TRANSCRIPT OF THE OPEN CABINET MEETING

December 3, 2002

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	Hon. 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
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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

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TUESDAY, DECEMBER 3, 2002

The cabinet met at 10:41 a.m.

Opening Remarks

Hon. G. Campbell: We're going to begin. This is going to be different than the normal open cabinet meetings that we've had. We often, in cabinet, as you know, have presentations on a wide variety of things.

There are few things that are more important to British Columbians than health care, and there are few things that are more important than that British Columbians understand the challenges we face with regard to health care. In fact, at the end of the day, if British Columbians don't embrace solutions to the health care problems that challenge us, then we're not going to be successful in meeting the needs of patients across this province.

Today we're going to have what is effectively a presentation on a variety of issues that are focused on health care. As you know, today 41 cents of every single dollar we spend goes to health services in the province. We increased the budget by $1.1 billion last year, from $9.3 billion to $10.4 billion.

I'm pleased that today we have in our gallery Mayor Colin Kinsley, who is the mayor of Prince George, as you know, and has been the head of the federal task force on rural and remote medicine. He certainly has been active in highlighting some of the challenges we face in rural and remote British Columbia in terms of meeting the needs of patients in those communities.

I think it's important to note, before we begin, that none of these solutions that we've come forward with will happen overnight. It's, unfortunately, going to take a lot of work and a lot of cooperation with a lot of players and a lot of people across the province to make sure that we continue to build on what is in fact the healthiest population in the province and to make sure that we keep that record and move forward with even better results.

Today we're going to start the presentation with the Minister of Health Planning. As you know, Sindi was challenged, when she started, with providing us with a long-term plan for health care - long term, in this case, being ten years. We need not just a health care plan for how we meet the needs of patients. We need a plan for how we build the human resource infrastructure for health care again, which was allowed to deteriorate over the last decade. We need a plan for how we maximize and optimize the benefits of technology investment. We need a plan for how we make sure that we maximize the benefits to patients of capital investments on behalf of the taxpayers.

There's no one in this room that's not aware of the challenges. I thought it would be worthwhile for us to spend some time today to go through that in a comprehensive way.

I'm going to turn this over to Sindi now. Sindi is going to talk about the health vision. Katherine will talk about independent living. Sindi is then going to talk about the Pharmacare challenges we face, with Colin. Then we're going to talk briefly about the health sector human resources challenges that we face. At the end of the day, if you don't have the human resources, you don't have much of a health care system.

Sindi, take it away.

For Information: Health Vision

[10:45]

Hon. S. Hawkins: Thank you, Premier.

You know, I'm really excited to have this opportunity this morning to talk about our vision

for health care in this province and our plan - what we're doing to meet that vision. I can tell you that we've heard from a lot of British Columbians. The Premier has led several dialogues across this province. One was in the fall of 2000, when we went to about 16 communities. We heard that change was necessary. The Premier again led a dialogue at the Wosk centre last year. Again, we heard that change was necessary. The status quo wasn't an option, and people wanted us to act. That was the message we got.

Every province in the last ten years has been going through reviews and reports, and they've been looking at ways to make their health care system sustainable. In the last few weeks you've seen two major reports: the Kirby report that came out of the Senate committee and the Romanow report that was released last week. Romanow talks about what the provinces might do or could do, but I can tell you that we couldn't wait for his report. We had to act when we got elected. In the last year we've done quite a bit to start improving our health care system so it starts working for patients again. I can tell you I am very, very proud today to release this document. It's *A Picture of Health: How We Are Modernizing British Columbia's Health Care System.*

I want to talk to you about the plan. The plan is based on improving health care for British Columbians, and it's based on these four long-term goals that will meet our vision: accessible, high-quality health care; a patient-centred public health care system; improved health and wellness; and sustainable, affordable health care.

Over the past 40 years the health care system, as you know - and you've probably been through it a few times - has grown in bits and parts, sort of pieced together in a really uncoordinated way and often with little regard to actually focusing on the patient. There really was no thought, I think, put towards more efficiency, cost-effectiveness - looking at performance measurement outcomes or good patient outcomes for the huge money that we invest in it - or to the organization and coordination of services when we were introducing new treatments, new technologies and new knowledge.

I just want to take you back to when medicare first started. When it first started in 1965, all we had was hospital insurance, and now we've layered on just an incredible amount of other things. We've layered on not only hospital insurance but Pharmacare, ambulance, telehealth, prevention and wellness, and home and community care among other things. You know what? People have told us, certainly when we travelled around and held our dialogues, that the system is confusing. It's poorly structured; it's poorly organized and really not always focused on patients. We thought: "They're right, and we have to do something about that." In fact, in the last four decades, while we've been going through medicare, the world changed, but our health care system didn't. It stayed the same, and it continued to run the same old way as it did over the past 40 years when it first started.

Well, I'll tell you. We are not underestimating the challenges. We have a lot of challenges and pressures facing our system and facing how we deliver quality health care today. Some of the challenges are that we have a growing population, an aging population. It's rich in diversity. We have a very diverse ethnic population in the province. Our population is spread over a very large geographic area - lots of mountain ranges and challenges there. The province - and you've heard the Premier say this before - is larger than England, France and Germany combined. Then you couple on that our challenges with the rising costs of technology and drugs, and you're beginning to see some of the challenges we're facing in trying to make our system more sustainable.

I don't have to tell you that our public health care costs are escalating. I think back in the early 1990s our health care budget was about $5 billion. Today it's $10.4 billion, and as the Premier mentioned, it takes up 41 percent of our total provincial budget. We recognize that the health care system can't continue to grow the way it has been. We have to recognize that there won't be enough money to keep it going in its current form.

[10:50]

Health care costs have been growing three times faster than the rate of our economy. The costs since 1991…. Pharmacare costs alone have been rising at a rate of 14 to 17 percent a year. In the 1990s, as I mentioned, the health care budget was $5 billion. When we took over, it was around $9 billion, and in the last year we have added $1.1 billion to the health care budget. That is a whopping 41 percent, as I mentioned. Most of that $1.1 billion went to increase wage settlements. That's where it went. It was gobbled up by doctors' salaries, by nurses, by health science professionals.

You know what? We knew we had to do that. We value our health professionals. We are challenged in meeting the human resources workforce for our province. We know we want to keep them here. We want to recruit them here. We now have the highest-paid doctors and nurses and other professionals in Canada, and we recognize we need to do that to meet our citizens' health needs.

I can tell you we had to do some stuff to make sure we got that money. We had to pay for those wage increases. We had to raise MSP. We had to raise tobacco taxes and sales tax to cover the additional money to cover those wage settlements. You should know that all the income tax we take in, all the sales tax, all the medical service premiums and even the lottery money combined don't bring in enough money to pay for health care today.

I think you should know we're not alone in our sustainability challenge. Every other province, every other territory is trying to grapple with this problem. Each one of us is dealing with the hard reality of not having the resources to keep the system going to meet

the health needs and demands in the way the system is organized in the current form. Governments have grappled with this in the past, and former governments have patched up the system in their own different ways. What we're seeing today are the results of a very sick system, and we hear that from patients and health care providers all the time. They say: "Fix it."

Our emergency rooms are overwhelmed. Patients need access to surgery and treatment. There's a critical need for long-term care, and we are looking at addressing that. We know there is a need for more doctors, more nurses, more pharmacists and other kinds of health care providers, and the list goes on and on. Every province, every territory is trying to find the resources, trying to look at strategies and trying to save and renew public health care.

The Romanow report came out last week, and it says the answer is more money and more bureaucracy. Well, we the provinces have been saying for years: "Yes, more money is needed from the federal government." When medicare was started 40 years ago, the federal government and the provinces shared in a 50-50 partnership. Right now the federal government picks up 14 percent of every dollar that is spent. The provinces pay 86 percent, and Romanow recommends that the federal government now increase its share to 25 percent. That still leaves the provinces - that still leaves us - picking up 75 percent of the health care costs.

What can we do to make our health care system more sustainable? Well, we recognize we have to modernize our health care system. We have to bring it into the twenty-first century. We can't have it stuck back 40 years ago when it first started. We want a health care system that works for patients. We want a health care system that's well managed, that's well planned, that's well coordinated, and that's working for patients today and working for us into the future.

As the Premier mentioned, it's not an easy task. I don't think we ever pretended - and I don't think the Premier ever said - it was going to be easy. We have always said it's not going to be fixed overnight. We're not going to be looking at short-term band-aid solutions. We are looking at fixing it over the long term, and it's going to take some time. But I can tell you the good news is: we've already started, and that's what our plan is about today. We're telling you what we've done and how we're going to get there to a system that's well planned, well coordinated, well managed and that puts the patient right at the centre.

For starters we've improved health care governance. We reduced the number of health authorities. We had 52 that were dysfunctional, didn't work and weren't well coordinated. We went to six. They're better coordinated, and they are making efforts to share

resources, because they know that by working together, they can better help meet patients' needs. Guess what. We are leading in Canada. We are the only ones in Canada to ensure that every health authority has a performance contract with specific outcomes that are being monitored, measured and reported to ensure that we get the best value for every dollar that's spent in health care.

Our deputy travels to other provinces and meets with other deputies. Colin and I travel, and we meet with other ministers. I saw a report from the Northwest Territories, and they are talking about accountability performance-type contracts for their health care system too. So when Romanow talks about accountability, we're already leading the way. We're setting an example for other jurisdictions.

[10:55]

In order to make sure our health care system remains focused on patients, we gave health authorities the tools they needed to be more flexible in how they direct resources to where patients need them the most. Last year, I think you'll probably recall, we saw two examples of how the system didn't work because we didn't have the resources or couldn't move the resources into the right places so that patients didn't suffer. We were all very upset to hear about a little girl from Terrace that broke her arm, and for three days she suffered while she was shuffled around from hospital to hospital only to find out that the orthopedic surgeon she needed wasn't available when she needed the service. I think we can all agree that the system failed when that little girl needed it the most. As another example, last Christmas - I remember Colin talking about it - we saw a major inner-city emergency room, St. Paul's Hospital, close down because they were overwhelmed by patients and were simply unable to move the resources they needed - nurses - into the emergency room from other places because of inflexible union contracts.

We're looking at all options to make sure patients get the access they need to health services. We're implementing all kinds of solutions that we think will ensure that situations like the ones I mentioned will be an exception and not the norm. That's why we asked our health authorities earlier this year to review the way emergency services, acute services and community health services were delivered across our province and in their regions. We wanted them to come up with a plan that made sure patients have access to high-quality health services that they can have confidence in and count on to be there when they need them.

Again I can tell you that we're leading the nation on setting access standards for care. For the first time ever, Premier, we established provincewide access standards and guidelines for health authorities to follow to make sure patients in all parts of the province are getting access to the care they need. People in all regions of the province know that

health services in areas with very small populations are hard to keep because of the high turnover. We acknowledged the need to move to a more rational system of locating health services to provide the right balance of accessibility and quality, and I think every health authority is doing its best to move in that direction to make sure patients are getting the right access to high-quality health care.

It's interesting. When you think about health care, I think a lot of people think about hospitals. They think about buildings, and they think about facilities. In fact, health care is more than about a building or just a facility or just one kind of provider. When you think about health care, it's not just about a doctor; it's not just about a nurse. There's a whole team of professionals that work to deliver that care. It's more about having the confidence that there are stable, high-quality services that can be counted on to be delivered by the most appropriate health care provider when you need them.

You know, when Romanow was the Premier of Saskatchewan, unfortunately the province saw the shutdown of 50 hospitals. When we looked at reorganizing our system, we didn't do that. We didn't do that. We recognized that we had to make some adjustments, like Kimberley Hospital, but now we have a better facility in Cranbrook. The region has access to more resources, more stable services and more high-quality services. We've been able to recruit specialists there, and they can offer patients over a greater area a broader range of care, and that's good news. That's good news for patients, and patients now know exactly which hospital has the services they need and where the resources are focused.

For another example, West Kootenay-Boundary Regional Hospital in Trail, as a result of the redesign in the Kootenays, recruited three new specialists. They have two general surgeons and one new plastic surgeon to serve that area. The East Kootenay Regional Hospital in Cranbrook now has an internist specializing in intensive care, and diagnostic and treatment services including cardiology, respiratory and gastroenterology. Those are services they now have stabilized in their community.

For the first time in years, the emergency room at VGH - Vancouver General - UBC and Richmond hospitals have achieved 100 percent staffing levels, and they've seen significant reductions in emergency room waiting times. I can tell you, Shirley and I did a lot of work around human resource planning around nurses, and to her credit. With the seats she's added and working with me on the nursing strategy and loan forgiveness for a lot of these professionals, I think we've made a significant mark in reducing the vacancy rates for nursing positions across the province.

Hon. G. Campbell: How far have we gone on it? Where are we on the vacancies - do you know? - for nurses?

Hon. S. Hawkins: Well, I know we've reduced them by 30 percent. That was a little while ago.

[11:00]

Interjection.

Hon. S. Hawkins: Oh, it's 60 percent. There you go. I knew we had made a significant mark. We've reduced the vacancy rates by 60 percent over the year.

We have also moved to improve rural services. Colin announced in April that we are investing $30 million in ambulance services. That's for training, for equipment, for more positions. We've looked at how we can move on that.

We've invested in new medical and nursing spaces. I'm going to talk about that later, at the end of the meeting.

We're investing in hospitals. We're doing a $50 million expansion at Prince George, and we've got a commitment to build MSA General Hospital in Abbotsford. I can tell you that the academic ambulatory care centre at VGH is a signal of a new partnership with the private sector. That's a $90 million investment that will not only improve patient services; it will also enhance training for several hundred medical students and 580 medical and allied health professionals.

Compare that with the VGH Tower, Premier, that you talked about. It's been sitting virtually empty for a decade - a huge public investment - and we've never been able to complete it. We can't just be building empty shells.

We need public-private partnerships. In fact, we've always had a role for private sector in the health care system. Just think about it. Since medicare started, the private sector has been very much a part of our health care system. In B.C. we've historically contracted out for diagnostic services, for lab services and even for private patient services. One of the largest groups of private providers in our public health system is doctors. They bill to the public health system, and these arrangements are all within the principles of the Canada Health Act.

We will remain, and we are, very committed to the Canada Health Act and to the principles of the Canada Health Act, but we're also very much committed to looking at all the options that provide our citizens with improved access to care. That's important to us. We're not going to put on blinders, and we're not just going to say that we're only going to

do things one way. We are going to look at all our options. The options must present a good business case. We have to find good value for the money that we spend, and it has to fit within the principles of the Canada Health Act. But, again, we are examining all options for new capital to see if we can take advantage of partnerships in the private sector. We have developed guidelines for public-private partnerships to make sure that any increased role of private sector involvement will not undermine the equity and universality of the Canada Health Act principles.

In our plan we also talk about primary health care. We talk about renewing primary health care. You hear this term a lot, and I know sometimes we throw around terms without ever considering whether people actually understand them, and that is one of the terms. You probably heard about primary health care through the Kirby report and recently in the Romanow report. But I think I heard primary health care described as one-stop shopping. I think that's kind of a neat way to describe it. Primary health care is really about the first contact that people have with the health care system. Where would you go if you needed a health care service or a community service? It can mean a visit to the family doctor, the community health nurse, the pharmacist, the dietician, the physiotherapist. Primary health care really is about working as a team. It's about building teams - not working in silos, but actually working together to look after the patient as a whole.

We recognize that doctors can't do it on their own. It's more about better patient care by providing teamwork - health professionals that work together. As I say, it's about building these teams, building these networks, to make sure that patients get good access to care 24-7, 52 weeks a year, and we are looking at how we can do that.

[11:05]

We're looking at how we can also provide health care services to people with chronic diseases like asthma, diabetes or heart failure, because they really do put a burden on the health care system. Frankly, many of these diseases are preventable. We are working right now in my ministry and in Colin's ministry with many partners - patients, doctors, nurses, pharmacists, the industry, health authorities, disease groups. We're developing strategies to empower the people that are living with chronic illnesses to be able to make them the experts on their own illnesses. Our goal really is to be able to provide patients and families with the knowledge, with the resources, with the skills. Give them experience so that they can manage their own care and reduce the devastating complications that can result if their diseases aren't well managed.

Well, that takes me into prevention and wellness. I think one of the biggest gaps in our health care system is the shortfall we have in health promotion and prevention services. Those are the services that are aimed at keeping people healthy. You know, I think we all

have to realize we have a responsibility to make the right choices for healthy living. We all know. I mean, if I ask people, "Do you think smoking is good for your health, or do you think you should be eating high-fat foods…?" I see Sandy saying yes, but I think he knows what the right answer is. We all know that lifestyle….

Hon. G. Campbell: Let's test it. Is it good for your health, Sandy?

Hon. S. Hawkins: Is smoking good for your health, Sandy? [Laughter.]

We all know that lifestyle issues affect our health. Good, healthy diets, physical activity and not smoking go a long way to reducing the risk of chronic diseases. Our health care system traditionally has been focused on illness, on looking after acute care, and the majority of our dollars have been spent there.

We need to shift our thinking more to staying healthy so we don't get sick. We are looking at how we do that. Our health authorities are looking at how we can do that. We have the *B.C. HealthGuide* and the NurseLine. We have an aboriginal companion document to the *B.C. HealthGuide* for that population. Those are just some of the things we're doing to help people take greater responsibility for their own health.

Well, one area that traditionally didn't receive a lot of attention was the area of mental health. Our Premier and our government are committed to doing a better job in addressing the issues so that people with mental illness can manage their illness better, can reduce their degree of disability and can achieve their full potential. Premier, I'm going to turn the floor over to Gulzar, our Minister of State for Mental Health, for a few minutes just to speak on that issue.

Hon. G. Campbell: Can I just check one thing? Have you finished on prevention?

Hon. S. Hawkins: Yes, I have.

Hon. G. Campbell: Are there any questions from anyone on anything Sindi has done so far? I just have one question on prevention. One of the challenges we face is that people tend to take prevention and say that's the panacea. If we would just prevent anyone from getting sick, then everything would be fine. Obviously, there are some huge personal benefits of that, but isn't it true that about 70 cents of most of the dollars we spend on health care go to the last year of people's lives, regardless of how healthy their life is or not?

Hon. S. Hawkins: There is a huge investment in the end years. You're right. But there is also a huge burden on the chronic, preventable diseases - diabetes, heart failure. If we

looked after that, we may not have to get into the severe complications we do for end-of-life costs that end up being ramped up. It reduces some of that.

Prevention, Premier, is also about immunizations. I should remind people - the flu shot. How many people had their flu shot this fall? It's little things like that too.

Hon. G. Campbell: Prevention is more than that. It seems to me that if we lock this into just health care, we tend to lock it into a silo that we were just talking about trying to open up. Prevention may be what Christy is trying to do, with more physical activity and more physical education in high schools. It may be encouraging people to be more active, whatever it is - all those sorts of things. Right?

Hon. S. Hawkins: Absolutely. Actually, Christy and I are working on an initiative to get kids more active in schools. We're going down that road.

Hon. G. Campbell: I really want us to try and get to some sort of concrete things. People will often do it if they know what they need to do - right? Part of not just this kind of information but sharing information with people about what they do in terms of prevention, nutrition and exercise…. We know we have to exercise more. I certainly know I have to exercise more, and I know my nutrition should be better. How we sort of get behaviours changing around that seems to me to be a pretty critical….

Rich Coleman points out that he may need to exercise a little more too.

What are the behaviours? How do we get those behaviours happening?

Hon. G. Plant: Public shaming. [Laughter.]

Hon. G. Campbell: I thought that was sort of a badge of honour. It wouldn't be the first. I'm not sure it worked before. [Laughter.]

[11:10]

Hon. S. Hawkins: You're right. There's bits and parts everywhere. We are working on a prevention and wellness strategy that's going to tie it together and really take it through several ministries so that we do have programs that are more real and that we can roll out and, really, that people…. You know, it really is about self-responsibility, though, too. I can't tell you to do it. You have to make up your mind that you need to do it too, but we're trying to find ways to encourage people to get into that state of mind.

Hon. G. Campbell: I get that these things expand, but for example, if we had a…. Well,

parenting programs make a difference. We know that makes a difference in terms of early childhood development. We know that makes a difference in terms of…. Well, there's a whole bunch of things - right?

When I was a parent, I can remember being told how your child would hopefully develop, but I can't remember much information being given to me. I mean, I accessed it through going to the library and stuff like that, but there weren't a lot of easy rules that I knew about naturally - right? I know today that if you read for 20 minutes to your child, the child is probably going to be better off. I'd encourage every parent to do that, but I don't think I was told that explicitly. I know that's way over where you primarily want to be, but….

Hon. S. Hawkins: You make a good point there. One of things we are looking at is evidence-based strategies, so Christy and I are working on an action school strategy, and we are looking at how we make it based on evidence.

Hon. G. Campbell: Okay.

Joyce.

Hon. J. Murray: Sindi, are you working with naturopathic physicians in your team of thinking about prevention? My experience with naturopathic medicine is that it does focus on chronic disease management but also prevention, wellness, strengthening the immune system and so on.

Hon. S. Hawkins: There are partners in the different disease group-based strategies. I'm not sure if that's one of the providers, but if they want to get involved, they can certainly contact the ministry, and I will go back and ask the ministry if they are involved.

Hon. G. Campbell: Okay.

Graham and then Geoff.

Hon. G. Bruce: Sindi, I just wanted to be sure on this. Coming back to the nurses training and physician training, you touched very quickly on the loan forgiveness program. Often when I'm out and around speaking to people, people come up and say: "I've got this great idea." Can you just explain exactly what we are doing there? The other aspect is: how many additional nurses are we hoping to have in training by 2005?

Hon. G. Campbell: Shirley's going to answer the question. We're going to deal with more human resources near the end of the agenda.

So, Shirley, on the question.

Hon. S. Bond: In terms of the forgivable loan program, Graham, it's a program that Sindi and I looked at, at the very beginning of our mandate - in August, as a matter of fact, of last year. What it does is encourages, at this point in time, those students who are training to be physicians and also nurses to apply to serve in what we consider underserved areas of the province. If they choose to do that, they will receive loan forgiveness on the B.C. portion of their loan - 20 percent each year for five years.

We're actually currently examining the takeup of that program. I think that we haven't done as good a job of advertising and taking advantage of that program, so we're going to be looking at how we've messaged that and how we get that information out. We're also looking at the scope of that program and using it as a template for further opportunities in terms of encouraging people to serve in rural and remote areas of the province.

In terms of the number of seats, in 2002 and 2003 we added 651 new student spaces for registered and practical nurses - so over the last two years 1,266 new spaces - and I will be continuing to build the number of seats over the next two years significantly.

Hon. S. Hawkins: Premier?

Hon. G. Campbell: Yes.

Hon. S. Hawkins: I stand to be corrected on the nurse vacancy rate. I've just got the information. We are down 40 percent from 1,000 nurses to 600.

Hon. G. Campbell: There are 600 vacancies remaining?

Hon. S. Hawkins: Right.

Hon. G. Campbell: We've eliminated 400 of the vacancies in the last 18 months?

Hon. S. Hawkins: That's right, but you know what? I heard the other day - good point…. I haven't for months heard the term "nursing crisis." I think we've done a good job in filling a lot of the spots, we've done a good job recruiting, and we've done a good job adding seats in training.

Hon. G. Campbell: Geoff.

[11:15]

Hon. G. Plant: Thanks.

I just wanted to go back to the slide earlier in the presentation to make sure that I understand what it means, and this is the slide that says that health spending of $10.4 billion takes all of…. I sometimes meet with constituents who actually labour, unfortunately, under the misapprehension that MSP premiums pay for health care. This slide suggests that personal income tax of $4.8 billion, social services - that is, the sales tax - of $3.8 billion, MSP premiums of $1.3 billion and $500 million in lottery funds would all have to be put together. Essentially, that means every single dollar that the province collects in provincial income tax and every single dollar that we collect in social service tax, as well as MSP premiums.

It's hard to make big numbers real in the minds of people. For most people, that's all the taxes they pay. What that means is that for most people in British Columbia, all of the taxes they pay added together barely pay for the health care system.

I think that in terms of thinking about the impetus for reform, it's helpful to me to try to get my head, in a practical way, around the issue of figuring out just how darned expensive this thing has become and how all-consuming it has become.

Hon. S. Hawkins: That's a good point.

Hon. G. Campbell: I think it is surprising to people when they hear that all of the sales tax - every cent of sales tax that we take in the province - is going into health care. Every cent that we take for income tax goes to health care. Every cent for MSP goes to health care, and you have to throw in $500 million from lotteries to get up to $10.4 billion.

Hon. G. Plant: I mean, we obviously get help from the federal government on this, but that's a different.... It's a way of illustrating just how significant the burden is.

Hon. G. Campbell: Right.

Hon. G. Plant: Anyway, thanks.

Hon. S. Hawkins: Thank you.

Hon. G. Campbell: One of the major issues that we face in any health care system - and this is not new; this is not just being discovered; it's been known for a long, long, long time - is the challenges that we face with mental illness. The Seaton royal commission

mentioned mental illness as a challenge. I know when I was involved in the city back in the eighties, it was a challenge how we provided for people. As you know, Gulzar is focusing his attention and our attention on trying to come up with a comprehensive program to deal with mental illness.

It seems to me the most important thing for all of us to remember is that in every one of our communities, in every one of our neighbourhoods, in every one of our walks of lives, there are people that are suffering from mental illness. It's nothing to be ashamed about. It's something that's there, which we have to deal with constructively. Actually, I think it's one out of four people that has some form of mental illness at some point in their life. Gulzar?

Hon. G. Cheema: Thank you, Premier. Thank you, Sindi.

I think, Premier, what you have said is absolutely right. We are the only government in the Commonwealth with a minister responsible for mental health, and that shows your commitment and our government's commitment.

In March of this year we announced our $263 million commitment to mental health. I know every time I say $263 million - Shirley Bond is here - I can see a big smile on her face. We are fulfilling our promise to fully fund the $125 million mental health plan to build up community mental health services and to support mental health clients in the communities in which they live.

We are spending $138 million to build home-like facilities across the province. These are more appropriate care settings for patients who have been living in outdated facilities and in institutional care at Riverview Hospital. As a result, when the patient is moved to a new facility, their funding will travel with them to their new home. These new homes include Iris House in Prince George and Seven Oaks in Victoria. We are building two new home-like facilities in Kamloops. We are also doubling the size of Iris House in Prince George, and we are choosing a site for a facility in the central Vancouver Island area. Our government has provided an additional $3 million this year to ensure that patients are fully supported during their transition to these new facilities.

Together with the health authorities, we are providing better, non-institutional care environments for mental health patients, and we are building community mental health capacity to support clients in their home regions. We are creating a system of mental health care where patients will be able to access the appropriate care in their own community.

Mr. Premier, I'm very excited about our progress, and we are very proud of our

achievement in this area. Thank you.

Hon. G. Campbell: Thanks, Gulzar. Sindi?

Hon. S. Hawkins: Thanks, Premier. I just want to say that we're also focusing our efforts on a lot of other areas, on improving aboriginal health and improving rural health. I know Katherine's going to talk about community and long-term care, but I think what's important to understand is that there are a lot of reports that have come out. I mean, we saw the Kirby report in five different chapters and the Romanow report, which is 400 pages - which I'm trying to get through.

[11:20]

But you know what? This is a plan. We're already doing this. This isn't what we should be doing or what we could be doing. This is what we're already doing, and I really encourage all British Columbians to read this. It's very readable. It's in plain English, and it tells you what we're doing and how we're going to get to our vision of making sure we have a high-quality health care system that meets patient needs.

Premier, I'll take any further questions and close there.

Hon. G. Campbell: Any questions? Judith.

Hon. J. Reid: You recommend that people read this. I wanted you to tell people how they're going to access it.

Hon. S. Hawkins: It's on the webpage. If people don't have access to the Web, they can certainly phone Enquiry B.C., and we will send one out. And it's on the back. I can hold up the back here: www.gov.bc.ca/bchealthcare. Or they can phone 1-800-465-4911, so it's very easy to get hold of.

Hon. G. Campbell: Rick?

Hon. R. Thorpe: Thanks, Sindi. Will people also be able to go to their local MLA's office or perhaps even the government agent's office to pick up a copy throughout British Columbia?

Hon. S. Hawkins: Good point, Rick. We didn't want to print a lot. We wanted to see what the demand was out there. If people want it, we've printed a few, and MLA offices can certainly ask for them. That's a good point. Government agents' offices are probably

another good place to put some.

Hon. G. Campbell: Christy?

Hon. C. Clark: On the subject of mental health, perhaps, Gulzar, you could answer a question for me. The move to community care is important from my perspective, because as a society we obviously need to improve care for people who are mentally ill. As a society, I think we need to have a better understanding of the fact that people who are mentally ill aren't a separate society or aren't separate from our society.

They're part of the fabric of our society, and any one of us could become mentally ill or any one of our children could be diagnosed with a mental illness. I think one of the things that will be most important is continuing to educate the public about those facts. Perhaps you could tell me what we're doing to make sure we begin to approach what I think would be a big and important cultural change.

Hon. G. Cheema: Thank you for the question. That is one of the major difficulties we face, because people have difficulty understanding that mental illness is not their problem. If you look at the statistics, one in four to one in five British Columbians will have a mental illness during their lifetime. No single community and no single family is immune from this problem. That's the message we are trying to convey.

When I was appointed a minister of state, the Premier gave me three responsibilities. One of the responsibilities was to have a public information campaign, and we are in the process of developing that campaign. In fact, we are doing a lot for that area of responsibility. We fund about $1.2 million through various mental health organizations in this province to promote understanding and also acceptance of mental illness.

We have come a long way, but we have a lot to do in the future. I think the most difficulty I face as a minister of state when I go out there is the challenge that people still are having difficulty understanding; plus, there is a stigma and discrimination with mental illness. That needs to be changed, and it can only change if we all focus. Part of the public information campaign will involve schools. It will involve school boards and various ministries. I think this will be helpful.

In the long run, what we need to have is a multi-year approach. It cannot be done in one year. I'm in the process of having this public information campaign focus on the needs not only of adults but also of the youth population. That's why, along with Gordon Hogg, we do have the youth mental health plan, and we will be releasing that plan very soon. It will focus on one of the most important parts that has been missed in the past - that is, a youth mental health plan. I think we just need to have somewhat more patience, and we

will have a plan that will be very effective.

[11:25]

This plan should be on a continuous basis. As MLAs and as ministers, we need to continue to focus on that. I was very pleased when the Premier was able to participate in the Bottom Line conference. He was able to talk about the mental health issue. There's no Premier in this country that has ever taken that responsible role. I think that's very positive. That's part of the campaign. We need to do that more.

Hon. G. Campbell: George.

Hon. G. Abbott: Thanks, Premier.

The provincial health officer recently came out with a report in respect to aboriginal health and some of the indices of how well or not well government and society are doing in respect to that issue. Could you, Sindi, provide some information for me and the rest of cabinet with respect to the kind of initiatives we have underway in respect to aboriginal health and where the government's going on that?

Hon. S. Hawkins: Thank you, George. You're right. The provincial health officer released a report on aboriginal health in October. It's quite a significant document. For the first time we actually have benchmarks and places where we can start to look at how we're measuring health status in that community.

I can tell you that their health status is less than the general population. Their life expectancy is seven and a half years less than the general population. He did say that we are making gains. There was good news. There were improvements. The infant mortality is the same as the general population. That's a huge indicator.

We know there's more for us to do. Frankly, we're working with four aboriginal policy tables. We're working with the First Nations Chiefs Health Committee. The health authorities are working on aboriginal health plans that have to be locally and regionally and culturally sensitive. We will be releasing very shortly the aboriginal health guide, which is a companion guide to the *B.C. HealthGuide.* It was developed by aboriginal people for aboriginal people. It's very culturally sensitive and helps them to access the health services.

I know that the Premier and certainly Colin and I work with the federal government to try to access the kinds of funds we need to make sure that we are meeting the health needs of our aboriginal population, but that's a challenge, because a lot of aboriginal people fall

between the cracks of federal and provincial jurisdiction. We have to work together to make sure that we're addressing their needs. They're citizens of our province, and we have to make sure that every citizen in the province gets the health care they need.

Hon. G. Campbell: Can I just mention two things on that? Then we'll go on with Katherine. The first one just goes back to mental illness. I do think it's really important for us to remember that mental illness isn't all about taking people who have mental illnesses and putting them into community facilities or whatever. Mental illness is treatable now; it's treated now. There are people who are having treatments for mental illness, and you'd never know that was taking place.

The challenges we face with anxiety disorders and depression are substantial. A lot of addictions that we see societally, addiction services, are actually people trying to self-medicate for whatever their problem is. I do think an important part of opening up the discussion about mental illness is to recognize that people with mental illnesses are in our midst.

I personally wouldn't know immediately - like that - that someone had diabetes. They're in our midst. I wouldn't necessarily know that someone who had some other chronic disorder was in our midst. I wouldn't know, if Gary hadn't told me, that he had Crohn's disease. Those physical disabilities are there and are treatable and allow people to carry out their day-to-day lives in a way that looks - whatever we call it - regular, normal, healthy, typical.

The same thing is true now with mental illnesses. I think the issue is to try and make sure that people feel comfortable coming forward and dealing with that in the workplace, throughout society. If we can create an environment where that happens, I think there's no question…. When you look at all the reports that we've seen on health care for the last decade and a half, they'll tell you that will take a great deal of pressure off the acute care system that we currently know there's so much pressure on. That's critical.

On aboriginal health care, we have - I know Geoff has, I have and George has - all been pursuing, creating, the kind of response that's necessary. I think, again, we have to look at the results that we've had in terms of aboriginal health care. If you look at the results, you know that whatever programs we put in place - for whatever well-intentioned meanings they were put in place when they were put in place - didn't work.

[11:30]

We are trying to find new ways, new avenues, new healing processes that are there by working with the aboriginal leadership. We've seen a model that's been created in

cooperation with aboriginal leadership with regard to children and families. There are adaptive opportunities with that model in terms of aboriginal health care, in terms of aboriginal education. All of those things are part of what we hope will be a comprehensive sort of move forward so we start getting improvement and results.

I do think it's also important to reiterate what Sindi said. Results don't mean that a week next Thursday everything's going to be fine. Results are going to take a long time to get to, but if we at least are making progress in all of these areas, I think we'll be doing some good for people across the province.

Do you want to introduce Katherine, or do you want me to?

Hon. S. Hawkins: You can.

Hon. G. Campbell: I'd like to introduce Katherine Whittred. Katherine was given the responsibilities, as you know, for intermediate, long-term and home care. We are trying to move forward with, again, filling the gap that has existed and been identified for a long, long time with regard to a continuum of care and a continuum of services. Katherine is going to speak briefly about independent living.

Katherine.

For Information: Independent Living

Hon. K. Whittred: Thank you, Premier, and thank you, Sindi, for particularly focusing on the long-term goals we are setting out to achieve over the next ten years.

I'd like to take just a moment and put home and community care within the context of those goals. The key, I think, to achieving these goals in the home and community care sector is, in fact, to provide seniors with the entire range of options that support their independence and their quality of life. Sindi mentioned that in many areas of health care, there's really been very little change in the last 30 years. That's also true in home and community care.

One of the very difficult situations to deal with is that, in fact, the achievement of these goals is compromised to a large extent by the fact that many of our facilities are very outdated. They simply are no longer structurally capable of providing the kinds of options that contemporary long-term care is headed toward.

The achievement of goals in the health sector overall - home and community care play a very big role in this. I think it is, in fact, key to keeping people out of emergency wards

and out of acute care beds. In that respect, the status quo is simply not an option.

Another area I think we have to build on in terms of sustainability is to work on our historic relationship with the profit and not-for-profit sector to ensure that there are many options that are affordable and available to seniors across the province.

What is the current picture of our seniors? Well, currently there are about 540,000 seniors in British Columbia. By the year 2010 - and that's a mere seven years away - there will be an additional 120,000 seniors, which is equivalent to a city the size of Abbotsford. Now, when you think about it, this is a phenomenal increase. That's 22 percent more people over the age of 65 in the next seven years.

Hon. G. Campbell: I'm getting closer to being 65. Could we move the seniors age up a little, please?

Hon. K. Whittred: Actually, Premier, I think you'll remember that I recommended that a week or two ago. I'm getting even closer than you are.

Hon. G. Campbell: No. Go on.

Hon. K. Whittred: This increase in the seniors population, combined with the lack of a consistent plan over the last ten years, is what really presents us with our challenge. But you know, there's lots of good news. We talked about prevention. British Columbia's seniors are, in fact, very healthy and very active. B.C. seniors live the second-most disability-free years in Canada - 69 years. They live the longest. We have the longest life expectancy. We've added, in fact, four years to that in the past 20 years. All in all, we're extremely fortunate. Our seniors are healthy, they live longer, and they're active in their communities much longer than previous generations were.

[11:35]

But what about those who do need some support? What we have in the system right now are limited choices. We have traditionally had the option, on one hand, of home care and, on the other hand, of going into a facility. Our goal is to create more options along this continuum of care so that every senior can have a care option that is going to best suit that person's needs.

Filling the gap means we are adding choices to the continuum of care. The principal choice we are adding at this time is the assisted-living option. This is an option that will encourage independence. It will encourage involvement in the community. It is, in fact, an ideal solution for people who need some supports but don't need 24-hour, seven-days-a-

week nursing care. But I do want to emphasize that there will always be facility nursing care there for those who need it. It will continue to be a major part of this sector, and it will continue to be there for people who do require that level of nursing care.

Who is the kind of person that would benefit from and would choose to be in assisted living? Well, let's look at Dorothy. Dorothy is low income. She's over 75 years old. She probably has some degree of disability or a chronic condition. She's starting to use more health care resources. She may, in fact, have had two or three emergency visits in the last year. She probably needs help with her grocery shopping. She no longer is able to cook and do her cleaning and is certainly not able to maintain her home. However, she still wants to be independent. She's still able to be quite independent, and she still wants to be a part of her community. Dorothy would be an ideal candidate for the assisted-living program.

Just what is assisted living? A lot of people ask me that. Well, assisted living in a publicly funded setting includes three things. First of all, it's a private housing unit with a lockable door. That's pretty straightforward. Second, it includes hospitality services and a minimum of two meals a day, of which one must be the main nutritious meal. It includes housekeeping, laundry, social and recreational opportunities, and a 24-hour-response emergency system. Third, it provides personal care services. This means services that assist a person with the activities of daily living such as transferring, perhaps, from bed to a wheelchair; moving around safely; assistance with personal hygiene, bathing, grooming, dressing; perhaps help with eating, managing medications and so on.

What does assisted living look like? Well, on your screen you see a typical assisted-living residence. This is the floor plan from Nikkei Home, which was opened very recently. You'll see it is a small suite with a small kitchenette, living area, bedroom and, of course, a bathroom that's completely outfitted for the use of seniors. Most seniors accommodations do not have bathtubs. They have showers with the proper bars and so on.

I just want to mention here as an aside that you'll sometimes hear me talk about "unit" or "bed," and I use those terms interchangeably. That is because when we're talking about independent living units such as assisted living, somehow unit seems more appropriate than bed. Bed is kind of a medical term that's often used by people when we're measuring those, and I just wanted to clear up that notion.

Over the past year I've had the privilege of participating in the opening of many new projects around the province. For example, on your screen you see Rose Manor. Rose Manor is another very good example of a joint project between the health authority and B.C. Housing, where it was converted into a number of assisted-living suites. Rose Manor

offers a full spectrum of services, by the way, from residential care right through assisted living.

[11:40]

I was also in Terrace this last summer and opened a facility called McConnell Estates. It was another example. It was one that was really quite creative in that it had been built in conjunction with an existing long-term care facility, and they were joined so that they could share kitchen facilities and make it a little bit more efficient. These three projects we've noted here - Nikkei, Rose Manor and McConnell Estates - sort of demonstrate the spectrum of possibilities for health authorities. One of them is a new build. Rose Manor is a conversion, a renovation. Of course, McConnell Estates is one where we saw a bit of innovation in the plan of the building.

The benefits of assisted living, of course, are many. They are a solution for seniors and people with disabilities who need assistance. Certainly, this allows them to feel secure in their environment. It allows them to socialize and to have friends within that environment. It provides them with regular staff who are monitoring their well-being. Certainly, family stress is reduced because they know that their loved ones are secure.

The progress to date. We are making good progress in monitoring the system. Health authorities now have in place a framework to allow them to move forward with their plans. We have ensured that low- and modest-income seniors will have an option to facility care. We are making progress on our commitment to deliver our 5,000 new intermediate and long-term care beds by 2006. I have provided you in your packages with a list of recently completed projects.

I'm also very happy to note that B.C. Housing, in conjunction with both the Vancouver coastal health authority and the Vancouver Island health authority, have issued their first requests for proposal to commence on the 3,500 units I announced earlier this year with my colleague the Minister of Community, Aboriginal and Women's Services.

That completes my update, Mr. Premier.

Hon. G. Campbell: Thanks, Katherine. Any questions? I have one question. Sorry, Sandy. Go ahead.

Hon. S. Santori: With respect to the assisted living, Katherine, and the services that are going to be provided, there are some arguments that are being made with respect to home care. I know we did make some changes with respect to the home support in the types of services that are being provided, which excluded housekeeping and personal

care.

The benefits that we identify through assisted living…. The question that I'm being asked on a regular basis is: would those same benefits not be even cheaper to complement the assisted-living facilities and actual structure through an assessment basis to provide those same services within one's home? If that's accurate, is there a move towards enhancing home support as the demand increases? When we look at the numbers of seniors, whether or not the additional units - I don't know the answer to that question - will be able to accommodate the increasing number of seniors…. Will we have to look towards providing more of the assisted living-type services through an assessment basis within someone's home environment?

Hon. K. Whittred: Thank you, Sandy, for the question. Home care is presently available to seniors in the home environment, and it is delivered on much the same basis as any other service in terms of assessment. Patients are assessed by a case manager in the system, and then they are recommended services in terms of that assessment. I think what you're saying is: shouldn't we be moving toward a different system of delivering home care services? Is that what you're asking?

Hon. S. Santori: Well, under the assisted living, there is assistance with respect to shopping and taking patients to their doctor's visits, etc., which, under our current policy or the policy that was introduced back in 1998 or '99, does not include those services. Do you project a need to be able to expand those types of services in a home environment to allow us to achieve that increase in seniors between now and 2010? The argument being made is that we may not have to build as many structures and that it would be more cost-effective, as the population of seniors increases, to expand the current services to include such things as housekeeping, doctor's visits, shopping, etc.

Hon. K. Whittred: Sandy, we are looking at all sorts of different models, and certainly home care is right at the top of my agenda in terms of looking at different models of delivering the service. However, I should point out that even today, the policy would be that if a client were going to need to go into a facility because there were not services such as housekeeping or shopping available, those services would be provided. So that would be part of the assessment program.

[11:45]

Hon. S. Santori: My question is related to services. Let me try to ask the question in a shorter version. Will we have the capacity in terms of being able to achieve the construction of these facilities at the same pace that the seniors population is growing? What kind of pressure is that going to put on government resources? If things don't

change to the degree we would like them to, can we meet that demand on an increasing number of seniors?

It is a service issue, but I'm looking more at a cost-effective method of providing for seniors as opposed to enhancing current home care programs. How are we going to meet that demand, and do the 5,000 additional units actually respond to the 2010 numbers? That is what I'm getting at.

Hon. K. Whittred: Well, I think it goes a distance to responding, but I do know we have to build capacity in all areas of home and community care, including home care. The challenge right now is to find the model that is going to deliver that service, particularly in rural areas. Delivery of home care in rural areas, as you know, is a very challenging matter with the travel and so on that's involved. We certainly have that at the top of our agenda in terms of looking at what other jurisdictions do, how we can deliver that service, what kind of assessments we do and the whole picture.

Hon. G. Campbell: I think the issue here is…. I mean, yeah, we're going to have an estimated 120,000 additional seniors as our population base. What we've missed in the past is the gap between home and institutional care, or whatever that's called. Obviously, if there are real benefits to providing services in the home as opposed to trying to create the capital plant outside ? if the home is as satisfactory as a capital plant ? then that's something we want to do as we look to build that continuum of care over the longer term. This is a start of filling a pretty substantial gap between what we know we need in terms of facilities. There are all sorts of supports we may be able to provide that are more cost-effective as we move forward.

Part of what we have to recognize is that growth in population. As the baby boom moves through what we used to call retirement age at 65, there are significant pressures that are going to be put on the system. As they move to 75 and then to 80, those pressures are going to increase still further.

I think the fastest-growing demographic cohort we have in the province is 85 and older right now. It's great that we're getting that cohort growing, because it means the system's working, but it also means we have to change the way we think about the system. I think that in 1967, when the Canada Health Act was created and when medicare got started as a national program, 50 percent of all Canadians were under 29 years of age. They don't put nearly the pressures on the health care system as the people who are over 75 years of age, and we know that. That's what we're trying to plan for in the future, I think.

Hon. S. Santori: If I could add one more question on that note - and you brought up the issue of rural. I didn't. Where there is a challenge - and we've spoken about this before -

is the whole issue of capacity and the involvement of the private sector. When you get into some of the smaller communities, the economies of scale in terms of an incentive for a private sector investor to make that investment aren't there to pick up the slack. That's why I think there may be more of a need - and I'm glad the Premier touched on that - to look at providing the services at someone's home. I don't believe that in a lot of areas in rural B.C., you will get that private sector involvement. If someone is going to put in that type of cost or expense, they may do it where the market will dictate more and more possibility for growth - in a bigger centre than it is there.

I'm at comfort that those would be options we would look at down the road to enhance at-the-home service as opposed to always looking at structures. Economically it may not make sense for some investors to do that - or the government, for that matter. It doesn't even have to be the private sector.

Hon. G. Campbell: Greg?

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

Katherine, my question is around the call for proposals in the Vancouver coastal and B.C. Housing. I had some questions around that through the constituency. It went along two different lines. First, did it have to be new housing, or could conversions be eligible for that? If it was an apartment building or perhaps a hotel or something like that, could it also be eligible? Secondly, when you say "the private sector," do you mean non-profit societies? Or can these be for-profit companies that in fact tender on these assisted-housing units as well?

[11:50]

Hon. K. Whittred: Actually, the tender could be either a non-profit or a for-profit company. These initial calls for proposal that have gone out from the Vancouver coastal health authority are the first that will be from this program, and I believe they are for 100 units that will be in South Vancouver, Richmond and Coast-Garibaldi.

From the program, of the 3,500 units that we discussed with B.C. Housing and with Minister Abbott, 1,000 of those are going to be rent supplements to the private sector. This is the quickest way that we can actually get beds on board, because the beds already exist. These can be on stream as early as the spring of 2003. That is the plan - that they will be able to start admitting clients between April and July of 2003.

Hon. G. Halsey-Brandt: When you say "rent supplement," the program would pay a rent subsidy to the provider of the housing or perhaps the client?

Hon. K. Whittred: No, it would be the provider of the housing, and it would be a rent subsidy in keeping with our plan that this program is to be affordable for low- to moderate-income people.

Hon. G. Halsey-Brandt: In order to get a head start, there could be existing buildings there now, and it plugs in that rent subsidy to get people in those beds in the spring. Is that…?

Hon. K. Whittred: Yes.

Hon. G. Halsey-Brandt: As opposed to building a brand-new building.

Hon. K. Whittred: Yes, that's right - as opposed to building a brand-new building. The health authority is going out and making a call for existing providers who have space available to bid on providing these particular beds, and they will provide the rent supplement so that it is affordable for the individuals who are going into the suites.

Hon. G. Campbell: I just have one question. When you see the Nikkei Home, etc., do we set physical standards for assisted-living units? In other words, it's got to be 700 square feet, or it's got to be this - that sort of thing.

Hon. K. Whittred: No, we do not set standards. Those are really more the standard of B.C. Housing. This is a negotiated process, I believe, between B.C. Housing and the health authority.

In fact, as the units unfold over time, I think we're going to see a broad range of facilities. The one that we showed today is simply one example, and I would think that is probably on the bigger side rather than the smaller side. I think many of them will be, in fact, much smaller than that. I don't know. George may want to add to that from the housing perspective.

Hon. G. Campbell: George.

Hon. G. Abbott: I think you've pretty well covered it off actually. The process is one where B.C. Housing and the health authority work with the non-profit. In the case of Nikkei…. Nikkei is an excellent example. They have a range of sort of seniors housing, supportive living and now the assisted-living piece.

B.C. Housing and the health authority work through with the non-profit on what it is they need and what's going to work for the residents that are moving in there.

Hon. G. Campbell: Correct me if I'm wrong, but I think part of the standard is set by the federal government in negotiations on the units that they're supporting too - isn't it?

Hon. G. Abbott: The federal government is not terribly prescriptive around that point. The federal government is primarily concerned that we are adding housing options for people and that they are in fact independent units, which works very well for us because what we're aiming for is for people to have the opportunity to live independently but with support, so that they don't have to access that long-term or complex care.

Hon. G. Campbell: The reason I ask this is because I think there's a partner in developing seniors independent-living units, intermediate and long-term care units, and that's local governments. Seniors live in communities. Communities, if you want to create the cohesion and the stability for seniors, should actually have places that they can live in the neighbourhoods where they have spent their lives - right?

[11:55]

I know - and again, this is just personal - that my mother had to move from a single family home out of the neighbourhood to find accommodation that would meet her needs as she got older. One of the challenges I think we face in looking at this is not…. I'm not as concerned about accessing the investment dollars to build these. I think it's accessing timely, properly zoned, properly designed buildings to be approved. It can take months to get that done.

I think one of the things we have to do is try and short-circuit that by pointing out the social benefits, the social cohesion and stability benefits we get by providing these facilities where people live. Where people live is not just in Trail or in Clinton or in Prince George or in Burnaby. It's where they live in the neighbourhoods that they've raised their families, where they know what the local shopping is like, where they know where their local physician is and stuff. If we take them and push them far away from those services that they get, I think it makes it much more difficult for them to have the sense of independence that's so critical to the quality of their lives.

George?

Hon. G. Abbott: If I could just add to that, Premier, one of the pleasures I had in the last week was the official opening of 35 units of assisted living in the city of Vernon. It was really a classic in terms of the kinds of partnerships that we're trying to forge here. Not only did the government of British Columbia and the government of Canada, through the Canada-B.C. affordable housing agreement, come in as partners, but the Knights of

Columbus were the non-profit through their Okanagan Commemorative Pioneer Cultural Society. As well, the Real Estate Foundation brought about $300,000, as I recall, to the table to make the partnership possible, and as you pointed out, it was also a great example of how the local government can step up to the plate. The city of Vernon waived the development cost charges for that as well as assisted in the provision of services, the planning for the services. The regional district was also a partner.

So when several partners come together, as they did in that project, it becomes a huge win-win not only for all the partners involved but of course for the 35 or more people who are going to be enjoying that new housing and health opportunity in the city of Vernon and the North Okanagan.

Hon. G. Campbell: Great.

Shirley?

Hon. S. Bond: Thank you, Premier. Just further to your point.... I'll also be checking with George about what that municipality did in terms of waiving costs, etc., because on Friday in Prince George we're actually bringing together a group of people who are very interested in looking at integrated housing for seniors, including perhaps this component in terms of looking at a continuum of care and opportunity.

The exciting part for me is that the initiative for this is actually coming from a seniors organization itself, which has a facility at this point in time and wants to expand that. They want to look at the possibility of an integrated-type complex with a variety of levels of housing. We're bringing together, I think, a representative from BCBC, the municipality, the Rotary club and seniors themselves for the very kinds of thinking that Katherine has outlined today.

Their vision is an exciting one, and it's coming from a group of seniors who simply want some of the barriers removed and want a chance to be able to develop their own thinking around the kind of housing that they want right in the core of and in the heart of a community.

I think we've given them an opportunity to look at those kinds of possibilities. I think it's just the beginning of great opportunities for seniors, municipalities and government to work together on those projects. I'm hopeful that our municipality will consider being as generous as obviously some of the others in the province are. Too bad the mayor left, because he could have heard that before he exited.

Hon. G. Campbell: That's why he left.

Hon. S. Bond: That's right.

Hon. G. Campbell: Thanks, Shirley.

Thank you very much, Katherine.

Sindi on Pharmacare.

For Information: Pharmacare

Hon. S. Hawkins: Thank you, Premier.

Another part of our vision document actually discusses Pharmacare and certainly deals with the rising costs of drugs. As we saw in Katherine's presentation, with the growing number of seniors and our aging population, I think drugs will play an even larger role in health care than they do now. We know drugs are important. Drugs manage disease, they improve health, and they even prolong life. So it is an important part of health care.

At this point, if I can, Premier, I'd like to turn it over to Colin to talk about Pharmacare - the cost, the pressures we're facing there - and then I'll come back and talk about the reference drug-pricing program.

Hon. G. Campbell: Okay.

Colin?

[12:00]

Hon. C. Hansen: Thank you.

First of all, as Sindi was noting, there's a great section in this document on Pharmacare. I know that if people are watching this at home and if they have access to a computer, they're going to be able to download this entire document, including the section on Pharmacare. I think towards the end of this, they're going to put it up on the screen. So if people want to grab a pen and paper, they can jot down that website address, as well, as to where they can get access to it.

Hon. G. Campbell: Didn't I see you on public television once?

Hon. C. Hansen: But it is a great document. We're all quite proud of it, so we want to make sure that people get their hands on it.

Pharmacare is obviously such an important and integral part of health care delivery in British Columbia, but it's important, I think, to understand that Pharmacare is not part of the Canada Health Act. It's something where each province is really on its own when it comes to both structuring and funding, because there is not, at this stage, funding that comes from the federal government for Pharmacare programs across the country.

I want to reiterate where we're at with some of these Pharmacare changes. I haven't got anything new that I want to bring to the table today, but I know this will create a context for what Sindi is going to deal with in a few minutes. First of all, it's important to point out that our Pharmacare program in British Columbia covers 100 percent of British Columbians, and there are very few provinces that have that feature. Every province is structured differently, as I mentioned.

Pharmacare really is very much about seniors. Even though seniors today make up about 13 percent of our population, they make up about 50 percent of British Columbians who tap into Pharmacare benefits. Even though we're all eligible for it, we have to hit certain deductibles before we actually tap into those benefits. I think it's important that we look at it in that context, because changes, I think, have to be very sensitive to the needs of seniors around the province.

If you go back to the late 1960s when medicare was first brought in, we had a total of about 639 approved drugs that were available to be prescribed in Canada. By contrast, we have over 21,000 drugs today. There has been just a huge increase in the number of drugs that are available. Quite frankly, they do remarkable things in terms of allowing us to treat illnesses, to keep people out of hospitals and to manage chronic diseases, so it really has been a revolution over these last number of years.

But I think the one thing that is so vital to us is that we need to ensure that the Pharmacare system is sustainable into the future. We have to make sure that those seniors who rely on the Pharmacare program will be able to continue to rely on it in the years to come. Look at how Pharmacare pressures have grown. I've actually shown this slide before in other contexts, but I'll just reiterate what it says.

Let's start at the bottom, where we look at a growth in the B.C. population of 18 percent. The number of beneficiaries - that's the number of people actually tapping into those Pharmacare benefits - is up by 40 percent. The number of prescriptions that have been issued is up 51 percent from a decade ago, and the cost per prescription is up 63 percent. You have to compound all those aspects to come up with the total cost

pressures and expenditure growth that we've seen in the Pharmacare system - 147 percent over the ten-year period.

B.C. has by far the most generous Pharmacare system in all of Canada. We currently pay, out of the taxpayers' pocket in British Columbia, 53 percent of all of the prescriptions that are issued in the province. By comparison, the Canadian average is about 43 percent. You can look at our neighbouring province of Alberta, which is 39 percent, or the largest province in Canada, Ontario, which is at 39 percent. British Columbia has by far the most generous program in the whole country.

As we look at trying to make sure the Pharmacare system evolves in a way that is fair and allows us to sustain those benefits, we have indicated we want to bring in an income-based Pharmacare system that means British Columbians will be able to access the medications they need based on their ability to pay. That is one of the principles we're pursuing - the principle of fairness - so that everybody, regardless of age, gets access to the medications they need. It's not based strictly on the age they happen to be.

We also, I think, have to be very careful in how we transition from where we are now to where we need to get to in the new system. Clearly, there are a lot of seniors living on fixed incomes who have designed their cash flow and their household expenditures around what they currently expect to be in place today. That's our big challenge right now. The reason why we're taking our time to do the income-based Pharmacare system right is that we want to be sensitive to the needs of lower- and middle-income seniors as we transition from where we are now to where we need to get to in the future.

[12:05]

Many of you may be aware that the Romanow report last week flagged some additional dollars that were being recommended around a national program for prescriptions, specifically around catastrophic drug costs. What Romanow is proposing is that there be funding available, that the feds should pick up 50 percent of the cost of drug expenditures over $1,500 per person. That sounds great until you start reading the fine print in terms of how he plans to get there. He says that it should be conditional on expanding the existing drug programs in provinces, and he talks about three ways that those federal dollars could flow to support a Pharmacare program. That's by lowering existing deductibles, by broadening eligibility and by expanding the drug formularies.

I think one of the problems we've got is that we already have the most generous program in all of Canada, so to ratchet up from where we are now doesn't help us to sustain that Pharmacare program in the future in a way that's sustainable. There's a quote, actually, out of Romanow, which I'll just read quickly, that I think sort of underscores the problem

that Romanow is bringing us. He says that this proposal that he has "provides a clear incentive for provinces and territories to expand their coverage" and to reduce disparities across the country. What he means by disparities is that you've got provinces that have virtually no Pharmacare program at all for most of their citizens. British Columbia, on the other hand, has a very generous and very rich Pharmacare program. I think there's a real contradiction in where Romanow is coming from. On one hand, he wants to simply ratchet up what every province is doing, but he also wants to address this disparity from province to province. Quite frankly, you can't have it both ways. I think, clearly, we want to work with the federal government to make sure that as they implement that, they do it in a way that helps British Columbians meet their needs and their expectations in the future.

There are three big issues that I think we have to deal with. One is prevention. We have to make sure that we keep more people healthy so that their reliance on pharmaceutical drugs can be kept to a minimum in the years to come. We need a fair and equitable system for our Pharmacare program, which we're moving towards. We also have to address utilization to make sure that we do away with overprescribing or unnecessary prescribing. I think, finally, we have to make sure that we get the best therapeutic value out of every single medication that's on our Pharmacare system.

With that, I think I'll segue back to Sindi, who's going to talk a bit more about the reference drug program.

Hon. G. Campbell: Sindi.

Hon. S. Hawkins: Thanks, Colin, and thank you, Premier.

As you know, for the last seven years we've had a reference drug program in our Pharmacare program, and, frankly, it's contributed to controlling the costs of drugs in that program. Let me try and explain what the reference drug pricing program is, because I know there is always confusion on what we're talking about.

The reference drug program does this. It takes drugs which are chemically different but have the same mechanism of action - so they're chemically different, but they act the same - and we group them in a category. They are known to be equally safe and effective. What Pharmacare does, then, is look at the least expensive drug in that category of drugs. That least expensive drug is then called the reference drug. That is the drug that Pharmacare will pay for in that program - okay? - so then that drug is known as the reference drug.

If the reference drug…. Okay, back a second. If the patient wants the drug that was ordered, Pharmacare will pay up to the reference drug, so the patient can pay the

difference and get the drug they want. But within that category of drugs, we'll pay the price of the reference drug, or we'll pay for the reference drug. Then if the reference drug doesn't work - because that does happen - if the patient doesn't tolerate it or if it doesn't work for the patient, Pharmacare will pay for the drug that was ordered. That's what the reference drug program is about. We'll pay for the drug that was ordered, on special authority by the doctor. The doctor just has to quickly fill out a form, and we'll do that.

The reference drug program is based on a principle of therapeutic substitution. Frankly, it's been studied. It's been studied by Harvard, by the University of Washington and by McMaster University, and it has been found to be safe and cost-effective.

[12:10]

Well, we made a commitment. When we got elected, one of our new-era commitments was to "work with doctors, pharmacists and others to find a cost-effective alternative to reference-based pricing." There were a lot of concerns we heard in prior years about this program, and we committed to having a look to see if we could find a cost-effective alternative.

I appointed a panel last November to address this new-era commitment. The panel reported back in April, and I will be releasing the report today. The panel was headed by George Morfitt. You'll all know him as the former auditor general of British Columbia. They were mandated to review the efficiency and impact of the reference drug pricing program, to meet with stakeholders, and to evaluate and recommend any alternative cost-effective options if they found them.

We had committed to working with doctors, pharmacists and others. The panel was composed of Mr. Morfitt, a doctor, a pharmacist, a social worker who worked with seniors, and a businessman with very strong financial and health care volunteer work. It was quite a good group. The panel made ten recommendations, and frankly, they found no cost-effective alternatives to the reference drug program. They also found that the principle of therapeutic substitution of the reference drug and for others in the same category was safe and cost-effective. That was one of their findings. They recommended that the current program should continue while we look for other cost-effective alternatives or options.

The panel further recommended that we should do a further, broader review of the reference drug pricing program within a broader review of the whole Pharmacare program to find alternatives. They met with a lot of stakeholders. They met with a lot of disease-based groups. They met with individuals. They met with pharmacists. They met with physicians. I think there were 46 submissions to their panel. They recommended that

we work with stakeholders, that stakeholders should be included in the process of this broader review, and that we continue to collaborate with other provinces and territories and the federal government to look at programs like one that we are doing - the common drug review. We're doing that on a national level - all the provinces.

They also said we should explore opportunities for increased research and development investment. I think we're very clear we do believe that we can have a province where pharmaceutical research and development can thrive alongside a program that offers patients the right drug in the most cost-effective way. We want to continue working with pharmacists, doctors and our pharmaceutical companies. We want to foster a climate where our stakeholders - including pharmaceutical companies - compete, invest and work in partnership with the provincial government.

The pharmacy, big pharma…. We know they invest a lot in research. They find cures. They find drugs that mitigate illness and help people. They also create jobs. Those jobs employ British Columbians, and their tax dollars support our health care system. So we want to have meaningful consultations. We want to work with the pharmaceutical industry to help us find more cost-effective alternatives. They know we're challenged with rising drug costs, and they know we need to find ways to control our costs.

We do accept the principle of therapeutic substitution, and we're willing to work with doctors, pharmacists and those in the pharmaceutical industry to explore other options and solutions in controlling our drug costs. You know, we are going to engage in a broader operational review of Pharmacare and have more meaningful consultation with stakeholders and our partners. If no cost-effective alternatives can be found which achieve the same or better savings as the reference drug pricing program, we will keep this program.

As I said, we looked at the recommendations. We have decided a broader operational review of Pharmacare is the way to go, and I'm going to release the panel's findings today with the hope that we can build on those recommendations and create a drug program that puts patients first.

Premier, I know that Rich and Shirley have further comments on this issue. They've been working very hard on the life sciences file, and I know they want to comment.

Hon. G. Campbell: Rick?

[12:15]

Hon. R. Thorpe: Thanks, Premier.

Yes, I have been working together with Minister Bond on strengthening our Canadian partnership in Innovation British Columbia. On November 18, I released to Minister Rock and Minister Stewart from the federal government our strategy on where we're going and how we're going to strengthen our Canadian partnership and how we're going to focus on a life sciences centre of excellence that's connected, making our knowledge investment work here in British Columbia.

As part of our life sciences priority, British Columbia is aiming to establish a centre of excellence in life sciences, research based at the University of British Columbia, with major regional nodes located at the University of Northern British Columbia, the University of Victoria and Simon Fraser University, as well as smaller nodes at other institutions and locations throughout the province. The life sciences centre of excellence and regional nodes will provide a focal point for cutting-edge, interdisciplinary life sciences research. In practice, our life sciences initiative will deliver health care and industry technologies with a global application.

One of Canada's innovation goals is to, by the year 2010, develop ten internationally recognized technology clusters. British Columbia is already moving in the direction of establishing ourselves as a global leader in life sciences. In British Columbia today we have the fastest-growing biotech sector in Canada, and our provincial investments are aimed at accelerating research in broader life sciences.

Mr. Premier, I believe we have an opportunity, together with my colleague Minister Bond, to have a renewed, revitalized partnership of dialogue with our biotech sector here in British Columbia, with our universities and our colleges, and with our researchers and pharma companies as we move forward with our knowledge-based economy.

I believe very strongly that British Columbians will win because we'll have affordable, sustainable, world-leading health care and medications. I believe an industry grows in British Columbia because we have a province which welcomes and encourages research and commercialization. Of course, our students, our youth and our best and brightest win because we're going to put those extra resources into our universities, colleges and research.

Premier, I guess what I'd like to say is that it's really time for a renewed, revitalized partnership of dialogue with all of the interested stakeholders, for the benefit of all British Columbians. I'm committed to working with you, Minister Bond and our government in Innovation British Columbia to ensure that we have a world-class connected life sciences cluster here in British Columbia.

Hon. G. Campbell: Thanks, Rick.

Shirley?

Hon. S. Bond: Thank you, Premier.

Certainly, we believe that our government and this province have in the last 18 months laid the groundwork for some outstanding progress and work that will continue in the life sciences field in Canada - our initiative with the universities, our life sciences, the base we've created in terms of the centre that will be created at the University of British Columbia and the two medical programs at the University of Northern British Columbia and UVic.

The model we're using is excellent, and as a matter of fact, it is being looked at around North America because we are looking at a delivery that uses new technology. We'll be using telehealth and telemedicine. We're going to specialize the focus of the training that is done for physicians in those particular off-site…from the University of British Columbia.

We recognize completely that research has an enormous benefit not only for the health and well-being of the citizens of British Columbia and Canada, but it also is a great stimulator of the economy in this province.

We have done a number of things, including creating a leading-edge endowment fund. We're pleased to say that the first chair in that, the B.C. Leadership Chair for Spinal Cord Research, has been awarded to the University of British Columbia for a joint chair with the Rick Hansen Institute for spinal cord research. That will leave a legacy in the world, in fact, as they move closer to looking at how we can create the cures that we believe are possible. We also have the Michael Smith Foundation for Health Research. It is an extraordinary group of researchers that we've managed to retain and recruit in the province because of that program.

We are excited about the foundation we have laid in the province. We believe our partnership we're pursuing with the federal government will only enhance the groundwork that's been done here in British Columbia. We're excited about the future of our initiatives, and we think they will pay dividends to the province in the very short term.

[12:20]

Hon. G. Campbell: Thanks, Shirley.

Let me just say that the issue of how we deal with drug costs within the overall health

care system, both inside and outside of it, is something that is a problem for every province. When the Premiers' Council on Canadian Health Awareness was put together, one of the first areas we focused our attention on was the management of our drug costs, the establishment of formularies. Right now there are at least 11 separate formularies across the country. It makes no sense for us to do 11 times over the research that's necessary to decide whether drugs are effective, whether they're useful, whether they're safe. The federal government does the first cut on research with regard to new drugs to decide they're safe.

One of the challenges, as you know - and we certainly have all felt it as Premiers - is that one province accepts a drug, and then the marketing campaign starts across the country for all provinces to accept the drug. We are working now on a new protocol where we will do this once, where the provinces agree together that they will accept a new drug for the formulary, etc. That's been worked on for the last year now.

You know, there just really are some fundamental flaws in some of the sort of easy solutions that Mr. Romanow is suggesting. He's got a tome on conventional wisdom. If you want to read about conventional wisdom, you can read 400 pages of it called the Romanow report. More money and more bureaucracy are not the answer to the problem.

Failing to understand that there are substantially different Pharmacare regimes across the country is a problem. Trying to impose one-size-fits-all solutions is a problem. Deciding you're going to establish a new commission on accountability…. It was like he didn't even know that we had accountability contracts in British Columbia, which is, as far as I know, the only province to set standards and say: "This is what we expect you to meet."

There's no discussion by Mr. Romanow about the full partnership. The full partnership is not just governments. It's not just the provincial government working with the federal government. It's citizens working with governments to understand what's taking place. It's professionals working with citizens working with governments to understand what's taking place.

I think that Mr. Romanow certainly was a disappointment. Mr. Kirby, I think, talked yesterday a little bit about Mr. Romanow and some of his solutions or lack of direct suggestions or concrete suggestions for solutions. We have to take all these reports now - the Clair report, the Fyke report, the Mazankowski report, the Romanow report, the Kirby report, the legislative report of the province, even the Seaton royal commission report - and put them together and say: how do we make this work for patients across the country?

One of the huge challenges we face is not just efficacy, not just whether drugs are working for people or not. One of the panaceas is, "Let's just do all generics," when one of the things we know is that generics push their costs as close to the other drugs as they possibly can and say that's a generic.

There is also a problem in misuse. Colin mentioned that. I think we should never underestimate the challenge that overuse of drugs creates. All of us in our lives, I'm sure, have examples of people who used the wrong drugs in the wrong combination at the wrong time. One of the benefits of assisted living, actually, is that it may well be that some seniors who need help to make sure they're taking the right drugs at the right time in the right order are given assistance in doing that, and that will maintain a healthier life.

I guess the important thing for us to remember as we deal with Pharmacare and the expansion of drug costs is that we all have to be in this together. Patients have got to be part of it. The professionals have got to be part of it. The provincial and federal governments have got to be consistent in the approach. There's a role for all of us to play in that. That's, I think, the real challenge we have as we move forward.

There's no question that pharmaceuticals do a great benefit. There's no question there have been a number of breakthrough drugs in the last decade that have made people's lives just enormously healthier. There's no question we want to encourage that research to continue on and to build, hopefully, here in the province of British Columbia.

The study, I think, points out that if you limit the degree that you're thinking about in terms of pharmaceuticals, you're going to limit the options that you have to actually solve the problem. There are estimated direct cost savings of up to $12 million and indirect cost savings of up to $50 million. We have to actually get a handle on that and see how that works throughout the province, throughout the communities of the province and as a cost on the province. What are the costs, and what are the benefits? I'm pleased to hear that one of the things you're going to do is move forward with that comprehensive look at how our drug regimes are working in British Columbia to meet the needs of patients in a cost-effective manner.

[12:25]

Hon. S. Hawkins: Thank you, Premier. I think that is important, because one of the things the panel did point out was that people found the Pharmacare program very confusing, and they wanted us to work with the partners and make it more streamlined, make how it works more transparent and clear. We are going to get on with that operational review over the next year.

For Information:

Health Sector Human Resources

Hon. S. Hawkins: The last part I'm going to talk about, but it's just one part in our vision document, is human resources. There's a ton of information in this vision document, *A Picture of Health*. One of the more important areas, I believe, is the area of human resources. If we didn't have people to work in the system, we wouldn't have the high-quality health care that we can deliver across this province.

We have suffered shortages across the province through very many different professions. The shortages have hit not only our province but other parts of the country as well. Every province is grappling with this. I think there are two reasons why we are experiencing health professional shortages today. First of all, in B.C. we haven't trained enough people. In the past the incomes, perhaps, weren't competitive enough.

Before the election, we committed to developing a ten-year health human resources plan. We are making efforts to do that. We've already started recruiting and retaining our health professionals to improve delivery of patient care across the province.

I want to talk first about doctors. Even though we have the most doctors in Canada per 100,000 here in B.C., we still need to train more doctors so that they actually stay here in B.C. We have been a net importer of doctors in this province, and we made a commitment that we were going to train more. We're going to do that.

On top of the training, we are now paying doctors top dollar here in this province. We made and recently signed an agreement for an additional $392 million for fee increases and on-call compensation. Frankly, that makes B.C.'s doctors among the highest paid, if not the highest paid, in Canada. Shirley and Rick have been working on this initiative. Certainly Shirley, with the life sciences initiative, is increasing the number of medical students at UBC from 128 to 224 by 2005. Again, I think we're leading in Canada by training them differently. We've established two satellite medical schools: one at the University of Victoria and one at the University of Northern B.C. in Prince George. There will be 24 students in each of those places. For the first time ever we're going to train doctors in the north, and we're going to increase their training opportunities.

We've added another $30 million to paramedics so we could buy new equipment so they had the tools to work with when they're doing their jobs. We funded 24 new paramedic positions, and we're providing training to bring 1,500 paramedics up to level 1 status. Those are the kinds of measures we're taking to improve health care and improve care in rural communities.

The health sciences seats this year in 2002-03 were increased by 116. In the health sciences area the professionals you're probably familiar with are medical lab techs, sonographers, radiation therapy, respiratory therapy and midwives. We've also added 430 seats for care aides, and we have added - Shirley's been very busy - 1,266 more nursing education seats. That is a huge investment in nursing education. On top of that, we've made B.C. nurses the best paid in the country. Last year we settled a 23 percent wage lift for them. Couple that with our lowest income tax rate, and you do have some of the highest compensated health care professionals in Canada.

If you look at the slide - and I hope it's there for you - you can see that a first-year nurse starting out in B.C. is the highest compensated in Canada. Being a former nurse, I think that's good news. That means we are able to keep our nurses; we're able to attract them. We have made a lot of progress, given only one year to do it, with the $21 million nursing strategy that we announced last year.

[12:30]

I'm happy today to announce our 2002-03 plans for our nursing strategy with plans to support nurse recruitment, education and retention. I have to say, with last year's strategy that was rolled out, we not only met targets, but we exceeded them. We're pretty proud of that. Of the $21 million that was spent last year, we supported over 400 non-practising nurses - nurses who lived in B.C. but weren't in the workforce. We gave them grants to upgrade their skills and knowledge and to re-enter the workforce.

We recruited 40 foreign specialist nurses into those hard-to-fill areas. Where we saw nurses working very hard in the emergency room, in the operating room, in the ICUs, we made sure we went out and got them the help they needed. We gave grants to foreign-trained nurses who live here in B.C. to get their hospital English and also to upgrade their skills and knowledge so we could get them back in the workforce. Three hundred and fifteen nurses who were already in the workforce from across the province were supported to take specialty education to prepare them for critical care roles and specialty services in those areas that I mentioned - again, intensive care, dialysis, operating room, mental health.

Our nursing vacancies, as I mentioned earlier…. I stood to be corrected, and now I've got the information right. We've cut them from 1,000 down to 600. Thanks to the Health Match program, nurses have access to employment across B.C. They go to one agency, and they know what positions are available across the province.

Again this year, Shirley and her ministry have been very busy working with mine. Shirley,

as I mentioned, has added 1,266 new seats to nursing programs. I think that is something we can be very proud of. I think we recognized right off the mark that we had to make an investment. We wanted to make sure our patients got good care. I don't know if you know, but four out of five care providers in the health care system are nurses. They are the backbone of the system, and we have to make sure we are providing that resource so our patients get good care.

This year we are funding a total of $21.5 million towards the 2002-03 nursing strategy. Of that, $10.8 million is coming from the Ministry of Health Planning and the health authorities' commitment, and Advanced Education, through Shirley's ministry, is providing $10.7 million. Dedicated to funding nursing grants is $8.8 million - and that's been annualized into the base of the health authority budgets - $1.1 million will help nurses to return to work, and almost $1 million will go to new and continuing initiatives.

Some of those initiatives are around recruitment of non-practising nurses. We found that was a very valuable well to tap. We figured there were probably around 4,000 nurses in the province that weren't working. We gave them the opportunity to access grants. I believe the course they took was six or nine months, and they got their RN again, and they're back to the workforce. I think we made the benefits and wages attractive enough that we got nurses back. We're going to do that again.

We're going to fund specialty education. We're going to fund gerontology education workshops. As you know, we've got a huge seniors and aging population. We've got to make sure we give them the right kind of resources to look after them. Gerontology means the study of seniors, of aging. We think that's an important resource to get out there.

We're going to give pharmacology education to LPNs, and we've got money put away for first nations nursing strategies. We think that's really important, and we wanted to start addressing that. Certainly, under the Ministry of Advanced Education's funding, that is going for education and training spaces.

We are very committed to not only recruiting and retraining nurses in B.C., but we're also offering programs to improve the quality of their professional lives. Again, we're going to be tracking how we do over the course of the year, and I'll be reporting back next year on the success of these initiatives.

At this time, Premier, I want to say thank you very much for giving me the opportunity to present to cabinet - and not only to cabinet but to the population, to our citizens out there - our vision, our plan of what we want the health care system to look like. We want it to be high quality. We want it to meet the needs of our citizens. We recognize that there are a

lot of challenges ahead of us, but we also recognize that there are solutions, and we're going to continue to find those solutions. I think we can, with the help and patience of all British Columbians, make our public health care system sustainable. I encourage everyone to get on the website or to call, and we would be happy to make sure this document is available to you.

Hon. G. Campbell: Thanks, Sindi.

Sandy?

[12:35]

Hon. S. Santori: A question, Sindi. It is encouraging to see the human resource strategy rolling out. My question, though: with respect to the accountability contracts that we have with all of the health authorities, is it incumbent upon them to develop their own human resource strategy within their own health region to ensure that we do not get gaps throughout the province in terms of being able to facilitate the human resource requirements in a particular region in the province? We may reach the global number corporately as government, but how do we ensure that the health authorities in fact have human resource strategies for their particular regions and centres?

Hon. S. Hawkins: We're working very closely with the health authorities. My ministry planners have actually identified human resource planners in each health authority, and we're working on their plans to mesh with ours. They will identify and inform us what the needs are in the region. We also look at it across the province, because obviously there are very special areas where we need to train professionals.

Each health authority might not have those services. We're looking broader than each health authority. We're also looking at the provincial-level services as well. But we are working in a very coordinated, close relationship with the health authorities to meet those needs across the province and in every region.

Hon. G. Campbell: Thanks, Sindi.

I want to thank everyone for taking the time today, and I hope people have found it informative. For me, I guess the most telling issue we face is not just that we spend more than 40 cents out of every provincial dollar, but that health care is changing dramatically in our world. It's changing dramatically in our world across the country, not just in British Columbia. Everyone faces this.

The effort that's been put forward by Sindi and her ministry to put together this report is

actually to provide British Columbians with that information, so I do hope that British Columbians will go to the website, go to the constituency office, go to the agent, go somewhere where they can get this information.

Let's put it back in context. In 1967, when medicare was "invented," there were zero heart bypass surgeries that were done. Today there are 2,509. There were zero cataract removals - over 31,000 today. There were zero hip replacements - over 2,800 today. There were zero kidney transplants - 166 today.

Today as we sit in the province and work to try to provide patients with care they need in a way that's not just cost-effective but that's truly supportive, we look at the drug expenditures in B.C. that are increasing at roughly $300,000 a day.

I think one of the many things we've done right is that we have focused first on human resources, and we should never underestimate the challenge that we face in dealing with human resources - nurses, doctors, physiotherapists, pharmacists, occupational therapists, etc. The human resource costs are about 80 percent of the acute care costs in British Columbia. When we added $1.1 billion to the budget, over $685 million went to pay for salaries for people. As Sindi's just pointed out, we now have some of the best-paid physicians and the best-paid nurses in the country. In fact, 10 cents out of every dollar we pay go to physicians. Every dollar we collect for taxes goes to physicians in British Columbia.

I think we now have a base that we can move forward from. But I think one of the overwhelming messages that I have received certainly in the last 12 months - maybe even longer than that; maybe 15 - is that people want to be part of the solution. They don't want to be seen as a burden on the system. They want to be responsible. They want to use the system properly. We have to find ways to make information available to them, and this may be one way that we can do that.

I know this is an extraordinary way of doing it, in terms of the cabinet. But people should understand that in every single cabinet meeting we have in British Columbia, we have an item called health care. We have an item where we're updated, where we're dealing with a report, where we're trying to move forward to create a better quality of care for patients in the province. As I say, it's very important that citizens be included in that.

Some days - most days, lots of days - we hear health care stories through our news media. It's important to recognize that our news media are actually doing a pretty good job of identifying the problems that we're confronted with in British Columbia. Also, I would hope that they would be interested in looking at the solutions that we may be approaching. In fact, I would be glad if anybody in the news media decided that if they

wanted to ask regular questions, as hard-hitting as they would like, they would just give us a day to get the facts together and respond. We're glad to do that with any outlet that's interested in doing that. We're glad to do it with citizens.

[12:40]

I know that we all get questions from citizens with regard to health care. I think this is an asset that we've built up. While we look at the challenges we face, it is very important that we don't lose track of the fact that we have a great health care system here. We've got great people that are at work in the health care system here. We have pressures that are mounting and building, which we have to deal with, and I think our challenge is to confront those pressures now and not put them off again so they're visited on another generation of British Columbians.

We can protect health care. We can provide for health care. We can improve health care, if we do this together. That's why I think this planning document is so critical and so important. I guess, for me, one of the things that brings home how fortunate we are to live in a province where we do have health care that works for people is the incident we all read about and worried about over the weekend when Mike Harcourt fell from his deck and - I guess you call it in layman's terms - broke his back.

Just think of that. We have a health care system where someone who falls 20 feet and breaks his back can be retrieved by paramedics, protected by paramedics, be helicoptered into a specialist area and get a six- or seven-hour operation. The prognosis is hopeful for Mike and for his family. While all of our prayers go out to Mike and his family - and we know all British Columbians' do - I also know we have a great health care system that's going to help him get to a full and complete recovery.

That's what we're trying to protect here. What we're trying to make sure is that's available for people throughout our province throughout the years ahead of us. If we don't deal with some of these difficult issues today, I think we jeopardize some of those methods of care and those services in the long term for the future. I think it's always necessary to have a plan. If you don't know where you want to go, it's hard to figure out whether you've got there or not.

We're going to have a plan for human resources. We're going to have a plan for capital plant. We're going to have a plan for providing for intermediate and long-term care housing. We're going to have a plan for technology. We're going to have a plan that connects British Columbians. We're going to have a plan that connects caregivers and patients, because that's how we end up with a long-term health care system that works for the people who live in this province, regardless of where they live.

We've just taken the first steps forward in British Columbia, and I think we've got many steps to follow, but I'm confident that working together, we'll get there. We'll be leading the way in provision of top-quality health care to the patients and the people that live here. So, Sindi, Colin, Katherine, Gulzar, thank you for your work. Thank you for your contribution.

This meeting is adjourned.

The cabinet adjourned at 12:43 p.m.