TRANSCRIPT OF THE OPEN CABINET MEETING

December 12, 2001

Province of British Columbia
EXECUTIVE COUNCIL

Premier and President of the Executive Council	Hon. Gordon Campbell
Minister of State for Intergovernmental Relations	Hon. Greg Halsey-Brandt
Deputy Premier and Minister of Education	Hon. Christy Clark
Minister of Advanced Education	Hon. Shirley Bond
Minister of Agriculture, Food and Fisheries	Hon. John van Dongen
Attorney General and Minister Responsible for Treaty Negotiations	Hon. Geoff Plant
Minister of Children and Family Development	Hob. Gordon Hogg
Minister of State for Early Childhood Development	Hon. Linda Reid
Minister of Community, Aboriginal and Women's Services	Hon. George Abbott
Minister of State for Community Charter	Hon. Ted Nebbeling
Minister of State for Women's Equality	Hon. Lynn Stephens
Minister of Competition, Science and Enterprise	Hon. Rick Thorpe
Minister of State for Deregulation	Hon. Kevin Falcon
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
Minister of Provincial Revenue	Hon. Bill Barisoff
Minister of Public Safety and Solicitor General	Hon. Rich Coleman
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

WEDNESDAY, DECEMBER 12, 2001

The cabinet met at 9:01 a.m.

Premier's Opening Remarks

Hon. G. Campbell: Over the last few weeks at open cabinet meetings we have gone through strategic shifts of all of the ministries, with the exception of one. Today we are going to start off with the Ministry of Health Planning and the Ministry of Health Services, dealing with their core services review. It will be the final ministry that we actually deal with in terms of strategic shifts.

Then we have the issue with regard to restructuring health authorities. That will be next on the agenda.

We'll start today with Colin.

Health Ministries

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

Today, on behalf of the four health ministers - Gulzar and Katherine as ministers of state and Sindi and I as responsible for the two ministries overall - we want to present to cabinet the results of phase 1 of the core review for both of these ministries. I'm going to start out, and Sindi will pick up halfway through.

The strategic shifts that we are proposing are the basis for renewing our health care system in this province. First, I want to outline for you what we see as the vision for health care and then set out some of the current realities, which have both their pluses and their minuses. We will share with you the problems and the challenges that confront us in the months and years to come, and then I will sketch in the strategic shifts that we believe will address these challenges and help to make that vision a reality.

As you know, the two ministries - the Ministry of Health Planning and the Ministry of Health Services - by necessity must work very closely together. Certainly, as we've gone through this process, it has been a joint effort by the two ministries, because we do have to share that common vision.

Our task is nothing less - and I know this may sound dramatic, but I don't think it's an understatement - than saving and renewing our public health care system in British Columbia. The vision that we strive for is to deliver high-quality public health care services that meet the needs of patients where they live and when they need them.

The two ministries have three goals in common. The first goal is to offer high-quality patient-centred care. This means that patients receive appropriate, effective, quality care at the right time and in the right setting. Most important, this means that health services are planned, managed and delivered around the needs of the patient - not the needs of the providers, not the needs of the policymakers, not the needs of the managers or the administrators but the needs of the patients. That is the principle that will drive all of our considerations.

[9:05]

Our second goal is to improve both the health and the wellness of the people of this province. Health and wellness of individuals is determined by a number of factors. I think that most, if not all, of you around this table have direct responsibilities in your ministries for issues that affect the health and wellness of British Columbians.

Health and wellness is driven by some big, overarching factors. Early childhood development, Linda's responsibility, is key to health and wellness. Education is one of the biggest drivers when it comes to good health outcomes. Certainly, when it comes to their health and wellness, British Columbians are relying on the work of Shirley and Christy. Economic status is one of the big health drivers. With all of the economic portfolios around this table, it is critical in terms of economic security and employment that those are driven in a way that will produce good health outcomes for British Columbians, because British Columbians are counting on you. Finally, in terms of environment, there are the issues around clear water and clean air, which Joyce and Stan obviously take responsibility for. We're counting on those programs as well.

It's also important that we affect the personal decisions and behaviours of individuals, because we must deal with public expectations. We currently undertake some major prevention strategies that are aimed, for example, at tuberculosis, sexually transmitted diseases and HIV as well as injury and selected chronic illnesses. With access to accurate and timely information, British Columbians can make wise choices. In doing so, they can safeguard their own health and wellness and their quality

of life. We want to provide assistance to British Columbians who need care when they're sick, but helping them to stay healthy and stay out of the health care system in the first place is also equally as important.

Our third goal is key to both the present and the future of our health care system. We want to ensure that we can provide sustainable, affordable public health care. Unless we renew our health care system in a way that we can afford in future generations, we will not be able to address those first two goals that I've outlined. We cannot hope to have a system of services that focuses on patients or a system that ensures quality services when and where people need them if we don't ensure the sustainability of that system.

Our goal is to create a planned, efficient, affordable and accountable public health care system where the governors, the providers and the patients accept their share of responsibilities for the provision and the use of those services. It has been stated many times that we cannot continue to provide more and more of the same in the health sector but that we must introduce ways of being more efficient and more accountable for what we spend.

As you can see, our health goals are ambitious, but they also suggest the complexity that is our health care system today. Our services have grown incrementally over the past 40 years, bringing in new treatments, new technologies and new knowledge. I think one of the things that is so difficult to deal with is the ever-expanding public expectations of what their health care system should deliver.

Here is a picture on the screen that really shows how complex the system is today and many of the players and the diverse roles that have to work together to deliver health care. We have the Health Research Foundation and colleges and universities who train our health care providers. We have the two Ministries of Health. We have 22 professional regulatory bodies. We have a Medical Services Commission. There are 52 health authorities and the hospitals and services that fall under their jurisdictions. We have a provincial ambulance service, and we have the tens of thousands of nurses, physicians, physiotherapists, care aides and the other health care providers who we depend upon across British Columbia.

What this picture doesn't show is the strengths and the weaknesses of the system. Complex, which it is, is not necessarily a bad thing. In the twenty-first century we have to come to realize that we're living in a complex world. The system has both its good and its bad points within that complex system.

People say they find the system confusing. We also hear from patients that they have received excellent, first-class care by dedicated, efficient and effective health care providers around the province. On the positive side, we must acknowledge that British Columbia has one of the healthiest populations in the world. But British Columbians know that there is room for improvement in that system as well.

[9:10]

We must remind ourselves that consistent with the Canada Health Act, all residents of British Columbia are insured for the medically required services they need. Regardless of income, we are all protected from the potentially enormous costs of illness.

British Columbia is also a leader and an innovator in a number of areas, such as PharmaNet, which is our provincial pharmacy computer network. It helps protect the health and privacy of British Columbians.

We also have extremely high quality data about the health status of our populations. It allows us to address some of the particular issues where we have some weakness, such as areas around aboriginal health, which require particular effort and attention in the years to come.

In British Columbia we also have among the best outcomes in the whole world for some treatments of cancer. I know we often talk to individuals who have that huge anxiety about being diagnosed with cancer. They feel they must go down to the U.S. to get the best care in the world, when in fact, we here in British Columbia have the best outcomes for the treatment of some cancers.

The B.C. Centre for Disease Control is a leader in the prevention and detection and control of many communicable diseases.

Throughout British Columbia there are many successful and innovative approaches to health care delivery that are patient-centred and cost-effective and deliver excellent health outcomes.

We need to bear in mind these strengths as we move forward to address some of our challenges, because clearly, there are also some negative aspects and some problems in our current health care system. One of those is that we have a very fragmented system. There is a need for seamless care for the individual from the time they first contact the health care system until they get the services and surgery or treatments they require. We often talk to patients that, in the course of one day, will be subjected to multiple blood tests which are totally redundant and unnecessary but are required only because our system is so fragmented today.

We have escalating costs which, by and large, up till now have been out of control. In the last year alone we've pumped an extra $1.1 billion into the health care budget, an increase of 13 percent. I think British Columbians, by and large, will not tell you that they're getting better health care in British Columbia as a result of all that additional money being pumped into it.

We have a continuing problem with wait-lists. Certainly some of the job actions of last summer exacerbated some of those wait-lists. Wait-lists themselves are not necessarily a bad thing. We can't expect that you can walk in and get surgery on demand anywhere in the world, and British Columbia is no exception. But clearly, when we talk to our individual constituents and British Columbians who are just extremely anxious that they can't get the surgery in a timely fashion, there are some issues that must be addressed.

We have a shortage of health professionals. There's been lots of attention paid to the nursing shortage and, to some extent, the doctor shortage, but really there are a range of health professionals that we're facing shortages in today. We have to ensure that those are addressed. That's particularly problematic in some of the rural and remote parts of British Columbia.

There is a lack of focus on the patient. We must be concerned about the stresses that we're putting on our health care providers. A case in point recently was the stress on emergency room nurses and doctors in some of our major hospitals. We must deal with those, but we must deal with them in a way that doesn't lose focus on the patient. That has to be our number one concern. It's also the number one concern of those health care providers.

There's also a loss of confidence in the health care system. Most British Columbians today do not have confidence that our health care system is going to be there for them and their families when they need it, where they live, where they are and for the services that they require.

There's also a big lack of flexibility in the system. It's not just a lack of flexibility in the collective agreements, which there's been some discussion about in recent weeks. Clearly, that is a big problem, but there's also a lack of flexibility in the scope of practice of many health professionals in the province. This is an area that we must address in the years to come.

The budget for our publicly funded health care system currently stands at $9.5 billion. That is just under 40 percent of our provincial budget. This next slide that is before you shows the increase in health expenditures from 1975 to the present. I want to emphasize that these are per-capita increases. If I presented for you the absolute dollar increases, it would be even more dramatic than this. You can see from this slide the huge increase in the per-capita cost of our hospital system. There's a big increase in the cost of physicians and other health professionals across that slide.

[9:15]

Those are dramatic numbers and dramatic increases in costs, but the scope of the health care system has expanded considerably. As part of that, we have seen rising labour costs and the costs of new technologies. New drugs have been a huge cost driver in the system but also a huge benefit. This is serving an ever-growing and aging population in British Columbia, a population that expects more than just protection from the catastrophic illnesses that the Canada Health Act was originally designed for.

At this point I want to turn it over to Sindi to address some of the problems and challenges and the strategic shifts that we're proposing.

Ministry of Health Planning - Strategic Shifts

Hon. S. Hawkins: Thanks, Colin.

I'm going highlight the challenges and the problems we face in our health care system, and then I'll address the strategic shifts that we know we have to make to help overcome the challenges and problems.

The problems in the current health care system can be summarized in three broad categories: planning and management, demand versus need and sustainability. In planning and management, first, I think we've seen that over the past 40 years the health care system has grown into a patchwork of services. This piecemeal kind of approach has discouraged - and I would say even defeated - any real efforts for health planning in a way that best serves the needs of our patients and the public. We've been left with a system that's complex, fragmented and very difficult to manage. Our public health care system, we believe, needs to be streamlined, and it needs to be made much more accountable.

Secondly, it seems to me that as more health services have become available, the line between demands and needs seems to have blurred. Over the past decade we've seen that the public has been encouraged to look to government to meet a wide range of health and health-related needs and demands. At the same time, because of advances in technology and clinical interventions, we also have a broader range of health services that the public now feels entitled to. In order to support the health services that common sense says are necessary, I think it's critical that we make the distinction between needs and demands and not confuse one with the other.

Last, I want to talk about sustainability. We have a real challenge with sustainability. We recognize that the health system can't continue the way it's been growing, and we recognize that there won't ever be enough money to sustain the system in its current form. In fact, as Colin mentioned, health care costs have just been escalating. In B.C. they've been growing three times faster than the rate of our economy. Pharmacare costs alone have been rising at a rate of 15 to 20 percent per year. But you know what? We're not alone. Sustainability isn't just a B.C. problem; it's in every province in Canada. We have it in B.C., Saskatchewan, Manitoba, Alberta, Ontario, Quebec, Nova Scotia, New Brunswick, Newfoundland and even Prince Edward Island. All of them are dealing with a very hard reality of not having the resources to deal with the needs and demands, and all of them are trying to find the resources and new strategies to meet the challenge of sustainability and to renew public health.

Every province in the last ten years has gone through reviews and reports and has looked at ways to sustain its health care system. Sustainability really is at the top of the agenda in every province, and I know, Premier, that you've been working really hard to get it to the top of the federal agenda. In fact, we had a meeting here that you hosted in August, and you certainly are leading the charge with the other Premiers in fighting for our fair share of federal funding. Seven years ago, I might add, of every dollar that the province spent on public health care in B.C., 18 cents of it came from the federal government. Today that share is only 14 cents of every dollar. Again, I would note that our Premier is hosting an extraordinary meeting on health in January. That meeting is primarily to sit down and specifically discuss the issue of health care sustainability and federal contributions to public health care.

We have rising costs, rising demands and falling federal contributions, and we know there won't be enough money to sustain the system in its current form. So like every other province that's making changes to sustain their public health care system, we know we have to do the same. We know we have to make some shifts and find new strategies to save and renew our public health care system so that it's there for us and for future generations.

[9:20]

I want to talk about the first shift that we need to make. We've identified three areas in which we believe change is necessary to achieve those goals we've set for ourselves and to help us to realize our new-era vision of renewed public health care.

First, to address poor management and planning, we clearly want to move from fragmented management, lack of clear performance expectations and little focus on patient involvement or outcomes to a planned, well-managed system that responds to patient needs and is accountable to the public for results.

In the present system, as Colin mentioned, there hasn't been long-term planning done to save or renew public health care. The focus has been on inputs, on funding, rather than on health outcomes, and patients and providers have certainly felt left out. They either haven't been asked or they haven't been listened to, to get their ideas on how they would improve the health care system. We have 52 health authorities and thousands of health providers who haven't been provided with clear expectations of what we want accomplished with our health dollars. Because there are no clear lines of accountability, we've been unable to take action when performance has fallen short.

To make this shift to better planning and management, first we need to develop a sound strategic plan. That's a long-term health plan that includes, for example, a health human resources plan, a technology plan, an equipment plan and an intermediate- and long-term plan - some of the components of that long ten-year plan.

I want to make it clear that the plan is the means to the end. It's not the end. It took decades to get us here, and it's going to take a long time for us to get where we want to be. It takes a long time to train those doctors, to train those nurses and to train those pharmacists that we know we're going to need. We realize that we have to start somewhere, and we're beginning to develop those plans and those strategies that we need.

I'm not going to pretend, and I'm not going to try and kid everyone that it's going to be easy. In fact, I think that everyone around the table knows - since the last six months that we have been dealing with this - that it is going to be very challenging. We are going to be persistent. We're going to be relentless in the pursuit of our goals that we've set for our health care system. We are planning for ten years down the road so we can see long-term changes and improvements. As I mentioned before, the problems have been decades in the making, and we're committed to developing a ten-year plan to start solving them.

Secondly, we need to put in place clear expectations of our health care system and performance in that system to ensure accountability for good outcomes. For example, we need accountability frameworks and performance contracts for health authorities so they clearly know what's expected of them and what they're accountable for.

Most importantly, I think, we need to listen to patients and the public, because they use the system. We need them to help guide us in making those changes to save and renew the public health system. I think we can do this by simple things like patient and public satisfaction surveys.

Our second shift. We need to be mindful of the distinction between need and demand. I think we have to move from expectations for a publicly funded health care system that meets all needs and demands regardless of the cost or the benefit to the patient to a public health care system that will address patient needs and deliver good outcomes - that means both health and management outcomes - and that will provide real value for taxpayers. Patients, the public - all of us - have to realize the health care system can't be all things to all people. There are limits to what the public health care system can provide, and we believe that it's up to government to provide leadership to define those limits along with the appropriate choices within those limits.

The third shift that we're proposing relates to the challenges of affordability and sustainability. Each and every year, we've been faced with increasing demands for health services. Health care costs, as I said, have been growing three times faster than our economy. This is due primarily to factors which you've heard before: the growth in our population; changing demographics, with an increase in aging and immigrant populations; advances we've seen in technology and drugs - the ability to provide more sophisticated services certainly impacts on that; and, lastly, this sense of entitlement. By this, I mean the public has demanded more and more services from the publicly funded health care system, and governments really have been reluctant to take leadership in defining those limits within their ability to pay.

We need to shift away from our current pattern, where the costs in the public system have been rising at incredibly unsustainable rates, and we need to move to a sustainable system where the government, the public, health providers and patients all feel a shared responsibility for costs and for appropriate use of these services.

[9:25]

The three strategic shifts will really require a commitment from both Ministries of Health - the Ministry of Health Planning and the Ministry of Health Services - the health authorities, health service providers, patients who use the public health care system and, in fact, every British Columbian. We are confident, though, that the efforts to make these shifts will be worthwhile, because we believe these shifts will result in a patient-centred, integrated, sustainable system with quality services delivered to patients when and where they need them.

We believe the benefits of these shifts, then, will result in improved health for British Columbians by ensuring that better care is available for British Columbians when they need it now and certainly in the future. Again, the task is challenging. We know we have to find ways to save and renew public health care. These shifts, we believe, will allow us to keep focused on our goals.

I want to tell you now what we're doing to get us there and the part that my ministry will play in that planning. We all recognize, I think, that the way the current system is structured and managed is no longer affordable. Given the resources we have available, we can't keep going the way we are, so we have to make significant changes. Those changes are in how, where and to whom health care is provided. We believe that government's role is to lead those changes.

First, I think it's important to understand the broader role of government in health care. In our regionally managed system of health that we have here in B.C., government isn't actually in the business of managing and delivering health services. The health authorities are responsible for the planning, the managing and the delivery of health services in their areas and, also, for implementing those health system changes and improvements.

The government's role, then, is to provide the overall direction to set policy and legislation and to fund the health authorities. Within that broad role of government, my ministry is responsible for developing the tools we need to build a high-quality, patient-centred, sustainable and accountable health care system. Those tools include a sound strategic long-term plan for health care in our province, and we're developing a ten-year plan for health care. Another tool is legislation. Another is policy and, certainly, setting provincial health standards.

We use these tools as government to direct the health care system in ways that will ensure that all British Columbians have fair access to reliable high-quality health services wherever they live. While the role of my ministry is to develop those specific plans and policies we need for patient improvements and certainly for long-term sustainability, we also have the provincial health officer, who complements the work of my ministry by monitoring and reporting on the health of the population, by telling us how our strategies for change are improving the health of the population and, certainly, by recommending what actions we need to take. Those are the core functions of the Ministry of Health Planning.

What are our major activities? Well, our major activities in the immediate future are, in fact, in keeping with many of the new-era commitments that we made for health care. We're going to restructure the health system so health authorities can be more effective, efficient, responsible and accountable. Getting this right will certainly provide us with the foundation to make health system and patient care improvements.

We're developing performance management contracts so we can hold our health authorities accountable for patient and management outcomes. There will be clearly stated government expectations for performance, including transparent policy and standards for the level and quality of health services that are being provided.

As I said before, we're developing a sound strategic long-term plan, and that's a ten-year plan. That plan will identify health priorities for the immediate, the intermediate and the long term, and it will also outline a blueprint for major system changes that we know we need to make and need to implement in the coming years.

With some of my colleagues around the table, we're already beginning to address some of the shortages in health care providers, and we're developing plans. We've implemented some of them with Shirley in Advanced Education. We've added nurses and LPN spaces to colleges and universities. We've added nurse refresher programs. We are certainly working with the University of British Columbia, UNBC and UVic on a collaborative medical school project that's going to train more doctors in areas of the province where we need them. We're also developing plans to meet capital equipment and technology needs.

[9:30]

Certainly, Katherine has been working very hard on plans for an intermediate, long term and home care strategy, and Gulzar is working on a mental health plan. That's all being done so that we can save and renew our public health care system. We're prepared to really focus on patients and their needs, because we want to and we need to, to achieve better health outcomes. We'll be developing strategies, then, that will emphasize preventive care and will establish better ways for managing chronic diseases such as diabetes and asthma. We'll develop strategies that provide better care for people with mental illness and renew our system of care for the elderly in the home and in the community.

Certainly we need to breathe new life into primary care. Primary care is where patients first enter the health care system. We know there is a lot of inappropriate use of emergency rooms and, perhaps,

walk-in clinics, when patients should be entering the system in less expensive ways that provide quality and continuity of care for them.

Premier, those are some of the first key steps we're taking to make these kinds of patient care improvements. My ministry is working on a service plan that will provide more details. It will be available early next year.

I'm going to send it over to Colin to wrap up and deal with the priorities in his ministry.

Ministry of Health Services - Strategic Shifts

Hon. C. Hansen: Great. Thank you, Sindi.

As Sindi has outlined, while the two ministries are distinct and unique, they have to work very closely together to achieve that vision we outlined earlier. While the Ministry of Health Planning develops the government expectations for health service performance - what I like to call the tools of accountability - it's the Ministry of Health Services that funds, directs, monitors and evaluates the performance of the health system, using those tools.

Ensuring that the health authorities are accountable is one of the primary functions of the Ministry of Health Services. In the past governments have failed because we have not developed and communicated clear expectations, and previous governments have not ensured that there has been good performance management of our health care system. This has resulted in too many inefficiencies and too much duplication, which has clearly contributed to the lack of a sustainable health care system in this province.

In the past we have seen two major areas of health care services that have been ignored or, certainly, not given the attention they deserve. One of those is the whole area of mental health, and the other is the area of community care or, as we can refer to it, intermediate, long-term and home care. When the cabinet was appointed on June 12, I think it was a clear signal that there was priority being given to these two areas, with the appointment of Gulzar as Minister of State for Mental Health and Katherine's appointment as Minister of State for Intermediate, Long Term and Home Care.

There are lots of good ideas that come to us. Everybody around this cabinet table talks to individuals in their communities who have really good, thoughtful ideas as to how we can fix the health care system. I get lots of that input in letters and phone calls. Some of the best ideas come when you sit down with the front-line health care providers. Sitting down in the staff room in a hospital in a small community, talking to the nurses and the doctors, you realize they have some of the best ideas. The Ministry of Health Services is, in fact, the delivery mechanism for those changes that need to take place.

As Sindi has said, we will be reducing the number of health authorities in the province, and we will be creating a new framework for the provincial and tertiary programs and introducing a new business relationship between government and the health authorities. That is a relationship which has not worked well in the last number of years. That's not to say that it's the fault of people who have worked at the health authority level. Clearly, there has been far too much micromanagement of the system from the Ministry of Health in its previous incarnation. There is also a concern on the part of the ministry that the health authorities aren't accountable in a way that really shows that dollars are being spent with the best effectiveness.

[9:35]

Part of the major strategies in the Ministry of Health Services will be to realign the ministry. We'll be looking for a smaller ministry - less administration in the core operations of the ministry. Those dollars that will be saved will be redirected into direct patient care. We will be developing that new business relationship with health authorities. The announcement around the restructuring of the health authorities is an opportunity to get a fresh start on that relationship - to let that previous relationship be history and to start fresh with one that is going to be positive and meet the needs of patients, which is obviously the primary objective.

There has to be new accountability built into the system. Sindi mentioned earlier the performance contracts that we'll be putting in place. We're not there to micromanage the delivery of health care. We're not there to tell the administrators around British Columbia how to do their jobs on a day-to-day basis. What we will be doing is setting out the performance contracts that will clearly set out the expectations for those administrators as to what services must be delivered for patients and British Columbians in general.

The other side of that is the clear accountability that has to flow from that afterwards. We will be measuring those outcomes, and we will be holding them accountable for delivering on the performance contracts that we have mutually agreed to.

Next, there is going to be a phase-in of needs-based funding. We've had many complaints around the province of the inequities in the way available health dollars are allocated to the regions. We will be developing a new funding formula. Health Planning will be developing it, and we will be implementing it in Health Services to ensure that every region of the province gets a fair allocation of health dollars, not just based on the population living in that region but based on the demographic factors that drive health care costs in those regions.

Finally, we'll be putting in place a leadership council. The leadership council will really be the key forum to sort out some of the challenges that we will be facing in the health care system. We need a system that is much more streamlined when it comes to developing the new policy frameworks that we will be requiring, because we will be in a health care system that will be changing quite quickly in order to meet the changing needs of patients and British Columbians.

This is not a full menu of the initiatives but, rather, examples of some of the strategies that we will be pursuing.

In closing, let me say that the Ministries of Health Planning and Health Services have separate but complementary roles in leading the health system renewal. We are committed to working together to focus on patient care, to manage our resources better, to ensure our providers are more accountable and to ensure more personal responsibility among patients. These changes are significant, and they are challenging.

It means that we must also manage the change process with care to ensure that quality services continue to be available to patients throughout British Columbia. We cannot change in an irresponsible way. We have to change in a way that allows for necessary needs of British Columbians to be met on a day-to-day basis while we're going through these changes.

The Ministries of Health Planning and Health Services are committed to working together to renew British Columbia's health care system and to restore the public confidence that their health care system will be there for them and their families when they need it. On behalf of Gulzar, Katherine, Sindi and myself, I am requesting cabinet approval for the strategic shifts that we have outlined today.

Thank you.

Hon. G. Campbell: Questions? Linda.

Hon. L. Reid: Thanks, Premier.

Colin, we've had a long history in our province of denominational health care providers - St. Paul's, Mount St. Joseph. Give me a sense of how their future will be affected by the discussions today.

Hon. C. Hansen: There is a significant involvement by the denominational health authorities. They have a very good and active association that represents them. I've met with them on many occasions. You know, as we go through these changes, we want to protect the services that those facilities are delivering.

There is a denominational agreement in place with, I think, virtually all of those facilities. Some of them are quite big. St. Paul's Hospital, for example, is a denomination-based hospital with a fabulous 100-year history of service to the community. There are other small organizations. There are some small care homes in the province, for example, that are denominationally based. We want to protect them. As we go through the restructuring, we want to make sure that they are impacted in ways that are only positive in the future.

Hon. L. Reid: Thank you very much.

Hon. G. Campbell: Greg.

Hon. G. Halsey-Brandt: Colin, you've asked us to endorse these strategic shifts. One of them is…. You alluded to a needs-based funding formula. It seems that every time I talk to an administrator, that's what they say they present in terms of a budget to the province of British Columbia. Everything is based on needs in terms of their staffing, the size of the hospitals and the delivery. You talk about making a shift to needs-based. That implies that we haven't got one now. What do you mean by

needs-based? Right now is it based on the population in a region, or is it based on a base budget that just keeps growing every year? Are we now going to have a look at how old the population is or levels of wellness in the community? What do you want us to do in terms of where this money's going to go?

[9:40]

Hon. C. Hansen: Actually, I'm glad you asked that question. What we have had up till now is really a very ad hoc way of developing budgets. There's nobody that can describe to you today why a region gets a particular allocation of money, other than: "It was historical, and we've added to it a little bit. Some people started complaining that there were cost drivers, so we added a little bit more." It's not based on any kind of a process that really ensures fairness in allocation.

Today, for example, you will hear people making the claim that somehow we're not funding the collective agreements in the years to come. What happened in the past was that we would say…. Let's say $23 million is going to be needed for a particular aspect of a collective agreement. Well, the ministry would literally make an allocation for the $23 million that is earmarked for that particular purpose. Say a new CT scan goes in. Out of the capital budget for equipment will come the cost of the CT scan, typically shared with the hospital districts in those areas. Then they come back and say they need money to operate it. Okay: here's $170,000 for the operation of the CT scan over the coming 12 months.

What we want to do is get rid of that prescriptive, micromanaged process and say to every region of the province that based on the size of the population, based on the number of people over the age of 65, based on all of those needs in the region, we will allocate a share of the available health budget. Then we'll give the flexibility to those local administrators to manage within that envelope, rather than the Ministry of Health Services telling them how they have to spend every single penny within that budget.

Hon. G. Halsey-Brandt: Is this going to be done over two or three years, with some dialogue with the regions?

Hon. C. Hansen: It will be phased in. You will see the first stage of that with the new budget year, starting April 1.

Hon. G. Halsey-Brandt: Thank you.

Hon. G. Campbell: Gordie Hogg, followed by Graham.

Hon. G. Hogg: Following up on Greg's comment, Colin, at Peace Arch Hospital the foundation contributes enormous millions of dollars to equipment. I know that foundations have traditionally been closely aligned with hospitals. As we've looked at different forms of regionalization, that has dissipated somewhat. I wondered if you've looked at the whole role of foundations and the millions of dollars they bring into the system across the province and how those dollars will roll into the system. How can we rationalize it across the province? How can they be specifically tied into? I'm assuming we still want that community involvement and the volunteers and the great dollars they bring into the system, but we need to find a way to make sure that's connected. I wonder if you've thought about how that might fit into the system.

Hon. C. Hansen: Yes, in fact, there's been a lot of consideration of that. The foundations are actually totally independent of government. We play no role in the appointment of their board members or their management. They don't receive funding from government. I think the Peace Arch Hospital in your constituency is a perfect example of a hospital that has an independent foundation that just does great work. There are many of those foundations around the province. As we go through these changes, we want to make sure that we enhance the work of those foundations. We certainly will not be doing anything to affect them in any of the results of these shifts or the restructuring that Sindi will be outlining later. Those are great organizations, and we want to enhance their work and maintain their independence. They're very valuable to those communities.

Hon. G. Halsey-Brandt: I think one of the issues over the years has been that they will want to buy a piece of equipment which may not fit into a provincial strategy or plan with respect to that equipment. Then the ministry becomes responsible for the operating costs associated with that. I think there needs to be some rationalization of how that whole process works. There has been great frustration on the part of the foundations, I know, as they come forward with what they think are specific needs. But as we talk about regionalization, that has to fit into the kind of overall plan and context for service delivery across the province.

I think that maybe we need to look at the coordination of foundations or a foundations association that looks at or relates in some way to the things we're looking at in a broad sense across the province.

[9:45]

Hon. G. Campbell: One of the issues, though, is that we haven't had a plan. It's not very hard to figure out why they couldn't fit into the plan when there wasn't one there. That's actually a major thrust of what we have to try and establish: the plan that's in place. Most of those foundations want to support not just their hospital. They would certainly want to support their hospital, but they want to do it in a constructive and useful way. The big shift, number one, moving to a planned, managed system, I think is critical. Also, if you look at the third shift and sustainability, that's actually almost inviting foundations to say: "How can we help more? What are the obstacles we put in your way in terms of acting as a foundation, whether it's in Cowichan or Dawson Creek?" I think a critical part of that is that first step, the plan. What we heard last year literally all through the province was that there was no plan.

Colin.

Hon. C. Hansen: Just to add to that, there is an association of those foundations, but that's not something we direct from government. The foundations themselves have come together to form an association. I actually met with that organization recently and had a good discussion about how we can help them to thrive and grow.

I think there also has to be a connection between purchase of new equipment and the operating dollars to fund it. In the past what has happened is that there have been so many players that…. You get the foundation that will raise the money for the equipment, and then the local hospital has to convince their health authority to convince the provincial government to provide the funding for the operating dollars. We want to basically streamline that so that at the health authority level, they have the authority and the flexibility to make those decisions, to meet the needs of patients in that particular region. They don't have to come cap in hand to Victoria, because we will be giving them the allocation up front.

Hon. G. Campbell: Graham, followed by Rick.

Hon. G. Bruce: Colin, you touched very briefly on some budgetary pressures, the increased amounts needed for health care. Often out there we hear the whole issue of health care as just requiring more dollars. I just want to get the size of the current fiscal problems that you face right now in context. Did I hear you say that there was a billion dollars put into the budget last year, which would be for '01-02, over the previous year and that there are current pressures on top of that already? Mind you, we're - what? - nine months into that fiscal year.

Then it seemed to me that somewhere along the line, not today, I heard from you before, I thought, that the option…. If we don't make some significant changes in how we deliver health care, the way we're going right now, by 2005 that budget of $9.5 billion would be $14 billion, and by 2010 it would be $19 billion. Are those actually true numbers?

Hon. C. Hansen: Those are pretty good numbers. If you look at the budget from the last fiscal year to what is currently there, there's an increase of $1.1 billion. If we start looking forward, the growth pressures, if the status quo prevails, would be an increase of between 7 and 8 percent in the health budget, most of that consumed with increases in the collective agreements with the various health unions. There are some huge cost pressures that we're facing. Clearly, it's just not sustainable in the future.

Hon. G. Campbell: Rick.

Hon. R. Thorpe: Thank you, Mr. Premier.

Colin, you talked about the need for change and for focusing on the patient and that basically a culture change is going to be required. When I've spent time in the Penticton hospital or visiting the Summerland hospital, one of the things I've heard many, many times from front-line workers, nurses on the floor working with patients, is that they have ideas on how the hospital can be more efficient. There seems to have been - and I know I'm not supposed to talk in generalities, as my oldest daughter always tells me - a disconnect between senior management and what's actually happening on the floor with respect to the patients. How are we going to make that connect?

Everyone's going to have to work together here to ensure that that culture change takes place so the patient is the priority and receives the services. How do you envisage that happening?

Hon. C. Hansen: I think that under the performance contracts we will be developing, there will be, as one of the accountabilities that will be given to the administrators, the necessity for them to build their relationships. They will be measured in terms of how well they relate to their medical staff in those regions but also in terms of how well they develop their community relations.

I think there has to be put in place the opportunities for input both by individuals in the community and by those working in the health care system to ensure that those inputs are real and meaningful. I hear the same kinds of things in talking to front-line workers: they sometimes feel that they've got some really good ideas, but nobody's listening. That will be part of the expectation put on the health authorities.

Hon. R. Thorpe: Thank you, Colin.

You just mentioned the communities. What role in this change do you see the community and the volunteers of the community playing as we refocus and establish the patient as a priority in health care?

[9:50]

Hon. C. Hansen: You might be jumping a bit ahead to Sindi's presentation on restructuring. Clearly, I would argue that in the last ten years there has been a diminished opportunity for community input under the current structure. We have not seen a sense in communities that the current health authorities have been really reflecting some of the community values and aspirations. We hope that the new system, which Sindi will be outlining, will address some of those.

Hon. R. Thorpe: Thank you.

Hon. G. Campbell: Lynn.

Hon. L. Stephens: Thank you, Premier.

Colin, there's a lot of expensive diagnostic equipment in our health care facilities, and it always seemed to be that we weren't utilizing it as much as we could. We certainly didn't seem to have the flexibility of the hours of the later nights and weekends or maybe even 24 hours a day. With these strategic shifts that you're outlining here, will we be able to get that kind of flexibility to provide more service using those really expensive diagnostic machines?

Hon. C. Hansen: Two things will be changing. One is that the cost of equipment and other capital expenditures will no longer be a free good. In the past what has happened is that the ministry has provided funding, whether it's for a new facility or new expensive equipment, and then the ministry maintains the debt-servicing costs.

In the future what will happen is that the debt servicing will become a responsibility of the health authorities and will be built into the allocation that goes out to the health authorities. They will have to manage those equipment costs in the way that, basically, we have to manage our own household debts. If we want to purchase a new fridge, we've got to pay for it and pay for the cost of the interest payments on it. We expect that out of the process, there will be much greater incentive for them to maximize the usefulness of their existing expensive equipment.

Currently and the way we've worked up until now, it's cheaper to get the provincial government to buy you a second piece of diagnostic equipment rather than paying the evening premium shifts, for example, because the second diagnostic equipment was free. Essentially, the provincial government paid for it.

We will be changing that and building those incentives in. But rather than us micromanaging and telling them how many hours they have to run their CT scanners, we will be building in all of the incentives that will basically lead to good management and good stewardship of the available health dollars.

Hon. L. Stephens: Right. Glad to hear it. Thanks.

Hon. G. Campbell: Okay, we've got three strategic shifts that are highlighted here.

Linda?

Hon. L. Reid: Thank you, Premier.

Colin, I have a real passion, and have had for some time, for the notion of increased palliative care across this province. It started many years back, when I met an individual in hospital who said: "Look, I'm dying, but I'm not sick. I want community services." Allow me to commend the work that has been undertaken on behalf of the palliative care community, but if there's any update available, I'd certainly appreciate that.

Hon. C. Hansen: I will turn this over to Katherine, because she has been doing a lot of work in this area.

Hon. G. Campbell: Katherine.

Hon. K. Whittred: Thank you, Premier.

Yes, several weeks ago I announced an end-of-life strategy. Dr. Romayne Gallagher, who is a physician at University Hospital, is appointed to come up with a strategy over the next several months for end-of-life care. There are a number of community people working with her, and we're very optimistic that there will be guidelines put in place for the health authorities to follow regarding this.

Hon. L. Reid: Excellent. Thank you.

Hon. G. Campbell: There was a very good presentation, as well, by Dr. Molloy, I think it was, at the dialogue on health care about how we deal with those things. I do want to take a moment to say that this is probably one of the most vexatious problems that we face or that any government across the country faces. You clearly can't get to where you want to go if you don't have a plan, and I think it's important we have decided to move in that direction.

One of the things Colin mentioned is that there really has not been a shortage of ideas for what we have to do to try and get the health care system on track. There has been a shortage of will to do it. I believe we should all understand that these are difficult shifts to undertake. This is not going to be something where everyone says it's necessarily right.

I think if we're doing it for the right reasons and are trying to get the patients back at the centre of the health care system, there's much more chance that we're going to have an improved quality of system over the next number of years. I also want to remind everyone of what Sindi said, and that is that this is not going to happen overnight. This is going to take a long-term commitment to these principles as we move forward.

I think you've highlighted some very important shifts. The cabinet certainly, I think, approves them. We wish you luck in carrying them out. Good luck.

[9:55]

Hon. C. Hansen: Thank you.

Hon. G. Campbell: We now are going to go on. I just want to take a moment to say that that is the final presentation on the first phase of the core review from the ministries. This has been a very difficult process, I know, for many of you. I think the shifts…. Often, when we see them go through the open cabinet meetings, people go through them quickly, and they don't realize in some cases how fundamental those shifts are going to be and how much they're going to change the way government looks and the shape of government.

I want to thank you, as ministers, for the work that you have done, but I also want to thank all of your staff, who I know have spent an awful lot of time working through this process. It has been a difficult process. I think it's one that is necessary for government to do. I wouldn't want to do it every month, but it is something that we have to do.

I think it's important for us to note that the issues that we dealt with are actually critical to the long-term delivery of service. They're critical also to establish, I think, for the people of the province and the people in the public service where it is we're going, what we're trying to do and how we're trying to accomplish it. When we look at accountability issues, I think they're critical.

We have finished this first phase, and it's important. Early next year we'll be going through the Crown corporations in a very similar kind of a fashion as we have now.

We're now getting to the point where what we've done in core review meets up with what Gary is doing in Finance, because the core review is critical to recognizing where we're going in terms of the financial shape of the province in the future. All of you will have service plans that will be prepared for the budget on February 19 that will outline and give some flesh as to how we're going to put these shifts into place.

I did want to say that it's very important that we look forward in what we're doing. I think the goals you've established for yourselves are critical. The shifts are fundamental. They are critical in terms of establishing accountability, not just for ourselves around this table but for ourselves to our caucus and for ourselves to the people of the province.

Again, I want to say to you and your staff that I think this was a very worthwhile exercise and endeavour. Congratulations to them for the time and the effort they put into it.

The next item on our agenda is the restructuring of health authorities, and that's going to be led by Sindi.

Restructuring Health Authorities

Hon. S. Hawkins: Thank you, Premier.

Today I want to talk about a new era for patient-centred health care.

I want to say, first of all, that when I was a head nurse, I learned early on in my career that when you had tough news to deliver to a patient or a family, the best course was always to level with them, to tell them straight up and to be open and honest about the situation. Today I feel like I'm kind of back on the ward, because I think it is time to level with every British Columbian about the state of health care in our province.

Today our so-called health care system, as we all know, isn't meeting patients' needs. As for tomorrow, the current system, if it's left the way it is, is simply not sustainable, not by any measure.

It's true: the system has been patched up over the years by many governments. Basically, over the years what we've seen as a result is that the signs of sickness are everywhere. We've all heard the stories. We've all talked to patients. We've all had the calls to our office. We know our emergency rooms are overwhelmed. Our surgical wait-lists are growing longer every day. There is a critical need for long-term beds across the province, and everybody knows we need more doctors, more nurses, more pharmacists, more technicians. The list just goes on and on.

When we talk about it, I think that we have to remember that it's individual patients, at a time when they need government's help the most, who are paying that huge price for what can only be described as years, decades, of dreadful planning, unimaginative policy, timid reforms and, really, a shocking absence of accountability.

I believe it was this lack of long-term vision, Premier, which led you to create the Ministry of Health Planning. And it was these kinds of concerns that the Legislature's Select Standing Committee on Health certainly heard in their deliberations and consultations as they toured the province over the past few months and certainly wrote about in their report tabled on Monday.

[10:00]

The public knows that change is necessary, and the public, I believe, is ready for it. Now, with the understanding and with the patience of all British Columbians, I believe that we can lay the foundation for a new way of delivering health care in British Columbia.

Like all of you around the table here, in beginning my job I did look to the commitments we made to British Columbians in our New Era document. I looked to our new-era vision for health care. Simply put, we made a commitment to save and renew public health care in B.C. Our new-era vision for health is for high-quality public health care services that meet all patients' needs where they live and when they need them. We also committed, in our new era, to focus funding on patient care by reducing waste in the system and by eliminating administrative duplication and costs from provincial government mismanagement.

I want to say again that these are long-term goals. We recognize that these goals can't be met overnight. The challenges we're facing are long-term. The problems have been building up for decades, and we need solid planning in place before we can make the kind of changes we know we need to make to improve our health care system. It took years to get us here, and we know there's

no quick fix. It will take time, but we are prepared to put the time into planning to start solving the problems.

Today I'm going to present a plan to you that I believe will meet both of our new-era commitments over the long term. The plan will streamline and improve one of the most complex and costly health care systems in Canada if not the world.

This slide shows you the administrative nightmare that we currently face. It's certainly a system that encourages gridlock and inefficiencies, where patients often fall through the cracks. We currently have seven community health services societies, 11 regional health boards and 34 community health councils, for a total of 52 health authorities, three separate governance models, confusion and, really, overlapping inefficiencies. Each one of these 52 has their own administration, their own bureaucracy - 52 CEOs, nearly 600 board members. It really is a system that has too many walls and too many barriers. There are walls that divide communities, walls that divide doctors and administrators and walls that divide patients from the services they need.

I don't think you can find one person that says the system works. It doesn't work. It's poorly structured, and it's poorly organized. We've seen a decade of piecemeal growth with no central vision. Really, the result is a staggering 52 health authorities doing their own thing. All too often, instead of working together for patients, we find they're coming into conflict with each other.

I want to give you an example in my own part of the province. I come from the Okanagan. I think when people think of the Okanagan, they think of Kelowna, Penticton and Vernon. We share a valley, a beautiful lake. We share a telephone book, a highway, a university college and even a TV station. Vernon and Kelowna even share an airport. We don't share a health region. Even though hundreds of patients come from Vernon to Kelowna General to be treated every year - because, I believe, that's probably the best option for those patients - our hospital isn't funded for that. We're simply in that situation because Vernon's in a different region from Kelowna. These are the kind of artificial walls, Premier, that we need to break down when we think about how we can do what's best for patients and improve patient care.

Secondly, lots of the functions of the health authorities are often duplicated, and they're inefficient. We can look across the board, from payroll systems to warehouses, from the cost of annual financial audits to board expenses for nearly 600 board members.

Thirdly, the current system, with dozens of health authorities, means most regions are simply too small. They lack the sufficient resources to provide that broad range of necessary services that we know all the regions need to deliver to their patients, and they certainly lack the resources to retain and recruit the health professionals needed in those areas to serve patients.

Finally, again, sustainability. The way the system is structured is certainly not sustainable. We're spending almost half our provincial budget, as Colin outlined, in health care services today. Yet when we travel around the province, when we hear from patients, when we get the letters and when we get the phone calls, what are people saying? They're saying that they're not getting the care they need. The current system seems to exacerbate that problem. There's so much administrative overlap and duplication that precious resources are being diverted not to patient care but, it seems to me, away from patient care.

[10:05]

When we were developing this new structure, we established three goals. We felt that the model that we were going to choose had to meet these goals.

First, we looked for a model that would support the delivery of high-quality patient-centred care. That means patients will get appropriate, effective, quality care at the right time in the right setting.

Second, the structure had to support improved health and wellness for all British Columbians. That means giving patients better, more equitable access to the services they need. It also means that patients will be satisfied with the care they get and, certainly, that the public overall will have a renewed confidence in their public health care system.

Third, the model we chose had to support a sustainable, affordable public health system that meets patients' needs not just for today but into the future for generations to come.

The structure we have chosen does meet our three health goals. It has three basic elements. I'll discuss each of these in greater detail shortly, but I want to give you the big picture now, starting with

the communities and working back to Victoria.

Health care services will be managed locally through 15 health service delivery areas. These were chosen to reflect local patient referral patterns, economic patterns such as where people shop or do their business or socialize. They certainly reflect natural geographic boundaries.

These health service areas fall within five geographic health authorities. Those five health authorities will be responsible for governing, planning and coordinating services across the 15 local health service delivery areas. We're also, for the first time, creating a provincial health services authority. This authority will coordinate the delivery of highly specialized services that can't be offered in all regions. By those, I'm talking about those high-cost, very specialized services like cancer care, kidney dialysis, transplantation and high-risk maternity and cardiac care. Those are examples.

This slide shows you how we're going to move from a structure that was far too complicated to one that is much simpler and much more effective. As you can see, patients are right at the top, because we know we have to refocus our attention and our hard-earned tax dollars not to layers and layers of administration but on meeting our patients' needs.

Patients will be served by 15 new health service delivery areas that will manage care at the local level. These health service delivery areas will be governed by five health authorities. Each of those authorities will be accountable to the government. A provincial health services society coordinates and ensures equitable, fair access to highly specialized services, as I mentioned, like cancer care and cardiac care, for patients from all over the province.

As you can see, this structure is simplified. It's functional. It's highly accountable to patients and to government. I believe it provides that clear mechanism to implement the changes that we talked about that we need to make to realize our goals of sustainability of quality health care. It certainly provides clearer lines, logical lines, of accountability.

Now I'm going to explain the changes that will improve patient care.

The new structure will support effective planning and management. We believe it will increase efficiency. It includes clear lines of accountability to government for patient and management outcomes, and it will be equitable, with patient resources distributed fairly throughout the province. It ensures that all areas, including rural and remote communities, will have opportunities to input into local health care decision-making. We know that communities value that, and we wanted to make sure that this was a very key and important element in the model.

It ensures that all health authorities will be self-sufficient, which they aren't now. It ensures that they will be in a position to supply that broad range of necessary patient services that we expect to be delivered in the areas - the services that they need. It also ensures that the regions will have the resources they require to recruit and retain their human health resources - provide the providers that they need to serve patients.

For the first time ever in British Columbia there will be representation or representatives from all the areas of the province working closely together to coordinate those high-level services and to provide fair access for patients for those specialized provincial services that patients require all across the province.

[10:10]

Now, this map shows you the 15 health service delivery areas. They are essential, because patient care is coordinated at the local level. The health service areas are the front line for patient care. Each area will be managed by senior staff. They'll be reporting to the CEO of one of the five health authorities, and the senior staff of these areas, then, will be responsible for that delivery of the full range of necessary services in their area. Certainly, they will be responsible for meeting the performance objectives that will be set by the health authority.

Why did we choose 15 health service delivery areas? Well, we felt they would provide us with the best opportunity to be able to consistently deliver that full range of patient care at the local level, and we felt they would provide the kind of local input that communities value and feel is required to reflect their unique needs.

There were a number of factors, again, that led us to shape these areas the way we did. As I mentioned before, they reflect and respect the long-established patient-and-doctor referral patterns as well as economic and social patterns. We looked at unique geographic factors in the north and in

the Kootenays, because we know they distinguish various areas of the province. We also had to weigh the benefits of having that critical mass of resources and people to support the health services in those areas. We felt we'd struck a good balance. We chose a balanced approach that recognized local needs, provincial resources and the ability to provide high-quality patient care.

I'd like to now describe the five new geographic regions being created to replace the 52 health authorities, councils and societies which currently exist. This map will show you the northern health authority. This covers the entire north and will be the governing body responsible for the health services delivery areas known as the northwest, the northern interior and the Peace-Liard.

In front of you now is the map that shows the interior health authority. It will work with the four health service delivery areas of Okanagan, East Kootenay, Kootenay-Boundary and Thompson-Cariboo.

The next health authority is the Vancouver coastal health authority. It will cover the North Shore, Coast-Garibaldi and Vancouver-Richmond health service delivery areas - three health service delivery areas.

The Fraser health authority encompasses the Fraser Valley, the South Fraser and the Simon Fraser health service delivery areas.

The fifth health authority is the Vancouver Island health authority. It covers all of Vancouver Island, the Gulf Islands and part of the Central Coast. It will serve the capital and central North Island health service delivery areas. In this model, you see that each health authority will have a sufficient population base and budget to deliver that full range of patient services. It also allows for regions to have the funds that they can reallocate to address the gaps in service.

In the model we are currently working under, we see regions that are very small. Some of the CHCs had populations of less than 2,000. They certainly didn't have the budgets, then, for reallocating funds. If, perhaps, in part of their little region they lost a doctor or a bunch of nurses, they didn't have the funds to recruit and retain and provide that necessary range of services. We feel this allows for that flexibility, and it certainly allows for that critical mass of population and resources.

With five instead of 52 health authorities, we can effectively plan and roll out health system improvements that enhance patient care and health outcomes. We'll have the opportunity to realize significant economies of scale by developing those shared services and combining functions such as systemwide payroll, purchasing, scheduling, human resources and financial services. Again, the patchwork of the 52 health authorities that we see today didn't really encourage shared services or finding those economies of scale. They often didn't talk to each other. We feel this model will allow us to do that.

[10:15]

Just as an example, over the next three years we feel we will have the opportunity to save about $1.4 million in board expenses and another million dollars in auditing fees. In a patient-centred system, $1 million means a lot. What does $1 million mean, spent on patients instead of accountants? Well, $1 million means over 400 chemotherapy treatments for kids suffering from cancer, and $1 million could pay for 7,000 consultations for seniors with arthritis. For those who may have suffered a heart attack recently, it could mean nearly 300 angioplasties, or 3,300 more MRIs for patients that we know are on waiting lists and desperately need treatment.

I want to say that when you hear that inevitable cry about how hard our hearts must be for taking these steps. I want you to think about patients who aren't getting the care they need today, and you'll know that the status quo isn't an option. We think this structure will provide clearer lines of accountability, and we'll back that up by performance contracts spelling out exactly what we expect from each health authority as well as the consequences for non-performance. Health authorities will be directly accountable. That, again, is a real change from how the system operates today.

The sixth health authority we're recommending is a new provincial health services authority which will oversee the coordination, as I said, and certainly the delivery of all those highly specialized programs like cancer treatment and transplants for the entire province.

Why a provincial health services authority? We think there are clear advantages to having one. The most important one is that for the first time ever there will be representatives from all over the province, and they will have the responsibility for making sure there is access to those specialized services for the patients in their regions. This is a major step forward because it creates a more equitable alternative to what we have right now in the current system. In the current system we have

one board, which is the Vancouver-Richmond board. It has control over the coordination of all these services. Our new structure will ensure that all regions are accountable, that they're represented and that their patients will have fair access to provincial services.

From a government point of view, the Ministry of Health Services will now have only one body to hold accountable for delivering those provincial and highly specialized services, and we'll have one centralized authority that will develop standards of care. They'll be responsible for assessing changing technology, and we know how rapidly that changes. They'll be one authority that will be responsible for reviewing requests for new or enhanced specialized programs. Now there will be one body, for the first time ever, to consolidate those services, and we think we will be able to realize some savings from that as well. Let me say that the savings we realize as we move forward in this model will all be put back into patient care. I think that's a real bonus.

Finally, for the first time ever, this model allows for regional involvement in planning any expansion of these services across the province. In the past Victoria did that without a lot of input from around the regions. If we decided that we wanted to expand cardiac surgery, the Ministry of Health, in its previous incarnation, used to do that. Now we'll sit down with all the regions and look at what's best for the province, and the regions will be involved in expansion of those services.

Premier, with cabinet's approval today, all existing health boards will be replaced with six new health authority chairs. Over the next few months each chair will work to develop a board of governors for their respective health authority. The new chairs and boards must demonstrate strong leadership skills and a business orientation. The chairs' mandate over the next few months will be to assume legal responsibility for the health authority. They'll work with a health authority CEO to establish an appropriate management structure, and they'll assume a leadership role in initiating those systemwide changes in health services delivery that we know we have to make.

An implementation team will then work closely with the board chairs, the CEOs and the deputy minister to implement this new structure. My ministry is currently working on an accountability framework which will be introduced between our Health ministries and the health authorities, and it will clearly outline the authority's role and the government's expectations. The framework will include performance contracts that detail expected patient and management outcomes, and the board chairs and CEOs will be expected to provide leadership to ensure that these contracts are adhered to and that each authority is operating within its fiscal means and working to meet patients' needs. That's the priority.

[10:20]

Those are the major elements of our new health governance model. I just want to clarify the role between government and the health authorities. The government is getting out of the business of micromanaging the delivery of health services, and we're going to concentrate on setting the overall direction. Government will be responsible for setting policy, standards, legislation, providing funding to the health authorities and monitoring and evaluating the health system's performance.

The health authorities, on the other hand, will be accountable to government. They'll be accountable for delivering and managing health services within the 15 local health service delivery areas, reporting on their performance in terms of patient care and management outcomes. Through the health service delivery areas, we want to make sure that the health authorities ensure that local voices are being heard and local concerns are being addressed.

In conclusion, I am seeking cabinet approval for this new patient-centred health services delivery model of 15 front-line health service delivery areas governed by five health authorities plus one provincial health authority. Let me say that I'll be the first to admit that it's not the magic answer to all that ails our health system in B.C., but it is the first step, and it is going to be a lengthy and difficult road. I believe it will lay the foundation for the platform that we need to realize our new-era goals for health care.

If it meets cabinet's consent, I will then seek your approval to announce the new board chairs who will lead each of the new health authorities. They will oversee the actual day-to-day business of restructuring. The chairs then, as I mentioned, will work to appoint an accountable board of trustees over the next couple of months to ensure that there is a strong community representation from each of the 15 local health service delivery areas.

I want to acknowledge that this plan has been some time in the making. There has been a team from both ministries that has been working extremely hard for the past couple of months to weigh the various options and develop the best possible plan. I'm confident that these efforts will pay off.

This new structure provides for better management. It helps our system become more affordable and sustainable, not to mention more accountable. Most importantly, I believe it will ultimately put health dollars back where they're needed the most, and that's in patient care. In other words, I think it's a critical step forward in realizing our government's commitment to health care in our government's new-era vision for health care. We are committed to high quality public health care services that meet all patients' needs where they live and when they need them.

I will conclude there, and I would be happy to take questions, and Colin as well. His ministry has been involved in the implementation. If there are implementation questions, Colin's available for those.

Hon. G. Campbell: Okay. I've got a number of questioners. We'll start with George, followed by Lynn, and then Geoff, Bill, Rick, Sandy and Murray.

Hon. G. Abbott: Thank you, Premier.

First of all, I want to commend you for a really clear and effective presentation on quite a complex issue here. I want to ask you a couple of questions. The first is around regional hospital districts, which are an adjunct to regional districts and which partner with the province for major and minor capital. They've been around for about 30 years, and they've gone through some shifts as governance models have shifted in B.C. What does the future hold for them?

Hon. S. Hawkins: Regional hospital districts share capital costs. We met with the Union of B.C. Municipalities health committee and with the regional hospital district committee. The boundaries won't change; they won't be affected by this. We expect our health authorities to work with the regional hospital districts. They want to play a more meaningful role in health planning. We expect that the regions will involve them in there. They will continue to function as they always have but working within the boundaries of the new region. We'll let the health authority chairs and CEOs and our leadership team from the ministry work on how we can effectively do that.

[10:25]

Hon. G. Abbott: I'm always impressed by how strongly and, frequently, how emotionally people feel about their health services and about their health facilities. I think it's probably true for rural B.C., and I expect it's true for urban B.C. as well.

When I was in Enderby recently for an MLA day, over 50 people showed up, almost all of them very concerned about some changes that the health region had made with their facilities. This is just to follow up on Rick's very good although apparently premature question about local input. You make reference to it a couple of times in the presentation. How do we ensure that there is that local input and that people are somehow plugged in or heard around what they think ought to be happening with their local services and their local facilities?

Hon. S. Hawkins: Well, first of all, George, I think you hit the nail right on the head. People are concerned. I can't underscore enough how sick the system is. People are afraid that change is going to take away health services in their community or they're not going to be involved. I can tell you right now that the announcement I made today is not going to change their world as of this moment. They're still going to continue to get good care, and we're still going to be providing them access to the best care available. What we're trying to do is make sure that there's good care and continuity of care and consistency of care that patients get and that there's fair and equitable access across the province to the kind of care that people expect and need. As far as how they get involved in health planning or decision-making in their new areas, we are going to have performance contracts with the health authorities, and that is going to be one of the key elements.

We are not going to be prescriptive and tell the regions or the local health service delivery areas how they're going to do that, but they will be measured and monitored on how much community involvement they are involved in. They might do it by patient satisfaction surveys, they might do it by community advisory groups, or they might do it in other ways. We will expect them to include providers, patients and other members of their communities in that decision-making.

Hon. G. Abbott: Thank you.

Hon. G. Campbell: Lynn.

Hon. L. Stephens: Thank you very much.

Sindi, I, too, want to congratulate you. It was an excellent presentation. I think the plan you've laid out for us will go a long way to fixing what we all know are some terrible dysfunctional health regions around the province.

I want to ask you about one authority, the provincial health services authority. You talked about the specialized services. How will their boards be affected? How will the boards of the Cancer Agency and B.C. children's and women's be affected under the new provincial authority?

Hon. S. Hawkins: I'm going to let Colin take that for implementation.

Hon. C. Hansen: Thanks.

Actually, what will happen to those existing boards is they will be replaced, effective today, with what will initially be a one-person board for the provincial health service authority. Subject to the approval of cabinet on this restructuring, the appointment of that new chair will go ahead. There are some existing boards that will be replaced and brought into that new authority. That's going to include the children's and women's hospital. It would include the B.C. Cancer Agency - not to be confused with the Cancer Society, which is a totally separate, not-for-profit organization, or the Cancer Foundation, which is separate. It will include the B.C. Transplant Society, the B.C. Centre for Disease Control, and the B.C. Mental Health Society, which administers Riverview Hospital. Those boards will be thanked, as of today, for their services.

I think it's important to stress that whether it's these boards or whether it's the boards of the 52 health authorities, the people that have served on these boards have put in hundreds of hours of volunteer time for their communities to make these boards successful. This restructuring is in no way a reflection of the work that those volunteers have done. This is a time when we have to restructure to make the system work for patients, and it's in no way a reflection of the work that's been done.

Also, in those boards that I mentioned - again, coming back to the point that Rick asked earlier this morning - the foundations continue. They're totally independent. We want to make sure that these facilities continue to have their identities. From the public's perspective, all of these organizations - the Cancer Agency, the Transplant Society, children's and women's hospital - will continue to be independent entities providing the specialized care that they do so well today.

[10:30]

Hon. L. Stephens: One follow-up question. With the other boards around the province that represent the other health authorities, when are those changes going to be happening?

Hon. S. Hawkins: Lynn, are you asking what happens to the existing boards?

Hon. L. Stephens: Yes.

Hon. S. Hawkins: They will be dissolved, and we'll be appointing new chairs if cabinet approves this structure.

Hon. C. Hansen: Today.

Hon. L. Stephens: Will that be today as well?

Hon. S. Hawkins: That will be today.

Hon. G. Campbell: Geoff.

Hon. G. Plant: Thank you, Premier.

I have three different questions. The first, arising out of the last question, is about implementation, I guess, legislatively. Does the existing statutory framework permit this to be done by regulation, and therefore, when we say the intention is to do it as of today, assuming we decide to do it, we will in fact have the power as a cabinet to do it as of today?

Hon. S. Hawkins: We got independent legal advice. [Laughter.]

Interjection.

Hon. G. Campbell: She said they got independent legal advice.

Hon. G. Plant: Well, I hope you paid for it then.

Hon. C. Hansen: Basically, it was….

Hon. S. Hawkins: It was cheaper than yours.

Hon. C. Hansen: I'm sure we'll get the bill, whether it was from the Ministry of Attorney General or otherwise.

The legal authority is there to do this effective today. There are provisions under the Health Authorities Act that allow us to make these changes today. I think that come the next legislative session, there will be some cleaning up.

For example, the Health Authorities Act provides for community health councils around the province, which will no longer exist. They will be amalgamated, in essence, and the provision is there for it. Come next legislative session, there will be legislation brought forward to basically clean up the legislation and remove some of the sections that will now become redundant. The other authority that's required is under the Society Act. We'll be using those two acts for the changes that are needed.

Hon. G. Plant: Could you tell me what the place is for the Nisga'a and their health authority in the vision you have just outlined for reorganizing health regions and so on?

Hon. C. Hansen: Last night I phoned Shirley Morven, who is the chair of the Nisga'a Valley health authority. Actually, I tried to phone as many people as I could that were going to be affected by this change. I had a good discussion with her. The Nisga'a Valley health authority was set up as a result of the Nisga'a agreement implementation legislation. It will continue to be there, and it will continue to function in the way it functions today.

There is some very good work that has been done in the northwest sector of the province around aboriginal health issues, and Shirley Morven and her health authority in the Nass Valley have been instrumental in driving some of those programs. We expect that those initiatives will continue and that the relationship between that health authority and the regional health authority will be built upon and will grow in the future.

In no way does it affect the Nisga'a Valley health authority other than there being a broader pool of resources across the north to meet the needs of individuals who live in the Nass Valley, as for those who live elsewhere in the north.

Hon. G. Plant: But the authority will continue after this reorganization. That's helpful.

The third question I wanted to ask you is, again, quite different. As a resident of the Vancouver-Richmond area, I have become accustomed to try to figure out what the Vancouver-Richmond health board does and looks like and how, under the former model, it has had responsibility for everything from kind of street-level care all the way up to tertiary care in the major hospitals. Can you just elaborate a little bit on what is going to happen to the old Vancouver-Richmond health board under this model so that I can get a better picture of what that will look like?

Hon. S. Hawkins: Currently the Vancouver-Richmond board has funding to provide their primary, their community and secondary services, but they also hold that big envelope for those high-level provincial and specialty services. What will happen under the new structure is that the funding for those specialized and provincial services will be pulled out of what is currently Vancouver-Richmond and put into our new provincial health services authority.

[10:35]

Because Vancouver-Richmond provides a lot of those high-level services - I mean, we don't do cardiac surgery all over the province, and we don't do transplants all over the province - they will get that funding back in the way of performance contracts from the provincial health services authority. Vancouver-Richmond will get their funding for the services that every other region will get, plus through contracts now they will get funding for those high-level provincial services.

Hon. G. Campbell: Thanks.

I've got Bill, Rick, Sandy and Murray.

Hon. B. Barisoff: Thank you, Premier.

I've actually got two questions, Sindi. The first one is: why are you appointing these boards and not electing them? Then the other one follows up along the lines that George was talking about. Volunteers have played a really important role in local hospitals. I know Colin started to answer that. How is the new structure going to affect volunteers in the local areas?

Hon. S. Hawkins: Bill, I'll take the first question, and Colin wants to do the volunteer one.

We looked at how the boards would be set up. We looked at a lot of advice that was given to us. We wanted to make sure that we had the best balance of capable and qualified governors on those boards, and we felt appointing them was the best way to do it.

They look after a heck of a lot of money. We transfer almost $6 billion of the provincial budget to those six health authorities. It's a very complex business. It's multimillion-dollar enterprises. We want to make sure that the people that serve on those boards have the knowledge, the expertise and the business and leadership skills to be able to manage those kinds of regions. We have lots of new and important changes taking place, so we felt that was the better model to go with. That's why they're being appointed rather than elected.

Hon. G. Campbell: Can I just jump in there for one sec too?

One of the challenges with the previous system was that there was no accountability in it. If you've got hundreds of volunteers working out there, they're volunteering, and they're doing their best to do the job for you, but at the end of the day the accountability really rests with the Minister of Health Planning, the Minister of Health Services and the Minister of Finance. I think we should avoid the myth that suggests that that isn't the biggest decision that's made in health care.

Then I think what we're trying to do is ask: how do you deliver those resources to patients in the most effective way? We have to make sure there's an accountability network built in for that as well. This is a way of making sure that the health care system is accountable.

One of the things the critics said about the previous system - the first iteration, the second iteration and the third iteration that we saw over the last ten years - was that it was never accountable. Even within the system, people said that the rewards were for people who were not accountable. The rewards seemed to go to people who weren't accomplishing the goals that they set out for themselves at the beginning of the year.

There is a big shift taking place here with regard to these authorities. There will be accountability contracts, they will be expected to deliver on them, and they will be reporting to the province. The ground-up part of that comes from the local health service areas and also from the part of the contract that says you must consult with people in the communities that you're serving.

I know, from going around the province, that there are literally dozens of health-watch societies and health groups and communities that want to have input. Part of the task - one of the accountability measures - will be: have you gone out and delivered that? Then at the end of the day you have to deliver your services to patients on behalf of the province, because it's a provincial service.

Colin.

Hon. C. Hansen: Well, I think you stated it very well there, but just to add to that, a lot of the volunteer input at the community level is anxious about the way health services get delivered. There needs to be a relationship between those community volunteers on advisory boards working with the administration, because it's the administrators that are going to have the ability to actually shape the delivery of patient care. That's what many of these community groups are most anxious about.

There will be a much more direct relationship between those who can actually implement the change at the community level and the community volunteers who are anxious to see those changes meet community needs. There is a great opportunity in this new model for volunteers to take a much greater role than they have in the past. I think that's going to be quite exciting.

Hon. G. Campbell: I've got Rick, Sandy and Murray.

Hon. R. Thorpe: Thank you, Premier.

Now I'll try to ask a timely question.

Hon. L. Reid: Do your best.

[10:40]

Hon. R. Thorpe: I'll do my best. Thanks, Linda.

Colin, Sindi, as I talked about the change earlier, communities…. I'm going to just talk about my own riding here for a second. The community of Summerland is very, very concerned about their future, as I'm sure many communities are, with respect to health care. They have a group working together that actually wants to be part of the solution. They realize that it's not sustainable the way it is now.

I just wonder what kind of process or program the new board chairs are going to have to perhaps visit the communities within the regions and to establish those links as early as possible so that they can help get some community feedback and community solutions and so we can have health care for patients where they live and when they need it. I'd just like some comment on that, if I could.

Hon. C. Hansen: Thank you, Rick.

Those are the kinds of processes and relationships that we're not going to be dictating from Victoria. Every community, every region, is different in this province. The new boards, I think, have to approach those challenges in ways that meet those community interests. Initially, subject to cabinet approval, there'll be the appointment of just the one chair. The other members of these boards will be appointed over the coming four to five months - faster if we can get it done. I think it's important that we get those boards up to full strength as quickly as possible.

They will be working with individual communities to try to ensure that whatever changes come down the road in the next little while will be reflective of community needs. I have no doubt that the people of Summerland will be well consulted under this new process and will be involved in the decisions in terms of the future of health care in our community.

Hon. R. Thorpe: Thank you.

Hon. G. Campbell: Sandy.

Hon. S. Santori: Thank you, Premier.

Just a couple of questions. First of all, who will determine the level of care in a particular health service delivery area?

Hon. S. Hawkins: My ministry is working on developing provincial standards. Then the regions, looking at the needs in the different health service delivery areas, will be implementing strategies to meet those standards. It will be in consultation with the health service delivery areas, working within the context of a region, though. We're trying to work at sustainability. We're trying to make sure that care is delivered to patients but that it's continuity of care and that there's a guaranteed level of care. They will be responsible for identifying the needs in the different areas and then saying how best it's delivered across the region.

Hon. S. Santori: My other question is: can you define where you live? Not you personally. [Laughter.]

Hon. G. Campbell: Perhaps you can get that number later, Sandy. [Laughter.]

Hon. S. Hawkins: If cabinet approves this structure - I believe it does meet our new-era commitment - where you live will be determined by your local health service delivery area and the region within which you reside.

Hon. S. Santori: The reason I ask that question - and this is my final comment - is that it was encouraging to hear that it will be based somewhat on population demographics as well as natural borders and geography. I would hope that when we create levels of services and access to health facilities, we recognize - and I'm going to give this a rural perspective, again, Premier - that the ability to access health care strongly determines the economic viability of a region, in order to attract industry and attract investment.

I'm not suggesting that every community, as we have it now, has their own hospital and expects us to provide health care to the same degree at every facility. I don't support that at all. I think that's one of the major problems we have. I think we must, in making these decisions, if those regions are somewhat condensed…. It's not in terms of what we're trying to do with health care but the economic impact it may have if your closest facility for respectable care is four hours away.

[10:45]

Hon. C. Hansen: Thank you, Sandy. I think we're very sensitive to that as we look at implementation. When we talk about the health care that you need where you live when you need it, we have a responsibility to deliver a health care system that meets the urgent needs of every British Columbian 24 hours a day, seven days a week. We can't do that under the existing models that we have today.

If you have somebody who is in an accident, say, and has a severely broken leg and needs to see an orthopedic surgeon, we're not going to have an orthopedic surgeon in every single community in the province. What it means is there's going to be capacity at that local community level to ensure that that patient's needs are met, and the health system will take over that patient's health care delivery at the community level. It may mean that patient gets transported to another neighbouring community which has an orthopedic surgeon, but the health system will ensure that those services are delivered starting right at that community level.

We've also got to look at some new models. There are some tremendous opportunities around telehealth and telemedicine. We now have some pilot projects currently going on in Terrace and in Cranbrook, where they are linked to specialists at Vancouver Hospital in real time with telecommunications which allow the local doctors in those communities to have real-time consultations with specialists at Vancouver Hospital using video technologies and the ability to transfer digital information.

Those things are quite exciting, and I think it will allow us to deliver a much higher level of patient care where people live. I think it's an exciting future.

Hon. S. Santori: If I could just make one more comment, I guess the fear out there now is the creation of megahospitals in two or three strategic locations within the province and that, basically, all patients are going to be shipped to them. I'm sure you've all heard it, but I think I've been given a level of comfort in prior conversations that we've had over this matter. I feel comfortable that's not the direction we're going.

Hon. G. Campbell: I think the other thing that's important here is that one of the challenges with the fragmentation we face…. Actually, it was one of your constituents who said to me that it's very difficult for him to figure out which hospital he's supposed to take someone who has been hurt to. There are two hospitals that are 40 minutes apart. Do you take him over here for his leg and over here for his head injury? I think those are things that we haven't been able to systemically deal with. By creating not just a self-delivery area but the authorities, it gives you the critical mass that you need to make sure that the professionals you need, the equipment you need and the facilities you need are properly planned to meet that patient's needs as he's rushing from wherever his accident was into the facility that he's after.

Hon. S. Hawkins: Can I just say that this structure is the first step to going down that road of proper planning around services, guaranteeing where services can be delivered and making sure that they're there for patients when they need them.

I want to make it really clear: the announcement today, if approved by cabinet, doesn't change people's lives as of 10 o'clock this morning. They're still going to get the services. The next four to six months we're going to start looking at how they can best be delivered. Again, that's going to be up to the new boards and the ministry, working together, to make sure that there are services in place for patients in all areas of the province.

Hon. G. Campbell: Okay. I've got Murray, followed by Rich, Linda, Dick and John.

Hon. M. Coell: Thank you, Premier.

Sindi, you're going to replace about 600 board members with, I gather, about 50 or 60. I wonder if you could comment on the composition of the new boards and the selection criteria you're going to be using, either you or Colin, to appoint the new boards and the numbers you're expecting.

Hon. S. Hawkins: The chairs will be appointed, if approved by cabinet, today. Then the chairs will work over the next couple of months to look for members for their boards.

We are advised that the boards shouldn't be more than nine, so boards will be between six and nine members. We are looking for good representatives from the regions around the province. We're looking for representatives from the local health service delivery areas to be on their regional boards.

[10:50]

I must tell you that we are moving to a more effective and accountable governance structure, so we're looking for the kind of individuals that demonstrate strong leadership and that have fiscal management and accountability backgrounds. We also want to make sure, obviously, that these people have a strong interest in helping us to sustain the health care system. We're looking for people who have those strong business skills and abilities to manage multimillion-dollar businesses. Those are the kind of people that we're hoping will come forward and serve on these boards.

Can I just say that the provincial health services authority, which is that sixth health authority, will have membership from the five regions, plus there will be other members on that board. How that board will be set up is still evolving. That will be done in consultation, again, with the ministry and the new board chair that will be appointed.

Hon. G. Campbell: I think a critical component of that is that each of the five regions will be sitting on the provincial agency.

Hon. S. Hawkins: Yes.

Hon. G. Campbell: Rich, Linda, Dick and John.

Hon. R. Coleman: First of all, I, too, would like to compliment you on your presentation and, in addition to that, thank you for something that's long overdue. I like the accountability contract side of this thing, because I don't think our health regions have been accountable to government for a long time. I know that as MLAs we've been summoned or called to different meetings in our region where somebody wants to tell us that they need more money, and we're supposed to go and lobby for additional funding for a region without really even a back-up business plan that says what the accountabilities and the outcomes for this are. I think it's long overdue that we're actually going to do this. I'm glad you're putting into place the contracts that will allow us to do that.

I also like the tertiary care side. I think we have to remember that health care in this province is global. You can't just isolate it in one area. If I need heart surgery, I want to be able to get it. I want to be able to get it in a timely manner, like any other citizen of this province. We have to build that expertise, that personnel development and all of that into our tertiary care. I think you're moving down the right road there.

I just have a quick question on two things. One is the flexibility of your personnel to implement the plan. I think that as you go to tertiary care and start specializing in areas, you're going to need the ability to move your skilled personnel back and forth from facilities as the need arises. Secondly, how are you going to deal with your management teams? Obviously you need some pretty skilled people at the upper levels just to run these accountability contracts in these regions. How are you coming along finding the people that can actually run the plan for you?

Hon. G. Campbell: Colin.

Hon. C. Hansen: We have some good talent in British Columbia that we can call upon to provide the leadership for these health authorities and for the health service delivery areas. Right now, under the current system, we have 52 CEOs. We will wind up with six CEOs for the six health authorities. Clearly, there are some other talented people who will not be called upon to be CEOs but will be called upon to be the senior operating officers at the health service delivery level and at the community level. There has to be leadership at the community hospitals and for those community programs as well. There are good people we can call on to make this thing happen, and there's a lot of good work that's been done already.

When it comes to the areas of flexibility, we do have some challenges with the collective agreements in terms of being able to ensure that front-line workers, and support workers in particular, are used as effectively as possible to deliver patient needs in British Columbia. We do have some challenges around that side of flexibility that we will have to work on.

Hon. G. Campbell: Linda, Dick and John.

Hon. L. Reid: Colin, over the years our province has delivered health care in partnership with a variety of entities, whether it be the Salvation Army or the British Columbia Diabetes Association. How do you envision those partnerships continuing?

[10:55]

Hon. C. Hansen: Actually, I think those partnerships will be strengthened by this model. When I talk to some of these various advocacy organizations that are dealing with chronic diseases like the Diabetes Association, they have very strong interests around policy formation and budget allocation, but they've also got strong interests in the actual way that health services are delivered in British Columbia. This new structure will allow us to deal with the policy level at the provincial level, which is where it should be, but also to have a more streamlined structure at the health authority level, where they will be able to impact on decisions that affect actual delivery of care.

Organizations like the Salvation Army do tremendous work around the province in facilities. In fact, just this last week we were working around some issues with detox, and one year ago, actually, the previous government was threatening to impose regulations on their Lydia House in Mission, which is a supportive recovery house, that would have effectively shut down that operation. Sorry - that one's with the Union Gospel Mission. I had the opportunity to phone Reverend Maurice McElrea last week and tell him we're changing those requirements to allow Lydia House to continue to do its good work. I think this new structure will allow for better relationships with those various associations in the years to come.

Hon. L. Reid: Colin, thanks. I'll just make one final comment.

I absolutely support the work they do, but I think even more vital to the exercises is the support those agencies provide to families. I thank you for your support.

Hon. G. Campbell: Dick and then John.

Hon. R. Neufeld: Thank you, Premier.

I'll speak briefly. I think most of the questions have been asked about the regions and the health authorities. Coming from the Peace-Liard part of the province….

A Voice: What part?

Hon. R. Neufeld: The Peace-Liard.

A Voice: It's the first time you've mentioned it.

Hon. R. Neufeld: The northeast authority, being the largest one in the province - actually, east, west, from about 100 Mile House all the way north, including the northern interior and the northwest. There's obviously going to be some angst amongst some of the people in that area. They'll have all kinds of questions about what's going to happen.

I know you have taken some hard questions from those of us that live in that area specifically, and I appreciate the answers and the straightforwardness you've given those responses, both Sindi and Colin. I know you're going to work hard with that region to make sure it works well for everyone up there. I, for one, thank both ministers for the hard work you and your staff have done to address any of those problems that we foresee could happen in those areas. You've been very good at it.

I will work very closely with you as best I can to make sure it happens and it happens well. That's what you envision, and that's what I envision. I believe there are a lot of people in the northeast, the northwest and the northern interior that want it to work well. They've lived in a pretty fragmented system for quite a while, and at the end of the day, I think they're going to be pretty happy that you have finally put something in place that's going to work for better health delivery to people in that area.

Thank you very much for your hard work, to both you and your staff.

Hon. S. Hawkins: Thanks, Dick. I was expecting another shot.

Hon. R. Neufeld: Pardon me? [Laughter.]

Hon. S. Hawkins: I've got the scars to prove it.

Can I just say that this is going to take a commitment from all of us and certainly from all of our caucus members as well. I appreciate the support that's been shown around that.

Hon. C. Hansen: Can I add to that, just to follow up on comments that Richard made? One of the things that's really important for people to recognize is that patient referral patterns will continue. I know that in the Peace-Liard region people rely a lot on accessing hospitals and health care services

in Alberta, because it's closer. The same with the Kootenays, where I know that people go to Lethbridge or Calgary.

One of the things that we've had up till now is if a patient were to go from Dawson Creek to Grande Prairie to have surgery, the charge for that goes to the provincial government in Alberta. They then send that bill to Victoria, and it gets paid from Victoria. The real problem is that we haven't properly resourced the health delivery system in Dawson Creek and in the Peace-Liard region so that service could actually be provided there.

It's part of the changes we'll be making that will ensure that the dollars will flow in a much more logical way so we can build up the resources at the level of the health service delivery areas to maximize the ability of the health professionals that work in that region. We won't have to rely so much on patients going across into Alberta to get the care they need or, in fact, having to go to Vancouver.

With these new structures there's nothing that says that patients are going to have to change their referral patterns, but we will be able to create more capacity at that regional level so that patients won't have to travel as much in the future.

Hon. G. Campbell: John.

[11:00]

Hon. J. van Dongen: Thank you, Premier.

There are certainly a lot of things about this proposal that I like, and I want to thank the ministers for bringing it forward. I think the key thing is that this proposal is going to shorten the distance between the patients and the ministers responsible. I think it's really, really critical that the dollars get down to the patient level. I think this system will really help do that.

I just have one quick question. How will the B.C. Ambulance Service fit into the system? Who will the Ambulance Service report to? Will that be on a regional authority basis or a health authority basis, or will it be within each service delivery area? I think that's a critical piece of the hospital system.

Hon. C. Hansen: We have no plans at this time to change the Ambulance Service. It is a provincewide service which is currently administered directly by the Ministry of Health Services. We will be looking at that. We will be looking at it from the perspective of what makes sense for patients and how we best meet the needs of communities. Certainly, I was very interested in reading the report of the legislative standing committee, where they made the proposal that ambulance service be provided on a health authority basis, on that regional basis, rather than administered from Victoria, in essence. Those are opportunities that I think we have to look at in the future, but no decisions have been made, and we'll be looking for input.

Hon. G. Campbell: I've got Greg and then Gulzar.

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

I'll be brief, but I know it's a question I'm going to get when I get back to the riding, and it does affect all of us.

I was very pleased with your provincial health services authority and the fact that the five geographical regions, I guess, will have representation on that authority. Some regions may not deliver cardiac surgery or whatever, but at least now they'll have a voice in terms of how that's delivered, probably in Vancouver or Victoria.

My question comes because the facilities that the provincial health services authority will have authority over are a mixture of existing facilities that now deliver regional services. Some are almost hospital-specific, and some are ward-specific. You mentioned cancer care, the bone marrow ward in VGH. I assume those employees will work for this new region as opposed to the provincial health services. We've got almost whole hospitals. In some hospitals different wards will now deliver "a provincial service." How does that come together to work on the ground for these people?

Hon. C. Hansen: Well, the provincial health services authority will have contracts with these various facilities in the provision of those provincial and tertiary care services. I'll give you an example that happens now. The B.C. Cancer Agency is responsible for cancer care delivery around the province. Under the current system it technically falls under the Vancouver-Richmond health board. Yet if you take the cancer clinic in Kelowna, which occupies the third floor of Kelowna General Hospital, that's

not administered by the local health authority there. It's on contract to the Cancer Agency, which falls under the auspices of the Vancouver-Richmond health board.

This new model, where we're taking those provincial and tertiary services and putting them in this unique authority called the provincial health services authority, will really streamline that and make the delivery of those provincial services and the relationships between the community facilities and the regional facilities, I think, much more streamlined and much more accountable in the future.

Hon. G. Halsey-Brandt: The provincial services could still be out of that hospital in Kelowna, but it'll report to that provincial agency rather than, in your example, the Vancouver-Richmond health board.

Hon. C. Hansen: Yes, that's right. If you take St. Paul's Hospital, for example, where the cardiac program and the provincial renal agency are run, we expect that will continue to be the case, and it'll be done on contract from the provincial health service agency to the Providence Health Group in Vancouver.

Hon. G. Halsey-Brandt: Thank you.

Hon. G. Campbell: Gulzar.

Hon. G. Cheema: Premier, for the last six months there has been one concern from the mental health community. Whenever there was crisis for the funding, money was taken from the mental health patients and was given to the hips and hearts. I just want to ensure that with this new restructuring, the patients' money for mental health should be protected - because they don't make noise, and they are left behind most of the time. I just want to ensure, on behalf of the patients and in my role as advocate for mental health in this province and with the various ministries, that there is protection of the mental health funding with the new structures when they are put in place.

Hon. G. Campbell: Sindi.

[11:05]

Hon. S. Hawkins: Thank you, Gulzar. That's an excellent question, and you play a very good role as the advocate. We are going to have performance contracts with the health authorities. They are going to be required to do mental health plans, and they will be held accountable for the level of spending they do in mental health. It will be protected funding.

Hon. G. Cheema: Thank you.

Hon. G. Campbell: Any other questions?

I think that around the table you've heard both some of the concerns and also strong support. This is an important step down the road. Let's get on with it. Congratulations.

In view of these changes, Sindi is able to tell you the names of the chairs of the various authorities.

Sindi, if you'd like to do that now, you can do that.

Hon. S. Hawkins: Thank you, Premier, and I appreciate the approval of cabinet.

Before I announce the new board chairs, I do want to acknowledge and thank the hundreds of volunteers who have sat as trustees on the boards over the past years. I know it's been difficult, and there's been uncertainty over the last few months, but I do want to acknowledge their commitment to patients, to health care and to public service. It certainly has been greatly appreciated.

Now I am very pleased to announce our new health authority board chairs. For the provincial health services authority, Mr. Wynne Powell; for the northern health authority, Harry Gairns; the interior health authority, Alan Dolman; the Fraser health authority, Mr. Barry Forbes; the Vancouver Island health authority, Jac Kreut; and the Vancouver coastal health authority, Keith Purchase. I really want to thank each of them for taking on this new responsibility. I wish them all the best. I think it's going to be challenging and exciting, and I wish them all the best in the task ahead of them.

Thank you.

Hon. G. Campbell: Thank you, Sindi. I just want to reiterate what you said there. I forgot to mention that.

The structure in the former health authorities that the hundreds of volunteers were working in on behalf of people in the province was simply not working. It wasn't because of the volunteers; it was an institutional structure that didn't work. This is a step to change that institutional structure so we can focus resources on patients and so we can deal with those regional issues that every single one of us has heard in any travels around the province. Generally, you hear about health care, you hear about the economy, and you hear about transportation. It doesn't matter what region in the province you're visiting. I think this is a very important step.

It's also important to note - and I do want to note - the work that has been done by the ministries with regard to this. It is very difficult to deal with these kinds of changes. As someone mentioned in the discussion or the questions, our hospitals are very important community cornerstones. They're part of what community life is. Bringing volunteers back and making them welcome and making them feel like they're an important part of the health care system is an important part of what the thrust of this program is about in terms of making sure the community hospitals are properly taken care of. I do think this is a step in the right direction.

I agree with you that the quality of the people who have decided to stand forward as chairs is excellent, but there is a lot of work that we have to do before we start to bear the fruits of this very early decision. Thank you very much.

The meeting is adjourned.

The cabinet adjourned at 11:08 a.m.