with the government, if in your ministry you find something that makes a whole lot of sense, it may well fit into one of the assessment criteria and can move forward.

Joyce has got - what's it called? - Land and Water British Columbia Inc. Is that what it's called? Joyce's ministry, Stan's ministry, Mike's ministry, John's ministry, Richard's ministry - there are lots of opportunities out there. I think it's a step. My hope is that we'll find we have so much pressure on this that we need more, because it will mean we're actually succeeding in a place where we need success.

All in favour of the plan that's been put forward? Consider that approved.

Thank you very much.

The meeting is adjourned.

The cabinet adjourned at 11:57 a.m.

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