Health Systems Update
Bilan de l’évolution des systèmes de santé
2005-2006
Volume I

13th Edition | 13e Édition

The Change Foundation
Creative Change for Better Health

Canadian College of Health Service Executives
Collège canadien des directeurs de services de santé
About The Change Foundation

Recognized as one of Ontario’s resources for driving positive change in health care, The Change Foundation has enjoyed rapid and progressive growth since its beginning in 1997. It was the visionary thinking of the Ontario Hospital Association (OHA) that enabled the development of the Foundation. The OHA endowed the Foundation with part of the proceeds from the sale of Blue Cross in 1997 and gave it a broad mandate to ‘promote, support and improve health and the delivery of health care’.

Today the Foundation is a federally incorporated, not-for-profit corporation with a charitable registration. Located in Toronto, Ontario we continue to promote research and innovative change to improve health and health care by working with health care providers, managers and other health leaders across the continuum.

Bringing together health care providers, managers, researchers and policy makers provincially, nationally and internationally, The Foundation has assumed a unique vantage point from which to study, understand and directly impact on the evolution of the Canadian health and health care systems. Laying the groundwork for all Foundation activities is our commitment to knowledge creation and exchange. Together with our stakeholders, the Foundation is researching, creating, innovating and networking at the forefront of trends and change in health and health care delivery.

To find out more about the Foundation, visit TCF web site http://www.changefoundation.com

About the Canadian College of Health Service Executives

The Canadian College of Health Service Executives (CCHSE) was founded in 1970 on a strong belief that creating a national association of health service executives would provide the opportunity for professional support and contribute to the advancement of health services leadership and management. Today, the College represents over 3,000 members and serves a broad range of health service executives throughout the country.

The College offers a forum for the exchange of ideas and information, a career network, and professional development opportunities. The professional designations of Certified Health Executive (CHE) and Fellow (FCCHSE), as well as highly regarded educational programs have established the College as a leader in continuing management education for health service executives.

The College strongly believes that excellence in health services leadership and management can be achieved by developing relationships with other professional organizations. Partnerships and collaborative ventures are pursued with associations, universities, health services providers, government and corporations who have a common interest in advancing leadership and research in health services management.

To find out more about the Canadian College of Health Service Executives, visit the CCHSE web site http://www.cchse.org.
The Change Foundation

Depuis sa création en 1997, The Change Foundation (la fondation) n’a cessé de progresser et est rapidement devenue un des moteurs du changement pour le mieux dans le secteur de la santé en Ontario. C’est l’esprit visionnaire de l’Association des hôpitaux de l’Ontario (AHO) qui est à l’origine du développement de la fondation. L’AHO a en effet disposé par donation d’une partie des recettes de la vente de la Croix Bleue en 1997 et a confié à la fondation le mandat de promouvoir, de soutenir et d’améliorer la santé et la prestation des soins de santé.

La fondation est aujourd’hui un organisme sans but lucratif constitué sous le régime de la loi fédérale et jouissant du statut d’organisme de bienfaisance enregistré. Établie à Toronto (Ontario). Elle continue de promouvoir la recherche et l’innovation de concert avec les fournisseurs et les dirigeants du continuum des soins de santé.

La fondation constitue un observatoire de choix en réunissant des fournisseurs, des gestionnaires, des chercheurs et des décideurs à l’échelle provinciale, nationale et internationale, pour mieux étudier, comprendre et influer directement sur l’évolution de l’état de santé des Canadiens et de notre système de soins de santé. L’engagement de la fondation à l’égard de l’acquisition et du partage des connaissances est la pierre angulaire de toutes ses activités. En collaboration avec les intéressés, la fondation s’emploie à faire de la recherche, à créer, à innover et à former des réseaux à l’avant-garde des tendances et des changements dans le domaine de la santé et des services de santé.

Pour de plus amples renseignements au sujet de la fondation, veuillez consulter le site http://www.changefoundation.com

le Collège canadien des directeurs de services de santé

Le Collège canadien des directeurs de services de santé (CCDSS) a vu le jour en 1970, fort de la conviction qu’une association nationale du personnel cadre de la santé permettrait d’assurer un soutien professionnel et de contribuer au progrès de la gestion des services de santé. Le Collège compte aujourd’hui plus de 3 000 membres et offre toute une gamme de services aux dirigeants de services de santé dans tout le pays.

Le Collège constitue en outre une excellente tribune pour l’échange d’idées et de renseignements, le cheminement de carrière et le perfectionnement professionnel. Les désignations professionnelles très prisées de CHE (Certified Health Executive) et de fellow, FCCDSS, ainsi que les programmes éducatifs du Collège ont fait de ce dernier une figure de proue dans l’éducation permanente des dirigeants de services de santé.

Le Collège est convaincu que l’excellence dans la gestion des services de santé passe par des partenariats avec d’autres organisations professionnelles et, à cette fin, poursuit des initiatives de collaboration et des partenariat avec les associations, les universités, les fournisseurs de services de santé, les autorités gouvernementales et les sociétés qui partagent un intérêt commun pour l’avancement du leadership et de la recherche dans la gestion des services de santé.

Pour de plus amples renseignements au sujet du Collège canadien des directeurs de services de santé, veuillez consulter le site http://www.che.org
Acknowledgement

The College and The Change Foundation wish to thank the dedicated staff of the National, Provincial and Territorial Ministries of Health, Health and Social Services and Health and Community Services, as well as the Canadian Institute for Health Information (CIHI), and the Canadian Institutes of Health Research (CIHR).

In addition, we want to acknowledge and express our appreciation to Sivan Bomze for the preparation and coordination of this year's edition of HSU.

The Change Foundation and The College hope that this document will inform and enlighten you as to the changes that have taken place over the past year in the field of health care across Canada and beyond.

Remerciements

Le Collège et The Change Foundation expriment leurs sincères remerciements au personnel dévoué du ministère fédéral et des ministères provinciaux et territoriaux de la Santé, des Services sociaux et des Services communautaires, ainsi qu’à l’Institut canadien d’information sur la santé (ICIS) et aux Instituts de recherche en santé du Canada (IRSC).

Nous tenons en outre à exprimer notre appréciation du travail de Sivan Bomze dans la préparation et la coordination de la présente édition du Bilan.

The Change Foundation et le Collège espèrent que le Bilan constituera une source précieuse d’information sur les changements survenus au cours de la dernière année dans le secteur de la santé au Canada et ailleurs
TABLE OF CONTENTS

INTRODUCTION ...................................................................................................................................................1

PART A THE HEALTHCARE STORY IN CANADA 2005-06: A HIGHLIGHT ..................................................4

PARTIE A ABRÉGÉ CHRONOLOGIQUE DU SECTEUR DE LA SANTÉ AU CANADA EN 2005-2006 ..................10

PART B POLITICAL, ECONOMIC, SOCIAL AND HEALTH STATUS/RISK, TECHNOLOGICAL
CHANGE IN HEALTHCARE: AN ENVIRONMENT SCAN ..............................................................................17

  1.0 POLITICAL .................................................................................................................................................17
    1.1 Federal Cabinet .........................................................................................................................................17
    1.2 Federal legislation .................................................................................................................................17
    1.3 Judicial Rulings ......................................................................................................................................17

  2.0 ECONOMIC ...............................................................................................................................................17
    2.1 General Economic Indicators for 2005 – 2006 ......................................................................................17
    2.2 Health Economics ..................................................................................................................................18

  3.0 SOCIAL ......................................................................................................................................................22
    3.1 Ageing Population ...............................................................................................................................22
    3.2 Urbanizing Population .......................................................................................................................23
    3.3 Ethnicity of Population .......................................................................................................................23
    3.4 Patient Expectations ...........................................................................................................................23

PART C KEY TOPICS IN MORE DETAIL ......................................................................................................25

  SECTION 1 REGIONALIZATION .....................................................................................................................27
  SECTION 2 HUMAN RESOURCES: HEALTH LEADERS AND MANAGERS ..............................................32
    Physician ....................................................................................................................................................32
    Non-Physician ..........................................................................................................................................32
  SECTION 3 HEALTH INFORMATION AND HEALTH TECHNOLOGY ......................................................56
  SECTION 4 PRIMARY HEALTH CARE .........................................................................................................63
  SECTION 5 PUBLIC HEALTH (POPULATION AND COMMUNITY HEALTH) .............................................68
  SECTION 6 MENTAL HEALTH ....................................................................................................................79
  SECTION 7 HOMECARE AND LONG TERM CARE ....................................................................................83
  SECTION 8 PHARMACARE ...........................................................................................................................88
  SECTION 9 WAIT TIMES ...............................................................................................................................96

PART D: FEDERAL, PROVINCIAL AND TERRITORIAL UPDATES 2005-2006 ........................................100

INTRODUCTION ..............................................................................................................................................100

UPDATE BY JURISDICTION ..............................................................................................................................101
  Northwest Territories ..................................................................................................................................101
  Yukon Territory ...........................................................................................................................................109
  British Columbia .......................................................................................................................................117
  Alberta .........................................................................................................................................................137
  Saskatchewan .............................................................................................................................................156
  Manitoba ....................................................................................................................................................179
  Ontario .......................................................................................................................................................197
  Quebec .........................................................................................................................................................250
  New Brunswick .........................................................................................................................................277
  Nova Scotia ..................................................................................................................................................286
  PEI ..............................................................................................................................................................306
  Newfoundland and Labrador ....................................................................................................................324
INTRODUCTION

The Canadian College of Health Services Executives is pleased to present this year’s Health System Update (HSU) in partnership with The Change Foundation. The Health Systems Update provides an annual update on health reform in Canada. It identifies the issues and environmental factors affecting health delivery and allows leaders to keep track of changes at political, fiscal and management levels in every area of the country.

The 2005 product includes some new enhancements as well as in-depth analysis of the various policy and practice trends in health care across Canada. Included are submissions from each of the provincial and territorial Ministers of Health outlining changes in the health care system of the respective jurisdictions.

The HSU strives to provide the most accurate, comprehensive and up-to-date information available about health system developments across Canada. You will notice some new features in the report this year, including a revamping of the section Key Issues in More Detail which highlights trends across provinces and territories, during 2005-2006. The new format has been introduced this year to make it easier to either select key information or alternatively, to find more detailed information on a particular theme or jurisdiction. As such, you will find that the same information is, at times, displayed in more than one way.

As always, the Canadian health care systems continued to evolve over this last year. The most important issue that emerged at the top of the agenda was the need for timely access to quality care, and better management and reduction of wait times. To address this growing concern, focus was placed federally-provincially and territorially on the training, recruitment and retention of health care professionals; health information and technology advancements; primary health care objectives; preventative measures and homecare initiatives. Needless to say, given these many developments, health care has stayed at the forefront of the Canadian public policy agenda.

From this year’s submissions, it is clear that the federal, provincial and territorial governments are pursuing common goals that will improve health care, particularly in the areas outlined at the First Minister’s Meeting of 2003. The main initiatives include accountability, continuing regionalization, implementation of health information systems and new health technologies, a focus on patient safety and public health, primary health care renewal, and the recruitment, training and retention of health care professionals. These are all issues that are considered high priority, not only in improving quality of care, but also in containing costs of health care.

Over the last 12 years, the College has received many positive comments about the value and utility of a document that synthesizes new health-related initiatives in all of Canada’s jurisdictions. The Change Foundation and the Canadian College of Health Service Executives hope that you will find this year’s HSU an even more effective tool in your health care planning and decision-making.

Dr. John Hylton, CHE  
President & CEO  
Canadian College of Health Service Executives

President & CEO  
The Change Foundation
INTRODUCTION

Le Collège canadien des directeurs de services de santé, en partenariat avec The Change Foundation, est heureux de vous présenter l’édition 2005 du Bilan de l’évolution des systèmes de santé. Chaque année, le Bilan donne un aperçu de la situation de la réforme de la santé au Canada, et passe en revue les enjeux et les facteurs qui influent sur l’environnement de la prestation des services de santé. Les dirigeants de ces services peuvent ainsi prendre connaissance des changements survenus aux niveaux politique, financier et gestionnel dans toutes les régions du pays.

Le contenu de la présente édition comprend de nouvelles améliorations et s’est enrichi d’une analyse exhaustive des tendances qui se dessinent dans la théorie et la pratique, ainsi que des exposés sur les changements apportés à leurs systèmes respectifs que nous ont fait parvenir les ministères provinciaux et territoriaux de la Santé.

Le Bilan s’emploie à communiquer aux lecteurs l’information la plus précise, complète et récente sur les nouveaux développements dans le domaine de la santé au Canada. Cette année, nous y avons ajouté d’autres caractéristiques, en particulier dans la section ‘Key Issues in More Detail’ qui fait ressortir les tendances constatées dans les provinces et les territoires en 2005-2006. Cette nouvelle présentation vous permettra de trouver plus facilement les principales informations ou de passer tout de suite aux renseignements plus détaillés sur les sujets qui vous intéressent de près. Vous retrouverez donc parfois les mêmes informations à différents endroits.

Comme toujours, le système canadien de soins de santé a poursuivi son évolution. La nécessité d’un accès en temps opportun à des soins de qualité, une gestion plus rigoureuse et la réduction des temps d’attente se sont hissés en tête des grandes préoccupations de l’an dernier. Pour y répondre, le gouvernement fédéral, aussi bien que les provinces et les territoires, ont mis l’accent sur la formation, le recrutement et la rétention des professionnels de la santé, l’information, l’adoption de nouvelles technologies, les soins primaires, les mesures préventives et les initiatives de maintien à domicile. La santé est donc demeurée au centre des politiques publiques du Canada.

Il ressort clairement des exposés que nous avons reçus cette année que les gouvernements fédéral, provinciaux et territoriaux poursuivent des objectifs communs pour l’amélioration des services de santé, en particulier dans les domaines déterminés au cours de la réunion des premiers ministres en 2003. La responsabilité, la poursuite de la régionalisation, la mise en place de systèmes d’information sur la santé et de nouvelles technologies, ainsi que le recrutement, la formation et le maintien en poste des professionnels de la santé constituent les principaux champs d’action. Toutes ces questions sont jugées hautement prioritaires, non seulement pour améliorer la qualité des soins, mais pour en maîtriser les coûts.
Depuis douze ans, nous recevons de nombreux commentaires élogieux sur la valeur et l’utilité d’un document de synthèse faisant état des nouvelles initiatives dans le domaine de la santé partout au Canada. The Change Foundation et le Collège canadien des directeurs de services de santé espèrent que Bilan de cette année s’avérera un outil encore plus efficace pour vos travaux de planification et la prise de décisions.

Dr. John Hylton, CHE  
Président et chef de la direction  
Collège canadien des directeurs de services de santé

Président et chef de la direction  
The Change Foundation
PART A The Healthcare Story In Canada 2005-06: A Highlight

The following is a chronology of significant health events that occurred in Canada in 2005-2006.

APRIL 2005

13 CIHI reports that more patients are receiving transplants than 10 years ago, despite a stagnant organ donation rate.
16 Health Canada announces new initiatives to improve drug safety and foster transparency. Two new regional centres will open to collect adverse drug reaction reports. This includes an Office of the Public Ombudsman which is involved in resolving complaints and a Pediatrics Office that is engaged in coordinating nutrition, drug and food safety issues for children. Also launched are two publicly accessible websites on drug safety: drug information database (MedEffect; launched August 9th 2005 ) and database of health product adverse reactions (Canada's Canadian Adverse Drug Reaction Information System – CADRIS; launched May 25th 2005).
20 In April 2005 the House of Commons passed legislation that would compensate all recipients of tainted blood.
21 Dr. Alan Bernstein recommended for re-appointment as President of the Canadian Institutes of Health Research by Health Minister Dosanjh.
22 Federal/Provincial/Territorial Ministers of Health announce creation of the Pan – Canadian Public Health Network.
24 The government of Canada announced funding for the establishment of six National Collaborating Centres (NCCs) for Public Health. The NCCs facilitate information sharing and collaboration between federal, provincial and territorial governments, academic institutions, international experts, non-government organizations, researchers and health professionals. Each NCC will build on regional expertise to address key priority areas in public health and contribute to the development of a pan-Canadian public health strategy. The NCCs are located as follows: environmental health in British Columbia; infectious disease in Winnipeg; public health methodologies and tools in Ontario; public policy and risk assessment in Quebec; health determinants in Atlantic Canada and Aboriginal health in British Columbia.
25 The Federal Health Minister announced a $75 million federal initiative to bring more internationally educated professionals into the health care system over the next 5 years. The funding is estimated to assist in the assessment and workforce integration of approximately 1000 physicians, 800 nurses and 500 other regulated health care professionals. Numbers varying depending on the priorities of provincial and territorial governments.
26 The governing Liberal Party reached an agreement-in-principle with the opposition New Democratic Party to earn support for the minority government's budget. The agreement includes a $4.6-billion boost in social program spending over two years (May 19th, 2005 Bill C-48 passed).
26 Nova Scotia 2005 budget. Through new health care, equalization and offshore funding agreements, the province expects about $259 million extra from Ottawa in 2005. For health programs, spending is up 9.3 per cent over 2004-05. This is to reduce wait times, recruit doctors and nurses, and pay for programs like home care.
MAY 2005

9 The future head office of the Assisted Human Reproduction Agency of Canada will be located in Vancouver. The Agency will be established in January 2006 under the federal Assisted Human Reproduction Act, which became law March 29, 2004. It will regulate assisted human reproduction activities in Canada under the application of ethical principles.

19 $15 Million will be allocated over the next four years to support national initiatives to reduce wait times. Included within the Federal Budget 2005, the direct federal funding is expected to complement provincial/territorial wait time initiatives. This money will support relevant patient/provider education, the sharing of best practices, and the facilitation of input on wait times issues from a variety of sources, including decision-makers, providers and patients, and essential research.

26 The Federal Health Minister announced $13 million in federal funding for a total of 11 projects on collaborative patient-centred practice. Examples include establishing an innovative model of collaborative care for patients transitioning from acute to community care (Dalhousie University); Enhance inter-professional education through linked research initiatives and demonstration projects (Calgary Health Region); Collaborative, community-based geriatric care (University of Manitoba) etc. Projects are funded under the Interprofessional Education for Collaborative Patient-Centred Practice initiative. It is part of the Pan-Canadian Health Human Resources Strategy, which also includes initiatives to improve health human resource planning, and recruitment and retention.

JUNE 2005

8 New report released by CIHI shows mortality rate lower in higher volume hospitals showing that Canadians have a better chance of surviving some specialized surgeries within hospitals where greater numbers of these procedures are performed.

9 The Supreme Court of Canada (SCC) with the Chaoulli Decision struck down a Quebec law that prohibited people from buying private health insurance to cover procedures already offered by the public system. The court found that Quebec laws violate the Quebec Charter and the Canadian Charter of Rights and Freedoms. The SCC suspended the judgment for 12 months, from the date issued. Historically, the Canadian Supreme Court has avoided direct intervention in health care policy-making. The release of the Chaoulli decision dramatically changed this posture. The new role that the courts may play in health care is of crucial importance not only to the courts, but to the Canadian public and their governments.

February 16th 2006, Quebec responds to SCC Chaoulli Decision and unveils new health plan for the province; setting acceptable wait times and opening private health insurance for only cataract, hip and knee replacement surgery.

JULY 2005

4 Two new reports on Health Canada's Primary Health Care Transition Fund (PHCTF) were released. The Interim Report highlights major achievements of the primary health care renewal initiatives underway while the Summary of Initiatives report provides details on each PHCTF funded project. The PHCTF has been assisting provinces and territories to introduce long-term improvements to primary health care. To raise awareness and to promote understanding amongst Canadians of primary health care, a
National Primary Health Care Awareness Strategy's campaign was launched in September.

Dr. Brian Postl was appointed as the Federal Advisor on Wait Times. Dr. Postl’s role will be to work with the federal, provincial and territorial governments to achieve commitments made by First Ministers in the 10-Year Plan to Strengthen Health Care.

AUGUST 2005

A memorandum of understanding (MOU) was signed between Health Minister Ujjal Dosanjh and United States Ambassador David Wilkins to enable simultaneous exchange and comparison of information between national laboratories (PulseNet USA and PulseNet Canada) to speed up response times and capacities when managing infectious disease outbreaks.

A Canadian Institute for Health Information report suggests that for the first time in at least 30 years, more doctors are coming back to Canada than leaving and that there has been a five per cent increase in the number of doctors working in Canada since 2000.

A contribution of more than $71 million aimed at addressing substance abuse in Canada is to be disseminated over the next three years for national, regional and community initiatives. The breakdown includes $29 million under the Drug Strategy Community Initiatives Fund and $42 million through the Alcohol and Drug Treatment and Rehabilitation Program with $4 million of the overall funding to be allocated specifically for projects in Québec.

SEPTEMBER 2005

Conjoint report released today by the Canadian Institute for Health Information (CIHI) and the Canadian Nurses Association (CNA) shows that there were 878 licensed nurse practitioners in various provinces and territories across the country in 2004, an increase of more than 20% from 2003. The report indicates that almost half (45.1%) of licensed nurse practitioners employed in 2004 worked in the community health sector, 22.8% in the hospital sector and 3.8% in the nursing home or long-term care sector.

All provinces and territories have or are working on legislation to support the regulation of nurse practitioners.

The National Pharmaceuticals Strategy organized a Working Conference on Strengthening the Evaluation of Real World Drug Safety and Effectiveness. The conference aims to explore how to enhance the post-market evaluation of the safety and effectiveness of prescription drugs. Recommendations arising from the conference will be used to further develop a way forward in preparation for the National Pharmaceuticals Strategy report due to Ministers of Health by June 2006.

A study release by the Canadian Institute for Health Information (CIHI), showed that more than half (57%) of patient visits to selected Canadian emergency departments in 2003–2004 were for less-urgent or non-urgent conditions with only 0.5% of patients considered severely ill—meaning they needed life-saving interventions.
Inaugural Meeting of the Canadian Academy of Health Sciences (CAHS) took place in Vancouver. Modeled on the US Institute of Medicine, the CAHS will develop informed, strategic assessments on urgent health issues and provide a recognized and authoritative Canadian health science voice internationally.

OCTOBER 2005

Federal Government Announced $300 Million for Health Promotion and Disease Prevention as part of the Integrated Pan-Canadian Healthy Living Strategy, approved by the Federal, Provincial and Territorial Ministers of Health. Included in the Strategy are pan-Canadian healthy living targets - which seek to obtain a 20% increase in the proportion of Canadians who are physically active, eat healthy and are at healthy body weights. Intersectoral working groups were formed to propose actions in the implementation of the Strategy. Canada now joins countries from around the world in an innovative and integrated approach to combat major preventable chronic diseases.

The Government of Canada hosted an international meeting on Global Pandemic Influenza Readiness. Health ministers from 30 countries and representatives from nine international organizations met in Ottawa to discuss the best ways to work together in planning, preparing for and responding to a possible pandemic influenza. The meeting concluded with unanimous support for the Ottawa Statement. It is anticipated that this meeting will support and contribute to other international initiatives related to pandemic influenza preparedness.

NOVEMBER 2005

The Canadian Institutes of Health Research (CIHR) released research reports “Towards Canadian Benchmarks for Health Services Wait Times” to inform on the development of benchmarks for wait times in the areas of cancer, joint replacement and sight restoration.

One-year extension of the Official Languages Envelope of the Primary Health Care Transition Fund was announced by the Minister for Official Languages, in the amount of $10.6 million, permitting the launch of new initiatives in the 2006-2007 fiscal year.

The Ontario Government introduced LHIN legislature. LHINs are designed to plan, integrate and fund local health services – including hospitals, community care access centres, home care, long-term care, mental health, community health centres as well as addiction and community support services. LHINs would not be providers of direct services. Ontario’s model would respect the governance of the existing health care organizations. On March 28, 2006, the Local Health System Integration Act, 2005 (LHSIA) was presented to the Lieutenant Governor in Council and received Royal Assent.

DECEMBER 2005

The provinces and territories established benchmarks for evidence based waiting times for radiation therapy, hip fracture fixation, hip and knee joint replacement, cataract removal, breast and cervical cancer screening, and cardiac bypass surgery. Other benchmarks will be developed as new evidence is produced through consultation with the Canadian
Institutes of Health Research (CIHR) and through collaboration with some of Canada’s top clinicians.

**JANUARY 2006**

No health events/activities report.

**FEBRUARY 2006**

1 Conference Board of Canada released a report indicates that BC & Alberta have the top performing health systems in Canada overall, but that all 10 provinces have room for improvement. *Healthy Provinces, Healthy Canadians: A Provincial Benchmarking Report* compares and evaluates the performance of provincial health-care systems in Canada based on comparable health indicators released by the provinces in 2004.

6 Conservatives were elected January 23rd with a minority government, under Mr. Stephen Harper. Mr. Tony Clement was sworn in as Minister of Health whose duties include responsibility for public health.

15 Dr. Brain Day, an orthopaedic surgeon was elected as the future president-elect of the Canadian Medical Association. Dr. Day is the largest individual shareholder of the private Cambie Surgery Centre and the first CMA president in many years whose practice exists largely outside the public health care system. The presidency rotates among the provinces and will locate in British Columbia in 2007-2008.

20 Canadian Medical Association Journal (CMAJ) editor Dr. John Hoey and senior deputy editor Anne Marie Todkill were dismissed after a long running dispute with the journal's owner, the Canadian Medical Association (CMA). At issue is the editorial independence of the journal.

March 17th the majority of members on the Canadian Medical Association Journal's editorial board resigned to protest the dismissal of senior editorial staff.

**MARCH 2006**

1 Alberta Premier Ralph Klein’s “Third Way” unveiled a vision for potential health care reform in the province. The plan embraces increased reliance on private care by offering to allow doctors to work simultaneously in both public and private health care sectors under certain restrictions and requirements.

In April 20, 2006, bowing to public pressure at home and opposition in Ottawa, Alberta shelved its controversial health-care reforms. An "aggressive" work-force policy to bring more health-care workers to Alberta cities and rural areas to alleviate waiting lists will be adopted.

16 The Alberta provincial government is putting $116 million into expanding access to electronic health records. By 2008, the government hopes to have every Albertan on the system. Currently, about 570,000 people have information on Alberta Netcare.
Health Minister Tony Clement today launched a new web-based resource on pandemic influenza that will give Canadians access to a one-stop source of information on pandemic influenza and Canada's preparedness (www.pandemicinfluenza.gc.ca).
PARTIE A ABRÉGÉ CHRONOLOGIQUE DU SECTEUR DE LA SANTÉ AU CANADA EN 2005-2006

AVRIL 2005

13 L’Institut canadien d’information sur la santé (ICIS) publie un rapport sur les dons d’organes et les transplantations. Le nombre de receveurs de greffes a augmenté depuis dix ans, malgré la stagnation du nombre de donneurs.


20 La Chambre des communes adopte une loi qui permettra d’indemniser toutes les victimes du sang contaminé.

21 Le ministre de la Santé, Ujjal Dosanjh, recommande la reconduction du mandat du Dr Alan Bernstein à titre de président des Instituts de recherche en santé du Canada.

22 Les ministres fédéral, provinciaux et territoriaux de la Santé annoncent la création du Réseau pancanadien de santé publique.

24 Le gouvernement du Canada annonce la mise sur pied de six Centres nationaux de collaboration en santé publique (CNC). Leur fonction principale consistera à établir des liens, à collaborer et à communiquer avec tous les intervenants du milieu de la santé publique, notamment les provinces et les territoires, les experts internationaux, le milieu universitaire, les organisations non gouvernementales, les chercheurs et les professionnels de la santé. Ils tireront parti de l'expertise régionale, nationale et internationale pour compléter les contributions de personnes et d'organismes dans tout le système de santé publique, favorisant ainsi l’atteinte des objectifs de la Stratégie pancanadienne de santé publique. Les CNC sont répartis comme suit selon les disciplines : hygiène du milieu, Colombie-Britannique; maladies infectieuses, Prairies (Winnipeg); mise au point de méthodes et d'outils en santé publique, Ontario; politiques publiques et évaluation des risques, Québec; déterminants de la santé, Canada atlantique; santé autochtone, Colombie-Britannique.

25 Le ministre fédéral de la Santé annonce l’injection de 75 millions de dollars dans une initiative visant à attirer plus de professionnels de la santé ayant une formation de calibre international dans les cinq prochaines années. Selon les estimations, ces fonds devraient contribuer à l’évaluation et à l’intégration d’environ 1 000 médecins, 800 infirmières et 500 autres professionnels de la santé réglementés. Leur nombre variera selon les priorités des gouvernements provinciaux et territoriaux.

26 Le gouvernement libéral minoritaire conclut un accord de principe avec le Nouveau Parti démocratique (NPD) pour que ce dernier appuie le budget. Le NPD a posé comme
condition que les dépenses au titre des programmes sociaux soient augmentées de 4,6 millions de dollars sur deux ans. (Le projet de loi C-48 a été adopté à cette fin le 19 mai 2005.)

La Nouvelle-Écosse présente son budget 2005. Grâce à de nouveaux accords touchant la santé, la péréquation et les hydrocarbures extracôtiers, la province prévoit recevoir 259 millions de dollars de plus d’Ottawa. Les dépenses au titre de la santé sont rehaussées de 9,3 % par rapport à 2004 afin de réduire les temps d’attente, de recruter des médecins et des infirmières et de financer des programmes de soins à domicile.

MAI 2005

9 Le siège social de la future Agence canadienne de contrôle de la procréation assistée sera situé à Vancouver. L’Agence sera établie en janvier 2006 en vertu de la Loi sur la procréation assistée qui a reçu la sanction royale le 29 mars 2004. Elle sera notamment chargée promouvoir l'application des principes d'éthique liés à la procréation humaine.

19 Un financement direct de 15 millions de dollars sur quatre ans – prévu dans le budget fédéral 2005 – est attribué à des initiatives nationales qui viendront compléter celles des provinces et des territoires pour réduire les temps d’attente. À titre d’exemples de telles initiatives, on retrouve l’éducation des patients et des fournisseurs de soins, le partage de pratiques exemplaires, des travaux de recherche indispensables, ainsi que la facilitation de la collecte de données sur les temps d’attente provenant de différentes sources – notamment les décideurs, les fournisseurs et les patients.

26 Le ministre fédéral de la Santé annonce un investissement de 13 millions de dollars dans 11 projets de formation interprofessionnelle pour une pratique en collaboration centrée sur le patient (FIPCP). Voici quelques exemples de ce genre de projets : Formation interprofessionnelle pour des soins de transition innovateurs dispensés en équipe (Université Dalhousie); Créer un environnement d'apprentissage professionnel grâce aux communautés de pratique : une solution de rechange au préceptorat traditionnel (région sanitaire de Calgary); Formation interprofessionnelle en soins gériatriques (Université du Manitoba). Ces projets sont financés dans le cadre de l’Initiative FIPCP, elle-même intégrée à la Stratégie pancanadienne en matière de ressources humaines en santé qui vise à améliorer la planification, le recrutement et le maintien en poste du personnel de la santé.

JUIN 2005

8 L’ICIS publie un nouveau rapport révélant que les taux de mortalité sont inférieurs dans les établissements hospitaliers à volume élevé, et que les Canadiens ont de meilleures chances de survie après certains types de chirurgies très spécialisées s’ils optent pour des hôpitaux où ces chirurgies sont pratiquées en grand nombre.

9 L’arrêt de la Cour suprême du Canada dans l’affaire Chaoulli est rendu public. Cette décision invalide les dispositions législatives interdisant la souscription à un régime privé d'assurance pour couvrir des soins de santé déjà pris en charge par la Régie de l'assurance maladie du Québec. La Cour a statué que ces dispositions portaient atteinte aux droits garantis à la fois par la Charte québécoise et la Charte canadienne des droits et libertés.
Elle a toutefois accepté par la suite de suspendre les effets de son jugement pour une période de 12 mois. Jusque là, la Cour s’était toujours abstenue d’intervenir directement en matière de politiques de santé. L’arrêt Chaoulli aura de grandes répercussions. Les tribunaux pourraient désormais être appelés à jouer un nouveau rôle d’une importance cruciale non seulement pour eux, mais pour les citoyens et leurs divers paliers de gouvernement.

Le 16 février 2006, pour se conformer à l’arrêt Chaoulli, le gouvernement du Québec a dévoilé de nouvelles mesures établissant des délais maximaux d’attente et autorisant le recours à une assurance privée, mais uniquement dans les cas de chirurgie de la cataracte et de remplacement de la hanche ou du genou.

**JUILLET 2005**

4 Publication de deux nouveaux rapports sur le Fonds pour l’adaptation des soins de santé primaires. Le *Rapport provisoire* fait état des principales réalisations des initiatives en cours financées par le Fonds et le *Résumé* des initiatives donne des détails sur tous les projets. Le Fonds permet d’offrir aux provinces et aux territoires les ressources nécessaires pour apporter des améliorations à long terme dans le secteur des soins primaires. Une stratégie nationale de sensibilisation a été lancée en septembre pour mieux faire comprendre aux Canadiens les tenants et aboutissants des soins de santé primaires.

21 Nomination du Dr Brian Postl à titre de conseiller fédéral sur les temps d’attente. Son mandat consiste à travailler de concert avec le gouvernement fédéral et les gouvernements provinciaux/territoriaux pour honorer les engagements pris par les premiers ministres dans le *Plan décennal pour consolider les soins de santé*.

**AOÛT 2005**

12 Le ministre de la Santé, Ujjal Dosanjh, et l’ambassadeur des États-Unis au Canada, David Wilkins, signent un protocole d’entente par lequel les laboratoires PulseNet USA et PulseNet Canada pourront procéder à des comparaisons et des échanges simultanés de données pour accélérer le temps de réponse et renforcer les capacités de gestion en cas de flambée de maladies infectieuses.

24 L’Institut canadien d’information sur la santé publie un rapport dans lequel on constate que, pour la première fois depuis au moins 30 ans, le nombre de médecins qui sont rentrés au pays est supérieur au nombre de médecins qui ont déménagé à l’étranger. On constate aussi une augmentation de 5 % du nombre de médecins qui travaillent au Canada depuis 2000.

30 Le gouvernement fédéral annonce une contribution de plus de 71 millions de dollars sur trois ans à des initiatives nationales, régionales et communautaires axées sur la lutte contre l’alcoolisme et la toxicomanie au Canada. Le Fonds des initiatives communautaires de la Stratégie antidrogue recevra 29 millions de dollars et 42 millions de dollars seront attribuées au Programme de traitement et de réadaptation en matière d'alcoolisme et de toxicomanie. Une part de 4 millions de dollars du financement global sera affectée à des projets mis en œuvre au Québec.
SEPTEMBRE 2005

7 Publication d’un rapport conjoint de l’Institut canadien d’information sur la santé et de la Canadian Nurses Association (CNA). En 2004, 878 infirmières praticiennes exerçaient leur profession dans différentes provinces et dans les territoires : une augmentation de plus de 20 % par rapport à 2003. Toujours en 2004, près de la moitié (45,1 %) des infirmières praticiennes autorisées travaillaient dans le secteur de la santé communautaire, 22,8 % en milieu hospitalier et 3,8 % dans les maisons de convalescence ou les établissements de soins de longue durée.

Toutes les provinces et les territoires ont déjà adopté des lois, ou s’apprêtent à le faire, pour réglementer la profession d’infirmière praticienne.

12 Début de la Réunion de travail sur le renforcement de l'évaluation de l'innocuité et de l'efficacité des médicaments dans le monde réel. Cette réunion de deux jours organisée dans le cadre de la Stratégie nationale relative aux produits pharmaceutiques (SNPP) a pour but d’explorer des moyens d'améliorer l'évaluation de l'innocuité et de l'efficacité des médicaments déjà commercialisés. Les recommandations qui en découleront seront prises en compte dans la préparation du rapport sur la SNPP qui sera présenté aux ministres de la Santé en juin 2006.

14 Publication d’une étude de l’Institut canadien d’information sur la santé qui révèle qu’en 2003-2004, plus de la moitié (57%) des visites dans les services d’urgence sélectionnés ont été faites par des personnes dont l’état ne requérait aucun soins urgents ou dont les soins pouvaient être différés. Seulement 0,5 % des patients ont été jugés gravement malades, en ce sens que les interventions pratiquées ont pu leur sauver la vie.


OCTOBRE 2005

20 Le gouvernement fédéral annonce un investissement de 300 millions de dollars pour la promotion de la santé et la prévention des maladies, dans le cadre la Stratégie pancanadienne intégrée en matière de modes de vie sains approuvée par le ministre fédéral et les ministres provinciaux et territoriaux de la Santé. La Stratégie poursuit des objectifs pancanadiens en matière de modes de vie sains qui visent à accroître de 20 % la proportion de Canadiens et de Canadiennes qui font de l'activité physique, qui mangent bien et qui ont un poids santé. Des groupes de travail intersectoriels ont proposé des mesures qui seront prises en considération au cours de la mise en œuvre de la Stratégie. Le Canada fait maintenant partie des pays qui ont adopté une approche innovatrice et intégrée dans la lutte contre les maladies chroniques évitables.

25 Début de la réunion internationale de deux jours à Ottawa sous le thème de la Préparation mondiale en vue d’une éventuelle pandémie de grippe. Le gouvernement du Canada accueille les ministres de la Santé de 30 pays et des représentants de neuf
organisations internationales qui discuteront des meilleurs moyens de collaborer à la planification, à la prévention et à l'intervention en cas de pandémie de grippe. La réunion prend fin par un appui unanime à la Déclaration d’Ottawa. Cette rencontre devrait aider à faire avancer d'autres initiatives internationales de préparation et d'intervention en cas de pandémie de grippe.

NOVEMBRE 2005

16 Les Instituts de recherche en santé du Canada publient les rapports de recherche commandés pour Établir des points de repères canadiens concernant les temps d'attente dans les services de santé dans trois domaines prioritaires, soit le cancer, le remplacement articulaire et la restauration de la vue.

18 Le ministre responsable des Langues officielles annonce la prorogation d’un an de l’enveloppe de 10,6 millions de dollars attribuée aux langues officielles par le Fonds pour l'adaptation des soins de santé primaires. Cette mesure permettra de lancer de nouvelles initiatives au cours de l’exercice 2006-2007.

24 Le gouvernement de l’Ontario dépose un projet de loi portant sur la création de réseaux locaux d'intégration des services de santé (RLISS) qui pourront planifier, intégrer et financer les services de santé locaux – y compris les hôpitaux, les centres d’accès aux soins communautaires, les soins à domicile, les soins de longue durée, les services de santé mentale, les centres de santé communautaires, les services aux toxicomanes et les services de soutien communautaire. Les RLISS ne fourniront aucuns services directs et le modèle de l’Ontario respectera le mode de gouvernance des organismes de santé existants. La Loi de 2005 sur l’intégration du système de santé local a reçu la sanction royale du lieutenant-gouverneur en conseil le 28 mars 2006.

DÉCEMBRE 2005

12 Les provinces et les territoires établissent des points de repères concernant les temps d’attente documentés dans les cas de radiothérapie, de réparation de fracture de la hanche, de remplacement des articulations de la hanche et du genou, de chirurgie des cataractes, de dépistage du cancer du sein et du col de l’utérus, et des pontages aorto-coronariens. D’autres points de repère seront définis dans l’avancement des travaux de recherche en consultation avec les Instituts de recherche en santé du Canada et d’éménents cliniciens du Canada.

JANVIER 2006

Rien à signaler.

FÉVRIER 2006

1 Dévoilement du rapport du Conference Board intitulé Healthy Provinces, Healthy Canadians: A Provincial Benchmarking Report. On y apprend que ce sont la Colombie-Britannique et l’Alberta qui, d’une manière générale, offrent les meilleurs systèmes de santé au Canada, quoiqu’il y ait place à l’amélioration dans chacune des dix provinces. C’est la première fois que l’on compare et évalue le rendement des systèmes
Assermentation de l’honorable Tony Clement à titre de ministre de la Santé et responsable de la santé publique au sein du gouvernement conservateur minoritaire dirigé par M. Stephen Harper, qui a remporté les élections du 23 janvier.

Élection du Dr Brian Day, un chirurgien orthopédiste, à titre de président désigné de l’Association médicale canadienne (AMC). Le Dr Day est l’actionnaire majoritaire de la clinique privée Cambie Surgery Centre et le premier président de l’AMC depuis nombre d’années à pratiquer surtout en dehors du système public de soins de santé. La présidence est assumée à tour de rôle dans les provinces et sera en Colombie-Britannique en 2007-2008.


Le 17 mars, la majorité des membres de l’équipe des journalistes ont remis leur démission en signe de protestation contre ce limogeage.

MARS 2006

Le premier ministre Ralph Klein dévoile sa vision d’une éventuelle réforme des soins de santé en Alberta. Défini sous le vocable de « troisième voie », le plan prévoit un recours accru au privé en permettant aux médecins de travailler à la fois dans le secteur public et le secteur privé, sous réserves de certaines conditions.

Devant le tollé du public albertain et de l’opposition à Ottawa, le gouvernement a mis de côté sa réforme controversée le 20 avril 2006, et l’a remplacée par une politique « vigoureuse » sur la main-d’œuvre visant à recruter davantage de travailleurs de la santé dans les villes et les régions rurales et alléger ainsi les listes d’attente.

Le gouvernement de l’Alberta injecte 116 millions de dollars dans l’expansion du réseau des dossiers de santé électroniques, avec pour objectif que tous les Albertains soient enregistrés dans le système d’ici 2008. À l’heure actuelle, les dossiers d’environ 570 000 personnes sont versés dans le réseau Alberta Netcare.

Le ministre la Santé Tony Clement lance un nouveau site Web qui affiche de l’information de plusieurs ministères et organismes du gouvernement du Canada sur l’influenza pandémique et l’état de préparation du Canada.

http://www.influenza.gc.ca/index_f.html
DÉCISIONS ÉCLAIRÉES ...

... MEILLEUR SYSTÈME DE SANTÉ

De nos jours, les circonstances sont telles dans le domaine de la santé que chaque décision administrative est cruciale. Les gestionnaires et les leaders, qu'ils soient infirmières, infirmiers, médecins ou directeurs d'établissement, révèlent sur leur expérience et leur formation pour diriger le meilleur pour des ressources disponibles, orienter le rendement, équilibrer les coûts et les besoins de la clientèle. Que fait-on de l'ouverture de recherche sur le système de santé qui pourrait être à la fois des choix avantageux. Mais comment accéder à ces résultats de recherche, en interagir à la connaissance et en appliquer les recommandations dans la gestion quotidienne des services de santé?

Le programme Formation en utilisation de la recherche pour cadres supérieurs et les organismes de services de santé à l'Alberta intègre de la recherche dans le processus décisionnel.

PART B  Political, Economic, Social and Health Status/Risk, Technological Change in Healthcare: An Environment Scan

The First Ministers’ Health Accord and the 10 Year Plan to Strengthen Health Care in 2004, committed the federal, provincial and territorial governments to significant health care renewal moving from mere debate to health delivery. The economic, social and political environments will affect the ease within which reforms will take place, and how successful they will be. This section provides an overview of Canada’s characteristics today, review the governments response to the Health Accord and what is the forecast for the years ahead.

1.0 POLITICAL

1.1 Federal Cabinet
The Liberal minority government fell November 28th, 2005 after the Conservatives, New Democrats and Bloc Québécois united to defeat Paul Martin's Liberals on a no-confidence vote.

Only two months later, on January 23rd, the Conservatives were elected with a minority government, under Stephen Harper. Tony Clement is sworn in as Minister of Health on February 6th, 2006. Clement’s duties include responsibility for Public Health, a junior-minister position that was axed in Prime Minister Stephen Harper’s streamlined cabinet.

1.2 Federal legislation
No major health related Federal legislation received Royal Assent in 2005-2006 as most legislative initiatives died with the dissolution of Parliament November 29th, 2005.

1.3 Judicial Rulings
The Supreme Court made a historic decision, June 9th 2005, when it voted 4:3 in favour of allowing Quebec patients to purchase private insurance to cover medical treatments that are already provided by Medicare.

The reason for their decision was that long waiting lists for services in the publicly funded system are causing physical and psychological suffering, protected against in the Canadian Charter of Rights and Freedoms. This decision could open the door to the privatization of health, and has ignited much debate across the nation. Opponents argue that privatization will lead to two-tier health care in Canada, while proponents argue that privatization will alleviate increasing pressure on the public system.

2.0 ECONOMIC

2.1 General Economic Indicators for 2005 – 2006
- Growth in 2005 was 2.9%. Real Gross Domestic Product (rGDP) growth for 2006 is expected to be approximately 3.0%, and is expected to reach 3.1% in 2007. Nunavut had negative real Gross Domestic Product (rGDP) growth in 2005, and growth in the Atlantic Provinces, Central Canada, Manitoba and the Northwest Territories were below the national average. While British Columbia, Alberta, Saskatchewan, and Yukon
experienced higher growth rates than the national average. Alberta had the highest growth rate at 4.5%, which is largely attributed to surging oil prices in 2005 which led to huge gains in corporate profits and a spurt in business investment and personal expenditure (Statistics Canada)\(^1\).

- The consumer price index increased by 1.7% in 2005 (Statistics Canada)\(^1\).
- The population reached 32.422 million in 2005, a 0.14% rate of growth for Canada's population as a whole. The Atlantic Provinces, Saskatchewan, Yukon and the Northwest territories experienced decreases in their population, while Central Canada, Western Canada and Nunavut experienced population growths. Alberta experienced the highest population growth with a 0.76% population increase. Apart from Alberta, the only two regions to record a growth rate above the national average were British Columbia (0.19%) and Nunavut (0.37%). Three others recorded positive growth, but below the national average: Quebec (0.09%), Ontario (0.08%) and Manitoba (0.02%) (Statistics Canada)\(^2\).
- The national unemployment rate in 2005 was 6.7%, down by 0.5% from 7.2% in 2004. The highest provincial rate for 2005 was in Newfoundland & Labrador, at 17.4%, and the lowest in Alberta, at 3.3% (Statistics Canada)\(^3\).
- The Liberal 2005 federal budget, tabled in February 2005, promises commitments in five key areas: maintaining sound financial management, securing social foundations, achieving a productive and growing economy, moving towards a green economy and sustainable communities, and meeting global responsibilities. Main areas that the budget allocated to health care are health human resources and wait times initiatives\(^4\).
- The Conservative 2006 federal budget, tabled in May 2006, promises commitments in five key areas: accountability; lowering taxes by reducing the GST; strengthening the justice system; direct assistance in lieu of national childcare; and delivering health care by addressing the fiscal imbalance and establishing a patient wait times guarantee with the provinces\(^5\).

### 2.2 Health Economics

#### 2.2.1 Long-term Government Spending Commitment on Healthcare

##### 2.2.1.1 Liberal Budget 2005 (February 23\(^{rd}\) 2005)

- The “10-Year Plan to Strengthen Health Care” provided a $41.3 billion federal investment in health care, signed by all premiers in September 2004. For the 2005-06 budget that meant $2.5 billion added to the Canada Health Transfer, and $625 million set aside for wait time’s initiatives (includes clearing backlogs, more human resources, more training and improved ambulance services). $805 million of additional funding has been committed over the next five years, of which $75 million goes to helping foreign-trained professionals. 

---

2. [http://www.statcan.ca/Daily/English/060328/d060328e.htm](http://www.statcan.ca/Daily/English/060328/d060328e.htm)
medical professionals to start working in Canada; $170 million to improve Health Canada’s ability to monitor and respond to safety concerns caused by drugs and medical devices; $300 million to help strengthen health promotion strategies; $34 million for development and testing of a “prototype vaccine for an influenza pandemic”; $90 million for health-risk assessments of toxic substances; and $110 million for the Canadian Institute for Health Information for performance measurement.  

• Under Bill C-48, otherwise known as the Liberal-NDP Budget Deal—the Liberal minority government committed to make payments in a number of priority areas resulting in a $4.6-billion boost in social program spending over two years. The funding set out in the Act is as follows: $900 million for the environment (including assisting public transit); $1.5 billion to enhance access to post-secondary education and support training; $100 million for a pension protection fund for workers; $1.6 billion for affordable housing; and $500 million in foreign aid.

2.2.1.2 Conservative Budget 2006 (May 1st, 2006)

• Money for health care solutions did not rate a mention in the Conservative 2006 budget. As cutting health care waiting lists remains one of the Conservative’s top five priorities, health care will probably be one of the most expensive initiatives this government undertakes. Negotiations with the provinces and territories will be needed about how to properly deal with this.

---

6 www.fin.gc.ca
20.2.2 Government Expenditure on Health in 2005

- Total public and private Health Expenditure in Canada in 2005 was forecasted to be $142 billion. This represents an average of 10.4% of GDP. Of that, private sector Health Expenditure was forecast to be $43.2 billion and public sector Health Expenditure at $98.8 billion in 2005 (HCC, 2006; CIHI, 2006; CIHI, 2005a, b).

See Appendix A for national health expenditure trends from 1975 to 2006

- According to OECD’s latest report, total health spending in Canada accounted for 9.9% of GDP in 2004, one percentage point above the 8.9% average in OECD countries. Countries where spending on health as a percentage of GDP is higher than in Canada include the United States (15.3% of GDP spent on health in 2004), Switzerland, Germany and France (11.6%, 10.9%, and 10.6% respectively of their GDP spent on health). The United Kingdom was below the OECD average at 8.3% (OECD, 2006).
Chart 2. Per Capita Expenditures by Source as a Share of Total Health Expenditures, Canada, 1975-2004f

*2004 data are forecast, not actual. Source: CIHI

Table 11. Health Care Spending as a Share of Government Spending by Provinces and Territories, 2001/02 and 2004/05

<table>
<thead>
<tr>
<th>Province</th>
<th>2001/02</th>
<th>2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>35.2%</td>
<td>37.9%</td>
</tr>
<tr>
<td>Alberta</td>
<td>30.6%</td>
<td>33.6%</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>34.7%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>35.5%</td>
<td>37.7%</td>
</tr>
<tr>
<td>Ontario</td>
<td>36.5%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Quebec†</td>
<td>35.4%</td>
<td>37.4%</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>27.8%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>34.5%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Prince Edward Island*</td>
<td>29.8%</td>
<td>29.4%</td>
</tr>
<tr>
<td>Newfoundland and Labrador†</td>
<td>34.5%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Nunavut†</td>
<td>20.4%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Northwest Territories*</td>
<td>23.2%</td>
<td>25.9%</td>
</tr>
<tr>
<td>Yukon†</td>
<td>30.8%</td>
<td>29.6%</td>
</tr>
</tbody>
</table>

*Includes social services.
2.2.3 Composition of Health Care Expenditure

- In 2005, hospitals care comprises the largest share of health expenditure, at 29.9%. Drugs consumed the next largest share (17.4%), followed by physicians (12.8%) and other professionals (10.7%). Other institutions (9.3%), public health (5.5%), other health spending (6.1%), administration (4.1%), and capital expenses (4.2%) made up the rest (Health Council of Canada, 2006; CIHI, 2006a, b).

Drugs continue to consume an increasing share of Canada's health care dollar, accounting for the second largest category of health expenditures next to hospital services (CIHI, 2006a, b).

3.0 SOCIAL

3.1 Ageing Population

- The proportion of the population aged 65 and over stood at 13% of the nation’s population. Nova Scotia and Quebec were the nation’s oldest provinces, (median age 38.8 years), and Alberta (median age 35.0 years) the youngest (Census, 2001). Population projections indicate that persons between 35 and 55 will gradually decline over the next 25 years to approximately 27% in 2026. The proportion of the seniors will
increase to just over 21% by 2026 (using traditional threshold of 65 years to define elderly persons). The increase will put significant pressure on the health care system since older age groups require considerably more health care resources than younger age groups: people between the ages of 45 and 64 have an average cost of $9520 for males and $9181 for females per year, while people between the ages of 65 and 74, costs averaged $12,030 for males and $10,436 for females (CIHI, 2005a, b).

- In 2003, life expectancy at birth in Canada was 79.7 years, which is approximately two years higher than the OECD average (OECD, 2006). Countries that have a higher life expectancy than Canada include Japan, Switzerland, Sweden and Australia.

3.2 Urbanizing Population
- Canada is continuing to become increasingly urbanized: almost 80% of the population lives in an urban centre of 10,000 people or more. According to Census 2001 (most recent available data from Statistics Canada), from 1996 to 2001, the nation's population further concentrated in four broad urban regions: the extended Golden Horseshoe in southern Ontario; Montréal and environs; British Columbia's Lower Mainland and southern Vancouver Island; and the Calgary-Edmonton corridor. In 2001, 51% of Canada's population lived in these regions, compared with 49% in 1996. Outside the urban centres, the population of rural and small-town areas declined 0.4%. The urbanization will continue to affect the quality of care in rural and remote areas. More attention is being paid to recruitment and retention for the North, and for rural areas, since these tend to be relatively under serviced and are having difficulties retaining professionals.

3.3 Ethnicity of Population
- 2005 marked the sixth year in a row that Canada met or exceeded planned immigration levels. A preliminary figure for the number of immigrants in 2005 is 244,600, which is in the planned range of 220,000 to 245,000 that Parliament announced the previous year. More than half of the immigrants that arrived in 2005 were in the economic classes (i.e., skilled workers and business class immigrants). More than half of all immigrants (53%) end up in Ontario (Statistics Canada).

3.4 Patient Expectations
- According to the Pollara 7th annual Health Care in Canada survey: 50% of respondents indicated that their confidence in the public health care system is falling, only 5% of respondents are becoming more confident in public health care. Eroding levels of faith in public treatment coincide with growing awareness of private options, heightened by the recent Supreme Court decision that opened up a potential new role for private service providers. 45% of the public, 49% of nurses and 74% of physicians support the idea that Canadians should be allowed to pay out of pocket to purchase quicker access to health services funded under the public system. But most respondents believe private health care would have both good and bad effects. A majority of Canadians believe it would create a two-tier system (68%), lead to a shortage of physicians in the public system (61%) and
increase costs (58%), but more Canadians also believe it would result in shorter wait
times (68%) and improve the quality of their treatment (60%).

- A poll by Pollara, after the landmark Supreme Court of Canada decision struck down a
  Quebec ban on private health insurance showed that 63% of Canadians would be willing
to "pay out of pocket" to gain faster access to medical services for themselves or their
family members, 55% agree with the Supreme Court decision that they should have the
right to buy private health insurance if the public system cannot provide medical services
in a timely fashion and 73% of those surveyed believed that the ruling was a step toward
creating a two-tiered health-care system in the country.

- Another Pollara poll indicated that 50% of Canadians feels they have to wait too long to
receive test results. The study also reveals widespread concern about both access to
specialists and intercommunication between hospitals; only 22% of Canadians believe the
current system is doing a good job of sharing healthcare information between facilities,
and 54% of Canadians are worried about having to travel unreasonable distances to see a
medical specialist. The results also indicate that residents in rural Canada (68%) are most
worried about having to travel unreasonable distances to access medical specialists,
showing that more work is still needed to increase access in remote areas. However, rural
residents (83%) rated having the most advanced technology in Canada's healthcare
systems as 'very important', compared to their urban counterparts at 76%.

References and Resources:

Canadian Institute for Health Information. (2005a). Exploring the 70/30 Split: How Canada’s
Health System Is Financed. Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2005b). National Health Expenditure Trends, 1975-
2005. Ottawa: Canadian Institute for Health Information.

Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2006b). Health Care in Canada. Ottawa: Canadian
Institute for Health Information.

(Annual Report). Retrieved June 8, 2006:


---

10 http://www.hcic-sssc.ca/
11 http://www.pollara.com/Library/News/PayforHealth.html
12 http://www.pollara.com/Library/News/HealthcareConcern.html
PART C  Key Topics in More Detail

INTRODUCTION

The following analysis focuses on key topics of the Canadian Health Care System for 2005-2006. An investigation of this year’s trends provides a clear picture of the health of Canadians, and of changes that have been occurring in the health care system. This is supplemented with a description of some important initiatives and programs that the federal, provincial and territorial governments are developing and implementing to address high priority concerns in health care and to further develop their strategies of achieving a universal, accessible, portable, comprehensive and publicly administrated health care system.

The key topics addressed this year are as follows:

- Regionalization
- Human Resources: Health Leaders and Managers
- Health Information and Health Technology
- Primary Health Care
- Public Health (Population and Community Health)
- Mental Health
- Homecare and Long Term Care
- Pharmacare
- Wait Times

For all topics listed above, except in the case of wait times, the information in this section is extracted directly from the federal/provincial/territorial government submissions. For wait times, the information was derived indirectly from the content of the submissions and supplemented with additional material produced within this past year.

Each of the key topics begins with a brief introduction that includes some current data highlighting any challenges that remain, and then focuses on the separate initiatives for the given 2005-2006 year as per the federal/provincial/territorial material received on each particular theme.

The aim of the new format is to provide an informative snapshot of the health policy initiatives in each province and territory and at the federal level for the 2005-2006 year. Further information can be obtained from the actual submissions in Section D and the references listed throughout the section.
INTRODUCTION

L’analyse qui suit porte sur les grands sujets qui ont retenu l’attention dans le système de santé canadien en 2005-2006. L’examen des tendances de cette année donne une très bonne idée de l’état de santé des Canadiens et des changements qui se sont produits dans le système. À cela s’ajoute une description de certains programmes et initiatives envisagés ou adoptés par les gouvernements fédéral, provinciaux et territoriaux pour répondre aux préoccupations jugées hautement prioritaires, et pour mettre au point leurs stratégies visant à offrir un système de santé universel, accessible, transférable, complet et administré par l’État.

Voici les grands sujets abordés cette année :

La régionalisation
Les ressources humaines : dirigeants et gestionnaires de services de santé
L’information sur la santé et les technologies de la santé
Les soins primaires
La santé publique (santé de la population et santé communautaire)
La santé mentale
Les soins à domicile et les soins de longue durée
L’assurance-médicaments
Les temps d’attente

Exception faite des temps d’attente, l’information sur tous les sujets énumérés ci-dessus a été directement tirée des exposés que nous avons reçus des autorités fédérales, provinciales et territoriales. Dans le cas des temps d’attente, les données proviennent indirectement de ces exposés et de la documentation supplémentaire que nous avons réunie l’an passé.


Cette nouvelle mise en forme permet d’obtenir un instantané des initiatives en matière de politique de la santé dans chaque province et territoire et au niveau fédéral. On trouvera des renseignements plus détaillés à ce sujet dans la section D où figure l’intégrale des exposés assortie de références.
Section 1 Regionalization

During the 1990’s, in an effort to reduce fragmentation of the health delivery system most provinces in Canada underwent regionalization, with the intention of making the system more responsive to local needs. During that time, all provinces (except for Ontario) and the Northwest Territories were regionalized, although the specific structures differed. The Yukon is no longer regionalized, and Nunavut is phasing out three health and education boards by July 2000, making the Government of Nunavut fully responsible for administering services. Furthermore, Prince Edward Island announced that as of April 2005 the Regional Integrated Health Authorities previously established would be amalgamated under the Department of Health, hence abolishing the regionalized structure (Casebeer, Reay, Golden-Biddle, et al., 2006).

Effective 2004, Ontario joined the regionalization “bandwagon” but has chosen a different approach (a “made-in-Ontario solution”), by implementing “LHINs” (Local Health Integration Networks) rather than regional health authorities. The main difference between these two approaches is that LHINs will support local governance of health delivery organizations (i.e. hospitals, long-term care facilities, etc. keep their boards); LHINs will be purchasers rather than providers of direct services and LHIN boundaries will be permeable for patients (i.e. patients can cross LHIN boundaries to seek physician and/or medical care) (Ontario Government, 2006).

The benefit of regionalization is that health authorities are responsible for smaller geographic areas than the provinces, and can thus address local needs more efficiently and with more ease. Additionally, responsibility is farther down, so the health regions are easily accessible to the people they serve, and their processes (as well as their errors) are more apparent (Casebeer, Reay, Golden-Biddle, et al., 2006).

Current Data:

Challenges addressed by regionalization:

- Fragmented health care systems lack continuity of care- especially with the public’s heightened perception of:
  - Escalation in wait times
  - Decline of access to health services
  - Wasteful health care spending
- Local and regional needs are not being addressed
- Management of large populations, various hospitals and numerous health care workers is difficult

Challenges encountered with regionalization:

- Ideals and process work better in theory than in practice. The structural change is easy but merging cultures is difficult and causes many problems
- Power Imbalance struggles for dominance and feelings of loss of identity and value
• Requires time to realize effects and evaluate impacts on both small and grand scales
• Health care providers often not provided the support necessary to implement ideals of service integration
• Public is often kept in the dark (Casebeer, Reay, Golden-Biddle, et al., 2006).
TABLE 1.1: Regionalization Overview

**Current national structure:**
- Table 1.1 an overview of the current structure of regions in each province and territory.

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Previous Structure</th>
<th>Current Structure</th>
<th>Governing Structure</th>
<th>Established</th>
<th>Restructured</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>52 Health Authorities</td>
<td>5 Regional Health Authorities</td>
<td>6 – 9 member boards, appointed by Minister of Health Planning</td>
<td>1997</td>
<td>2001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Provincial Health Services Authority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td>17 RHA</td>
<td>9 Regional Health Authorities</td>
<td>Board members appointed</td>
<td>1994</td>
<td>2003</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>32 District Health Boards</td>
<td>13 Regional Health Authorities</td>
<td>Each board has 12 appointed board members</td>
<td>1992</td>
<td>2001-02</td>
</tr>
<tr>
<td>Manitoba</td>
<td>12 RHA</td>
<td>11 Regional Health Authorities</td>
<td>Each board has 9 – 15 appointed members</td>
<td>1997-98</td>
<td>2002</td>
</tr>
<tr>
<td>Ontario</td>
<td>District Health Councils in advisory capacity</td>
<td>14 Local Health Integration Networks</td>
<td>A 9 member Board of Directors, appointed by Ministry</td>
<td>1973</td>
<td>2004-05</td>
</tr>
<tr>
<td>Quebec</td>
<td>Health and Social Service Regional Councils</td>
<td>18 Agence de développement de réseaux locaux de services de santé et de services sociaux</td>
<td>Each with a 16 member board appointed by Minister</td>
<td>1989 - 92</td>
<td>2003</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>4 Regional Health Boards</td>
<td>9 District Health Authorities</td>
<td>Each has 12-15 voting members, 2/3 appointed by Minister from list of nominations, 1/3 appointed by Minister through public appointment process</td>
<td>1996</td>
<td>2001</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>Regional Health Corporations</td>
<td>8 Regional Health Authorities</td>
<td>Each has a Board of Trustees with 15 appointed members</td>
<td>1993-94</td>
<td>2002</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>4 RHA and 1 Provincial Health Services Authority</td>
<td>Provincial, no longer regionalized</td>
<td>Changing the role of the Department of Health from responsibility for quality of advice and assistance to services to responsibility for direct service delivery.</td>
<td>1993-94</td>
<td>2005</td>
</tr>
<tr>
<td>Newfoundland &amp; Labrador</td>
<td>14 Regional Health Boards</td>
<td>4 Regional Integrated Health Authorities</td>
<td>15 – 18 member boards selected by Ministry</td>
<td>1994</td>
<td>2003-04</td>
</tr>
<tr>
<td>Nunavut</td>
<td>3 Health and Education Boards</td>
<td>No longer regionalized</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>7 Health and Social Services Authorities</td>
<td>8 Health and Social Services Authorities</td>
<td>6 – 13 board members appointed by Minister</td>
<td>1997-98</td>
<td>2002</td>
</tr>
<tr>
<td>Yukon</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: [www.regionalization.org](http://www.regionalization.org) last accessed: 15/08/05
Federal Perspective: Health Canada

No developments to report for 2005/6.

Provincial/Territorial perspective: Ministries of Health

Common elements of these strategies are:

- Legislation
- Restructuring
  - Dissolution
  - Realignment/Addition

**Contents for this section**

**Provincial/Territorial perspective: Ministries of Health**

**Common elements of these strategies are:**

- Legislation
  - Ontario: November 24, 2005, introduction of the *Local Health System Integration Act* (Bill 36). Seven days of public hearings on the Bill were held across the province in late January and early February 2006. March 28, 2006 the *Local Health System Integration Act* received Royal Assent. The legislation will provide LHINs with responsibility and authority for: local health system planning; local health system integration; accountability and performance management of certain health service providers; local community engagement; and funding. Currently work is underway for the development and implementation of regulations and policies.
  - New Brunswick: November 28, 2005 was the effective date for *An Act Respecting Mental Health and Public Health Services*. 647 full time equivalents (FTEs), reflecting 240 FTEs and 407 FTEs for public health services and mental health services respectively, were transferred to the eight Regional Health Authorities.

- Restructuring
  - Dissolution
    - Prince Edward Island: Dissolution of five regional health authorities. All health services, with the exception of the five community hospitals, are now managed through a provincial departmental management structure.
  - Realignment/Addition
    - Nova Scotia: Provincial programs address health issues across sectors of the health system that are beyond the mandate of any single DHA or health organization. They develop service standards, monitor their achievement, and provide advice to the Department of Health based on best practices, stakeholder input and research-based evidence.
• Current Provincial Programs are: Cancer Care Nova Scotia; Nova Scotia Diabetes Care Program; Reproductive Care of Nova Scotia; Nova Scotia Breast Screening Program; Cardiovascular Health Nova Scotia; Nova Scotia Provincial Blood Coordinating Program; and Nova Scotia Hearing and Speech Program.

• Prince Edward Island: In 2005, the health and social services system underwent a restructuring process. Creation of two new departments, Department of Health, and the Department of Social Services and Seniors, to replace the former Department of Health and Social Services. Upon completion of restructuring, departmental responsibility for managing programs and services were realigned as outlined in the table below.

<table>
<thead>
<tr>
<th>Distribution of PEI Department of Health and Social Services Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Department of Health</strong></td>
</tr>
<tr>
<td>Acute Care Services</td>
</tr>
<tr>
<td>Addiction Services</td>
</tr>
<tr>
<td>Adult Protection</td>
</tr>
<tr>
<td>Ambulance Services - Air Ambulance</td>
</tr>
<tr>
<td>Ambulance Services - Ground Ambulance</td>
</tr>
<tr>
<td>Chief Health Officer</td>
</tr>
<tr>
<td>Community Care Facilities</td>
</tr>
<tr>
<td>Diabetes Program</td>
</tr>
<tr>
<td>Environmental Health</td>
</tr>
<tr>
<td>Health Information Resources</td>
</tr>
<tr>
<td>Homecare and Support</td>
</tr>
<tr>
<td>Long Term Care (Nursing Home) Services</td>
</tr>
<tr>
<td>Medical Education / Physician Recruitment Programs</td>
</tr>
<tr>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Nursing Recruitment and Retention Strategy</td>
</tr>
<tr>
<td>Out-of-Province Hospital Services</td>
</tr>
<tr>
<td>Out-of-Province Physician Services</td>
</tr>
<tr>
<td>PEI Dialysis Program</td>
</tr>
<tr>
<td>Physician Payment Services</td>
</tr>
<tr>
<td>Public Health Nursing Programs</td>
</tr>
<tr>
<td>Vital Statistics Program</td>
</tr>
<tr>
<td>Adoption Services</td>
</tr>
<tr>
<td>Dental Public Health Services</td>
</tr>
<tr>
<td>Disability Support Program</td>
</tr>
<tr>
<td>Drug Cost Assistance Program</td>
</tr>
<tr>
<td>Early Childhood Services</td>
</tr>
<tr>
<td>Environmental Health Services</td>
</tr>
<tr>
<td>Family Housing Program</td>
</tr>
<tr>
<td>Foster Care Services</td>
</tr>
<tr>
<td>Job Creation / Employment Enhancement Programs</td>
</tr>
<tr>
<td>Senior Citizens’ Housing Program</td>
</tr>
<tr>
<td>Seniors Emergency Home Repair Program</td>
</tr>
<tr>
<td>Social Assistance Program</td>
</tr>
</tbody>
</table>

References and Resources:

For additional information and detail on specific activities in each province please refer to Section D.


Section 2 Human Resources: Health Leaders and Managers

Physician

One of the biggest challenges that the Canadian health care system faces is the shortage of physicians - a growing reality that has become more evident as many Canadians are left without a regular family physician and increasingly are confronted with long wait lists to see certain specialists (Canadian Institute for Health Information, 2002; Organization for Economic Co-operation and Development, 2006; Statistics Canada, 2006).

Across the country the distribution of health providers varies, depending on the health needs and size of the population, the availability of employees and employment in a given region, where health care providers choose to practice and other factors. As the number of physicians and certified specialists varies substantially across the country each provincial/territorial government contends with recruiting and retaining physicians to address their particular shortages. A summary of the current national and provincial landscape with respect to physician human resources- as well as challenges and strategies for the future are outlined and summarized in the following sections (Canadian Institute for Health Information, 2005a, b, c and 2006a, b).

Non-Physician

There are many different professions that make up our health care delivery system. Ensuring that the right numbers of health care providers with the right mix of skills and training are available where and when needed is a complex task monitored by each of the provincial/territorial governments with varying degrees of success (Canadian Institute for Health Information, 2005c and 2006a, c).

Nurses, as one such health professional, play a major role in the health care sector. Nursing shortages have been documented Canada wide and the pressures on the nursing workforce is about to exacerbate as at least 13% of nurses are about to retire in 2006. This is occurring at a time when population growth and an ageing population are placing increasing pressures on the health care system and its employees/providers (Canadian Institute for Health Information, 2006b, c).

A variety of other professionals are required to keep our health care system operating. Pharmacists, therapists, technologists, social workers and many others are all part of the “health care team.” As integral members they are often viewed as secondary, especially in reference to the demands for more of both physicians and nurses. As such, this past year, few changes were made to alleviate the need for an increase in allied health practitioners (Canadian Institute for Health Information, 2005c and 2006a, b).

A summary of the current national and provincial landscape with respect to non-physician human resources, as well as challenges and strategies for the future are outlined and summarized in the following sections.
Current Data

- Health care leaders in Canada have witnessed, over the past few years, increasing challenges associated with attracting and retaining senior leaders/managers. Issues of aging, burnout, mentoring, and a lack of succession planning and appropriate training in an ever-changing, increasingly complex health care environments are all worrisome signs that a potential leadership crisis is looming, if not already here.

- According to the 2001 National Occupational Classification (NOC) System from Human Resources Skills and Development Canada (HRSDC) there are approximately 98,000 health care leaders and managers in Canada. Their ranks include CEO’s, hospital administrators, presidents, vice presidents, chief financial officers, executive directors, federal/provincial/territorial Ministers, Deputy Ministers and Assistant Deputy Ministers of Health, senior managers in health regions, hospitals and other healthcare organizations, general managers, chiefs of medical staff, admissions directors, head nurses, nursing supervisors, health policy researchers, consultants, program officers and others.

- The absence of sustainable leadership from governments, leaves more executives in charge of the health system- operating at a local level as well as within health professional associations. This raises the question of whether or not these individuals have been sufficiently prepared to assume the leadership roles and responsibilities expected of them?

- A survey of 108 CEO’s in 2001 found that 31.5% of this group was over 55 years of age and just 9% were between the ages of 35 – 44.

- The number of CEO’s who have left their posts increased 142% in 2005. The average tenure for outgoing CEO’s has fallen to five years with the majority of the departures occurring in the health care industry.

- The data signifies that there will be a shortage when the current generation of health care leaders retires. Health human resource planning has been identified as a critical element by different levels of government, but most of this concern is directed at health professions other than health care leaders and managers (Canadian College of Health Service Executives, 2006). See Appendix B for current figures of registered health personnel

Physician shortages:

- Low number of physicians per capita: 2.1/1,000 in 2004- well below most other OECD (2006) countries averaging 3/1,000. The doctors per capita have remained stable since 1990 while in most other countries have continued to increase at least slightly.

- Family physician shortage: 15% of Canadians reported difficulties accessing routine care and 23% reported difficulties accessing immediate care for minor health problems (Statistics Canada, 2006).

- Statistics Canada’s Canadian Community Health Survey 2003 report noted that only 86.3% of Canadians had a regular family physician (Canadian Institute for Health Information 2005a, b).

(33.8% versus 33.7%, respectively). Suggesting that there are proportionately fewer family physicians accepting new patients in Canada in 2004 than in 2001 (20.2% versus 23.7% respectively (Canadian Institute for Health Information 2005a, b).

- Among the provinces, Alberta and Prince Edward Island had the largest percentage increase in the number of physicians. The number rose by 19% and 18%, respectively, between 2000 and 2004. Increases also occurred in New Brunswick (9.5%), Newfoundland and Labrador (7%), Nova Scotia (5.4%), British Columbia (4%) and Ontario (4%) ((Canadian Institute for Health Information 2005b, 2006a).

- Four provinces exceeded the national ratio of 189 physicians per 100,000 population (2004): Quebec and Nova Scotia had the highest ratio (213); British Columbia (196); and Newfoundland and Labrador (192). The provinces with the fewest physicians per 100,000 population were Prince Edward Island (152) and Saskatchewan (154) (Canadian Institute for Health Information 2006a).

**Potential causes for physician shortages or proliferation:**

- Changes in physician supply are accounted for by the following: longer postgraduate training 26%, decreased intake of International Medical Graduates 22%, changes in rotating internship 21%, increase in retirement (aging physician population) 17%, decreases in medical school enrollment 11%, physicians moving abroad 3% (Canadian Institute for Health Information, 2005c).

- Change in priorities- increasing proportion of females in medical workforce opting to work fewer hours to meet their family commitments.

- Doctors returning: For the first time, more physicians have returned to Canada than moved abroad. In 2004, 317 physicians returned and 262 moved abroad. Between 2000 and 2004, the number of physicians who left Canada declined by 38%, down from 420 physicians who left in 2000 (Canadian Institute for Health Information, 2006a).

![Figure 10. Number of Physicians Who Moved Abroad or Returned From Abroad, Canada, 2001 to 2005](source: SMGB, CIHI)
Figure 7. Number of Physicians, Graduates of Foreign Medical Schools, by Physician Type, Canada, 2001 to 2005

Notes:
From 2004 onwards, in Newfoundland and Labrador and Saskatchewan, non-certified specialists have been counted as specialists. In all other provinces, non-certified specialists are counted as family medicine physicians. Please refer to the methodology for full details.

Figure 8. Number of Physicians, Graduates of Canadian Medical Schools, by Physician Type, Canada, 2001 to 2005

Notes:
From 2004 onwards, in Newfoundland and Labrador and Saskatchewan, non-certified specialists have been counted as specialists. In all other provinces, non-certified specialists are counted as family medicine physicians. Please refer to the methodology for full details.
Provincial physician gains and losses: Some jurisdictions (British Columbia, Alberta and Ontario) have registered net physician gains due to migration between jurisdictions in each year during the period 2000 to 2004. Other jurisdictions (Saskatchewan, Manitoba, Quebec and Newfoundland and Labrador) have registered net physician losses due to migration during the period 2000 to 2004 (Canadian Institute for Health Information, 2005a).

Canadian physicians are concentrated in urban areas, particularly specialist physicians. Just under 16% of family physicians and 2.4% of specialists were located in rural and small-town Canada, where 21.1% of the population resided in 2004 (Canadian Institute for Health Information, 2006a).

Results of the 2004 National Physician Survey showed that practice patterns of family doctors in urban and rural areas tend to have different characteristics. Results reflected that physicians in rural and remote communities tend to have a broader scope of practice and perform a greater range of clinical procedures than their urban colleagues. However, practice patterns among all family physicians are changing with scope of practice narrowing rather than expanding (Canadian Institute for Health Information, 2006b).

Although there are fewer family doctors per capita in rural areas, these physicians are more likely to accept new patients. Across Canada, 20% of family physicians reported accepting new patients in 2004. The rate for rural physicians was higher, at 34% and lower only 18% for urban family physicians (Canadian Institute for Health Information, 2006b).

Nationally, the percentage of international medical graduates (IMGs) within the Canadian medical workforce continued to decline somewhat over the last few years, from 23.1% in 2000, to 22.6% in 2003, to 22.3% in 2004 (Canadian Institute for Health Information, 2006b).
• Heavier reliance on foreign-trained physicians in rural Canada: IMGs in 2004 accounted for 26.3% of all physicians in rural Canada, compared with 21.9% in urban areas. Also, IMGs accounted for 26.9% of family physicians in rural areas, compared with 22.6% in urban areas (Canadian Institute for Health Information, 2006b).

![Graph showing number of family medicine physicians and specialists, Canada, 2001 to 2005](image1)

**Figure 1.** Number of Family Medicine Physicians and Specialists, Canada, 2001 to 2005

**Notes:**
From 2004 onwards, in Newfoundland and Labrador and Saskatchewan, non-certified specialists have been counted as specialists. In all other provinces, non-certified specialists are counted as family medicine physicians. Please refer to the methodology for full details.

![Graph showing percentage of family medicine physicians and specialists, Canada, 2001 to 2005](image2)

**Figure 2.** Percentage of Family Medicine Physicians and Specialists, Canada, 2001 to 2005

**Notes:**
From 2004 onwards, in Newfoundland and Labrador and Saskatchewan, non-certified specialists have been counted as specialists. In all other provinces, non-certified specialists are counted as family medicine physicians. Please refer to the methodology for full details.
Challenges

- Current training programs and work environments, as well as planning models, are not geared towards inter-professional delivery of care. Without this directional shift, a population-based approach to health needs cannot take hold and the skills of other health professions cannot be fully tapped (Health Canada, 2006; Health Council of Canada, 2006).
- Lack of concentration from the federal and provincial governments on health leaders/managers within health human resource planning. Furthermore, no current training
programs geared towards promoting health care leaders/managers from providers within the health care sector (Canadian College of Health Service Executives, 2006).

Non-Physician Shortages:

- In 2003, registered nurses (RNs), licensed practical nurses (LPNs), and registered psychiatric nurses (RPNs) accounted for just under half of all health care workers in Canada (Canadian Institute for Health Information, 2005a, b, c).

![Graph showing percent change from 1980](image)

**Figure 1. Percentage Growth in the Number of RNs Employed in Nursing Since 1980, Canada, 1980–2005**

**Notes**

1980 is used as the base year in Figure 1. Yearly figures are calculated as a percentage change from the 1980 total.

The apparent decrease in 1988 is largely attributed to a substantial increase in the number of "Not Stated" records in the Ontario data for that year.

The increase in 2000 is partially attributed to the identification of comparatively fewer duplicates in the Ontario and Quebec data that year.

The increase in 2003 is largely attributed to methodological changes in the submission of Ontario and Quebec data that year.
As of 2006, those provinces and territories that have legislation and regulations regarding Nurse Practitioners (NPs)\textsuperscript{13} in place or in progress include Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia, the Northwest Territories and Nunavut. The Yukon Territory is currently without legislation governing NPs (Canadian Institute for Health Information, 2006a, b, c).

Potential causes for non-physician shortages or proliferation:

- Assuming a retirement age of 65, Canada can expect to lose 29,746 RNs aged 50 or older by 2006 - 13% of the 2001 nursing workforce (Canadian Institute for Health Information, 2005a, b, c).

---

A nurse practitioner (NP) is a registered nurse that has completed advanced education and training in the diagnosis and management of common medical conditions, including chronic illnesses. Nurse practitioners provide a broad range of health care services similar to those provided by physicians. An NP can serve as a patient’s regular health care provider and see patients of all ages.
Canada’s nurses are getting older. The average age of registered nurses (RNs) in 2004 was 44.6 years, up from 41.4 in 1994. Over the last decade, the number of RNs aged 50 to 54 employed in nursing rose by 6.5%. This group accounted for 17% of the entire regulated nursing workforce in 2004 (Canadian Institute for Health Information, 2005a, b, c).

The percentage of the RN workforce who graduated in foreign countries ranges from a low of 1.2% in New Brunswick to a high of 15.0% in British Columbia (Canadian Institute for Health Information, 2005a, b, c).
Figure 20. Percentage Distribution of RN Workforce by Location of Graduation and Province/Territory of Registration, Canada, 2005

Figure 4. Percentage Distribution of RN Workforce by Age Group, Canada, 2001, 2003 and 2005

Note:
One RN did not state their Year of Birth in 2005 and is not included in calculations for this figure.

Figure 5. Percentage of RN Workforce by Age Group and Province/Territory of Registration, Canada, 2005

Note:
One RN did not state their Year of Birth in 2005 and is not included in calculations for this figure.
Northwest Territories and Nunavut data combined for 2005.
As of 2005, there were a total of 1,026 licensed NPs registered in Canada (Canadian Institute for Health Information, 2005a, b, c).

Rates of full-time employment are substantially higher for NPs than for other RNs. In 2005, more than 75% (75.9%) of licensed NPs with employment worked full-time; that compares to rates of about 54% for the RN workforce (Canadian Institute for Health Information, 2005a, b, c).

**Challenges**

- Current training programs and work environments, as well as planning models, are for the most part not geared towards inter-professional delivery of care. Without this directional shift, a population-based approach to health needs cannot take hold and the skills of other health professions cannot be fully tapped (Health Canada, 2006; Health Council of Canada, 2006).

- Lack of concentration from the federal and provincial governments on health leaders/managers within health human resource planning. Furthermore, there are few training programs geared towards promoting health care leaders/managers from providers within the health care sector (Health Canada, 2006; Health Council of Canada, 2006).

---

**Figure 22. Destination for RN Graduates by Province/Territory of Graduation, Canada, 2005**

**Notes**

- Only Canadian graduates employed in Canada in 2005 are included in Figure 22 (n = 230,286).
- The three most frequently identified destinations for RN graduates are included in this figure, not all Canadian destinations are presented.
- Northwest Territories data includes only one destination of RN graduates due to small cell values.

---

- As of 2005, there were a total of 1,026 licensed NPs registered in Canada (Canadian Institute for Health Information, 2005a, b, c).

- Rates of full-time employment are substantially higher for NPs than for other RNs. In 2005, more than 75% (75.9%) of licensed NPs with employment worked full-time; that compares to rates of about 54% for the RN workforce (Canadian Institute for Health Information, 2005a, b, c).

**Challenges**

- Current training programs and work environments, as well as planning models, are for the most part not geared towards inter-professional delivery of care. Without this directional shift, a population-based approach to health needs cannot take hold and the skills of other health professions cannot be fully tapped (Health Canada, 2006; Health Council of Canada, 2006).

- Lack of concentration from the federal and provincial governments on health leaders/managers within health human resource planning. Furthermore, there are few training programs geared towards promoting health care leaders/managers from providers within the health care sector (Health Canada, 2006; Health Council of Canada, 2006).
Federal perspective: Health Canada

In 2004, federal, provincial and territorial governments, in their "Ten-Year Plan to Strengthen Health Care," renewed their commitment under the 2003 Health Accord, and agreed to increase the supply of health professionals in Canada. Ensuring an appropriate supply and distribution of health care workers will help meet the identified needs of the population—patients receiving timely, quality care, and that workplaces remain healthy and safe for our health care providers.

The administration and delivery of health care services are the responsibility of each province or territory based on particular needs of each, whereas the federal government assists provinces in research, development and funding of approved strategies. The federal government does though provide direct health care services to First Nations and Inuit people for which it has a mandate.

Health Human Resources: Physicians

Contents of this Section

Health Human Resources (Physicians) Strategies, suggestions and initiatives:
- Aboriginal Health Human Resources Initiative
- Inter-professional education for collaborative patient-centred practice
- Recruitment and retention:
  - Family medicine image enhancement led by The College of Family of Physicians
    - Promotional strategy directed to Canadian public
    - Promotional strategy directed to medical students
  - Enhancement of physicians HHR in Rural Canada
  - Increase capacity to assess and prepare International Medical Graduates (IMG)
    - Expand/develop programs to assist with licensure processes and requirements
    - Oriented programs to support faculty and MDs working with IMGs
- Pan-Canadian Health Human Resource Planning:
  - HHR data enhancement thru Canadian Institute for Health Information (CIHI)
  - HHR education data enhancement thru Health Canada and Statistics Canada
  - HHR modeling and forecasting
  - Framework for Collaborative Pan-Canadian HHR Planning

Strategies, suggestions and initiatives:
- Aboriginal Health Human Resources Initiative:
  - Building on Pan-Canadian Human Health Resource Strategy in partnership with the 5 National Aboriginal Organizations and National Aboriginal Health Organizations, to:
    - Increase the number of Aboriginal health care providers
    - Adapt existing health care curriculum so that will be culturally appropriate
    - Increase the retention of health care providers working in Aboriginal communities
    - Promote health care careers to First Nations and the Inuit
• Federal funding of demonstration projects:
  o Inter-professional education for collaborative patient-centred practice
  o Priority focus and future projects: continuing education; promising practices; sustainability; leadership; liability; legislation/regulation – scope of practice

• Recruitment and retention:
  o Image enhancement of primary health care to both the Canadian public and future medical students
  o Enhancement of HHR opportunities in Rural Canada to physicians
  o Increase capacity to assess and prepare International Medical Graduates (IMG).
    – Expand/develop programs to assist with licensure processes, requirements and placements

• Systemic data collection:
  o HHR data enhancement, modeling, planning and forecasting thru Canadian Institute for Health Information (CIHI); Health Canada and Statistics Canada

**Health Human Resources: Non-Physicians**

**Contents of this Section**

**Health Human Resources (Non-Physicians) Strategies, suggestions and initiatives:**

- **Aboriginal Health Human Resources Initiative**
- **Inter-professional team building for collaborative patient-centred practice**
- **Recruitment and retention:**
  - Nursing image enhancement led by the Canadian Nursing Association
    - Promotional campaign directed to Canadian public
  - Federal, provincial/territorial task force on International Educated Nurses (IEN)
  - Integration of Internationally Educated Health Professionals Initiative
- **Pan-Canadian Health Human Resource Planning:**
  - HHR data enhancement thru Canadian Institute for Health Information (CIHI)
  - HHR education data enhancement thru Health Canada and Statistics Canada
  - HHR modeling and forecasting
  - Framework for Collaborative Pan-Canadian HHR Planning

**Strategies, suggestions and initiatives:**

- Aboriginal Health Human Resources Initiative:
  - To increase the number of Aboriginal health care providers
  - Adapt existing health care curriculum so that will be culturally appropriate
  - Increase retention of health care providers working in Aboriginal communities, especially nurses
Promote health care careers to First Nations and the Inuit

Inter-professional team building for collaborative patient-centred practice.

Nurse Practitioners in Primary Health Care: Canadian Nursing Association (CNA) to develop recommendations to support NP implementation.

Recruitment and retention:

Nursing image enhancement by the CNA: Promotional campaign to reinforce valuable service and exemplary care provided by nurses.

Federal, provincial/territorial task force on International Educated Nurses (IEN): CNA funded by Human Resources and Social Development Canada (HRSDC) to conduct analysis on IENs in Canada.

Integration of Internationally Educated Health Professionals Initiative.

- The Federal Health Minister announced a $75 million federal initiative to bring more internationally educated professionals into the health care system over the next 5 years to help address shortages and assist efforts to reduce wait times for care. The identified priority professions are: medicine, nursing, medical radiation technology, medical laboratory technology, physiotherapy, occupational therapy, and pharmacy.

- Development of an orientation program for internationally educated professionals steered by an interdisciplinary working group of representatives from the fields of occupational therapy, physiotherapy, nursing, medical radiation technology, and medical laboratory technology.

Federal focus on a Pan-Canadian Health Human Resource Planning:

- HHR data enhancement thru Canadian Institute for Health Information (CIHI): Develop national, minimum data set and supply based database and reporting systems.

- HHR education data enhancement through Health Canada and Statistics Canada: Assess and report on education indicators necessary to monitor the supply of health professionals.

- HHR modeling and forecasting: Concerned with federal, provincial/territorial modeling capacity to assess supply and demands of health providers.

- Framework for Collaborative Pan-Canadian HHR Planning: Facilitate collaboration, risk and duplication avoidance associated with the current province by province approach to HHR planning.
Provincial/Territorial perspective: Ministries of Health

*Health Human Resources: Physicians*

### Contents for this Section

**Strategies to address challenges of Physician Human Resources:**
- Improve upon per capita physician practice and distribution
  - Incorporate financial incentives and enhanced medical education to live in remote and rural areas
  - Increase medical school accessibility
- Increase supply of health care providers ensuring availability when and where needed
  - Increase medical school enrollment or promote expansion
- Improve upon utilization and distribution of existing health care providers
- Remuneration and alternate payment plans
- Reduce barriers for internationally educated health providers
  - Assessment
  - Matching service
  - Resident Status

---

**Strategies to address challenges of recruitment and retention:**
- Improve upon per capita physician practice and distribution
  - Incorporate financial incentives and enhanced medical education in remote/rural areas
    - Salary/Benefits Package
      - Yukon: Financial bonuses
      - Northwest Territories: Comprehensive salary and benefits package includes: competitive recruitment; retention bonuses; northern allowance; call-back compensation; moving assistance; special leave; self-funded leave plan; sick leave; maternity leave; and group health benefits
        - Return of Service Bursaries for medical students who agree to reside and work in NWT upon completion of studies.
        - Resident Travel Bursary offered to offset travel costs for a resident who completes a component of their training in NWT.
    - Medical Student Bursaries
      - Northwest Territories: Comprehensive salary and benefits package includes: competitive recruitment; retention bonuses; northern allowance; call-back compensation; moving assistance; special leave; self-funded leave plan; sick leave; maternity leave; and group health benefits
      - New Brunswick: Bursaries for medical students, business grants and guaranteed minimum income for family practitioners establishing practice in designated area.
- **Financial/Grant Assistance**
  
  - Northwest Territories: Comprehensive salary and benefits package includes: competitive recruitment; retention bonuses; northern allowance; call-back compensation; moving assistance; special leave; self-funded leave plan; sick leave; maternity leave; and group health benefits
  
  - Manitoba: Conditional financial assistance for family physicians and Physicians training in a needed specialty, available to eligible physicians who have practiced in Manitoba for one year in a rural or urban area.
  
  - New Brunswick: Bursaries for medical students, business grants and guaranteed minimum income for family practitioners establishing practice in designated area.

- **Continuing Education**
  
  - Manitoba: Conditional financial assistance for family physicians and physicians training in a needed specialty, available to eligible physicians who have practiced in Manitoba for one year in a rural or urban area.
  
  - Prince Edward Island: Provide clinical rotations for medical students and residents in family medicine and various specialties ranging from two weeks to 12 weeks in duration.

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Salary/Benefits Package</th>
<th>Medical Student Bursaries</th>
<th>Financial/Grant Assistance</th>
<th>Continuing Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yukon</td>
<td>Northwest Territories</td>
<td></td>
<td>Northwest Territories</td>
<td>Manitoba</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>New Brunswick</td>
<td></td>
<td>New Brunswick</td>
<td>Saskatchewan</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td></td>
<td></td>
<td>Manitoba</td>
<td>British Columbia</td>
</tr>
<tr>
<td>British Columbia</td>
<td></td>
<td></td>
<td>Saskatchewan</td>
<td>Prince Edward Island</td>
</tr>
</tbody>
</table>

- Increase medical school accessibility
  
  - British Columbia: Have a distributed medical program at UNBC, UVic, UBC Vancouver and UBC-Okanagan (with further commitment to facility expansion) alleviating regional issues over access to physician services- by providing a pool of student doctors who will complete residency rotations in hospitals outside of the lower mainland. Will play an important role in recruiting more doctors to rural and remote communities.
  
  - New Brunswick: The Université de Sherbrooke will establish a satellite campus in Moncton New Brunswick. The program will be done in collaboration with the Université de Moncton and the various Regional Health Authorities. The students would normally have gone to Sherbrooke, where the Province currently purchases the medical seats. Future plans for Saint John.
  
  - Alberta: Expansion in rural residencies openings.
• Increase supply of health care providers ensuring availability when and where needed
  o Increase medical school enrolment or promote expansion
    – British Columbia: Plans to increase number of first year spaces, postgraduate medical education positions (residencies). Government investing to expand and upgrade academic space in teaching hospitals around B.C. – with money going towards renovations and upgrades of seminar rooms, on-call rooms, offices and library space.

• Improve upon utilization and distribution of existing health care providers
  o Yukon: Visiting Specialists Program brings itinerate specialists to the territory to provide services not available locally- e.g. resident physicians.
  o Saskatchewan: Physicians play a role as part of interdisciplinary health care teams. Physician representatives are part of regional health authority planning teams as RHAs develop their plans for primary health care.
  o Ontario: The Underserviced Area Program helps underserviced communities across the province improve access to health care services by providing a variety of integrated initiatives aimed at attracting and retaining health care providers through financial incentives and other innovative community supports (e.g. Northern Ontario Virtual Library).
  o Quebec: A new special agreement on networked clinics has been in effect since June 1, 2005. This agreement provides monetary incentives for private clinics, and in some cases CLSCs, to be designated by health and social service boards (one clinic per 50,000 people, on average). These clinics provide expanded access to walk-in diagnostic and medical services that are available over extended operating hours and are linked to the usual attending physicians.

• Remuneration and alternate payment plans
  o Newfoundland: Additional dollars for physicians who provide after hours and On-call services.
  o Manitoba: Two new remuneration funds were created with recently signed Master Agreement.
  o Alberta: The new Master Agreement makes provision for Alternate Relationship Plans (ARPs, formerly known as alternate payment and alternate funding plans), and for the first time gives them equal standing with fee-for-service expenditures as a spending priority.

• Reduce barriers for internationally educated health providers
  o Assessment:
    – Nova Scotia: Recruitment of physicians for the Clinical Assessment for Practice Program (CAPP) a streamlining effort to assess qualifications of internationally trained specialists.
    – Matching service:
- British Columbia: Invested an additional $1.65 million in entry-level residency positions for IMGs. For the first time, B.C. is accepting candidates who wish to pursue specialist residencies. Placements will be determined by matching the candidate’s assessment results and interests with the specialty program’s readiness to train.

- Ontario: The ministry announced that, IMGs would be able to participate in the second iteration of the 2006 national physician matching process for postgraduate medical training positions in Ontario.

  o Resident Status:
    - Manitoba: The Physician Resource Coordination Office was implemented in November 2005 to assist and support Regional Health Authorities in physician recruitment and retention efforts and to assist physicians with immigration, obtaining licensure and employment in Manitoba.
    - British Columbia: IMGs on temporary work permits can now gain permanent resident status within six to eight months under the B.C. Provincial Nominee Program (BC PNP), instead of waiting up to three years. Makes it easier to settle families and set up practice, helping address pressures in the health care system, especially in rural British Columbia.

**Health Human Resources: Non-Physicians**

Content for this Section

**Provincial/Territorial perspective: Ministries of Health**

**Strategies to Address Challenges of Non-Physician Human Resources:**

- Improve upon per capita health care providers practice and distribution
  - Incorporate financial incentives to live in remote and rural areas
  - Enhance rural education programs
  - Promote health care careers
  - Increase academic accessibility
- Increase supply of health care providers ensuring availability when and where needed
- Improve upon utilization and distribution of existing health care providers
- Reduce barriers for internationally educated health providers
- HHR data collection and monitoring
- Legislation

**Strategies to Address Challenges of Non-Physician Human Resources:**

- Improve upon per capita health care providers practice and distribution.
  - Incorporate financial incentives to live in remote and rural areas.
    - Northwest Territories: provide and promote return of service bursaries to residents pursuing full time studies towards careers in front line health care or social service.
- Northwest Territories: promote employment within NWT to professionals in southern Canada for health and social service professions.
- New Brunswick: Provincial Health Bursary Program recruits new graduates from targeted health occupations into positions with the Regional Health Authorities.
- Saskatchewan: Establish a provincial recruitment agency to help attract hard-to-recruit professionals and locate health professionals in hard-to-recruit-to areas.
- British Columbia: Nurse practitioners eligible to have their student loans forgiven if agree to work in a publicly funded facility in an underserved area of the province.

○ Enhance rural education programs
- Northwest Territories: promote and provide opportunities for professional development initiatives and individual succession planning including but not limited to supporting transfer opportunities, cross-training and specific training.
- New Brunswick: Expand internship/residency programs in allied health based on needs and opportunities identified by professional groups and employers.
- New Brunswick: Annual Clinical Leaders Sponsorship Fund implemented to support networking amongst clinical leaders and their provincial and national peers.
- Saskatchewan: Enhance practical nursing training in locations where shortages exist.
- Saskatchewan: Increase ability to provide students with clinical placement.
- British Columbia: Nursing strategy funds a province wide education plan that is rural focused and practice driven to meet needs of nurses working in rural communities.

○ Promote health care careers
- Northwest Territories: promote and support baccalaureate programs in health careers to residents specifically targeting youth.
- Northwest Territories and Saskatchewan: Explore summer employment opportunities for students training to be health professionals.
- Saskatchewan: Increase the profile of health careers in elementary and high schools.

○ Increase academic accessibility
- Newfoundland: Bursary programs for students in physiotherapy, occupational therapy, speech language, pathology and audiology.
- Alberta: The Enhancing Clinical Capacity Project Fund (ECCPF) established to encourage, stimulate and finance innovative projects that enhance the capacity of organizations to provide health disciplines students with clinical learning opportunities in alternative, sustainable ways. The fund will address access to health education programs, including clinical placement problems.
- Ontario: An additional $3 million is provided to fund the Ontario Primary Health Care Nurse Practitioner Education Program, which is delivered by a consortium of
ten universities, and offers a post-baccalaureate certificate to graduates. In 2005/06, two initiatives to support recruitment and retention of nurse practitioners were introduced.

- Ontario: In 2005/06, colleges and universities will receive up to $72.3 million in operating grants for the nursing degree program. This increase will fund continued enrolment growth in the programs as well as Second-Entry degree nursing programs, including programs designed to enable an RPN to upgrade to a B.Sc.N.

- Ontario: The new Medical Laboratory Science program at the University of Ontario Institute of Technology will also increase the supply in 2008 when the first 30 students are expected to graduate.

- Increase supply of health care providers ensuring availability when and where needed
  - New Brunswick: Minister of Health and Wellness announced $500,000 for the implementation of a new Allied Health Professionals Resource Strategy, targeting primarily, health occupations with greater than 10 per cent forecasted shortages.
  - Ontario: The government launched its HealthForceOntario Strategy which aims to fill the shortage of health care professionals in Ontario by ensuring the right supply and mix of health care professionals. The HFO Strategy has three components:
    - Creating four new roles in areas of high need: Physician Assistant, Nurse Endoscopist, Surgical First Assist, Clinical Specialist Radiation Therapist.
    - Developing workforce by setting up a one-stop centre for internationally educated health professionals to obtain the information they need to work in Ontario.
    - Better equipping the province to compete for scarce health care professionals, in the rest of Canada and throughout the world, by establishing a marketing and recruitment centre including a comprehensive job portal.

- Improve upon utilization and distribution of existing health care providers
  - Saskatchewan: Establish health labour market council made up of Saskatchewan Health, Saskatchewan Learning, health employers and educational institutions to better integrate planning to match the supply and demand for health professionals.
  - Ontario: Underserviced Area Program provides operational funding for Nurse Practitioner positions and nursing stations in rural and northern communities whose population cannot support the services of a full-time primary care physician.
  - Ontario: Announced a fund that will help retain nurses- intended to assist hospitals with costs associated with orientation training and education so that nurses are prepared to fill vacancies due to hospital service changes.
  - Ontario: The ministry approved and funded the development of a curriculum to integrate inter-professional education at the Michener Institute.
    - Educational opportunities on the Picture Archiving and Communication System (PACS) were funded by the ministry and offered at the Michener Institute to
provide knowledge and skill on the efficient management of the information acquired.

- The ministry funded the Michener Institute to pilot a new Anesthesia Assistant Program which provides training for respiratory therapists and registered nurses who can participate as part of the anesthesia care team.

- Reduce barriers for internationally educated health providers
  
  o Saskatchewan: Assist internationally educated health professionals (IEHPs) to integrate into health sector. Projects include: Analysis of barriers impacting IEHPs; On-line portal for IEHPs and their families; Faculty development and mentoring modules for IEHPs; A bridging program for IEHPs; and Assessment tools to assess IEHPs’ readiness to practise and residency training.
  
  o Nova Scotia: IEHPs provides recruitment and training opportunities in hopes of increasing the number of health care professionals immigrating to Nova Scotia
  
  o Ontario:
    - Strategic Planning Project for IEHPs, including the completion of an environmental scan to identify initiatives currently underway for IEHPs, success and gaps.
    - Continued funding for the Michener Institute's Access and Options for Foreign Trained Health professionals project
    - Development of a CD/booklet resource for college guidance counselors advising IEHPs interested in practicing medical radiation technology and medical laboratory technology in Ontario.

- HHR data collection and monitoring
  
  o Northwest Territories: Conduct exit interviews to expand the base of knowledge regarding reasons for employee departure in order to better inform future practice
  
  o Newfoundland: Initiative to collect, update and examine key workforce statistics to better advise on workforce modeling and forecasting
  
  o Saskatchewan: Clarify the human resource needs for the current primary health care model and the pace for implementation.
  
  o Alberta: The Health Workforce Information Network (HWIN) Initiative, linked to the Alberta Provider Directory, will provide data on the health work force for policy and planning purposes.

- Legislation
  
  o Quebec: On April 5, 2006, the Conseil des ministres adopted a health workforce renewal strategy. A monitoring committee was established, chaired by the ministère de la Santé et des Services sociaux (MSSS) and made up of representatives from the ministère de l’Éducation, ministère du Loisir et du Sport, ministère de l’Emploi et de la Solidarité sociale, ministère de l’Immigration et des Communautés culturelles, Secrétariat du Conseil du trésor, and Office des professions du Québec.
References and Resources:

Physicians:
For additional information and detail on specific activities in each province please refer to Section D.


Canadian Institute for Health Information. (2002). *Perceived Surplus to Perceived Shortage: What happened to Canada’s Physician Workforce in 1990s?* Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2005a). *Supply, Distribution and Migration of Canadian Physicians*. Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2005b). *Geographic Distribution of Physicians in Canada: Beyond how many and where*. Ottawa: Canadian Institute for Health Information.


Canadian Institute for Health Information. (2006b). *Health Care in Canada*. Ottawa: Canadian Institute for Health Information.


Non-Physicians:
For additional information and detail on specific activities in each province please refer to Section D.

Canadian Institute for Health Information. (2005a). *Supply, Distribution and Migration of Canadian Physicians*. Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2005b). *Geographic Distribution of Physicians in Canada: Beyond how many and where*. Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2005c). *Canada’s Health Care Providers 2005*. 

Canadian Institute for Health Information. (2006b). *Health Care in Canada*. Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2006c). *The Regulation and Supply of Nurse Practitioners in Canada: 2006 Update*. Ottawa: Canadian Institute for Health Information.


Section 3  Health Information and Health Technology

Through the provincial submissions under the heading of Health Information, the following areas were included:

- Transparency and reporting on the government and the health care system
- Conducting research
- Health promotion and updates for the public
- Health Technology

Information technology. From websites and digitized health records to various diagnostic and decision aids- is having a dramatic effect on the health care system. One revolutionary tool to emerge with the Internet is the personal health record, which registers all physician and hospital visits. It allows better continuity of care among clinicians and in different settings. At the same time, it helps providers identify trends in use. Data processing applications have the potential to markedly decrease hospital administrative expenses and improve customer service (Canada Health Infoway, 2005, 2006; Canada Health Infoway and Health Council of Canada, 2006).

Telehealth. Visits to physicians and hospitals can be better managed or even eliminated through Telehealth systems, which are a valuable demand management tool throughout the world. Trained nurses listen to patients describe their symptoms and use “decision trees” to provide information and advice on whether and where to seek help. Telehealth is a valuable service in Canada’s vast remote areas, where access to treatment is extremely difficult. Using computers, telephones and video links, Telehealth can be used in nearly every area of health care, from emergencies to homecare, whether it’s for direct care, consumer or practitioner education, or administration (Davis, Howard, Brockway, 2001; O'Hanley, 2002).

A well-established health information system is essential not only in clinical care, but also in the development of new health technology. Diagnostic image sharing and robotic devices that facilitate delicate surgery, for example; each requires an advanced health information system to process and transmit data. The necessary investments in health information and health technology can be significant. Both federal and provincial governments have made significant efforts in 2006 to respond to these challenges (Canadian Institute for Health Information, 2005).

Current Data:

- Canada Health Infoway's (CHI) mandate is to provide a fully interoperable Electronic Health Records (EHR) for 50% of Canadians by 2009. The Health Council of Canada has called for 100% coverage by 2010 (Health Council of Canada, 2006). See Appendix C for a description of the potential impacts of the HER.
- To meet the Infoway mandate will be expensive. CHI published a consulting report last year (CHI 2005) that calculated it would cost $1 billion a year over a 10- year period to ensure 100 per cent coverage.
- CHI argues that this investment would more than pay for itself from savings accruing from avoided duplicated diagnostic tests and reduced incidence of medical errors.
The projected rate of Electronic Health Records (EHR) coverage varies among provinces. Newfoundland anticipates a fully functional, province-wide EHR by 2009. The Premier of Alberta has promised an EHR for every Albertan by 2008. Based on performance to date, these are enormously ambitious goals (Canada Health Infoway, 2006).

**Diagnostics**

- Compared to the 20 OECD countries reporting MRI data for the latest year comparable data were available, Canada ranked 12th, reporting 5.5 MRI scanners per million people. Japan and the U.S. had the highest number, with 35.3 and 27.0 per million, respectively. The median was 6.7. Canada ranked 15th among the 21 OECD countries reporting data on CT scanners, with 11.3 per million population. Japan and the U.S. had the highest number again, at 92.6 and 32.0 per million, respectively. The median was 14.0.

- A report released by the Canadian Institute for Health Information (CIHI) shows steady investment in MRI (magnetic resonance imaging) and CT (computerized tomography) scanners in Canada. The number of MRI scanners in 2005 was up more than 35% from five years earlier, while the number of CT scanners increased 19% in the same period.

- While Canada has fewer machines per million people, it uses its MRI scanners more intensively than the U.S. and England—the only other countries collecting comparable data. In 2004–2005, numbers of MRI exams per scanner were almost 40% higher in Canada than in the U.S. or England. At the same time, the U.S. performed more than three times the number of exams, reporting 83.2 MRI exams per 1,000 population in 2004–2005, compared to 25.5 in Canada and 19.0 in England. Canada also had about 50% more exams per CT scanner than the U.S. However, when comparing exams per population, the U.S. performed nearly double the exams, with 172.5 CT exams per 1,000 population, compared to 87.3 in Canada. The report also contains new data which show a substantial growth in the number of exams per 1,000 population. MRI exams per 1,000 population increased 13.3% in 2004–2005 from the year before, while CT exams per 1,000 population grew by 8.0% over the previous year.

- Increase in the number of MRI, CT scanners, and medical imaging workforce: At the beginning of 2005, Canada had 176 MRI scanners, up from 157 in 2004 and 130 five years earlier. The number of CT scanners installed as of January 2005 rose to 361, up from 346 the year before and 303 five years earlier. The number of medical imaging professionals also increased. There were 177 new medical radiological technologists in 2004, bringing the total number up to 12,229. The number of diagnostic radiologists also went up by 61 during the same period, bringing the total number of diagnostic radiologists up to 1,967.

- Provincial and territorial variations in number of machines and exams per population: The number of exams per 1,000 population varied significantly across the country in 2004–2005, with MRI exams ranging from a high of 36.6 per 1,000 population in Alberta to a low of 8.5 per 1,000 in Newfoundland and Labrador. The Canadian average was 25.5 (Nova Scotia is not included in the MRI-per-1,000-population comparison, because of a different reporting method used by two hospitals). For CT exams, the number ranged from 134.8 per 1,000 population in New Brunswick to 78.2 in British Columbia. The Canadian average was 87.3.
Alberta, British Columbia, and Quebec have experimented with allowing privately funded diagnostic imagery clinics (Canadian Institute for Health Information, 2005).

Waiting times for diagnostic procedures ranged from a median 5 weeks for a CT scan to a median wait of 12 weeks for an MRI in 2001 across Canada. Wait times for ultrasound was 2.5 weeks across Canada (Fraser Institute). In 2003, the average waiting time for MRI scans was 47 days as against 31 for CT scans (Noseworthy, 2005).

**Federal Perspective: Health Canada**

**Canada Health Infoway**

The Canada Health Infoway is an independent not-for-profit corporation working in collaboration with members of Canada’s 14 federal, provincial and territorial Deputy Ministers of Health. Canada Health Infoway is focused on nine EHR investment areas: Registries, Diagnostic Imaging, Drug Information Systems, Laboratory Information Systems, Interoperable electronic health records (EHRs), Telehealth, Public Health Surveillance, Innovation & Adoption and Infrastructure.

- Funding: Infoway is funded by the federal government which, to date, has provided $1.2 billion for investment in joint projects with the provinces and territories.
- Co-invests with Jurisdictions: Infoway’s investment contribution, on average, is 75% of eligible project expenses with provinces, and up to 100% with territories.
- Exceeded 2005-06 Investment Targets: Infoway’s $381M in investment approvals/commitments exceeded the target by $56M. This represents a 95-per-cent increase over last year and more than doubles Infoway’s approved investments since inception, with the cumulative now standing at $702.4M. A total of 58 new projects were launched across Canada.
- Shifted to Implementation from Planning: Half of Infoway’s projects are now in implementation phase, a five-fold increase from 2004-05.
- Focused on Privacy and Security: Renewed focus on privacy and security with the establishment of an Infoway Chief Privacy Strategist and comprehensive Privacy and Security Architecture.
- Supported Clinician Adoption: Infoway worked closely with healthcare organizations to accelerate electronic health record adoption by physicians, nurses, pharmacists, and other professionals.
- Additional Project Funding: An additional $400M is estimated to be required to complete future phases of current projects. Most of this additional funding will be spent on Drug, Lab and iEHR projects as they move from planning to implementation phases.
Provincial/Territorial Perspective: Ministries of Health

**Telehealth**

- Saskatchewan: In 2005-06 the telehealth network was expanded by 8 sites to bring the total to 26 sites. It allows residents in remote areas access to some specialists without having to leave the community.
- Quebec: Is involved in tele-consultation via videoconference; this is being applied in a number of medical specialties such as psychiatry, genetics, general practice, nephrology and rehabilitation. Other more specific applications allow remote consultations and diagnoses to take place, primarily in pediatric cardiology, tele-speech language pathology and tele-pathology, tele-radiology, and tele-home monitoring. The videoconferencing network also allows tele-training to take place in a number of remote establishments.
- Nova Scotia: The Nova Scotia Telehealth Network (NSTHN): Currently identifying actions to increase utilization of the available hospital-based network and actions required to facilitate access to Telehealth technologies in home, long-term care, and other community settings. In addition, the particular needs of francophone communities and First Nations communities for access to Telehealth services will be examined.
- Newfoundland: Approves provincial plan for telehealth, which will provide direction for all aspects of telehealth including clinical video-conferencing (e.g. tele-oncology, tele-diabetes), and interoperability amongst telehealth activities and with provincial Electronic Health Records (EHR) plan. The implementation plan is in the final stages and will be initiated in the next fiscal year.

**Health Information / Electronic Health Record (EHR)**

- Yukon: A new Client Registry and a Drug Information System is currently in the process of being developed.
- Alberta: The seven rural health regions, through the Rural Shared Health Information Program (RSHIP) have implemented a common health information system (clinical, financial, and administrative applications).
- Saskatchewan: In 2005, began to implement the first EHR solution, the Pharmaceutical Information Program, which allows clinicians to view complete patient drug profiles. Work also continues on Lab Results reporting and Diagnostic Imaging systems. In 2006, new technologies for Primary Health Care supporting team based methods of delivery will be introduced as well as a new Surgical Information System, which supports the Action Plan challenge to reduce wait times for surgical procedures.
- Manitoba: Preparing to launch the next phase of Hospital Information System Project (HISP) with a planning project focused on Community Hospitals and Long-Term Care facilities. This planning project is expected to begin in late May - early June 2006 and planned to be finished November 2006.
- Ontario: 14 local data management partnerships, made up of health information management officials from hospitals and the community care sector were put in place to work with their
Local Health Integration Networks- identifying best practices, standards, tools, and policies for better data quality and management.

- **Ontario**: As part of the focus on closing information gaps, the ministry will be implementing the Health Outcomes for Better Information and Care (HOBIC) initiative. This initiative will involve the province-wide, standardized collection of patient health outcomes reflective of nursing and other health care disciplines.

- **Quebec**: Bill 83, adopted by the *Assemblée nationale du Québec*, contained legislative measures that modified the rules governing the sharing of health information and made provision for the creation of regional information retention services.

- **Nova Scotia**: The Nova Scotia Hospital Information System (NSHIS) continues to be implemented and is on target for completion in all 34 hospitals in the 8 District Health Authorities (DHAs) by March 31, 2006. Primary Health Care Information System (PHCISP), as part of Nova Scotia’s Primary Health Care Transition funding, will begin installation for qualifying clinic sites during Spring of 2005 and plans to have as many as 150 primary health care providers using the new systems by September 2006.

- **Newfoundland**: A Request for Proposals for pilot testing an Electronic Medical Record (EMR) in Fee-for-Service Physician Practices is in process, with awarding of a contract planned by the end of this fiscal year. Newfoundland & Labrador Centre for Health Information (NLCHI) will begin implementation in May 2006 of the provincial drug information system - the Newfoundland and Labrador Pharmacy Network. Health information system already implemented in the province are: Meditech software in all Regional Integrated Health Authority (RIHA) facilities that provide acute and long-term care services; Client and Referral Management System (CRMS) for use in all RIHA in the provision of community-based services. A new CRMS module to manage payments to clients is currently being developed.

- **Prince Edward Island**: The upgrade of the PeopleSoft Human Resource Management System, which includes upgrades to the health payroll system, commenced in January 2006. The Pharmacy Network project will create a database containing prescription information collected from both physicians and retail pharmacies for all individuals receiving prescriptions within PEI. It will involve modifying the existing system and the retail Pharmacy systems to capture the required information. The system will be accessed by all retail and institutional pharmacy sites, emergency departments and physician sites.

**Digital Imaging**

- **Newfoundland**: NLCHI has begun the implementation of the provincial Diagnostic Imaging/Picture Archiving and Communications System. This information system will facilitate the sharing of images and reports among the Regional Integrated Health Authorities (RIHA).

- **Nova Scotia**: The Department in cooperation with DHAs, and with support from Canada Health Infoway, is enhancing and expanding the current provincial Picture Archiving and Communications System (PACS) environment including the capability to store images centrally in a provincial Diagnostic Image Archive. The planning phase is complete and implementation began April 1, 2005. The expected completion date is September 2006.
Health Information / Publications

Provincial Ministry Websites

Include issues as annual reports, health indicators and health studies/research conducted within or on behalf of the ministry over a given year or collectively over a number of years. These reports are often used to guide public health updates.

The following are direct addresses to provincial ministries of health publication/report sites:

- Northwest Territories: Health Social Services publications
  [www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp](http://www.hlthss.gov.nt.ca/content/Publications/Reports/reports.asp)

- Newfoundland: Health and Community Services Publications

- New Brunswick: Publications
  [www.gnb.ca/0051/pub/index-e.asp](http://www.gnb.ca/0051/pub/index-e.asp)

- Saskatchewan: Department and Stakeholder Publications

- Manitoba: Publications

- British Columbia: Annual Service Plan Reports
  [www.bcbudget.gov.bc.ca/Annual_Reports/2005_2006/default.htm](http://www.bcbudget.gov.bc.ca/Annual_Reports/2005_2006/default.htm)

- Reports and Publications

- Yukon: Publications and Resources

- Nova Scotia: Department of Health Reports
  [http://www.gov.ns.ca/health/reports.htm](http://www.gov.ns.ca/health/reports.htm)

- Nova Scotia Health Network
  [http://www.nshealthnetwork.ca/index.cfm](http://www.nshealthnetwork.ca/index.cfm)

- Prince Edward Island: Health

- Alberta: Publications

- Ontario: Professional Publications Online

- Quebec: Documentation Publications
• Nunavut: Health Information and Research

• Furthermore consider: Statistics Canada and CIHI, for developing health information
  management, reporting, analysis and research capabilities.

References and Resources:

For additional information and detail on specific activities in each province please refer to
Section D.

Canada Health Infoway (2006). Fulfilling the Promise: Canada Health Infoway Inc. Annual

Canada Health Infoway (2005). Canada Health Infoway's Ten Year Investment Strategy - Pan
Canadian Electronic Health Record: Projected Costs & Benefits.

Canada Health Infoway & Health Council of Canada (2006). BEYOND GOOD INTENTIONS:
Accelerating the Electronic Health Record in Canada. Conference Proceeding, June 11-
13, 2006, Montebello QC

Canadian Institute for Health Information. (2005). Medical Imaging in Canada 2005. Ottawa:
Canadian Institute for Health Information.

identifying and addressing the root causes of critical incidents in healthcare. Retrieved

Davis, P., Howard, R., & Brockway, P. (2001). An evaluation of telehealth in the provision of


Papers .6(1):24-7.

Section 4  Primary Health Care

Primary health care is viewed as the foundation of Canada’s health care system in that it is usually the first point of contact Canadians have with the system. It is widely recognized that, primary care is the entry point to an integrated, continuum of care based health care system and that in order to be effective it must be comprehensive (Health Canada, 2006; National Primary Health Care Awareness Strategy, 2006; Health Council of Canada, 2006).

After the 2003 First Ministers’ Accord, provincial governments committed to improving primary health care in order to ensure that citizens receive needed care from an appropriate health care provider when and as needed. The goal by 2011 was that “at least 50 per cent of their residents will have access to an appropriate health care provider, 24 hours a day, seven days a week.” This target was slightly altered in the 2004 Ten-Year Plan with “the objective of 50 per cent of Canadians having 24/7 access to multidisciplinary teams by 2011” (Health Council of Canada, 2005).

Current directions in reforming primary health care include creating inter-professional teams to provide a wide range of health promotion and treatment services. All provinces and territories are now implementing some form of a team approach.

Current Data:

- It is believed that successful reform of Primary Health Care will:
  - Augment an integrated health care delivery system and strengthen continuity of care;
  - Shift the focus from practitioners to the people/populations who utilize and receive health care;
  - Make better use of health professionals and promote better team dynamics and partnerships;
  - Place a stronger emphasis on health promotion and disease prevention; and
  - Ensure appropriate access to specialized health resources (Health Council of Canada, 2005).

- The Primary Health Care Transition Fund common objectives, agreed to by federal, provincial, and territorial governments, are to (HCC, 2005):
  - Increase the number of people with access to primary health care organizations accountable for the provision of a clearly defined set of comprehensive health services to a defined population;
  - Increase health promotion, disease and injury prevention, and the management of chronic diseases for both individuals and communities;
  - Expand each person’s 24/7 access to essential health services;
  - Ensure each person has the most appropriate care, provided by the most appropriate professional through multidisciplinary primary health care teams;
Provide timely access to a team of health care providers that address health problems and coordinate patient care;

- Actively address the needs of communities as well as providing appropriate care to individual patients;
- Ensure that each person’s health care is coordinated and integrated with other health services provided by institutions and community and other government organizations (Health Council of Canada, 2005).

The purpose of primary health care renewal is to improve the quality, accessibility and sustainability of front-line health care services to ensure that Canadians receive the most appropriate care, from the most appropriate provider, when and where they need it. It is intended to offer lasting solutions to many of the problems with today’s health care system, including long wait times and limited access to essential services (Health Canada, 2005).

Federal perspective: Health Canada

Primary Health Care Transition Fund

On November 18, 2005, a one-year extension of the Primary Health Care Transition Fund was announced, in the amount of $10.6 million, permitting the launch of new initiatives in the 2006-2007 fiscal year.

- The Federal Health Minister announced funding for projects on collaborative patient-centred practice.

<table>
<thead>
<tr>
<th>Contents for this Section</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provincial/Territorial perspective: Ministries of Health</strong></td>
</tr>
<tr>
<td>Common elements of these strategies are:</td>
</tr>
<tr>
<td>- <strong>Improved continuity and coordination of care:</strong></td>
</tr>
<tr>
<td>o greater access to providers 24 hours a day, seven days a week;</td>
</tr>
<tr>
<td>o use of multidisciplinary teams and new ways to organize people to deliver primary health care;</td>
</tr>
<tr>
<td>- <strong>Early detection and action:</strong></td>
</tr>
<tr>
<td>o a stronger focus on health promotion and prevention;</td>
</tr>
<tr>
<td>o a focus on chronic disease management;</td>
</tr>
<tr>
<td>- <strong>Better information:</strong></td>
</tr>
<tr>
<td>o the expansion of the electronic health record and telehealth technologies;</td>
</tr>
<tr>
<td>- <strong>Incentives to change practice:</strong></td>
</tr>
<tr>
<td>o the use of innovative funding models;</td>
</tr>
<tr>
<td>o the integration of non-medical personnel;</td>
</tr>
<tr>
<td>o innovative recruitment and retention strategies</td>
</tr>
<tr>
<td>- <strong>Primary health care evaluation</strong></td>
</tr>
</tbody>
</table>
Provincial/Territorial Perspective: Ministries of Health

Common elements of these strategies are:

- Improved continuity and coordination of care:
  - Greater access to providers 24 hours a day, seven days a week;
    - Alberta: objectives of the Primary Care Initiative Agreement addressed through the development of Local Primary Care Initiatives now known as Primary Care Networks (PCNs). PCNs are partnerships between the health regions and physician groups to provide a defined set of primary care services ranging from population health through minor surgery and emergency care, and based on 24/7 management of access to appropriate primary care services, access to diagnostic services and coordination of access to homecare, emergency room, long-term care, secondary and public health services. As of March 2005, 14 Networks have begun operation and another 15 are under development.
    - Manitoba: The Physician Integrated Network (PIN), currently in development, focuses on the engagement of autonomous, independently owned fee-for-service physician groups. Interdisciplinary collaboration will be a key feature as this approach evolves. The objectives of the project include: improved access to primary care, improved providers’ access to and use of information systems, improved work environment for providers, and a demonstrated improvement in primary care with specific focus on chronic disease management.
    - Ontario: The Government has emphasized the need to strengthen the primary health care models and has allocated $600 million for 2005-2006 for primary health care operations. This includes $100 million for incentives to family physicians for enhanced primary care services including preventive and comprehensive care incentives.
      - Family Health Teams remain a central element of Ontario’s strategy to improve primary health care access. An example of interdisciplinary collaborative care will provide patients with a health care provider 24 hours a day, 7 days of weeks. Teams will include physicians, nurses, nurse practitioners, and other health care providers such pharmacists, dieticians, midwives, social workers, health educators and others that will provide comprehensive care with an increased emphasis on health promotion and disease prevention and chronic disease management.
    - Quebec: A major concern is the accessibility to frontline care, which has driven the implementation of groupes de médecine familiale (GMF) and the development of networked clinics in the Montreal region. After agreement with the Fédération des médecins omnipraticiens du Québec (FMOQ), these medical clinics will be tailored to the characteristics of urban medical practice and will meet the need to provide the public with more comprehensive medical services and extended operating hours.
  - Use of multidisciplinary teams and new ways to organize people to deliver primary health care;
- New Brunswick: Primary Health Care nurse practitioners are now part of the New Brunswick health care system. At the end of December 2005, 27 nurse practitioners were practising in various primary health care settings: community health centres, family practices, emergency rooms, and nursing homes; within a collaborative and interdisciplinary care model.
- Nova Scotia: Nurse Practitioners incorporated into multidisciplinary teams in 14 communities.
- Newfoundland: Increase participation of family practice physicians in primary health care teams.
- Prince Edward Island: Family Health Centres were operational in 5 communities using newly renovated facilities and expanding existing family physician services to include primary care nurses and other health professionals working in collaborative practices.
- Atlantic Provinces: Ongoing joint initiative to deliver continuing professional education modules to primary health care providers in all 4 provinces.

- Early detection and action:
  - A stronger focus on health promotion and prevention;
    - Yukon: Major activities included information technology projects in mental health, public health, and client registry, initiating a Diabetes Collaborative, undertaking a participatory alcohol and drug research project and making a health guide and web-access information available to the Yukon public.
  - A focus on chronic disease management;
    - British Columbia: Steps taken to improve upon chronic disease management:
      - Implementing 4 provincial chronic disease management collaboratives with IT support and a patient self management initiative.
      - In partnership with the BC College of Family Physicians, BC physicians are receiving professional development on how to help patients set self-management goals (i.e., lifestyle changes such as diet and exercise).
      - In partnership with the BC College of Physicians and Surgeons, GPs are receiving training on how to self-evaluate their practice.

- Better information:
  - The expansion of the electronic health record and telehealth technologies;
    - See under ‘Health Information and Health Technology’.

- Incentives to change practice:
  - The use of innovative funding models;
- See under ‘Human Resources: Physician and Non-Physician’
  - The integration of non-medical personnel;
    - See under ‘Human Resources: Non-Physician’
    - Manitoba: The Physician Integrated Network (PIN)
- Innovative recruitment and retention strategies
  - See under ‘Human Resources: Physician’
  - Manitoba: The Physician Integrated Network (PIN)

- Primary health care evaluation
  - Nova Scotia: Current activities focus on primary health care indicator development and capacity building within the District Health Authorities to evaluate the impact of changes made as a result of renewal activities and enhance the ability to continue to improve the primary health care system beyond the transition phase.
  - Alberta: Provincial evaluations are underway for both Health Link Alberta and the 10 initiatives funded through the Capacity Building Fund.
  - New Brunswick: There has been significant ongoing effort to develop and implement appropriate data collection and monitoring processes in all primary care sites to improve accountability and evaluation.

References and Resources:

For additional information and detail on specific activities in each province please refer to Section D.


Section 5  Public Health (Population and Community Health)

Public health focuses on what needs to be done as a society to help each and every individual stay healthy. Public health is about the way individuals live and as such it encompasses everything we do. For the federal/provincial/territorial governments, public health is made up of a range of efforts to keep people healthy (and reduce the demand on the health care system). This includes activities like immunization, healthy eating and physical activity programs, infection control measures in hospitals, along with the detection, lab testing and regulation that supports these activities. By helping Canadians stay healthy, public health can relieve some of the pressure on the health care system. This ideology is based on the concept introduced in the 1974 Lalonde Report, which established the importance of moving away from an illness-oriented health care model to a wellness model (Public Health Agency of Canada, 2005, 2006).

Both the terms "population health" and "community health" are frequently used in place of the term "public health" (Public Health Agency of Canada, 2005, 2006).

Population Health

Population health aims to improve the health of the entire population and to reduce health inequities among groups, by considering and acting upon the broad range of factors and conditions that have a strong influence on health. The Public Health Agency of Canada unifies, integrates and balances the entire spectrum of health system interventions from prevention and promotion to health protection, diagnosis, treatment and care (Public Health Agency of Canada, 2005, 2006).

An underlying assumption of a population health approach is that reductions in health inequities require reductions in material (socioeconomic status) and social inequities. Therefore a population health approach, extends beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, reduce disparities, and strengthened social cohesion and citizen engagement (Public Health Agency of Canada, 2005, 2006).

Community Health

Community health is defined as the level and distribution of disease, functional status and well-being of the community. As a perspective of public health it assumes the community to be an essential determinant of health and the indispensable ingredient for effective public health practice (Public Health Agency of Canada, 2005, 2006; Canadian Institute for Health Information, 2005).

Influences on community health can be defined as those factors that affect the health of a community. These include both integral and derived variables. Influences include community attributes (biological characteristics, social attributes, built environment, health services, economic resources, population-based programs, collective lifestyles and health practices) and situational attributes (natural environment, cultural context, political context) (Public Health Agency of Canada, 2005, 2006; Canadian Institute for Health Information, 2005).
Current Data:
• The Government of Canada’s commitment to renew and strengthen public health included the establishment of six National Collaborating Centres (NCC) for public health. The NCC for the Social Determinants of Health was assigned to Atlantic Canada. Although located regionally, it is intended to provide a national focal point as one key component of the overall pan-Canadian public health strategy, drawing on regional, national and international expertise (Canadian Institute for Health Information, 2006; Health Council of Canada, 2006).

• Canada’s Food Guide to Healthy Eating: Health Canada is revising the guide to Healthy Eating for release in the Fall of 2006 to ensure that it reflects current scientific evidence concerning the relationship between diet and health, and continues to promote a pattern of eating that meets nutrient needs and minimizes the risk of nutrient-related chronic diseases such as Type II diabetes (Canadian Institute for Health Information, 2006).

Aboriginal

• Life expectancy for Aboriginal communities is below the national average (77 male and 82.1 female) at 70.4 for Registered Indian males (69.2 for Registered Indian Male on Reserve) and 75.5 for Registered Indian females (74.3.2 for Registered Indian Female on Reserve) in 2001.

• The demographic structure of the Registered Indian population is relatively youthful and is growing more rapidly than the Canadian population as a whole. In 2001, the average number of children per family for the Registered Indian population living on reserve was approximately twice that of the entire Canadian population. With the birth rate of the aboriginal population expected to increase by around 3% annually from 1998 to 2008.

• The Infant Mortality Rate (IMR) for the Registered Indian on-reserve population was 7.2 in 2001 as compared to 5.2 for the total Canadian population.

• Compared to the general Canadian population: Heart disease is 1.5 times higher; Type 2 diabetes is 3 to 5 times higher among First Nations people and rates are increasing among the Inuit; and Tuberculosis infection rates are 8 to 10 times higher.

• Aboriginal people in Canada continue to be over-represented in the HIV epidemic: Although they represent only 3.3% of the Canadian population, Aboriginal persons comprised 5-8% of prevalent infections (persons currently living with HIV infection in Canada) and 6-12% of new HIV infections in Canada in 2002 (Indian and Northern Affairs Canada, 2005).

Chronic Diseases

• An estimated two-thirds of deaths in Canada are associated with chronic diseases, including cardiovascular disease, cancer, lung diseases and diabetes. There is an increasing focus on chronic disease management in order to reduce the impact of chronic diseases on health, prevent the occurrence of chronic diseases and reduce costs associated with them.

• Chronic disease costs the Canadian economy an estimated $80 billion annually through illness and disability.

• Focus shifting to health prevention—smoking cessation, exercise, promoting healthy eating habits, weight loss — to reduce their risk for chronic diseases such as diabetes, cancer, and
lung or heart disease. Yet funding for health education and promotion is dwarfed by investments in treatment. A recent report by the Organisation for Economic Co-operation and Development (2006) calculates that Canada spends just eight per cent of total health care expenditures on public health and prevention.

- Provincial governments are setting policies, in chronic disease management, that help create healthy schools, work environments, and communities. Chronic disease management includes:
  - Identifying patients with chronic disease;
  - Having access to data on individuals and populations through high-quality information systems;
  - Organizing patients by risk;
  - Involving patients in their own care;
  - Using case managers to coordinate care;
  - Using interprofessional teams;
  - Integrating specialist and generalist expertise;
  - Minimizing unnecessary visits and admissions; and
  - Providing care in the least intensive setting (Health Council of Canada, 2006).

---

**Chart 3. Leading Causes of Death, Worldwide, 2005**

- Cardiovascular disease 30%
- Communicable diseases, maternal and perinatal, nutritional deficiencies 30%
- Cancer 13%
- Other chronic disease 9%
- Injuries 9%
- Respiratory 7%
- Diabetes 2%

Source: World Health Organization
Obesity

- Obesity rates have increased in all OECD countries in recent decades. In Canada, in 2004, the adult obesity rate was 22.4%. The obesity rate in Canada remains much lower than the United States (30.6% in 2002), the United Kingdom (23% in 2004). In Canada, obesity is estimated to account for roughly 2% to 3.5% of total health expenditure. Since there is a time lag between the onset of obesity and health problems that results from obesity (diabetes, heart disease, asthma, for example), the recent increases in obesity will likely lead to higher health expenditures in the future (Organization Economic Co-operation and Development, 2006).

- There are differences between provinces in measured obesity among adults. Results from Statistics Canada’s 2004 Canadian Community Health Survey (CCHS) show that adult men in Newfoundland and Labrador (33%) and Manitoba (30%) were more likely to be obese, relative to the Canadian average (23%). Among women, obesity rates are higher in Newfoundland and Labrador (35%), Nova Scotia (30%) and Saskatchewan (33%) than the national average of 23% (Canadian Institute for Health Information, 2006).

- Among children (2 to 17 years), the CCHS results show that the overweight/obesity rate in 2004 was significantly higher than the Canadian average (26%) in Newfoundland and Labrador (36%), New Brunswick (34%), Nova Scotia (32%) and Manitoba (31%)—and significantly lower in Quebec (23%) and Alberta (22%) (Canadian Institute for Health Information, 2006).

- Promoting healthy weights involves more than simply prescribing diet and exercise—social and environmental factors can also play a role according to a new report from the Canadian
Population Health Initiative (CPHI, 2006) at the Canadian Institute for Health Information (CIHI). Data in the report show that adults in the highest-income households are less likely to be inactive, compared to adults in the lowest, lower-middle, middle and upper-middle income households. High-income adults are also more likely to report consuming fruit and vegetables five or more times a day. Overall, less than one-fifth (18%) of Canadians report being active, and one-quarter (25%) report being moderately active. Adults living in Canada’s urban cores report being less overweight and obese (Canadian Institute for Health Information, 2006).

In 2005, CIHI’s Canadian Population Health Initiative commissioned the public opinion research firm POLLARA to nationally survey in regards to their views on health and healthy weights. More than half of those polled (56%) think reducing obesity is very important to the overall health of Canadians, and nearly three-quarters (73%) view reducing obesity as a personal responsibility. The survey also asked Canadians about their views on a variety of potential initiatives to promote healthy weights, some of which have more supporting evidence than others. The majority of those polled strongly support future initiatives that would ensure people have access to reasonably priced foods (78%) and that would require fast food companies to provide nutritional information about each product they sell (68%). Over half (57%) strongly support offering incentives to employers who provide fitness facilities or programs to their workers. Thirty-nine percent (39%) of Canadians polled believe that encouraging the development of communities where cars are not always needed to get around is very important to the health of the people in their community. Nearly one-quarter (24%) strongly support charging more tax for less healthy food choices (Canadian Institute for Health Information, 2006).

A number of provinces have introduced policies for schools. For example, New Brunswick has adopted a comprehensive policy on food and nutrition to provide students in public schools with healthy food and beverage choices. British Columbia has also introduced guidelines for food and beverages to eliminate the sale of junk food in schools. Ontario and Alberta have introduced policies regarding minimum physical activity requirements in schools (Canadian Institute for Health Information, 2006).

Past research has linked obesity with a number of major preventable chronic diseases, including cardiovascular disease, hypertension, type II diabetes, arthritis and some types of cancer (Canadian Institute for Health Information, 2006).

Researchers estimate total direct cost of weight-related major chronic diseases towards Canada’s health system was nearly $1.6 billion in 2001; coupled with indirect costs, this total was $4.3 billion (Canadian Institute for Health Information, 2006).

**Tobacco**

According to OECD (2006), Canada provides an example of a country that has achieved remarkable progress in reducing tobacco consumption. In 1980, the rate of daily smokers among adults was 34%, and 15% in 2004, the lowest rate among all OECD countries. OECD attributes much of this decline to policies such as public awareness campaigns, advertising bans and high taxation.
Avian Influenza

- Since mid-December 2003, Asian countries have increasingly reported outbreaks of highly pathogenic avian influenza H5N1 in chickens and in ducks.
- Health Canada, together with other federal government departments and provincial and territorial governments have taken action in a number of areas to protect Canadians. Activities include: Maintaining the Canadian Pandemic Influenza Plan. A plan that maps out how Canada will prepare for and respond to pandemic influenza. The Agency continues to work on the plan based on new information that becomes available. The plan also provides a model for responding to other infectious disease outbreaks.
  - Establishing a contract for pandemic vaccine production. Canada being the first country to plan for a secure vaccine supply through the contracting of a domestic supplier.
  - Creating a national antiviral stockpile for use against an influenza pandemic. The national antiviral stockpile will be used to treat identified priority groups agreed upon by a national expert committee.
  - Managing the National Emergency Stockpile System (NESS, from beds and blankets and the supply of pharmaceuticals.
  - Providing international leadership on pandemic preparedness. Canada is collaborating with the WHO, other international organizations and other countries to improve global pandemic preparedness. Canada is co-leading with the United Kingdom discussions related to the supply and use of antivirals within the Global Health Security Action Group with the G7 plus Mexico.
  - Managing a real-time alert system for serious respiratory illnesses (SRIs), including SARS and avian influenza, to ensure timely dissemination of information to the provinces and territories.
  - Putting in place a hospital-based surveillance system to detect cases and clusters of severe or emerging respiratory infections and to effectively prevent and contain their spread in acute care facilities.
  - Monitoring the global situation and verifies information received from the Global Public Health Information Network (GPHIN) alert system. GPHIN tracks thousands of global media stories on public health issues and allows the Public Health Agency to quickly identify and monitor cases of severe respiratory infections around the world.
  - Ongoing support and maintenance of Quarantine Services at the Toronto, Vancouver, Montreal, Calgary, Edmonton, Halifax and Ottawa international airports. Quarantine officers provide health assessments for international travellers who have signs of illness (Canadian Broadcasting Corporation, 2006).

Federal perspective: Health Canada

Health Canada, either directly or through agreements with communities, provides community-based public health programs to First Nations and Inuit communities and limited treatment services in isolated communities. The community-based health services encompass a wide range
of programs which include well-baby clinics; health education and promotion; immunization; addiction prevention and treatment; and community health nurse services. In addition, in isolated communities, where access to treatment services is limited, the department provides nurses who are specially trained in an expanded role.

First Nations and Inuit Health

The First Ministers’ Meeting on Aboriginal Issues held in November 2005 fulfilled commitments made at the previous First Ministers’ Meeting in 2004 to hold a meeting on Aboriginal issues and to table a Blueprint on Aboriginal Health. The 2005 meeting focussed on five key priorities: health, education, housing, economic opportunities, and relationships. A commitment was made to close the gap in health status between Aboriginal peoples and other Canadians within ten years. Specific targets were set to reduce infant mortality, youth suicide, childhood obesity and diabetes by 20% in five years, and by 50% in ten years. A commitment to double the number of Aboriginal health professionals within ten years was also made. Specific federal initiatives include the following:

- Health Integration Initiative
- Tobacco Use Cessation Practices
- Tuberculosis in First Nations Communities
- Aboriginal Diabetes Initiative
- National Aboriginal Youth Suicide Prevention Strategy: In 2005, Health Canada began to implement the strategy as a national program, with the aim to reduce risk factors and promote protective factors against suicide in Aboriginal communities across Canada. Funding for this new program was allocated in the Federal 2005 Budget in the amount of $65 million.

- Maternal and Child Health Program in First Nations Communities: Established in 2005, with Health Canada’s $110 million investment over the next five years. The purpose of this program is to improve health and social outcomes for pregnant women, and families with infants and young children.

- Early Childhood Development in First Nations and Inuit Communities: In 2005, Health Canada’s initiatives focussed on integrated service delivery for First Nations and Inuit communities with a view to improving efficiencies and reducing reporting burdens for the following federal programs: Aboriginal Head Start On Reserve (Health Canada); Aboriginal Head Start Urban and Northern Communities (Public Health Agency of Canada); the First Nations and Inuit Child Care Initiative (Human Resources and Social Development Canada); and Indian and Northern Affairs Canada funded daycares in Alberta and Ontario.
Common elements of these strategies are:

- **Addictions**
  - Smoking/Tobacco
    - Treatment/cessation: Nova Scotia (Nicotine treatment programming and pharmacological cessation aids).
    - Policy/Legislation: Manitoba (*Non-Smokers Health Protection Act*), Nova Scotia (Enforcement of the Smoke-Free Places Act), British Columbia (Clean win for B.C. in tobacco ruling), Quebec (Bill 112 modified the Tobacco Act).
  - Gambling
    - Prevention and treatment services: Saskatchewan.
  - Drugs
    - Crystal Meth: British Columbia (for treatment programs and support), Manitoba (restricting supply and reducing demand by targeting drug production and focusing on public awareness campaigns).

- **Pandemic/Infection Disease**
  - Planning and preparedness: Manitoba.
  - Avian Influenza.
    - Health information: Northwest Territories (fact sheets).
    - Disease prevention: British Columbia (increased flu vaccine order), New Brunswick, Prince Edward Island.
• Immunization/Vaccinations
  o Northwest Territories: Offered free influenza vaccinations to all residents and published brochure- *Myths and Facts about Influenza Vaccine.*
  o Yukon: Changes to the Immunization Schedule- introduction of vaccines for varicella for infants, pertussis for adolescents, pneumococcal for infants and toddlers, and meningitis for infants and adolescents.
  o British Columbia: Expanded vaccine program- Two-month old infants were eligible for the meningococcal C conjugate vaccine; Children aged 18 to 48 months were eligible for the chickenpox vaccine; Grade 12 students became eligible for the meningococcal C conjugate vaccine in 2005; Susceptible women (those who have not had chickenpox) of childbearing age are now eligible for the varicella vaccine.
  o Saskatchewan: Introduced two new vaccines into the routine publicly funded immunization program- pneumococcal conjugate (infants 2 months of age), influenza vaccine (children 6 - 23 months of age).
  o Prince Edward Island: All children born after April 1, 2005 receive the pneumococcal conjugate vaccine administered at 2 months, 4 months, 6 months and a booster at 12 - 18 months of age.

• Sexual Health
  o Health information: Yukon (education curriculum, toll-free line, health promotion strategy), Manitoba (sexual and reproductive health promotion)
  o Campaign: Yukon (Condom distribution campaign)

• Nutrition
  o Health information: British Columbia (electronic professional services database to provide up-to-date nutrition information), Manitoba (Food and Nutrition web site to provide education/prevention information with nutrition and infant feeding resources).
  o Health promotion: Nova Scotia (Provincial Breastfeeding and Baby-Friendly Initiative).
  o Community grants: British Columbia (community kitchens, gardens, good food boxes, and other local activities).
  o Campaign:
    - Yukon: *Drop the Pop, Drink to your health!*
    - British Columbia: Action Schools! BC Healthy Eating Module; School Fruit & Vegetable Program (to promote healthy eating and increase access to healthier snacks in schools by providing one serving of BC-grown fruits or vegetables to children twice a week at ten elementary schools).

• Prevention/Intervention Programs
  o Nova Scotia: In February 2006, Nova Scotia Health Promotion and Protection was formed from Nova Scotia Health Promotion, formerly the Office of Health Promotion, Public Health Branch of the Department of Health and the Office of the Chief Medical Officer of Health. Chief business areas include: healthy eating; healthy sexuality;
physical activity; tobacco control; injury prevention; addictions; chronic disease prevention; health protection and public health; and communications and social marketing.

- Health promotion campaign: Nova Scotia (Social Marketing Campaign for Parents-targets parents of young children aged 0-12 and focuses on healthy eating, physical activity, car seats/booster seats, and second hand smoke in the home).
- Injury prevention: Manitoba (Falls Prevention Strategy and Safety Aid Initiative), Nova Scotia (Prevent Alcohol and Risk Related Trauma in Youth or P.A.R.T.Y).
- Suicide Prevention Strategy: Nova Scotia.
- Promoting physical activity: Manitoba (In motion).

- Childhood screening:
  - British Columbia: Universal hearing, dental and vision screening for every child under age six.
  - Manitoba: I HEAR Manitoba (Infant Hearing Screening Early Assessment and Referral) screens hearing at birth.
  - Saskatchewan: Development of a provincial vision for Children’s Mental Health Services that aims to promote effective health and disease prevention through the development of a children’s mental health strategy.

- Quebec: An agreement on health and social services reached under the Paix des Braves was signed with the Grand Council of the Crees. It will see the annual operating budget of the Cree Board of Health and Social Services of James Bay increase by $40 million over five years, which will allow health provisions contained in the James Bay and Northern Quebec Agreement to be implemented. The additional funding will be used to strengthen prevention efforts and core services within the various First Nations’ communities.

References and Resources:

For additional information and detail on specific activities in each province please refer to Section D.

Canadian Institute for Health Information. (2005). Developing a Healthy Communities Index. Ottawa: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2006). Improving the Health of Canadians: Promoting Healthy Weights. Ottawa: Canadian Institute for Health Information.


Section 6   Mental Health

Health Canada estimates that about one in five Canadians suffer from a mental illness at some point in their life. In a 2002 Statistics Canada survey some 2.6 million Canadians 15 years of age and older reported symptoms or feelings associated with major depression, mania disorder, one of three types of anxiety disorders, or dependence on alcohol or illicit drugs. This equates to more than 10% of all respondents (Statistics Canada, 2003).

Those individuals who receive treatment for their mental health and/or substance dependence problem use a wide variety of services. For most Canadians their first and often only contact with the health system is with a family physician (Statistics Canada, 2003).

The extent to which Canadians use mental health services varies by age and other factors. For example, although mental health or substance problems are more common among those 15 to 24 years of age than among older adults, fewer 15-to-24-year-olds reported having used mental health services in the Statistics Canada survey. Only one quarter of people in this age group reporting symptoms consulted with a health professional or used some type of resources, compared to 32% overall (Statistics Canada, 2003).

After a three year study, the Senate social affairs committee on mental health and addiction, headed by Liberal Senator Michael Kirby, released its final report in May 2006, entitled Out of the Shadows at Last. The report calls for the creation of a Canadian Mental Health Commission to campaign against the stigma and discrimination faced by people with mental health problems. Currently Canada is one of the few major developed countries without a comprehensive plan for the prevention, treatment and rehabilitation of mental illness (Standing Senate Committee on Social Affairs, 2006).

Current Data:

Use:

- Approximately 7% of all general hospital and psychiatric admissions were due primarily to mental illness and/or addiction in 2002-2003.
- Only 32% of Canadians with symptoms suggesting one of the surveyed mental disorders or substance dependencies consulted a health professional (psychiatrist, family physician, medical specialist, psychologist or nurse) for their mental health or addiction problems in 2001.
- About 5% reported that they did not get around to getting the help needed while 34% reported that they preferred managing the problem themselves.

Coverage:

- Of Canadians aged 20 or older, 47% to 72% who consulted a mental health professional in 2001 reported having some form of government or private insurance cover the services.
- For 12% of Canadians cost of services prevented them from getting help for their mental health.
Spending:

- Mental illnesses were the second-highest source of direct health care costs in Canada in 1998, after cardiovascular diseases.
- The economic impact of mental illnesses in Canada was approximately $14 billion in 1998.
- Average acute care and psychiatric hospital costs per patient were highest for patients with bipolar disorder ($7,980), schizophrenia ($6,972) and depression ($5,568) in 2002-2003 (Canadian Institute for Health Information, 2005).

Federal Perspective: Health Canada

Canadian Mental Health Commission

An Interdepartmental Task Force on Mental Health was created in July 2005. The Task Force is co-led by Health Canada and the Public Health Agency of Canada, and brings together representatives from approximately twenty federal departments to study federal activities in mental health, mental illness and addiction, with the goal of strengthening policy collaboration and coherence in these areas.

On November 24, 2005, the previous Liberal government, under Paul Martin, proposed that a Canadian Mental Health Commission be established, in consultation with provinces/territories, stakeholders and Aboriginal leaders, as a first step in national efforts to address mental health and mental illness issues. The proposed Commission would act as a national (not federal) focal point in Canada for knowledge exchange and increasing public awareness regarding mental health and mental illness, and operate at arms-length from all governments and mental health stakeholders.

Aboriginal Mental Wellness Advisory Committee

In 2005, Health Canada established the Aboriginal Mental Wellness Advisory Committee to develop a strategic action plan to improve First Nations and Inuit mental wellness outcomes. The strategic action plan will build on collaborative efforts that have examined Aboriginal mental health and wellness issues in recent years. The Committee includes a number of key stakeholders including the Assembly of First Nations, Inuit Tapiriit Kanatami, provincial and territorial governments, professional organizations and other knowledgeable groups such as the Aboriginal Healing Foundation. It is anticipated that the Committee’s strategic plan will be finalized in 2006.

Provincial/Territorial Perspective: Ministries of Health

Key provincial mental health developments for 2005/6:

- Yukon: Assessment of the housing needs of persons with serious mental illnesses will be undertaken this fiscal year.
• British Columbia: 25 acute neuropsychiatric beds will transfer from Riverview Hospital to a new mental health facility scheduled to open in Kamloops in winter 2005/06. The new facility is adjacent to Royal Inland Hospital, which will provide improved access to diagnostic and treatment services, including an expanded emergency department, MRI and CT scanners, laboratory and pharmacy services, speech pathology and neurosurgery.

• Alberta: A Mental Health Innovation Fund was established ($25 million in each of the next three years) to facilitate implementation of the provincial and regional mental health plans.
  o Approved projects cover a broad spectrum of priority areas (e.g., crisis; case coordination; shared care; tele-mental health; prevention, promotion and public awareness; supportive housing) and population groups (e.g., children, youth, seniors, Aboriginals) across the three key strategic directions—support and treatment, risk reduction and capacity building.

• Manitoba:
  o Development of a provincial eating disorders and disordered eating strategy - This work is intended to inform and guide planning for effective prevention of disordered eating, enhance capacity for early identification and intervention, and ensure accessible supports and services for individuals with eating disorders. Completed activities include the development of a comprehensive list of body image/eating disorder prevention resources for schools, development of information for physicians and health professionals, and training in eating disorders for mental health workers.
  o Development of a provincial suicide prevention strategy – In collaboration with the Provincial Committee on Suicide Prevention and led by Manitoba Health, the work included a literature search, jurisdictional review and 11 focus groups with consumers, service providers and specific at-risk groups, including the Aboriginal community. A final document was created called the Framework for Suicide Prevention Planning in Manitoba that will guide the implementation of the strategy.

• Ontario: Will expand services in the five following key areas:
  o Crisis response and outreach, to provide access to a range of services and supports on a 24/7 basis to individuals experiencing a mental health crisis.
  o Short-term residential crisis support beds, which are often referred to as "safe beds," that can be used as an alternative to custody or hospital beds.
  o Court support services, located in the courts, to assist with cases involving the mentally ill.
  o Intensive case management, to identify and provide the services required to keep people in the community with adequate supports.
  o Supportive housing services, which provide longer-term housing together with mental health services.

• Quebec: The plan d’action en santé mentale 2005-2010 was made public in June 2005. Entitled La force des liens, it strives to give Quebec an efficient mental health system that acknowledges the role of users and provides access to treatment and support services for
children, youth, and adults of all ages with mental health problems and for people at risk of suicide.

- Nova Scotia: Department of Health initiated a 3-5 year provincial depression strategy to raise awareness for early detection and intervention.

References and Resources:

For additional information and detail on specific activities in each province please refer to Section D.


Section 7  Homecare and Long Term Care

More Canadians are living longer than ever before. The nation’s life expectancy is one of the highest in the world, more than 79.9 years in 2003, therefore older adults can, on average, look forward to better quality and longer lives. However, many Canadians have a need for continuing care. Continuing care services are provided both in the home and in specialized facilities and are designed to provide care when one can no longer live safely at home or when one needs support to do so.

The term “continuing care” reflects two complementary concepts: care that continues over a long period of time and an integrated program of care that continues across different parts of the health system, from community services to geriatric units in hospitals.

The way in which continuing care, long term and homecare, are structured, delivered and financed has become a key policy issue in many parts of the country. The ageing population is one factor driving this focus. Homecare is becoming an increasingly important part of the health system often substituting for care in hospitals or long-term care facilities.

For patients and clients, homecare allows them to remain independent in their own homes and provide preventive services to reducing long term care needs. Services may include home support (i.e. housekeeping) and clinical care (such as administration of intravenous medication). The importance of homecare was highlighted in the Ten-Year Plan to Strengthen Health Care signed by the First Ministers in September 2004.

Current Data:

Use:

- Over 110,000 Canadians lived in the 1,343 residential care facilities that provided 24-hour personal care, medical and/or nursing supervision or institution-based care in the second quarter of 2001/2002 (Canadian Institute for Health Information, 2005).

- 1.2 million Canadian teens and adults reported using homecare services in 2003.

- According to the Romanow Commission, 17% of elderly persons receive formal homecare services and this number is expected to increase as the population ages and with technological advances making more services available in the home (e.g. dialysis) (Canadian Institute for Health Information, 2005).

- Compassionate care benefits were committed as part of the 2003 Health Accord and started in January 2004. These benefits ensure job protection for employees who need to leave their job to care for a critically ill family member. Based on a physician referral, they will provide a maximum of six weeks of employment insurance is provided, as well as job protection, though this varies by province/territory (Health Council Canada, 2006).

Coverage:

- Funding for homecare services consists of a mix of federal, provincial and territorial programs, private insurance, user fees and other out-of-pocket charges.
• 73% of spending on residential care in Canada was funded by the public sector in 2004.

• Homecare services covered under public programs vary across the country, with provinces and territories tending to cover services such as assessment and case management, nursing care and home support. But only some include prescription drugs and various types of therapy in publicly funded homecare programs (Canadian Institute for Health Information, 2005).

Spending:

• An average of $178 to $665 per person was spent by public sources on residential care in 2004.

• $54 to $158 per person was spent by provinces and territories on public-sector homecare in 2004 (Canadian Institute for Health Information, 2005).

Challenges:

• Homecare programs are undervalued and underfunded relative to population need, leading to higher costs elsewhere in the health care system, as well as poorer quality of life for individuals.

• The focus on homecare services following acute health problems is important but ignores many Canadians with chronic illnesses, including those with mental illness, who could manage at home with some support.

• The two-week time limit is particularly problematic for people needing mental health and palliative care—both require flexible support systems and long term programs of care.

• Services to support Canadians who wish to die at home are largely unavailable or, where they do exist, are not integrated with other parts of the health care system.

• Existing programs to assist individuals wishing to support family members dying at home also need significant improvements (Health Council of Canada, 2006).
Federal perspective: Health Canada

No developments to report for 2005/6.

Provincial/Territorial Perspective: Ministries of Health

Common elements of these strategies are:

- Expand community care options
- Improve access to continuing care services
- Enhance skill of front-line workers
- Legislation

Contents for this Section

Provincial/Territorial perspective: Ministries of Health

Common elements of these strategies are:

Expand community care options:

- Northwest Territories: Funding allocated to the Yellowknife Association of Concerned Citizens for Seniors (YACCS) for the design of a 24-unit seniors dementia facility.

- New Brunswick: Within Addiction and Mental Health Services, two homecare initiatives were undertaken. The implementation of a provincial Telemental Health system will allow more individuals to receive psychiatric consultation within their home communities. As well, mobile crisis response services will be enhanced within three Regional Health Authorities. This will increase capacity to provide community-based interventions to consumers in crisis, effectively decreasing the need for hospitalization.

- Nova Scotia: Self Managed Care helps Nova Scotians with physical disabilities to gain more control of their lives. The program provides funds to eligible individuals so that they may directly employ people who provide home support and personal care services (Further information on Continuing Care in Nova Scotia is available at: http://www.gov.ns.ca/health/ccs/default.htm)

Improve access to continuing care services:

- Yukon: $400,000 in funding to open 7 intermediate care beds.

- British Columbia: Government is working to provide at least 5,000 new residential and assisted living beds by 2008.

- British Columbia: Updated and modernized the Community Care and Assisted Living Act to protect the health and safety of seniors and people with disabilities in licensed community care facilities and registered assisted living residences.

- British Columbia: An expanded toll-free telephone information line is giving seniors one-stop access to a range of information- including health services - on government services.
• Alberta: A Home/Community Care Innovation Project is underway after an assessment of the strategic innovations required to modernize home/community care services. The project will support the expansion of home/community based health care services and development of an integrated community care system. Examples include: collaboration between regions, collaboration between and integration of the various components of the care continuum, and implementation of common assessment tools across the regions.

• Prince Edward Island: New initiative, reorganizing to a provincial homecare program.

• Saskatchewan: Minimum Data Set/Resource Utilization Groupings (MDS/RUGS), the classification system for residential long-term care, is fully implemented in all long-term care facilities in Saskatchewan- facilitating better care planning, quality indicators and outcome measurements, which will improve client care. It also provides increased efficiency in record keeping and facilitates program monitoring and evaluation at the facility and regional health authority level. MDS/RUGS results in improved quality of information, which can be used for identifying resident needs as well as areas to target for program improvement/development and staff education.

• Ontario: Formal linkages between CCAC case management and Family Health Teams will help to avoid hospital admissions and improve health care management of mutual clients, especially those dealing with chronic illness.

• Ontario: 2005 Provincial Budget announced an investment in LTC homes of $2.75 billion in 2005/06. This represents a $264M increase over 2004/05 interim actuals which will fund improvements to the safety and quality of care provided to residents, the opening of new LTC beds and a freeze in co-payment rates for the second year in a row.

• Ontario: An additional 45,100 acute hospital clients will receive homecare services in 2005-06 as a result of investments. In addition, CCACs are relieving pressure on hospitals by taking 7,600 post-hospital hip and/or knee total joint replacement client referrals from hospitals.

• Ontario: Joint initiative between Homecare and Community Support Branch and Hospitals Branch will orient more hospitalized patients with end-stage-renal disease and new to dialysis treatment, to in-home peritoneal dialysis instead of in-hospital hemodialysis.

• Ontario: To improve the quality of life in long-term care homes, the Long Term Care home reform strategy supports:
  o a strong role for Family Councils and Resident Councils within LTC homes
  o making it easier for couples to live together in LTC homes
  o toughen enforcement by mandating reporting of suspected abuse, introducing whistleblower protection and targeted surprise inspections of homes with poor track records (all annual inspections are now unannounced)
  o strengthen accountability through a public website that provides information to seniors and their families about individual homes and their records of care. The ministry will also be kept accountable through the Staffing Report, which monitors the progress towards achieving staffing targets.
• Ontario: The government invested $2.7 million to build a Seniors’ Health Research Transfer Network that will support putting health research into practice with all health care providers who work in geriatric care and involve front line providers in setting research priorities, and to hire eight regional coordinators to implement RNAO Best Practice Guidelines in LTC homes.

• New Brunswick: Under the auspices of the Provincial Health Plan, significant enhancements have been made to the Extra Mural Program (EMP) to enhance the provision of acute and palliative care services in the home. Enhancements have included funding for human resources and short-term personal support services. The Program is also piloting telemonitoring in the home, as a mechanism to improve service delivery for patients with chronic diseases and those who live in rural or remote areas.

Enhance skill of front-line workers:

• Yukon: Consent to care training is underway for all care providers

• Alberta: Alzheimer’s in-service training initiative has exceeded the training goal of 3,000 front line care workers as over 7,000 workers have now completed the training program.

• Alberta: Core competencies for Health Care Aides have been developed for use by educational institutions and employers- all health care aides working in long-term care are expected to have achieved these core competencies.

Legislation:

• Manitoba: Introduced a Personal Care Home Standards Regulation under The Health Services Insurance Act in 2005. Standards monitoring now informs the annual personal care home licensing process, along with the results of other departmental monitoring of personal care homes.

References and Resources:

For additional information and detail on specific activities in each province please refer to Section D.


Section 8  Pharmacare

Canadians are consuming more medication than ever before. In the last ten years, the volume of prescriptions dispensed to Canadians grew by over 70%. A recent study suggests that variation in the use of medications might explain why drug spending differs from province to province. Other factors may include differences in population size, demographics and health status; the price of drugs; the use of generic drugs; the increase in health cases benefiting from drug therapy; emergence of new drug therapies to treat previously untreatable conditions; changes in the prescribing patterns of physicians; and the greater propensity to use drugs to treat conditions not previously considered problematic (Health Council of Canada, 2005, 2006; Canadian Institute for Health Information, 2006).

In Canada, part of the drug bill is paid by both the public and private sectors. Public-sector payers include the various bodies of government, Workers Compensation Boards and other social security schemes. Prescribed drugs for the military, the Royal Canadian Mounted Police, veterans, inmates in federal jails and Status Indians and Inuit and some individuals eligible through Citizenship and Immigration are covered by the federal government. Provincial and territorial governments cover prescribed drugs to patients in hospitals across the country as well as a variety of programs that cover parts of the total drug bill (e.g. seniors). Each province and territory has developed its own publicly funded drug plan(s). As a result, families with similar incomes and medical needs may receive very different government-funded benefits, depending on where they live (Health Council of Canada, 2005, 2006; Canadian Institute for Health Information, 2006).

There are a total of 19 publicly-funded drug plans in Canada: ten provincial, three territorial, and six federal. Each of the 19 plans has its own definitions of eligible populations, coverage policies, formularies for included drugs, co-payments, deductibles, and out-of-pocket caps. Each plan has its own system for dealing with catastrophic drugs, with some protecting all residents and some protecting only limited groups of people within the province. There are disease-specific plans in many of the jurisdictions as well; these provide public funding for the drugs associated with rare and/or high-cost conditions. In these cases, a patient’s disease determines his or her drug coverage, as does the province they reside in. In some cases, coverage differences may be significant enough to cause people to move from one province to another in order to be protected against high drug expenses (Health Council of Canada, 2005, 2006; Canadian Institute for Health Information, 2006). See Appendix D for a comparison of provincial and territorial drug subsidy programs.

The absence of a national pharmacare approach has led to discrepancies among the provinces and territories. Some provinces grant comprehensive programs providing protective coverage while others have a number of coverage gaps. While access to medically necessary drugs outside of hospitals, does not fall under the jurisdiction of the Canada Health Act, consistency of access may be attained through the implementation of a pan-Canadian standard for drug coverage (Health Council of Canada, 2005, 2006; Canadian Institute for Health Information, 2006).
Where are we now?

In the 2004 Ten-Year Plan to Strengthen Health Care health ministers were directed to establish a task force to develop and implement a National Pharmaceuticals Strategy and report on progress by June 30, 2006. The strategy was to include:

- Cost options for catastrophic drug coverage
- National formulary for participating jurisdictions
- Faster access for breakthrough drugs
- Better monitoring for safety and effectiveness
- Purchasing strategies
- Action to influence prescribing behaviour
- Action to support electronic prescribing

In October 2005, health ministers met and reaffirmed their commitment to the National Pharmaceuticals Strategy and at that time asked their officials to:

- Accelerate the work on catastrophic drug coverage and to undertake research on expensive drugs for rare diseases
- Expand the scope of the Common Drug Review (national committee that recommends whether drugs should be funded) to consider all drugs, not just new ones
- Work towards a common national formulary (a listing of drugs that are approved for public funding)
- Give the Patented Medicine Prices Review Board (PMPRB) responsibility to monitor and report on non-patented drug prices
- Collect, integrate and disseminate information on the real-world risks and benefits of drugs (Health Council of Canada, 2005, 2006; Canadian Institute for Health Information, 2006).

**Definitions of terms:**

- **Co-payment:** the proportion of the cost of each prescription that must be paid by an individual; may take the form of a percentage of the cost or a specific dollar amount per prescription.
- **Deductible:** the initial amount of drug expense that must be paid by an individual before a drug plan reimburses any expense, generally computed on a yearly basis.
- **Out-of-pocket cap:** plan provisions that restrict the total amount of deductibles and co-payments that will be imposed on an individual; either a fixed dollar amount, or an amount determined by family income.
- **Catastrophic drugs:** drugs whose expenses are so high that they could threaten a person’s financial security but nonetheless are necessary for maintenance of health or survival.
Current Data:

Use

- Over 380 million prescriptions were filled in 2004, an increase of 74% over the past 10 years (Canadian Institute for Health Information, 2005).

Coverage:

- Public sector expenditure on prescribed drugs was estimated to have reached $8.4 billion in 2004 and $9.5 billion in 2005, representing annual growth rates of 9.9% and 12.4%, respectively.
- According to a Statistics Canada survey, 79% of Canadians aged 12 or older reported having some public and/or private drug insurance in 2003 up 18% points from 1996/1997. In 2003, rates ranged from 66% in Prince Edward Island to 89% in Quebec. The difference is largely attributed to the significant variations in the public drug plans (Canadian Institute for Health Information, 2006).

Spending:

- Canada has the third highest total drug expenditure per capita among OECD countries, after the United States and France.
- Total drug expenditure is estimated to have reached $22.3 billion in 2004 and $24.8 billion in 2005, representing annual increases of 10.9% and 11.0%, respectively.
- Total drug expenditure per capita in Canada is expected to have reached $698 in 2004 and $770 in 2005, representing annual rates of increase of 9.9% and 10.2%, respectively.
- Among major categories of health expenditure, drugs have accounted for the second largest share, after hospitals. The share of drugs in total health expenditure is estimated to have reached 16.9% in 2004 and 17.5% in 2005 with hospitals hovering around 30%.
- Expenditure on prescribed drugs reached $18.5 billion in 2004 and $20.6 billion in 2005, representing annual growth rates of 12.3% and 11.5%, respectively. Expenditure on non-prescribed drugs is forecast to have reached $3.8 billion in 2004 and $4.2 billion in 2005, representing increases of 4.6% and 8.9%, respectively.
- Private sector expenditure on prescribed drugs is estimated to have reached $10.1 billion in 2004 and $11.1 billion in 2005, with corresponding annual growth rates of 14.3% and 10.6%.
- $13.3 billion was spent on retail drugs by the private sector in 2004. Of that total, $9.5 billion was spent on prescriptions. Out-of-pocket funds paid for the remaining $3.8 billion over-the-counter drugs and personal health supplies.
- 3% of households reported spending more than 5% of their after tax income on prescription drugs in 2002.
- Total drug expenditure per capita is estimated to range from $652 in British Columbia to $837 in Ontario.
- The share of prescribed drugs in total drug expenditure is estimated to range from 78.9% in Prince Edward Island to 87.0% in Quebec.
The proportion of prescribed drugs financed by the public sector in 2005 varied across the provinces and is estimated to range, from a low of 32.3% in New Brunswick to a high of 50.9% in Manitoba (Canadian Institute for Health Information, 2006).
Challenges:

- Across Canada coverage for prescription medications continues to be uneven, leaving an unacceptably large number of Canadians with minimal or no protection against rising drug costs.
- Increasing costs and evidence of patient safety concerns underscore the need for better management of prescription medications.
- Not all jurisdictions have adopted practices such as reference-based pricing. Money can be saved while maintaining quality of care by focusing policies and drug plan management on “good but less expensive” products. Some provinces have realized savings from directly linking evidence based prescribing protocols and policies with the lowest cost therapies.
- Electronic systems are needed to link information about drug products, patients and their medications. This linkage will further ensure that prescribing is based on scientific evidence and reduce adverse events caused by medication errors (Health Council of Canada, 2006).

Federal perspective: Health Canada

No developments to report for 2005/6.

Contents for this Section

Provincial/Territorial Perspective: Ministries of Health

Common elements of these strategies are:

- New Drug coverage
- Drug review
- Drug information and electronic systems
- Legislation
Provincial/Territorial Perspective: Ministries of Health

Common elements of these strategies are:

- New Drug coverage
  - British Columbia: First province to approve and cover the cost of the drug Herceptin for all eligible breast cancer patients— who gained access to the promising drug therapy through an $8-million commitment from the Ministry of Health, the PHSA and the BC Cancer Agency.
  - British Columbia: Patients with rheumatoid arthritis, glaucoma, migraines and high blood pressure are among those who will benefit from access to eight new drugs under PharmaCare. In July and August 2005, PharmaCare listed the following prescription medications for coverage:
    - Humira, used to treat rheumatoid arthritis.
    - Combigan, for glaucoma and ocular hypertension.
    - Axert, for migraine.
    - Teveten Plus, for high blood pressure.
    - Avodart, for enlarged prostate (prostatic hyperplasia).
    - VFEND, for invasive fungal infections in immune-compromised patients.
- Keppra, for epilepsy.
- Xalacom, for glaucoma and ocular hypertension.

- Drug review
  o British Columbia: PharmaCare makes program improvements and increased the number of drugs reviewed over the past year by 293%. In 2004, PharmaCare completed 14 drug reviews and approved five. In contrast, in 2005, PharmaCare completed 55 drug reviews and approved 29. This includes only the brand name drugs, not generics.
  o Alberta: The Canadian Coordinating Office for Health Technology Assessment is responsible for delivery of the Common Drug Review (CDR) to participating drug plans. As of February 23, 2006, reviews and recommendations have been completed for 36 drugs.

- Drug information and electronic systems
  o British Columbia: Government is improving patient care and safety by making medication histories available to authorized medical practices through PharmaNet. PharmaNet is the secure computer network that links all community pharmacies in B.C. and many hospital pharmacies, to a central database. The computer network protects British Columbians from potentially dangerous medication interactions and duplications.
  o Saskatchewan: The Pharmaceutical Information Program (PIP) medication profile electronic viewer became operational in October 2005. PIP provides authorized health care professionals (e.g. pharmacists and physicians) with confidential access to a medication profile containing all prescription drugs dispensed by Saskatchewan community pharmacies. A full production rollout is underway in 2006 to extend the medication profile viewer to as many pharmacies, emergency rooms, physician clinics, long-term care and homecare facilities in the province as possible. PIP will be broadened in future phases to include electronic prescribing and integration with pharmacy computer systems.

- Legislation
  o Manitoba: Effective April 1, 2005, the Pharmacare deductible was adjusted. For families with incomes of $15,000 and under, the new deductible rate is 2.44%, up from 2.32%. For families with incomes above $15,000, the deductible rate rose from 3.48% to 3.65%, and 4.2% from 4.0% for adjusted incomes greater than $40,000 and less than or equal to $75,000, as well as, 5.25% from 5.0% for adjusted incomes greater than $75,000.
  o Nova Scotia: Revisions made to the Seniors’ Pharmacare Program in regards to the co-payment and premium maximums, effective April 2006.
  o Nova Scotia Diabetes Assistance Program (NSDAP) is a provincial drug plan which covers the medications and supplies, necessary to manage diabetes, effective January 2006.
References and Resources:

For additional information and detail on specific activities in each province please refer to Section D.


For Comparison of Provincial and Territorial Drug Subsidy Programs:

British Columbia Pharmacare: www.healthservices.gov.bc.ca/pharme


Manitoba Pharmacare Program: www.gov.mb.ca/health/pharmacare/index.html


New Brunswick Prescription Drug Program: http://www.gnb.ca/0212/intro-e.asp


Prince Edward Island Pharmacy Services: www.gov.pe.ca/infope/Government/GovInfo/Health/Pharmacy_Services

Newfoundland and Labrador Prescription Drug Program: www.gov.nl.ca/health/nlpdp

Yukon Pharmacare: www.hss.gov.yk.ca/programs/insured_hearing/pharmacare

Northwest Territories: www.hlthss.gov.nt.ca/content/About_HSS/about_index.htm

Section 9 Wait Times

Recent findings in Statistics Canada show that access to the health care system and wait times for surgical services specifically- remains a primary concern for a large majority of Canadians in all the provinces/territories. According to Statistics Canada, waiting for care is not “inherently problematic”, but perceptions based on some patients’ experiences of adverse effects and/or feelings they have simply waited too long for care- have elevated the issue publicly and influenced political concern. This perceived crisis is one of the reasons the federal and provincial governments have vowed to set benchmarks by the end of the year for how long patients should have to wait for certain procedures (Statistics Canada, 2006).

Wait times/accessibility are one of the dimensions of quality health care and one of its forms of measurement.

Current Data:

• Few people feel waiting times have decreased, 3% of the public (Pollara, 2005a, b).

• Women (71%) are more likely than men (61%) to say waiting times have gotten longer.

• 70% of the public expect emergency room waits to take two hours or more (Pollara, 2005a, b).

• The proportion of patients who felt their waiting time was unacceptable was highest among those who waited for specialist visits (29%) and diagnostic tests (24%). It was lowest among those who waited for non-emergency surgery (17%) (Pollara, 2005a, b).

• According to Statistics Canada (2006), among Canadians who had waited for specialist visits, 37% reported unacceptable waits. Similar dissatisfaction rate was observed among Canadians who waited for a diagnostic test.

• In a 2001 OECD wait time patient survey in five English speaking countries, Canada had the second highest percentage of patients waiting longer than 4 months for elective surgeries (27%); the only other country that had a higher percentage than Canada was UK (38%). It is worth noting that UK had increased its health care funding and dramatically reduced wait times in the previous few years (Organization for Economic Co-operation Development, 2003a, b). In Canada, the “Ten-Year Plan to Strengthen Health Care”, signed by all Premiers in September 2004, provided $625 million for wait times initiatives. Provinces and territories have been leading the way by actively developing strategies to reduce wait time through centralized registries and prioritization systems (Health Council of Canada, 2006).

Challenges:

• The 2005 Supreme Court of Canada’s ruling in Chaoulli-Zeliotis vs. Government of Quebec gave Quebec citizens the right to purchase private insurance to pay for medically necessary health care services when wait times are unreasonably long.

Strategies:

• Making wait time a performance accountability measure
Setting national standards and benchmarking wait times for medical procedures across health care organizations

Providing additional funding for 5 priorities (hip and knee joint replacements, cataract surgeries, cancer surgeries, cardiac procedures and MRI exams) to reduce wait times (Health Council of Canada, 2006).

**Acute Care Utilization:**

- Each year, Canadians make over 14 million visits to emergency departments (EDs). According to Statistics Canada, one in eight Canadians aged 15 years and older were treated in an ED for their most recent injury in 2003. ED visit rates were highest for the very young and the very old.

- Patients were more likely to visit EDs between 8:00 a.m. and 8:00 p.m., with the morning being the peak arrival time. Pediatric hospitals, had a second and higher peak in visit volumes from 7:00 p.m. to 10:00 p.m.

- Overall, 12% of ED patients arrived by ambulance in 2003-2004. Arrival by ambulance was more likely (52% of visits) among those older than 85 years. Although this age group accounted for only 2.9% of ED visits, they represented 14% of ED ambulance arrivals.

- More than half (57%) of ED visits in 2003-2004 were for less urgent conditions (e.g. chronic back pain or minor allergic reactions) or non-urgent conditions (e.g. sore throat, menses, or isolated diarrhea) based on the Canadian Triage and Acuity Scale (CTAS).

- Nearly one in five Canadian adults (18%) responding to an international survey on ED use in 2004 said they could have received their emergency department care from a regular physician in a non-ED setting. This compares to between 6 and 16% of adults who visited EDs in Australia, New Zealand, the UK and the U.S.

- Almost half of the patients visiting EDs completed their visit in approximately two hours or less- measuring from the time of registration or triage to the time of ED discharge. However, 10% of patients spent 36 minutes or less (10th percentile) and 10% spent over six hours in the ED (90th percentile) in 2003-2004. The amount of time that patients spent in the ED varied according to the severity of their illness, the patients age, the amount of other patients being cared for and the time of the day the visit took place.

- Half of all patients waited 51 minutes or less to be seen by a physician. For 10% of patients, this time was 10 minutes or less (10th percentile), and for another 10%, the wait was 165 minutes or longer (90th percentile).

- On average, physicians assessed patients with more urgent conditions more quickly than patients with less urgent conditions. For the most severely ill patients (CTAS I), the median wait time to see a physician was five minutes in 2003-2004. Median wait times to see a physician for other patients grouped by level of severity ranged from 36 to 60 minutes.

- 76% of those visiting EDs in 2003-2004 completed their visit in less than four hours- comparable to the U.S. (72%), but less than in England (96%).

- While approximately 11% of ED patients were admitted to a hospital bed in 2003-2004, overall, more than half of all hospital admissions (excluding maternal conditions) came through the ED (53%) in that year. However, hospital admission rates through the ED varied
across the country. For example, the Northwest Territories had the highest admission rate through EDs (97/1,000 population). Ontario had the lowest (38/1,000 population) (Canadian Institute for Health Information, 2005).

Perceptions of Waiting Times for Elective Surgery in the Past 2 Years

For more information, see the following provincial government wait times website at:

NWT: Northwest Territories does not have a website dedicated to wait time information.
Yukon: Yukon does not have a website dedicated to wait time information.
BC: http://www.healthservices.gov.bc.ca/waitlist/index.html
AB: http://www.ahw.gov.ab.ca/waitlist/WaitListPublicHome.jsp
SASK: http://www.sasksurgery.ca/wait-list-info.htm
ON: www.ontariowaittimes.com
QC: http://wpp01.msss.gouv.qc.ca/appl/g74web/default.asp
NB: http://www.gnb.ca/0217/NBSCN-RSCNB/index-e.asp
NS: http://www.gov.ns.ca/health/waittimes/
NFLD: Newfoundland does not have a website dedicated to wait time information.
PEI: Prince Edward Island does not have a website dedicated to wait time information.
References and Resources:

Canadian Institute for Health Information. (2005). *Understanding Emergency Department Wait Times*. Ottawa: Canadian Institute for Health Information.


INTRODUCTION
The following section includes the actual federal- provincial- territorial governmental submissions received for the year 2005-2006 provided (with the exception of Nunavut which abstained). This year they will be laid out in two formats. First, we have included each submission in the exact format it was provided (except for Quebec where the submission has also been translated). Then we have presented the information from the submissions by topic. It should be noted that both formats contain the exact same information. We hope this new format will improve the usability and usefulness of the HSU as a reference tool.

INTRODUCTION
Cette section comprend tous les exposés reçus des gouvernements fédéral, provinciaux et territoriaux pour l’année 2005-2006 (à l’exception du Nunavut qui n’a rien envoyé). L’information qu’ils contiennent est présentée de deux façons : 1) l’exposé intégral tel que reçu [celui du Québec ayant été traduit par nos soins]; 2) un regroupement par thèmes des données tirées des exposés. Dans les deux cas, l’information est exactement la même. Nous espérons que cette nouvelle présentation rendra le Bilan encore plus utile et plus facile à utiliser.
UPDATE BY JURISDICTION

Northwest Territories

SECTION I: Political Updates

Current Political Representation

- Consensus government: last election November 24, 2003
- Minister of Health and Social Services: J. Michael Miltenberger
- Deputy Minister of Health and Social Services: D.J. (Dave) Murray

Legislative Amendments

- **Personal Directives Act**: This new Act was given assent in October 2005. The Act came into effect on January 1, 2006. NWT residents 19 years of age and older may make legally binding personal directives which set out in advance instructions about their health care and personal matters. Further, the Act allows for the designation of an agent of choice to act for an individual in the event of incapacity.

- **Tobacco Control Act**: This Bill was introduced in the House and received second reading in October 2005. The Bill proposes to control where smoking may occur and how cigarettes can be displayed and sold.

- **Tlicho Community Services Agency Act**: This Act came into force on August 4, 2005. The Act establishes the Tlicho Community Services Agency (TCSA) as a Board of Management subject to the provisions of the Hospital Insurance and Health and Social Services Administration Act.

SECTION II: Structure and Finance Updates

Fiscal Activity

- There were no changes in funding formulas for 2005/2006.
- In 2005/2006, the Department’s total revised budget, including approved supplementary appropriations was $260,894,000. Significant changes from 2004/05 include:
  - $3,162,000 in additional costs for hospital services from Capital Health Authority of Alberta due to increased utilization and rate changes.
  - $5,272,000 in additional expenses as a result of a collective agreement between the Government of the Northwest Territories and the Union of Northern Workers.
• $1,000,000 in contribution funding to the Yellowknife Association of Concerned Citizens for Seniors (YACCS) for planning and design of a seniors’ dementia facility.
• $5,927,000 in savings resulting from the amalgamation of Human Resources to the Financial Management Board Secretariat.

• For 2006/2007, the Department’s opening Main Estimates for Operations Expenses were $265,186,000.

• Expected changes for 2006/2007 include:
  o Compensation and Benefits to be $1,567,000 less than in the 2004-05 fiscal year.
  o Grants and contributions to be $1,610,000 more than in the 2004-05 fiscal year.
  o Other expenses, including materials, purchased and contract services, fees and payments to be $4,711,000 more than in the 2004-05 fiscal year.

• For further information on the Department of Health and Social Services main estimates for 2005/06 and 2006/07 refer to the following web address: http://www.gov.nt.ca/FMBS/documents/mainestimates/MainEstimates.html.

**Governance and Management**

• Under direction of the Minister, eight Health and Social Services Authorities plan, manage and deliver community and institutional-based services.

• The Joint Leadership Council is made up of the Minister, Deputy Minister and Chairs of the Health and Social Services Authorities. This Council:
  o provides advice to the Minister;
  o sets direction for planning system-wide initiatives and issues;
  o reviews and recommends approval of system-wide plans, reports and results information;
  o shares information and discussion of health and social services issues, concerns and best practices;
  o provides direction to the Joint Senior Management Committee; and
  o reviews and recommends approval of reports made by the Joint Senior Management Committee.

• The Joint Senior Management Committee is collectively made up of the Department’s Senior Management Committee and the Chief Executive Officers of the HSS Authorities. This Committee:
  o coordinates system-wide activities including service delivery approaches, business and operational planning, and administrative support;

• Shares information of relevance to the NWT HSS system;

• Provides analytical and planning support to the Joint Leadership Council; and

• Coordinates and liaises with other stakeholders at the national and territorial level.
Institutional Change/Reform

- In 2005 the Inuvik Regional Health and Social Services Authority (IRHSSA) was divided into two new Authorities: the Beaufort Delta Health and Social Services Authority (BDHSSA) and the Sahtu Health and Social Services Authority (SHSSA). The new Beaufort Delta Authority continues to serve the eight communities of the Beaufort Delta region (Aklavik, Fort McPherson, Holman, Inuvik, Paulatuk, Sachs Harbour, Tsiigehtchic, and Tuktoyaktuk). The new SHSSA serves the five communities of the Sahtu region (Colville Lake, Deline, Fort Good Hope, Norman Wells, and Tulita).

- The Tlicho Community Services Agency (TCSA) was established on August 4th, 2005, replacing the former Dogrib Community Services Board. The TCSA is unique among health and social services boards, as it is also responsible for education programs. The TCSA consists of five members, one from each community in the Tlicho region, and a Chair. The TCSA serves the communities of Behchoko (formerly called Rae-Edzo), Gameti, Wekweti and Whati.

Regionalization Activity

- The Department is undertaking a Facilities Review. The review will determine an equitable way of allocating resources for facilities, based on nationally recognized benchmarks. A set of recommendations will be made regarding the delivery model for facility-based healthcare in the NWT.

SECTION III: Support and Innovation in Health Care

Human Resources: Physicians

- The GNWT offers physicians and specialists a comprehensive salary and benefits package that includes:
  - competitive recruitment and retention bonuses;
  - northern allowance;
  - call-back compensation;
  - moving assistance;
  - special leave;
  - self-funded leave plan;
  - sick leave;
  - maternity leave; and
  - group health benefits
More information on contracts and compensation can be found under Careers at http://www.hlthss.gov.nt.ca

- As of January 2006 there were 56 General Practitioners and 22 specialist positions in the NWT. The following table outlines the breakdown of physician positions by Authority:

<table>
<thead>
<tr>
<th>General Practitioners</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deh Cho</td>
<td>2.5</td>
</tr>
<tr>
<td>Tlicho</td>
<td>2.0</td>
</tr>
<tr>
<td>Fort Smith</td>
<td>4.5</td>
</tr>
<tr>
<td>Hay River</td>
<td>7.0</td>
</tr>
<tr>
<td>Sahtu</td>
<td>2.0</td>
</tr>
<tr>
<td>Inuvik</td>
<td>9.0</td>
</tr>
<tr>
<td>Yellowknife</td>
<td>29.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialists @ STHA</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB/GYN</td>
<td>3.0</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>3.0</td>
</tr>
<tr>
<td>Internist</td>
<td>3.0</td>
</tr>
<tr>
<td>General Surgeon</td>
<td>3.0</td>
</tr>
<tr>
<td>Orthopaedic Surgeon</td>
<td>2.0</td>
</tr>
<tr>
<td>ENT</td>
<td>2.0</td>
</tr>
<tr>
<td>Radiologist</td>
<td>2.0</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>2.0</td>
</tr>
<tr>
<td>Anaesthesiologist</td>
<td>1.0</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>1.0</td>
</tr>
</tbody>
</table>

- A number of recruitment and retention initiatives are ongoing. These include:
  - Physician Recruiter position whose primary focus is attracting and retaining permanent physicians for Stanton Territorial Hospital.
  - Halftime Physician Recruiter position whose primary focus is attracting and retaining permanent physicians for Yellowknife Health and Social Services Authority.
  - Return of Service Bursaries for medical students who agree to reside and work in the NWT upon the completion of their studies.
  - Resident Travel Bursary offered to offset travel costs for a resident who completes a component of their training in the NWT.
Human Resources: Non-Physicians

- As of April 1, 2005, Human Resources functions within the GNWT were centralized into one Department, the Financial Management Board Secretariat (FMBS). This includes the centralization of all Human Resources staff and functions previously employed by the Department of Health and Social Services, and all Health and Social Services Authorities with the exception of the Hay River Health and Social Services Authority. The Department released *Amended Implementation Plan: A Comprehensive 5 Year Human Resource Strategy* in December 2005. The report can be found online at http://www.hlthss.gov.nt.ca/.

Health Information and Telemedicine

- The Department is working with Canada Health Infoway Inc. (Infoway) to establish an NWT interoperable electronic health record (iEHR) that will enable and support the implementation of the Integrated Services Delivery Model (ISDM), and allow NWT healthcare providers to have instant access to patient medical records. The following initiatives have made the following progress:
  - The Department is developing an Informatics Strategic Plan with Infoway funding support. Infoway is funding the development of a detailed plan for a diagnostic imaging picture archiving computer system. Infoway is also providing funds to develop a high level strategic plan for telehealth, which includes support for the implementation of the Integrated Service Delivery Model;
  - The Department has delivered a high-level project roadmap identifying the required components for an iEHR, and set out the proposed order for implementation over the next 4-5 years;
  - The Department is currently undertaking a project to conduct detailed planning for an iEHR. This phase is expected to be complete in Spring 2006.

- In December 2005, the Department released the *NWT Health Status Report 2005*, an update to the report published in 1999. The report presents information on the health status of NWT residents along with information on some factors known to influence health status.

- In October 2005, the Department released the *2004-05 Community Client Feedback Report*. The report shows the results of the Community Client Feedback Survey done in October 2004. 512 forms were completed, 478 of which were from communities outside of Yellowknife. Overall, 89.3% of respondents were satisfied or very satisfied with the friendliness of staff, and 88.8% were satisfied or very satisfied with the quality of service received. The most common area of improvement cited was accessibility, noted by 41% of respondents. The full report can be found at http://www.hlthss.gov.nt.ca.

- Telehealth is broadly defined by the Department of Health and Social Services as "the process of using information and communications technologies to deliver health and social service information, services and expertise over short and long distance".

106
The Department, in partnership with HSS Authorities, specialists and southern hospitals, is using telehealth services to improve access to health services for people in remote communities; support doctors and health care providers to use technology to access peer information and medical education; and improve the efficiency of specialized health services within the NWT.

SECTION IV: Health Programs and Services

Community Health Initiatives

- An integrated service delivery model has been developed to define levels and types of service across the HSS system. This delivery model is used as the basis for determining staffing mix and how funds will be allocated to HSS Authorities.

Population Health-Based Initiatives

- As part of the ongoing Don’t Be a Butthead campaign, The Department of Health and Social Services launched the Create the Smoke Free Future contest in January 2006. Students from grades 3 through 12 are invited to express what they think about smoking through video, music, writing, or through visual arts such as painting, drawing, carving, or dance. Judges will select one junior winner to win $250 or a digital camera, and one senior winner, who will work with a professional artist to turn their artwork into a professionally produced creation.

- In early 2006, the Department launched Smoke Screening, an awareness campaign aimed at youth from grade 6 to 12. A curriculum based on ten anti-smoking commercials from around the world was provided to schools. Students are encouraged to discuss the messages and pick their favourite commercial. Prizes for participation are available.

- Not-for-profit non-government organizations can apply for up to $10,000 in projects under the Health Promotion Fund. Projects must promote healthy lifestyles and practices. Details on accessing the program may be found in the document Guide to GNWT Grants & Contributions Program on-line at http://www.hlthss.gov.nt.ca.

- The Social Program Departments published the report Homelessness in the NWT: Recommendations to Improve the GNWT Response in November 2005. Further work on homelessness includes the development of a Policy Framework to strengthen collaboration between the Social Program Departments, and the continued funding of emergency and transitional shelters in the territory.

- In response to the worldwide concern about Avian Influenza, the Chief Medical Health Officer published four Fact Sheets. The first contains general health information for the public, the second is intended for physicians and health care workers, the third provides information on the NWT’s approach to surveillance and monitoring of birds, and the fourth answers frequently asked questions.
• The NWT offered free influenza vaccinations to all residents in the fall of 2005. To encourage uptake, the Department published a brochure titled *Myths and Facts about Influenza Vaccine*.

**Primary Care Initiatives**

The Department and Authorities continued to implement the Integrated Service Delivery Model (ISDM). The ISDM is a team based, client-focused approach to provide health and social services. It focuses on illness and injury prevention and health promotion. Primary community care is one of three key elements to better integrate health and social programs and services. “Primary Community Care” is similar to “primary health care” except it is used to show the need to direct services toward the community level, as close to the client as possible.

The principles of Primary Community Care are:

- **Universality:** Individuals have access to the services they need and are treated fairly and with respect in the health and social services system.
- **Personal Responsibility:** Individuals and families have personal responsibilities to address their health and social needs.
- **Basic Needs:** Publicly funded programs and services will address basic health and social needs in a way when an individual or family cannot meet these needs.
- **Sustainability:** The health and social services system will operate in a way that does not threaten its ability to meet basic health and social needs over the long-term.
- **Continuum of Care:** Programs and services will fit together as seamlessly as possible and will be integrated with other services wherever possible.
- **Prevention-Oriented System:** All activities of the health and social services system will support the maintenance of physical, social and mental health in addition to the treatment of illness and injury.
- **People-Oriented System:** All activities of the health and social services system will support an approach that places the needs of people first.

**Home Care Initiatives**

- Depending on a patient’s needs, home care is provided by doctors, nurses, home support workers, social services workers and many other health and social services workers. Anyone can access home care support if they have a need identified by an assessment.
- Coordinated home care programs in most regions in the NWT have continued to expand into outlying communities. Approximately 90% of communities have, at a minimum, home support services available to residents.
- All home care programs are assessed using a standard Continuing Care Assessment and Placement Package to ensure clients are cared for in their homes and communities for as long as possible before being admitted to long-term care facilities.
Mental Health Initiatives

- The Department continued implementation of Mental Health and Addiction Services in the NWT, including the addition of the following positions:
  - Community Wellness Workers;
  - Mental Health/Addiction Counsellors; and
  - Clinical Supervisors.
- The Community Wellness Worker provides communities with education, prevention and awareness initiatives in the areas of addictions, mental health issues and family violence.
- The Mental Health/Addiction Counsellors are the clinical piece of the program. The position provides communities with therapeutic counselling services and also provides support to the Community Wellness Workers.
- The Clinical Supervisor supervises the Mental Health/Addiction Counsellors and Community Wellness Workers. They also serve as consultants for the rest of the Primary Community Care team for any mental health or addiction case.

Long-Term Care Initiatives

- A review of long-term care facilities was completed in 2005-06. Renovations and upgrades will begin in 2006-07.
- In January 2006, the Department allocated multi-year funding for 2005-2007 to the Yellowknife Association of Concerned Citizens for Seniors (YACCS) for the design of a 24-unit seniors dementia facility. The next phase of the project will be the tender for and construction of the building.

Pharmacare Initiatives

- There were no substantial changes to drug plan coverage during 2005/2006.

Yukon Territory

Section I: Political Updates

Current Political Representation

- Yukon Party: in power since October 2002
- Premier: Dennis Fentie
- Minister of Health and Social Services: Brad Cathers (Elected November 2002, became Minister December 2005)
Deputy Minister of Health and Social Services: John Greschner

**Legislative Amendments**

- The Yukon completed consultations with owners of large public drinking water systems and bulk water delivery businesses, and is currently undertaking consultations with owners of small public drinking water systems and stakeholders to develop a Drinking Water Regulation under the *Public Health and Safety Act*.
- September 2005 amendments were made to Communicable Disease Regulations under the *Public Health and Safety Act* to expand the current list of diseases that must, by law, be reported to the Yukon Communicable Disease Control.

**Section II: Structure and Finance Updates**

**Fiscal Activity**

- The 2005/06 Operations & Management Budget Estimates for Insured Health & Hearing Services (includes Yukon Hospital Corporation), Community Programs, Community Nursing & Emergency Services, and Continuing Care (includes Home Care) was $108,274,000.
- The Capital Budget Estimate for these programs was $12,790,000.
- The main capital projects for 2005/06 were multi-level care facilities in Dawson City and Watson Lake, Yukon Hospital Corporation equipment, the purchase of 2 new ambulances, Ambulance Services equipment, and increased honorarium, training, clothing and ambulance maintenance in communities.

**Governance and Management**

- The Minister of the Department of Health and Social Services is responsible for the delivery of all insured health care services in the territory. A Director, as appointed by the Commissioner in Executive Council, administers the health care insurance plans. The Yukon Government directly manages the provision of health services other than those managed by the Yukon Hospital Corporation or provided by private business.
- Health-related services managed by the Yukon Government include Insured Health Services (Physician, Hospital) and Yukon government-funded benefit programs including the Chronic Disease and Disability Benefits Program, Children’s Drug and Optical Program, Pharmacare Program, Extended Benefits Program and Travel for Medical Treatment Program.
- Other health programs provided by the Yukon government include hearing services, dental health, environmental health, health promotion, mental health services, communicable disease control, community nursing, (includes Watson Lake Cottage Hospital), emergency medical services, and continuing care (including home care and long-term care facilities).
• The following public boards and committees also provide governance and management:
  o The Yukon Hospital Corporation, Board of Trustees governs the operation of the Whitehorse General Hospital.
  o The First Nations Health Committee, a committee of the Yukon Hospital Corporation Board, governs the First Nations health program offered through the hospital.
  o The Health and Social Services Council provides an advisory function to the Minister.

_Institutional Change/Reform_

• No major functional changes within the funding or organization of institutional settings.

_RegionaIization Activity_

• The Yukon does not have a regionalized service structure.

• An appointed Board of Trustees operates the Yukon Hospital Corporation. The Corporation governs the operation of the Whitehorse General Hospital on behalf of all Yukoners.

• The Board of Trustees consists of 14 persons nominated by: Yukon First Nations; councils of rural municipalities; Council of Yukon Indians or its successor; City of Whitehorse; medical staff of the Corporation; non-medical staff of the Corporation; the public at large and the public service of the Yukon.

_Section III: Support and Innovation in Health Care_

_Human Resources: Physicians_

• A four year funding agreement was negotiated with the Yukon Medical Association, effective April 1, 2004. The agreement provides a 6.5% fee increase over the four year term. The Yukon Physician Recruitment and Retention program was implemented to address related concerns, offering financial bonuses in return for service commitments.

• Agreements typically detail the relationship and flow of funds to fee-for-service and alternative payment physicians; the change to fees; on-call coverage; provisions for recruitment and retention benefits, continuing medical education, medical practice insurance; continuance of service; assurance of cost; dispute resolution; and assurance of a more transparent recruitment process.

• There were 54 resident general and family physicians and eight specialists providing services in the Yukon in 2004/05

• Approximately 10% of physicians in the territory are being remunerated through alternative payment plans. This includes two rural physicians who are required to work in conjunction with Community Nurse Practitioners and five resident specialists in Whitehorse who are remunerated under alternative payment plans.
• In addition to the above services, a Visiting Specialists Program brings itinerate specialists to the territory to provide services not available locally. Further, the Visiting Physician Program provides itinerant services to 10 rural and remote communities that do not have resident physicians.

**Human Resources - Non-Physicians**

• The recruitment and retention of nurses to the territory continues to be a high priority.
• A Registered Nurse retention bonus of $3,000 per year was instituted in July 2001.
• A Community Nurse Practitioner retention bonus of an additional $3,000 per year was also instituted in July 2001.
• The Nursing bursary program is under review
• The recruitment and retention of Speech Language Pathologists, Physiotherapists and Occupational Therapists is a high priority and staffing is currently at a critically low level.

**Health Information and Telemedicine**

**Health Information**

• An assessment of health information management and technology requirements for the department is underway.
• Assessment of the department’s need for access to electronic health and social services research and best practices data bases has been completed, and an evaluation is underway to determine an appropriate vendor to meet these needs.
• A mental health information system, SYNAPSE, has been implemented; this system is part of an eventual electronic health record.
• The Tuberculosis module of the iPHIS (Public Health Information System) has been implemented at Yukon Communicable Disease Control, headquartered in Whitehorse. The Immunization module has been implemented in all community health centres.
• Continuing Care (Home Care and Long term care facilities) has successfully implemented an electronic health care record and case management system that has integrated RAI assessment tools.

**Health Technology**

• Telehealth services (video conferencing and store and forward technology) is available in all but four communities. Plans are underway to offer these services to the remaining four communities. The main applications are mental health, therapy services, professional, patient and public health education, family visits, and X-ray support.
• Information technology applications have been implemented in Mental Health (Synapse), Yukon Communicable Disease Control (Tuberculosis module of iPHIS) and Community Nursing (iPHIS, immunization module), supported by funding from Primary Health Care Transition Fund.

• A new Client Registry and a Drug Information System is currently in the process of being developed.

Section IV: Health Programs & Services

Community Health Initiatives

• The provision of insured physician and hospital services in all Yukon communities is administered centrally by the Yukon Government, Department of Health and Social Services.
  o No major health systems projects were initiated. However, the following outlines the basic services available in rural Yukon communities: Four Yukon communities outside Whitehorse have resident physicians and the remainder is served by visiting physicians.
  o Health Centres with Community Nurse Practitioners serve all 12 rural and remote communities.
  o Home support programs are provided in all 12 rural and remote communities and four of the communities have dedicated home care nursing.
  o The Children’s Dental Program provides preventive and restorative services from preschool to Grade 8 in all communities (and up to Grade 12 in communities without a resident dentist).
  o Various other health services (mental health, rehab, home care, hearing services, etc.) are provided by visits from health professionals who travel to the communities. Some elements of mental health and rehab are now part of a telehealth pilot project (see Health Technology).
  o The Healthy Family Initiative for early intervention to improve the quality of life for Yukon children and their families, based on the Hawaiian model, is in place.

Population Health-Based Initiatives

• The population has been experiencing a growth in the number of seniors in recent years. This has had a significant impact on the seniors’ drug and extended benefit programs, home care service levels, and the demand for facility based long term care services.

• A major initiative is the Active Living Strategy, a collaborative effort of several government departments and community partners.

• The Yukon Government, in partnership with the Recreation and Parks Association Yukon, has undertaken a mass media tobacco reduction campaign with funding from Health Canada directed to young adult smokers (ages 18-34 years). This campaign includes the distribution
of QuitPacks, a slingback which contains tools and resources to assist young smokers in becoming smoke-free.

- At the same time, there are many initiatives underway to prevent or reduce smoking among youth. These activities include awareness raising about the tobacco industry and engaging in a range of activities intended to stimulate discussion and debate among youth in schools and youth-serving organizations.

- Making sense and moving forward: Report on the 2003 Yukon Youth Smoking Survey was distributed in October 2005 throughout the Yukon.

- A revised Questions and answers on sexual health has been printed and distributed, training on the use of Choices and Changes, a sexual health education curriculum, a toll-free sexual health information line, YK-STYLE, continues to operate, a fulsome condom distribution campaign continues, and a sexual health promotion strategy is being developed.

- Governmental and non-governmental organizations collaborate to promote breast health awareness on an annual basis.

- A prostate health awareness campaign was launched in September 2005, and there are plans to do a similar awareness campaign this fall.

- Drop the Pop, a school-based program directed at primary school students and Drink to your health! a public education campaign were launched in March 2006 to increase awareness and knowledge about healthier drink choices.

- Yukon joined the Joint Consortium on School Health, and has undertaken a number of initiatives to promote healthier school communities.

- Prevention and management of communicable disease continues to be a priority, especially in relation to food, water and blood-borne illnesses. Outreach nursing services to high-risk groups, and a dedicated Hepatitis C nurse are examples of specific activities.

- Changes to the Yukon Immunization Schedule include the introduction of vaccines for varicella for infants, pertussis for adolescents, pneumococcal for infants and toddlers, and meningitis for infants and adolescents.

**Primary Care Initiatives**

- The Yukon Government received $4.5 million through the Primary Health Care Transition Fund administered by Health Canada, starting in 2002. Initiatives under the fund will conclude in September 2006. Yukon initiatives focused particularly on meeting the Fund objectives to:
  - increase emphasis on health promotion, disease and injury prevention and management of chronic disease; and
  - facilitate coordination and integration among health services.

- Two core initiatives are underway. These are:
  - to refocus organization structure and processes; and
• to implement improved technology to support the structure and processes.

• Initiatives have been undertaken to address the following goals:
  o Improving health information to the public;
  o Promoting healthy living;
  o Addressing key health issues; and
  o Improving cooperation and collaboration

• Major activities included information technology projects in mental health, public health, and client registry, initiating a Diabetes Collaborative, undertaking a participatory alcohol and drug research project and making a health guide and web-access information available to the Yukon public. Monies available from the Territorial Health Access Fund will enable some primary care initiatives to be sustained beyond the period of Primary Health Care Transition Fund funding.

**Home Care Initiatives**

• Home care has experienced significant volume increases in all areas of service provision over the last fiscal year. The challenge remains to meet this demand over large, isolated geographic areas.

• Program expansion to remote, rural communities has been increased through a traveling outreach therapies team. All Yukon communities are visited on a regular rotational basis.

• Additional nursing resources have been added to meet the increased client need in the communities.

• Implementation of an integrated electronic health care record system, including the MDS home care assessment tool (integrated throughout continuing care which includes home care, day programs, therapy services and long-term care facilities.

**Mental Health**

• A full-time psychiatrist was recruited to the Yukon in October 2002. In addition, a child psychiatrist and a geriatric psychiatrist provide services to Yukoners during itinerant clinics and via televideoconferencing.

• Monitoring of in-patient care and emergency services provided by Whitehorse General Hospital is now done through the hospital’s Patient Care Team.

• Outreach services to persons with serious mental illnesses have been expanded in Whitehorse and rural Yukon, and a healthy living partial day program developed.

• Mental Health Services, Yukon Family Services Association (a non-profit organization) and Alcohol and Drug Services recently completed a project, funded through the inter-jurisdictional envelope of the Primary Health Care Transition Fund to improve services to individuals with concurrent (mental health and substance abuse) disorders.
• Education, case consultation and direct clinical services have been provided using televideoconferencing technology.

• Assessment of the housing needs of persons with serious mental illnesses will be undertaken this fiscal year.

**Long-Term Care Initiatives**

• Work on the development of Continuing Care regulations and standards is currently underway.

• Implementation of an integrated electronic health management system (home care and long-term care facilities) includes MDS assessment tool.

• Case management and assessment training is complete.

• Consent to care training is underway for all care providers

• $400,000 in funding to open 7 Intermediate care beds.

**Pharmacare Initiatives**

• Nothing to report at this time.
Section V: Other Health System Initiatives

- Nothing to report at this time.

British Columbia

Section 1: Political Updates

Current Political Representation

- B.C. Liberal Government: next election; May 12, 2009
- Premier: Honourable Gordon Campbell
- Minister of Health: Honourable George Abbott
- Deputy Minister of Health: Dr. Penny Ballem

Section 2: Legislative Amendments

Spring 2005

No legislative amendments – election writ in effect.

Fall 2005

Health Statutes Amendment Act, 2005 (Bill 15)

- This Act makes a change to the status of nurse practitioner (NPs) under the Health Authorities Act. Specifically, it excludes NPs from the collective bargaining process that applies to registered nurses.
- Bill 15 also amends the Vital Statistics Act to authorize Cabinet to make an order authorizing the CEO of the Vital Statistics Agency to enter into information sharing agreements with specified public bodies under certain terms and conditions. These agreements must state who will have access to the disclosed information, the circumstances under which information will be disclosed, the limits attached to the disclosure of information, how the information will be stored, how compliance with the agreement will be monitored, and the term of the agreement. Cabinet may make regulations prescribing those bodies with whom the CEO of the Vital Statistics Agency can enter into information sharing agreements.
- [These amendments came into force on Royal Assent November 24, 2005.]
Section 3: Fiscal

For further information on the Service Plan for 2005/06 – 2007/08 for the Ministry of Health Services please follow the web address:
http://www.bcbudget.gov.bc.ca/2006/sp/hlth/

Section 4: Governance and Management

No change from 2004.

Section 5: Institutional Change/Reform

In June 2005, the Minister of Health assumed the responsibilities of the Minister of State for Mental Health. The Ministry of Health Services was renamed the Ministry of Health.

Section 6: Regionalization

Health authority accountability

Health authorities sign performance agreements with the Ministry of Health that hold them accountable for the delivery of patient care, health outcomes and how health dollars are spent. A provincial Leadership Council, made up of health authority Chief Executive Officers and Senior Executives from the Ministry of Health meet regularly to ensure health authorities are meeting the targets set by their performance agreements.

Performance agreements provide a framework against which the overall performance of the system as a whole can be monitored, evaluated and reported. The agreements define performance deliverables and service requirements in broad areas of service and finance and specific areas of reform in emergency care, surgical services, home and community care and mental health services for three fiscal years. Performance targets are meant to challenge each health authority to achieve its maximum potential in key service areas, while taking unique geographic and demographic challenges into account.

In addition to building collaboration across the health care sector, performance agreements have proven to be effective in addressing concerns about accountability in the health care system and in acting as drivers of change and improvement. They have enhanced accountability by setting out mutually defined performance expectations and requiring reports on how expectations are met. In addition, the 2001 consolidation of 52 health authorities to six has created the critical mass within health authorities to support well-functioning internal audit programs. The Office of the Auditor General reports that all six health authorities have set up an internal audit unit.
Section 7: Human Resources: Physicians

B.C. medical school expansion

- University of British Columbia (UBC) distributed medical programs are now in place in Prince George and Victoria, and the medical school facilities have expanded under a $134 million commitment announced in March 2002. The expansion included $110 million for a new Life Sciences Centre at UBC Vancouver and about $24 million for new facilities at the University of Northern British Columbia (UNBC) and the University of Victoria (UVic).
- The distributed medical programs focus on rural, geriatric and aboriginal health issues. They will enable undergraduate medical students to study close to home and will help alleviate regional issues over access to physician services by providing a pool of student doctors who will complete residency rotations in hospitals outside of the lower mainland.
- UBC-Okanagan in Kelowna will be home to the province’s fourth medical program. By 2009, this distributed medical program will have first-year spaces for at least 30 students.

More medical school spaces

- BC’s annual intake for medical students was 128 in 2003. The medical school’s expansion doubles the number of first-year spaces to 256 by 2007.
- All undergraduate medical students take the first semester at UBC and then disperse to UBC, UNBC or UVic.
- There are now 24 first-year spaces at the Northern Medical Program, UNBC, 24 first-year spaces at the Island Medical Program, UVic, and 176 first-year spaces at Vancouver-Fraser Medical Program, UBC, for a total of 224 potential graduates per year by 2009.
- A final 32 first-year medical school spaces will be added in 2007 for a total of 256 potential graduates per year by 2011/12. Of these, eight are expected to go to UNBC, eight to UVic and 16 to UBC Vancouver-Fraser.
- The recently announced Okanagan Medical Program will add at least another 30 first-year spaces when the program begins in 2009/10.

More residencies

- Postgraduate medical education positions (residencies) will expand to keep pace with the medical school expansions. Since July 2003, the Ministry of Health has approved funding for 89 new postgraduate entry-level (residency) positions.
- The number of entry-level residency positions will increase to at least 256 by 2011/12.

Enhanced Infrastructure for Medical Education
The B.C. Government is investing $27.6 million to expand and upgrade academic space in teaching hospitals around B.C. to support the increasing number of undergraduate and postgraduate medical students. The money will go toward renovations and upgrades of academic space, such as seminar rooms, on-call rooms, offices and library space.

**Residency spaces increased for International Medical Graduates**

- In November 2001, the number of IMG family practice entry-level residency positions increased from four to six at St. Paul’s Hospital.
- In November 2005, government invested an additional $1.65 million to bring the entry-level residency positions for IMGs from six to 18. For the first time, B.C. is accepting candidates who wish to pursue specialist residencies. Six of the new positions are for family medicine and six are for specialties such as internal medicine, general surgery, psychiatry, pediatrics, pathology, anesthesiology, obstetrics and gynecology. The specialties will be determined by matching the candidate’s assessment results and interests with the specialty program’s readiness to train. (This is no longer a 2-year program for only family medicine.)

**Immigration process speeds up for international doctors**

Foreign doctors practicing medicine on temporary work permits in B.C. can now gain permanent resident status within six to eight months under a new component of the B.C. Provincial Nominee Program (BC PNP). Previously, foreign doctors waited up to three years for the permanent resident application process to be completed. The new component makes it easier for them to settle their families and set up practice here, helping address pressures in the health care system, especially in rural British Columbia.

**Recruiting more doctors to rural and remote areas**

- Studies show that doctors tend to practice in the regions where they trained. The new distributed medical programs at UNBC, UVic and UBC-Okanagan will play an important role in recruiting more doctors to rural and remote communities.
- Through physician compensation, government has allocated $58.5 million towards rural programs that encourage physician recruitment, retention and education.
### Total Number of Medical Practitioners by Specialty

**British Columbia**  
**Comparison 2003/04 and 2004/05**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Practitioners 2003/04</th>
<th>Practitioners 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td>4,573</td>
<td>4,629</td>
</tr>
<tr>
<td>Dermatology</td>
<td>66</td>
<td>64</td>
</tr>
<tr>
<td>Neurology</td>
<td>92</td>
<td>96</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>557</td>
<td>584</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>185</td>
<td>197</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>182</td>
<td>180</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>82</td>
<td>79</td>
</tr>
<tr>
<td>General Surgery</td>
<td>190</td>
<td>191</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>160</td>
<td>180</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>63</td>
<td>68</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>21</td>
<td>26</td>
</tr>
<tr>
<td>Urology</td>
<td>71</td>
<td>73</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>206</td>
<td>214</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>536</td>
<td>569</td>
</tr>
<tr>
<td>Radiology</td>
<td>251</td>
<td>263</td>
</tr>
<tr>
<td>Pathology</td>
<td>139</td>
<td>134</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>380</td>
<td>412</td>
</tr>
<tr>
<td>Paediatric Cardiology</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Physical Medicine &amp; Rehab</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>69</td>
<td>39</td>
</tr>
<tr>
<td>Medical Microbiology</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>47</td>
<td>50</td>
</tr>
<tr>
<td>Clinical Immunization and Allergy</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>8,083</strong></td>
<td><strong>8,271</strong></td>
</tr>
</tbody>
</table>

### Section 8: Human Resources – Other Health Care Professionals

*Recruit, retain and educate more nurses*

- Since 2001, government has committed more than $84.2 million towards the recruitment, retention and education of nurses in British Columbia.
• Since December 2001, the total increase in nurses with a practicing licence in B.C. is more than 2,100. (More than 1,300 RNs and more than 800 LPNs).

• The Ministry of Health has worked with the Ministry of Advanced Education to expand nursing seats, with 2,500 new nursing seats since 2001.

• As of March 2006, more than 980 nurses had been funded through the Return to Nursing initiative.

• As of March 2006, more than 1,200 LPNs had received funding through the LPN Upgrade Program allowing them to work to their full scope of practice.

• An estimated 6,500 more nurses – including RNs, RPNs and LPNs – are expected to graduate between 2002 and 2006.

• B.C.’s first group of nurse practitioners graduated in May of 2005 and hold key positions on primary health care teams.

• Specialty Education Incentives - More than 10,000 nurses across the province have been funded for continuing and specialty education since 2001

• The Aboriginal Nursing Strategies were established to increase the number of Aboriginal and non-aboriginal nurses working with Aboriginal communities in remote, rural and underserved communities throughout B.C.

• Quality of work life for nurses has been one of the nursing strategy goals since 2003. Funds have been provided for projects related to: increasing front line nurse leaders, innovative schedules and flexible work places; developing creative clinical experiences: encouraging collaborative practice and decreasing aggression towards nurses in long term care settings.

**Recruiting more nurses to rural and remote areas**

• In 2005, the Northern Health Authority recruited 48 of 58 nursing graduates from UNBC into positions in acute care and public health facilities in Fort St. John, Prince Rupert, Terrace, Smithers, Burns Lake, Fort St. James, Vanderhoof, and Prince George. This year’s nursing influx follows 2004’s recruitment of 33 of 38 UNBC nursing graduates to positions across Northern BC.

• In 2005 health authorities committed to hiring all new RN and RPN graduates. This includes hiring for non-urban settings in NHA and IHA.

• The Ministry of Health provided funds in 2004/05 to translate knowledge learned from the national 2005 *Nursing Practice in Rural and Remote Canada Study* into effective recruitment and retention strategies for rural nurses in BC.

• In 2005/06, nursing strategy funds have supported a province-wide education plan that is rural focused and practice driven to meet the needs of nurses working in, or planning to work, in rural communities.
B.C. registers first nurse practitioners

British Columbia welcomed its first group of provincially-educated nurse practitioners (NP) in 2005. NPs are registered nurses with advanced education, knowledge and skills. As part of primary health care teams, NPs diagnose common illnesses, order investigations, prescribe medications and provide follow-up.

- In May 2003, government announced a total of 30 new spaces for NP education at UBC and UVic. These programs started in September 2003. A third program at UNBC, was funded for 15 seats and started in September 2005.

- The Health Professions Amendment Act, which was passed on October 22, 2003 allowed for the rollover of the Registered Nurses Association of British Columbia to the College of Registered Nurses of British Columbia (CRNBC) and the recognition of the role of NPs as advanced practitioners within the health profession of registered nurses. The new CRNBC became a reality on August 19, 2005 and the first NPs were registered in early October 2005.

Government invests in health care professionals’ partnerships

Government invested $400,000 in a partnership to encourage collaboration among students and practitioners from different health disciplines to improve patient care. The funds, spread over four years, support the Interprofessional Network of British Columbia (In-BC). This network brings together the province’s six health authorities and post-secondary educational institutions to improve health care. In-BC projects involve students and health professionals representing a wide range of disciplines, including medicine, nursing, midwifery, pharmacy, rehabilitation services and social work. In-BC is the first interprofessional network of its kind in North America.

Expanding loan forgiveness

B.C.’s student loan forgiveness program was expanded in December 2004 to include four health professions whose graduates are needed to provide support for children in rural and remote areas of the province. Speech language pathologists, audiologists, occupational therapists and physiotherapists became eligible for the program, and can eliminate their B.C. student loans in three years. The loan forgiveness program has been in place for graduates from accredited schools in nursing (including licensed practical nursing), and medical, midwifery and pharmacy schools since August 1, 2000. In October 2005, B.C.’s student loan forgiveness program was further expanded. Nurse practitioners are now eligible to have their B.C. student loans forgiven over three years if they agree to work in a publicly funded facility in an area of the province that is currently underserved.

Section 9: Health Information

BC Health Guide helps improve access to health care

- The BC Health Guide Program is one way that government is developing new and creative programs to empower British Columbians to make the right health decisions for themselves
and their families. Launched in Spring 2001, the Program provides health information, advice and support 24 hours a day, 7 days a week through an integrated suite of self-care resources (BC HealthGuide handbook, BC HealthGuide OnLine, BC HealthFiles and BC NurseLine).

- BC NurseLine provides confidential health information and advice, enhancing British Columbians' access to health information and assisting them obtain the appropriate care when they need it. Translation services are available in 130 languages, including Mandarin and Cantonese.
- BC NurseLine was enhanced with a Pharmacist Service in June, 2003. Pharmacists are available to answer medication related questions between 5:00 p.m and 9:00 a.m. daily.
- A related telehealth service, Dial-A-Dietitian, provides free nutrition information line for British Columbians Monday to Friday, 9:00 a.m. to 5:00 p.m.
- The BC First Nations Health Handbook, an Aboriginal companion guide to the BC HealthGuide handbook, was distributed in fall 2002.
- In June 2004, the BC HealthGuide handbook was made available in French.
- A redesigned version of BC HealthGuide OnLine (www.bchealthguide.org) was launched in September 2005.
- Translations in Chinese and Punjabi are forthcoming.

Research

Funding to support mental health research

The Province provided $10-million in funding to help establish three new research chairs and a new Institute of Mental Health at UBC. The funding matched a $10-million private gift to UBC and will put B.C. at the forefront of mental health research, training and policy. The $20 million will:

- Create three $5-million endowments to support research chairs in child and adolescent psychiatry, geriatric psychiatry and depression, and psychotherapy.
- Develop fellowships, junior faculty positions, and support for communicating research and clinical findings to clinicians and mental health professionals.

$2 million invested in improving women’s health research

Government invested $2 million through the Women’s Health Research Institute at BC Women’s Hospital & Health Centre to fund investigation into health issues unique to women. The research will provide health care professionals with evidence-based research to support prevention, diagnosis and treatment services for women. New funding will:

- Enable ongoing research on health issues throughout all phases of a woman’s life;
• Improve clinical practices and policy development;
• Develop women’s health research partnerships through sharing technology that will link researchers, women, policy makers and health care providers.

$6.1 million invested in UBC blood research

The Centre for Blood Research officially opened in March 2005 at UBC’s new Life Sciences Centre. The centre focuses on the Canadian blood supply system, including improving transfusion services and developing artificial blood components. Provincial funding of $6.1 million helped create the facilities. The long-term goal of the centre is to make Canada a donor-free society by the year 2025.”

$100 million for Health Research

In February 2005, government committed an additional $100 million to the Michael Smith Foundation for Health Research (MSFHR). MSFHR is British Columbia’s premier health funding agency, supporting BC’s best and brightest health researchers and health research trainees through personnel funding and infrastructure support programs. MSFHR is a third-party, independent organization, working with health research stakeholders across BC to identify, prioritize and respond to provincial priorities. In addition to its funding role, MSFHR acts as a leader, partner and catalyst to advance provincial, inter-provincial and national initiatives that expand health research support and opportunities.

Section 10: Health Technology

Telehealth

• Telehealth helps to overcome barriers of geography, transportation infrastructure, or socio-economic disparity by using communications and information technology (such as video conferencing) to deliver health and health care services, information and education where participants are separated. It enables clinical consultation, continuing professional education, health promotion and healthcare management to be delivered to rural and remote areas. Both broad and low bandwidth infrastructure and technology are used to provide services.

• Telehealth videoconferencing technology is now in place in more than 66 communities in B.C., encompassing nearly 125 dedicated sites in B.C.’s health care facilities, compared to 11 communities in 2001.

• Significant investments are being made across the province in diagnostic imaging systems. Seen as one of several key building blocks of the Electronic Health Record (EHR), diagnostic imaging is one area where the linkage and integration between telehealth and the EHR is very apparent. Transmission of live echocardiogram and ultrasound images for interpretation, along with store-and-forward transfer of digital images for review and assessment, are currently occurring in several health authorities.
• Hand-held devices, the Internet, and other technologies (including transfer of information over regular phone lines) are also being implemented where they provide practical solutions to identified needs. Telehealth services are currently available in approximately 20 clinical program areas. Oncology, mental health/psychiatry, maternal/fetal medicine, medical genetics, orthopedics, pharmacy, thoracic surgery, trauma, and wound care program areas are all applying telehealth technology to service delivery. Services for children are available in the areas of psychiatry, rehabilitation and development, eating disorders/nutrition, neonatology, cardiology, oncology, palliative care, physiotherapy, and speech therapy.

Section 11: Primary Care

Primary health care in British Columbia is undergoing far-reaching modernization. The Ministry of Health Services, regional health authorities, physicians, nurses, midwives, paramedics and all members of the health care team, including patients, have been working together since 2001 to develop a robust primary health care system. Examples of the increased range of integrated primary health care delivery models in the province include:

• Forty-Nine new practice models for improved quality of patient care.
• Forty-Two emerging primary health care networks.
• The addition of pharmacists to the BC Nurseline, who provide after hours advice.
• Establishing Nurse Managed Care/ Nurse First Call practices, where patients receive care from Advanced Practice nurses, in six rural/remote communities.

Province improves chronic disease management

• Traditionally, the health care system has been focused on acute and episodic care. Since 2001, government has taken steps to design the system in a way that will better support patients with chronic diseases.
• A large percentage of health care resources are spent on chronic disease management with 5 per cent of patients using more than 30 per cent of physician services. This 5 per cent consists mainly of patients with chronic disease whose health is likely to decline.
• The MoH developed standards of care for diabetes, hypertension, congestive heart failure, asthma, chronic obstructive pulmonary disease (COPD), kidney disease and depression.
• The province has led a series of collaborative efforts with stakeholders and health experts using the latest research and best practices, setting standards of care and performance targets for physicians caring for patients with chronic diseases. Physicians involved in a provincial congestive heart failure collaborative exceeded targeted outcomes for their patient’s health. Through provincial diabetes collaborative, seven thousand patients were monitored and received optimum care.
• BC Diabetes Guidelines are now available on Personal Digital Assistant (palm pilot) so that doctors can easily access guidelines during office visit.
Community collaborative efforts focused on diabetes, depression, congestive heart failure and kidney disease have taken place in the Northern Health Authority.

A provincial kidney disease initiative is helping detect kidney disease earlier and standardize kidney care.

Through the UVIC Centre on Aging, patients with chronic diseases are being trained to manage their own symptoms and treatment.

In partnership with the BC College of Family Physicians, BC physicians are receiving professional development on how to help patients set self-management goals (i.e., lifestyle changes such as diet and exercise).

In partnership with the College of Physicians and Surgeons, GPs are receiving training on how to self-evaluate their practice.

A CDM Toolkit is providing information technology for physicians to better monitor their patients and provide guidelines based care.

**Government encourages British Columbians to protect their health**

The Ministry of Health joined the Canadian Diabetes Association to launch Diabetes Awareness Month in November with a strong message to British Columbians that everyone needs to be involved to prevent the onset of this chronic disease. Government supported the Canadian Diabetes Association’s “Get Serious” month-long public awareness campaign.

**Section 12: Community Health Initiatives**

**Infection Disease Prevention**

**B.C. puts in place an HIV/AIDS strategy**

- September 2003, *Priorities for Action in Managing the Epidemics – HIV/AIDS in B.C.: 2003-2007* was released to health authority CEOs and AIDS community service organizations. The directional document serves as a blueprint to guide and support community and health authority efforts to manage the HIV/AIDS epidemic in B.C.

- Advances in medical science, improved quality of care and support, have enabled many people living with HIV/AIDS to manage their health more effectively and extend their life expectancy.

- In 2003, B.C. made HIV a reportable disease, to better track the course of the disease, to reach those who are not aware of their exposure to HIV and to protect the public from ongoing transmission.

- Government’s strategy focuses on sustained effort in four key areas:
  - Prevention – achieve a 50% reduction in both the number of people becoming infected each year and the number who are HIV-positive but unaware of their infection.
o Care, Treatment and Support – increase the proportion of HIV-positive individuals who are linked to appropriate services by 25%.

o Capacity – improve the province’s response to B.C.’s current HIV/AIDS epidemics and anticipate and respond to future developments.

o Cooperation and coordination – encourage consensus and co-operation among stakeholders at the federal, provincial, regional and community levels.

- Each B.C. health authority has developed, or is developing, an HIV service plan.
- The Dr. Peter Centre, in downtown Vancouver, opened September 25, 2003 and is designed to provide comprehensive comfort care for people with HIV and AIDS.
- Through BC Housing, government provided $4.3 million in operating subsidies for the Dr. Peter Centre, over 35 years, for the housing component of the project. The Ministry of Health Services and Vancouver Coastal Health provided $3.9 million in capital, Vancouver Coastal Health provides $1.8 million annually for the 24-hour care in the residence and Provincial Health Services Authority provides $1 million in annual operating funding for the day centre.

**Flu doses increase to largest amount ever**

In 2005, the Ministry of Health increased its flu vaccine order by 10% to 1.28 million doses – the largest number ever ordered for B.C. Regional health authorities across British Columbia started their annual influenza vaccination clinics in early November. All eligible British Columbians can access the free flu vaccine from their local public health unit or their doctor.

**Meningitis, chickenpox vaccine programs expanded**

Immunization programs announced in September 2004 were expanded to ensure children and high-risk groups are protected from vaccine preventable diseases. This includes:

- Two-month old infants were eligible for the meningococcal C conjugate vaccine in June 2005, a full seven months ahead of the original implementation date of January 2006;

- Children aged 18 to 48 months were eligible for the chickenpox vaccine beginning April 1, 2005, for one year, to ensure that those who weren’t eligible for the infant and kindergarten vaccine program can now get it.

- Grade 12 students became eligible for the meningococcal C conjugate vaccine in 2005. This is a two-year catch up program to ensure all school age children are protected against meningococcal C disease;

- Susceptible women (those who have not had chickenpox) of childbearing age are now eligible for the varicella vaccine because chickenpox can be fatal for an infant, if the mother contracts the illness while she is pregnant. The chickenpox vaccine is not recommended for women who are pregnant.
Air quality in B.C.

The 2003 provincial health officer’s annual report found that British Columbians enjoy good air quality by Canadian and world standards, but indoor and outdoor air pollutants can cause harmful health effects. Annual health care costs of treating illness resulting from air pollution are estimated at $167 million. The levels of air pollutants in B.C. vary, with the Interior, the north and the Lower Fraser Valley having more exposure to pollutants. Five priority actions are recommended:

- Reduce exposure to second-hand smoke across the province;
- Decrease exposure to airborne particles in interior and northern regions;
- Reduce aboriginal people’s exposure to indoor air pollutants such as molds and second-hand smoke;
- Reduce vehicle emission and other transportation pollutant exposure in the Lower Fraser Valley;
- Provide public education programs on what individuals can do to improve air quality.

Section 13: Population Health-Based Initiatives

B.C. communities get healthier

Premier Gordon Campbell proclaimed March 19, 2005 as the first annual ActNow BC day, with the goal of making the province the healthiest jurisdiction ever to host an Olympic and Paralympic Games in 2010. ActNow BC combines cross-government and community-based approaches to address common chronic disease risk factors through programs and initiatives that support healthier eating, physical activity, ending tobacco use and promoting healthy choices during pregnancy. In the 2005 throne speech, government made healthy living one of B.C.’s five Great Goals for a Golden Decade.

Act Now funding includes:

- $500,000 in 2005/06 to develop the Action Schools! BC Healthy Eating Module;
- $450,000 in 2004/05 and 2005/06 for an electronic professional services database to provide up-to-date nutrition information to dietitians;
- $1.5 million in 2005/06 in grants to communities via health authorities for community kitchens, gardens, good food boxes, and other local activities;
- $1.5 million in 2005/06 to support municipal governments, health districts and partner organizations promote healthy lifestyles;
- $285,000 to support communities develop healthy public policy and encourage public leaders to talk about healthy planning in their communities.
B.C. expands early childhood health screening

The launch of a new $73 million program to provide universal hearing, dental and vision screening for every child under age six will give B.C. children the best possible start on a healthy, happy life. The Province will invest the money over the next three years in new infant and early childhood screening and intervention programs including:

- A Sound Start, a program to ensure children born with congenital hearing loss will receive early screening, diagnosis and treatment ($19 million).
- Vision screening, including increased coverage for eyeglasses for children from low-income families and families on income assistance ($19 million).
- Dental screening and support programs, including increased dental coverage for children in families on income assistance and those receiving MSP premium assistance ($35 million).
- Increased dental and eyeglass coverage represents a $7.5 million annual commitment to the health of over 203,000 children in low-income families and took effect April 1, 2005.

Healthier eating in B.C. schools

A new pilot program was launched in September 2005 to promote healthy eating and increase access to healthier snacks in schools. The School Fruit & Vegetable Program will provide one serving of BC-grown fruits or vegetables to children twice a week at ten elementary schools. The ministry provided $300,000 to fund the study, which will be administered and delivered by the BC Agriculture in the Classroom Foundation.

First forum to promote health in B.C. schools

Educators, health professionals, parents, students and municipal leaders met in Vancouver in January 2005 for the first-ever forum to promote health in B.C. schools. A panel of educators and students helped to develop a framework for health-promoting schools for all students in B.C. Completion of the framework is expected by spring 2005.

Province invests in community health promotion fund

The Province announced a $5-million grant in April 2005 to the Union of BC Municipalities to help kick start local government involvement in building healthier communities throughout the province. This investment will help UBCM members get to work at the local level to establish proactive health promotion and prevention programs that will help achieve B.C.’s health and fitness goals. As one of the nine organizations that make up the BC Healthy Living Alliance, UBCM has been an active member of the province’s efforts to establish the goals of ActNow BC.

Food guidelines to help schools improve student health

The Province introduced guidelines in November 2005 for food and beverage sales in schools to help eliminate junk food and improve student health and achievement. In B.C., one in four children between the ages of two and 17 is overweight or obese. Through ActNow BC, B.C.’s
goal is to lead the way in North America in healthy living and physical fitness. A report on food
sales and policies in B.C. public schools found:

- At elementary schools, 33% of beverage vending machine slots and 30% of snack machine
  slots contain “more healthy” choices.
- At secondary schools, 26% of beverage vending machine slots and 19% of snack machine
  slots contain “more healthy” choices.
- Less than 18% of schools have a policy or guideline in place that calls for competitive
  pricing of food and beverages to promote healthy choices.

**Clean win for B.C. in tobacco ruling**

The Supreme Court of Canada in September 2005 ruled unanimously in favour of B.C.’s effort
to hold the tobacco industry to account for practices that have harmed British Columbians. The
province is proceeding with its case to recover the costs that are owed to the taxpayers of B.C.
The lawsuit alleges that, since the 1950s, the tobacco industry failed to warn consumers about
the harmful and addictive nature of tobacco.

**Section 14: Mental Health and Addictions Initiatives**

The Province of British Columbia envisions a comprehensive, integrated, evidence-based system
of mental health and addictions services. These services focus on health promotion, prevention,
treatment and recovery and support individuals’ and families’ resiliency and self-care. B.C. has
developed various strategies and initiatives to improve health outcomes for individuals with
mental disorders and/or substance use disorders, their families and the communities in which
they live.
The province-wide delivery of addictions and mental health services is provided through the
health authorities. The recent alignment of addictions services with mental health services offers
new opportunities for improving access and responsiveness.

**New funding to fight crystal meth**

B.C. announced $7 million in September 2005 in additional funding and new initiatives to
continue the fight against crystal meth. That funding included

- $2 million for treatment programs similar to Meth Kickers program in Kamloops;
- $3 million on a public awareness campaign including $1 million for school-based initiatives
  and $2 million on a public advertising campaign;
- $2 million to help communities by providing $10,000 seed grants.

An additional $8 million was announced in February 2005 to increase bed capacity for youth
with addictions and build crystal meth treatment programs and support.
Expanding assessment services for children with FASD

Government funded $3.5 million to expand diagnostic and assessment services for children with special needs, including those with Fetal Alcohol Spectrum Disorder. The funding is a part of government’s commitment to strengthen services for children and youth with special needs. Through the Provincial Health Services Authority, funding is being directed to enhance assessment and diagnostic services for children with possible FASD and other complex developmental-behavioural conditions at the regional and provincial levels. These services will build on the existing network of diagnostic and assessment services for Autism Spectrum Disorder.

Patients to benefit from neuropsych move to Kamloops

Patients will receive expert care in a state-of-the-art setting when provincial neuropsychiatric beds from Riverview Hospital are transferred to a new mental health facility in Kamloops. As part of the Riverview Hospital Redevelopment Project, 25 acute neuropsychiatric beds will transfer from Riverview Hospital to a new mental health facility scheduled to open in Kamloops in winter 2005/06. The new facility is adjacent to Royal Inland Hospital, which will provide improved access to diagnostic and treatment services, including an expanded emergency department, MRI and CT scanners, laboratory and pharmacy services, speech pathology and neurosurgery. The care for the patients in Kamloops will be supported through the Provincial Neuropsychiatry Program at UBC, which provides central intake, screening and referrals through assessment and treatment beds operated by Vancouver Coastal Health.

Premier’s Task Force on Homelessness, Mental Illness and Addictions

The Premier announced the formation of the Task Force at the Union of British Columbia Municipalities annual convention in September 2004. The Task Force is working to enhance BC’s system of housing and support services to help people break the cycle of homelessness. Twelve projects are underway in nine cities, with a total of 533 new units and shelter beds created.

New funding to target youth addictions treatment

In 2005/2006, the Ministry of Health provided an additional $6 million in annual funding to develop specialized youth addictions treatment services in the health authorities.

Section 15 and 16: Home Care and Long Term Care

B.C. is expanding its home and community care sector to provide more independent housing options, modernize residential care, improve home care/support and provide for end-of-life care.

Home and community care services provide a range of health care and support services for eligible residents who have acute, chronic, palliative or rehabilitative health care needs. These

132
services are designed to complement and supplement, but not replace, the efforts of individuals to care for themselves with the assistance of family, friends and community.

Home and community care services:

- support clients to remain independent and in their homes as long as possible;
- provide residential services and independent living services to clients who can no longer be supported in their homes;
- provide services at home to clients who would otherwise require admission to hospital or would stay longer in hospital; and
- provide respite for the client’s unpaid caregivers.

Since 2001, BC Housing and health authorities have been working in partnership with for profit and non-profit housing and care providers to give British Columbia seniors more options that provide the right care in the most appropriate setting.

Advancements in clinical practice, home technology and housing options mean more people can and want to live in their own homes and communities. B.C. is upgrading residential care beds to improve the quality of care for seniors and people with disabilities. Assisted living units are being developed for seniors and people with disabilities who can no longer live at home but do not require the 24/7 nursing care provided in residential care facilities. Enhanced home care, independent living, adult day care and hospice beds are part of the continuum of services that will be available to seniors and people with disabilities.

B.C.’s Seniors’ Housing and Care Strategy – 2001 to 2008

- Research and evidence from international and national seniors’ care planners – and the experiences of seniors themselves – indicate that B.C. is taking the right approach to improving seniors’ care.
- In the fall of 2004, government concluded a dialogue on health and aging that gave us the benefit of the best evidence available today, in Canada and in the world, about actions that have been shown to improve seniors’ care.
- The province will be following up on that dialogue to refine the next phase of our strategy to create the best system of support for seniors in Canada.
- We look forward to hearing from the new Premier’s Council on Aging and Seniors’ Issues to ensure B.C. seniors have the housing and care services they deserve.

Key health achievements for B.C. seniors and those with disabilities

- Reduced average wait times for residential care from up to one year to an average of 60 to 90 days between 2001 and 2005.
- Government is working to provide at least 5,000 new residential and assisted living beds by 2008.
• Modernized and replaced outdated residential care beds.

• Updated and modernized the Community Care and Assisted Living Act to protect the health and safety of seniors and people with disabilities in licensed community care facilities and registered assisted living residences.

• Since 2001, government spending on seniors’ housing and care has increased by about $100 million more annually.

• The actual, average cost in 2004 of operating a residential care bed is approximately $4,500 a month. The lowest-income seniors continued in 2005 to pay only $854 per month. Government subsidizes more than half the operating costs for the highest-income seniors.

• Health authorities are working to enhance home care and home support services throughout their communities.

• An expanded toll-free telephone information line is giving seniors one-stop access to a range of information – including health services – on government services.

**Facilities updated/constructed in 2005 for Seniors/Persons with Disabilities**

• Burns Lake - 17 new Assisted Living (AL) units (construction began Aug. 2005)
• Salt Spring Island – 30 new AL units (construction began July 2005)
• Surrey – 165 AL units as part of Fleetwood Villa, a Campus of Care (construction began July 2005)
• Powell River – 40 AL units (construction began July 2005)
• Abbotsford – 104 AL units at the Tabor Home’s Campus of Care (construction began July 2005)
• Lake Country – 25 AL units (construction began August 2005)
• Morgan Heights – 70 new residential care beds, 18 AL units at The Residence (opened July 2005)
• South Surrey Seniors Village – 85 new residential care beds, 42 new AL units (opened July 2005)
• White Rock – 84 new AL units at Evergreen Heights Baptist (construction began July 2005)
• Vancouver – 36 AL units and 154 residential care beds at Haro Park Campus of Care (opened March 2005)
• Ladysmith – 75 residential care beds, 12 geriatric mental health beds (construction began March 2005)
• Ucluelet – 10 new AL units at Sea View (construction began October 2005)
• Chilliwack – 66 new AL units (opened October 2005)
• Fort St. James – 2 new AL units (construction started October 2005)
• Rose Manor – 70 refurbished AL units (opened October 2005)
Richmond – 10 hospice/end-of-life care beds at Salvation Army Rotary Hospice House (opened September 2005).
Chilliwack – 10 bed hospice (construction began July 2005)
Mission – 10 bed hospice (opened July 2005)
Surrey – 10 bed hospice (opened July 2005)
Langley – 10 bed hospice (opened July 2005)
Maple Ridge – 10 bed hospice (construction began August 2005)

Section 17: Pharmacare

PharmaCare subsidizes eligible prescription drugs and designated medical supplies, protecting British Columbians from high drug costs. PharmaCare provides financial assistance to British Columbians under Fair PharmaCare and other specialty plans

B.C. pushes for national PharmaCare program

Premier Gordon Campbell was instrumental in Federal Provincial Territorial discussions in 2004 for the federal government to accept a national Pharmacare program. Canada’s premiers support the development of a national pharmaceuticals strategy to improve access to safe, affordable and effective drug therapies, protect Canadians from catastrophic drug costs and ensure the sustainability of the health care system. British Columbia is co-leading the National Pharmaceutical Strategy.

BC first to fund drug to benefit breast cancer patients

B.C. was the first province to approve and cover the cost of the drug Herceptin for all eligible breast cancer patients. Breast cancer patients in British Columbia gained access to the promising drug therapy through an $8-million commitment from the Ministry of Health, the PHSA and the BC Cancer Agency. In clinical trials, patients treated with Herceptin after completing chemotherapy had their rate of cancer recurrence cut by more than half, and had improved survival rates. It is expected that about 160 women in B.C. can benefit from the drug each year, at an annual cost of up to $8 million.

Patients benefit from new drugs under PharmaCare

Patients with rheumatoid arthritis, glaucoma, migraines and high blood pressure are among those who will benefit from improved health and quality of life through access to eight new drugs under PharmaCare. Decisions about drug coverage are based on scientific evidence that clearly shows a medication is safe, cost-effective and improves patient outcomes. In July and August 2005, PharmaCare listed the following prescription medications for coverage:
- Humira, used to treat rheumatoid arthritis.
- Combigan, for glaucoma and ocular hypertension.
• Axert, for migraine.
• Teveten Plus, for high blood pressure.
• Avodart, for enlarged prostate (prostatic hyperplasia).
• VFEND, for invasive fungal infections in immune-compromised patients.
• Keppra, for epilepsy.
• Xalacom, for glaucoma and ocular hypertension.

More than 10,000 patients will receive coverage for these drugs in 2006.

**PharmaCare makes program improvements to benefit British Columbians**

- BC’s PharmaCare program increased the number of drugs reviewed over the past year by 293%. In 2004, PharmaCare completed 14 drug reviews and approved five. In contrast, in 2005, PharmaCare completed 55 drug reviews and approved 29. This includes only the brand name drugs, not generics.
- PharmaCare expenditure has increased 25% from $635 million in 2000/01 to almost $793 million in 2004/05.

**PharmaNet**

- PharmaNet is an innovative, province-wide network linking all pharmacies into a central set of data systems which, in turn, provide improved data and services to support drug dispensing, drug monitoring and claims processing. Australia is now considering the B.C. model as a prototype for a similar initiative. PharmaNet was cited in a 2004 CIHI report as an example of innovation in patient safety.
- Government is improving patient care and safety by making medication histories available to authorized medical practices through PharmaNet. Expansion of access to PharmaNet is being supported by a change in the proper legislation with amendments to the Access to PharmaNet Patient Record Information Regulation. PharmaNet is the secure computer network that links all community pharmacies in B.C. and many hospital pharmacies, to a central database. The computer network protects British Columbians from potentially dangerous medication interactions and duplications.

**Modernize and Improve Administration of Medical Services Plan and PharmaCare**

Government has contracted with MAXIMUS BC to modernize and improve the administration of MSP and PharmaCare. This is intended to improve services to British Columbians:

- reduced wait time for phones and correspondence;
- quicker processing times;
- faster and more user friendly automated services.
Measures have been taken to ensure the confidentiality of the public's information is protected. B.C. leads Canada in privacy protection. The agreement protects employee jobs and working conditions for current staff.

**Section 18: Other**

No other updates to report at this time.

**Alberta**

**Section I: Political Updates**

*Political Representation*

Progressive Conservative Party: last election November 2004
- Premier: Ralph Klein
- Minister of Health and Wellness: Iris Evans
- Deputy Minister of Health and Wellness: Paddy Meade

*Legislative Amendments*

In the spring 2005 Session the Smoke Free Places Act received assent.

The Act protects minors and sets a minimum provincial standard for protection from second-hand smoke for Alberta by defining the types of facilities in which smoking may or may not occur. Subject to specific exceptions, it prohibits smoking in a public place, a workplace and a public vehicle. Offences are also prescribed. The Act and its accompanying regulation came into effect January 1, 2006.

The Smoke Free Places Signs Regulation was also developed to support the provisions of the Smoke-Free Places Act. A sign indicating the status of the establishment must be posted at every entrance to the enclosed public place, including public transportation such as taxis, or indoor workplace so that it is clearly visible to those entering.

During 2005, the Health Care Protection Regulation was amended to remove the list of enhanced medical goods and services and to remove the prescriptive costing formula used to calculate the costs of an enhanced good or service. The changes allow regional health authorities to:
- Determine for, within the broad definition provided by the *Health Care Protection Act*, what is an enhanced good or service.
- Determine the rates for the enhanced goods or services.
In the summer of 2005 the Hospitalization Benefits Regulation was amended to remove preferred accommodation rates from the regulation and allow regional health authorities to set rates.

In January 2006, the Food and Food Establishment Regulation was amended to:

- better define the application of the regulation to community settings; and
- avoid the application of the regulation in a manner that had an undue negative impact on volunteer community organizations and events.

The existing regulation was repealed and replaced by a new regulation with a new name: the Food Regulation.

In January 2006 the remaining sections of the Blue Cross Amendment Act, were brought into force to amend the ABC Corporation Act. The amendments in conjunction with the revised ABC Benefits Corporation Regulation, establish a payment in lieu of taxes program for the ABC Benefits Corporation to level the playing field with other supplementary health insurance providers.

**Institutional Change/Reform**

In May of 2005, health care experts from around the world gathered in Alberta for The International Symposium on Health. The symposium gave Alberta an opportunity to examine a range of possible solutions to the challenges facing the health care system. From this experience the province learned that there is no single solution to Alberta’s challenges in health care delivery.

Since then Alberta has continued to develop and implement numerous ideas and improvements that meet patients’ needs, and make a positive difference in the health of Albertans. The goal of this health renewal plan, Alberta’s Third Way in health care, is to improve the public health care system – to make it stronger and better than it is today. In 2005, Alberta announced 13 renewal initiatives as part of a made-in-Alberta approach to health system delivery. This Third Way approach is about unleashing innovation, challenging the status quo and charting a new course to make our health care system among the best in the world. The following actions were identified:

- Put an overall health policy in place.
- Improve access and efficiency
- Get serious about wellness and injury prevention
- Make children’s health the top priority
- Improve access to mental health services
- Implement an electronic health record for all Albertans
- Expand primary health care
- Make changes to legislation and regulations
- Control spiralling drug costs and increase coverage
• Improve quality of long term care
• Increase the supply of health care providers
• Address the health needs of rural communities
• Examine supplementary health insurance

Some of the innovative initiatives Alberta has recently implemented to improve health care services in the province and the health of Albertans include:

• The hip and knee replacement pilot project: The first eight months of the pilot resulted in decreased wait times from 35 weeks to six weeks for the first orthopedic consult, and from 47 weeks to 4.7 weeks from the first orthopedic consult to surgery. The length of stay in hospital went from 6.2 to 4.3 days.

• The implementation of Primary Care Networks: Alberta currently supports 11 Primary Care Networks with 400 physicians and teams of health professionals providing service to 500,000 patients. Another 18 Primary Care Networks are in various stages of development in health regions across the province.

• The establishment of the Mental Health Innovation Fund: Thirty new projects across Alberta will share in $75 million over three years to provide a wide range of mental health services. These projects will meet the on-going mental health needs of residents in each health region.

Reorganization Activity - Health Authority Funding and Financial Accountability

Nothing to report at this time.

Section II: Structure and Finance Updates

Fiscal Activity

The 2005/2006 spending for Alberta Health and Wellness is forecasted to be $9.208 billion.

This is an increase of over $800 million or 10 per cent from the 2004/2005 actuals. Highlights of the 2005/2006 planned spending include:

• $5.644 billion, an increase of $458 million or 9 per cent. The health authorities will also receive $64 million for health capital facilities. This is the first year of a $1.4 billion commitment on 20 new capital projects.

• $1.7 billion for the trilateral agreement between the Alberta Medical Association, the regional health authorities and the department.

• $629 million for a government sponsored non-group benefit program. Over 90 per cent of the spending is for prescription drugs primarily for seniors.
Governance and Management

Since April 2003 the Alberta health system structure consists of 11 health boards: nine regional health authorities (RHAs) and two provincial boards – the Alberta Cancer Board and the Alberta Mental Health Board. Board members are appointed and accountable to the Minister of Alberta Health and Wellness for health system performance.

RHA accountability is managed through four key documents:

- **Health Plan** – a three-year planning document, amended annually for approval by the Minister. A health plan must address legislated responsibilities, align with the goals of the Ministry’s business plan, and indicate what accomplishments are intended in respect to stated government expectations. Submission of the health plan is required by December 31, allowing sufficient time for review, amendment and approval, prior to the commencement of the next fiscal year.

- **Business Plan** – outlines what specifically will be accomplished in the first year of the health plan and identifies the financial and other resources required to accomplish intended results. A draft business plan is submitted with the health plan and is finalized once the provincial budget is known, generally in February or March of the subsequent year.

- **Two types of quarterly reports:** a performance progress report and a financial report. The performance progress report, due 45 days after the end of a quarter, indicates the extent to which the RHA is meeting health plan strategies and business plan objectives. The financial report, due 30 days after the end of a quarter, is prepared and submitted in accordance with requirements set out in the Ministry’s Financial Directives.

- **Annual Report** – indicates how the RHA has discharged its legislative responsibilities and reports performance accomplishments during the period.

Performance Agreements form the basis of accountability for the two provincial boards. These agreements set out the Minister’s expectations of the board, the obligations of the Minister, measures to assess performance and the expected results to be accomplished on an annual basis. As appropriate, the agreement may also require the submission of business, financial, capital, health workforce, information management and information technology plans. Agreements link to the provincial fiscal year, may cover two or three years, and are negotiated and approved before commencement of the next performance period. The two provincial boards submit quarterly performance reports and an annual report.
Section III: Support and Innovation in Health Care

Human Resources: Physicians

Alberta had 6,279 fully registered physicians as of December 31, 2005. The number of fully registered physicians in Alberta increased by 189 in 2005 and 221 in 2004. The breakdown for specialists and non-specialists was as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Specialists</th>
<th>General Practitioners</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>2,549</td>
<td>2,700</td>
<td>5,249</td>
</tr>
<tr>
<td>2001</td>
<td>2,664</td>
<td>2,785</td>
<td>5,449</td>
</tr>
<tr>
<td>2002</td>
<td>2,807</td>
<td>2,882</td>
<td>5,689</td>
</tr>
<tr>
<td>2003</td>
<td>2,884</td>
<td>2,985</td>
<td>5,869</td>
</tr>
<tr>
<td>2004</td>
<td>3,015</td>
<td>3,075</td>
<td>6,090</td>
</tr>
<tr>
<td>2005</td>
<td>3,097</td>
<td>3,182</td>
<td>6,279</td>
</tr>
</tbody>
</table>

Medical training opportunities have expanded in Alberta in recent years. Alberta’s medical school enrolments totalled 191 seats in 1990/1991 and 228 seats in 2001/2002, an increase of 19 per cent. Seats have been provided for each exiting student to enter medical residency training. Since 2000, Alberta’s medical residency training positions have increased by approximately 16 per cent, from 716 in 2000, to 886 in 2004. There were 20 rural residencies in 2004/2005; this will increase to 30 in 2005/2006.

Since 2001, Alberta has also provided a number of non-CaRMS (Canadian Resident Matching Service) positions for International Medical Graduates. For July 2005, the Alberta International Medical Graduate Program has made a total of 16 Family Medicine residency entry positions and 12 specialist training positions available. Only 12 Family Medicine and nine specialty places could be filled in 2004. These positions are over and above numbers required to meet demands created by students exiting medical school training.

Alberta Health and Wellness has implemented a multi-level on-call remuneration program for specialist physicians with a provincial framework and provincial standards. The program has been in place for four years. Rural On-Call covers 87 rural sites, and Specialist On-Call covers approximately 500 approved programs across the province.

In December 2003, a new tri-lateral master agreement for physician services in Alberta was ratified by Alberta Health and Wellness, the Alberta Medical Association and the nine health authorities. With an unprecedented eight-year term, this agreement extends and expands the Physician Office System Program, creates a new Primary Care Initiative, incorporates the specialist and rural on-call programs, provides fee increases totalling 9.1 per cent over the first three years, and allows for other subsidiary agreements to be added in the future. The tri-lateral parties (Alberta Health and Wellness, Alberta Medical Association and the health regions) are currently negotiating the 2006/2007 and 2007/2008 financial reopener for the Master Agreement.
The new agreement also makes provision for Alternate Relationship Plans (ARPs, formerly known as alternate payment and alternate funding plans), and for the first time gives them equal standing with fee-for-service expenditures as a spending priority. As of February 2006, Alberta has:

- 6 academic ARPs in operation involving 472 physicians.
- 2 additional academic ARPs in development which will involve 121 physicians.
- 24 non-academic ARPs in operation involving 336 physicians.
- 59 new non-academic ARPs in development, of which 10 are in the final stages of this process.

**Human Resources: Non-Physicians**

In 2004, Alberta was a signatory to a new Health Accord. Alberta will complete a comprehensive workforce plan and a physician resource plan by December 31, 2005, to meet the obligations of the Health Accord. The plans focus on the overall goal of having the optimal number, mix and distribution of health service personnel required for the provision of accessible, quality, patient-focused health services for Albertans, in a sustainable health care system.

The Health Workforce Information Network (HWIN) Initiative, which will provide data on the health work force for policy and planning purposes, is underway. It will be linked to the Alberta Provider Directory.

The Alberta Provider Directory (ABPD) is the Alberta implementation of the Western Health Information Collaborative (WHIC) Provider Registry System. A standardized registry of service providers is one of the fundamental building blocks of the Electronic Health Record and comprehensive health work force planning. (See Section III, Part C)

The Enhancing Clinical Capacity Project Fund (ECCPF) was established to encourage, stimulate and finance innovative projects that enhance the capacity of organizations to provide health disciplines students with clinical learning opportunities in alternative, sustainable ways. The fund will address access to health education programs, including clinical placement problems.

During the first round, 11 of 13 proposals were approved by the ECCPF Committee for a total of $2,883,900 in funding. These proposals were approved by the Minister and are now receiving their funding.

During the second round, 13 proposals were approved by the ECCPF Committee for a total of approximately $4.6million in funding.

The Alberta Government’s Three-Year Plan for the Continuing Care Sector outlined in the document, Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta include the following major health work force initiatives:

- A Health Care Aide Provincial Curriculum is currently being distributed to post-secondary educators, employers, and other training agencies. This curriculum is based on the core
competencies developed throughout the Continuing Care Workforce Working Group, a multi-stakeholder group comprised of representatives of the regional health authorities (RHAs), non-RHA organizations providing continuing care services and the ministries of Health and Wellness and Advanced Education.

Health Care Aide Awareness & Promotion Strategy addresses major challenges faced by employers in recruiting health care aides.

A Provincial Alzheimer Disease/Dementia In-Service Training Strategy has been completed. This project will provide a minimum of 7,000 front-line workers who currently provide services in rural and urban areas in the three continuing care streams (facilities, supportive living and home care) with the specialized education and training required for the provision of quality services to individuals with Alzheimer Disease and other types of dementia. A Train-the-Trainer Model is utilized and over 200 health professionals will also be trained through this process.

The Alberta Government has met the target of a 10 per cent increase in nursing education seats as outlined in Strategy Seven of the Nursing Strategy for Canada (November 2002). Between the years 1999/2000 and 2004/2005, there was a total increase of 1,875 seats for all RN nursing programs. That can be broken down as follows:

- Diploma: 457 seat expansion
- BSc programs (incl. Transfer programs): 1278 seat expansion
- MA, PhD, advanced training: 140 seat expansion

Between the years 1990/2000 and 2004/2005, there was a total increase of 857 seats for all LPN nursing programs.

Between the years 1999/2000 and 2004/2005, there was a total increase of 47 seats for all RPN nursing programs.

Total increase in nursing numbers from 30,000 in 1998 to over 34,000 in 2004. The 2004 numbers are: 5,700 LPNs; 27,348 RNs; and 1,241 RPNs.

Strategies to increase work satisfaction and employee retention are being developed by the regional health authorities through their Council of Chairs.

**Health Information and Telemedicine**

Alberta Health and Wellness continues to provide information technology solutions to help Alberta’s authorized health care providers share relevant patient information. The aim is to improve the health of Albertans, the quality of their care, and the sustainability of Alberta’s health system.
Alberta Netcare Electronic Health Record (EHR) is an Internet portal that today provides health care providers with relevant patient information from systems across the province, such as prescription and dispensing data, allergies and lab test results.

The EHR began rolling out in August 2003. At the end of 2005, more than 17,000 health care providers had voluntarily signed up to receive access.

In Alberta, much progress has been made to develop the provincial EHR. Capital Health, Calgary Health Region, and the seven rural regions have developed a strong collaborative approach resulting in a common vision. Capital Health has led the development of the Alberta Netcare portal. Collaborative work between Alberta Health and Wellness, and Calgary and Capital Health regions to develop an information exchange hub will link clinical databases at the regional level, to share information such as laboratory test results, diagnostic images and patient encounters through the portal. To complement this activity, Alberta Health and Wellness is developing patient, provider and facility registries. Security, authorization and access are managed at a provincial level.

Feedback on the value of the EHR from physicians using the system has been positive. Many have indicated they have changed treatment plans for patients as a result of the information they accessed through Alberta Netcare.

In addition to valuable patient information, Alberta Netcare includes decision support tools to alert physicians to possible drug-to-drug or drug-to-allergy interactions at the time of prescribing. Research studies conducted in other parts of Canada suggest that tools like the one in Alberta Netcare can significantly reduce the number of inappropriate prescriptions and adverse effects.

The Provincial HISCA provider data standard was approved in July 2005. The Western Health Information Collaborative (WHIC) provider data standards and definitions were also developed and provided the foundation for the national draft HL7 provider definitions to be balloted.

Alberta continues to participate in the WHIC provider directory initiative. The Alberta Provider Directory will manage information on providers of 30 registered health professions. The directory tool has been implemented, and there are projects in place to populate the data from the various registration bodies.

The Alberta Provider Directory will support both the Alberta Netcare EHR and Alberta Health and Wellness services. Detailed requirements have been defined, established and completed for the Alberta Provincial Provider Registry. This key EHR initiative will form the basis for the strategy and implementation of a provincial provider registry. Integration of the Provider Directory to the EHR will be developed in 2006 and 2007.
Canada Health Infoway is a federal corporation that funds EHR and telehealth initiatives. Infoway is partially funding Alberta’s Electronic Health Record. Canada Health Infoway acknowledges Alberta’s EHR leadership.

**Access Services provide access to health information and health services.**

Alberta’s Telehealth Network is one of the largest in Canada and is recognized as a worldwide leader in telehealth. The network continues to experience growth in all areas. Telehealth, through videoconferencing and other leading edge technologies provides Albertans convenient access to specialty health assessment, specialty care and a wide range of health services.

Improved access to health services for rural Albertans, including consultations, health promotion and education opportunities for patients and caregivers.

Provides improved and cost effective methods for connecting health system staff for continuing education and business meetings, thus greatly reducing travel costs. There are now over 270 telehealth systems in use in all manner of health facilities province-wide.

There are telehealth services in approximately 30 clinical areas including diagnosing lung cancer, monitoring heart and dialysis patients, and responding instantly to emergencies hundreds of kilometers away.

Through this Telehealth network, Albertans from across the province are receiving the specialized care they need without the need to travel far away from their local community support network.

A number of initiatives are underway to enhance stakeholder infrastructure to enable information exchange. These include:

- The seven rural health regions, through the Rural Shared Health Information Program (RSHIP) have implemented a common health information system (clinical, financial, and administrative applications).

The Physician Office System Program (POSP) is a tri-lateral initiative and an integral component of the province’s electronic health record strategy, technology made available to physicians through POSP means better access to important clinical information and support for decision making. As of March 31, 2006, POSP will have about 3,000 physician participants. This represents about 54 per cent of the 5,521 eligible physicians. Physician intake by fiscal year has been:

- 45 in 2001/2002,
- 1,108 in 2002/2003,
- 193 in 2003/2004,
The seven rural regions represent 23 per cent of the participation physician population whereas Capital has 38 per cent and Calgary has 39 per cent.

The physician office systems are working within the boundaries of the clinic; however, there is need to evolve these systems to be integrated with the Provincial Alberta Netcare Electronic Health Record (EHR) and the RHAs. To address the integration need, further inform vendors of mandatory provincial requirements and protect physicians in their purchasing decisions, the Physician Office Vision 2008 project will articulate the information technology vision for Alberta physician offices in the context of Alberta Netcare 2008.

POSP also offers change management support to help physicians assess their needs, choose products and services, and manage the installation and change that accompanies the expansion of computer technology in a physician office.

Western Health Information Collaborative (WHIC) (with AB perspective)

The Western Health Information Collaborative (WHIC) is an initiative sponsored by the Western Premiers and Deputy Ministers of Health to explore collaborative opportunities with respect to health information system development initiatives. This collaborative explores common opportunities that meet western provinces’ and territories’ health information needs and supports the strategic directions and initiatives at the national level. The WHIC process for project initiation and approval involves the following key steps:

- identifying common opportunities for collaboration;
- validating with participating jurisdictions;
- formalizing collaborative projects with lead, participating and supporting jurisdictions;
- obtaining commitment and funding;
- undertaking projects within appropriate structures;
- ongoing facilitation, coordination and process support through the WHIC Secretariat; and
- project and content leadership throughout the provinces/territories.

Alberta participates in the majority of WHIC initiatives, which encompass the following EHR projects:

- Provider Registry
- Client Registries
- Pharmacy/PIN
- Laboratory Information
- Architecture
- Telehealth
- Primary Care
Alberta is the lead province for Pharmacy/PIN, and Chronic Disease Management as well as a Telehealth Change Management initiative.

Section IV: Health Programs and Services

Community Health Initiatives

Alberta Health and Wellness contributed $2,330,000 to support community-based HIV organizations and community projects through the Alberta Community HIV Fund (ACHF), a joint community/provincial/federal fund disbursement model. ACHF is a collaborative partnership between the Alberta Community Council on HIV (ACCH), Alberta Health and Wellness and the Public Health Agency of Canada. Presently, 14 Alberta community-based HIV organizations and the ACCH receive operational funding. Thirteen projects, sponsored by other community organizations, are also being supported.

Alberta Health and Wellness issued a report with 99 recommendations aimed at improving Alberta’s organ and tissue donation and transplantation system. Building on those recommendations, the department prepared a document entitled “Getting Started:

- Implementation Strategy for an Integrated and Coordinated System for Donation and Transplantation in Alberta” that outlines implementation activities.

- Implementation activities already underway or completed include development of policies for new legislation, examination of potential for designated centres, identification of barriers to donation, and improvement of self-sufficiency in accessing tissues for transplantation.

The Alberta Strategy will link with the work of the Canadian Council for Donation and Transplantation where appropriate.

Population Health-Based Initiatives

The December 2001 report of the Premier’s Advisory Council on Health identified 44 recommendations for health reform, the first of which was “to stay healthy”. In response, Alberta Health and Wellness, working in collaboration with other government departments and organizations, developed the Framework for a Healthy Alberta that outlined 10-year objectives and targets to improve healthy behaviours and reduce the risk of chronic disease. The Framework is intended to guide government departments, regional health authorities and community organizations in the development of policies, programs and services to decrease the incidence of heart disease, cancer, lung disease, diabetes and other chronic diseases, and the number of injuries in Alberta.

A working group has been established to review the Framework to identify targets that need to be revised based on current evidence. They will also identify next steps in implementation and monitoring progress.
Alberta Health and Wellness’ three year Healthy U initiative, focuses on raising awareness among Albertans about the importance of healthy eating and active living through key components:

- A media campaign communicates the Healthy U message to all Albertans.
- Healthy U @ work provides more targeted information to employees and employers.
- The Community Choosewell Challenge challenges communities to compete to become one of the healthiest communities in Alberta.
- Healthy U Crew, a group of young individuals, share information at local events around the province.
- A website provides access to credible information and weekly tips.

Phase II of Healthy U is underway and has a primary focus on children and their parents and caregivers. The Snactivity Box, a resource kit for registered day home and day care providers is being distributed in stages. It provides information and activities for them to use with young children in their care.

The Premier’s Award for Healthy Workplaces has been introduced. It recognizes the efforts of employers to promote healthy workplaces including healthy eating and active living programs.

In July 2003, a Memorandum of Understanding was signed between Alberta Health and Wellness and Health Canada to participate in the World Health Organization (WHO) Countrywide Integrated Non-communicable Disease Intervention Program (CINDI). The WHO CINDI Program is a cooperative international effort to promote activities that focus on risk factors (such as smoking, alcohol abuse, inadequate dietary intake and sedentary lifestyles) that are common to major non-communicable diseases. This memorandum officially recognizes Alberta, via the Alberta Healthy Living Network (AHLN), as a demonstration site for an integrated approach to chronic disease prevention and health promotion. The Healthy Alberta Communities project will link evaluation outcomes for the AHLN to CINDI.

Alberta Health and Wellness is an active participant of the Coordinating Committee of the Alberta Healthy Living Network, which provides leadership for an integrated approach to chronic disease prevention and health promotion. The activities of the Network supplement Alberta Health and Wellness prevention initiatives, for example, the Framework for a Healthy Alberta, Healthy U, the Alberta Diabetes Strategy and participation in the Integrated Pan Canadian Healthy Living Strategy.

The Alberta Blood Borne Pathogens (BBP) and Sexually Transmitted Infections (STI) Strategy 2005-2011 is in development to provide direction for the prevention, care and management of BBPs and STIs in Alberta.

Alberta Health and Wellness is taking the lead in facilitating a Population Health Provincial Non-Prescription Needle Use (NPNU) Consortium to prevent the transmission of blood-borne pathogens and to reduce the harm associated with non-prescription needle use. The NPNU
Project is advised by a broad-based, 39-member, multi-sectoral, provincial consortium that addresses emerging issues and policy recommendations from seven task groups regarding priority themes including: surveillance, public awareness, Aboriginal groups, prisons, mental health services, addiction services, and community and professional development. An Opioid Dependency Treatment Coordinating Committee has also been established to assume central leadership for the delivery of opioid dependency services in the province.

The Alberta Diabetes Strategy (2003-2013) focuses on both primary prevention and management of diabetes. Key components of the strategy include:

- Financial assistance for low-income Albertans without private insurance to help them purchase the supplies that assist them to manage their disease.

- The community based *Keep Your Body in Check Program*, developed in May 2004 in partnership with the Canadian Diabetes Association (CDA) was launched in three communities (Norwood/Edmonton city center communities, St. Paul/Bonnyville and Medicine Hat). The program targets families, youth and Aboriginal youth and aims to educate Albertans on how to reduce their risk of developing type 2 diabetes. There have been 8,036 registrations to date.

- Educational tools for people with diabetes and for health professionals, based on the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada, were recently developed. Dissemination of these resources will take place this spring to many stakeholders including regional health authorities.

- A mobile team of health professionals visit off-reserve Aboriginal communities to screen individuals for diabetes and its complications. A total of 16 communities have been visited since November 1, 2003.

New cross-ministry initiatives have been established for the province which includes a project to develop a comprehensive provincial strategy to promote health, well-being and mental health of all children and youth.

Alberta Health and Wellness has lead responsibility to facilitate the development of this strategy, which will be built by addressing the determinants of health that will improve the wellness of children and youth. The project was launched in January 2006. Nine ministries, the Alberta Alcohol and Drug Abuse Commission (AADAC), Alberta Mental Health Board and the Public Health Agency of Canada are involved.

Three priorities for immediate (18 months to 3 years) action have been identified: healthy eating and active living, building resiliency (the capacity to respond positively to life’s challenges) and healthy choices (in areas of risk taking such as sexuality, use of alcohol, tobacco and other substances, sports and vehicle use).

Actions to address these priorities will be further advanced in the longer term (10 year) strategies along with additional priorities that will be identified as the strategy continues to develop.
The Alberta Cervical Cancer Screening Program is a new program operated by the Alberta Cancer Board. The program provides a population-based approach to cervical cancer screening targeting Alberta women 18 to 69 years of age with the goal to reduce the incidence and mortality from cervical cancer through enhanced prevention, early detection and treatment of precursor conditions.

The Alberta Breast Cancer Screening Program was announced in October 2004. The collaborative program will be coordinated by the Alberta Cancer Board and includes radiologists and health regions as key partners. Alberta women 50 to 69 years of age will be targeted for screening mammography. The goal is to decrease mortality from breast cancer.

The Alberta Perinatal Health Program was established on July 1, 2004, to promote maternal health, positive birth outcomes and healthy infancy by providing provincial leadership and enhanced support to health regions, health professionals, Alberta Health and Wellness and other stakeholders. This provincial program is administered through a partnership between two health regions and the Alberta Medical Association.

Alberta Health and Wellness will provide over $6.5 million for a managing obstetrical risk program over five years to be administered through the Alberta Perinatal Health Program.

Alberta Pandemic Influenza Contingency Plan advancements included an internal exercise for emergency preparedness, an estimate of funds required for supplies to be stockpiled and completion of a strategy to encourage self care when ill with influenza during the annual influenza season and in the time of a pandemic. A provincial stockpile of 2.6 million doses of antiviral medications has been secured for administration to Albertans, according to specific priority groups, during an influenza pandemic.

A provincial Smallpox Emergency Response Plan has been developed in the event of accidental or purposeful release of the smallpox virus. The plan provides a public health response to any smallpox threat in Alberta and provides a model for regional health authorities to build regional smallpox plans.

Alberta Health and Wellness facilitated the development of the Environmental Health Field Manual for Private, Public and Communal Drinking Water Systems in Alberta.

Membership on the committee included representatives from regional health authorities; the Provincial Laboratory of Public Health; Alberta Environment; Health Canada; Prairie Farm Rehabilitation Administration; Alberta Infrastructure and Transportation; and Alberta Health and Wellness. It is estimated that approximately 600,000 Albertans do not have access to drinking water provided by an approved municipal water treatment facility. Untreated, uninspected and unmonitored systems are a potential concern to public health and occasionally present conditions that warrant an emergency public health response. The manual is designed as a reference guide for public health inspectors of regional health authorities and includes an emergency response protocol that the health authorities can apply in the event of a laboratory confirmation of
bacteriologically failed or otherwise unsafe drinking water. The manual is in its second revision and has been distributed throughout Canada.

**Immunization Program**

Alberta Health and Wellness is leading the development of a province wide immunization strategy that will address immunization rates currently below target for all Albertans. This strategy will encompass the results of a literature review; local, provincial, national and international environmental scan; and extensive consultation with stakeholders. The Alberta Immunization Strategy will recommend evidence based strategies that will be implemented over a 10 year period and address all age groups within Alberta’s population. The target release date for the strategy is June – September 2006.

Alberta Health and Wellness provides provincial recommendations and guidelines to assist with implementing the provincial immunization program in the form of an Alberta Immunization Manual (AIM). The last revision to the AIM was in 2001. The format of this manual will be completely revised which provide a comprehensive program guidelines that will be used by public health staff in the health regions who operationalized Alberta’s Immunization Program. The final draft of this manual is targeted for September 2006. Extensive consultation with public health staff in the health regions will occur at that time.

Work continues to promote routine childhood immunization by practicing physicians in Alberta by discussing immunization with the parents and referring them to their local public health office. Specific print items are available on the public government website under the logo “Prevention in Practice” for physicians to order or download.

New pamphlets have been developed for some of the routine childhood vaccines to be used by public health staff in the health regions and work continues to develop the remaining pamphlets for all routine childhood vaccines.

**Primary Care Initiatives**

A key section in the new tri-lateral agreement is a Primary Care Initiative Agreement, supported by $100 million of federal funding, intended to achieve the following objectives:

- increase the proportion of Albertans with ready access to primary care;
- coordinate 24/7 management of access to primary care services;
- increase emphasis on health promotion, disease and injury prevention, care of the medically complex patient and patients with chronic illness;
- improve coordination and integration with other health services including secondary, tertiary and long-term care through specialty linkages to primary care; and
- use of multi-disciplinary teams to provide comprehensive primary care.
These objectives will be addressed through the development of Local Primary Care Initiatives now known as Primary Care Networks (PCNs). PCNs are partnerships between the health regions and physician groups to provide a defined set of primary care services ranging from population health through minor surgery and emergency care, and based on 24/7 management of access to appropriate primary care services, access to diagnostic services and coordination of access to home care, emergency room, long-term care, secondary and public health services.

A tripartite Primary Care Initiative Committee has responsibility for managing this initiative approving development of PCNs based on a review process including a letter of intent and the development of a business plan. As of March 2005, 14 Networks have begun operation and another 15 are under development.

Approved Networks will receive up to $50 per informally or formally rostered patient per year to improve primary care services provided by the network.

Alberta’s Primary Health Care Transition Fund was approved by Health Canada in 2002 to support transitional costs of implementing large-scale primary health care initiatives intended to improve access, accountability and integration of services through fundamental and sustainable change to the organization, funding and delivery of primary health care services.

To date the Fund has supported:

- the development and implementation of a province-wide 24/7 nurse-based health information and advice service, Health Link Alberta, which has been operational province-wide since June 2003; and

- the implementation of a Capacity Building Fund which is funding 10 initiatives intended to develop and integrate:
  - innovative health promotion, disease and injury prevention and chronic disease management programs; and
  - innovative care models based on the use of multi-disciplinary teams and other integrated care models, effective change management strategies, education and training activities for health professionals and infrastructure.

Initiatives include an interdisciplinary primary health care clinical team training initiative, two primary health care centres emphasizing expanded access to primary health care services and use of multi-disciplinary teams, two chronic disease management initiatives, a diabetes initiative, two shared care models, a comprehensive and multi-disciplinary child and youth health network and a mental health diversion project.

Provincial evaluations are underway for both Health Link Alberta and the 10 initiatives funded through the Capacity Building Fund.

Additional initiatives focusing on training and inter-disciplinary care have been funded to support the development of the PCNs and leverage off the ten initiatives now well under development.
**Home Care Initiatives**

See Long-Term Care Initiatives.

**Mental Health**

Mental health services were transferred from the Alberta Mental Health Board (AMHB) to the regional health authorities on April 1, 2003. A steering committee comprising the AMHB, regional health authorities, Alberta Alliance on Mental Illness and Mental Health, Alberta Medical Association, Alberta Psychiatric Association and Alberta Health and Wellness guided the development of advancing the Mental Health Agenda. A Provincial Mental Health Plan for Alberta through an extensive consultation process. The Provincial Mental Health Plan released in May 2004 sets out a new direction for mental health in Alberta.

Each health authority now has an approved regional mental health plan aligned with the Provincial Mental Health Plan. These plans outline how they will enhance the capacity of the system, address gaps and improve access to mental health services.

A Mental Health Innovation Fund, which will provide $25 million in each of the next three years, was announced as part of Budget 2005 to facilitate implementation of the Provincial Mental Health Plan and regional mental health plans. Thirty projects approved for funding were announced in November 2005. Two health authorities were requested to re-submit proposals, so additional projects will be announced.

The approved projects cover a broad spectrum of priority areas (e.g., crisis; case coordination; shared care; tele-mental health; prevention, promotion and public awareness; supportive housing) and population groups (e.g., children, youth, seniors, Aboriginals) across the three key strategic directions of the Provincial Mental Health Plan – support and treatment, risk reduction and capacity building.

**Long-Term Care Initiatives**

Alberta continues to collaborate with regional health authorities to facilitate the shift to community based continuing care options that will enable aging in place by providing support to seniors in their own communities. The promotion of standards for quality of care remains a priority of continuing care reform.

**Expand community care options**

Continue the shift so more Albertan over 75 years of age receive community-based continuing care services, reducing the ratio of those in institutions from 70.5 per thousand in 2003/2004 to 69 per thousand in 2005/2006.

A Home/Community Care Innovation Project is underway. An assessment of the strategic innovations required to modernize home/community care services has been completed.
The proposed strategic innovations will support the expansion of home/community based health care services and development of an integrated community care system. Examples include: collaboration between regions, collaboration between and integration of the various components of the care continuum, and implementation of common assessment tools across the regions.

Regional health authorities continue to expand community based health care options, such as supportive living settings, allowing seniors to maintain their independence and remain in the community with the support services they need, rather than entering long-term facility based care prematurely.

Currently, there are an estimated 20,000 supportive living spaces in Alberta.

**Improve access to continuing care services**

Coordinated access policies have been developed which require regions to provide care management and seven day access to continuing care services. These policies are now in the process of being implemented, with full implementation targeted for 2007.

Alberta Health and Wellness, in collaboration with the regional health authorities has developed and implemented policies on inter-regional transfers for continuing care.

**Enhance skill of front-line workers**

The provincial Alzheimer’s in-service training initiative has been completed. The goal of training 3,000 front line care workers was exceeded as over 7,000 front line care workers have now completed the training program.

Core competencies for Health Care Aides have been developed for use by educational institutions and employers. All Health Care Aides working in long-term care are expected to have achieved these core competencies in 2008.

**Implement the interRAI suite of assessment and care planning tools**

The interRAI tools will facilitate standardized, comprehensive assessment and care planning for all continuing care clients and will provide quality indicator and resource utilization information for use by health regions and Alberta Health and Wellness.

It is anticipated that the interRAI tools and the systems to support the tools will be fully implemented and functional by December, 2007.

**Finalize and implement the continuing care health service and accommodation standards**

The MLA Task Force on Continuing Care Health Service and Accommodation Standards gathered feedback from a variety of stakeholders and the public on a new set of draft continuing care standards.
It is anticipated that the new continuing care health service and accommodation standards will be finalized and released in the spring of 2006 for implementation in the 2006/2007 fiscal year.

**Pharmacare Initiatives**

*Alberta Electronic Health Record*

Alberta Netcare is the new name to describe all activities related to the Alberta Electronic Health Record (EHR). Various projects, products, programs and services continue to emerge across the province. Alberta Wellnet, the name of the branch within Alberta Health and Wellness responsible for developing and delivering the EHR, has been changed to the Information Systems Delivery branch.

The Alberta EHR is an electronic clinical health information network that links community physicians, pharmacists, hospitals, and other authorized health care providers from across the province. It helps health care providers quickly see, and in some cases update, health information such as patients’ allergies, prescriptions and laboratory results.

To do this, the Alberta EHR brings together three technology applications in one view to make it easy to access the information: the Pharmaceutical Information Network (PIN), the Person Directory, and the Laboratory Test Results History.

Physician office and pharmacy system vendors are working with the Information Services Delivery branch to complete revisions to their software to interoperate with the Alberta EHR. This means that health care providers will soon be able to benefit from the Alberta EHR without changing the management software tools they have become familiar with, such as electronic medical records and the pharmacy dispensing systems.

*Common Drug Review*

The Common Drug Review (CDR) is a single process for undertaking reviews and providing recommendations for new drugs and new drug combinations to participating federal, provincial, and territorial drug benefit plans in Canada. The CDR consists of a critical appraisal of the best available clinical and phamo-economic evidence, and listing the recommendations made by the Canadian Expert Drug Advisory Committee.

The Canadian Coordinating Office for Health Technology Assessment is responsible for delivery of the CDR to participating drug plans. As of February 23, 2006, reviews and recommendations have been completed for 36 drugs.

Alberta Health and Wellness has integrated the CDR process into its decision-making processes. Alberta has retained drug review processes for products other than those reviewed by CDR. The Minister continues to make all formulary listing decisions based on advice from the Expert Committee on Drug Evaluation and Therapeutics.
National Pharmaceutical Strategy

The federal, provincial and territorial governments are working together to develop a National Pharmaceuticals Strategy (NPS) to address challenging drug issues in an integrated, comprehensive and collaborative approach.

Alberta is actively engaged in the NPS.

Saskatchewan
Section I: Political Updates

Political Representation

- New Democratic Party: last election November 2003
- Premier: Lorne Calvert
- Minister of Healthy Living Services: The Honourable Graham Addley (appointed October 14, 2005)
- Deputy Minister of Health: John Wright
- Associate Deputy Minister of Health: Mike Shaw
- Assistant Deputy Minister of Health: Max Hendricks (March 1, 2006) /Lawrence Krahn (retired February 28, 2006)
- Assistant Deputy Minister of Health: Duncan Fisher

Saskatchewan is striving to provide the timely care Saskatchewan residents require through the public Medicare system. We are working to reduce wait times through our surgical care network and through investments in health services, health providers and the health infrastructure.

Legislative Amendments

The Osteopathic Practice Repeal Act, 2005

The Act, which was originally enacted in 1944, was outdated and there are no practicing osteopaths in the province. The Act was granted Royal Assent on May 27th, 2005.

Repeal of the Act enables recently trained Canadian graduates of osteopathy to practice in Saskatchewan, enables freedom to practice in the province as long as they do not engage in any invasive treatment that might encroach on the scope of practice of any regulated health profession.
The Youth Drug Detoxification and Stabilization Act
The Act allows for involuntary detoxification and stabilization of youth through an order by two physicians for a period of five days, with the possibility of extension for a maximum of two additional five-day periods. Involuntary detoxification/stabilization will serve as a measure of last resort for parents, legal guardians and judges when it is determined that a youth’s substance use presents a risk to his/her own safety or the safety of others. The Act was given Royal Assent on December 2, 2005 and came into force on proclamation April 1, 2006.

The Hearing Aid Sales and Services Act
The Act came into force in March 2006. Under this legislation, all private sector hearing aid businesses are required to be licensed with Saskatchewan Health. Hearing aid vendors will be required to be compliant with the legislation to ensure consumers receive quality hearing services and hearing aids from trained practitioners who meet the accepted standards of practice. Saskatchewan Health, as the regulatory body responsible for the legislation, will have ability to investigate complaints from consumers and take action if the complaint is found to be valid.


Section II: Structure and Finance Updates

Fiscal Activity

- The Department of Health’s 2005-06 budget totalled $2.9B, which was an increase of $192M (7.1%) over the 2004-05 budget. The increase provided for:
  - increased investment in regional health services through 12 Regional Health Authorities (RHAs);
  - significant investments to help recruit and retain valued health professionals;
  - new diagnostic and medical equipment to provide health professionals and patients with better information faster;
  - improved coordination and efficiency of surgical access through the provincial waitlist strategy;
  - continued expansion of primary health care through the development of teams of multi-disciplinary health providers in each region; and
  - increased investment in the provincial drug plan.
- Of the total $192M increase, $87M (5.1%) was provided to health regions to:
  - meet labour agreements for 37,000 health care workers;
  - support specialized hospital programs, which benefit all residents of Saskatchewan; and
  - address inflationary pressures.
• $8.1M (14.9%) is designated for cancer programs to address priority operating pressures, predominately the increased costs of providing cancer treatments (i.e. drug costs and the increasing complexity of treatment).

• Other initiatives include:
  o $16.2M in additional funding to cover escalating drug costs of the Saskatchewan Prescription Drug Program and allow for the addition of new drug treatments to the provincial formulary;
  o $20.2M for diagnostic and medical equipment;
  o $8.9M in funding to reduce the number of patients, who have been waiting in excess of 18 months for inpatient surgery and over 12 months for day surgery, and for initiatives to improve system performance and wait list management;
  o $10.5M in funding to increase diagnostic imaging services capacity and new technologically advanced diagnostic equipment; and
  o $9.3M increase to fund the expansion of Primary Health Care and to implement new Care Teams.

Governance and Management

• In 2002 Saskatchewan proceeded with the development of a new accountability relationship with the Regional Health Authorities (RHAs). The relationship is based on The Regional Health Services Act, which was proclaimed on August 1, 2002.

• Regional Health Authorities were created under the Regional Health Services Act. The legislation provides the RHAs with a broad range of powers to plan for and manage the regional provision of health services in their regions.

• Regional Health Authorities as well as the Saskatchewan Cancer Agency in collaboration with the Minister /Department are responsible for planning, managing and delivering health services to the residents of Saskatchewan.

• The Minister’s Forum and the Leadership Council have been established. The Minister’s Forum includes all the RHAs and the Saskatchewan Cancer Agency (SCA) Chairs. The Leadership Council is chaired by the Deputy Minister of Health and includes RHA and the SCA CEOs. The two bodies provide advice and make recommendations to the Minister and the Deputy Minister on system-wide issues.

• This new governance structure has resulted in considerable benefits:
  o a revised planning cycle for the Regional Health Authorities;
  o a new budget planning process provides the regions with input to the budgeting process, allowing for better annual and long range planning; and
  o a new accountability framework that guides the relationship with RHAs and the SCA. This new operational process includes a document for each region that defines program
and service expectations and includes the measures by which RHA and the SCA performance will be monitored.

Institutional Reform

Department of Health Organization Chart

Project Hope

On August 4, 2005, Premier Lorne Calvert announced Project Hope, a three-year, $15M (annualized) plan to prevent and treat substance abuse.

Healthy Living

The Hon. Graham Addley, was appointed to Cabinet on October 14, 2005 as Minister of Healthy Living Services. Minister Addley is responsible for initiatives related to the First Ministers’ Accord, Project Hope, Review of the Children’s Mental Health Services, the Cognitive
Disabilities Strategy and addictions, as well as broader files including mental health services, health promotion and active living, tobacco reduction, and problem gambling.

**Regionalization Activity**

- On August 1, 2002, *The Regional Health Services Act* created 12 Regional Health Authorities (RHAs) from the province's existing 32 health districts. The Act not only established new health regions but also fully described the revised approaches to accountability and to program services and standards.
- The establishment of these 12 RHAs has resulted in a new relationship between the key players of the health system and a clear definition of the responsibilities and expectations for each partner.
  - Since the RHAs retain responsibility for the expenditure of such a large portion of total provincial expenditures, it was necessary to link the operational and strategic planning of the regions more closely with provincial planning processes.
- 2003-04 was the first full year in the new planning cycle. RHAs submitted plans in the fall based on a defined set of planning and funding guidelines provided to them in early summer. The planning guidelines were based on the overall direction set in the department strategic plan and the funding targets were established for two years.
- Setting out expectations is an important starting point, as Saskatchewan Health seeks to realize the shared vision of “building a province of healthy people and healthy communities”. This will provide a solid foundation for a more effective and cooperative health care system well into the future. In consultation with the RHAs, an Accountability Document was developed in 2003-2004, and this approach continued in 2004-2005 and 2005-2006. The Accountability Document sets clear goals and service expectations for RHAs, and establishes the indicators and measures required to support RHA accountability and reporting.
- Through the efforts of both an internal and an external committee on indicator development, Saskatchewan has done extensive work over the past several years to define and refine the indicators and measures set out in the Accountability Document. The 2006-07 Accountability Document will continue the process of clarifying expectations of RHAs and supporting more refined reporting to government and the public, ultimately enhancing the accountability of the health system to the people of Saskatchewan.
Section III: Support and Innovation in Health Care

Human Resources: Physicians

- The overall supply of physicians has been steadily increasing over the past few years. The head count of all licensed physicians in Saskatchewan, including temporary licensed locums, was 1,622 at the end of March 2001 and was 1,728 at the end of December 2005. This number excludes medical health officers and residents, and allocates non-certified specialists (in transition to certification) to the specialist category.

<table>
<thead>
<tr>
<th>LICENCED</th>
<th>March/01</th>
<th>March/02</th>
<th>March/03</th>
<th>March/04</th>
<th>March/05</th>
<th>Dec/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practitioners</td>
<td>909</td>
<td>897</td>
<td>900</td>
<td>905</td>
<td>927</td>
<td>954</td>
</tr>
<tr>
<td>Specialists</td>
<td>713</td>
<td>725</td>
<td>729</td>
<td>749</td>
<td>753</td>
<td>774</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,622</td>
<td>1,622</td>
<td>1,629</td>
<td>1,654</td>
<td>1,680</td>
<td>1,728</td>
</tr>
</tbody>
</table>

- Saskatchewan continues to have a lower supply of specialists and an average number of general practitioners in comparison to the other provinces.

- The current negotiated settlement, ratified by the Saskatchewan Medical Association (SMA) in June 2003, covered three years, April 1, 2003 to March 31, 2006. It provided for a combination of fee increases, funding for new fee schedule items, and increased funding for strengthening current initiatives and developing new programs to improve the practice environment. Negotiations are currently underway for a new contract.

- Saskatchewan has a wide range of programs, developed jointly by the Saskatchewan Medical Association and Saskatchewan Health, to assist with the recruitment and retention of physicians. The following programs are provided on an ongoing basis:
  - Medical Student and Resident Bursary Programs;
  - Rural Practice Establishment Grant Programs;
  - Regional Practice Establishment Grant Program;
  - Rural Practice Enhancement Training Program;
  - Re-Entry Training Program;
  - Rural Extended Leave Program;
  - Rural Travel Assistance Program;
  - Rural Emergency Care Continuing Medical Education Program;
  - Locum Service Program;
  - Emergency Room Coverage and Weekend Relief Program;
- Specialist Emergency Coverage Program;
- Specialist Recruitment and Retention Fund Bursary Program;
- Specialist Physician Enhancement Training Program;
- Long Service Retention Program; and
- Physician Incorporation.

- The majority of Saskatchewan physicians work under a fee-for-service reimbursement agreement. A growing number of physicians are exploring alternative payment arrangements as a means to stabilize their income, provide greater practice flexibility, work more directly as members of multi-disciplinary teams, and focus on prevention services. Saskatchewan Health has been developing and piloting alternative payment arrangements with physicians on a voluntary basis since 1992. The majority of alternate payment projects are administered through regional health authorities that contract with or employ the necessary physicians to provide the service. The funding for these projects, particularly in the case of family physician services, is established through a population-based methodology.

- Within Saskatchewan's Action Plan for Primary Health Care, physicians play a role as part of interdisciplinary health care teams. Physician representatives are part of regional health authority planning teams as RHAs develop their plans for primary health care.

**Health Human Resources: Non-Physicians**

- A three-year collective agreement was reached with the Saskatchewan Union of Nurses in late 2005, while a four-year collective agreement was reached in early January with the provider unions.

- *Working Together: Saskatchewan’s Health Workforce Action Plan* was released on December 14, 2005. The Plan flows from the First Ministers’ Meeting in the fall of 2004, where a commitment was made to accelerate health human resource planning and make action plans public by December 31, 2005. It also builds upon the 2001 *Action Plan for Saskatchewan Health Care*.

- The Plan contains 5 goals, which are:
  - The health care system has a sufficient number and effective mix of health care professionals who are used fully to provide safe, high-quality care.
  - The health system has safe, supportive, and quality workplaces that help to retain and recruit health care professionals.
  - Aboriginal people fully participate in the health sector in all health occupations.
  - The education and training supply of Saskatchewan health care professionals is aligned with projected workforce requirements and health service needs.
  - The health workforce is innovative, flexible and responsive to changes in the health system.
There are 82 actions in the plan that focus primarily on: (1) linking young people early and often to health employers, (2) enhancing self-sufficiency within available resources, (3) focusing on Saskatchewan’s competitive advantage – Aboriginal youth population; and (4) strategic and ethical recruitment.

The Workforce Action Plan sets a direction for a more integrated workforce and includes initiatives to align service and health planning with supply, improve health workplaces and address issues affecting key health professionals.

Rather than focusing solely on the number of health professionals needed, the plan reflects the value of a workforce responsive to health needs, skill mixes and service delivery.

Extensive consultations took place with stakeholders in developing the plan, including an October 2005 conference focused on Finding Common Ground, which was hosted by the Canadian Policy Research Network (CPRN). Collaboration and partnership of stakeholders will be vital to the ongoing success of this plan. For this reason, a workforce steering committee will be established, made up of representatives from the health and learning sectors. This committee will guide future actions and help measure progress.

Health related bursaries are awarded to a wide range of nursing and allied health disciplines, composed of 20 types of allied health bursaries and six categories of nursing bursaries. Approximately 500 bursaries are awarded annually. Upon graduation, bursary recipients are required to provide a specified period of service in a publicly funded position in Saskatchewan. As of December 31, 2005 over 290 new bursaries and 100 continuing bursaries to health (non-physician) students have been awarded. In addition, we have awarded 40 new and 53 continuing physician bursaries.

The Nursing Education Program of Saskatchewan (NEPS) training capacity is 400. This includes the introduction of nursing as a second-degree option, which began in May 2005 with a planned annual intake of 50 graduates with a degree in other disciplines. The second-degree option is based on a modified NEPS curriculum and will be two calendar years in length.

RHAs surveyed 37,000 employees in May 2005. The focus of the survey was part of an ongoing commitment to work with employees to improve quality of workplaces. The survey results were officially released on December 12, 2005. Health employers will use these results to develop more specific actions to improve workplaces, and help fulfil regional health authority accreditation requirements.

Based on the survey company’s (NRC Picker) national database, Saskatchewan healthcare employees on average are more positive than their national counterparts. Survey results showed physical environment, safety and respect were the highest rated topic areas; while learning environment was the lowest rated topic area.

Just over 100 participants completed a six-module Executive Leadership Program throughout 2005-2006. The program used face-to-face workshops, a series of directed reading components, case studies and group support. The purpose of the program was to provide leaders in the RHAs, Saskatchewan Cancer Agency and Saskatchewan Health with educational opportunities to develop the leadership capabilities and support networks to perform the functions required to effectively run a world-class health care system.
• Saskatchewan Health hosted an Aboriginal representative workforce strategies information session in August 2005. Representatives from federal and provincial departments attended the session. This one-day session will be repeated and expanded. An Aboriginal representative workforce information sharing opportunity is being organized using satellite telecast for health employers, First Nations, Métis health organizations and other stakeholders. The information session will look at successes with representative workforce initiatives.

On May 30 & 31, 2006, Saskatchewan will be hosting an Aboriginal Health and Human Resources Forum, in partnership with the Government of Canada and the Saskatchewan Association of Health Organizations.

• The province, in partnership with RHAs, expanded the Saskatchewan Immigrant Nominee Program (SINP) to include a health professions category. The province began nominating physicians in 2002 and included nurses the following year. The program allows foreign-educated nurses and doctors practising under a temporary work permit to apply for landed immigrant status in an expedited manner.

In October 2005, the SINP was expanded to include all other skilled health occupations. This includes health occupations requiring at least one academic year of post-secondary education and/or one year of job-specific training.

• The government continues to make investments to create a more representative workforce by helping employers provide cultural awareness training for the current workforce. Health regions have offered this training to over 11,000 health employees as of October 2005.

• To help measure the performance of RHAs and the SCA, a number of human resource indicators are being tracked and reported, as part of the accountability document. These indicators include:
  1. The number of sick hours per FTE by union affiliation
  2. The number of overtime hours per FTE by union affiliation
  3. The number of paid FTEs by region
  4. The number of lost time claims per 100 FTEs
  5. The number of days (severity) of WCB claims per 100 FTEs
  6. Percentage of self-identified aboriginal employees
  7. Worked hours (excluding sick hours and claimed lost time) as a percentage of paid hours

**Health Information and Telemedicine**

• The Health Information Solutions Centre (HISC) at Saskatchewan Health is working in consultation with the RHAs and other stakeholders on the implementation of a provincial health sector Information Technology (IT) strategy. This strategy will be delivered through a province-wide health information network. This is a multi-year development, which supports health system priorities at the provincial and local levels.
The provincial IT strategy supports health care professionals in providing quality care by utilizing modern technologies to enable secure and timely access to the health information they require in providing care for their clients, who often receive services at different points across the provincial health system.

HISC delivers secure wide-area networking, application hosting and IT help desk services for health regions; provides electronic health record capabilities to integrate health information from different systems and service locations to support better patient care; supports the implementation of new technologies such as telehealth; and facilitates the use of statistical information to support improvements in the management, planning and evaluation of health services.

In 2005-06 the telehealth network was expanded by 8 sites to bring the total to 26 sites. It allows residents in remote areas access to some specialists without having to leave the community. The telehealth technology uses computers and a sophisticated video conferencing system to allow physicians in urban areas to see patients and provide consultation services to patients in rural remote areas without them leaving their community. It also allows health care providers, patients, and the public to participate in continuing education and health information programs.

HISC’s infrastructure delivers cost-effective information technology solutions such as a common integrated clinical system (ICS) solution for mid-sized health regions in the province. Saskatchewan is working very closely with Canada Health Infoway on electronic health record (EHR) developments and HISC is also implementing innovative technologies to support new provincial Action Plan initiatives such as the Saskatchewan Surgical Care Network and the province’s Health Quality Council.

Privacy protection and information security are key considerations in all developments. In 2003, Saskatchewan Health has implemented new legislation, The Health Information Protection Act (HIPA), to provide the appropriate legislative and policy framework to ensure personal health information is appropriately safeguarded.

Saskatchewan is working very closely with other provinces to coordinate information technology developments in order to avoid duplication of effort and ensure that common IT standards are adopted to facilitate system inter-operability. For example, Saskatchewan has partnered with the other western provinces in a joint project to develop a Provider Registry system, with support from Canada Health Infoway, to enable health care providers to be consistently identified across systems at a regional, provincial and inter-provincial level.

We are participating with Manitoba, Alberta and British Columbia on the Western Health Information Collaborative (WHIC) Chronic Disease Management project to jointly develop and pilot the implementation of common data standards and electronic messages to facilitate the delivery of care to chronic disease patients by existing regional diabetes and primary health care teams.

In 2005, Saskatchewan began to implement the first EHR solution, the Pharmaceutical Information Program, which allows clinicians to view complete patient drug profiles thus improving patient safety. Work also continues on a number of other new sector-wide EHR developments such as Lab Results reporting and Diagnostic Imaging systems. In 2006, new
technologies for Primary Health Care supporting team based methods of delivery will be introduced as well as a new Surgical Information System, which supports the Action Plan challenge to reduce wait times for surgical procedures.

Health Technology

See Health Information section.

Section IV: Health Programs and Services

Primary Health Care

- Since the release of the "Action Plan For Saskatchewan Health Care", Saskatchewan Health has been working hard to facilitate a major reorganization of primary health services.

- Milestones in primary health care in Saskatchewan to date are:
  - in August 2003 created HealthLine, a 24-hour telephone health advice line;
  - increased the number of primary health care teams to 37;
  - improved the delivery of primary health care services which are supported through a four-year, $18.6M (in total) federal Primary Health Care Transition Fund until 2005-06;
  - established directors of Primary Health Care and team facilitators in each RHA;
  - developed the Provincial Diabetes Plan;
  - received updated annual primary health care plans and diabetes plans from each RHA;
  - added diabetic supplies such as needles, syringes, lancets and swabs to the Saskatchewan Drug Plan on July 1, 2003;
  - provided funding to two RHAs in 2003 to support consultations for the development of a provincial diabetic foot program;
  - began licensing Registered Nurses (RNs) qualified to practice in an expanded role as Nurse Practitioners (NPs) in 2004;
  - completed a pilot project on team development;
  - partnered with the Réseau Santé en Français on two Primary Health Care Transition Fund (PHCTF) projects ("Setting the Stage" and "Children and Seniors the Heart of a Healthy Community");
  - implemented a national primary health care awareness strategy on behalf of a Federal/Provincial/Territorial partnership to develop;
  - developed a provincial primary health care evaluation framework; and
  - continued to participate in a number of projects funded by Health Canada through the Primary Health Care Transition Fund including development of:
- common evaluation criteria for HealthLines,
- a Chronic Disease Information Technology program,
- common national strategies regarding the nurse practitioner.

**Diabetes Prevention and Control**

- A Provincial Diabetes Advisory Body was established in 2001 to provide the Department with advice on issues pertaining to successful co-ordination of diabetes programs. Membership includes three representatives from the aboriginal community, one each representing the Federation of Saskatchewan Indian Nations (FSIN), the Métis Nation of Saskatchewan (MNS), and First Nations and Inuit Health Branch (FNIHB); three health region representatives, two physicians, one representative from Canadian Diabetes Association, and five representatives from Saskatchewan Health.

- In February 2004, Saskatchewan Health finalized the Provincial Diabetes Plan, which provided regional health authorities with a framework for a comprehensive and coordinated team approach to diabetes management, recognizing that the person with diabetes is responsible for self-management of the disease.

- Since 2003, RHAs have been asked to submit a diabetes plan and annual update to Primary Health Service Branch (PHSB) that outlines their planned initiatives to address diabetes in their region. These plans are reviewed annually to determine alignment with the direction provided in the Provincial Diabetes Plan.

- The Provincial Diabetes Co-coordinator, and Aboriginal Diabetes Consultant continue to provide support to regional health authorities and Aboriginal communities in addition to facilitating the development of initiatives that are provincial in nature. The following are provincial initiatives developed or under development:
  
  o Diabetes Education for Health Care Providers program - Funding was provided by the Department of Health to Saskatchewan Institute of Applied Science and Technology (SIAST) in 2002 for the development of two diabetes education programs. These programs, “Basic” and “Advanced” Diabetes Education for Health Care Providers are offered by distance delivery. The “Basic” program is designed for care providers such as home care aides, emergency service providers as well as community diabetes workers in First Nations communities. The “Advanced” program is designed for nurses, pharmacists, dietitians and others.

  o Risk Identification of the Foot in Diabetes - Saskatchewan Health, in partnership with RHA podiatrists and SIAST developed “Risk Identification of the Foot in Diabetes” presentation and training materials. These materials are used in the on-going delivery of workshops aimed at training care providers to identify and classify the diabetic foot at risk to facilitate appropriate care and referrals to minimize or delay the onset of foot complications.

  o Diabetic Foot Program (under development) - Funding has been provided to Regina and Saskatoon RHAs to support the consultation process with health professionals and care providers for the development of a provincial diabetic foot program. This program will
include clinical practice guidelines for the screening and management of complications associated with the diabetic foot.

- **Provincial Diabetes Symposium** – One-time funding was provided to the Canadian Diabetes Association (CDA) to plan and host a diabetes symposium, which took place on September 15 and 16, 2005. Approximately 350 health care providers from Saskatchewan participated in the event. Continuing education credits were available for physicians, pharmacists and dietitians. Dr. Steven Harris, Dr. Michael Rachlis and Dr. William Osei were key-note speakers.

- **Insulin Adjustment Learning Module** - Funding was provided to develop the Saskatchewan Insulin Adjustment Module. This Module contains an educational component, demonstration of competency process, and guidelines for the development of Regional policies to support Registered Nurses with additional training to perform an insulin dose adjustment service on behalf of physicians for their clients.

- Since November 2001, several new drugs used to treat diabetes have been approved for coverage under the provincial Drug Plan, and are available under Exception Drug Status. The Saskatchewan Prescription Drug Plan was expanded in July 2003 to include coverage of diabetic supplies, including needles, syringes, lancets and swabs. The additional coverage will lower the out-of-pocket expenses for some persons with diabetes, especially those with lower incomes.

- Saskatchewan Health continues to work with the Federal Government and other provinces on the development of a National Diabetes Strategy and the National Diabetes Surveillance System.

- Using information from other databases in Saskatchewan (Personal Registry System, Hospital Separations, Physician Billings), the Population Health Branch has developed a Saskatchewan Diabetes Profile. This profile “Saskatchewan Diabetes Profile 1996/97 to 2000/01” describes diabetes trends in the province and in regional health authorities over a five-year period. This profile is currently being updated to provide data to support program planning and to track progress in reducing the incidence of diabetes over the long term.

- Diabetes is the leading cause of kidney failure. About 45% of the people requiring dialysis are diabetic. The province also has Chronic Renal Insufficiency (CRI) clinics operating in the Saskatoon and Regina Qu'Appelle health regions. The goals of CRI educational sessions are to delay or prevent the need for dialysis and to better prepare patients in making their treatment choices - hemodialysis, peritoneal or home dialysis, or transplant. About 45% of the patients attending these clinics are diabetic as well. At June 30, 2005, there were 875 patients attending CRI clinics, 619 patients on dialysis (hemodialysis and peritoneal dialysis) and 400 patients living with a kidney transplant.

- Dialysis centres in Regina and Saskatoon Health Regions serve about 80% of Saskatchewan’s hemodialysis patients and acts as “home units” for seven satellite operations in Prince Albert, Lloydminster, Tisdale, Yorkton, Swift Current and North Battleford.

- Saskatchewan Health provides funding to Saskatchewan Health Research Foundation and the Health Quality Council from which grants are awarded. The Health Quality Council is
undertaking a Chronic Disease Management Collaborative to support research projects surrounding best practices for the management of diabetes in Saskatchewan. The Collaborative is planned to extend over an 18-month period commencing in November 2005.

- From 1999 to 2003, seven sites received funding as demonstration projects. An evaluation report, “Using a Population Health Approach: Lessons Learned from the Population Health Promotion Demonstration Sites for the Primary Prevention of Type 2 Diabetes” was released. RHAs are using the evaluation information to develop regional initiatives that focus on primary prevention and health promotion to stop or delay the development of Type 2 diabetes.

**Community Health Initiatives**

- Saskatchewan Health provides funding to regional health authorities to provide community services. These services include outpatient mental health services; alcohol, drug and problem gambling services and rehabilitation; inpatient mental health services in selected hospitals and residential care for mental health; and alcohol and drug treatment.

- Saskatchewan Health is responsible for coordinating the delivery of education, prevention and treatment services for problem gambling. Saskatchewan Health initiatives include:
  - Outpatient services in health regions;
  - Funding for in-patient treatment services;
  - Specialized day treatment programs;
  - Problem gambling help line services;
  - Support for community development initiatives, education and learning opportunities;
  - Provincial prevention and public education programs;
  - Training for new counsellors as well as advanced training opportunities for existing health region and help line counsellors; and
  - Research.

- In 2005-06, Saskatchewan Health will provide $4.0M for problem gambling prevention and treatment services. This is the second highest provincial per capita expenditure on problem gambling in Canada.

- Saskatchewan Health is involved with a number of initiatives providing support services to individuals and families affected by Fetal Alcohol Spectrum Disorder (FASD), including

**Saskatchewan Prevention Institute: Provincial Fetal Alcohol Spectrum Disorder Prevention Program** - The Saskatchewan Prevention Institute Incorporated, a non-profit organization, coordinates and administers a provincial FASD Prevention Program. The provincial departments of Health and Community Resources and Employment fund the program. Initiatives include raising public awareness and providing education across the
province; developing and distributing resources and information; providing provincial coordination, and supporting communities in their efforts to address FASD.

**Provincial Clinical Teratology Program** - Saskatchewan Health has contributed funding since 1999 to support the Provincial Clinical Teratology (the study of malformations or serious deviations) Program within the Department of Paediatrics at the University of Saskatchewan. The clinic is located at the Kinsmen Centre and works with a team of professionals and service providers in making a diagnosis and identifying further needs. The Fetal Alcohol Spectrum (FAS) Clinic is provided one-day per week. A traveling clinic also provides services a few times a year.

Saskatchewan Health is also overseeing a range of initiatives under the Cognitive Disabilities Strategy that will provide individuals and families affected by cognitive disabilities, including Fetal Alcohol Spectrum Disorder (FASD), with better access to supports and strengthen prevention and early intervention of FASD. These services are not designed to replace existing services or to develop a new service delivery system, but rather are designed to enhance existing supports, fill service gaps and support frontline service providers.

KidsFirst North Program is a key interdepartmental initiative designed to support families in vulnerable circumstances in developing the capacity to nurture their children. Emphasis is also placed on the prevention of FASD.

- Saskatchewan Health has been involved in developing a Provincial Strategy for Individuals with Cognitive Disabilities. A key component of the strategy is to provide supports based on the functional impact of the disability, which will allow for more flexible and individualized responses to individual needs. The Cognitive Disabilities Strategy includes:
  1. Increased access to assessment and diagnostic services
     - Additional assessment and diagnostic resources to the regional health authorities of Regina Qu’Appelle, Saskatoon, and Prince Albert Parkland.
     - Development of a telehealth pilot in the north to improve access to FASD diagnosis and assessment.
  2. Strengthened access to supports based on need
     - Hiring of four community based Cognitive Disabilities Consultants to provide families, caregivers and service providers with increased knowledge about effective support planning and implementation.
     - New funding for individualized and flexible supports to supplement and extend existing program capacity.
  3. Strengthened prevention and early intervention of FASD
     - Hiring of additional home visitors for the *KidsFirst* North to encourage vulnerable women to have alcohol-free pregnancies.
• Development of sample curriculum units relating to FASD for secondary school students.

• Province wide intervention training to enhance the ability of physicians, health care providers and other frontline service providers to support and assist women who are at risk of having an infant with FASD.

4. Support for the Saskatchewan Fetal Alcohol Support Network (SFASN)

• Funding to provide information and referral services to individuals and families that are impacted by FASD.

• SFASN assists professionals with specific information and presentations.

5. Extra-judicial Sanctions Project

• Youth who are suspecting of having FASD are referred to an alternative measures program when they are facing criminal prosecution.

• Youth will receive assessment and diagnosis if necessary, be held accountable for their offence in ways that are meaningful to them, and participate in short and long term intervention plans that have been tailored to their needs.

• The primary objective of the seniors’ portfolio is to promote and enhance the health and well-being of older persons in Saskatchewan by working collaboratively with stakeholders to jointly address issues related to older persons. The Minister Responsible for Seniors' role is to provide a voice and sensitivity to seniors’ issues across program areas and Departments.

• Services provided include the Provincial Advisory Committee of Older Persons (PACOP). This 13-member committee reports directly to the Minister Responsible for Seniors and offers advice and guidance to the Minister on seniors’ issues. The PACOP and Alzheimer Society of Saskatchewan presented *A Strategy for Alzheimer Disease and Related Dementias in Saskatchewan* to the Minister in January 2005.

• The Saskatchewan Cancer Agency (SCA) provides approximately 38,600 radiation therapy treatments and 16,400 chemotherapy treatments to cancer patients out of its Saskatoon and Regina cancer clinics. In addition, approximately 5,900 chemotherapy treatments are provided to cancer patients in communities across the province through the Community Oncology Program of Saskatchewan (COPS).

• All RHAs have a Quality of Care Coordinator (QCC) or designated person to review concerns about the care of a client. Saskatoon and Regina each have a full time person dedicated to this process. The Saskatchewan Cancer Agency also has a Coordinator for quality of care questions or concerns. The role of the QCC is to:
  
  o assist individuals and families with questions or concerns about health services in their region;

  o ensure individuals are informed about their rights and options; and

  o recommend changes and improvements to enhance the quality of health services delivered in the region based on their findings and trends of concerns raised.
The Acquired Brain Injury (ABI) program's mandate is to enhance the rehabilitation outcomes and improve the quality of life of individuals with an acquired brain injury and their families. The ABI Partnership Project is a joint initiative, funded by Saskatchewan Government Insurance and managed by Saskatchewan Health that has worked to provide a coordinated and integrated continuum of community based services across the province for individuals with ABI, their families and communities.

A provincial advisory group has played an instrumental role in providing ongoing consultation to the project. Consisting of 40 programs, including three outreach teams, the ABI Partnership Project provides services through health regions and community-based organizations throughout the province. The program will also focus on a community injury prevention grant program, and community training and education initiatives.

The program's most recent evaluation report was released in the 2004-05 fiscal year, which highlighted client outcomes for its service delivery structure. Results included:

- cost-benefit analyses;
- a literature review, which indicated that components of the Partnership meet the needs of individuals with moderate to severe acquired brain injury;
- survey results which indicated that the Partnership strives towards continuous quality improvement in providing client-centred care; and
- a good client service match and that Partnership services are responsive to addressing clients’ varied needs.

The program is undertaking a current evaluation with continued focus on client and program outcomes and client, family and community satisfaction with services.

Population Health-Based Initiatives

Regional Health Authorities (RHAs) have the authority to identify and address specific health needs and issues at the regional level. In addition to region-specific strategies, numerous province-wide projects are underway.

Province-wide health initiatives include:

- Saskatchewan Health, in collaboration with the Public Health Agency of Canada and the RHAs, has continued work on the contingency plan for pandemic influenza and supports other government departments and crown corporations to incorporate pandemic influenza preparedness into their business continuity plans. Tabletop exercises have been organized for some RHAs, and a joint planning day for all RHAs was held in February 2005. Saskatchewan Health has prepared and distributed fact sheets on influenza/pandemic/avian flu as well as influenza prevention and self-care to all media and the general public. The province is also participating in a national stockpile of antiviral medication.

- Saskatchewan Health, in co-operation with Regional Public Health Services and First Nations jurisdictions, with assistance of federal funding, introduced three new vaccines into the routine publicly funded immunization program:
- meningococcal conjugate vaccine program was initiated in October 2004 for infants at 12 months of age, preschool (age 4) and an adolescent catch-up dose at Grade 6;
- varicella immunization, commonly known as chickenpox, started on January 1, 2005 for all infants 12 months of age, and an adolescent catch-up dose at Grade 6. The vaccine is provided to children who have not had chickenpox disease;
- beginning April 1, 2005, pneumococcal conjugate immunization will be provided universally to all infants 2 months of age (born on or after February 1, 2005);
- in the fall of 2005, influenza vaccine was added to the publicly funded immunization program for all children 6 - 23 months of age.

The Saskatchewan West Nile Virus Working Group, a multi-disciplinary group of representatives from government and external stakeholders formed in 2000, developed the Provincial West Nile Virus Response Framework. The provincial program has focused on a number of surveillance systems and an integrated pest management approach to mosquito control, as well as public education. It provided municipalities with grants for approved mosquito control programs to reduce the risk of West Nile Virus to humans. Communities were eligible for grants of up to $1.50 per capita, with the province contributing $2.00 for each $1.00 of approved municipal expenditure. Saskatchewan Health contracted an entomologist to coordinate the provincial response plan including mosquito surveillance and public communications and to help the municipal governments develop local mosquito control programs.

**Provincial Population Health Promotion Strategy**


- *Healthier Places to Live, Work and Play...A Population Health Promotion Strategy for Saskatchewan* was released in April 2004. The four priority areas for action defined in the Strategy are:
  - Mental Well-Being;
  - Accessible Nutritious Food;
  - Decreased Substance Use and Abuse; and
  - Active Communities.

- Saskatchewan Health hosted an evaluation workshop in October 2005 for the RHAs and their inter-sectoral partners. The purpose of the workshop was to build knowledge and skills for evaluation of their local regional population health promotion plans.
• Health regions submitted updated Regional Population Health Promotion Plans in December 2005. Saskatchewan Health reviewed plans and is providing feedback to health regions.

• The Health Promotion Unit conducted a workshop at the Moving Forward Conference on upstream strategies to prevent substance use and abuse. The workshop highlighted evidence based strategies and the need to work inter-sectorally.

• Saskatchewan Health provided funding for new staff (one full time equivalent in each Regional Health Authority) to support the health promotion and primary prevention of substance use/abuse as outlined in the Population Health Promotion Strategy and Project Hope.

_Tobacco Use Reduction_

• The smoke-free enclosed public place provisions of _The Tobacco Control Act_ came into effect on January 1, 2005. Saskatchewan Health oversaw the implementation of the new provisions and worked with public health inspectors in Regional Health Authorities to enforce the Act.

• In January, the Supreme Court upheld the display ban provisions of The Tobacco Control Act and tobacco enforcement officers began enforcing the ban.

• The Minister of Healthy Living Services issued a challenge to all grade 12 classes to graduate tobacco free.

• Saskatchewan Health provided Regional Health Authorities funding to enhance their public health capacity, including enforcement of _The Tobacco Control Act_.

_Mental Health_

• The Mental Health program funds mental health services to residents of individual Regional Health Authorities (RHAs) in Saskatchewan, including Child and Youth Services, Adult Community Services, Psychiatric Rehabilitation Services, Mental Health Inpatient Services and residential services. Provincial rehabilitation and forensic services are located at Saskatchewan Hospital North Battleford (SHNB). Saskatchewan Health reviews mental health services on an annual basis, producing a document called the _Mental Health, Alcohol and Drug Services, Problem Gambling and Acquired Brain Injury Program Review_ that is used to assist with regional health authority and department planning for mental health services. Additionally, in-depth reviews are carried out in individual RHAs. Currently, a review is being undertaken in Prairie North, with Sunrise RHA almost complete. Reviews have been completed for Sun Country, Cypress and Kelsey Trail RHAs.

• The Saskatchewan Mental Health Advisory Council advises the Minister and senior officials at Saskatchewan Health on policies, priorities and resources aimed at meeting the mental health needs of the people of Saskatchewan.

• A stakeholder consultation in May 2005, followed by a final report completed in September 2005 outlines the development of a provincial vision for Children’s Mental Health Services.
The project aims to promote effective health and disease prevention through the development of a children’s mental health strategy, which arose out of the Child Advocate Report.

- Saskatchewan Health also provides funding to Regional Health Authorities for the rehabilitation and reintegration of youth under the Youth Criminal Justice Act. Services include community-based programs that provide treatment, supervision and other services.

**Home Care Initiatives**

- The Home Care program provides help to people who need acute, palliative and supportive care to remain independent at home. Home Care provides the following services: assessment and care coordination, nursing supervision and nursing care, personal care, homemaking, meals, respite services, home maintenance and therapies.

- A Home Care Program Review was completed and includes an assessment regarding program design and vision; the range and mix of services; the capacity to meet need; and financial resources. The review has also identified strengths and weaknesses and recommended potential change and future direction to improve program effectiveness and efficiency.

**Long-Term Care Initiatives**

- The purpose of special-care homes (SCH) is to provide long-term care (LTC) to meet the needs of individuals, usually with heavy care needs (Level 3 and 4), that cannot be met through home-based/community services. These homes are publicly funded facilities that provide 24-hour, supervised, institutional long-term care services to individuals.

- Minimum Data Set/Resource Utilization Groupings (MDS/RUGS), the classification system for residential long-term care, is fully implemented in all long-term care facilities in Saskatchewan. It facilitates better care planning, quality indicators and outcome measurements, which will improve client care. It also provides increased efficiency in record keeping and facilitates program monitoring and evaluation at the facility and regional health authority level. MDS/RUGS results in improved quality of information, which can be used for identifying resident needs as well as areas to target for program development and staff education.

- Personal Care Homes provide an alternative residential option for individuals who neither need nor wish to use the services of the publicly funded home care, public housing or special-care home systems. These homes are privately owned and operated facilities that do not receive public funding and which offer accommodation, meals and assistance or supervision for adults aged 18 and over.

- Initiatives include making personal care homes more accessible to those with limited income and the development of improved standards.
Pharma-care Initiatives

- The governance/management of the Saskatchewan Prescription Drug Plan follows The Prescription Drugs Act. Financial benefits provided by the Drug Plan follow The Prescription Drugs Regulations, 1993. The plan is structured to assist families with low incomes, families with high drug costs and those with a combination of both.

- The Special Support Program is designed to help those whose drug costs are high in relation to their income. Based on the information provided on the application form along with Drug Plan records, the Drug Plan determines the amount of benefit for which the beneficiary is eligible. A family may qualify for Special Support based on the family's annual adjusted income. Income adjustments are made by deducting $3,500 for each dependent under 18 years of age. The family's co-payment is determined by the amount that the family drug costs exceed 3.4 percent of the adjusted combined family income from the most recent tax year. If the annual benefit drug cost exceeds 3.4 percent of the adjusted income, the family qualifies for a lower co-payment to reduce their share of drug costs and spread the cost over the six-month deductible period.

- All Saskatchewan residents except those covered by other agencies (i.e. Registered Indians, Veterans, RCMP, Canadian Forces and Workers Compensation Board) are eligible for coverage under the Drug Plan. During the 2004/2005 fiscal year, in excess of 119,000 families received financial assistance with their prescription costs. This represents 25.3% of families that receive prescription drugs. As of February 28, 2006, 86,826 families were registered in the Income Based Special Support program. Of these families 61,530 had family drug costs greater than 3.4% of their family income. The Special Support Program provides additional financial support (i.e. decreased deductibles and/or co-payments) to help those whose drugs costs are high in relation to their income.

- The Drug Plan budget increased from $170.9M in 2004/05 to $187.1M in 2005/06.

- The Pharmaceutical Information Program (PIP) medication profile electronic viewer became operational in October 2005. PIP provides authorized health care professionals (e.g. pharmacists and physicians) with confidential access to a medication profile containing all prescription drugs dispensed by Saskatchewan community pharmacies. A full production rollout is underway in 2006 to extend the medication profile viewer to as many pharmacies, emergency rooms, physician clinics, long-term care and home care facilities in the province as possible. PIP will be broadened in future phases to include electronic prescribing and integration with pharmacy computer systems. PIP is a key component of the Electronic Health Record strategy for Saskatchewan. The costs of the project are being shared with Canada Health Infoway.

Acute & Emergency Care

Emergency Medical Technician Training and Dispatch Initiatives

- In 2002-03 a three-year Emergency Medical Technician (EMT) training initiative began with a goal of training new or existing emergency medical service providers to the EMT-Basic Level and in future implementing a service standard of having at least one EMT on every
ambulance call provided in the province. To date, training was provided or arrangements are in place for a total of 106 students.

- Emergency medical services dispatch continued to improve. All ambulance services in the province are now dispatched through one of five wide-area dispatch centers. This ensures appropriate service for patients and better coordination and use of ambulances.

**Surgical Wait List Initiatives**

- The Saskatchewan Surgical Care Network (SSCN) was established in March 2002. This is an advisory committee to Saskatchewan Health dedicated to creating a more reasonable, fair surgical system for all Saskatchewan people. The SSCN has been working with key health partners to improve the system’s effectiveness, organization and efficiency, so that those who require surgery receive it within appropriate time frames.

- The SSCN has overseen the following actions:
  - Established a Registry Office and developed a province-wide computerized Surgical Patient Registry. This Registry tracks all patients needing surgery in the province who go through the operating room;
  - Developed target time frames for surgery to allow the health regions to better monitor and track patients and help ensure they receive care according to their level of need;
  - In March 2004, Target Time Frames for Surgery were announced as “performance goals” for the surgical care system;
  - Provision of better public information through a surgical web site launched in January 2003. This site provides information on wait times and how to access surgical services in the province. Contacts in each health region have been established so that patients can call to inquire about their own waits for surgery;
  - Implementation of a new Patient Assessment Process to increase consistency and fairness by standardizing the factors physicians will use to assess their patients’ level of need for surgery. This will help to ensure those with the greatest need for surgery to receive it first.

**Diagnostic Imaging Strategy**

- In June 2004, a Steering Committee of key stakeholders was established to obtain expert assistance in the development of a diagnostic imaging strategy.

- On January 31, 2004 the Minister of Health announced the establishment of a Diagnostic Imaging Network. Through collaboration with participating partners, the Network will act as a provincial advisory body to assist in province-wide strategic planning and coordination of the diagnostic imaging system.

- The Diagnostic Imaging Network members acknowledge the importance of standardizing wait time definitions and priority levels province-wide, and are therefore, currently studying
preliminary information relating to a common wait time definition and priority groupings for diagnostic imaging procedures.

Section V: Other Health System Initiatives

Family Health Benefits

- The Family Health Benefits Program provides extended health benefits to lower income working families to assist with costs of raising healthy children. The plan includes coverage for child dental services, eyeglasses, medical supplies and appliances, prescription drugs, and ambulance services.
- Adults in these families receive additional coverage for eye examinations, chiropractic services, as well as a semi-annual Drug Plan deductible of $100.
- During 2004-2005 the average number of families eligible for Family Health Benefits was 20,189. This includes 26,303 adults and 35,321 children.

Healthy Living / Project Hope

- Under the portfolio of Healthy Living, Project Hope’s initiatives include:
  - the expansion of HealthLine to provide information and referrals on addictions issues;
  - a crystal methamphetamine (crystal meth) media campaign targeted at parents and youth;
  - education and prevention through the Alcohol and Drug Prevention and Education Directorate of Saskatchewan Health;
  - the provision of resource officers in schools, who can directly help young people at risk of substance abuse;
  - regional recruitment of Prevention Coordinators;
  - the establishment of a Research Chair in Substance Abuse at the University of Saskatchewan;
  - the Youth Drug Detoxification and Stabilization Act, passed in December 2005;
  - enhanced methadone services;
  - the successful recruitment of a Health, Enforcement and Education in Partnership (HEP) Coordinator;
  - expanding the ability to treat addiction, by developing more detox beds, creating and expanding more outreach services, developing a mobile treatment service and recruiting more addictions counsellors;
  - “going after the source” through supply reduction, by recruiting drug enforcement and Safer Communities and Neighbourhoods Act (SCAN) officers, urging the federal government to strengthen drug possession penalties and building on “MethWatch”, a
coalition of retail and wholesale businesses that restricts the supply of ingredients used in crystal meth;

- Restrictions were put in place regarding the sale of certain cold remedies containing pseudoephedrine, one of the ingredients used to make crystal meth. Cough and cold remedies, containing only pseudoephedrine, are now kept behind pharmacy counters. As well, the volume of pseudoephedrine that may be sold at any transaction is now limited at 3,600 milligrams; and

- coordination through the Community Development Framework, which amalgamates and empowers communities to battle substance abuse issues and the development of a treatment database with updated information about treatment options.

Aboriginal Health

- Saskatchewan Health provides health care services to Aboriginal people through Regional Health Authorities and provincial programs. Regional Health Authorities plan for and manage the provision of health services in their regions, which includes understanding the population within their region and responding to the health care needs of Saskatchewan’s diverse populations.

- Aboriginal people tend to have specific health care needs and lower health status than other Canadians. The 2004 First Ministers Communiqué on Aboriginal Health and the 2005 Aboriginal Blueprint to Strengthen Health Care include commitments to take action to improve the health status of Aboriginal people. The national Aboriginal health blueprint was released as a “work in progress” and will lead to the development of plans at the provincial level.

- The Saskatchewan health blueprint approach document is built on the priorities that emerged from provincial blueprint engagement sessions and submissions. This document was developed as a starting point and does not represent a final blueprint plan for the province. The Saskatchewan Approach document can be found at [http://www.health.gov.sk.ca/aboriginal_sk_approach.pdf](http://www.health.gov.sk.ca/aboriginal_sk_approach.pdf)

Manitoba

Political

- New Democratic Party: last election June 2003
- Premier: Hon. Gary Doer
- Minister of Health: Hon. Tim Sale
- Minister of Healthy Living: Hon. Theresa Oswald
- Deputy Minister of Health and Healthy Living: Arlene Wilgosh
Legislative

Changes in Health and Health related Legislation

- The Manitoba Council on Aging Act (Bill 8) received royal assent and came into force on June 16, 2005
  - This Bill continues the Manitoba Council on Aging. The Council provides advice to government on matters relating to the aging process and the needs of seniors. It also promotes public understanding about the aging process.

- The Emergency Measures Amendment Act (Bill 15) received royal assent and came into force on June 9, 2005.
  - This Bill authorizes the province to enter into agreements with other jurisdictions about emergency planning and providing assistance during emergencies. It deals with the qualifications of people from other jurisdictions who provide emergency assistance in Manitoba, as well as liability for their actions while here.

- The Regional Health Authorities Amendment and Manitoba Evidence Amendment Act (Bill 17) received royal assent on June 16 and will come into force upon proclamation.
  - This Bill enhances the safety of hospital patients, residents of personal care homes and other people receiving health services. The Regional Health Authorities Act is amended to deal with critical incidents. A critical incident is an unintended event that harms a person while he or she is receiving health services. The Bill requires regional health authorities, health corporations and certain health care organizations to report and investigate critical incidents, to keep records about them, and to keep the people affected fully informed. It also permits the patient, a patient’s relative or an employee of a regional health authority, a health corporation or certain health care organizations to report an incident and the incident must be investigated.

  Amendments are made to The Manitoba Evidence Act concerning committees that deal with critical incidents, hospital standards, medical staff and research. What happens at those committees cannot be disclosed in legal proceedings, as long as certain information, such as patient records or the facts of a critical incident, is otherwise available to the patient or person affected. Also, committee members and persons who provide information to committees are protected from liability.

  The Bill includes a consequential amendment to The Mental Health Act to permit information to be disclosed to a committee formed to look into a critical incident.

- The Workplace Safety and Health Amendment Act (Needles in Medical Workplaces) (Bill 23) received royal assent on June 9th and came into force on January 1, 2006.
  - This Bill requires medical workplaces to protect workers by ensuring that safety-engineered needles - such as shielded needle devices or retractable needle systems - are used whenever possible. In addition, they must implement safe work procedures and practices relating to the use of needles.
- The Health Services Insurance Amendment and Prescription Drugs Cost Assistance Amendment Act (Bill 42) – This bill received royal assent and came into force on June 16, 2005.
  - This Bill makes several amendments to The Health Services Insurance Act. The key amendments are as follows:
    - the information-gathering powers of the committee that monitors patient use of the health care system, and the limitations on those powers, are clarified;
    - the power to prescribe services for which no benefit is payable is amended; and
    - the powers of inspectors under various provisions of the Act are made consistent.
    - This Bill also amends the powers of inspectors under The Prescription Drugs Cost Assistance Act, making them consistent with those under The Health Services Insurance Act. Other amendments to The Prescription Drugs Cost Assistance Act reflect recent changes in the law allowing "nurse practitioners" to prescribe drugs in certain circumstances.
  - The Regulated Health Professions Statutes Amendment Act (Bill 43) - This Bill received royal assent on June 16, 2005 and came into force on September 1, 2005 for all health professions statutes except The Medical Laboratory Technologists Act (which is not yet proclaimed) and The Occupational Therapists Act which came into force on December 15, 2005. The amendments for the Medical Laboratory Technologists Act will become effective when the Act does.
    - This Bill amends 19 statutes that regulate the practice of health professionals.
    - Most of the statutes are amended to allow the regulatory bodies to waive registration or licensing requirements if there is a public health emergency and health professionals must be brought in from elsewhere in Canada or from the United States. Amendments to The Denturists Act and The Opticians Act do not include these provisions.
    - The amendments to all statutes require the regulatory bodies to collect certain demographic information about their members and give it to the minister for an electronic registry of health service providers.
    - The minister may then use the information for limited purposes, and share it, in non-identifying form, with authorized entities such as regional health authorities.
    - The Medical Act is further amended to clarify what information is to be included in the physician profiles that the College of Physicians and Surgeons will make available to the public.
- The Statutes Correction and Minor Amendments Act – (Bill 50) - This Bill received royal assent and came into force on June 16, 2005.
  - This Bill corrects typographical, numbering and other drafting errors. It also makes minor amendments to various Acts and repeals an obsolete Act. The amendments related to health are as follows:
- The Elderly and Infirm Persons Housing Act to delete references to personal care homes;
- The Health Services Insurance Act to clarify the age description in part of the definition “dependant”;
- The Human Tissue Gift Act to add a definition of “minister” and correct a typo;
- The Mental Health Act to correct a spelling error;
- The Personal Health Information Act to revise the French version of the definition “health”;
- The Pharmaceutical Act to remove any restrictions on the ability of a registered nurse (extended practice) to prescribe drugs in accordance with the regulation under The Registered Nurses Act;
- The Non-Smokers Health Protection Act by changing its number in the Continuing Consolidation from S125 to N92.

- The Medical Amendment Act (Bill 207) – This Bill received royal assent and came into force on June 16, 2005.
  - This Bill amends The Medical Act. It allows physicians more flexibility to practise non-traditional therapies and other therapies that differ from prevailing medical practice, without the potential for professional discipline unless the non-traditional or differing therapy involves a greater risk to patient health.

- The Dental Hygienists Act (Bill 5) – This Bill received royal assent on December 8th, 2005. The transitional provisions came into force on royal assent. The remainder will come into force on a day fixed by proclamation.
  - This Bill defines the practice of dental hygiene and provides for the regulation of the profession.
  - It includes provisions to
    - establish the College of Dental Hygienists of Manitoba;
    - establish a governing council with public representatives;
    - require the registration of dental hygienists;
    - create processes for handling complaints and discipline.

- The Dental Association Amendment Act (Bill 6) – This Bill received royal assent on December 8th, 2005 and was proclaimed on March 24, 2006.
  - The amendments to The Dental Association Act in this Bill allow the Dental Association to regulate dental assistants. They also amend the Act to remove all references to administrative rules since the Association deals with administrative matters by by-laws.

- The Occupational Therapists Act - S.M. 2002 chapter c.05 (was proclaimed on December 15, 2005)
This Act came into force on December 15, 2005 in order to allow time to develop and adopt regulations that are necessary under the Act. The new act provides for increased public accountability, changing the education standard, requirements for continuing competence and updating of the scope of practice and updated disciplinary procedures.


### Updates on Advisory Committees/Working Groups:

- The College of Medical Laboratory Technologists of Manitoba Transitional Council was established in 2003. The Medical Laboratory Technologists of Manitoba Transition Council (MLTMC) is moving forward with its mandate of transitioning to a College of Medical Laboratory Technologists of Manitoba. The Transitional Council has appointed a Registrar and commenced the registration process. It is anticipated that the College will commence its operations in 2006.

- The Dental Hygienists of Manitoba Transitional Council will be established by May, 2006 to get the new College of Dental Hygienists of Manitoba up and running.

- The Personal Health Information Act (PHIA) Steering Committee, with Government and external representatives, was established in 2002. PHIA requires the Minister of Health to undertake a comprehensive and public review of the legislation. The PHIA Review Steering Committee reviewed feedback received during the public consultation process, and will be proposing amendments to the Act. Recommendations for amendments to the Act are currently under review within government. [http://www.gov.mb.ca/health/phia/index.html](http://www.gov.mb.ca/health/phia/index.html)

### Fiscal

- The provincial health care budget for 2005/2006 was $3,389,760.2 - an increase from 2004/2005 of 6.3%. The budgeted increase for 2006/07 is 6.4%.

### Governance and Management

- No material changes in 2005/06.

### Institutional Change/Reform

- No material changes in 2005/06.

### Regionalization

- No material changes in 2005/06.

### Human Resources: Physicians

- Manitoba has enhanced its financial incentive programs to provide conditional financial assistance for family physicians and physicians taking training in a needed specialty such as
Emergency Medicine or Anaesthesia. Conditional grants are available to eligible family physicians who have practiced in Manitoba for one year in a rural or urban area, or to physicians who undertake additional training in a needed specialty.

- The Physician Resource Coordination Office was implemented in November of 2005 to assist and support Regional Health Authorities in their physician recruitment and retention efforts and to assist physicians with immigration, licensure and employment in Manitoba.

- A new Master Medical Remuneration Agreement between Manitoba Health and the Manitoba Medical Association (MMA) was reached on June 27, 2005 covering the period April 1, 2005 to March 31, 2008.

- In general, fee-for-service (FFS) and alternately remunerated (ALT) physicians received an overall increase of 7.5% (non-compounded) for the term of the agreement or, 2.5% each year for 3 years beginning April 1, 2005.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS only</td>
<td>30%</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>ALT only</td>
<td>15%</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>FFS &amp; ALT</td>
<td>55%</td>
<td>55%</td>
<td>61%</td>
</tr>
</tbody>
</table>

- Two new remuneration funds were created with this Agreement; $15 million “Shoring-Up Fund” to be applied to selected tariffs and priority alternately funded physician groups and, $5.5 million “Exceptional Issues Fund” to address outstanding FFS issues to designated blocs of practice. In addition, 4 existing funds were continued and/or enhanced: Professional Liability Insurance Fund, Continuing Medical Education Fund, Maternity/Paternity Benefits Fund and the Physician Retention Fund.

- Concurrent with the Master Agreement, Manitoba Health and the MMA entered into a Memorandum of Understanding (MOU) which sets out the formal process by which physicians, in partnership with Manitoba Health, can develop innovative strategies and initiatives to deliver medical services to the public.

**Human Resources: Non-Physicians**

- The current nursing agreement expires in October 2007. Employers and the union have submitted proposals for a new/revised collective agreement.

**Health Information**

- A privacy impact assessment tool is now in use.
- Government, regional and university stakeholders continue to work together toward a coordinated approach to the development of health information management, reporting, analysis and research capabilities.
• Business case process approach has been established for ICT related initiatives.

**Health Information Standards Council of Manitoba**

• Responsible for identification, development and dissemination of health information and technology standards and guidelines in order to promote the effective use of information and the protection of privacy.

• Formal liaison/networking relationships with the health provincial standards bodies and other standards related entities at the local, national and international level.

**Federal/Provincial/Territorial Collaboration**

Active participant in Infoway’s EHR Standards Collaboration Process, with representation on the EHR Standards Steering Committee, EHR Standards Advisory Committee and the pan-Canadian Standards Groups, specifically and at this time Client Registry, Provider Registry, Digital Imaging.

Active participant and/or contributor to other health information standards related activities including HL7 Canada, CIHI’s Partnership for Health Information Standards, and the International Organizational for Standards Health Informatics and Harmonization Working Groups.

Active participant in the Western Health Information Collaborative (WHIC) where participation on collaborative projects provide opportunities for further development of a personal electronic health record.

Active participant in the Canadian Integrated Public Health Surveillance (CIPHS) project that is part of the Network for Health Surveillance in Canada, now incorporated as part of the Canada Health Infoway (CHII) mandate.

Active participant in many Canada Health Infoway initiatives, in particular standards development, architecture blueprint refinement, and specific CHII investment initiatives.

**ICT Strategy & Enterprise Architecture Project**

A project is underway to develop an ICT Strategy & Enterprise Architecture for Healthcare in Manitoba. Deliverables will be:

An Enterprise Architecture to ensure a common, coherent Target State for all ICT initiatives.

A 5 year ICT Roadmap showing initiatives with high level scope, benefits, dependencies and timeframes for each project.

A sustainable, continuous process to maintain the Enterprise Architecture and, review and amend the 5 Year Roadmap on an annual basis.
Health Technology

Public Health

- Manitoba Health previously implemented the Public Health Information System (iPHIS), as a seven-month pilot project which was completed in 2004.
- Since then, Canada Health Infoway has been promoting and supporting extensive planning and development of a Pan Canadian Public Health Surveillance System, which has resulted in the completion of detailed requirements definition and planning for the development of an integrated set of components for this system.
- Manitoba is beginning preliminary planning work to assess the implications of the more strategic Pan Canadian Health Surveillance System.

Chronic Disease Management (CDM)

- The three diseases selected for this initiative are diabetes, hypertension, and chronic kidney disease. Manitoba will be focusing on diabetes.
- The Western Health Information Collaborative (BC, AB, SK, MB) project team has completed the definition of the core data sets and information exchange messages.
- Manitoba has completed the detailed business and technical requirements for implementation in Manitoba. Two sites have been selected to implement and test the infrastructure. The BC CDM Web Application/Toolkit has been acquired and customized for use in Manitoba. Manitoba is currently working collaboratively with BC and Saskatchewan (also acquired the BC CDM Web Application) to incorporate the CDM core dataset and information exchange messages into the core application for use in all three jurisdictions.

Hospital Information System Project (HISP)

- The Hospital Information System Project involves the implementation of a patient-centric information system and will be a source for Electronic Health Record (EHR) clinical data.
- Functions include patient management, admissions, discharges, transfers and scheduling appointments and resources.
- Project scope includes teaching hospitals, community hospitals and long-term care facilities with the initial phases addressing the teaching hospitals.
- A contract was signed in June 2005 for the initial HISP implementation at St. Boniface General Hospital. This project formally commenced in September 2005.
- Manitoba is preparing to launch the next phase of HISP with a planning project focused on Community Hospitals and Long-Term Care facilities. This planning project is expected to begin in late May - early June 2006 and planned to be finished November 2006.
- The expected deliverables for this next project are an overall implementation strategy for HISP in community hospitals and long-term care facilities, as well as a detailed plan for the
implementation of Tier 2 software solutions from Momentum Healthware in two regional health authorities - Interlake and Central.

**Client Registry/EMPI (Enterprise Master Patient Index)**

- Manitoba Health has completed the first of four implementation phases of its Provincial Client Registry project, with the financial support of Canada Health Infoway.
- The Provincial Client Registry will be used by Manitoba’s health care sector for identity management and for linking an individual’s identifiers and demographic information from disparate information systems.
- The Implementation Phase started in September 2005 and is planned to be completed by August, 2007. Up to 19 source systems will be connected to the Provincial Client Registry, including Manitoba Health’s Insurance Registry.

**Provincial Radiology Information System and Picture Archiving and Communications Systems (RIS/PACS)**

- Manitoba has completed its detailed planning for a province-wide RIS/PACS solution.
- The Winnipeg Regional Health Authority (WRHA) has selected a vendor, AGFA, and is working with them in preparation of rolling out the AGFA RIS to WRHA facilities. This region-wide RIS solution is an integral part of the provincial RIS/PACS vision.
- Brandon Regional Health Authority (BRHA) has an established RIS/PACS solution that will be leveraged to accommodate other parts of the province.
- Manitoba Health, WRHA, Diagnostic Services of Manitoba (DSM) and BRHA are working together with Canada Health Infoway to implement a Provincial PACS solution. A component of this project will also address the rural RIS requirements by leveraging existing RIS investments.

**Provider Registry**

- Original implementation was completed in March 2003.
- Subsequent releases implemented in April 2004 and December 2004.
- Current release implementation planned for May/June 2006.
- Several Provider Data Sources engaged to supply data to the Registry.

**Integrated Electronic Health Record (iEHR)**

- Manitoba is working with Canada Health Infoway to develop an iEHR Solution that is a combination of people, organizational entities, business and clinical processes, systems, technology and standards that interact and exchange clinical data to provide high quality and effective healthcare.
• Preliminary and detailed planning is underway and expected to proceed over the next 12 months.

• Key areas of focus include:
  o *Clinical Data Repositories:* Operational data stores that hold and manage clinical data collected from service encounters at the point of service locations.
  o *Enterprise Application Integration:* Tools and techniques that promote, enable and manage the exchange of information and distribution of business processes across multiple application systems.
  o *Clinical Results Viewer:* Client Application systems that allows authorized users to access and view patient/person EHR Data in as easily customizable manner.

**Cadham Provincial Laboratory**

• The objective of this project is to replace the existing laboratory information system (LIS) at Cadham Provincial Lab with a new system that meets current and future business needs.

• The new system must fit within the provincial Electronic Health Record Strategy and provincial lab strategies currently under development in Manitoba. Stakeholder engagement and the documentation of the business requirements are underway.

**Primary Data Centre – WRHA**

• The major outcome of this project is to acquire appropriate space to accommodate the needs of a new Primary Data Centre and to expand the Provincial Data Network (PDN) connectivity between Health Sciences Centre, St. Boniface General Hospital and the Primary Data Centre.

• Several in-flight projects are dependent on the outcomes of this project e.g. Health Information System Project (HISP), provincial Diagnostic Imaging/Picture Archive Communications System (DI/PACS) and Client Registry (CR).

• The result of this deliverable will be the delivery of healthcare information to users when and where they need it. This space will have the required environmental services to house new and current applications, and to support Electronic Health Record initiatives.

**Selkirk Mental Health Centre (SMHC) - Redevelopment Project**

• Manitoba Health is proceeding with implementation of a strategic initiative that will see the physical redevelopment of the Selkirk Mental Health Centre and formation of a provincial Acquired Brain Injury program. Construction is slated to be completed in October 2008.

• As part of the redevelopment activities, a detailed assessment of the information technology requirements for the new facilities and associated Extended Treatment and Rehabilitation and Acquired Brain Injury programs will be conducted.

• Preliminary planning is underway to conduct this assessment.
Primary Care

Manitoba Approaches to Primary Care (MAPC)

Manitoba has a long history of innovative approaches to the delivery of primary care to its residents. For example, Community Health Centres within Manitoba have been a model of collaborative, community-based service delivery for many decades. In addition, non-physician primary care providers have also been key in northern and isolated communities and, more recently, the Primary Health Care Transition Fund has supported the exploration of many different primary care delivery options. Hence, all of these are Manitoba Approaches to Primary Care (MAPC).

The Physician Integrated Network (PIN) is an approach, currently in development, which focuses on the engagement of autonomous, independently owned fee-for-service physician groups. Interdisciplinary collaboration will be a key feature as this approach evolves. The objectives of the project include: improved access to primary care, improved providers’ access to and use of information systems, improved work environment for providers, and a demonstrated improvement in primary care with specific focus on Chronic Disease Management.

To fully achieve the articulated objectives, it will require a collection of interlinked, yet flexible, elements (structure and practice model, information systems and knowledge, funding and remuneration and monitoring and evaluation). This then becomes the heart of the PIN Project, where all four elements will be implemented in a phased manner.

An Advisory Committee with representation from senior and executive health sector administration has been established to provide input/feedback into the development and implementation of MAPC, including the PIN project.

Primary Health Care Transition Fund (PHCTF)

Manitoba divided its PHCTCF grant into 2 phases. Phase I includes five priority initiatives which were designed to improve Manitobans’ access to a range of appropriate primary health care (PHC) services; facilitate interdisciplinary, integrated delivery of PHC; and enable informed public participation in the discussion and design of PHC reform initiatives. In addition, these initiatives provided a foundation upon which regional health authorities could proceed to reorganize, integrate and enhance primary health care services in partnership with key stakeholders.

Phase II was developed based upon proposals submitted to Manitoba Health by the regional health authorities and CancerCare Manitoba. The seventeen initiatives that make up Phase II build upon Phase I and support the following overarching Primary Health Care.

Community Health

- Public Health activities in 2005/06 included:
o Tabling of a new Public Health Act.
o Planning for enhanced public health surveillance and a laboratory information system.
o Promotion of primary prevention and healthy living throughout program areas.
o Extensive planning for enhancement of storage and distribution of vaccines and other drugs.
o Planning and research related to c Difficile
o Completion of implementation of expanded immunizations for children.
o Implementation of Manitoba Tobacco Strategy and the *Non-Smokers Health. Protection Act*, and ongoing measures to discourage access to tobacco products.
o Implementation of partnership and funding for the Chronic Disease Prevention Initiative.
o Activities related to prevention of sexually transmitted infections and the promotion of healthy sexuality.
o Planning activity for the provincial tuberculosis program.
o Planning activity related to preparedness for pandemic influenza.
o Management of a comprehensive West Nile Virus Program.
o Organization of various education events for health professionals – e.g. tuberculosis, diabetes education, travel health, health disparities.

- Manitoba Health/Healthy Living and Regional Health Authorities have agreed to a list of deliverables including: immunization, sexually transmitted infections, injury reduction, breastfeeding initiation and duration, health planning with Aboriginal Manitobans and regional diabetes initiatives in a multi-year process.
- Development of models for inter-jurisdictional partnership in management of diseases
- Further detail on community health initiatives is included in the Population Health-based Initiatives” section of the report.

**Population Health-Based Initiatives**

Examples of current activities that promote healthy living and lifelong health of all Manitobans include:

- *Nutrition Initiatives* – provision of expertise and capacity for identifying and responding to current and emerging food and nutrition issues, and provides interdepartmental representation on food and nutrition issues.

- *Healthy Schools* - Works with partners (Healthy Child Manitoba, Manitoba Education, Citizenship and Youth, school divisions, and regional health authorities) to promote the physical, emotional, and social health of school communities, including children, youth, their families and school staff.

- *Injury Prevention* - Working with regional health authorities and other departments and stakeholders on an Injury Prevention Strategy and on regional injury prevention frameworks
which include targets and activities to reduce leading causes of death and hospitalization. Best practice documents have been produced on four injury causes to assist in planning responses. Initiatives are being developed to promote bicycle helmet use, increase children’s safety on farms and promote water safety to reduce drowning.

- **Increasing Physical Activity** - Manitoba Health and Healthy Living, is co-leading with Manitoba Culture, Heritage and Tourism, the physical activity health promotion strategy, Manitoba in motion. In motion is a provincial strategy to help all Manitobans make physical activity part of their daily lives for health benefits and enjoyment. The goal is to increase physical activity in Manitoba by 10% by the year 2010. Manitoba in motion joins with community partners, in the health, (including RHAs) healthy living, recreation, sport and education to raise activity levels and reduce barriers to physical activity.

**Toward strengthened health for children, examples of current activities include:**

- **Nutrition/Breastfeeding Initiatives** – A Food and Nutrition web site to provide education/prevention information as well as electronic resources about nutrition; infant feeding resources, developed by a partnership of government and service providers; partnership with Manitoba Council on Child Nutrition to promote healthy school eating policies and practices and a school Healthy Vending project; partnership with Manitoba Education, Citizenship & Youth and Dietitians of Canada to develop provincial guidelines to support implementation of school nutrition policies; analysis of national and provincial child nutrition survey data to produce reports on obesity and child nutrition in Manitoba; a Baby Friendly Manitoba Committee, including RHA as well as independent expert members, plans and coordinates activities to support breastfeeding as the best first source of nutrition for babies. Healthy Living has developed a Breastfeeding Strategy and Framework with RHAs and other stakeholders to increase breastfeeding initiation, increase breastfeeding duration and increase exclusive breastfeeding to six months as recommended by Health Canada.

- **Infant Hearing Screening** – As part of the Children’s Therapy Initiative, “I HEAR Manitoba” (acronym for Infant Hearing Screening Early Assessment and Referral) screens infant hearing at birth. Led by Brandon RHA, and operating in Brandon and Assiniboine health regions, it is being expanding to include other rural and northern regions on a phased-in basis.

- **Sexually Exploited Children and Youth** - Working with interdepartmental partners to address the issue of sexual exploitation of vulnerable children. Resources have been produced to increase awareness for professionals working with high-risk vulnerable children. Funding has been provided to develop training for front line workers to recognize at-risk children and youth and to intervene effectively with youth involved in the sex trade.

**To address health issues of particular importance to women, activities include:**

- **Women’s Health Profile** - One of the initiatives proposed in the Strategy was a Women’s Health Profile to identify useful indicators of women’s and teen girls’ health. Toward the Profile, Health has partnered with the Women’s Health Clinic and the Prairie Women’s Health Centre of Excellence to provide a report on existing women’s and teen girls’ health
profiles in other jurisdictions and health indicator information. Funding to conduct the profile has been secured through a partnership with Healthy Living, Health Canada and Women’s Health Bureau. The profile will review over 100 indicators of women’s health.

- **Reproductive Health Strategy** to enhance reproductive health promotion and improve reproductive health services including teen clinics, increasing access to reproductive health supplies, and unintended pregnancy services. A new Reproductive Health Clinic to provide a range of reproductive health services is in the planning stages. The clinic will be operated by Women’ Health Clinic and the WRHA.

- **Emergency Contraception** - Emergency contraception also known as Plan B has been added as a benefit under Pharmacare.

- **Applied Behavior Analysis (ABA) for Children with Autism**. In partnership with Manitoba Family Services and Housing and Manitoba Education, Citizenship and Youth, Manitoba Health provides funding to St. Amant Centre to provide clinical psychology supports to school-age children with autism whose families are implementing an ABA program.

To address health priorities related to seniors, current activities include:

- **Falls Prevention Strategy and Safety Aid Initiative** – A falls prevention strategy is near completion to identify activities to reduce hospitalizations and deaths due to falls. Several initiatives have been developed including supports to promote bone health, improved vision to reduce falls, and increased awareness about falls risks. The SafetyAid program home safety and crime prevention program was expanded to include a falls prevention component for senior homeowners. Home safety and falls prevention audits are conducted by a visiting team and home safety and falls prevention supplies (e.g. non-slip bathmats) are provided. Operates in Winnipeg, Brandon and Portage la Prairie and further expansion is planned.

**Aboriginal Health**

A myriad of initiatives related to the Aboriginal community in Manitoba underway include but are not limited to the following:

- **Aboriginal Strategy on HIV/AIDS** – Aboriginal Health Branch staff took the lead in the development of “As Long as the Waters Flow,” an Aboriginal Strategy on HIV/AIDS. An Implementation Advisory Committee was established to undertake an environmental scan of existing HIV/AIDS services available to Aboriginal people. The scan is expected to be completed in 2006.

- **Multi Governmental Working Group on First Nations (formerly Romanow Joint Working Group)** - Branch staff participate in the multi-sectoral working group involving both levels of Federal Government (First Nations and Inuit Health Branch, Indian and Northern Affairs Canada), Province of Manitoba and First Nations. Priority areas include: Health Human Resources, Exploration of Fiscal Frameworks, Jurisdiction, Integration of Services and Governance and Primary Health Care.
• **Traditional Aboriginal Wellness Policy (TAWP)** - The policy recognizes the importance of Aboriginal values, traditions and practices as a compliment to mainstream systems to build healthy Aboriginal communities.

• **First Nation Personal Care Homes (PCH)** - Indian and Northern Affairs Canada (INAC) directed the six unlicensed PCHs on reserve to become eligible for provincial licensing by March 31, 2006. Branch staff participates in the First Nation PCH Networking Group meetings and provide relevant information related to provincial standards, licensing and capital guidelines. Work is ongoing with INAC, Manitoba Health and First Nations toward licensing on an interim basis until a First Nation licensing and monitoring mechanism is in place.

• **Norway House Health Integration Initiative** - First Nations and Inuit Health Branch committed $750K for a two-year period to integrate and provide a continuum of health services for on-reserve residents of Norway House First Nation as well as those in the adjacent Northern Affairs community of Norway Hose. Partners include Manitoba Health, INAC, Norway House Cree Nation, Norway House Mayor and Council, BRHA and FNIHB (Manitoba region) & Aboriginal Affairs.

• **Role of First Nation People with Regional Health Authorities** - In 2005, a second forum “The Role of First Nation People with Regional Health Authorities” took place. Participants included: RHAs, FNIHB, INAC and First Nations. The summary report and matrix of issues is in process of being sent to forum participants. The second forum provided an opportunity for the RHAs to present on their structures, processes and initiatives and action issues identified in the matrix.

**Aboriginal Health Deliverable** - Staff acts as a contact for RHAs and CancerCare Manitoba as they work towards meeting the Aboriginal Health Deliverable as part of the Performance Agreements signed in 2003 between the Minister of Health and the RHAs. Eight RHAs are engaging with Aboriginal communities and will identify elements for an Aboriginal specific Health Strategy while BRHA, Winnipeg and Nor-Man RHAs have advanced beyond engagement and are continuing implementation of Aboriginal specific health strategies. The RHAs & CancerCare MB are at various stages of implementation.

**Manitoba Metis Project** - The Manitoba Metis Federation (MMF) is involved in a tripartite government process that has identified health as a priority. Manitoba Health contributed $25K in 2004/05 for the MMF to consult with their constituents and identify priority areas. The MMF has now established a Health Secretariat and hired staff and is undertaking work on ways to improve health services for Metis people.

• **National Aboriginal Health Blueprint** - Staff participates with the objective of improving the health status of Aboriginal people and services delivery in Canada through concrete initiatives:
  • Improving delivery and access of services
  • Measures to ensure Aboriginal people benefit fully from improvements in the Canadian health care system,
  • A forward-looking agenda of prevention, health promotion and other upstream approaches.
Aboriginal Issues on Suicide - Suicide has been identified as one of the most urgent problems facing Aboriginal communities. Aboriginal Health and ANA co-chair the Aboriginal Committee for Suicide Prevention providing a network between jurisdictions, stakeholders and services and develop processes to assist Aboriginal communities mobilize and tackle the complex issue of suicide. A provincial suicide framework has been developed with an Aboriginal component.

Manitoba First Nation Disability Multi Sectoral Working Group - Aboriginal Health Staff participate in this multi-sectoral working group that is attempting to address service delivery issues faced by First Nation persons with disabilities in Manitoba.

Island Lake Regional Primary Health Care Centre Inc. - Aboriginal Health staff participates as a member on the committee. The Renal Health Program has been implemented, serving four Aboriginal communities and is located in Garden Hill.

Mental Health

Overview of the governance/management of services:

- Manitoba Health is responsible for developing provincial policies and coordinating planning across the full continuum of mental health and addiction services. Responsibility for the delivery of mental health services was devolved to Regional Health Authorities in 1997. Addiction services are provided by eight agencies that are funded directly by Manitoba Health including the Addictions Foundation of Manitoba. Only a few addictions programs are funded directly by Regional Health Authorities.

- Manitoba Health continues to be guided by Mental Health Renewal which was announced in 2001 to raise the profile of mental health within the health system. Mental Health Renewal also reflects a continued shift towards prevention, early intervention and community based service and support whenever possible.

- In 2001, a high level mental health renewal vision document was developed and made public. This document included a vision statement, principles, values, goals and objectives.

- Addictions and mental health have been identified as one of thirteen strategic priorities in 05/06 by Manitoba Health. Included in the strategic priorities is mental health promotion and substance abuse reduction as part of an overall healthy living strategy for the province.

Update on new strategies, programs and the outreach services for certain groups:

- Selkirk Mental Health Centre – The Selkirk Mental Health Centre is a provincial psychiatric facility in Manitoba. In 2004 the redevelopment of Selkirk Mental Health Centre was announced. The first phase of the redevelopment will include a new Psychogeriatric facility and an Acquired Brain Injury Program. The new facilities and the enhanced programming will better serve clients and will provide a more respectful environment.

- Manitoba Crystal Meth Strategy – This is a comprehensive government initiative aimed at restricting the supply and reducing the demand for crystal meth in Manitoba. The Manitoba
Meth Task Force which is co-led by representatives from Manitoba Health and Justice, oversee the development and implementation of the Crystal Meth Strategy. Seven committees and working groups have been formed to develop successful strategies to combat meth use and production. Training for front-line workers in identification and treatment of crystal meth as well as a public awareness campaign and public forums are key aspects to the strategy. In addition, the Government of Manitoba is working on legislation that would provide the ability for the court to mandate youth into custody for a seven-day stabilization period. The goal is to provide a seven day period where the child is not under the acute influence of drugs so that they can make a sober decision regarding treatment. As part of the overall Crystal Meth Strategy approximately $6.7M was added to mental health and addictions services in part because of growing concerns regarding timely access to addictions and mental health services and the growing concerns related to crystal meth.

- **Provincial co-occurring mental health and substance use disorders initiative** - The co-occurring disorders initiative began in 2002 and continues to progress. Consumers in both systems are now screened for a co-occurring disorder, assessed and with informed consent, an integrated treatment plan is developed. This initiative treats both the substance abuse issue and the mental health issue as primary and therefore no longer requires the individual to deal with each separately, or to deal with one prior to the other.

- **Winnipeg Drug Treatment Court** – This specialized court, which is funded by the Federal Government and the Province is led by a working group including Health, Justice, Addictions Foundation of Manitoba, Behavioural Health Foundation, RCMP, the Winnipeg Police Service and several community agencies. The court provides an opportunity for treatment rather than incarceration for those who have committed non-violent criminal acts motivated by an addiction to drugs. The purpose is to help addicts break their cycle of dependency and become more productive members of their community. This initiative commenced operation on January 10, 2006.

- **Development of a provincial eating disorders and disordered eating strategy** - Manitoba Health has been leading a process to develop a framework for enhancing resources for Manitobans living with eating disorders and disordered eating. This work is intended to inform and guide planning for effective prevention of disordered eating, enhance capacity for early identification and intervention, and ensure accessible supports and services for individuals with eating disorders. A number of activities have been completed including the development of a comprehensive list of body image/eating disorder prevention resources for schools, development of information for physicians and health professionals, and training in eating disorders for mental health workers. A working group has also been formed to make recommendations for the future development of community-based eating disorders treatment in Manitoba.

- **Development of a provincial suicide prevention strategy** – Manitoba Health is implementing a provincial suicide prevention strategy. This strategy was developed in collaboration by the Provincial Committee on Suicide Prevention led by Manitoba Health. The Committee’s work included a literature search, jurisdictional review and 11 focus groups with consumers, service providers and specific at-risk groups, including the Aboriginal community. A final document was created by the Committee called the Framework for Suicide Prevention Planning in Manitoba that will guide the implementation of the strategy.
One of the key recommendations of the strategy is that each region will develop a regional suicide prevention committee to organize suicide prevention work at the community level and that each committee be comprised of cross-representation from community sectors, (i.e. health, education, justice, etc. and relevant levels of government). In addition the report recommends that specific high risk groups, i.e. the Aboriginal community, youth and seniors develop suicide prevention committees to implement work plans using the Framework as a template and using the suggested activities as a guide for their work.

- **Development of a provincial drug strategy** – Manitoba Health is leading a process to develop a provincial drug strategy that will provide the framework upon which to develop activities that are coordinated and aimed at reducing the harms associated with alcohol and other drug use. This strategy will provide the framework for a coordinated approach which recognizes the importance of involving the community in developing responses to alcohol and drug use issues. Objectives of the strategy will be broad, long term and complimentary to those of Canada’s Drug Strategy - such as:
  - To decrease the number of young people who become harmfully involved with alcohol and other drugs;
  - To delay the age at which youth experiment with alcohol and other drugs;
  - To explore the use of innovative criminal justice measures for those harmfully involved with alcohol and other drugs;
  - To decrease the availability of illegal drugs and address new and emerging drug trends;
  - To decrease the incidence of communicable diseases related to substance use;
  - To decrease avoidable health, social and economic costs.

- **Acquired Brain Injury Planning** – A Community-Based Acquired Brain Injury Services Planning Committee was convened by Manitoba Health to develop a detailed model of community-based acquired brain injury services for Manitoba, including structure, governance, service components, working partnerships and funding mechanisms with a corresponding action plan to implement the model. A primary focus of the model is the establishment of a continuum of community-based services for individuals with acquired brain injury. A draft of the report outlining the proposed model will be distributed for stakeholder feedback before it is finalized.

**Funding Trends**

- Since 1999, funding for mental health services in Manitoba has increased by more than 40%. This increase has been driven by mental health reform which sought to reduce the institutionalization of people with mental illness by increasing the availability of community-based programs.

- At the same time, the scope of mental health services has expanded to include populations that were traditionally not served by community mental health programs such as acquired brain injury, eating disorders, suicide prevention, co-occurring addictions, Pervasive Developmental Disorders, etc.
• Funding to addiction agencies has also increased significantly since 1999. Most significantly, funding to the Addictions Foundation of Manitoba increased by 41% between 1999 and 2006.

Home Care

• No material changes in 2005/06.

Long Term Care

• Manitoba Health introduced a Personal Care Home Standards Regulation under The Health Services Insurance Act in 2005.
• Regular monitoring of standards is now an important part of Manitoba’s patient safety initiative. This monitoring is led by Manitoba Health with the participation of the local regional health authority.
• Standards monitoring now informs the annual personal care home licensing process, along with the results of other departmental monitoring of personal care homes.

Pharmacare

• The Pharmacare program in Manitoba operates under the legislative authority of The Prescription Drugs Cost Assistance Act. It is wholly administered by Manitoba Health.
• Pharmacare is an income-based drug benefit program. Coverage is based on a family’s adjusted total income. It provides 100% financial assistance for eligible prescription drug costs in excess of a pre-set deductible. The minimum deductible is $100.
• Published Estimates of Expenditures for Pharmacare for 2003/2004 are $160.8M. This is a 17.6% increase over 2002/2003 estimated expenditures for Pharmacare.
• Effective April 1, 2005, the Pharmacare deductible was adjusted. For families with incomes of $15,000 and under, the new deductible rate is 2.44%, up from 2.32%. For families with incomes above $15,000, the deductible rate rose from 3.48% to 3.65%, and 4.2% from 4.0% for adjusted incomes greater than $40,000 and less than or equal to $75,000, as well as, 5.25% from 5.0% for adjusted incomes greater than $75,000.

Ontario

Section 1: Political

• Last election was in October 2003: Liberal Government was elected
• Premier as of October 23, 2003: Dalton McGuinty
• Minister of Health and Long-Term Care: George Smitherman
• Deputy Minister of Health and Long-Term Care: Ron Sapsford
Section 2: Legislative Amendments

Ambulance Act Amendments 2005 - In 2005, amendments to the Ambulance Act (the Act) were enacted by the Budget Measures Act (No. 2), 2005, S.O. 2005, c. 31, Schedule 1 (Ambulance Act) which was introduced November 2, 2005, received 2nd reading December 12, third reading December 14 and received Royal Assent on December 15, 2005.

Under new section 4(2.1) of the Act, the Minister has the power (but not the duty) to designate one or more corporations without share capital as having the powers and responsibilities now given to an air or land base hospital under the Act. Where the Minister has made such a designation, all of the provisions of the Act and regulations that apply to a base hospital would also apply to the designated corporation, unless the Act or regulations specifically provide otherwise.

The 2005 amendment also expands the section 22(1)(e.6) regulation-making power to permit the making of a regulation respecting the functions and duties of base hospitals, corporations designated under section 4(2.1) and communication (dispatch) services.

The Local Health System Integration Act, 2005 – This act was introduced November 24, 2005. Second Reading was carried on December 7th, 2005 and it was ordered for third reading on February 15, 2006. Third Reading took place on February 27th and Royal Assent was received on March 28th, 2006.

The purpose of this Act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks.

The Transparent Drug System for Patients Act, 2006 was introduced on April 13, 2006. Second reading was carried on May 10, 2006, third reading June 19, 2006 and Royal Assent granted June 20, 2006.

The Act will strengthen the legislation, ensure the viability of pharmacists, and secure better access to better drugs for patients. The changes include:

- Regulating payments made to pharmacists (“rebates”) and permitting pharmacists to receive defined "professional allowances" under a new Code of Conduct,
- Securing volume discount benefits for government on drugs purchased for the public system
- Including a Pharmacy Council and a Citizen's Council in the legislation
Instituting an automatic second review of recommendations made to the Executive Officer by the Committee to Evaluate Drugs to designate drug products and decisions made by the Executive Officer not to designate a product as a listed drug product

- Improving transparency by requiring the Executive Officer to prepare an annual report
- A clause in the legislation that specifically prohibits therapeutic substitution.

Amendments to the Business Corporations Act authorizing the Lieutenant Governor in Council to make regulations to exempt classes of health profession corporations from the requirements for professional incorporation and to impose different requirements in their place.

Complementary amendments were also made to the Regulated Health Professions Act, 1991. These amendments were enacted by the Budget Measures Act, 2005, schedule B (Bill 197). Regulations were made under the Business Corporations Act and the Regulated Health Professions Act, 1991 to permit family members of physicians and dentists to own non-voting shares in physician and dentist corporations respectively. Bill 197 received Royal Assent on December 12, 2005 and Schedule B was proclaimed into force on January 1, 2006. Ontario Regulation 665/05 made under the Business Corporations Act and Ontario Regulation 666/05 made under the Regulated Health Professions Act, 1991 amending O. Reg. 39/02 (Certificates of Authorization) also came into force on January 1, 2006.

**Section 3: Fiscal**

**Funding Formula**

The Integrated Population Based Allocation (IPBA) is an evidence-based methodology for equitably distributing funding to Ontario hospitals. It ensures that funding allocations weigh consideration for base operations, growth, and hospitals servicing populations with high relative need at an equitable unit cost for care. It simultaneously adjusts for differences in population characteristics such as age, gender, population growth, and morbidity, and for differences in hospital characteristics such as teaching and acute program mix. The methodology was developed in a broad-based stakeholder consultative process, and is widely supported. Recent enhancements to the methodology entrenched the commitment to focus on stability and base operations, in the context of multi-year funding. Ongoing development is planned to broaden the scope of utilization and cost benchmarks to account for the non-acute components of hospital activity (ambulatory, rehabilitation and emergency).

**Budget**

Health care is a top priority for Ontarians. In 2006-07, the government of Ontario will invest a total of $35.0 billion in health care including both operating and capital expenditures. This investment represents an increase of $1.8 billion in funding from the 2005-06 Interim total of $33.2 billion.
**Operating** funding of $34.2 billion includes:

- $12.9 billion in operating support for Ontario’s 152 hospitals
- $8.6 billion in OHIP payments to physicians and other service providers
- $2.8 billion in Drugs programs
- $2.8 billion in Long-Term Care homes
- The remaining $7.1 billion in health care spending supports a wide range of services including funding for community services, devices, cancer care and health human resources.

*(Note: spending figures do not include Ministry of Health Promotion spending of $258M in 2005-06 and $363M in 2006-07).*

Health Care operating spending comprises approximately 44% of total government expenditures excluding public debt interest.

**Capital** spending will be $0.8 billion for health capital investments.

The government’s increased investments in the health care system mean that patients will benefit from access to the health care they need when and where they need it.

**Ontario’s Wait Time Strategy**

**Funding Provided for Additional Procedures**

In 2005/06, the following funding was provided to hospitals:

- $12M for 16,000 additional cataract surgeries;
- $53M for approximately 7,550 additional hip and knee joint replacements;
- $27M for 4,817 additional cancer surgeries;
- $15M for 58,500 additional MRI expansion hours of operation; and
- $47M for 6,998 net new cardiac procedures.

**Section 4: Governance and Management**

The ministry has overall responsibility for the health care system and ensures the provision of services to the Ontario public through such programs as health insurance, drug benefits, assistive devices, care for the mentally ill, long-term care, home care, community and public health. It also regulates hospitals and nursing homes, operates psychiatric hospitals and medical laboratories, and co-ordinates emergency health services.
Management Structure of the Ontario Ministry of Health and Long-Term Care

Minister of Health and Long-Term Care: George Smitherman
George Smitherman has served as Ontario's Minister of Health since the McGuinty government took office in November of 2003.

Parliamentary Assistants: Dr. Kuldip Kular, Monique Smith, Tim Peterson

Deputy Minister: Ron Sapsford
Ron Sapsford was appointed Deputy Minister of Health and Long-Term Care, effective March 1, 2005.

Associate Deputy Minister & Executive Lead, Health Results Team (HRT):
Hugh MacLeod

Hugh MacLeod was appointed Associate Deputy Minister and Executive Lead of the Health Results Team, effective June 23, 2004.

In his role as Executive Lead of the Ministry’s HRT, Hugh is leading key areas of health system reform, including: Access to Services/Wait Times, Primary Care, System Integration, and Information Management. A team of industry experts have been spearheading the delivery of results in these areas.

On June 29, 2005, the government announced the creation of a new Ministry of Health Promotion with Jim Watson as the Minister. It is the first time Ontario has dedicated a portfolio to promoting healthy living and illness prevention. Currently, transition process and realignment of programs and services between the newly created Ministry and MOHLTC is taking place.

In January 2006, Deputy Minister Ron Sapsford announced that the Ministry of Health and Long-Term Care would be reorganizing to adapt to its new role as health system steward. With the move to place responsibility for operational and funding decisions closer to service providers through the establishment of Local Health Integration Networks (LHINs), and other imperatives, such as health system pressures, the ministry needed to change its focus and embrace a new direction.

In its new role as health system steward, the ministry will provide overall direction and leadership for the system. It will focus on planning, and on guiding resources to bring value to the health system.

The new structure will be organized into five specialized functional divisions:

- Health System Information Management;
- Health System Strategy;
- Health System Investment and Funding;
• Health System Accountability and Performance; and
• Public Health and the Chief Medical Officer of Health.

The ministry's principal functions will be to:

• Establish overall strategic direction and provincial priorities for the health system;
• Develop legislation, regulations, standards, policies, and directives to support those strategic directions; and
• Monitor and report on the performance of the health system and the health of Ontarians.
• Planning for and establishing funding models and levels of funding for the health care system.

The Ministry reorganization is occurring in three phases, over a two and a half-year period. Phase 1 focuses on strategy — integrating, implementing and supporting the strategy division. Phase 2 will strengthen accountability, and will coincide with the implementation of Local Health Integration Networks (LHINs). In Phase 3, each of the new divisions will be fully functional. It is anticipated that reorganization will be completed by 2008.

On February 15, 2006, the Deputy Minister announced the appointment of five Assistant Deputy Ministers:
• Maureen Adamson, ADM, Health System Investment and Funding;
• Dr. Sheela Basrur, ADM, Public Health and Chief Medical Officer of Health;
• Adalsteinn (Steini) Brown, ADM, Health System Strategy;
• Hugh MacLeod, ADM, Health System Accountability and Performance; and
• Dawn Ogram, ADM, Corporate Support.

Section 5: Institutional Change/Reform

Changing Health Care

The Ontario government’s plan for innovation in public health care involves building a system that delivers on three priorities – keeping Ontarians healthy, reducing wait times and providing better access to doctors and nurses.

Key government strategies currently underway include:

The Wait Times Strategy

On November 17, 2004, Minister of Health and Long-Term Care, George Smitherman, officially launched Ontario’s Wait Time Strategy. The strategy is
designed to reduce wait times by improving access to healthcare services for Ontarians in five areas: cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements, and MRI and CT scans.

Ontario's Wait Time Strategy is tackling wait times on a number of fronts:

- Significantly increasing the number of procedures to reduce the backlog that has developed over the last decade
- Investing in new, more efficient technology such as MRI machines and extending hours of operations
- Standardizing best practices for both medical and administrative functions in order to improve patient flow and efficiency
- Collecting and reporting accurate and up-to-date data on wait times to allow better decision making and increase accountability.

On January 13, 2006, Minister Smitherman allocated $6.8 million to fund an additional 907 hip and knee replacements at 22 Ontario hospitals by March 2006. This “mid-year correction” was over and above the 6,700 additional hip and knee replacement surgeries that were allocated in 2005/06, for a combined total of 7,607 additional procedures. The allocation of additional cases took into account population demographics, surgery rates, current wait times, and hospitals’ ability to complete procedures by the end of March 2006.

On March 23, 2006, the Ontario government announced in its *2006 Ontario Budget* that it will continue to shorten wait times in 2006/07 by providing funding for additional procedures.

On April 28, 2006, the government invested $222.5 million for 154,000 more procedures, including:

- 9,000 more hip and knee joint replacements
- 25,850 more cataract surgeries
- 105,200 more MRI exams
- 4,700 more cancer surgeries
- 9,000 more cardiac procedures

Data on the government’s wait times website indicates that, during the last six months, cataract surgery median wait times dropped 21 per cent, times for hip and knee replacements decreased 19 per cent and 17 per cent respectively, and cancer surgery wait times dropped by four per cent.

An important part of the Wait Time Strategy is the development of a single wait time information system for Ontario to collect accurate and timely data. The Wait Times Information System will help doctors and hospitals work together to better understand and prioritize their patients. It will also help hospitals and the government to better target their resources to where they will have the most impact. Patients can also use reports from this system, in consultation
with their primary health care provider, to make informed choices about where to be referred for quicker service.
For more information, see the Ontario government’s wait time’s website at: www.ontariowaittimes.com.

**The HealthForceOntario Strategy**

In May 2006, the Ontario government launched its HealthForceOntario Strategy. This strategy aims to fill the shortage of health care professionals in Ontario by ensuring the right supply and mix of health care professionals.

The HealthForceOntario Strategy has three components:

1. Creating four new roles in areas of high need:
   - Physician Assistant
   - Nurse Endoscopist
   - Surgical First Assist
   - Clinical Specialist Radiation Therapist

2. Developing Ontario's workforce by setting up a one-stop centre for internationally educated health professionals to obtain the information they need to work in Ontario.

3. Better equipping Ontario to compete for scarce health care professionals, in the rest of Canada and throughout the world, by establishing a marketing and recruitment centre including a comprehensive job portal.

This strategy builds on initiatives that are already underway in Ontario to improve access to health care professionals, including:

- A 23 per cent increase in medical school enrolment
- The creation of 150 Family Health Teams
- More than doubling the number of training and assessment positions for international medical graduates
- Developing a comprehensive nursing strategy
- Opening a new school of pharmacy in Waterloo
- Reinforcing the new fully inter-professional curriculum at the Michener Institute, funded by the Ministry of Health and Long-Term Care

**Progress on Family Health Teams**

Progress on the establishment of Family Health Teams in Ontario has been significant. In April 2006, the government announced that it had reached its goal of creating 150 Family Health
Teams to be fully implemented by 2007-08. The teams are expected to improve access to health services for more than 2.5 million Ontarians.

**Protecting Public Health**

Additionally, major government initiatives such as **Operation Health Protection** – a three-year action plan to revitalize the public health system – and the development of the **Ontario Health Plan for an Influenza Pandemic**, which provides directions to governments and health care providers on the most effective ways to respond to a pandemic, are contributing to making Ontario a healthier place for Ontarians.

Information on pandemic planning in the health sector, including the Ontario Health Plan for an Influenza Pandemic, is available at [www.health.gov.on.ca/pandemic](http://www.health.gov.on.ca/pandemic). This web site also has information for employers.

**Strengthening the System**

**Integrating the Local Delivery of Care**

Another important part of the government’s plan for change is the creation of 14 Local Health Integration Networks (LHINs). The networks will allow local communities and health care providers to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The government will continue to set strategic directions and provincial standards for high-quality, accessible health care.

**Organizing Information**

Quality patient care requires quality information. This is why strengthening the province’s infrastructure is also part of the government’s plan to build a better health care system.

The province’s Information Management Strategy aims to address the system-wide need for better information, in sectors like acute care and community health. It supports major government initiatives, such as the Wait Times Strategy, the E-Health Strategy, and the establishment of 14 Local Health Integration Networks (LHINs). The strategy lays out a systematic approach for addressing data quality and integration issues. The end goal is not only better quality data, but a more organized, efficient, and ultimately, more sustainable way of managing health system information.

Initiatives that are underway are focused on improving data quality and management, closing information gaps and reducing the burden of data collection on health care providers.
Section 6: Regionalization

Local Health Integration Networks (LHINs)

Ontario is moving forward with a distinct, "Made-in-Ontario" model of localized health system management. Ontario’s Local Health Integration Networks (LHINs) are geographically based agencies that will re-orient the health system towards a more patient/client-centered model. These networks will not be responsible for delivering services directly. One of their key jobs will be to ensure that the delivery of local health services is coordinated.

On November 24, 2005, the Honourable George Smitherman, Minister of Health and Long-Term Care, introduced the Local Health System Integration Act, (Bill 36). Seven days of public hearings on the Bill were held across the province in late January and early February 2006. On March 28, 2006 the Local Health System Integration Act, 2006, received Royal Assent. The legislation will provide LHINs with responsibility and authority for

- local health system planning;
- local health system integration;
- accountability and performance management of certain health service providers;
- local community engagement; and
- funding.

Work is underway for the development and implementation of regulations and policies. The public has been kept informed through regular monthly bulletins posted on the MOHLTC web site at www.health.gov.on.ca/transformation.

Section 7: Health Human Resources

2005/06 Initiatives and Previously Announced Initiatives - Physicians

International Medical Graduates (IMGs)

The government continues to further improve access to physicians in Ontario by substantially increasing opportunities for international medical graduates (IMGs), by continuing to make available at least 200 IMG training and assessment positions each year, and funding IMG Ontario, the one-stop centre for access to information and evaluation. In February 2006, the ministry announced that, for the first time, IMGs would be able to participate in the second iteration of the 2006 national physician matching process for postgraduate medical training positions in Ontario. IMGs were offered thirty-five of the 70 positions available through the second iteration.

The ministry is also funding the Registration through Practice Assessment Pilot Program - which is being administered by the College of Physicians and Surgeons of Ontario (CPSO). This pilot project has been assisting experienced physicians from outside Ontario to achieve registration to
practice. The pilot was completed in March 2006 and the Ministry is undertaking an evaluation of its effectiveness as a physician supply initiative.

As a result of Ontario's IMG programs, 218 IMGs were offered training and assessment positions during the 2005/06 selection process for positions that begin in 2006.

**Northern Ontario School of Medicine (NOSM)**

The newly created medical school for Northern Ontario enrolled its charter class of 56 students in September 2005. The school has two main campuses in Thunder Bay and Sudbury, with teaching and research sites distributed across large and small northern communities.

The ministry has also been building post graduate specialty training capacity in the North. To date, 16 positions have been added in the North and by 2009, there will be 26 entry level positions. These positions, in conjunction with the 30 entry level family medicine positions already in place, will accommodate the first graduating class from NOSM.

**Increased Enrolment**

In 2002, a 30% increase in medical school enrollment was completed, adding a total of 160 new positions. A matching increase in the number of postgraduate positions to accommodate graduating medical doctors has been phased in over the last three years with the final addition of 37 new positions in 2006 to bring the total number of new postgraduate positions to 160.

In May 2005, government announced a 15% increase in medical school enrolment by 2009. This will equate to 104 new first year medical school spaces. 32 of these spaces were implemented in September 2005 and the remaining 72 will be implemented over the next three years. These 72 positions will be used to establish four medical education campuses affiliated with three of the province's medical schools in southern Ontario communities that have demonstrated success in the provision of distributed medical education.

This enrolment increase and the opening of the Northern Ontario School of Medicine will equate to a 23% increase in medical school enrolment in Ontario by 2009.

**Distributed Medical Education Programs**

The Ontario government funds a number of Distributed Medical Education Programs (DMEs) to provide clinical learning opportunities outside academic health science centres to improve the supply of health professionals in rural and undersupplied areas of the province. These bring together medical schools, rural and community based physicians, hospitals and communities in need of physician services. The DMEs improve physician recruitment and retention as they provide opportunities for more students and trainees to live and learn in the communities where they may decide to practice once their training is completed.
Family Medicine Training

The ministry is investing $45 million between 2004/05 and 2007/08 to expand the province's family medicine training programs by 70%, creating 141 new first-year family medicine residency positions by 2006. This initiative will result in 337 additional family physicians that will be ready for practice in Ontario by 2008.

Bursary Program

In 2004, the Ministry developed a 50% cost-shared bursary program for prospective Medical Officers of Health to undertake Masters Level training in public health. The Medical Officers of Health in Training Bursary Program will assist candidates in fulfilling the requirements for appointment, by the Ministry, of a Medical Officer of Health.

PAIRO Registry

The Professional Association of Interns and Residents of Ontario (PAIRO) Registry is intended to provide two way access between Ontario's communities, physicians-in-training and established physicians for both recruitment and retention purposes. The PAIRO Registry is meant to provide the communities with an opportunity to disseminate information about job opportunities and to provide physicians with community profiles and availability of work in Ontario.

Physician Supply in Ontario

One of the major issues facing health care in Ontario is the availability of appropriate physician resources (i.e., physician supply, mix and distribution in Ontario). In 2004, Ontario ranked 9th in supply of family physicians per 100,000 population, 3rd in the supply of specialists per 100,000 population, and 6th in total physicians per 100,000 population among the provinces and territories according to the CIHI's Supply, Distribution and Migration of Canadian Physicians report released in 2005.

Factors that influence physician supply include socio-demographic characteristics of the area; population health needs of the area; geographic considerations; referral patterns and proximity to an Academic Health Science Center (AHSC).

Ontario continues to move forward on initiatives to improve the supply, distribution, recruitment and retention of physicians in communities. Initiatives such as increasing enrollment in medical schools and improving access to practice opportunities for International Medical Graduates (IMGs) increase the supply of physicians. The expansion of distributed medical education programs, the opening of the Northern Ontario School of Medicine (NOSM) and an increased emphasis on family medicine will improve physician mix, distribution and recruitment. Retention initiatives such as the Underserviced Area Program (UAP) will continue to assist undersupplied communities.
Health Human Resource Distribution in Ontario

The Underserviced Area Program helps underserviced communities across the province improve access to health care services by providing a variety of integrated initiatives aimed at attracting and retaining health care providers.

The UAP works closely with underserviced communities and other ministry initiatives (e.g., International Medical Graduates, Rural and Northern Physician Group Agreements, Community Health Centre Program) in matching appropriate programs and optimal benefits to communities.

This "one-stop shop" helps communities recruit doctors, nurse practitioners and other allied health professionals to underserviced areas through financial incentives and other innovative community supports (e.g., Northern Ontario Virtual Library). In addition to recruitment and retention supports, UAP provides operational funding for Nurse Practitioner positions and nursing stations in rural and northern communities whose population cannot support the services of a full-time primary care physician. The UAP also helps ensure access to local health care services (e.g., Visiting Specialist Program).

Physician Services Agreement

Report of fee negotiations

The Ontario Medical Association and the Ministry ratified a four-year Physician Services Agreement covering the period from April 1, 2004 to March 31, 2008. This Agreement balances targeted investments in specific areas of concern to both the OMA and the Ministry with across-the-board fee increases. The Agreement supports the government's health transformation projects including primary care reform, the wait time strategy, addresses competitiveness with other provinces, as well as addressing fee disparities between general practitioners/ family physicians and specialists.

Synopsis of the agreements/change with the provincial medical associations

The 2004 Physician Services Agreement provides for:

- an across-the-board increase effective April 1, 2004 of 2.5% for family practice professional fees, and 2% for specialist professional fee codes
- a 1% increase to technical fees for diagnostic services effective April 1, 2005
- elimination of the billing threshold effective April 1, 2005
- targeted fee code adjustments and fee code changes to address sectional disparities
- targeted fee increases and investments in priority areas, including:
  - in-patient hospital services
  - new fees to ensure patient receives appropriate community care upon hospital discharge
  - investments in mental health, paediatrics, anaesthesia
o investments in preventative care
o new fee codes for chronic disease management
o investments in physician services in Long-Term Care facilities, including funding for an on-call coverage program

- expansion of Primary Care Renewal models
- increased funding for Academic Health Science Centres (AHSCs)
- additional funding for the Hospital On-Call Coverage (HOCC) program in order to expand the program
- incentives for in-hospital anesthesia and emergency room services
- a commitment to formalize an appropriate funding plan for laboratory physicians
- implementation of a clerkship stipend program
- new incorporation benefits.

The implementation dates of the Agreement vary depending upon the component of the Agreement.

**Physician Services Committee**

The Physician Services Committee (PSC) is a joint committee of the Ministry of Health and Long-Term Care and the Ontario Medical Association which oversees the implementation of the Physician Services Agreement and ensures that the Agreement commitments are fulfilled.

The PSC which originated in 1997 under a previous Physician Services Agreement has been continued under the current Agreement. The interest-based approach used by the committee has contributed to the development of a strong relationship between Ontario's physicians and the Ministry. The PSC has been successful in addressing a wide range of issues impacting on physician services within the health care system.

The 2004 Agreement has provisions for a number of committees, continuation of existing and creation of new committees. Of significance, two new joint Ministry-Ontario Medical Association committees to support implementation of the Agreement and health system planning have been established, the Primary and Community Care Committee and the Physician Hospital Care Committee.
Statistical Overview - Physicians

Physicians in Ontario

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2004</th>
<th>% Change 1999 - 2004</th>
<th>Physician per 10,000 pop - 1999</th>
<th>Physician per 10,000 pop - 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP/FPs</td>
<td>9,807</td>
<td>10,439</td>
<td>6.4</td>
<td>8.5</td>
<td>8.4</td>
</tr>
<tr>
<td>Specialists</td>
<td>10,673</td>
<td>11,354</td>
<td>6.4</td>
<td>9.3</td>
<td>9.2</td>
</tr>
<tr>
<td>Total Physicians</td>
<td>20,480</td>
<td>21,793</td>
<td>6.4</td>
<td>17.8</td>
<td>17.6</td>
</tr>
</tbody>
</table>

Source: PIO - OPHRDC

Data from the Ontario Physician Human Resources Data Centre indicate the following trends from 1999-2004:

- The number of active physicians in Ontario in 2004 was 21,793, a net increase of 6.4% since 1999.
- Almost 48% (10,439) were general practitioners/ family physicians (GP/FPs) and just over 52% (11,354) were specialists.
- Both the number of GP/FPs and the number of specialists increased by 6.4%.
- Rapid population growth (7.7%), however, resulted in a decline in the availability of physicians for every 10,000 people from 17.8 to 17.6.
- The ratio of GP/FPs for every 10,000 people decreased from 8.5 to 8.4, and the ratio of specialists for every 10,000 people decreased from 9.3 to 9.2.

2005/06 Initiatives and Previously Announced Health Human Resources Initiatives - Nurses

Strategies to Stabilize the Nursing Workforce (also see HealthForceOntario initiatives)

The government has been working to address the underlying reasons for the current nursing shortage. Strategies include:

- Increasing the percentage of nurses working full-time;
- Targeting investments to support recruitment and retention of nurses; and
- Improving nursing work environments.

Full Employment of Nurses

Recent investments have supported the creation of full-time nursing positions. Research indicates that many nurses prefer full-time employment, therefore lack of full-time work affects
nurses’ decision to stay in the province or in the profession. The goal is to see 70% of nurses employed full-time\[1\].

- The government is continuing to provide targeted funding for full-time nursing positions in hospitals. This funding was first provided in 2004 and allowed hospitals to create new full-time positions or convert existing part-time and/or casual positions to full-time.

- Investments to enhance care standards in long-term care and increased access to community mental health and home care have resulted in increased nursing care hours which have included more full-time nursing positions in these sectors.

**Recruitment and Retention**

In January 2006, the government announced a fund that will help retain nurses. This fund is intended to assist hospitals with costs associated with orientation training and education so that nurses are prepared to fill vacancies due to hospital service changes. This fund may be used to redeploy a nurse from an area with decreased need for nursing services to another area of the hospital where there are identified or imminent vacancies. It may also be used to provide nurses with opportunities to expand their knowledge and skills so they can work in other clinical areas or nursing roles within the hospital.

In 2005/06, the government provided Nursing Strategy funding to eligible organizations for the second year. The Nursing Strategy provides funding to implement a range of initiatives designed to support nurses at all stages of their careers.

- New nurses often report feeling inadequately prepared for the workplace. Now, every college and university nursing program in the province has been provided with funding to purchase clinical simulation equipment. This funding will help students make the most of their clinical placements and ensure that they have the experience they need to transition into the workplace.

- To further support new nurses, to help nurses move to different sectors and to increase capacity for clinical placements for nursing students, funding was provided to long-term care homes, public health units and home care agencies to develop mentorship and preceptorship programs.

- According to a study of Ontario new graduate nurses by McMaster University, only 36.5% of new graduates find full-time work. This can cause new graduates to consider leaving the province to practice, or leaving the profession. The New Graduate Initiative provided funding to employers to create temporary full-time positions for new graduates to support their transition to the workforce.

- Nurses are retiring early: the average retirement age for RNs in 2002 was 58.4 years and for RPNs was 56.7 years. The Late Career Nurse Initiative provided funding to hospitals and long-term care homes so that nurses over 55 could work in less physically demanding

---

\[1\] According to the *College of Nurses of Ontario Membership Statistics* at January 1, 2004, the rate of full time employment for RNs was 59.3% and for RPNs was 53.4%. Please note that these percentages do not include those nurses who did not indicate their employment status.
alternate roles for part of their work time. This will support these nurses to remain in the workforce and ensure that their knowledge and experience is not lost to the system.

**Improving Nursing Workplaces**

Injuries in healthcare workplaces are a major cause of dissatisfaction among nurses. According to the Health Care Health and Safety Association, since 1998 the health care sector has experienced a 5% increase in lost time injury frequency - but Ontario as a whole has seen an average decrease of 19%.

The government provided funding to long-term care homes and hospitals to purchase patient lifting equipment and provide education programs for the healthcare workers who use the equipment. This will increase the safety of patients, and at the same time reduce the number of musculoskeletal injuries among nurses and other healthcare workers.

Another safety initiative provided funding in 2004/05 for hospitals to move to safer medical equipment such as safety-engineered sharps.

**Supporting Nursing Practice**

**Best Practice Guidelines**

Investments to support nursing practice include providing funding to the Registered Nurses Association of Ontario (RNAO) for the development, implementation and evaluation of evidence-based best practice guidelines.

- Clinical Best Practice Guidelines will improve the quality and consistency of nursing care across the province so that maximum benefits are achieved for patients/clients, nurses and the larger health system.
- Healthy Work Environment Best Practice Guidelines will help employers improve nurse recruitment and retention, reduce nursing staff turnover rates, sick time and employee dissatisfaction; and improve patient care.

**Career/Professional Development**

The government provides funding for education grants to support the development of skills and specialties that allow nurses to provide quality care in a rapidly changing health care environment. The fund is administered by two professional associations, the Registered Nurses Association of Ontario (RNAO) and the Registered Practical Nurses Association of Ontario (RPNAO).

Nurses who take a course that will enhance the quality of care and services they provide are eligible for up to $1,500 per year for reimbursement. Health care employers who have paid education costs for nursing staff may also apply to have these expenses reimbursed.
**Research**

Investments in nursing research provide an evidence basis for nursing practice. They also support nurses as researchers.

Nursing research investments support several projects and programs of nursing research, including:

- The Nursing Health Services Research Unit (NHSRU) at McMaster University and the University of Toronto to investigate supply, distribution and deployment of nurses and ways of maintaining quality while realizing funding efficiencies. This information is used in health human resource planning.

- The Nursing and Health Outcomes Project (NHOP) has now become known as the Health Outcomes for Better Information and Care (HOBIC). Its focus is the province-wide, standardized collection of patient health outcomes, staffing and quality of worklife information reflective of nursing, pharmacy, physiotherapy and occupational therapy not only in acute care, complex continuing care, long-term care, rehabilitation, and home care, but also in primary care, mental health and public health.

**Nursing Management/Leadership**

The Ontario Ministry of Health and Long-Term Care provide funding to inform nursing leadership best practices:

- One of the Healthy Work Environment Best Practice Guidelines developed, implemented and evaluated by the Registered Nurses Association of Ontario will focus on nursing leadership. Additional information is available at:

  http://www.rnac.org/projects/hwe.asp

**Primary Health Care Nurse Practitioners**

Ontario currently invests over $44 million to support 400 Primary Health Care nurse practitioner positions in a variety of communities province-wide.

An additional $3 million is provided to fund the Ontario Primary Health Care Nurse Practitioner Education Program, which is delivered by a consortium of ten universities, and offers a post-baccalaureate certificate to graduates. The 2004 Budget included a commitment to double the number of education seats for nurse practitioners by 2007. In May 2006, the Minister of Health and Long-Term Care announced plans to expedite this seat expansion, so that 150 learners will be admitted to the program in September 2006, one year ahead of schedule.

In January 2004 the Minister of Health and Long-Term Care announced the Nurse Practitioner Integration Task Team. This Task Team is an action-oriented group established to advise on the implementation of the recommendations in The Integration of Primary Health Care Nurse...
Practitioners in the Province of Ontario report. The team will prioritize the recommendations, establishing short, medium and long-term objectives.

In 2005/06, two initiatives to support recruitment and retention of nurse practitioners were introduced:

- The amount of annual funding for 129 nurse practitioner positions was increased to bring them up to the Ontario average. This will allow these employers to offer more competitive salaries to support recruitment and retention of primary health care nurse practitioners.

- A new, more flexible, policy to support agencies that have been funded for a nurse practitioner position but have had chronic vacancies. Beginning in 2006, organizations will be able to use the funds to sponsor a local registered nurse to pursue his/her primary health care nurse practitioner education. The funds are used to cover education related expenses, including tuition, and to pay the nurse's salary while he or she attends school. In exchange, the new NP must agree to a return-of-service commitment to the position.

Nursing Education

As of January 1, 2005, regulations under the Nursing Act, 1991 were amended to include new entry to practice requirements for the two categories of nurses in Ontario. RNs require a baccalaureate degree and RPNs require a community college diploma.

In 2005/06, colleges and universities will receive up to $72.3 million in operating grants for the nursing degree program. This increase of $26.6 million over the investment in 2004/05 will fund continued enrolment growth in the program. Beginning in 2005/06, this program will also fund Second-Entry degree nursing programs, including programs designed to enable an RPN to upgrade to a B.Sc.N.

In September 2005, a pilot project in community-based nursing education was initiated. This program is offered jointly by Confederation College and Lakehead University in the northern communities of Dryden, Kenora, Sioux Lookout and Fort Frances, and will allow students to study nursing in their home communities.

Recent ongoing investments to support nursing education from the Ontario Ministry of Training, Colleges and Universities include funding to expand enrolment in graduate nursing programs (Masters and PhD), and to provide a tuition waiver for college and university nursing faculty enrolled in the PhD in Nursing.

RN Education

RN programs are offered in 20 communities across Ontario:

- Eleven universities offer collaborative baccalaureate programs with 22 community colleges.
- One community college offers a collaborative program with a university in another province.
- Two universities do not offer collaborative programs but grant RN degrees.
RPN Education

Twenty-three community colleges in 21 communities across Ontario offer diploma programs.

Support for Internationally Educated Nurses

Since 2004, the government's investment is approximately $4 million for bridging programs to support internationally-educated nurses who are preparing to work in Ontario. These projects develop ways for key stakeholders - employers, occupational regulatory bodies and educational institutions to assess existing skills and competencies, provide training and Canadian workplace experience, and help qualified individuals move quickly into the labour market without duplicating what they have already learned.

Supply of Nurses in Ontario

Ontario has two categories of nurses, Registered Nurses (RNs) and Registered Practical Nurses (RPNs). The RN category includes Registered Nurses in the Extended Class (RN(EC)s) who are commonly known as primary health care nurse practitioners (PHCNP).

According to the College of Nurses of Ontario Membership Statistics at January 1, 2005, there were:

- 139,011 nurses registered
- 118,250 employed in nursing
- 2,354 employed in both nursing and non-nursing
- 7,631 employed in non-nursing
- 9,906 not employed

The table below shows nurses by category and employment in the three largest sectors.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number Employed in Nursing</th>
<th>Sector</th>
<th>Number/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hospital</td>
<td>11,228 (46%)</td>
</tr>
<tr>
<td>RPN</td>
<td>24,482</td>
<td>Long-Term Care</td>
<td>8,147 (33%) (31.4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community[^2]</td>
<td>3,119 (13%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital</td>
<td>56,563 (64%)</td>
</tr>
<tr>
<td>RN</td>
<td>89,054</td>
<td>Community</td>
<td>15,843 (18%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long-Term Care</td>
<td>15,843 (9%)</td>
</tr>
</tbody>
</table>

[^2] The community sector includes nurses employed in public health units, community health centres, community home care agencies, Community Care Access Centres, and community agencies.
In 2005, there were 582 RN(EC)s employed in nursing in Ontario. The top five employers for PHCNPs are in the table below.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Number/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Centre</td>
<td>192 (32.3%)</td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>97 (16.3%)</td>
</tr>
<tr>
<td>Physician's Office/Family Practice Unit</td>
<td>78 (13.1%)</td>
</tr>
<tr>
<td>Colleges/Universities</td>
<td>20 (22.5%)</td>
</tr>
<tr>
<td>Other</td>
<td>34 (5.7%)</td>
</tr>
</tbody>
</table>

**2005/06 Initiatives and Previously Announced Health Human Resources Initiatives - Allied Health Providers**

**Mental Health**

- A Community Mental Health Careers website was launched on January 16th, 2006. The website [www.workinginmentalhealth.ca](http://www.workinginmentalhealth.ca) will help community mental health agencies recruit more broadly for providers. It will also generate Local Health Integrated network (LHIN) based statistics to assist with future local area planning and complement the Aboriginal Healing and Wellness Initiative by describing the Aboriginal mental health system. The Ministry also funded research into human resources providing mental health services to Aboriginal clients.

**Cancer Care**

- Ministry staff continues to work with stakeholders to explore the expansion of career options for radiation therapists that include both entry level and advanced practice roles. Ontario is funding a project to develop, pilot and evaluate five advanced practice Radiation Therapy roles.

**Internationally Educated Health Professionals**

The ministry undertook several projects in 2005/06 to increase access to practice in Ontario for internationally educated health professionals (IEHPs). These projects were funded through Health Canada as part of their five-year, $75 million initiative to increase access for IEHPs in Canada, for which Ontario has been notionally allocated $17.6 million over five years (2005/06 - 2008/09). Projects for 2005/06 included:

- Strategic Planning Project for IEHPs, including the completion of an environmental scan to identify initiatives currently underway for IEHPs, success and gaps, and
- Continued funding for the Michener Institute's Access and Options for Foreign Trained Health Professionals project
• Development of a CD/booklet resource for college guidance counselors advising IEHPs interested in practicing medical radiation technology and medical laboratory technology in Ontario.

**Interprofessional Education**

• As interprofessional education facilitates greater collaboration and practice in health care, the ministry approved the development of a curriculum to integrate interprofessional education at the Michener Institute. The funding provided in February 2006 supported the government's commitment to promoting a team approach which will improve access to health care, patient outcomes, and patient satisfaction.

**Clinical Education**

• Clinical training is a core aspect of the education of all healthcare students. However, it is becoming increasingly difficult to ensure that all healthcare students receive the appropriate amount of clinical training. The availability of clinical teaching resources and the clinical placements are becoming issues for healthcare students in Ontario. The ministry has provided funds for the enhanced use of simulation at the Michener Institute for magnetic resonance imaging. This will allow students to achieve maximum use of enhanced technological features and improve operational efficiencies in diagnostic imaging in a safe and realistic simulated learning environment.

**Magnetic Resonance Imaging (MRI)**

• The ministry funds the Michener Institute for Applied Health Sciences, which is the only educational institution that offers a formal MRI training program in Ontario. An additional cohort of 25 students was funded in January 2006 to make use of available clinical site. This will support Ontario's Wait Time Strategy, which helps ensure that Ontarians receive timely and appropriate access to five selected services, including MRI scans.

**Computerized Tomography Simulation Project**

• The ministry awarded development costs for the Computerized Tomography (CT) Simulation Project which allows students to acquire and manipulate images without compromising patient safety. This will improve operational efficiencies in diagnostic imaging across the province which is part of the CT Wait Time Strategy in March 2006.

**Picture Archiving and Communication System (PACS)**

• New CT and MR units generate extremely large datasets per examination. Educational opportunities on the Picture Archiving and Communication System (PACS) were funded by the ministry in October 2005 and offered at the Michener Institute to provide knowledge and skill on the efficient management of the information acquired.
Anesthesia Care

The ministry funded the Michener Institute in July 2005 to pilot a new Anesthesia Assistant Program which provides training for respiratory therapists and registered nurses who can participate as part of the anesthesia care team. The first cohort of eleven students entered the Program in January 2006. The introduction of anesthesia assistants will increase patient access to operating rooms, improve wait times for surgical procedures, help address operating room efficiency, and improve working conditions for the province's anesthesiologists.

Medical Laboratory Science

- The ministry provided funding in 2002 to the Michener Institute to support an increase of 32 entry-level positions over three years in the Medical Laboratory Science program in response to reports of current and impending shortages in laboratory services. The Michener maintained this new enrollment level in 2005/06. The new Medical Laboratory Science program at the University Of Ontario Institute of Technology will also increase the supply in 2008 when the first 30 students are expected to graduate.

Midwifery

- The Midwifery Education Program (MEP) is a consortium of three universities, Ryerson, McMaster and Laurentian, that offer a 4-year Bachelor degree in midwifery. The MEP has graduated an average of 32 new midwives a year over the past four years. Enrolment in the midwifery program increased to 60 new entrants in 2003, and has remained constant at this number.

Allied Health Human Resource Database (AHRDB)

- It has long been recognized that human resource planning initiatives have been inhibited by inadequate data. There is a critical need for better quality data tailored to meet health human resource planning requirements. The ministry is developing an allied health human resources database to enhance the capacity for integrated health human resource planning, including development of data-driven forecasts. It recently completed a pilot project capturing information from nine allied health regulatory colleges. The next step for the AHRDB is to transition the project to a long-term operationalization of the database.

- As part of the Ontario Government initiative to transform the health care system, an Information Management framework has been established to track and monitor how the health care system serves the public. Through this initiative, key areas of focus will involve producing better data, measuring performance, and supporting evidence-based decisions. As part of this work, supply indicators will be developed for health human resources in various settings such as hospitals, Community Care Access Centres (CCACs), Children's Treatment Centres (CTCs), and Community and Mental Health Facilities.
Section 8: Health Information

Managing Wait Times Information

A significant amount of progress has been made on developing the Wait Time Information System (WTIS) and Enterprise Master Patient Index (EMPI).

The EMPI – or Client Registry – will significantly advance the integration of services by enabling the flow of patient information across organizational silos. The WTIS will provide near real-time access information and alerts when wait time priority targets are being compromised at the physician, hospital, Local Health Integration Network (LHIN) and provincial levels. Furthermore, information will be used to monitor progress made in reducing wait times at these levels and identify where improvements must be made.

Phase 1 of the WTIS and EMPI, implemented by March 31, 2006 at five hospitals: Grand River Hospital, Hamilton Health Sciences Centre, St. Joseph’s Hamilton, Southlake Regional Health Care, and University Health Network. Phase I captures about 18% of the incremental wait time cases in Ontario, and engages over 300 surgical offices that use the WTIS and the patient priority ratings developed by the clinical expert panels.

In Phase 2 (April-December 2006), 50 additional hospitals will implement the provincial system, accounting for about 80% of all wait time funded cases. Hospitals will be divided into five or more groups with implementation efforts targeted at each successive group by December 2006.

The Wait Time Strategy’s information management and technology efforts have also been expanded to support other major access to care initiatives. For example, the University Health Network is leading the development of a provincial Critical Care Performance Measurement System as part of Ontario’s Critical Care Strategy. Performance data, which is being collected through an interim process, will be available in August 2006.

The process of implementing the provincial WTIS is having a number of unintended positive benefits. For example, many surgical offices did not have computers or basic internet access. The Smart Systems for Health Agency’s connectivity program has now connected surgeons to the internet. This will support the implementation of the WTIS and enable other electronic health initiatives ranging from simple email communication between providers to supporting physician portals into hospital and other information systems.

Managing Health System Information

The province’s Information Management Strategy aims to address the system-wide need for better information in sectors like acute care and community health. It supports major government initiatives, such as the Wait Times Strategy, the e-Health Strategy, and the establishment of 14 Local Health Integration Networks. The strategy lays out a systematic approach for addressing data quality and integration issues. The end goal is not only better quality data, but a more
organized, efficient, and ultimately, more sustainable way of managing health system information.

Partnerships with health care providers and organizations across the system that are involved in data collection, reporting and storing, have been key to the success of the strategy.

Initiatives that are underway are focused on improving data quality and management, closing information gaps and reducing the burden of data collection on health care providers.

Some of the results achieved so far include the following:

- In June 2005, three metric tonnes of paper were eliminated, and 20,000 person hours were freed up in Ontario’s CCACs, so that the focus can be on the management of care instead of on the production of paper.

- In December 2005, 14 local data management partnerships, made up of health information management officials from hospitals and the community care sector were put in place. They will work together, and with their Local Health Integration Networks, to identify best practices, standards, tools, and policies for better data quality and management.

- In April 2006, the Ministry announced that some Ontario hospitals were no longer mandated to collect and report nursing workload measurement data. Workload measurement data is currently collected by nurses in hospitals across the province, and is used for planning, budgeting and research purposes. Over the years, numerous concerns have been raised with respect to the validity and reliability of this type of data, drawing into question its utility as a measure of nursing productivity, and for cost allocation methodologies.

In the latter part of 2006, as part of the focus on closing information gaps, the ministry will be implementing the Health Outcomes for Better Information and Care (HOBIC) initiative. This initiative will involve the province-wide, standardized collection of patient health outcomes reflective of nursing and other health care disciplines. Implementation is planned to occur in phases, from 2006 to 2009. Collection of information about patient outcomes reflective of the nursing discipline will begin in various sites in acute care, complex continuing care, long-term care and home care. It will subsequently be expanded to additional disciplines (e.g., pharmacy, occupational therapy, physiotherapy) and additional sectors (e.g., rehabilitation, primary care, mental health and public health) across the province. Work is also underway to identify staffing and quality of work life indicators to link with and explain these health outcomes.

**Strengthening Health System Information Management for System Stewardship**

Good, solid facts about the health of populations, the utilization of services and the allocation of health care dollars will provide the evidence that is needed for health system and local health system planning, decision-making, measurement and reporting activities.

As part of its new role as health system steward, the Ministry of Health and Long-Term Care is putting in place a permanent structure that will be dedicated to managing this critical resource. In 2006, the ministry will be actively working to consolidate its information sources.
Ontario’s e-Health Strategy

To ensure that people in Ontario are benefiting as much as possible from e-Health, the Ontario government is renewing the provincial e-Health strategy.

Ontario’s renewed e-Health strategy will help ensure that the focus is on improving the delivery and management of care in Ontario.

The benefits of e-Health include:

- Providing Ontarians with timely, safe, quality care, and access to their own information and health knowledge to help them manage their own health and health care
- Helping clinical professionals to be well-informed, patient-focused and productive
- Enabling institutions to be more efficient, accountable and focused
- Ensuring managers/planners have the information to support integration, measurement and continuous improvement

The Smart Systems for Health Agency (SSHA) in Ontario was initially established to provide the e-Health technology infrastructure. SSHA is currently delivering the following services in accordance with the e-Health Strategy priorities:

- Secure Hosting
- Network Services
- Portal Services
- Secure Email
- Registration Services
- Contact Centre
- Privacy and Security Training
- Electronic Health Record
- Other critical health care applications

Ontario’s Current e-Health Priorities

Infrastructure

Smart Systems for Health Agency Network Connectivity and Communications

A single electronic network will link all authorized health care providers and allow them to share information within multi-disciplinary primary health care teams, among providers within LHINs and across the health system, and supports Ontario’s telehealth program as well as Cancer Care Ontario, Air Ambulance and the electronic Child Health Network (eCHN). As of March 2006,
100% of all hospitals, CCACs, LHINs and Public Health Units have been connected. In addition, 4% of physicians and 56% of long-term-care homes (currently 56%) were connected.

**Smart Systems for Health Agency Secure E-Mail for Health**

The Secure Email for Health (SEH) initiative will roll-out email to all health care providers. Where organizations or institutions have an existing email system – and certain criteria are met - an existing system may be integrated with SSHA's system, with directory synchronization. Where there is not an existing email system, or where the existing system is to be replaced, SSHA's SEH will be implemented. As of March 2006, secure e-Mail is being used by all CCACs.

**Client Registry/EMPI**

Client Registry and an Enterprise Master Patient Index (EMPI) is a cornerstone to the Electronic Health Record (EHR) in Ontario and is fundamental to e-Health services initiatives.

The Client Registry/EMPI is being introduced in 2006 by the Wait Time Information Strategy to support the roll-out of the wait time management system that will, in due course, be rolled out to all health providers

**Provider Registry, Identity and Access Management**

SSHA’s Registration Management Services (RMS) will:

- provide identity and access management services for all clients using SSHA’s infrastructure
- federate with the identity and access management services of designated institutions in Ontario’s healthcare environment

**Business Initiatives**

**Public Health I&IT Strategy**

The Public Health I&IT Strategy provides for the renewal of Public Health I&IT through targeted initiatives in the realm of e-Health Strategy including Communications Tools, Public Health Surveillance solutions, Standards and Architecture, and Transition Support.

Current e-Health initiatives for Public Health I&IT include:

- Integrated Public Health Information System (iPHIS): A communicable disease management and reporting system deployed in all 36 Public Health Units and the Public Health Division
- Public Health I&IT (PHIIT) Communications Portals: Two portals available (one for Public Health professionals and the other for members of the broader health sector), collaboration tools and a publication facility for publishing Important Health Notices
- Integrated Information System for Inspection Activities
- Immunization Information Management.
**Drug Information System**

Medication errors will be reduced through electronic prescribing, access to prescription history and drug interaction systems that alert prescribers to potentially dangerous interactions. The Drug Information System is currently comprised of one initiative – Emergency Department (ED) Access to Ontario Drug Benefit Drug History. This access is provided through a drug profile viewer which was deployed to 69 hospitals as of March 31, 2006.

**Ontario Laboratories Information System & Hospital Interface**

OLIS is an integrated province-wide system for the secure electronic exchange of laboratory information among authorized practitioners, laboratories and the MOHLTC.

OLIS will link labs with health providers, ensuring more timely results and helping to reduce the incidence of unnecessary duplicate testing.

As of March 31, 2006, OLIS clinical services (electronic ordering of lab tests and retrieval of results) was available to the early adopters.

**Physician IT Program**

The ePhysician Project was a partnership between the MOHLTC and the Ontario Medical Association (OMA) that developed a comprehensive IT solution for physicians, including office technology and applications for electronic medical records, plus support services. In March 2004 management of ongoing delivery of the Physician IT Program transitioned to the Ontario Medical Association.

A physician portal was launched in August 2005 and, as of March 2006, had 1700 registrants. In addition, over 640 physicians have been engaged by the Transition Support Group – specialists in the field who assist physicians and their staff to improve their medical practice through the use of information technology.

**Continuing Care I&IT Initiatives**

A standardized technology infrastructure has been implemented across the province’s CCACs.

Current e-Health initiatives for the Continuing Care sector include:

- e-Referrals & Access Tracking
- Standardized Common Assessment
  - Long-Term Care Homes - Resident Assessment: As of March 2006, in use at 15% of Long-Term Care Homes
  - Community - Adult Long Stay Client Assessment: As of March 2006, in use at 100% of CCACs
- Common Intake Assessment Tool: System completed as of March 2006
- Business Systems (MIS)
  - Financial & Statistical Management System

**Telemedicine**

Telemedicine is a service delivery channel that utilizes video and telecommunications technologies for:

- Clinical services (approximately 75% of current services in Ontario): Consists of patient:provider and provider:provider consultation using two-way teleconferencing and electronic medical devices such as digital stethoscopes, exam cameras, endoscopic exam cameras and digital radiography; transmission can be either in real-time or store-and-forward format for later assessment.
- Information Dissemination and Education (approximately 25% of current services in Ontario): Consists of using multi-point video-conferencing and web-casting and can support crisis management, as well as distance education.

**Wait Times Information Management System**

Development of the overall framework and requirements for Ontario’s wait time information system, including:

- reporting wait times on a local, provincial, and eventually LHIN basis;
- implementation of consistent methods for prioritizing patients in the five key service areas, using standardized prioritization tools and technology.

**Diagnostic Imaging Strategy**

Ontario has developed a Diagnostic Imaging (DI) / Picture Archiving and Communications System (PACS) strategy for Ontario. Future steps regarding this strategy will be evaluated as part of the e-Health Strategy renewal process.

**LHIN e-Health Planning Framework**

Local Health Integration Networks (LHIN) have a mandate to plan, coordinate, integrate and fund the delivery of health care services at the community level within their defined geographic regions. The Ministry of Health and Long-Term Care has developed a LHIN e-Health Planning Framework to guide the LHINs in developing e-Health plans for the sharing of health information.
Section 9: Health Technology

In March 2003, a consultation process with representatives from Academic Health Science Centres (AHSCs) and other key Ontario technology assessment stakeholders supported the concept that a single portal of entry process be established for the coordinated uptake and diffusion of new health technologies with evidence of proven effectiveness in improving patient outcomes. A single portal of entry was believed to provide a more consistent, informed, decision-making process for improving equitable access to new health technologies. In response, the Ontario Health Technology Advisory Committee (OHTAC) was created in October 2003 with secretariat and methodological support from the Medical Advisory Secretariat (MAS) of the Ministry of Health and Long Term Care (MOHLTC).

OHTAC is the single portal for providing advice to the health care system, including the Ministry of Health and Long-Term Care (MOHLTC), regarding the uptake, diffusion and distribution for new health technologies and the removal of obsolete health technologies. OHTAC focuses on the effectiveness in improving patient outcomes of new and emerging health technologies that have a significant impact on the health care system. OHTAC does not examine or provide recommendations for pharmaceutical products or information systems, engage in general disease management reviews but rather the integration of technologies related to specific diseases and conditions and does not infringe upon the important role of innovation through health research.

In February 2005, eighteen months after OHTAC was created, MAS commissioned a review of OHTAC and the MAS processes as part of its ongoing quality improvement initiative. The aim was to identify areas that required different or new processes and methodologies and consisted of a review of documentation and interviews with key informants. Professor Michael Drummond of the Centre for Health Economics, University of York (UK), conducted the review. In brief, he reported broad support for the rational approach to decision-making related to the adoption, diffusion and use of health technologies. He also commented that the Health Technology Assessment (HTA) Program in Ontario was excellent. Recommendations for improved effectiveness processes were made.

The December 2005 OECD report on "Health Technology and Decision Making" examined the MAS/OHTAC process and stated that “The Ontario model systematically incorporates evidence into decision making within the same health system that face similar concerns and patient needs. The Committee has created a process whereby local decision makers’ drive the agenda for HTA and at the same time improve the likelihood that HTA will actually be used. The policy in Ontario is intended to ensure that evidence is examined along the entire development cycle of the technology. It enables better use and dissemination of field evaluations of new (non-drug) technologies to provide needed evidence for decision making. It also enables an early assessment or evaluation of a technology that is based on the specific questions that decision makers have and is aligned to their needs”. The report also favourably examined the Ontario field evaluation of Positron Emission Tomography (PET).
The 2005 OECD report continues the OECD's 2004 interest in Ontario health technology assessment process. In their report of 2004, “Towards High Performance Health Systems”, the OECD stated “the committee (OHTAC) promotes the use of HTA in decision making by bridging the worlds of evidence and decision-making. Under this model, early assessments or evaluations of technology are based on the characteristics of the technology, the evidence available, and the needs of decision makers...The Ontario model is a systematic bottom-up method of incorporating evidence into decision making.”

Since October 2003, OHTAC has made recommendations to the Deputy Minister regarding 3523 health technologies. For more information please visit the MAS website [http://www.health.gov.on.ca/english/providers/program/mas/mas_mn.html](http://www.health.gov.on.ca/english/providers/program/mas/mas_mn.html) or the OHTAC website [http://www.health.gov.on.ca/english/providers/program/mas/ohtac_about.html](http://www.health.gov.on.ca/english/providers/program/mas/ohtac_about.html)

**Health Technology Evaluation and Assessment Program**

The Health Technology Evaluation and Assessment Program (HTEAP) exists to:

- Provide advice to government on the uptake and diffusion of new health technologies based on scientific evidence of effectiveness.
- Ensure a coordinated approach to policy decision-making regarding the introduction of new health technologies and the retirement of obsolete technologies. Technologies examined by HTEAP include diagnostic services and treatment therapies, but exclude pharmaceuticals and information systems.
- Conduct evidence-based analyses of medical scientific research for promising health technologies and combines this with relevant Ontario specific economic, demographic, professional utilization and legal information, and ethical and social considerations to provide decision-makers with policy advice on the health benefits and resource implications of each technology.

MAS works with medical professional bodies, including the Cardiac Care Network, the Clinical Oncology Group of Cancer Care Ontario and the Physician Services Committee Guidelines and Diagnostics Committees, as well as academic research bodies including the Program for Assessment of Technology in Health (PATH) at McMaster University, the Institute for Clinical and Evaluative Sciences (ICES), the Program in Evidence Based Care at McMaster University and the Usability Laboratory at University Health Network. MAS also works closely with clinical experts in the province and engage expert panels from time to time to ensure that its analyses are consonant with practice patterns as appropriate.

MAS initiates field evaluations of promising new health technologies where there is insufficient evidence of effectiveness to warrant investment as an insured health service.
The Health Technology Research and Evaluation Fund

This was one-time funding entirely used for research purposes. Established in 2004/05 and running until 2006/07, this Fund:

- Supports third parties to facilitate the Medical Advisory Secretariat and MOHLTC in working closely with appropriate stakeholders and experts in Ontario to achieve the desired objectives.
- Permits the provincial government to obtain credible third party expertise for projects which require arm’s-length standing, particularly where technologies are being field-tested or evaluated or assessed for their cost effectiveness against existing technologies and the government’s credibility must be maintained.
- Consists of the following multi-year projects:
  - Positron Emission Tomography (PET) Registry Study for patients with single pulmonary nodule, marker positive thyroid cancer and germ cell cancers.
  - The University Health Network Usability Lab which studies the usability of medical devices in the clinical environment and provides information regarding the necessary skill sets and prior knowledge needed to successfully operate the device.
  - Development of utilization guidelines for health technologies through Health Technology Utilization Guidelines of Ontario (Health TUGO) based out of the Program for Evidence-Based Care at McMaster University.
  - Shared Senior Research Associate based out of McMaster University that brings economic evaluation, decision analytic modeling and budget impact analyses expertise to the MOHLTC.
  - Field evaluation study led by PATH, including ICES leadership, to investigate ways of decreasing symptom-to-intervention times for primary angioplasty and thrombolysis.
  - PET Colorectal Cancer randomized control trial to determine the survival benefit and cost-effectiveness of PET as an additional staging tool.

Telemedicine in Ontario

Telemedicine utilizes videoconferencing, telecommunications, and digital store-and-forward technologies to connect patients - particularly those in rural, northern and under-serviced communities to the wide variety of clinical services in Ontario. Ontario is a recognized leader in telemedicine with one of the largest networks of operational sites in North America.

There are three geographically based networks funded by the ministry. These delivery entities use the backbone network infrastructure provisioned by SSHA:

- CareConnect - Serving Eastern Ontario, based in Ottawa
- NORTH Network – Serving Northern and selected regions in the South, based in Toronto
- VideoCare – Serving Southwestern Ontario, based in London
In 2004/05, over 25,000 videoconference events were coordinated across the province, most of which were clinical events. Telemedicine service activity includes the delivery of clinical services involving over 70 subspecialties. Highest users are psychiatry, dermatology, pediatrics, and cardiology. Additional service activity includes telestroke, neurology, burn management, internal medicine, oncology, surgery, anesthesia, dietary encounters, physical medicine rehabilitation, geriatrics, pathology, etc. These clinical applications account for 75% of telemedicine usage in Ontario. The remaining 25% of service activity consists of education and training, consultations between health professionals, and administrative events.

Videoconferencing will be rolled out to Public Health Units across the province because it can play a critical role in preparation, early detection and management of epidemic disease crisis. During the SARS outbreak, a 39-site real-time videoconference for health care professionals was taped and subsequently posted on the internet for province-wide access to breaking news on the management of this crisis.

Satisfaction with telemedicine among patients and providers has consistently been evaluated at over 90%. Reasons for high satisfaction include reduced travel time and cost, decreased waiting times for services and the ease of use of medical peripherals such as high-resolution cameras, digital stethoscopes and otoscopes.

**Telehealth Ontario**

Telehealth Ontario is a free, province-wide, confidential telephone-based health service that offers consumers health advice and information from a registered nurse. Telehealth Ontario is available 24 hours a day, 7 days a week and no health card is necessary to receive the service. Telehealth Ontario nurses help direct callers to appropriate health care options - including taking care of themselves at home, going to their family doctor, going to their local emergency department, or contacting an appropriate community service.
Section 10: Primary Care

Overview

Primary Health Care has been a foundation of Ontario’s health care system for many years now and is a key element of the government’s priority to ensure “Healthier Ontarians in a Healthier Ontario” in a transformed, results-based health care system. The key goals of the Primary Health Care Transformation Strategy are:

- improved access to primary health care
- improved quality and continuity of primary health care
- increased patient and provider satisfaction
- increased cost-effectiveness of primary health care services
- effective health promotion and disease prevention and chronic disease management strategies.

Ontario is building a strong foundation for primary care by:

- developing new Family Health Teams that consist of interdisciplinary teams providing enhanced comprehensive primary health care
- helping ensure family physicians and other interdisciplinary team members of the primary health care team are practicing in groups with identified (enrolled) populations;
- expanding its network of Community Health Centres to provide improved primary health care access for high-risk populations
- aligning current primary health care models to ensure consistent delivery of core services seen in family health teams
- ensuring 24/7 access to primary health care services is available through extended office hours and a telephone health advisory service.

Initiatives/Projects

Family Health Teams (FHTs) are a central element of Ontario’s primary health care renewal strategy through which the government will provide more Ontarians with access to primary health care. The locally-driven teams will provide interdisciplinary collaborative care so that patients have access to an appropriate health care provider, 24 hours a day, 7 days week through regular office hours, extended hours and a telephone health advisory service. The teams will include physicians, nurses, nurse practitioners, and other health care providers such as pharmacists, dietitians, midwives, social workers, health educators and others that will provide comprehensive care with an increased emphasis on health promotion and disease prevention and chronic disease management.

Family Health Teams will be developed to meet the unique needs of each community and no two teams will function exactly alike. Each FHT will maximize the expertise, preferences and skills
sets of each of its team members and cultivate interdisciplinary collaboration in unique ways. FHTs will not replace existing successful models but will build upon their strengths.

Ontario has committed to the implementation of 150 Family Health Teams by 2007-08. The first 69 Family Health Teams were announced in April 2005 and an additional 31 were announced on December 9, 2005, with the final 50 teams to be announced in spring 2006.

Ontario has several primary health care models. They are the Family Health Networks, Primary Care Networks, and Health Service Organization, Community Health Centres, Comprehensive Care Model (CCM) and Family Health Groups. They all have common elements:

- defined core services
- individual or groups of family physicians working together to provide comprehensive care to patients enrolled to them
- obligations to provide a combination of regular and enhanced office hours
- a telephone health advisory/triage service for after hours, weekends and holidays.

**Family Health Networks (FHNs)** have a minimum of three family doctors working together to provide comprehensive and preventive care management to patients. FHNs receive capitation for all enrolled patients based on a basket of primary care services with additional fee-for-service for some services, and additional premiums, incentives and bonuses. As of February 1, 2006, there were 70 FHNs with signed agreements.

**Health Service Organizations (HSOs)** have individual physicians and groups of physicians providing comprehensive care to enrolled patients. The majority of payments are for defined core services. Some HSOs receive grants for services by allied health professionals for targeted patient groups. As of February 1, 2006 there were 49 HSOs operating in Ontario.

**Primary Care Networks (PCNs)** family doctors work together to provide comprehensive care to enrolled patients. As of February 1, 2006 there were 12 PCNs operational in Ontario.

Per the Memorandum of the Agreement between the Ministry and the Ontario Medical Association, a working group was established to align elements of the HSO and PCN models into one model. This model will provide physicians with payments for common capitated services and some comprehensive care and after-hours care incentives and will be available to all physicians in Ontario by spring 2006.

**Family Health Groups (FHGs)** are fee-for-service group practices with a minimum of three family physicians that receive incentives for providing some core comprehensive and after-hours health care services to enrolled patients and enrolled patients previously without a physician.

In comparison to the FHN, the FHG is a simpler arrangement without specific governance requirements. As of February 1, 2006, there were 330 FHGs operating in Ontario.
**Comprehensive Care Model (CCM):** CCMs are the newest model arising from the 2004 Memorandum of Agreement between the Ontario Medical Association and the Ministry. The model is available to all family physicians in solo practice as of October 2005. Like the FHGs, this is primarily a fee for service model with incentives for providing some core comprehensive and after-hours health care services to enrolled patients and enrolled patients previously without a physician. As of February 1, 2006, there were 341 CCM physicians operating in Ontario.

**Community Health Centres (CHCs):** are a key element of Ontario’s primary care renewal strategy in meeting the needs of high-risk populations and communities. CHCs are community driven and provide primary care through inter-disciplinary teams including physicians, nurse practitioners, nurses, dietitians, therapists, counsellors, chiropodists, health promoters and outreach workers. CHCs develop in response to identified community needs. They identify priority populations for group and community programming. There are currently 54 CHCs and 10 satellite CHCs providing multidisciplinary health and social services to 330,000 high-risk or disadvantaged Ontario residents. Ontario has announced a three year plan to extend primary care access through an additional 22 CHCs and 17 satellite CHCs by 2007-08.

**Rural and Northern Physician Group Agreements (RNPGA)**  
(Formerly Northern Group Funding Plan (NGFP) and Community Sponsored Contracts (CSC))

The RNPGA is a new alternate payment plan for physicians that combines both Northern Group Funding Plans (NGFP) for 3 to 7 physicians and the Community Sponsored Contracts (CSC) for 1 to 2 physicians into one agreement.

The RNPGA was negotiated with northern physicians for northern physicians. The purpose of the new RNPGA is to solidify current physician resources and strengthen the recruitment of primary care physicians to Ontario’s most isolated northern communities. The RNPGA retains the complement based physician payment model that was the foundation of the NGFP and CSC and adds to the compensation the bonuses and incentives from other primary health care physician payment models (FHN, PCN, and HSO). A southern based RNPGA model is also being developed. As of February 1, 2006, there were 38 RNPGAs operating in Ontario (24 CSCs and 14 NGFPs).

A compensation element exclusive to the RNPG agreement is a rurality modifier that provides higher compensation to physicians in the most isolated RNPGA communities.

**Group Health Centre (GHC):** The GHC is a multi-specialty, interdisciplinary ambulatory care centre providing primary care, specialist care and outpatient surgery, diagnostics and rehabilitation. The GHC provides multi-specialty ambulatory care to over 58,000 people in Sault Ste Marie.

The GHC enrols patients, receives capitation payments and funding for services provided by allied health providers and specialists.
Telephone Health Advisory Service (THAS): THAS is a vital component of primary health care renewal. This service aids family physicians in providing 24-hour access to primary health care services by providing after-hours advice and triage service for enrolled patients of certain primary health care models via registered nurses, without charge to patients. THAS is integrated with family physicians via a report-back feature and access to a local on-call physician.

Primary Health Care Transition Fund (PHCTF): Ontario has proceeded with the implementation of nine key PHCTF initiatives totaling $213 million over four years (2001/02 to 2005/06). These initiatives include interdisciplinary demonstration, evaluation and research projects; accreditation and leadership training; the integration of mental health and rehabilitation initiatives in primary health care; communications and enrolment; and the development of information and contract management systems for new primary health care delivery models.

These initiatives were initially scheduled to sunset by March 31, 2006, but most have now been granted an extension to summer/fall 2006. The initiatives are transitional in nature and are intended to lead to sustainable change in the organization, funding and delivery of primary health care services. Results generated from PHCTF will inform future primary health care renewal directions.

Funding

The Government of Ontario has emphasized the need to strengthen the primary health care models and has allocated $600 million for 2005-2006 for primary health care operations. This includes $100 million for incentives to family physicians for enhanced primary care services including preventive and comprehensive care incentives.

Section 11: Community Health

Overview of Governance/Management of Services

Community health services, including community health centres, diabetes education centres, midwifery services and HIV/AIDS organizations, are governed by incorporated, community-based, not-for-profit agencies governed by locally elected boards of directors. The MOHLTC administers the organizations’ funding through service agreements.

Changes of service provision/strategic initiatives

Community Health Centres (CHCs)

- In 2005-06 the government is investing an additional $14.0 million in Community Health Centres over 2004-05 funding levels, to bring the total allocation in 2005-06 to $170.6 million including:
  - $5.0M to add 7 new Community Health Centres and 5 new satellite CHCs to the health care sector
• $9.0M to annualize the 2004/05 CHC investments, including 10 new satellite CHCs announced in November 2004
• The $5.0 million investment for new CHCs and satellite CHCs will grow to $18.6 million by 2007/08.
• On November 10, 2005, the Minister announced a CHC expansion plan and stated that once fully implemented, we anticipate that the new CHCs and satellite CHCs will serve an additional 200,000 people.

HIV/AIDS Funding Enhancements

• In 2005-06, the total HIV/AIDS funding for 2005/06 was $27.4M, which comprises $17.7M for AIDS Bureau, $9.7 for Ontario HIV Treatment Network (OHTN). The 2005-06 allocation included $4M in new funding to enhance HIV prevention initiatives and prepare for the 2006 International AIDS Conference in Toronto. The breakdown of the $4M increase is as follows:
  • $3.25M for HIV prevention initiatives in priority populations – gay/bisexual men, Aboriginal people, injection drug users, and Ontarians from countries where HIV is endemic;
  • $0.75M to support the 2006 International AIDS Conference in Toronto.

Hepatitis C Secretariat

The establishment of the Hepatitis C Secretariat was announced by the Minister of Health in October 2004. Responsibilities include:
• Administration of the Ontario Hepatitis C Assistance Plan
• Meeting the Ministry of Health and Long-Term Care's obligations under the Multi-Provincial Territorial Assistance Plan and the 1986-1990 Class Action Settlement Agreement
• Administrative and policy support to the Ontario Hepatitis C Task Force

The Minister appointed a 16 member Task Force effective April 1, 2005. The mandate of the Hepatitis C Task Force is to provide advice on strategies to improve all aspects of hepatitis C treatment, prevention, education and support in Ontario.

Collaborations with external organizations

Funding Trends

The Ontario Ministry of Health and Long-Term Care spent over $175 million in 2005-06 to fund Community Health Centres. In recent years, CHCs have benefited from additional funding for nurse practitioners and early childhood development.
The Midwifery Program budget was $6.2 million in 1994. In 2005-06, the Midwifery Program budget was $51 million. Ministry resources have enabled all registered midwives to have the opportunity to provide funded services in Ontario.

The Ontario Ministry of Health and Long-Term Care allocated $54 million in 2005-06 for HIV/AIDS related programs. The Ontario government operates a number of programs and services designed to assist people living with HIV/AIDS and communities at risk for HIV infection.

Section 12: Population Based Health Initiatives

Operation Health Protection


Since June 2004, significant steps have been taken to implement the Action Plan:

- In December, 2004, amendments to the Health Protection and Promotion Act to increase the independence of the Chief Medical Officer of Health received Royal Assent.
- In January 2005 the Ministry initiated and launched the following:
  - The creation of the Agency Implementation Task Force (AITF). The AITF is supporting the design and development of Ontario’s Health Protection and Promotion Agency.
  - The Ontario Health Protection and Promotion Agency is expected to be established by 2006/07. The Agency Implementation Task Force (AITF) presented a Phase One report to the Ministry in October 2005 and the final report was released March 20, 2006.
  - An operational review of public health laboratories was completed in October 2005.
  - The Government announced in the 2006 Budget, an investment of $31M over three years to support the relocation of the Central Public Health Laboratory and upgraded infrastructure for regional health laboratories.
  - The Ministry announced the creation of the Local Public Health Capacity Review Committee (CRC). The CRC will advise the Ministry on options to improve the configuration and function of the local Public Health Unit system.
  - The Ministry initiated 4 subcommittees to support the Provincial Infectious Diseases Advisory Committee (PIDAC): Infection Control (within healthcare facilities); Surveillance; Immunization and Communicable Diseases.
  - The Ministry announced the implementation of the Integrated Public Health Information System (iPHIS). iPHIS is a web-based integrated database for all health units to use for case and outbreak management and for the reporting of communicable and reportable disease
Information on infectious disease can be analyzed quickly, allowing health units to identify and track unusual and unexpected instances of infectious diseases.

- The Ministry has struck a Steering Committee to develop core competency training in infection, prevention and control for front-line healthcare workers. This is ongoing and a small pilot has been done in 3 acute care settings in the Spring of 2006.

- Implementation of ten (10) initial Regional Infection Control Networks is underway. The mandate of networks is to maximize coordination and integration of activities related to the prevention, surveillance and control of infectious diseases across the healthcare spectrum on a regional basis, including promoting a common and standardized approach to infection prevention and control activities, based upon best practices. Additional networks will be implemented throughout Ontario in the upcoming years.

**Overview of Governance/Management of Services**

The Chief Medical Officer of Health/Assistant Deputy Minister who reports jointly to the Deputy Minister of Health Promotion and the Deputy Minister of Health and Long-Term Care (MOHLTC) has overall responsibility for the Mandatory Health Programs and Services Guidelines (MHPSG).

The MHPSG, last published in December 1997, are province-wide standards that steer the local planning and delivery and services by boards of health. They set minimum requirements for fundamental public health programs and services targeting the prevention of disease, health promotion, and health protection. As of November 2005, four of the Program Standards were transferred to the Ministry of Health Promotion. The Minister of Health Promotion now has the authority under section 7 for these programs.

The MHSPG published by the Minister of Health and Long-Term Care under the authority of section 7 of the *Health Protection and Promotion Act* (HPPA), which also obliges the boards of health to comply with them. As of November 2005, four of the Program Standards were transferred to the Ministry of Health Promotion. The Minister of Health Promotion now has the authority under section 7 for these programs.

The MOHLTC/PHD and Ministry of Health Promotion assist boards of health in implementing the mandatory programs through the provision of professional, technical and administrative consultation and financial resources.

As part of the 2004 Ontario Budget, the government made a commitment to increase the provincial share of public health funding to 75% by 2007. Effective January 1, 2006, the provincial share of public health costs for the delivery of mandatory health programs and services increased to 65 per cent and will rise to 75 per cent by January 2007.

In addition, the MOHLTC and the MHP provide additional funding for specific public health programs (e.g., West Nile virus).
Transfer to Ministry of Health Promotion (MHP)

Effective November, 2005, a number of Ministry of Health and Long-Term Care programs were transferred to the new MHP. The following mandatory programs were transferred from the Public Health Division:

Chronic Disease Prevention and Health Promotion

Chronic Disease Prevention and Health Promotion provides public health, population health, health promotion and epidemiologic leadership and expertise to Boards of Health, the Ontario Health Promotion Resource System and other agencies. Programs and services include: chronic disease prevention (e.g., heart health, tobacco free living, healthy eating, healthy weights and regular physical activity); early detection of cancer; injury prevention including substance abuse prevention; reproductive health and child health. Key initiatives in 2005 included:

Mandatory Health Programs and Services Guidelines

- Chronic Disease Prevention
- Injury Prevention Including Substance Abuse Prevention
- Child Health
- Reproductive Health

Smoke-Free Ontario/Ontario Tobacco Strategy (OTS)

The Ministry of Health and Long-Term Care currently provides $50 million for tobacco control including funding for youth prevention programs, cessation, Aboriginal programs, Public Health Units, public education, evaluation and surveillance and provincial support programs. $1.0 million goes to the resource centres within the Ontario Health Promotion Resource Centres System.

The goals of the Strategy are prevention of tobacco use - helping youth not start to smoke, cessation - helping people quit smoking, and protection - helping Ontarians avoid second-hand smoke.

Healthy Weights

In 2004, the Chief Medical Officer of Health report was Healthy Weights, Healthy Lives. The report sets out a plan to promote healthy weights in Ontario. The goal is to help all Ontarians understand the factors that affect their weight and find the right balance between the food they eat and how physically active they are and to create environment – child learning and care centres, schools, workplaces; recreation centres, and communities – that promote physical activity and healthy eating. The report call on all levels of government, the health sector, the food industry, workplaces, schools, families and individuals to become part of a comprehensive province-wide effort to change all the factors that contribute to unhealthy weight.
The Ontario Heart Health Program

Phase II of the program has been implemented in 36 communities and will continue until 2008. This community-based program implements activities to address the modifiable risk factors (physical inactivity, unhealthy eating, and tobacco use) to support the prevention of cardiovascular disease. Phase II of the program will be enhanced by including chronic disease prevention as part of the program implementation. Activities will target the general population with special emphasis on children, youth, and women.

The FOCUS Community Program

Phase II of the program has been implemented in 22 communities and will continue until 2008. This community-based program implements activities to address problems including injuries associated with the misuse of alcohol and other drugs. The mandate for Phase II of the program was expanded to include alcohol as a risk factor for chronic disease prevention as part of the program implementation. Activities of the program will target the general population with a special emphasis on youth.

Stroke Strategy

Through the Ontario Stroke Strategy, a series of health promotion/prevention projects have been funded to address stroke prevention, especially in the population of 45 years and up. These projects include a public awareness campaign on the early warning signs of stroke; web-based tools for individuals to assess their risk for hypertension, production of an Implementation Guidebook to enable local communities to provide community-wide health promotion activities related to stroke prevention; continuation of building community capacity through work with health professionals in primary health care, secondary and tertiary care facilities; and the implementation of identified Best Practices/Promising Practices in stroke prevention in five communities in Ontario.

Ontario Health Promotion Resource System (OHPRS)

The OHPRS was established in 2000 as a consortium of health resource centres that support health promoters across Ontario. Currently, there are 23 resource centres, providing training, consultation services, print and electronic resources, referrals, network building opportunities and referral to health practitioners in public health units, community health centres, other health organizations.

Environmental Health Services

West Nile Virus

The Ontario government continues its commitment to the surveillance, prevention and control of this virus. The Ministry’s WNV program budget totals approximately $20M, comprising cost-sharing of the 36 public health units’ WNV programs, labs, and the Ministry’s own public communication and education program. This substantial programming has been in place since
2003. While the Ministry is the lead on West Nile Virus for the government the support of provincial partners is extremely important. Ministries of Agriculture, Food and Rural Affairs, Environment, Natural Resources, and Transportation, and the Ontario Realty Corporation are in continual communication with the Health Units. Other active partners include the Canadian Public Health Agency; Health Canada’s First Nations and Inuit Health Services, the Canadian Cooperative Wildlife Health Centre and the Canadian Blood Services.

Through O. Reg. 199/03 (Control of West Nile Virus Regulation), the local Medical Officer of Health carries out a WNV risk assessment in the community, and upon determining those required activities (if any) to control WNV in the community, is empowered to require municipality to take the required actions.

**Safe Water**

The Safe Water Unit of the Ministry has responsibility for drinking water protection, and recreational water protection:

- To ensure the community drinking water systems meet the health-related chemical, physical, microbiological and radionuclide objectives as published in the Ontario Drinking Water Standards and the Guidelines for Canadian Drinking Water Quality.
- To reduce communicable disease transmission from waters used for bathing at public: pools, spas, whirlpools, hot tubs, wading pools, and beaches.

**Infectious Disease Control**

In response to a recommendation by the Expert Panel on SARS and Infectious Disease Control (the Walker Panel) the Ministry established the **Provincial Infectious Diseases Advisory Committee** (PIDAC) to provide a single standing source of expert advice on infectious diseases for Ontario.

PIDAC advises the Chief Medical Officer of Health (CMOH) on prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases. PIDAC provides the CMOH with advice on issues such as guidelines and best practices for infection control, protocols to prevent and control infectious diseases, and immunization programs.

PIDAC brings together a high level of expertise from relevant fields across Ontario’s healthcare sector, including respected experts in infection prevention and control, infectious diseases, medical microbiology, public health, epidemiology, and occupational health and safety.

**Vaccines**

Three new publicly funded vaccines – pneumococcal conjugate, meningococcal C-conjugate and varicella vaccines.
The program expansion began in July of 2004. The following is an outline of the eligible age and risk groups by vaccine:

**Pneumococcal Conjugate Vaccine:**
- Routine infant program for infants under 2 years of age, born on or after Jan. 1/04
- High-risk program expanded to children 24 to 59 months of age inclusive

**Meningococcal – C Conjugate Vaccine:**
- Routine infant program for 1-year-old infants born on or after Sept. 1/03
- Catch-up program for children 12 years of age (grade 7) and youth ages 15 to 19 years
- High-risk program for high-risk persons of all ages

**Varicella (Chicken Pox) Vaccine:**
- Routine infant program for 1-year-old infants born on or after Sept. 1/03
- Catch-up program for susceptible (who have not had chicken pox) children 5 years of age
- High-risk program for susceptible high-risk person of all ages

**Research Activity**

**Walkerton Health Effects Study**

The London Health Sciences Centre and McMaster University receive funding for research that study, reviews and makes a determination of the long-term health implications arising from the Walkerton *E.coli* outbreak. This study responds to the concerns of the people in Walkerton and the medical community about the implications of the outbreak. Some of the research questions that the study is exploring include:

- the long-term health implications as a result of the Walkerton outbreak;
- the physical and psycho-social impact of the outbreak;
- a prospective cohort study of the characterization and management of long-term medical complications resulting from *E.coli* infection;
- the incidence of, risk factors for, and genotypes associated with irritable bowel syndrome following bacterial gastroenteritis, as well as the effect of acute bacterial gastroenteritis on gut permeability;
- permeability.

**PHRED**

The Public Health Research, Education and Development (PHRED) program is funded by the Ministry on a cost-shared basis to support two areas important to the public health system:

- applied research in public health practice
leadership in the undergraduate and graduate education of future health and public health professionals.

Section 13: Mental Health

Mental Health – Number of Adults and Children Served

The 2005 Provincial Budget provided that community mental health services will be expanded to serve an additional 33,989 patients in 2005/06 - rising to 78,000 new patients annually by 2007-08 and include increased access to assertive community treatment, case management, crisis response and early intervention services. The Province will be providing $531.9M in 2005-06, growing to $627.1M in 2007-08, for these services.

In April 2004, the Ministry of Children and Youth Services (MCYS) became the lead ministry responsible for programs and services that serve children, youth, and their families. To aid in the delivery of more seamless, coordinated service, the Ministry of Health and Long-Term Care transferred 17 of its 21 hospital-based children’s mental health outpatient programs to the MCYS. In 2004-05, the MCYS invested $25M in 2004-05 in community-based children’s community mental health programs, growing to $38M by 2005-06. This has allowed the community-based children’s mental health sector to treat an additional 7,000 children per year.

Mental Health

Total 2005/06 funding for Mental Health is $1,488.7M (Community Mental Health $531.9M, Addictions $141.2M, Ontario Mental Health Foundation $0.4M, Specialty Psychiatric Hospitals $653.1M, Provincial Psychiatric Hospitals $161.8M, and Municipal Taxation-Psychiatric Hospitals $0.3M).

The government is investing $27.5 million annually in community mental health agencies across the province that will provide services to an additional 12,000 people. Mental health services will be provided to non-violent offenders. People with mental illness who commit serious crimes will continue to be prosecuted under the Criminal Code.

The investment, the first of its kind in Ontario, will be used to expand services in the five following key areas:

- Crisis response and outreach, to provide access to a range of services and supports on a 24/7 basis to individuals experiencing a mental health crisis.
- Short-term residential crisis support beds, which are often referred to as "safe beds," that can be used as an alternative to custody or hospital beds.
- Court support services, located in the courts, to assist with cases involving the mentally ill.
- Intensive case management, to identify and provide the services required to keep people in the community with adequate supports.
- Supportive housing services, which provide longer-term housing with mental health services.
Since 1995, there has been a 27% increase in the number of mentally ill people who have been admitted to correctional facilities in Ontario.

The $27.5 million is part of the government's $65 million increase in 2004/05 to improve access to services for people with mental illness, announced on June 14, 2004. This funding brings the government's total annual investment in community mental health to $531.9 million in 2005-06. The government will add another $95.2 million over the next few years, reaching $627.1 million annually by 2007/08.

**Community Support Investment**

Total 2005/06 funding for CSS is $295.4 million.

Total new funding contained in two announcements, is $30.5 million;

- $24.9 million for community support and assisted living services in supportive housing, announced July 19, 2005, and
- $5.6 million for acquired brain injury services announced July 29, 2005.

Community support services expanded through this initiative include adult day programs, meal programs, community transportation, homemaking and personal support services and special services persons who are deaf or blind or have sensory impairments and will serve over 9,000 additional clients.

Acquired Brain Injury service expansion will provide immediate support to 25 persons identified as being in urgent need and implement new services benefiting 136 new clients in Durham, Simcoe, Ottawa and the District of Cochrane.

$6 million from Ontario’s end-of-life strategy funding has been allocated for volunteer hospice and other Community Support Service agencies.

In January 2006, a 1.5% one-time increase to base funding for Elderly Persons Centres (EPC) was distributed as a Special Grant under Section 5 of the Elderly Persons Centres Act for the 2005/06 fiscal year.

**Section 14: Home and Community Care**

**Our Investment in Home Care**

- The total funding for home care services is $1.46 billion in 2005-06, increasing to $1.65 billion in 2007-08.
- In 2005-2006, $156.1 million net increase in funding for home care.
**Number of Clients Receiving Care**

It is expected that 45,100 additional acute hospital replacement clients will receive home care services in 2005-06 as a result of our investments.

- By 2007-08, enhancements to home care will provide an additional 95,700 acute hospital replacement Ontarians with care in their homes.
- Formal linkages between CCAC case management and Family Health Teams will help to avoid hospital admissions and improve health care management of mutual clients, especially those dealing with chronic illness.
- Joint initiative between Home Care and Community Support Branch and Hospitals Branch will orient more hospitalized patients with end-stage-renal disease and new to dialysis treatment, to in-home peritoneal dialysis instead of in-hospital hemodialysis.
- In 2005/06, in addition to the 45,100 acute hospital replacement clients, CCACs are relieving pressure on hospitals by taking 7,600 post-hospital hip and/or knee total joint replacement client referrals from hospitals.

**End-of-Life Care Strategy**

- On October 4, 2005 the government announced a $115.5 million investment over three years in the End-of-Life Care Strategy to improve care services at home and in the community by:
  - Funding CCACs to provide more and better end-of-life care, including nursing and personal support services for people in their own homes.
  - Funding support for nursing and personal support services in residential hospices will be available to over 30 communities by 2007-08. Residential hospices offer care, compassion and dignity to those who are in their last stages of life while providing needed support to their families.
  - Strengthening the role of hospice volunteers. Volunteers are trained and supervised by paid staff to provide emotional, social and spiritual support to individuals and their families.
  - Through Ontario’s End-of-Life Care Strategy, over 6,000 more Ontarians will receive compassionate, end-of-life care in their homes by 2007-08.
  - In 2005-06, $39 million in new funding will improve end-of-life care services that are provided at home and in the community, so an additional 4,300 adults and children can receive the care that they need.
  - The End-of-Life Care Strategy will help shift care of persons in last stages of life from hospitals to home or another appropriate setting of their choice; will enhance an interdisciplinary team approach to care in the community; and will work towards better coordination and integration of local services.
CCACs: Ratio between Not-for-Profit and Profit

Ratio of contracts as of August 24, 2004:

- A basic review was done approximately 8 years ago and it was then determined that there were 51% not-for-profit and 49% for-profit
- The Ministry last looked at this approximately 2 years ago and the numbers were inverted (49% not-for-profit and 51% for-profit)

CCAC: Review of Competitive Bidding Process

- On May 30, 2005, the government received the report by the Honourable Elinor Caplan, who was commissioned by the Ontario government to do an independent review of the competitive bidding process used by Community Care Access Centres (CCACs) to select home care providers.
- The Caplan report contains 70 recommendations on a range of issues related to the competitive bidding process including continuity and quality of care, better integration of home care in the health care system, research, accountability and workforce stability.
- On December 7, 2005, the ministry provided the CCACs with the Contract Management Guidelines to Resume the Competitive Procurement Process Used by Community Care Access Centres. The guidelines support continuity in home care services delivered to clients and provide directions to CCACs on the resumption of the procurement of client services and contract extensions where necessary. CCACs can extend contracts no later than March 31, 2010. However, contracts can be extended for services provided in schools to no later than June 30, 2010 to ensure continuity of services throughout the school year. During the review the competitive bidding process was only used when absolutely necessary. CCACs were requested to extend contracts where possible. CCACs are not expected to issue revised RFPs until the ministry has reviewed contract template documents.
- Currently the ministry is developing a plan to implement the report and the government plans to respond to the report shortly.

CCAC and Community Support Services (CSS): Diagnostic and Medical Equipment Fund

- On March 4, 2005, the government announced an investment of $9.1 million to purchase diagnostic medical equipment for clients accessing services through Community Care Access Centres (CCACs) and Community Support Services (CSS) around the province.
- The money was used to purchase medical equipment to assist people in their own homes, in supportive housing and adult day programs in the community.
- The equipment includes mechanical lifts, bathing equipment, intravenous and feeding pumps, as well as devices designed to increase mobility such as door openers and wheelchairs.
Section 15: Long-Term Care

Our Investment in LTC

- The 2005 Provincial Budget announced an investment in LTC homes of $2.75 billion in 2005/06. This represents a $264M increase over 2004/05 interim actuals which will fund improvements to the safety and quality care provided to residents, the opening of new LTC beds and a freeze in co-payment rates for the second year in a row. This fiscal year’s investment includes the announced increase to the Raw Food and Other Accommodation envelopes: as of July 1, 2005, funding to the Raw Food Envelope increased by $0.10 per resident/day, and an increase of $0.66 per resident/day for the Other Accommodation Envelope was also made.

The government is committed to:

- $191M over two years beginning in 2004/05 to hire 2000 new staff including at least 600 new nurses and ensure a higher standard of care, such as having around-the-clock, on-site registered nursing care, and offering residents two baths a week. The Alternative Level of Care (ALC) strategy is also supported by this funding (see ALC section below).
- $340 million over two years to support system growth.
- 700 new LTC beds will be open within the 2005/06 fiscal year.

Staffing Report

- To track the sector’s progress in meeting the target of 2000 new staff and other new resident care requirements, all LTC homes are required to complete a multi-phase staffing report.
- The 2000 new staff target will be met over a two-year period. The ministry is continuing to collect staffing information to track the sector’s progress in reaching the staffing target.

Status of 2000 New Staff

- Based on the data reported by 528 LTC homes (which represents about 90% of the sector), there were a total of 36,810 Full-Time Equivalent (FTE) staffing positions during the baseline period. The sector reported a total of 39,144 FTE staffing positions during Phase 3. This translates to an increase of 2334 FTEs, including an increase of 472 nursing FTE’s when Phase 3 (January to June 2005) is compared to Phase 1 baseline period (January to June 2004).

Alternative Levels of Care

- The Government is investing $42.8 million in its Alternative Levels of Care (ALC) strategy. The strategy incorporates three complementary programs:
  - the Interim LTC Bed Program: $19.25M to create up to 500 interim LTC beds for people who are waiting in hospital for a permanent LTC bed in their community.
o the New Convalescent Care Program: $11.7 million to establish up to 340 convalescent care beds in LTC homes for people who no longer need intensive hospital care but are not yet ready to return home.

o the High Intensity Needs Fund (HINF): $11.85 million to purchase equipment and supplies needs for the care of residents who require the highest levels of care in a LTC setting.

**Stabilization Factor Funding**

- The increase of $1.01 per diem stabilization factor funding—$0.92 in Nursing and Personal Care (NPC), and $0.09 in Program and Support Services (PSS)—to support care requirements, was implemented in August 2005 and is retroactive to April 1, 2005.

**Increase to the Accommodations Envelope**

- In July 2005, the per diems were increased for the Raw Food and Other Accommodations by $0.10 and $0.66 respectively.

**Resident Co-Payment Freeze**

- In July 2005, the resident co-payment freeze was extended for a second year until July 31, 2006.

**Diagnostic Medical Equipment and Patient Lifts**

- In 2005/2006, there has been an investment of $7.2M for diagnostic medical equipment in LTC Homes
- In 2004/05, the investment for diagnostic/medical equipment in LTC Homes was $38.8M.
- For fiscal year 2005/06, the amount for mechanical patient lifts is $29M for both hospitals and long-term care homes

**Physician On-Call Coverage**

- As of October 1, 2005, LTC homes are eligible to receive $100 per bed (with a minimum of $10,000 per home and a maximum of $30,000 per home) to support after-hours physician on-call coverage for LTC homes.

**LTC Home Reform Strategy**

- To improve the overall quality of life in long-term care homes, the Long-Term Care Home Reform Strategy supports:
  o a strong role for Family Councils and Resident Councils within LTC homes
  o making it easier for couples to live together in LTC homes
toughen enforcement by mandating reporting of suspected abuse, introducing whistleblower protection and targeted surprise inspections of homes with poor track records (all annual inspections are now unannounced)

strengthen accountability through a public website that provides information to seniors and their families about individual homes and their records of care. The ministry will also be kept accountable through the Staffing Report, which monitors the progress towards achieving staffing targets.

**Public Reporting**

- The public reporting website was first launched in Fall 2004
- The website was enhanced to identify ministry sanctions imposed on LTC homes, e.g. suspension of admissions, in real time.
- The reporting website can be accessed through the ministry’s website; while those without internet access can phone the LTC Action Line at 1-866-434-0144. The website is the first of its kind in Canada.
- The public reporting website was most recently updated in October 2005. Currently, the site reflects the record of care from April 1, 2004 to March 31, 2005.

**Seniors Health Research Transfer Network**

- In August 2005, the government invested $2.7 million to build a Seniors’ Health Research Transfer Network that will support putting health research into practice with all health care providers who work in geriatric care and involve front line providers in setting research priorities, and to hire eight regional coordinators to implement RNAO Best Practice Guidelines in LTC homes.

**New Regulations**

- New regulations took effect January 2005 including:
  - That a registered nurse who is a member of the regular nursing staff of the home be onsite 24 hours a day, seven days a week in LTC homes
  - That each resident be given at least two baths or showers per week
  - That all planned food menus and menu cycles must be reviewed and approved in writing by each home’s dietician at least once a year (effective January 1, 2005).

**Sector Communication**

- In addition to the “LTCH Program news” bulletin, which is sent monthly to the Regions and LTCH Branch, in October 2005, the ministry launched the first issue of the quarterly “Program Brief”. The “Program Brief” updates the sector on key developments affecting
LTC homes. The French version of these bulletins is distributed to homes that provide services in French.

Section 16: Pharmacare

The Ontario Drug Benefit (ODB) program provides coverage to the following eligible recipients with a valid Ontario Health Card:

- Ontario residents aged 65 and over,
- Ontario residents receiving social assistance (Ontario Disability Support Program and/or Ontario Works)
- Ontario residents receiving professional services under the Home Care Program,
- residents of homes for special care and long-term care facilities, and
- all other Ontario residents who have registered in the Trillium Drug Program (TDP). The TDP is intended to provide catastrophic drug coverage for those Ontario residents who have high out-of-pocket drug costs relative to their net household income.

In addition, certain high cost outpatient drugs used to treat specific diseases/conditions are covered under the Special Drugs Program (SDP).

The ODB program is funded by both the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services.

Under ODB, the government provides coverage for over 3,300 prescription drug products (including some nutrition products and diabetic testing agents) listed as benefits in the Ontario Drug Benefit Formulary/Comparative Drug Index (Formulary).

Section 17: Performance Indicators

Measuring Health System Performance


The Ontario Health Quality Council, one of the main components of the Commitment to the Future of Medicare Act, was launched on September 12, 2005. The Council is an independent body with the mandate to monitor Ontario’s health care system and report to the public on how well the health system is performing. The Council submitted its first yearly report (as required
under S.5 of the Act) to the Minister of Health and Long-Term Care on March 30, 2006. The Minister tabled the report in the Legislature on April 26, 2006.

In developing its first report, the Council examined indicators of health system performance from many sources. The Ministry of Health and Long-Term Care was a source for validated indicators linked to provincial strategic goals. The Ministry also contributed data and other information.

A copy of the report and more information about the Council and its mandate are available at [http://www.ohqc.ca](http://www.ohqc.ca).

**Measuring Wait Times Performance**

In *A 10-Year Plan to Strengthen Health Care*, the Federal-Provincial-Territorial Ministers of Health agreed to establish evidence-based benchmarks for medically acceptable wait times by December 31, 2005 starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration. The pan-Canadian benchmarks for selected procedures were announced on December 12, 2005. As a follow-up to this announcement, Minister George Smitherman announced Ontario-specific targets for each of the five service areas with priority levels and wait time targets for each level. This information is based on advice from five clinical expert panels, and from subsequent advice from the expert panel chairs on a common and consistent approach to priority levels and targets.

The table below highlights the targets that have been set.

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Pan-Canadian Benchmarks</th>
<th>Ontario’s targets (in weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td>N/A</td>
<td>P1: Immediate</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>PII: 2 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIII: 4 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIV: 12 weeks</td>
</tr>
<tr>
<td>Radiation</td>
<td>4 weeks of being ready to treat</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Cardiac Bypass Surgery</strong></td>
<td>N/A</td>
<td>P1: Immediate</td>
</tr>
<tr>
<td></td>
<td>Level 1: 2 weeks</td>
<td>PII: 2 weeks</td>
</tr>
<tr>
<td></td>
<td>Level 2: 6 weeks</td>
<td>PIII: 6 weeks</td>
</tr>
<tr>
<td></td>
<td>Level 3: 26 weeks</td>
<td>PIV: 26 weeks</td>
</tr>
<tr>
<td><strong>Cataract Surgery</strong></td>
<td>16 weeks for patients at risk (which correlates with Ontario's PIII priority rating)</td>
<td>P1: Immediate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PII: 6 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIII: 12 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIV: 26 weeks</td>
</tr>
<tr>
<td><strong>Hip &amp; Knee Surgery</strong></td>
<td>Hip fracture: 2 days</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Hip: 26 weeks Knee: 26 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>P1: Immediate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PII: 6 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIII: 12 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIV: 26 weeks</td>
</tr>
<tr>
<td><strong>Diagnostic Scans</strong></td>
<td>MRI</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P1: Immediate</td>
</tr>
<tr>
<td></td>
<td>CT</td>
<td>PII: 48 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIII: 2 - 10 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PIV: 4 weeks</td>
</tr>
</tbody>
</table>
The public can follow progress on wait times in Ontario by going to the Ontario government’s wait times website at www.ontariowaittimes.com.

This website allows Ontarians to get information on wait times for key surgical procedures at local hospitals, and to see whether a procedure is available sooner at other hospitals. It is also designed to help professionals set priorities based on patients’ needs.

*Measuring Hospital Performance in Ontario*

The Ministry of Health and Long-Term Care and the Ontario Hospital Association (OHA) jointly sponsor the *Hospital Report Card Series*. The primary goal of the hospital reports is to improve health care by annually measuring hospital performance. Hospital reports provide hospital administrators and planners with a valuable evaluation tool to guide their future decision-making and assist in improving hospital performance.

The hospital reports follow a balanced scorecard approach reporting on cost management, clinical outcomes, patient satisfaction and the impetus for change at the hospital and system level.

In 2005, Ontario produced hospital reports in the following areas:

- Acute Care
- Complex Continuing Care
- Emergency Department Care
- Rehabilitation Services

In July 2006, an Acute Care report was released.

Each report includes a Women’s Health Perspective section.

Copies of all reports are available at www.hospitalreport.ca

**Quebec**

**Political Representation**

- Premier: Jean Charest.
- *Ministre déléguée à la Protection de la jeunesse et à la Réadaptation*: Margaret F. Delisle.
- *Sous-ministre de la Santé et des Services sociaux*: Juan Roberto Iglesias.
Legislative Modifications

Bill 38, adopted in June 2005, confirmed the creation of the position of Commissaire à la santé et au bien-être. The appointee will hold this position for five years and be eligible for one subsequent reappointment. His or her primary role will be to report on the performance of the health and social services system and propose changes to improve the system’s effectiveness and efficiency.

Bill 112, also adopted in June 2005, modified the Tobacco Act and strengthened efforts to fight smoking, especially among youth. It contained several measures related to prohibiting smoking in public places or near health and social service establishments or educational institutions, exercising greater control over advertising by tobacco product manufacturers, and reducing young people’s access to these products.

A review of the Youth Protection Act, tabled in October 2005, was designed to bring the legislative framework into line with current practices and knowledge. The proposed changes focused on making the youth protection system more timely and providing children with greater stability while in care.

The adoption of Bill 83 in November 2005 brought significant changes in how Quebec health and social services are organized and administered. The new legislation modified the Act respecting health and social services and contained several measures designed to clarify the responsibilities of the various levels within the health and social services system and thereby facilitate the implementation of local health and social service networks. It was also designed to facilitate information flow in support of teamwork and the sharing of knowledge, and to establish mechanisms guaranteeing the quality of services.

The Politique du médicament was the subject of extensive consultations conducted by the Commission des affaires sociales, which centred on four main areas: the accessibility of pharmaceuticals, the setting of fair and reasonable prices, the optimal use of pharmaceuticals, and the maintenance of a dynamic Quebec pharmaceutical industry.

Financial Issues

The 2006-2007 budget, for the period April 1, 2006 to March 31, 2007, contains expenditures of $22.1 billion.


Governance and Management

The past year saw ongoing implementation of important changes introduced several years ago in the general organization of services. Several initiatives were put forward to strengthen frontline services, including the implementation of groupes de médecins de famille (GMF) (also ongoing).
The inauguration of réseaux locaux de services de santé et de services sociaux (RLSSSS) and the creation of réseaux universitaires intégrés de santé (RUIS) were two other important organizational changes that were introduced to better integrate and prioritize services.

These changes required the various stakeholders in the system to make major adjustments in their practices. Similarly, to achieve higher quality services, measures such as reforming the complaint system and strengthening establishments’ obligations with respect to the safe delivery of services were adopted. Over the past year, these new ways of doing business became better established.

The document “Garantir l’accès: un défi d’équité, d’efficience et de qualité” (February 2006) put forward for consultation three categories of potential solutions in the effort to achieve more efficient use of the resources invested in health and social services and in enhanced quality of life for people. The first category involved pursuing and strengthening measures in preventive, frontline, and medical and hospital services. This category also included other measures to enhance the quality of health and social services. The second category addressed the Supreme Court of Canada ruling in the Chaoulli-Zeliotis case and consisted primarily of guaranteeing public access to certain medical procedures and establishing a limited role for private insurance in the areas of hip and knee replacement surgeries and cataract surgery. The third category opened a debate on issues related to the longer-term funding of the health and social services sector within a broader debate on the future of our public finances. A parliamentary committee is holding public consultations on this document, which began in April 2006.

**Institutional Reform**

See the section “Governance and management.”

**Regionalization**

See the section “Governance and management.”

**Human Resources: Physicians**

Work to update the physician complement projection model was completed over the past year. The first projections were generated on the numbers of physicians that Quebec will have over the next 10 years. A net gain of approximately 3,000 new physicians is expected by 2015 (1,500 additional specialists and 1,500 additional general practitioners).

Over the past year, the process of reviewing the plans régionaux d’effectifs médicaux (PREMs) in specialties and general practice was completed. The 2006 PREMs have been in effect since December 1, 2005 for specialties, and they cover the period December 1, 2005 to November 30, 2006. The PREMs essentially consist of the plans d’effectifs médicaux par établissement (PEMs) for all specialties. Last year, the Comités techniques des Tables PREM-RUIS played a central role in developing the PREMs, since these committees were mandated to develop a priority
recruitment scenario for medical specialists for the year 2006, by RUIS territory. It was necessary to harmonize the proposals put forward by the RUISs and the Comité de gestion des effectifs médicaux spécialisés MSSS/FMSQ (COGEMS).

These plans set growth targets with respect to the number of medical specialists in intermediate and remote regions, especially in local specialties, and promote the recruitment of medical specialists by establishments experiencing chronic shortages of these physicians.

To achieve the objectives, the PREMs come with a series of management rules governing all physicians. These rules address issues such as physicians returning from regions, applications for exemptions, approval of applications for additional training, and the recruitment of foreign physicians by universities.

The PREMs in general practice were developed using a methodology that quantifies the need for general practitioners in each Quebec region. A gross increase of 358 physicians is expected, to be divided among the various regions. These plans have been in effect since December 1, 2005. They include targets for each Quebec region with respect to authorized gross increases in the numbers of general practitioners over the period December 1, 2005 to November 30, 2006.

Under the 2006 plans, 51% of the new physicians will be starting their practices, i.e. 96 of the 190 new physicians expected in intermediate and remote regions. The 2006 PREMs allow for up to 223 new physicians, since in intermediate and remote regions, the distinction between the targets by physician category (new physicians versus physicians already in practice) is not binding. Based on the available recruitment opportunities, an intermediate or remote region may shift the makeup of its targets (new physicians versus physicians already in practice). It may not, however, exceed its total authorized recruitment.

Agreements with Federations and Associations

Medical Specialists

The Accord-cadre of October 1, 1995, which was extended for a third time in March 2003, ran out on March 31, 2004. Since on April 1, 2006 the negotiating parties had not yet agreed on terms to renew this framework agreement, it was not possible to set the overall budget envelope for specialists’ remuneration for 2004-2005 and subsequent years.

In the spring of 2006, the parties agreed to amend the aforementioned Accord-cadre. These amendments involved the rules in the General Preamble on medicine and surgery, the rules in the surgery addendum, and some rules in a few specialties. A certain number of articles were deleted or modified and others were added. Just under 20 of the articles involved fee changes. A few mixed remuneration models for some specialties were modified. In addition, special remuneration conditions were agreed upon for medical specialists in emergency medicine.

Negotiations to renew the Accord-cadre were in process as of April 1, 2006. The FMSQ insisted on reaching agreement on correcting the discrepancies in remuneration between medical
specialists in Quebec and the other provinces before entering into discussions on renewal of the *Accord-cadre*.

**General Practitioners**

The general agreement with the *Fédération des médecins omnipraticiens du Québec* expired on March 31, 2004. Discussions took place with respect to extending this agreement through to March 31, 2010.

Amendments 89, 90, 91 and 93 (amendment 92 has not been finalized) primarily involve administrative modifications or documents that are already being implemented. However, some of these modifications are more significant.

Amendment 90 is primarily devoted to harmonizing some articles. In particular, it harmonizes the nomenclature in all articles involving the musculoskeletal system with the nomenclature in effect for medical specialists. This amendment also introduces modifications to the agreement governing the remuneration of general practitioners who deliver services in intensive care and coronary care units. These modifications mean that, in the busiest units, a mixed remuneration mode, i.e. a daily flat rate and a percentage of fee-for-services, may apply.

In addition, a new special agreement on networked clinics has been in effect since June 1, 2005. This agreement provides monetary incentives for private clinics, and in some cases CLSCs, to be designated by health and social service boards (one clinic per 50,000 people, on average). These clinics provide expanded access to walk-in diagnostic and medical services that are available over extended operating hours and are linked to the usual attending physicians.

**Mixed remuneration mode and percentage of physicians not receiving fee-for-service remuneration**

Over the period October 1, 2004 to September 30, 2005, 3,272 medical specialists were remunerated based on the mixed remuneration mode.

Remuneration other than fee-for-service represented 28% and 22% of the amounts paid to medical specialists and general practitioners, respectively. These data are for the period October 1, 2004 to September 30, 2005.
## Makeup of Quebec Physician Complement - As of September 31, 2005, by Specialty

<table>
<thead>
<tr>
<th>Province of Quebec</th>
<th>Number of physicians September 2005*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPECIALTY</strong></td>
<td></td>
</tr>
<tr>
<td>General practice</td>
<td>7462</td>
</tr>
<tr>
<td>Allergy and clinical immunology</td>
<td>51</td>
</tr>
<tr>
<td>Pathology</td>
<td>191</td>
</tr>
<tr>
<td>Anesthesia-Resuscitation</td>
<td>583</td>
</tr>
<tr>
<td>Medical microbiology and infectious disease</td>
<td>155</td>
</tr>
<tr>
<td>Medical biochemistry</td>
<td>50</td>
</tr>
<tr>
<td>Cardiology</td>
<td>389</td>
</tr>
<tr>
<td>General surgery</td>
<td>498</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>299</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>96</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>60</td>
</tr>
<tr>
<td>Dermatology</td>
<td>179</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>178</td>
</tr>
<tr>
<td>Obstetrics-Gynecology</td>
<td>394</td>
</tr>
<tr>
<td>Hematology and medical oncology</td>
<td>210</td>
</tr>
<tr>
<td>Community health</td>
<td>134</td>
</tr>
<tr>
<td>Respirology</td>
<td>196</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>379</td>
</tr>
<tr>
<td>Physiatry</td>
<td>72</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>56</td>
</tr>
<tr>
<td>Neurology</td>
<td>216</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>277</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td>184</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>549</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1043</td>
</tr>
<tr>
<td>Diagnostic radiology</td>
<td>534</td>
</tr>
<tr>
<td>Radio-Oncology</td>
<td>67</td>
</tr>
<tr>
<td>Urology</td>
<td>150</td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>88</td>
</tr>
<tr>
<td>Nephrology</td>
<td>145</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>133</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>83</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>50</td>
</tr>
<tr>
<td>Neuropathology</td>
<td>0</td>
</tr>
<tr>
<td>Medical genetics</td>
<td>23</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sub-total for specialties</strong></td>
<td>7712</td>
</tr>
<tr>
<td><strong>Total physicians</strong></td>
<td>15174</td>
</tr>
</tbody>
</table>

*Source: Ministère de la Santé et des Services sociaux*

*Physicians who have billed a minimum of $5,500 during the quarter in question. They are assigned to the regions from which they obtained the major part of their remuneration.*
Human Resources: Paramedical Professionals

On April 5, 2006, the Conseil des ministres adopted a health workforce renewal strategy. A monitoring committee was established, chaired by the ministère de la Santé et des Services sociaux (MSSS) and made up of representatives from the ministère de l’Éducation, ministère du Loisir et du Sport, ministère de l’Emploi et de la Solidarité sociale, ministère de l’Immigration et des Communautés culturelles, Secrétariat du Conseil du trésor, and Office des professions du Québec.

The Act amending the Act respecting health and social services and other legislative provisions (Bill 83), adopted in November 2005, required agencies to develop three-year workforce plans.

An order-in-council on the working conditions of salaried employees in the health care system, adopted in December 2005, contained special provisions on recruitment and retention and on skills development.

The Nursing Workforce

As of March 31, 2005, Quebec had 39,229 nurses (full-time equivalent—FTE—of 32,591), 12,364 nurses with bachelors degrees (FTE of 10,531), 13,148 licensed practical nurses (LPN) (FTE of 10,721) and 34,893 Patient Service Associates (FTE of 26,800).

An overview and an update concerning the nursing workforce forecast were prepared and presented to the Forum sur la planification de la main-d’œuvre (PMO) infirmière on February 11, 2005. A meeting involving the Forum sur la PMO infirmière and other workforce planning groups in nursing and cardio-respiratory care is scheduled for September 2006. This will provide an opportunity to advance the implementation of the action plan.

There are currently 16 specialized nurse practitioners working in the system as candidates, and 10 nurses are completing their end-of-program placements. According to the workforce planning, 75 nurse practitioners will be added by 2010.

Health Information

Establishment and renewal of advisory committees

Several committees have continued their work, including:

- The Comité national permanent sur la sécurité et la protection des renseignements personnels, which focuses on the security and protection of personal information;
- The Comité de coordination et de concertation des ressources informationnelles. This committee, established in March 2002, constitutes an MSSS-Sogique inter-regional coordination and cooperation mechanism for implementing the Ministry’s information resource priorities;
• The Comité aviseur des ressources informationnelles du réseau sociosanitaire. This committee brings together representatives of professional associations, establishment associations, and other organizations heavily involved in the information sector;

• The Comité exécutif des ressources informationnelles. This committee, which reports to the ministère de la Santé et des Services sociaux through the sous-ministre adjointe à la Direction générale de la planification stratégique, de l’évaluation et de la gestion de l’information, is comprised of representatives of the main public players involved in implementing the computerization plan;

• The Comité de gestion du Fonds d’investissement pour l’informatisation des réseaux locaux de service (RLS).

Other committees have been created, namely:

• The Quebec-CIHI Committee, comprised of MSSS and Canadian Institute for Health Information representatives;

• The Comité sur l’optimisation des ressources informationnelles. This committee brings together MSSS, RAMQ, SOGIQUE and agency representatives. The goal of the optimization process is to improve the effectiveness of hardware and software infrastructure, to increase the robustness and availability of the infrastructure, and to generate quantifiable short- and long-term benefits.

In addition, the makeup and the mandate of the Comité sur la normalisation were determined, and its agency representatives were selected based on specific fields: security, clinical systems, computing and networking, and the financial aspect.

A forum promoting application of the ITIL methodology (Information technology infra-structure library) was also created.

Activities

Bill 83, adopted by the Assemblée nationale du Québec on November 25, 2005, contained legislative measures that modified the rules governing the sharing of health information and made provision for the creation of regional information retention services. Work is underway to implement these services.

• Other activities were performed or are ongoing, namely:

• Adoption by the Conseil des ministres on March 22, 2006 of a report on governance and the funding of the health and social services system computerization plan;

• Adoption of work to establish an overall architecture for information resources in the health and social services sector;

• Approval of the Plan intégré des ressources informationnelles en santé publique (PIRISP);

• Development by health and social service agencies of strategic information technology plans that dovetail with regional clinical projects and the system information technology plan;
• Development with the Canada Health Infoway (CHI) of 12 collaborative agreements;
• Identification of a series of priority ministry projects involving cooperation with the Canadian Institute for Health Information (CIHI);
• Ongoing evaluation of development alternatives for the Réseau de télécommunication sociosanitaire (RTSS) and enhancement of the videoconferencing service;
• Development of the Info-santé program, based on ministerial guidelines, with respect to the centralization of services in regional centres, telephone services, IT solutions and software upgrades, the addition of Info-social (social service) and Info-médicaments (medication) services, and the standardization of some clinical tools;
• Selection and funding of projects by the fonds d’investissement partagé (MSSS-system) for the computerization of the réseaux locaux de services (RLS);
• Ongoing work to implement the Cadre global de gestion des actifs informationnels, which addresses information security within health and social service agencies.

Systems

Of note in this area:
• Implementation of the technology infrastructure required to deploy a master patient index;
• Preparation of implementation of the ICD-10-CA (International Classification of Diseases, version 10, Canada) and CCI (Canadian Classification of Interventions) classifications for the Med-Echo information system;
• Acquisition of an IT application required to integrate a Santé-Société-Mieux-être component into the government portal;
• Development of influenza pandemic information systems.

Overview of major upcoming projects

Work with the Health Infoway is continuing on the following projects:
• Quebec interoperable electronic health record;
• Systems related to pharmaceuticals, diagnostic imaging and laboratories;
• Health professional directory and user directory;
• Tele-health;
• Public health.

A call for tenders was issued to acquire combined e-services, known as the Couche d’accès à l’information de santé (CAIS).

A call for tenders was issued to select a client evaluation tool. This tool is one of the elements in the information system supporting the Réseau de services intégrés aux personnes âgées.
**Tele-Medicine**

*Creation or renewal of advisory committees*

The tele-health sectoral group involving the RUISs and the MSSS is meeting regularly. Each RUIS has established a tele-health roundtable and related support team.

The MSSS has mandated the RUISs to develop tele-health activities within their territories. Each RUIS has devised a tele-health activity development plan tailored to the territory it serves. These plans have been submitted to the MSSS.

*Overview of main activities and systems*

The MSSS submitted eight tele-health projects for co-funding from the Canada Health Infoway (CHI). The primary goal of these projects was to set up networks across Quebec in the fields of remote consultation, tele-training, tele-pathology and tele-homecare. These would be designed to update and expand the current infrastructure and put new clinical processes in place.

In addition to these major projects, several other tele-health activities are underway in Quebec. One of the many fields involved is tele-consultation via videoconference; this is being applied in a number of medical specialties such as psychiatry, genetics, general practice, nephrology and rehabilitation. Other more specific applications allow remote consultations and diagnoses to take place, primarily in pediatric cardiology, tele-speech language pathology and tele-pathology, not to mention tele-home monitoring. The videoconferencing network also allows tele-training to take place in a number of remote establishments.

The MSSS has also mandated the RUISs, through their tele-health roundtable, to manage the digital radiology projects and archiving strategy (PACS project) throughout their territories. These projects, conducted jointly with Health Infoway, are underway in the four RUISs. They will allow tele-radiology to be performed, i.e. remote reading of images in regions that lack radiologists.

Quebec is also involved in work to establish a computerized reservation tool for tele-health sessions. Canada Health Infoway is coordinating the activities related to this Canada-wide project.

*Overview of major upcoming projects*

In coming months, most efforts will focus on completing tele-health and diagnostic imaging projects with the Canada Health Infoway.

**Primary Care Initiatives**

Accessibility is a major concern, especially with respect to frontline care, and this has driven the implementation of *groupes de médecine familiale* (GMF) and the development of networked
clinics in the Montreal region. After agreement with the Fédération des médecins omnipraticiens du Québec (FMOQ), these medical clinics will be tailored to the characteristics of urban medical practice and will meet the need to provide the public with more comprehensive medical services and extended operating hours.

Community Health Initiatives

A report by the directeur national de santé publique on Quebeckers’ state of health, entitled Produire la santé, was made public in April 2005. This report drew a portrait of health in Quebec and pointed the way to better health by outlining the most pressing preventable health problems and, especially, how to prevent them more effectively.

A report on nosocomial infections, written by Léonard Aucoin and published in June 2005, recommended several measures to improve the prevention and control of nosocomial infections, i.e. infections transmitted in care settings. One of the recommendations was that every establishment set up an infection control committee.

In June 2005, the government adopted Bill 112, which modified the Tobacco Act and strengthened efforts to fight smoking, especially among youth. It contained several measures related to prohibiting smoking in public places or near health and social service establishments or educational institutions, exercising greater control over advertising by tobacco product manufacturers, and reducing young people’s access to these products.

A report entitled L’amélioration des saines habitudes de vie chez les jeunes, submitted by Jean Perrault, Chair of the Équipe de travail pour mobiliser les efforts en prévention, was released in September 2005. He put forward a preventive approach to health among the youth, especially with respect to nutrition and physical activity.

The Plan québécois de lutte à une pandémie d’influenza was made public in March 2006. It contained 24 strategies and a series of concrete activities to be implemented at the provincial level. The regional health and social service boards will produce their Plan régional de lutte à une pandémie d’influenza so as to coordinate efforts in each region. Finally, on the local level, each establishment will prepare its specific plan in accordance with its mission. The national plan is based on five major components: public health, physical health, psychosocial intervention, communication, and the maintenance of services. The groups of players identified in the plan include the public, caregivers, and the various stakeholders and decision makers (especially elected officials). It contains measures to maintain the system’s services, primarily through the use of relief staff (retired people, new graduates, students, etc.) and volunteers.
Population Health Initiatives

First Nations

In May 2005, an agreement on health and social services reached under the Paix des Braves was signed with the Grand Council of the Crees. This agreement will see the annual operating budget of the Cree Board of Health and Social Services of James Bay increase by $40 million over five years, which will allow the health provisions contained in the James Bay and Northern Quebec Agreement to be implemented. The additional funding will be used to strengthen prevention efforts and core services within the various First Nations’ communities.

Youth

A review of the Youth Protection Act, tabled in October 2005, was designed to bring the legislative framework into line with current practices and knowledge. The proposed changes focused on making the youth protection system more timely and providing children with greater stability while in care.

The 2e Colloque sur la maltraitance envers les enfants et les adolescents — Contrer la maltraitance: un défi de société was held on October 24 and 25, 2005. It gave all stakeholders in the various sectors the opportunity to meet and discuss the issue of child abuse and thereby improve their practices and approaches.

Seniors

In September 2005, the Forum franco-québécois sur le vieillissement et la santé was held in Quebec City. This major event on aging brought together approximately three hundred experts and guests representing various sectors of society in France and Quebec. It was an ideal opportunity to analyse some preconceived ideas about aging, discuss the underlying assumptions, and generate new ideas on these issues.

In November 2005, the plan d’action 2005-2010 sur les services aux aînés en perte d’autonomie was launched. Under the theme Un défi de solidarité, this plan contains potential solutions addressing the major, guiding principles governing a person’s freedom of choice, the desire to allow people to remain in the community, caregiver support, the availability of information, and service delivery that is based on people’s real needs rather than being linked to a particular care setting.

Women’s health

This year, women’s shelters, which serve women who are victims of marital violence and their children, will receive funding of $3 million (annualized at $5 million), and women’s centres will receive financial assistance of $1.5 million (annualized at $2.5 million). Total funding of $49 million will be provided. There are currently 122 women’s centres in Quebec.
Addiction

The Plan d’action interministériel en toxicomanie 2006-2011 was also made public in March 2006. The Ministry coordinated the work that led to completion of this plan, in collaboration with the following entities: the ministère de l’Éducation; ministère du Loisir et du Sport; ministère de la Justice; ministère de la Sécurité publique; ministère de l’Emploi et de la Solidarité sociale; ministère de la Famille, des Aînés et de la Condition féminine; ministère de l’Immigration et des Communautés culturelles; Secrétariat à la jeunesse; Secrétariat aux affaires autochtones; Société d’assurance automobile du Québec; and Comité permanent de lutte à la toxicomanie. The plan proposes 41 joint measures designed to prevent, reduce and treat addictions within Quebec society.

Mental Health Initiatives

The plan d’action en santé mentale 2005-2010 was made public in June 2005. Entitled La force des liens, it strives to give Quebec an efficient mental health system that acknowledges the role of users and provides access to treatment and support services for children, youth, and adults of all ages with mental health problems and for people at risk of suicide.

Home Care Initiatives

An investment of $15 million was made in April 2005 in support of the Politique de soutien à domicile. This amount will allow materials to be purchased for use with the various groups of people receiving home support services.

Long-Term Care Initiatives

An investment of $16.9 million was made in August 2005 for the construction and renovation of long-term care residences.

Medical Insurance Initiatives

After extensive consultations conducted by the Commission des affaires sociales, Bill 130, designed to amend and enhance the current Act respecting prescription drug insurance, was tabled in November 2005.

Other Health Systems Initiatives

The Comité de travail sur la pérennité du système de santé et des services sociaux, chaired by Jacques Ménard, published its report in July 2005. This process was part of a larger debate around the long-term improvement and maintenance of a health and social services system that is accessible to all. The Ménard report draws a portrait of Quebec’s demographic situation and the
growth of health-related costs, then proposes various measures, including the creation of an insurance plan against loss of independence, and highlights the contribution that the private sector could make to the Quebec health care system.

The *Bilan des progrès accomplis à l’égard de l’entente bilatérale intervenue à l’issue de la rencontre fédérale-provinciale territoriale des premiers ministres sur la santé de septembre 2004* was published in October 2005. This report summarizes the progress made in the wake of the bilateral agreement entitled *Asymetrical Federalism that Respects Québec’s Jurisdiction*, under which Quebec will implement its own wait time reduction plan, based on its own objectives, standards and criteria, and the Government of Quebec will report to Quebeckers on the results obtained. The Quebec government summary primarily addresses wait times reductions, access enhancements, health human resources, primary care reform, pharmaceuticals, and public health.

Prepared by Claude Bégin
*Direction générale adjointe de la planification stratégique* - DGPSEGI
June 26, 2006

**Quebec**

**LA REPRÉSENTATION POLITIQUE**

- Parti libéral, élu en avril 2003.
- Premier ministre : monsieur Jean Charest.
- Ministre de la Santé et des Services sociaux : monsieur Philippe Couillard.
- Ministre déléguée à la Protection de la jeunesse et à la Réadaptation : madame Margaret F. Delisle.
- Sous-ministre de la Santé et des Services sociaux : monsieur Juan Roberto Iglesias.

**LES MODIFICATIONS LÉGISLATIVES**

Le projet de loi n° 38 a été adopté en juin 2005, confirmant la création du poste de Commissaire à la santé et au bien-être, qui sera nommé pour cinq ans, renouvelable une fois. Son rôle majeur sera de faire rapport sur la performance du système de santé et de services sociaux, tout en proposant des changements susceptibles d’en améliorer l’efficacité et l’efficience.

Le projet de loi n° 112 a également été adopté en juin 2005, apportant ainsi des modifications à la Loi sur le tabac qui intensifient la lutte contre le tabagisme, notamment auprès des jeunes. Il comprend plusieurs mesures qui concernent l’interdiction de fumer dans les lieux publics ou à proximité des établissements de santé et de services sociaux ou de maisons d’enseignement,
l’exercice d’un meilleur contrôle de la publicité par les fabricants des produits du tabac et la réduction de l’accès des jeunes à ces produits.

Le projet de révision de la Loi de la protection de la jeunesse, déposé en octobre 2005, propose des ajustements du cadre législatif aux pratiques et aux connaissances d’aujourd’hui. Les modifications visent notamment à améliorer la rapidité d’action du système de protection de la jeunesse et à assurer une plus grande stabilité aux enfants placés.

L’adoption du projet de loi no 83, en novembre 2005, marque une étape importante dans l’organisation et l’administration des soins de santé et des services sociaux au Québec. La nouvelle loi modifie la Loi sur la santé et les services sociaux. Elle permet d’instaurer plusieurs mesures visant à clarifier les responsabilités des différents paliers du réseau de la santé et des services sociaux en soutien à la mise en place des réseaux locaux de santé et de services sociaux. Elle vise à permettre également une circulation de l’information favorisant le travail d’équipe et le partage des connaissances, ainsi qu’à mettre en place des mécanismes devant garantir la qualité des services.

Le projet de Politique du médicament a été soumis à une vaste consultation à la Commission des affaires sociales. Il se déploie autour de quatre grands axes : l’accessibilité des médicaments, l’établissement d’un prix juste et raisonnable, l’usage optimal du médicament et le maintien au Québec d’une industrie pharmaceutique dynamique.

**LES QUESTIONS FINANCIÈRES**

Le budget de dépenses 2006-2007 portant sur la période s’étendant du 1er avril 2006 au 31 mars 2007, s’établit à 22,1 milliards de dollars.

Les dépenses gouvernementales, pour 2004-2005, dans le domaine de la santé et des services sociaux s’élèvent à 20,1 milliards de dollars alors que les dépenses probables pour l’exercice 2005-2006 devraient totaliser 20,1 milliards de dollars.

**LA GOUVERNE ET LA GESTION**

Au cours de la dernière année, les changements importants qui avaient été initiés il y a quelques années en ce qui a trait à l’organisation générale des services se sont poursuivis. Plusieurs initiatives ont été mises de l’avant pour renforcer les services de première ligne, dont la mise en place des groupes de médecine de famille (GMF) qui s’est poursuivie.

L’instauration des réseaux locaux de services de santé et de services sociaux (RLSSSS) et la création des réseaux universitaires intégrés de santé (RUIS) sont deux autres importantes modifications d’organisation de services qui avaient pour objectif de mieux intégrer et hiérarchiser les services.

Ces changements demandent une grande adaptation dans les pratiques de la part des différents intervenants du réseau. De même, pour assurer une qualité accrue des services, des mesures ont
été adoptées, telles la réforme du système des plaintes ou encore le resserrement des obligations des établissements quant à la prestation sécuritaire des services. Ainsi, la dernière année a permis de mieux ancrer ces nouvelles façons de faire.

Le document « Garantir l’accès : un défi d’équité, d’efficience et de qualité » (février 2006) soumet à la consultation trois ordres de solutions dans la recherche d’une plus grande efficience des ressources investies en santé et services sociaux et d’une meilleure qualité de vie des citoyens. La première piste de solution se rapporte à la consolidation et à la poursuite des actions en services préventifs, en services de première ligne et en services médicaux et hospitaliers ; d’autres actions s’ajoutent également afin de rehausser la qualité des services de santé et des services sociaux. La deuxième apporte une réponse au jugement de la Cour suprême du Canada dans l’affaire Chaoulli – Zeliotis et prend la forme, principalement, d’une garantie d’accès publique pour certaines procédures médicales et de l’ouverture limitée à l’assurance privée pour les chirurgies de remplacement de la hanche, du genou et de la cataracte. La troisième piste de solution ouvre un questionnement sur les enjeux liés au financement à plus long terme du secteur de la santé et des services sociaux, dans la perspective d’un plus vaste débat sur l’avenir de nos finances publiques. Ce document fait l’objet d’une consultation publique en commission parlementaire, qui a débuté en avril 2006.

**LA RÉFORME INSTITUTIONNELLE**

Voir la section « Gouverne et gestion ».

**LA RÉGIONALISATION**

Voir la section « Gouverne et gestion ».

**LES RESSOURCES HUMAINES : MÉDECINS**

Les travaux de mise à jour du modèle de projection de l’effectif médical ont été complétés au cours de la dernière année. Les premières simulations de projection du nombre de médecins dont disposera le Québec au cours des 10 prochaines années sont terminées. On entrevoit disposer d’un ajout net d’environ 3 000 nouveaux médecins d’ici 2015 (1 500 spécialistes de plus et 1 500 omnipraticiens de plus).

Au cours de la dernière année, l’exercice de révision des plans régionaux d’effectifs médicaux (PREM) en spécialité et en omnipraticie a été complété. En spécialité, le PREM 2006 est en vigueur depuis le 1er décembre 2005. Il couvre la période s’échelonnant du 1er décembre 2005 au 30 novembre 2006. Le PREM est essentiellement constitué des plans d’effectifs médicaux par établissement (PEM) pour toutes les spécialités. Cette année, les Comités techniques des Tables PREM-RUIS ont joué un rôle de premier plan dans la détermination des PREM puisqu’elles se sont vues confier le mandat d’élaborer un scénario de recrutements prioritaires de médecins spécialistes pour l’année 2006 par territoire de RUIS. Une réconciliation des propositions RUIS et de celles du Comité de gestion des effectifs médicaux spécialisés MSSS/FMSQ (COGEMS) a été nécessaire.
Ce plan fixe des cibles d’objectifs de croissance soutenant l’installation de médecins spécialistes en régions éloignées et intermédiaires, particulièrement dans les spécialités locales, et favorise le recrutement de médecins spécialistes dans les établissements connaissant une pénurie chronique de ces médecins.

Afin d’atteindre les objectifs, un ensemble de règles de gestion régissant tous les médecins accompagne ce PREM. Ces règles concernent, entre autres, les médecins de retour de régions, les demandes de dérogation, les approbations de demandes de formation complémentaire ainsi que le recrutement des médecins sélectionnés à l’étranger par les milieux universitaires.

Les PREM en omnipraticque ont été obtenus à partir d’une méthodologie qui permet de quantifier les besoins de médecins omnipraticiens pour chacune des régions du Québec. On prévoit la répartition de 358 ajouts bruts entre les différentes régions du Québec. Ce plan est en vigueur depuis le 1er décembre 2005 ; il indique à chacune des régions du Québec les cibles régionales d’ajouts bruts autorisés de médecins omnipraticiens pour la période s’échelonnant du 1er décembre 2005 au 30 novembre 2006. Le plan 2006 prévoit une installation de 51 % des nouveaux médecins en début de pratique, soit 96 des 190 nouveaux médecins attendus dans les régions intermédiaires et éloignées. Notons que le PREM 2006 permet d’accueillir jusqu’à 223 nouveaux facturants puisqu’en régions intermédiaires et éloignées la distinction des cibles, selon la catégorie de médecins (nouveaux médecins ou médecins déjà en exercice), est donnée à titre indicatif. En fonction des opportunités de recrutement qui s’offrent à elle, une région intermédiaire ou éloignée peut modifier la composition de ses cibles (nouveaux médecins ou médecins déjà en exercice) sans toutefois dépasser le recrutement total autorisé.

Les accords et les ententes avec les fédérations et les associations Les médecins spécialistes


Les négociations pour le renouvellement de l’Accord-cadre étaient en cours au 1er avril 2006. La FMSQ tenait absolument à conclure une entente sur la correction des écarts de rémunération constatés entre les médecins spécialistes du Québec et ceux des autres provinces avant d’entamer les discussions sur le renouvellement de l’Accord-cadre.
**Les médecins omnipraticiens**


Les amendements n°s 89, 90, 91 et 93 (l’amendement n° 92 n’est pas finalisé) comportent surtout des modifications administratives ou ayant trait à des documents déjà en application. Toutefois, certaines de ces modifications sont plus significatives.

L’amendement n° 90 est consacré principalement à l’harmonisation de certains actes dont tous ceux relatifs au système musculo-squelettique avec la nomenclature en vigueur pour les médecins spécialistes. Il introduit également des modifications à l’entente qui couvre la rémunération des médecins omnipraticiens pratiquant dans les unités de soins intensifs et coronariens ; ces modifications permettront, dans les unités les plus lourdes, une rémunération selon un mode mixte à savoir un forfait quotidien plus un pourcentage des actes posés.

De plus, une nouvelle entente particulière sur les cliniques-réseau est en vigueur depuis le 1er juin 2005. Cette entente prévoit des incitatifs monétaires pour les cliniques privées et exceptionnellement les CLSC désignés par les agences de santé et de services sociaux (en moyenne une clinique pour 50 000 personnes). Elles offrent une accessibilité accrue aux services diagnostiques et médicaux sans rendez-vous, selon des horaires étendus, en lien avec les médecins traitants habituels.

**Le mode de rémunération mixte et le pourcentage de médecins non payés à l’acte**

Au cours de la période s’échelonnant du 1er octobre 2004 au 30 septembre 2005, 3272 médecins spécialistes ont été rémunérés en fonction du mode mixte.

La rémunération autre qu’à l’acte représente respectivement 28 % et 22 % des montants versés aux médecins spécialistes et omnipraticiens. Ces données s’appliquent à la période du 1er octobre 2004 au 30 septembre 2005.
### Répartition des effectifs médicaux du Québec
#### au 31 septembre 2005 selon les spécialités

<table>
<thead>
<tr>
<th>Province de Québec</th>
<th>Nombre de médecins sept 2005*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omnipratiche</td>
<td>7462</td>
</tr>
<tr>
<td>Allergie et immunologie clinique</td>
<td>51</td>
</tr>
<tr>
<td>Anatomopathologie</td>
<td>191</td>
</tr>
<tr>
<td>Anesthésie-Réanimation</td>
<td>583</td>
</tr>
<tr>
<td>Microbiologie médicale et infectiologie</td>
<td>155</td>
</tr>
<tr>
<td>Biochimie médicale</td>
<td>50</td>
</tr>
<tr>
<td>Cardiologie</td>
<td>389</td>
</tr>
<tr>
<td>Chirurgie générale</td>
<td>498</td>
</tr>
<tr>
<td>Chirurgie orthopédique</td>
<td>299</td>
</tr>
<tr>
<td>Chirurgie plastique</td>
<td>96</td>
</tr>
<tr>
<td>Chirurgie cardiaque</td>
<td>60</td>
</tr>
<tr>
<td>Dermatologie</td>
<td>179</td>
</tr>
<tr>
<td>Gastro-Entérologie</td>
<td>178</td>
</tr>
<tr>
<td>Obstétrique-Gynécologie</td>
<td>394</td>
</tr>
<tr>
<td>Hématologie et oncologie médicale</td>
<td>210</td>
</tr>
<tr>
<td>Santé Communautaire</td>
<td>134</td>
</tr>
<tr>
<td>Pneumologie</td>
<td>196</td>
</tr>
<tr>
<td>Médecine interne</td>
<td>379</td>
</tr>
<tr>
<td>Physiatrie</td>
<td>72</td>
</tr>
<tr>
<td>Neurochirurgie</td>
<td>56</td>
</tr>
<tr>
<td>Neurologie</td>
<td>216</td>
</tr>
<tr>
<td>Ophtalmologie</td>
<td>277</td>
</tr>
<tr>
<td>Oto-Rhino-Laryngologie</td>
<td>184</td>
</tr>
<tr>
<td>Pédiatrie</td>
<td>549</td>
</tr>
<tr>
<td>Psychiatrie</td>
<td>1043</td>
</tr>
<tr>
<td>Radiologie diagnostique</td>
<td>534</td>
</tr>
<tr>
<td>Radio-Oncologie</td>
<td>67</td>
</tr>
<tr>
<td>Urologie</td>
<td>150</td>
</tr>
<tr>
<td>Médecine nucléaire</td>
<td>88</td>
</tr>
<tr>
<td>Néphrologie</td>
<td>145</td>
</tr>
<tr>
<td>Endocrinologie</td>
<td>133</td>
</tr>
<tr>
<td>Rhumatologie</td>
<td>83</td>
</tr>
<tr>
<td>Gériatrie</td>
<td>50</td>
</tr>
<tr>
<td>Neuro-pathologie</td>
<td>0</td>
</tr>
<tr>
<td>Génétique médicale</td>
<td>23</td>
</tr>
<tr>
<td>Médecine d’urgence</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sous-total des spécialités</strong></td>
<td><strong>7712</strong></td>
</tr>
<tr>
<td><strong>Total des médecins</strong></td>
<td><strong>15174</strong></td>
</tr>
</tbody>
</table>

**Source : Ministère de la Santé et des Services sociaux**

* Les effectifs correspondent au nombre de médecins ayant eu une facturation minimale de 5 500 $ durant le trimestre visé. Ces effectifs sont attribués à la région où ils ont obtenu la majorité de leur rémunération.
LES RESSOURCES HUMAINES : PROFESSIONNELSS PARAMEDICAUX


L’adoption, en novembre 2005, de la Loi modifiant la Loi sur les services de santé et les services sociaux et d’autres dispositions législatives (loi no 83) crée l’obligation pour les agences de réaliser un plan triennal pour la planification de la main-d’œuvre.


La main-d’œuvre infirmière

On dénombrait, au 31 mars 2005, 39 229 infirmières (équivalent temps plein – ETC de 32 591), 12 364 infirmières bachelières (ETC de 10 531), 13 148 infirmières auxiliaires (ETC de 10 721) et 34 893 préposés aux bénéficiaires (ETC de 26 800).


Actuellement, 16 infirmières praticiennes spécialisées sont en poste dans le réseau à titre de candidates et 10 infirmières sont en stage de fin de programme. La planification de la main-d’œuvre prévoit introduire 75 infirmières praticiennes d’ici 2010.

L’INFORMATION SUR LA SANTÉ

La création ou le renouvellement des comités consultatifs

Plusieurs comités ont poursuivi leurs travaux, notamment :

- le Comité national permanent sur la sécurité et la protection des renseignements personnels, au chapitre de la sécurité et de la protection de ces derniers ;
- le Comité de coordination et de concertation des ressources informationnelles. Ce Comité, mis en place en mars 2002, constitue un mécanisme de coordination et de concertation interrégionale MSSS-Sogique pour actualiser la mise en œuvre des priorités ministérielles en ressources informationnelles ;
• le Comité aviseur des ressources informationnelles du réseau sociosanitaire. Ce Comité regroupe des représentants d’associations professionnelles, d’associations d’établissements et d’autres organisations spécialement concernées par le sujet ;
• le Comité exécutif des ressources informationnelles. Ce Comité, sous la responsabilité de la sous-ministre adjointe à la Direction générale de la planification stratégique, de l’évaluation et de la gestion de l’information au MSSS, regroupe les représentants des principaux acteurs publics impliqués dans la réalisation du plan d’informatisation;
• le Comité de gestion du Fonds d’investissement pour l’informatisation des réseaux locaux de service (RLS).

D’autres comités ont été créés, notamment :

• le Comité Québec – ICIS, réunissant des représentants du MSSS et de l’Institut canadien d’information sur la santé;
• Le Comité sur l’optimisation des ressources informationnelles. Ce Comité regroupe des représentants du MSSS, de la RAMQ, de la SOGIQUE et des agences. La démarche d’optimisation a pour but d’améliorer l’efficacité des infrastructures matérielles et logicielles, d’accroître la robustesse et la disponibilité des infrastructures et de dégager des bénéfices quantifiables à court et moyen terme.

Par ailleurs, la composition et le mandat du Comité sur la normalisation ont été adoptés et on y a désigné des représentants d’agences, en fonction de volets spécifiques : la sécurité, les systèmes cliniques, l’informatique et la réseautique, ainsi que l’aspect financier.

On a également procédé à la création d’un Forum pour favoriser l’application de la méthodologie ITIL (Information technology infra-structure library).

Les activités

Le projet de loi no 83 adopté par l’Assemblée nationale du Québec le 25 novembre 2005 envisage des dispositions législatives modifiant les règles sur la circulation de l’information sur la santé et prévoit notamment la création de services régionaux de conservation. Des travaux sont en cours afin d’assurer la mise en œuvre de ces services.

D’autres activités ont été mises en place ou se poursuivent, notamment :

• l’adoption par le Conseil des ministres, le 22 mars 2006, d’un mémoire portant sur la gouvernance et le financement du plan d’informatisation du réseau de la santé et des services sociaux ;
• l’adoption des travaux de mise en place d’une architecture d’ensemble pour les ressources informationnelles du secteur sociosanitaire;
• l’approbation du Plan intégré des ressources informationnelles en santé publique (PIRISP) ;
• la préparation par les agences de santé et de services sociaux des plans stratégiques d’informatisation arrimés aux projets cliniques régionaux et au plan d’informatisation du réseau;
• la préparation avec Inforoute Santé Canada (ISC) d’une douzaine d’ententes de collaboration;
• la définition d’une grille des projets ministériels prioritaires impliquant une collaboration avec l’Institut canadien d’information sur la santé (ICIS);
• la poursuite de l’évaluation d’alternatives d’évolution du Réseau de télécommunication sociosanitaire (RTSS) et le rehaussement du service de visioconférence ;
• une évolution d’Info-santé, à la suite des orientations ministérielles, au sujet de la centralisation des services dans des centres régionaux, une mise à niveau en ce qui a trait à la téléphonie et à l’application informatique, l’ajout des services Info-social et Info-médicaments et la standardisation de certains outils cliniques ;
• la sélection et le financement de projets par le fonds d’investissement partagé (MSSS-réseau) pour l’informatisation des réseaux locaux de services (RLS) ;
• la poursuite des travaux de mise en vigueur du Cadre global de gestion des actifs informationnels portant sur la sécurité relevant des organismes du réseau de la santé et des services sociaux (RSSS).

Les systèmes

On note à ce chapitre :
• la mise en place de l’infrastructure technologique requise pour le déploiement d’un index patient maître;
• la préparation de l’implantation des classifications CIM-10-CA (Classification internationale des maladies, version 10, Canada) et CCI (Classification canadienne des interventions) pour le système d’information Med-Écho;
• l’acquisition d’une application informatique pour l’intégration d’un volet Santé-Société-Mieux-être au portail gouvernemental;
• le développement des systèmes d’information en lien avec la pandémie d’influenza.

Un aperçu des principaux projets à venir

Les travaux se poursuivent en collaboration avec l’ISC sur les projets suivants:
• le dossier de santé électronique interopérable du Québec;
• les systèmes relatifs aux médicaments, à l’imagerie diagnostique et aux laboratoires;
• le répertoire des intervenants et le répertoire des usagers;
• la télésanté;
• la santé publique.

Un appel d’offre a été lancé pour l’acquisition de services électroniques regroupés sous l’appellation de Couche d’accès à l’information de santé (CAIS).
Il y a eu appel d’offre pour le choix d’un outil d’évaluation de la clientèle. Cet outil est un des éléments du système d’information du Réseau de services intégrés aux personnes âgées.

**LA TÉLÉMÉDECINE**

*La Création ou le renouvellement des comités consultatifs*

La table sectorielle télésanté réunissant les RUIS et le MSSS se réunit régulièrement. Dans chaque RUIS, une table télésanté a été créée et une équipe a été mise en place pour lui apporter son soutien.

Le MSSS a confié aux RUIS le mandat de développer les activités de télésanté sur leur territoire. Chacun des RUIS a élaboré un plan de développement des activités de télésanté en relation avec son territoire de desserte. Ces plans ont été déposés au MSSS.

*Un aperçu des activités et des systèmes principaux*

Le MSSS a présenté huit projets de télésanté pour le cofinancement d’Inforoute Santé du Canada (ISC). Ces projets ont pour but principal de mettre en place des réseaux de consultation à distance, de téléformation, de télépathologie et de télésioins à domicile sur l’ensemble du territoire québécois. Ils visent la mise à jour du parc actuel d’équipement et son extension ainsi que la mise en place de nouveaux processus cliniques.

Mis à part ces projets d’envergure, plusieurs activités de télésanté sont en cours au Québec. Les domaines d’application sont multiples : téléconsultation par visioconférence dans de nombreuses spécialités médicales telles que la psychiatrie, la génétique, la médecine générale, la néphrologie et la réadaptation. D’autres applications plus spécifiques permettent des consultations et des diagnostics à distance, principalement en cardiologie pédiatrique, en téloorthophonie, en télépathologie, sans oublier la télésurveillance à domicile. Le réseau de visioconférence permet également la téléformation dans de nombreux établissements éloignés.

Le MSSS a également confié aux RUIS, par l’entremise de leur table télésanté, le mandat de gérer des projets de radiologie numérique et de stratégie d’archivage (projet PACS) pour l’ensemble de leur territoire. Ces projets sont en cours dans les quatre RUIS, en collaboration avec ISC. Ils rendront possible la téléradiologie, c’est-à-dire la lecture d’image à distance pour les régions dépourvues de radiologistes.

Le Québec participe également aux travaux pour la mise en place d’un outil de réservation informatisé pour les séances de télésanté. ISC coordonne les activités relatives à ce projet pancanadien.
Un aperçu des principaux projets à venir

Dans les prochains mois, la majorité des efforts seront mis sur la réalisation des projets de télésanté et d’imagerie diagnostique avec Inforoute Santé du Canada.

LES INITIATIVES EN SOINS PRIMAIRE

L’accessibilité est au cœur des préoccupations, notamment pour les soins de première ligne et elle a donné lieu à la poursuite de l’implantation des groupes de médecine familiale (GMF) de même qu’au développement de cliniques-réseau dans la région montréalaise. Après entente avec la Fédération des médecins omnipraticiens du Québec (FMOQ), ces cliniques médicales permettront de répondre à la fois aux caractéristiques de la pratique médicale urbaine et à la nécessité d’offrir aux citoyens un accès à des services médicaux plus complets sur des plages horaires étendues.

LES INITIATIVES EN SANTÉ COMMUNAUTAIRE

Le rapport du directeur national de santé publique sur l’état de santé de la population du Québec « Produire la santé » a été publié en avril 2005. Ce rapport dresse le portrait de la société québécoise en matière de santé et fournit des clés pour qu’elle puisse jouir d’une meilleure santé, en décrivant les problèmes évitables les plus criants auxquels elle doit faire face et, surtout, en expliquant comment mieux les prévenir.

Le rapport sur les infections nosocomiales, présidé par M. Léonard Aucoin et publié en juin 2005, recommande plusieurs mesures visant à améliorer la prévention et le contrôle des infections nosocomiales, c’est-à-dire celles qui se transmettent en milieu de soins. Parmi celles-ci, on propose qu’un comité de prévention des infections soit mis en place dans chaque établissement.

Le gouvernement a adopté en juin 2005 le projet de loi no 112, apportant ainsi des modifications à la Loi sur le tabac qui intensifient la lutte contre le tabagisme, notamment auprès des jeunes. Il comprend plusieurs mesures qui concernent l’interdiction de fumer dans les lieux publics ou à proximité des établissements de santé et de services sociaux ou de maisons d’enseignement, l’exercice d’un meilleur contrôle de la publicité par les fabricants des produits du tabac et la réduction de l’accès des jeunes à ces produits.


Le plan québécois de lutte à une pandémie d’influenza a été rendu public en mars 2006. Il présente vingt-quatre stratégies et une série d’activités concrètes à réaliser au niveau provincial. Les agences régionales de la santé et des services sociaux produiront ensuite leur Plan régional de lutte à une pandémie d’influenza pour coordonner les activités dans chaque région. Enfin, au plan local, chaque établissement préparera son plan spécifique en accord avec sa mission. Le plan
national se déploie selon cinq grands volets : la santé publique, la santé physique, l’intervention psychosociale, la communication et le maintien des services. Les groupes d’acteurs définis au plan sont les citoyens, les aidants naturels, les divers intervenants et les décideurs, dont les élus au premier chef. Il prévoit des modalités pour assurer le maintien des services du réseau, notamment par le recours à du personnel de relève (retraités, nouveaux diplômés, étudiants, etc.) et à des bénévoles.

LES INITIATIVES TOUCHANT LA SANTÉ DE LA POPULATION

Les autochtones

En mai 2005, une entente sur les soins de santé et les services sociaux, dans la foulée de la Paix des Braves, a été signée avec le Grand Conseil des Cris. Ainsi, le budget annuel de fonctionnement du Conseil cri de la santé et des services sociaux de la Baie-James augmentera de 40 millions de dollars en cinq ans. Cette entente permettra la mise en œuvre des dispositions relatives à la santé de la Convention de la Baie-James et du Nord québécois et les sommes additionnelles investies seront utiles pour renforcer les activités de prévention et les services de base à l’intérieur des différentes communautés autochtones.

Les jeunes

Le projet de révision de la Loi de la protection de la jeunesse, déposé en octobre 2005, propose des ajustements du cadre législatif aux pratiques et aux connaissances d’aujourd’hui. Les modifications visent notamment à améliorer la rapidité d’action du système de protection de la jeunesse et à assurer une plus grande stabilité aux enfants placés.


Les personnes âgées

En septembre 2005 s’est tenu à Québec le Forum franco-québécois sur le vieillissement et la santé. Cet événement d’envergure a regroupé environ trois cents experts et invités représentant différents secteurs des sociétés françaises et québécoises. Il a donné une occasion privilégiée d’analyser certaines idées préconçues quant aux réalités liées au vieillissement, de débattre de leurs fondements et de dégager des idées nouvelles sur ces questions.

En novembre 2005, le plan d’action 2005-2010 sur les services aux aînés en perte d’autonomie a été lancé. Sous le thème « Un défi de solidarité », le plan présente des pistes d’action en relation avec les grands principes directeurs prévoyant le respect de la liberté de choisir de la personne, la volonté de permettre le maintien dans la communauté, la solidarité à l’égard de la personne proche aidante, la disponibilité de l’information et une prestation de services fondée sur les besoins réels des personnes, plutôt que d’être liés à un milieu de soins en particulier.
La santé des femmes

Les maisons d’hébergement pour les femmes victimes de violence conjugale et leurs enfants recevront en cours d’année une somme de 3 millions de dollars, annualisée à 5 millions de dollars et une aide financière de 1,5 millions de dollars, annualisée à 2,5 millions de dollars est allouée aux centres de femmes. Le financement qui leur est accordé totalisera 49 millions de dollars. Il existe actuellement 122 centres de femmes au Québec.

La toxicomanie

Le plan d’action interministériel en toxicomanie 2006-2011 a été également rendu public en mars 2006. Le Ministère a coordonné les travaux menant à la réalisation de ce plan, en collaboration avec les ministères de l’Éducation, du Loisir et du Sport; de la Justice ; de la Sécurité publique ; de l’Emploi et de la Solidarité sociale ; de la Famille, des Aînés et de la Condition féminine ; de l’Immigration et des Communautés culturelles ; le Secrétariat à la jeunesse ; le Secrétariat aux affaires autochtones ; la Société de l’assurance automobile du Québec et le Comité permanent de lutte à la toxicomanie. Il propose 41 actions concertées visant à prévenir, à réduire et à traiter la toxicomanie au sein de la société québécoise.

LES INITIATIVES EN SANTÉ MENTALE

Le plan d’action en santé mentale 2005-2010 a été rendu public en juin 2005. Intitulé « La force des liens », il vise à doter le Québec d’un système efficient de santé mentale qui reconnait le rôle des personnes utilisatrices et qui offre l’accès à des services de traitement et de soutien pour les enfants, les jeunes et les adultes de tout âge ayant un trouble mental, ainsi que pour les personnes présentant un risque suicidaire.

LES INITIATIVES LIÉES AUX SOINS À DOMICILE

Un investissement de 15 millions de dollars a été accordé en avril 2005 dans le cadre de l’application de la Politique de soutien à domicile. Ce montant permettra l’achat de matériel utilisé auprès des différents groupes de personnes qui bénéficient de services de soutien à domicile.

LES INITIATIVES EN SOINS DE LONGUE DURÉE

Un investissement de 16,9 millions de dollars a été accordé en août 2005 pour la construction et le réaménagement de résidences dédiées à l’hébergement de longue durée.

LES INITIATIVES LIÉES À L’ASSURANCE MÉDICAMENTS
À la suite d’une vaste consultation à la Commission des affaires sociales, le projet de loi n° 130 a été déposé en novembre 2005, visant à modifier et à bonifier l’actuelle Loi sur l’assurance médicaments.

**LES AUTRERS INITIATIVES DU SYSTÈME DE SANTÉ**

Le Comité de travail sur la pérennité du système de santé et de services sociaux, présidé par M. Jacques Ménard, a publié son rapport en juillet 2005. Cette démarche s’inscrit dans le grand débat qui vise à améliorer et à maintenir à long terme notre système de soins de santé et de services sociaux accessible à tous. Le rapport Ménard brosse d’abord un portrait de la situation démographique du Québec et de la croissance des coûts liés à la santé. Ensuite il propose différentes mesures dont la création d’un régime d’assurance contre la perte d’autonomie et souligne l’apport que pourrait apporter le secteur privé dans le système de santé québécois.


Préparé par Claude Bégin  
Direction générale adjointe de la planification stratégique - DGPSEGI  
Le 26 juin 2006
New Brunswick

Political

- Progressive Conservatives re-elected June 9, 1993.
- Liberal party member for Saint John Harbour, elected in November 14, 2005 Bi-Election.
- Premier Bernard Lord.
- Minister of Health and Wellness, Elvy Robichaud. As of February 14, 2006, Minister of Health (and Attorney General), Brad Green, Q.C.
- Deputy Minister of Health and Wellness, Nora Kelly. As of February 14, 2006, Deputy Minister of Health, Nora Kelly.
- Family medicine is most often provided through privately owned physicians’ offices; eligible services are funded through Medicare. Some services are also provided in the private offices of other health professionals. There are no current plans to expand the range of privately provided services.

Legislative

- An Act Respecting Mental Health and Public Health Services was proclaimed on November 28, 2005 (respecting the transfer of public health services and mental health services to the eight Regional Health Authorities).
- An amendment to the Podiatry Act was passed on June 30, 2005.

Fiscal

- The budget allocated for the Department of Health and Wellness in 2005-2006 is $1.77 B, up 10.2% from the $1.61 B of 2004-2005. Within this overall budget, funding for Hospital Services rose by 11.1%, Medicare rose by 7.5% and the Prescription Drug Program rose by 8.0%.

Governance and Management

- Effective November 28, 2005, the formal governance structure for the Department of Health and Wellness changed, in accordance with the provisions of the Regional Health Authorities Act (2002), respecting the transfer of Public Health and Mental Health Services to the Regional Health Authorities. Mental Health and Public Health programs and services were transferred from the Department of Health and Wellness to the Regional Health Authorities on November 28, 2005. The Department will continue to fund, monitor and audit these programs and services devolved to the Regional Health Authorities.
- Effective February 14, 2006, the provincial government realigned the structure of government. The Department of Health and Wellness became the Department of Health. The Minister of Wellness, Culture and Sport is now responsible for wellness related initiatives.
• The Department of Health is responsible for policy (development and implementation), monitoring and evaluation, intergovernmental relations, funding, other functions (e.g. provincial drug plan, Medicare etc.) related to health and health care delivery.
  
o The Department of Health and Wellness hired co-CEOs in 2005 to lead a provincial Cancer Network in the development of a cancer strategy for New Brunswick.
  
o Regional Health Authorities are responsible for delivering Hospital Services (primary, secondary and tertiary care), Extra-Mural Program (in-home), and Addictions Services, and as of November 28, 2005, Public Health and Mental Health services.
    – Regional Health Authorities are answerable to government (Standing Committee on Crown Corporations) for their level and type of expenditures. Regional Health Authority boards have a combination of appointed and elected members.
    – Regional Health Authority Chief Executive Officers report to the Deputy Minister of Health.

• Since June 2004, the health system has been guided by “Healthy Futures: Securing New Brunswick’s Health Care System,” the Provincial Health Plan for the years 2004-2008.

• Regional Health Authorities developed three-year Regional Health and Business Plans, describing their planned activities, and how these support the priorities in the Provincial Health Plan.

Institutional Change/Reform

• See #1 and #6.

Regionalization

• The Lieutenant-Governor-in-Council proclaimed that November 28, 2005 was the effective date for An Act Respecting Mental Health and Public Health Services. Effective that date, 647 full time equivalents (FTEs), reflecting 240 FTEs and 407 FTEs for public health services and mental health services respectively, were transferred to the eight Regional Health Authorities.
Human Resources: Physicians

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Physicians with payments of $40,000/year or more, fiscal year 2004-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia</td>
<td>74</td>
</tr>
<tr>
<td>Dermatology</td>
<td>8</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>71</td>
</tr>
<tr>
<td>General Surgery</td>
<td>44</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>116</td>
</tr>
<tr>
<td>Neurology</td>
<td>11</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>7</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>41</td>
</tr>
<tr>
<td>Oncology</td>
<td>14</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>29</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>32</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>18</td>
</tr>
<tr>
<td>Pathology</td>
<td>43</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>44</td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>10</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>14</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>76</td>
</tr>
<tr>
<td>Urology</td>
<td>21</td>
</tr>
<tr>
<td>Vascular and Thoracic Surgery</td>
<td>12</td>
</tr>
<tr>
<td>General Practice</td>
<td>644</td>
</tr>
</tbody>
</table>

- In 2004-2005, 29% of all physicians who were paid $40,000 or more, received at least 51% of this pay through some mechanism, other than fee-for-service. It is expected that this percentage will rise over time.

- In July 2006, the Premier announced the opening of a distributed Medical Education Program. The Université de Sherbrooke will establish a satellite campus in Moncton New Brunswick. The program will be done in collaboration with the Université de Moncton and the various Regional Health Authorities. The first intake of 24 students will be in September 2006. The students would normally have gone to Sherbrooke, where the Province currently purchases the medical seats.

- In October 2006, the Premier also announced the development of a similar program for the city of Saint John. Discussions are underway with universities.

- As part of the Provincial Health Plan, new incentives were introduced to assist with recruitment and retention: bursaries for medical students, business grants and guaranteed minimum income for family practitioners who establish a practice in a designated area.

Human Resources: Non-Physicians
The 2002 study *Health Human Resources Supply and Demand Analysis* continues to inform New Brunswick’s health human resources strategy.

The provincial Health Human Resources Network continues to collaborate on regional and provincial recruitment and retention strategies.

In April 2005, the province announced an Allied Health Resource Strategy for New Brunswick designed to ensure New Brunswickers have access to appropriate health professionals to meet their health care needs.


Many of the initiatives of the Nursing Resource Strategy unveiled in April 2001 have been maintained, focusing on the recruitment and retention of nurses and licensed practical nurses, as well as their optimum utilization within the health care system.

Ninety-five (95) additional nursing university seats have being approved effective September 2005, as a means to prevent the foreseen nurse shortage.

New Brunswick has made great progress in retaining its nursing resources. In 2005, 86% of the new 2004 graduates re-registered in 2005.

Competitive employment benefits and a phased retirement program for nurses are important initiatives that will help attract candidates to the nursing profession, as well as keep experienced nurses in New Brunswick.

**Health Information**

New Brunswick continues to collect health information to support service planning and analysis, report to New Brunswickers, and fulfill intergovernmental commitments. New Brunswick issues an annual Health Care Report Card and a biannual report on comparable health and health system performance indicators.

Health information is periodically collected and released in issue-specific areas – recent reports include the *Research Project of Deaths by Suicide in New Brunswick between April 2002 and May 2003*, and the *External Review of New Brunswick Cardiac Services*.

**Health Technology**

Leadership for e-Health in New Brunswick comes from the Office of e-Health, a collaboration of the Department of Health and the eight Regional Health Authorities, with participation from the NB Medical Society and other key NB Government Departments. The Office of e-Health developed a comprehensive e-Health Strategy for New Brunswick which was approved in November 2005. This strategy identified five strategic directions:
o One Patient - One Record: An ongoing health care record of medical status and care delivery history that is available to authorized health care providers and to the individual, at any time and from any location.

o Telehealth: Bridging distances by bringing quality health services and information to patients who remain in or near their home communities.

o Clinical Systems Suite: Full suite of clinical systems for use by physicians and other care providers in day-to-day health care delivery.

o Administration and Accountability: Administrative systems to manage programs, and reporting systems to inform and explain how the health system is managed.

o Governance and Operating Structures: The work processes to manage the portfolio of development projects and systems.

Within those five directions, the strategy identifies eleven priority projects over the next six years:

1. Replacement of Medicare claims payment system
2. Replacement of the Hospital Information System at Atlantic Health Sciences Corporation
3. Implementation of a common Client Registry
4. Implementation of a Provider Registry
5. Implementation of a Drug Information System
6. Linking Hospital Information Systems through an Interoperability project
7. Implement a province-wide Diagnostic Imaging Archive
8. Implement a Surgical Access Management system
9. Replacement of Addictions Services Information System
10. Implementation of Health Surveillance systems for communicable disease
11. Evaluation of a Home Health Care Pilot project

Primary Care

- The range of primary health care services is governed/managed differently, depending on the service. Most fall under the oversight of Regional Health Authorities, while a major proportion of primary health care is also delivered in private physicians’ offices.

- Deriving its mandate from the Provincial Health Plan, the Primary Health Care Collaborative Committee has been formed to focus on a range of primary care issues, including addressing linkages between different aspects of primary health care, and considering a chronic care model for New Brunswick.

- Primary Health Care nurse practitioners are now part of the New Brunswick health care system. At the end of December 2005, 27 nurse practitioners were practising in various
primary health care settings: community health centres, family practices, emergency rooms and nursing homes.

- Consistent with the Provincial Health Plan, the government is supporting more community-based delivery models for primary health care, such as collaborative practices, and community health centres (CHC).
- One collaborative practice site has been opened.
- Five Community Health Centres were established with support from the Primary Health Care Transition Fund. Two more have since opened and a third is in planning. These sites are managed by the regional health authority.
- The Community Health Centres have a provincially approved framework and basket of services. This reflects a conceptual understanding of health, and recognizes the importance of population health in building healthy communities. The following components are core activities:
  - To enhance timely and appropriate access to primary health care services.
  - To ensure a strengthened role for the individual, family and community in health and health care delivery.
  - To develop linkages and collaboration among health services and with social and other community services.
  - To offer a comprehensive range of affordable and reliable primary health care services to a defined population based on their health needs.
  - To enhance the health status of communities through an increased emphasis on health promotion, disease and injury prevention and the management of chronic diseases in the community.
  - To establish an interdisciplinary approach to the delivery of primary health care services, so that the most appropriate service is provided by the most appropriate provider.
- The Collaborative Practice and the Community Health Centres are currently in the process of establishing an electronic patient record. The record is being coordinated provincially. Key next steps will be to:
  1) Maintain consistent implementations;
  2) Leverage work of other Regional Health Authorities (economy of effort);
  3) Support implementation within any future Community Health Centres.
- Nurse practitioners have been included in the service provider mix in the Community Health Centres and collaborative practices. As well, all health care providers are intended to work to full scope of practice within a collaborative and interdisciplinary care model.
- A training program, Building a Better Tomorrow, has been developed as part of an Atlantic multi-jurisdictional initiative. A series of training modules have been developed for health care providers working in Community Health Centres or collaborative practices, to enhance the effective implementation of a team approach in primary health care services. Currently being rolled out to all practice sites, the training has been well-received.
• There has been significant ongoing effort to develop and implement appropriate data collection and monitoring processes in all primary care sites to improve accountability and evaluation.

• There has been a commitment to involve key stakeholders in these initiatives. At the community level, all projects have community advisory committees. At the provincial level, there are ongoing, key steering committees that include government and regional health authority staff.

• The Community Health Centres and collaborative practices are funded within the global budget for the Regional Health Authorities. Most providers working within Community Health Centres are salaried under the Regional Health Authority (Doaktown).

• The bulk of primary care continues to be delivered by family physicians in private practice, under fee-for-service salary arrangements.

Community Health

• The Community Health Centres recognize the importance of community health in their framework and service delivery models. Work to address community health needs may be provided directly by the Community Health Centre or in partnership with other organizations or health care providers.

• See #11.

Population Health-Based Initiatives

Management/governance of Public Health programs and services in New Brunswick

• Public Health programs and services were transferred from the Department of Health and Wellness to the Regional Health Authorities in November 2005. The Department will continue to fund, monitor and audit the programs and services devolved to the Regional Health Authorities. The Medical Officers of Health will remain with the Department and will continue to be responsible to enact the Health Act and regulations. Environmental Health/Protection programs and services will remain within the Department.

Communicable Disease: Prevention, Management and Control

• By fiscal year 2005-06, children entering Grade 4 will have been vaccinated against hepatitis B as infants, and therefore the Grade 4 hepatitis B vaccine program that is now provided in schools will conclude.

• As part of the Department’s Provincial Health Plan, four new vaccines were incorporated into the routine childhood immunization schedule and the eligibility criteria for flu vaccine was expanded to include healthy infants, aged six to 23 months. Vaccines providing protection against chicken pox, meningococcal type C disease and whooping cough in adolescents were
introduced into the schedule, followed by a vaccine providing protection against invasive pneumococcal disease in January 2005.

- Planning for pandemic influenza is ongoing among the health care sectors and other sectors of business and society. Public Health has been working collaboratively with Regional Health Authorities and other stakeholders to develop plans in preparation for a pandemic at the local level. Departmental representatives have collaborated with the Public Health Agency of Canada, in the continued development of national and provincial plans. New Brunswick, along with all provinces and territories, as well as Health Canada, have participated in the purchase of a national stockpile of antiviral medication to be used, as per the nationally agreed upon priorities during the pandemic response.

**Environmental Health/Community Protection**

- There are two emerging zoonotic diseases of concern for New Brunswick– rabies and the mosquito borne West Nile virus.
- For the fourth year, wildlife rabies control measures were conducted, where cases of raccoon strain rabies had been detected previously. The department continued its rabies education and awareness campaign with pamphlets, radio and newspaper advertisements.
- Surveillance for West Nile virus focussed on testing wild birds and mosquitoes. The department continued the West Nile virus education and awareness campaign with pamphlets, radio and newspaper advertisements.

**Promotion of Health Lifestyles/Healthy Families**

- The Department of Health and Wellness recognizes the many benefits of breastfeeding, and promotes the Baby Friendly Initiative (BFI) within the province. BFI is a global initiative of the World Health Organization/UNICEF to promote, support and protect breastfeeding in hospitals and within communities. Public Health contributes to BFI by participating in the Provincial Breastfeeding Committee and Regional Committees.
- The Healthy Learners in School (high school pilot project) continued during the 2004-05 year in high schools in four districts, with efforts directed at the promotion of healthy lifestyles (stress reduction, physical activity and healthy eating), drug/tobacco use prevention/reduction, and sexual health.
- In October 2004, the province implemented the *Smoke-free Places Act* (SFPA). The legislation includes a complete ban on smoking in all enclosed public places and indoor workplaces in the province, with the exception of group living facilities and tourist accommodation facilities that can designate smoking rooms. The Act is enforced through a coordinated approach between Public Health Inspectors, Liquor License Inspectors, and Health and Safety Inspectors. A toll-free information line was established in mid-September 2005, which expanded to become a single entry point for people to report violations of the Act.

**Mental Health**
• See #6 and #15.

Home Care

• New Brunswick’s Extra Mural Program (EMP) provides comprehensive home health care services to all New Brunswickers in their homes and in their communities. The service is administered by the Regional Health Authorities following provincial standards and policies.

• Services are provided by physicians and EMP health professionals (nurses, dieticians, respiratory therapists, occupational therapists, physiotherapists, social workers and speech language pathologists).

• Under the auspices of the Provincial Health Plan, significant enhancements have been made to the EMP to enhance the provision of acute and palliative care services in the home. Enhancements have included funding for human resources and short-term personal support services. The Program is also piloting telemonitoring in the home, as a mechanism to improve service delivery for patients with chronic diseases and those that live in rural areas.

• Within Addiction and Mental Health Services, two home care initiatives were undertaken. The implementation of a provincial Telemental Health system will allow more individuals to receive psychiatric consultation within their home communities. As well, mobile crisis response services will be enhanced within three Regional Health Authorities. This will increase capacity to provide community-based interventions to consumers in crisis, effectively decreasing the need for hospitalization.

Long Term Care

• Long term care homes fall within the responsibility of New Brunswick’s Department of Family and Community Services.

Pharmacare

• The New Brunswick Prescription Drug Program (NBPDP) is a provincially-funded program which provides drug coverage to eligible New Brunswick residents. They include seniors who receive the Guaranteed Income Supplement, qualify through an income test, residents of nursing homes, clients of the Department of Family and Community Services, and others with certain medical conditions. Information regarding eligibility requirements for the various beneficiary groups and the list of drug benefits can be found at www.gnb.ca/0051/0212/index-e.asp

• The NBPDP budget increased from $132,003,000 in 2004/2005 to $142,600,000 in 2005/2006.

Other
The Provincial Health Plan provided a mandate for the establishment of four committees, to report to the Minister on health system issues.

- The Provincial Programs Steering Committee was established in 2004 to ensure New Brunswickers have access to specialized clinical programs, by ensuring full collaboration amongst Regional Health Authorities. This committee is chaired by the Minister of Health, and receives the reports of the following committees.

- The Patient Safety and Clinical Collaboration Committee was established in 2005, with a mandate to ensure New Brunswickers have access to safe, quality clinical programs in a timely manner. Representatives from all of the Regional Health Authorities and stakeholders are focusing on three areas: clinical programs; surgical access management; and best practices for patient safety.

- The Primary Health Care Collaborative Committee, as described in the section on primary health care was established in 2005 to develop and implement new ways of improving access and delivering primary health care to New Brunswickers.

- The Non Clinical Support Services Committee was established in 2005 with a mandate to review and recommend consolidation of appropriate Regional Health Authority non-clinical support services.

**Nova Scotia**

**Political**

- John Hamm, Progressive Conservative, Premier: August 16, 1999 – February 24, 2006
- Rodney MacDonald, Progressive Conservative, Premier: February 24, 2006-
- Election: June 13, 2006
- Angus MacIsaac, Minister of Health: August 2003 to February, 2006
- Chris A. d’Entremont, Minister of Health: February, 2006 -
- Rodney MacDonald, Minister of Health Promotion: December 19, 2002- February 2006
- Barry Barnet, Minister of Health Promotion and Protection: February 2006-
- Cheryl Doiron, Deputy Minister of Health: September 27, 2004-
- Robert C. Fowler, Acting Deputy Minister of Health Promotion and Protection: February 2006-
- Scott Logan, Assistant Deputy Minister of Health Promotion: December 2002- January, 2006
- Duff Montgomerie, Assistant Deputy Minister of Health Promotion and Protection: January 2006-
- The Department of Health does not fund privately owned and operated health care service delivery structures
**Legislative Changes**

- The Emergency Health Services Act, which came into effect on September 30, 2005, provides the regulatory framework for ambulance services, emergency health services, and related communication services.

- Passed in the Spring 2005 session of the Legislature, the Paramedics Act, regulating the practice of paramedicine in the province, will come into force when proclaimed by Government.

- The Involuntary Psychiatric Treatment Act was passed in the 2005 fall session of the Legislature. It will come into force when proclaimed by Government. The Act focuses primarily on processes for involuntary admissions and also includes provisions for leave certificates, community treatment orders, substitute decision making, and patient rights.

- The Optometry Act came into force on April 1, 2006. It replaces the former Optometry Act which regulated the practice of optometry.

- The Dispensing Opticians Act was passed in the 2005 fall session of the Legislature. It will come into force when proclaimed by Government. The Act replaces the current Dispensing Opticians Act which regulates the practice of dispensing opticians.

- Amendments to the Smoke-free Places Act were passed in the 2005 fall session of the Legislature. The Act will not come into force before December 1, 2006. The Act requires all indoor workplaces, all indoor public places, and all restaurant and bar patios to be smoke free. It does not permit designated smoking rooms in any of these locations with the exception of designated smoking rooms in facilities licensed under the Homes for Special Care Act and in hospital units for veterans.

- The Tobacco Damages and Health-care Costs Recovery Act was passed in the 2005 fall session of the Legislature. It will come into force when proclaimed by Government. The Act is similar to British Columbia’s legislation, which allows the Government to attempt to recover health care costs from the tobacco industry for tobacco related illnesses.

- The Health Protection Act came into force on November 1, 2005

**Updates or Reporting of New Advisory Committees/Working Groups**

The Health Professions Regulation Review Committee met for the first time in January 2006. This committee has a mandate to:

- Assess all new requests for self-regulation by health professions
- Assess all applications from professions which are currently self-governing to deregulate either in part or from all their professional regulations
- Provide appropriate written advice to the Deputy Minister and to the Minister regarding all regulation or deregulation requests, according to specific criteria
- Advise the Deputy Minister and the Minister on other issues relating to the regulation of health professionals, as directed
Consult with departmental programme directors, when requests impact on specific programme areas.

A Midwifery Legislation Committee was formed to enable work on midwifery legislation to proceed.

**Fiscal**

- The Department of Health’s budget for 2005-2006 exceeds $2.5 billion. The budget for 2004-2005 was approx. $2.38 billion.
- Nova Scotia spends approximately $2,500 a year on health care and related services for every man, woman and child in the province. Nova Scotia spends almost 46% of provincial government program spending on health care and related services. A major cost driver is the aging population, which increases expenditures on continuing care and pharmaceutical coverage.

**Governance and Management**

- The Department of Health is committed to the ongoing improvement of Nova Scotia’s health care system through planning, legislation, resource allocation, policy and standards development, evaluation and information management.
- District Health Authorities (DHAs) are responsible for governing, planning, managing, delivering, monitoring, evaluating and funding health services within each district and for providing planning support to the province’s 37 Community Health Boards (CHBs). Nova Scotia has 9 DHAs plus the Izaak Walton Killam Health Centre, which has its own board separate from Capital Health. DHAs are accountable to the Minister of Health.
- CHBs are responsible for the development of community health plans, which encompass primary health care, and for the identification of ways to improve the overall health of communities. CHBs are integral to planning and supporting the implementation of a community-based health care system that has primary health care as its foundation. Under the *Health Authorities Act*, CHBs are responsible for selecting two-thirds of the members of their respective DHAs. CHBs are accountable to their respective DHA.
- DHAs review and integrate community health plans received from their CHBs into their respective district health services business plans.

**Institutional Change/Reform**

In February 2006, the Premier, Rodney MacDonald, announced the creation of the Department of Health Promotion and Protection. Nova Scotia Health Promotion and Protection was formed from Nova Scotia Health Promotion, formerly the Office of Health Promotion, Public Health Branch of the Department of Health and the Office of the Chief Medical Officer of Health.
Nova Scotia Health Promotion and Protection’s chief business areas include:
  o Healthy eating
  o Healthy sexuality
  o Physical activity
  o Tobacco control
  o Injury prevention
  o Addictions
  o Chronic disease prevention
  o Health protection and public health
  o Communications and social marketing

**Regionalization**

Provincial programs address health issues across sectors of the health system that are beyond the mandate of any single DHA or health organization. They develop service standards, monitor their achievement, and provide advice to the Department of Health based on best practices, stakeholder input and research-based evidence.

Current Provincial Programs are:
  o Cancer Care Nova Scotia
  o Nova Scotia Diabetes Care Program
  o Reproductive Care of Nova Scotia
  o Nova Scotia Breast Screening Program
  o Cardiovascular Health Nova Scotia
  o Nova Scotia Provincial Blood Coordinating Program
  o Nova Scotia Hearing and Speech Program

- A comprehensive demonstration project involving acute and emergency care for, and the prevention and rehabilitation of stroke patients is being piloted by Southwest Nova District Health Authority.
- The Nova Scotia Breast Screening Program has several new fixed mammography sites
- Provincial Infection Control Consultant was hired to work with the District Health Authorities for the next three years

**Human Resources: Physicians**
The Master Agreement between Doctors Nova Scotia (formerly known as the Medical Society) and the NS Department of Health expires on March 31, 2008.

During the fiscal year, April 1, 2004 to March 31, 2005, there were 2,145 physicians registered with the MSI system providing clinical services in Nova Scotia. This represents an increase of 1.3% over the previous fiscal year (903 were GPs/Family Physicians and 1,242 were Specialists). This count includes all physicians with a payment during the fiscal year and is based on functional work distribution rather than licensed speciality.

Since 2000, there has been an increased number of physicians participating in both academic funding plans (AFPs) and community-based alternative payment plans (APPs). The numbers have increased by approx. 30% between 1997 and 2004/5.

Physician resource planning is ongoing to reinforce the efforts of the Department to recruit and retain physicians within the province, and the Maritime region. The Department of Health continues to work with key stakeholders to establish and oversee the processes supporting the development of a comprehensive physician resource plan. The main objectives of this work are to plan for the sustainability of physician resources, and to anticipate future changes that will have an impact on the need for or the availability of physicians.

Recruitment of physicians for the Clinical Assessment for Practice Program (CAPP) began during 2005. This program operated by the College of Physicians and Surgeons of Nova Scotia, in consultation with the Department of Health and Dalhousie Medical School, will assist in streamlining efforts to assess the qualifications of internationally trained specialists.

Policy development work is taking place in several key areas:

- A new framework for AFPs and APPs
- Managing "unattached" patients (patients without a family physician) in the hospital
- Physician on-call expectations, obligations and payments
- Core / foundational physician resources in regional hospital settings
- Ethics in international physician recruitment
- Provincial appeal mechanism
- Comprehensive locum policy

**Human Resources: Non Physician**

- Launched in 2001, Nova Scotia’s Nursing Strategy continues to make a positive contribution to nursing recruitment, retention and renewal throughout the province. It addresses nursing’s major challenges by providing a comprehensive, coordinated approach to continuing and specialty education, support for recruitment and orientation initiatives, appropriate workforce utilization, and improved quality of work life. By 2007, almost $60 million will have been invested in the Nursing Strategy.
• Data shows that the Nursing Strategy is successful. The overall number of employed nurses is higher than it was in 2001. Of these, significantly more nurses are employed in full-time permanent positions versus casual positions. Nova Scotia is currently retaining over 80% of its new graduates, 90% of whom have found full-time employment. In addition, the Strategy has provided financial support to over 213 nurses re-entering the profession, more than 50 of these in the last year. Since 2001, 398 nurses have accessed relocation allowances to work in Nova Scotia.

• Since 2003, government has invested $7.1 million to train an additional 240 nurses each year for four years. In 2005, a total of 238 nurses graduated from Dalhousie University, St Francis Xavier University, and their satellite campuses in Yarmouth and at Cape Breton University. In addition, 140 nurses graduated from the LPN program at the Nova Scotia Community College. The feasibility of further expansion of nursing seats, including the possibility of new education sites is being explored.

• Leadership development is a top priority for nursing. In 2004, a provincial working group was established to develop strategies to enhance nursing leadership development in Nova Scotia. In 2005-2006, the Department of Health will receive their report and recommendations, and will identify priorities for implementation.

• Recruitment and retention of nurses for rural and remote communities remains a priority. In May 2004, the Provincial Nursing Network released the report, *Rural and Remote Nursing – Recruitment and Retention in Nova Scotia*. The following priorities, aimed at sustaining the rural nursing workforce, were approved:
  o Development and implementation of a marketing strategy through partnerships between health providers, educational institutions and communities.
  o Support for employer initiatives to enhance quality of work life.
  o Support for leadership education for rural managers and nursing staff.
  o Monitoring and evaluating indicators that support planning for recruitment and retention of nurses in rural areas.

Implementation of these recommendations, in consultation with stakeholder groups, has begun and will continue into the next fiscal year. New opportunities to promote, support and enhance nursing in rural/remote areas are being explored. The Cooperative Learning Experience for BScN students is being expanded. It will fully fund all co-op placements and target long-term care and rural and remote communities for placements in 2005-2006.

• The current and future nursing shortage remains a primary concern. As 30% of Nova Scotia’s nurses near retirement, the retention of older nurses in the workforce is paramount. Government has been working closely with the Colleges of Registered Nurses and Licensed Practical Nurses of Nova Scotia to identify and make recommendations that will assist in the retention of late career nurses in the workforce. The report and recommendations of this committee is forthcoming.

• Health Human Resources Branch, Nova Scotia Department of Health completed an environmental scan of planning initiatives across health sectors, jurisdictions and professions. The scan is assisting in the identification of gaps in planning for health human resources at a
provincial, regional, national and international level. Planned initiatives for training and recruitment and retention to address the gaps include:

- Medical Laboratory Technologist education programme, beginning September 2007. The first class will graduate in 2009.
- Internationally Educated Health Professionals and International Medical Graduates Initiative, which provides recruitment and training opportunities, began January 2006. It will continue to 2010 and will increase the number of health care professionals immigrating to Nova Scotia.
- Return to Service bursaries for nurses, medical laboratory technicians, international medical graduates and other health professionals educated outside of Canada.

The Department of Health’s involvement in the Atlantic Health Education Training Study is ongoing in 2005. The Department also participates in the Atlantic Advisory Committee on Health Human Resources.

**Health Information/Technology**

In 2005, the Nova Scotia Minister of Health established the Wait Time Advisory Committee to oversee the province-wide collection and reporting of standardized wait time information and to offer advice on how to address bottlenecks in the system to shorten wait times. The Wait Time Advisory Committee is building on the work of the previous Wait Time Monitoring Steering Committee, which completed its work in 2004.

**The Nova Scotia Hospital Information System**

(NshIS) continues to be implemented across the province in District Health Authorities 1 - 8. The implementation is on target for completion in all 34 hospitals in these districts by March 31, 2006.

**Picture Archiving and Communications System**

PACS is a high-speed, graphical computer system that stores, retrieves and displays diagnostic images (such as MRI, CT scans, ultrasounds and X-rays). Enabled by Nova Scotia’s high-speed, provincial health data network, PACS can provide authorized health care providers with real-time access to diagnostic imaging reports and images across the province.

The Department in cooperation with DHAs 1 to 9 and the IWK, and with support from Canada Health Infoway, is enhancing and expanding the current provincial PACS environment including the capability to store images centrally in a provincial Diagnostic Image Archive. The planning phase is complete and implementation began April 1, 2005. The expected completion date is September 2006.

Client and Provider registries are foundation components of the Electronic Health Record.
The detailed Planning Phase for Client Registry started in December 2004 with completion in fall 2005. NS is currently participating in a study with Health Infostructure Atlantic (HIA) to identify Provider Registry collaboration options.

**Health Infostructure Atlantic**

The Secretariat Office has been in operation since May 2003 with approval from the Atlantic Premiers to continue operations until 2006 with the opportunity for a possible extension. The Secretariat, located in Halifax, has a mandate to coordinate and manage common health systems opportunities in Atlantic Canada. HIA is working on:

- Atlantic Diagnostic Imaging A6 (any report, any image, anytime, anywhere, any patient, in any Atlantic Province) Integration Strategy. The project will be completed between March and September 2005.
- Atlantic Provider Registry Business Case. The tentative timeline for completion of the Business Case is October 2005.
- Exploration of collaborative Atlantic opportunities with Infoway in the areas of Telehealth and Public Health Communicable Disease Surveillance and Management Systems.

**The Nova Scotia Telehealth Network (NSTHN)**

NSTHN is a video conferencing communications network, which provides services to 46 healthcare facilities in Nova Scotia. The NSTHN was Canada’s first province-wide Telehealth network. It works in collaboration with a number of partners including the District Health Authorities (DHAs) and the IWK Health Centre to provide health care services closer to home for patients and their families. One of the greatest benefits of the network is improving patient access to health care services close to their home. The network also provides health professionals from across Nova Scotia with access to educational opportunities in their own communities.

In 2005-2006, the Department of Health will be engaging its key stakeholders in the development of a road map for action to increase the utilization of Telehealth technologies to deliver health care services. This planning will involve identifying actions to increase utilization of the current hospital-based Telehealth network and identifying actions required to facilitate access to Telehealth technologies in home, long-term care, and other community settings. In addition, the particular needs of francophone communities and First Nations communities for access to Telehealth services will be examined.

**Primary Health Care Information System**

On March 17, 2005, the Department announced the vendor solutions and implementation phase for its Clinical and Practice Management Systems as part of Nova Scotia’s Primary Health Care Transition funding. A key goal of this project is to increase the use of electronic patient records
by primary health care organizations in the province. The Clinical and Practice Management Systems are important components of an electronic patient record.

The preferred vendor solutions are software packages that will allow primary health care providers to record their patient records electronically. This will improve integration, access, quality of care, and the security and privacy of primary health care information. The new systems will provide the capability for linkages to laboratory results, diagnostic imaging records, and hospital discharge summaries all within the electronic media. These linkages will be integrated to the new systems through the Interoperability Initiative.

District Health Authorities will receive funding until September 2006 to cover transition costs of primary health care organizations implementing electronic patient record systems through the Health Canada’s Primary Health Care Transition Fund.

The Primary Health Care Information System Program (PHCISP) will begin installation for qualifying clinic sites during Spring of 2005 and plans to have as many as 150 primary health care providers using the new systems by September 2006.

**Privacy**

The Department of Health is working in several key areas to protect the privacy of personal health information and ensure appropriate access to the information to support the provision of health care, research and planning. This work includes:

- Development and implementation of privacy standards for the Nova Scotia Hospital Information System and other health information systems
- Implementation of a Privacy Impact Assessment policy for Department of Health programs, services or systems that require personal information
- Stakeholder consultation for a health information privacy framework
- Leading the District Health Authorities and the Department of Health’s Provincial Programs in the development of privacy guidelines and best practices.

**Primary Care**

**Primary Health Care Renewal**

The Department is now building on the early work of the Strengthening Primary Care Initiative to develop and implement a community-based primary health care system for Nova Scotia based on a population health approach. The Advisory Committee on Primary Health Care Renewal (ACPHCR) was established in 2001 to advise the Department on the development of a community-based primary health care system. The direction outlined in the final report of ACPHCR was approved by the Department, and this direction now guides the work of District Health Authorities and the Department of Health in Primary Health Care Renewal. The ACPHCR has now evolved into the Primary Health Care Working Group.
$650,000 in funding was provided to support the formation of community-based collaborative primary health care teams. Funding was provided to District Health Authorities and to the Tui’kn initiative in Cape Breton to hire nurse practitioners

**Primary Health Care Transition Fund (PHCTF)**

In July 2002, the Department of Health submitted a proposal to Health Canada’s PHCTF for Nova Scotia’s share of the per capita portion of the federal funding. This amounted to $17.1M over four years. The proposal was approved by Health Canada in September of 2002. Nova Scotia’s process to undertake transition activities is in keeping with federal funding objectives, and involves:

- implementing enhancements to primary health care services and creating new ways to develop sustainable primary health care networks/organizations
- supporting change costs for primary health care professionals
- transitioning to an electronic patient record.

Since the implementation of the fund, more than 80 initiatives have been supported throughout the District Health Authorities. Federal funding supports the system transition and model implementation costs only. DHAs are required to demonstrate the operation sustainability of funded activities as part of the legislated business planning and accountability requirements.

**Nurse Practitioner and Enhanced Team Implementation**

Nova Scotia introduced the primary health care nurse practitioner in selected primary care practices in 2002. There are currently 19 approved, department-funded primary health care nurse practitioner positions in Nova Scotia. The province also supports an interdisciplinary team at an urban practice, and plans to implement more teams in the future.

**Diversity and Social Inclusion Awareness in Primary Health Care**

Diversity and Social Inclusion in Primary Health Care is an initiative to raise awareness of diversity and social inclusion issues (primarily related to race, language and culture) across a broad range of stakeholders and culturally diverse populations, and to develop guidelines and policies that address diversity and social inclusion issues in primary health care. A final report will be delivered by Spring 2006

**Primary Health Care Evaluation**

Nova Scotia is building upon its existing capacity to evaluate the impact of changes made as a result of renewal activities. Enhancing primary health care evaluation and research capacity throughout the province will strengthen Nova Scotia’s ability to continue to improve the primary health care system beyond the transition phase. Current activities focus on primary health care indicator development and capacity building within the District Health Authorities.

**Continuing Professional Education for Primary Health Care Providers**
Nova Scotia is the lead province in the Atlantic region’s collaborative initiative, Building A Better Tomorrow. This initiative supports providers’ transition to a renewed primary health care system and complements renewal activities currently underway in the Atlantic provinces. A key area of focus in 2005 was the development of a series of accredited modules (French and English) for face to face and web-based delivery. The goal is to have over 4000 primary health care providers receive the educational program.

**Primary Maternity Care**

A Primary Maternity Working Group was established in 2004 to develop a regulatory framework for the inclusion of midwives in collaborative teams delivering primary maternity care in Nova Scotia. A Midwifery Legislation Committee was formed to enable work on midwifery legislation to proceed.

**Community Health**

The Nova Scotia Department of Health has not adopted a definition of community health. However, it recognizes that integrated, community-based health care is the foundation of the Nova Scotia health system. Community-based health care is generally viewed as health care services based in the community to support individuals and families as close to home as possible. The term implies community involvement in planning for health care services.

**Population Health-Based Initiatives**

**Overview**

- Services are delivered through nine District Health Authorities (DHAs) and the IWK Health Centre with input from Community Health Boards (CHBs). Public Health Services and Addiction Services are two of the shared services within the DHA structure. As shared services, they are responsible for the delivery of services in one or more of the DHAs.
- District Public Health and Addictions Services are responsible for the operational delivery of health services, operational planning and management of services, monitoring and evaluation of services, and providing health information data.
- Funding for Public Health and Addictions Services is non-portable at the DHA level.
- In February 2006, a new department was formed bringing together the priorities of the former Nova Scotia Health Promotion (NSHP) with the Public Health areas of both NSHP and the Department of Health and the Office of the Chief Medical Officer of Health. NSHPP’s functions include: addictions prevention, chronic disease prevention which includes healthy eating, tobacco control, injury prevention and control, and chronic disease prevention, public health, health protection, physical activity and sport and recreation, and communications and social marketing. The Department of Health Promotion and Protection is responsible for funding, setting directions, providing provincial policy advice, developing standards, and monitoring and evaluation.
• Environmental Health Services are provided through the Departments of Agriculture and Fisheries, Environment and Labour, and Health

**Funding trends**

In the 2003 *Blueprint for Building a Better Nova Scotia*, the Nova Scotia Government committed to doubling the budget of the then Office of Health Promotion

**Population Health Programs or Strategies Addiction Prevention**

*Alcohol Strategy*
A provincial addiction prevention and community education coordinator has been hired to work with provincial and regional partners and stakeholders to support the development of a comprehensive alcohol strategy designed to reduce alcohol-related harms.

*A Better Balance: Nova Scotia’s First Gaming Strategy*
In April 2005, *A Better Balance: Nova Scotia’s First Gaming Strategy* was released by government. This strategy includes seven initiatives that are being led by NSHPP, along with $3 million in funding to accomplish the goals outlined in the strategy.

*Problem Gambling Strategy*
Although *A Better Balance* outlines an overall gambling strategy for the province, a more detailed strategy is needed to address the full range of gambling related prevention and treatment needs. Led by NSHPP, the development of a provincially coordinated problem gambling strategy begun in 2005 continues.

*Enhanced Services for Rural Women and Youth*
NSHPP directed funding to Addictions services in the DHAs to improve health outcomes for rural women and youth throughout the province. The funding provides resources to facilitate and evaluate a range of addictions services for women and youth based on current evidence of best practice and cost-effectiveness. This initiative places an emphasis on enhancing services and eliminating barriers to treatment for women and youth, and their families, who may be harmfully involved in substance use and/or gambling.

**Public Health HIV/AIDS Strategy**

Nova Scotia’s Strategy on HIV/AIDS was released in 2003. An update, focusing on strategic initiatives to increase accessibility to and/or expand services, particularly to those who are most vulnerable to HIV infection, was released on World AIDS Day, December 1, 2005,

*Standards for the Prevention of Blood-Borne Pathogen Infections*
Standards for preventing blood-borne pathogen infections were completed in 2004 with the participation/contribution of many community stakeholders.

*Vaccine Schedule*
A vaccine schedule consistent with the National Immunization Strategy is being implemented.

**Public Health Review**
Following the SARS outbreak in Ontario and the Naylor Report on the public health system’s response, the Federal/Provincial/Territorial Ministers of Health decided to “make public health a top priority by improving health infrastructure, and increasing international, provincial, territorial and federal capacity across the country”. In response, Nova Scotia embarked on an external review of the coordination, integration and comprehensiveness of its public health system. *The Renewal of Public Health in Nova Scotia: Building a Public Health System to Meet the Needs of Nova Scotians* was released in Spring 2006. The result will be a strengthened public health system that builds on the success of Nova Scotia Health Promotion and the public health functions. It will create a system that is coordinated, responsive and integrated. A transition team has been formed to oversee a multi-year undertaking aimed at the renewal of the public health system.

**National Collaborating Centre for the Social Determinants of Health**
The Government of Canada’s commitment to renew and strengthen public health included the establishment of six National Collaborating Centres (NCC) for public health. The NCC for the Social Determinants of Health was assigned to Atlantic Canada. Although located regionally, it is intended to provide a national focal point as one key component of the overall pan-Canadian public health strategy, drawing on regional, national and international expertise.

**Fluoride Mouthrinse Program Review**
The Fluoride Mouthrinse Program Review Committee has developed policy recommendations for standard calibration, community participation, monitoring and evaluation, and maintenance of professional competencies in relation to the provincial school-based Fluoride Mouthrinse Program. This program uses a population-based tool to identify schools eligible to participate. An evaluation of the tool is currently being undertaken.

**Nova Scotia Round Table for Youth Sexual Health**
Nova Scotia Round Table for Youth Sexual Health is a diverse group of community and government partners whose mission is to work collaboratively for the promotion and protection of sexual health for all youth within the province through policy development, advocacy and evaluative research. A framework for action has been developed and will be released in 2006.

**Youth Health Centres**
The Department of Health completed an evaluation of community-based Youth Health Centres in the province to provide policy makers and funding organizations with the evidence needed to make informed decisions and policies as well as to provide the Centres with information to support programming and to document the impact of their work. Standards have been developed. Provincial work related to clinical guidelines, orientation, partnership, informed consent and evaluation is underway.

**Injury Prevention and Control**

**Nova Scotia Injury Prevention Strategy**
In 2003, Nova Scotia became the first province in Canada to adopt a government funded and led injury prevention strategy. The Strategy addresses the leading causes of injury in the province eg. falls among the elderly, motor vehicle collisions and suicide. It also addresses improvements to policy, collection of injury statistics and cooperation amongst injury prevention partners.

**Preventing Falls Together**
NSHPP continued funding and supporting the partnership with Community Links for the Preventing Falls Together Initiative, which promotes the development of a network for falls prevention to work with seniors, caregivers, health professionals, government and community agencies.

**Injury Prevention Knowledge and Capacity Building**
NSHPP supports and delivers opportunities for the development of injury prevention knowledge and capacity at the community level. In November 2005, NSHPP co-hosted the Canadian Injury Prevention Conference held in Halifax.

**Road Safety Communications Strategy**
NSHPP maintains a partnership with Transportation and Public Works (TPW) and the Road Safety Advisory Committee (RSAC) composed of members from the Departments of Transportation and Public Works, Health Promotion and Protection, Service Nova Scotia and Municipal Relations, Justice and Health and the Nova Scotia Safety Council, the RCMP, Association of Police Chiefs of Nova Scotia, Insurance Bureau of Canada and Mount Saint Vincent University. Working with TPW and RSAC, NSHPP led the development of a comprehensive strategy for road safety communications.

**Suicide Prevention Strategy**
NSHPP led the development of a suicide prevention strategy, working collaboratively with Mental Health Services, Department of Health. The partnership will identify evidence-based approaches to the development and enhancement of societal, policy and individual supports to reduce suicide in Nova Scotia.

**Injury Prevention in Schools**
During the 2005-2006 fiscal year, HPP Launched the Prevent Alcohol and Risk Related Trauma in Youth (P.A.R.T.Y), an evidence-based resource designed to educate teenagers (ages 15 and 16) about the consequences of risk and serious injury. HPP’s goal is to deliver PARTY to 15,000 grade 10 students in Nova Scotia. Partnering with Emergency Health services, the Departments of Education and Transportation and Public Works and with Dalhousie University, PARTY will expand in 2006-2007.

**Healthy Eating**

**Health Eating Nova Scotia**
This strategy was released in March 2005. Developed by the Healthy Eating Action Group of the Alliance for Healthy Eating and Physical Activity, NSHPP has the lead in the implementation of the strategy. Its purpose is to promote an increase in the initiation and duration of breast feeding,
increase consumption of vegetables and fruit, promote healthy, affordable food choices for children and youth and increase the availability and affordability of healthy food for all Nova Scotians.

**Provincial School Food and Nutrition Policy**
There were public consultations on the draft *Provincial School Food and Nutrition Policy* in September/October 2005. HPP supported the development of the Department of Education’s School Food and Nutrition Policy, which addresses a variety of issues including: foods offered at school cafeterias, vending machines, canteens, fund-raising, portion sizes, nutrition education, vulnerable children and time to eat. The policy will be phased in over time, beginning in the 2006-2007 school year.

**Food Security**
NSHPP provided funding to the Atlantic Health Promotion Research Centre (AHPRC), in collaboration with the Nova Scotia Nutrition Council, to develop the *Working Together for Ongoing Food Costing & Policy Solutions to Build Food Security* report. In October 2005, in addition to the food costing model, NSHPP received the draft Food Security Policy Discussion Paper and policy lens.

**Health Promoting Schools**
Comprehensive School Health (Health Promoting Schools) is an approach to school-based health promotion involving a programs, activities and services that take place in schools and their surrounding communities. NSHPP provided funding for partnerships of school boards and district health authorities to implement Health Promoting Schools programs with a focus on healthy eating and physical activity.

**Breakfast Program**
NSHPP committed $750,000 to enhance and expand breakfast programs for elementary school children in Nova Scotia.

**Provincial Breastfeeding and Baby-Friendly Initiative**
The Provincial Breastfeeding and Baby-friendly Initiative (BFI) Committee provides leadership for the protection, promotion and support of breastfeeding, and for the implementation of the Initiative in the province. This involves collaboration between hospitals and community health services across the province. In October 2005, Nova Scotia became the second province in Canada to adopt a provincial breastfeeding policy following the Department of Health’s and NSHPP’s approval of the document, *Breastfeeding in Nova Scotia: Responsibilities of the Nova Scotia Department of Health and Nova Scotia Health Promotion*

**Physical Activity, Sport and Recreation**

*Active Kids, Healthy Kids: a Nova Scotia Physical Activity Strategy for Children and Youth*
An evaluation of this strategy is planned for 2006.

**Health Living Incentive**
Announced in 2005, the Healthy Living Incentive is a non-refundable $150 tax credit per child, which can be used for physical activity, sport and recreation activities that are registered with NSHPP.

**Sport Opportunities for Children and Youth in Nova Scotia**
This collaborative program provides structured and unstructured school and community-based programs to increase current levels of physical activity in children. The three year program, a comprehensive approach by all levels of government, began during 2005.

**Sport Futures Leadership Program**
This program focuses on increasing physical activity by assisting provincial sports organizations to provide fun, safe and inclusive activities for children and youth, regardless of gender, socio-economic status, disability, ethnic background or culture. Sport Futures Leaders work with volunteers to improve sport programming and increase recruitment of participants.

**Physical Activity Grants Program**
This annual program provides financial assistance to Nova Scotian organizations whose mandate promotes physical activity in inactive populations.

**Physical Activity Children and Youth 2 Accelerometer Study**
This 2005-2006 study surveys students in grades 3, 7, and 11 to gauge their physical activity levels. Results will be available by fall 2006.

**Active Transportation Framework**
Beginning in 2005, a framework to support active transportation initiatives and action plans for the implementation of these initiatives is being developed.

**Provincial Walking Initiative**
This initiative, a collaborative relationship with the Heart and Stroke Foundation of Nova Scotia, builds on the results of a consultation held in August 2005. It supports local-level initiatives to improve walking environments in the community, workplace and school. The project provides information, resources, social marketing activities, education, pedometer access and a recognition programme for individuals, schools, workplaces and communities to encourage participation at many levels.

**Tobacco Control**

**Tobacco Strategy Update**
A second progress report will be released, and a review of the strategy will take place during 2006/2007. Activities to date include:

- **Legislation** - Enforcement of the Smoke-Free Places Act continued. During 2006, this Act will be amended to no longer permit designated smoking rooms except for designated rooms in facilities licensed under the Homes for Special Care Act and in hospital units for veterans. Outdoor restaurant and bar patios will become smoke free.
- **Treatment/cessation** - Funding was provided to Addictions Services in the District Health Authorities to hire staff dedicated to nicotine treatment programming and to cover pharmacological cessation aids.

- **Community-based Programs** - Funding was provided to Public Health Services in the District Health Authorities to support community-based tobacco control initiatives.

- **Youth Prevention** - ou Choose, a tobacco media literacy curriculum supplement for high schools continued to be used during 2005.

- **Media/Public Awareness** - Year 4 of the tobacco public awareness campaign was implemented including: provincial dissemination of *Smoke-Free around Me*, a smokefree homes campaign *Great Reasons to Smoke* TV ads were re-aired. New print *Great Reasons to Smoke* ads were developed, and the Great Reasons to Smoke speakers’ booth toured provincial university campuses.

- **Chronic Disease Prevention** - *Comprehensive Workplace Strategy* NSHPP led the development of the strategy. The strategy will build on *HealthWorks: a National Strategy for Comprehensive Workplace Health* to provide a provincial approach to workplace health which encompasses organizational health, personal health practices and occupational health and safety workplace initiatives.

- **Social Marketing** - *Social Marketing Campaign for Parents: momsanddads.ca* A three-year, multi-media, social marketing campaign, targeting parents of young children aged 0-12 years was launched. The campaign focuses on healthy eating, physical activity, car seats/booster seats, and second hand smoke in the home.

### Mental Health

The Department of Health, Mental Health, Children’s Services & Addiction Treatment is responsible for policy, standards, monitoring and funding mental health services. Mental Health services for children, youth and adults are delivered through nine District Health Authorities and the IWK Health Centre. Core programs, across the life span, include: secondary prevention and promotion; outpatient and outreach services; acute, short stay and long-term psychiatric in-hospital treatment; specialty mental health services and community supports. Services are consumer and family focused and community-based where possible. Some mental health services are delivered through a shared care approach in collaboration with primary care services. All DHAs and the IWK Health Centre provide outpatient and outreach services through a network of more than 50 community-based mental health clinics. In-patient psychiatric units are located in eight of nine health districts. In addition, there are a number of day treatment programs, psychosocial rehabilitation programs, and specialty mental health services available throughout the province.

In 2003-2004, the Department of Health provided $2 million in funding to the DHAs and the IWK Health Centre to implement core service standards in key areas including community supports, crisis services and child and youth services. During 2005-2006, the Department of Health worked with teams of mental health clinicians and consumers to continue the implementation of core service standards as well as to begin the implementation of specialty...
service standards for: eating disorders; concurrent services for persons with mental health and chemical dependency disorders; neurodevelopmental disorders; early psychosis services; and services to seniors.

A plan for monitoring the quality, appropriateness and effectiveness of mental health services was initiated in 2003-2004. Included in this plan is a mental health profile for each DHA and the IWK Health Centre utilizing information from Statistics Canada’s Community Health Surveys, from the department’s ambulatory mental health information system (MHOIS) and from hospital discharge abstracts (CIHI). Pilot testing of standardized outcome (HoNOS) and satisfaction measures was also initiated in 2003-2004 with further development planned for 2005-2006.

In 2002, the Government provided $2 million for an Early Identification and Intervention Service (EIIS) for children up to their 6th birthday, diagnosed with Autistic Spectrum Disorder (ASD). A portion of this funding was permanently allocated to the Departments of Education and Community Services for support and transition to school services. In 2004, the Government announced an additional $4 million was being provided for the development and implementation of an Early Intensive Behavioral Intervention (EIBI) Program for young children with ASD. The treatment model is in the final stages of development. Province wide training is in process. It is estimated for full implementation it will take up to 3 years. An external evaluation is also in place, with the final report due in 2007.

In 2005 the Department of Health initiated a 3-5 year provincial depression strategy to raise awareness for early detection and intervention. Phase one targeted adolescents and seniors and approx. 6,000 information packages were disseminated.

A 6-month Youth at High Risk project has also been initiated through the joint efforts of the Department of Health and the Department of Community Services. A project manager is in place to develop recommendations and an implementation plan to move the project forward if government approval is granted.

**Home Care & Long Term Care**

- Continuing Care consists of a range of services to support individuals with identified health needs. Care is provided in a manner that enables the individual to live as independently as possible in the community, or in a residentially based service.
- Continuing Care services include home care, self-managed care, long term care, adult protection and care coordination. The Department of Health manages these services directly. Services are coordinated through a single entry access system. Assessment, care coordination and ongoing case management are a responsibility of the Continuing Care branch. The Branch works directly with approximately 140 provider organizations, including non-profit home support agencies, the Victorian Order of Nurses, and municipal, private for profit, and non-profit residencially based organizations.
- Home care programs provide support to approximately 12,000 Nova Scotians at throughout the year. Services include short term (acute) and longer term professional nursing care.
provided by registered nurses and licensed practical nurses. Home support services include personal care, respite, nutritional care, and essential housekeeping. Home oxygen services are provided through contracted oxygen vendors. Although not funded or regulated by the Department of Health, community supports such as adult day and volunteer programs, meals on wheels, and limited community rehabilitation services are available.

- Self Managed Care helps Nova Scotians with physical disabilities to increase control of their lives. The program provides funds to eligible individuals so that they may directly employ people who provide home support and personal care services.

- Residentially based programs provide support to approximately 6,600 Nova Scotians. These services include licensed nursing homes, licensed residential care facilities and a number of community-based options that provide services for up to three clients, and operate under interim standards.

- Adult Protection Support services are extended, under the authority of the Adult Protection Act, to adults 16 years of age or older who are abused or neglected (including self-neglect and/or neglect by a caregiver) and who cannot physically or mentally protect themselves. There are approx. 1,300 referrals for assistance annually. 75% of the referrals are for individuals over the age of 65 years.

- The 2005-2006 budget for continuing care was approximately $427 million. Home Care services cost $128 million, residentially based services $296 million, and administration $3 million. The budget for the previous fiscal year (2004-2005) was $376 million. The increase reflects the introduction of government funding for the health care costs of residents in long term care facilities.

- During 2006, a strategic framework for continuing care in the province will be released.

- Beginning in 2006, a planned approach to the recruitment of continuing care assistants will be implemented.

Further information on Continuing Care is available at [http://www.gov.ns.ca/health/ccs/default.htm](http://www.gov.ns.ca/health/ccs/default.htm)

### Pharmacare

**Nova Scotia Seniors’ Pharmacare Program**

- Pharmacare provides prescription drug insurance to eligible residents 65 years of age or older who are registered under the Medical Services Insurance (MSI) program and who do not already have prescription drug coverage through Veteran Affairs, or first Nations and Inuit Health or private drug plans.

- Pharmacare was established in 1974 under the authority of the Insured Programs Branch, Department of Health under Section 17 of the Health Services and Insurance Act. The Prescription Drug Plan Regulations became effective October 1, 1974 and were revised in January 1991. Additional regulations for the Seniors’ Pharmacare Program were approved June 27, 1995. There have been several revisions.


The following revisions to the co-payment and premium maximums for Pharmacare becomes effective in April 2006:

- premium paid by each eligible senior changes from $390 to $400 a year. The co-payment changes from an annual maximum of $350 to $360. The co-payment of 33% of the total cost of each drug prescribed to a maximum of $30 for each drug prescribed remains the same.

- Based on their annual income, over 50% of seniors are exempted from the payment of premiums. Other seniors may qualify for reduced premiums.

- The estimated cost of the program for 2006/7 is $172 million.

Further information on Nova Scotia’s Pharmacare Program is available at http://www.gov.ns.ca/health/pharmacare/default.htm

**Nova Scotia Diabetes Assistance Program (NSDAP)**

- The NSDAP is a provincial drug plan which covers the medications and supplies, necessary to manage diabetes, including insulin, oral blood glucose lowering drugs (anti-hyperglycaemics), blood glucose test strips, needles, lancets, and syringes

- Eligibility for the program is based on:
  - Permanent residency in Nova Scotia
  - Valid Nova Scotia health card
  - Under age 65
  - Confirmed medical diagnosis of diabetes
  - Agreement to verification of family income
  - Agreement to provide changes in size of family on an annual basis
  - No drug coverage through private insurance, Veterans Affairs, or First Nations and Inuit Health
  - Agreement to provide information about their diabetes when registering for assistance

- The amount of assistance provided by the Government of Nova Scotia is based on a deductible, calculated January 1st each year. The deductible is based on family size and income of the participant in the program.

- Everyone registered in the program is required to pay a co-payment of 20% for each prescription

Further information on the NSDAP is available at http://www.gov.ns.ca/health/pharmacare/dap/default.htm
Other

Healthcare Safety

Leading safety practices are being identified for application in Nova Scotia. The Department of Health is contributing to the *Safer Healthcare Now!* Campaign in the Atlantic Region. This campaign offers Canadian hospitals the opportunity to implement six (6) practices demonstrated to improve patient safety. All district health authorities and the IWK Health Centre are participating in the campaign by implementing one or more of the practices.

Some other provincial activities in progress include:

- Development of guidelines and tools for conducting meaningful quality review aimed at preventing things from going wrong or rectifying factors which contribute to adverse events;
- Implementation of a multi-phased disclosure policy which requires healthcare organizations to have processes in place to support clients and staff when disclosing adverse treatment/care events to clients;
- Expansion of opportunities to increase awareness of health care safety and safety practices through education sessions, participation in national patient safety week and establishment of stakeholder networks;
- Involvement by health system stakeholders and Department of Health staff on national patient safety initiatives such as the Canadian Medication Incident Reporting and Prevention System and committees of the Canadian Patient safety Institute.

PEI

Political Representation

Progressive Conservative Party: last election September 29, 2003

- Premier: Patrick Binns
- Minister of Health: J. Chester Gillan
- Deputy Minister of Health: David B. Riley

Legislative Amendments

A = assent
c.i.f. = came into force

**Health and Community Services Reorganization Act** [A June 7/05, c.i.f. Jan.1/06]
Dissolves health authorities, transfers assets and liabilities to government, makes consequential amendments to many other statutes.

**Community Hospital Authorities Act** [A June 7/05, c.i.f. Jan. 1/06]
Designates specific hospitals as community hospitals (c.h.), establishes c.h. authority boards, sets out roles and responsibilities, provides for appointment of administrators, and provides that the c.h. authorities contract with government for the provision of staff.

**Health Services Act** [A June 7/05, c.i.f. Jan.1/06]
New Act to replace the former Health and Community Services Act following the split of the Department of Health and Social Services into 2 distinct departments (Department of Health, Department of Social Services and Seniors). Sets out the responsibilities of the Minister of Health, provides for protection from liability for the Minister and employees of the Department, and protects the work of quality assurance groups.

**Long-Term Care Subsidization Act** [A June 7/05, c.i.f. Nov. 8/05]
Replaces what was formerly Part II of the Social Assistance Act, concerns subsidized care in nursing homes.

**Act to Amend the Social Assistance Act** [A June 7/05, c.i.f. Nov.8/05]
Severs the Act, Part II of former Act moves to new act, above, remainder becomes responsibility of Dep’t of Social Services and Seniors(DSSS).

**Act to Amend the Health and Community Services Act** [A June 7/05, c.i.f. Nov.8/05]
Deals with the split of the Department, allocates responsibility for health services to Department of Health, and responsibility for social services and services for seniors to DSSS.

**Health and Social Services Reorganization Act** [A June 7/05 c.i.f. Nov.8/05]
effects various consequential amendments to various Acts in order to reference the appropriate Department once the split occurs.

**Health Authorities Employees Act** [A June 7/05 c.i.f. June 28/05]
transfers all employees of the health authorities to government, and provides for labour relations dispute resolutions.

**Registered Nurses Act** [A Dec.16/4, c.i.f. Feb.25/06]
New statute to replace the former Nurses Act, governs the practice of registered nursing in the province.

**An Act to Amend the Tobacco Sales to Minors Act** [A Dec.6/05, c.i.f. Aug.1/05, section 11 June 1/05]
Changes title of the Act to the Tobacco Sales and Access Act, changes primarily concern retail sale of tobacco and designates places where tobacco cannot be sold.

**An Act to Repeal the Pre-Marital Health Examination Act** [A , c.i.f. December 15/05]
Repeals a dated piece of legislation concerning examinations that had been done in an effort to control the spread of syphilis.

**An Act to Amend the Tobacco Sales and Access Act** [A Dec. 15/05, c.i.f. June 1/06]
Amendments concern ban of display, advertisement and promotion of tobacco in retail premises; exception for tobacconists.

**An Act to Amend the Marriage Act** [A Dec. 15/05, c.i.f. May 05]
Changes provide for marriage commissioners’ licenses; also, wording of pronouncement at the end of civil ceremony changed so as to comply with new federal definition of marriage.

**An Act to Amend the Health Authorities’ Employees Act** [A Dec. 15/05, c.i.f. retroactive to June 28/05]
Clarified pension issues with respect to some civil service employees.

**Hospitals Act** [A Dec. 15/05, c.i.f. Jan. 06]
New Act replacing prior Act by the same name - reflects the newly reorganized health system.

**Regulatory Initiatives:**

**Public Health Act, Part II, Emergency Medical Services Regulations** [c.i.f. Apr.1/05]
Changed levels of licensing from 2 levels (basic, beyond basic) to 3 levels (EMT Level I, II, and III).

**Pharmacy Act**, [all of these c.i.f.May 1/05]
- Authorization Regulations
- Generally to update these regulations, and specifically to account for trade mobility requirements
- Drug Schedule Regulations
- New. Specify which drugs are restricted in various categories according to the National Association of Pharmacy Regulatory Authorities (NAPRA), Sets out some prohibitions concerning sale of drugs, and requires pharmacies to follow certain rules, depending on the category of the drugs
- Interchangeable Drug List Regulations
- New - establishes a committee to recommend and maintain an interchangeable prescription drug list for the province; sets out criteria for these drugs, rules for pharmacies, and rights of patients
- Standards Regulations
  - Updates standards for this profession, including rules for labeling and records.

**Tobacco Sales and Access Act Regulations** [c.i.f.Aug.1/05]
Amendments concern signs to be displayed in premises selling tobacco, and acceptable identification to establish proof of age. Revoke the old regulations under the Tobacco Sales to Minors Act.

**Marriage Act Regulations** [c.i.f. Aug.18/05]
Revokes an earlier provision; also revises some of the forms under the regulations, mostly to accord with the new federal definition of marriage.

**Vital Statistics Act Regulations** [c.i.f. Aug.18/05]
Replaces the phrase “bride and groom” with the word “spouses”. Revises some forms.

**Public Health Act - Slaughter House Regulations** [c.i.f. Dec.3/05]
Amendments concern an exception for processing a dead animal, subject to the special circumstances outlined.

**Adoption Act - Supported Adoption Regulations** [c.i.f. Jan.1/06]
Amendments to remove references to the health authorities.

**Child Protection Act Regulations** [c.i.f. Jan.1/06]
Same as above.

**Civil Service Act Regulations** [c.i.f. Jan.1/06]
Changes clarify which employees are not represented by the Union.

**Civil Service Superannuation Act - Participating Employer Regulations** [c.i.f. Jan.1/06]
Removed the health authorities from the list of participating employees.

**Community Hospital Authorities Act Regulations** [c.i.f. Jan.1/06]
New regulations under the new Act - concern the boards of the c.h.a.’s, including the interim appointed boards.

**Financial Administration Act - Special Project Funds Regulations** [c.i.f. Jan.1/06]
Revoked a reference to a Program no longer in operation.

**Health and Community Services Act Regulations** [c.i.f. Dec.31/05]
Revoked the regulations under the Act the day before the Act was repealed.

**Health Services Payment Act Regulations** [c.i.f. Jan.1/06]
Amendments remove references to the health authorities.

**Hospital and Diagnostic Services Insurance Act Regulations** [c.i.f. Jan.1/06]
Deletes references to health authorities and generally updated the regulations to reflect the reorganized health system.

**Hospitals Act - Hospital Management Regulations** [c.i.f. Jan.1/06]
Same as above.

**Housing Corporation Act - Low Income Assisted Home Ownership Supplement Program Regulations, Provincial Contribution to Senior Home Repair Regulations, and Serviced Lot Subsidy Regulations** [all c.i.f. Jan.1/06]
For the most part, the changes delete references to the “Board” and correct them with references to the “Corporation”.

Mental Health Act Regulations [c.i.f. Jan.1/06]
Amendments removed references to the health authorities.

Public Health Act - Notifiable and Communicable Diseases Regulations [c.i.f. Jan.1/06]
Clarified to whom the Chief Health Officer provides information.

Nurses Act - Discipline Regulations Revocation, Registration and Licensing of Nurses Regulations Revocation, and Schools of Nursing Regulations Revocation [c.i.f. Feb.24/06]
These old regulations under the old Act were revoked the day before the Act was repealed.

Registered Nurses Act - Nurse Practitioner Regulations, Professional Conduct Review Regulations, Registration and Licensing of Nurses Regulations, and Schools of Nursing Regulations [c.i.f. Feb.25/06]
New regulations written for the new Act governing the practice of registered nursing in the province.

Structure and Finance Updates

Fiscal Activity

- The Ministry of Health and Social Services & Seniors total expenditures represented more than 45% of the Provincial Government’s program spending in 2005/2006.
- The projected expenditures for the 2005/2006 fiscal year are $453 million, an increase of $8 million over the 2004/2005 fiscal year.
- The major cost drivers included acute care hospital services, including increased costs for enhanced services at the QEH related to improving access to services and reduction in wait times, increased cost associated with the new Prince County Hospital, long-term and home care services, information technology initiatives, and increasing rates for our residents requiring out of province hospital services.
- As well the delay in the implementation of the organizational restructuring in the health sector has contributed to an inability to reach original targeted savings from the reorganization.
Governance and Management

- The role of the Department of Health is to:
- provide leadership in innovation and continuous improvement and to provide specific high quality administration and regulatory services to the health system and Islanders.
- provide leadership in delivering provincial secondary acute and specialized services to improve the health and well-being of citizens.
- provide leadership in maintaining and improving the health and well-being of its citizens and to provide high quality, client-centred health services consistent with community needs.

The Department of Health fulfills this role through provision of public health services, primary care, acute care, community hospital and continuing care services to Islanders to help ensure their optimal health.

These services are delivered by over 4,000 dedicated professional staff through a large number of facilities and programs across the province, including provincial acute care facilities, community hospitals, provincial manors, a provincial in-patient mental health facility, a provincial additions treatment facility, family health centers, public health nursing, home care, community addictions programs, community mental health, the Chief Health Officer, Vital Statistics, and regulatory services.

Organization

As a department of government, the Department of Health is overseen by a Minister of the Crown, who is ultimately accountable for departmental performance and results to the rest of government and the citizens of the Province.

The Department of Health is managed by a Departmental Management Committee comprised of the Deputy Minister and 8 Senior Directors. This group is responsible for providing overall management direction to the department and for overseeing day to day operations.
An organizational chart and summary of principal roles for each division is outlined below.

**Direct “Service Delivery” or “Line” Divisions**

- **Acute Care:** Provides regional and provincial secondary, specialty services, and in-patient mental health services to residents of PEI. Facilities include Prince County Hospital, the Queen Elizabeth Hospital and Hillsborough Hospital. Administratively, one Executive Director is responsible for PCH and one Executive Director is responsible for QEHH / Hillsborough Hospital, each of who are members of the Departmental Management Committee.

- **Community Hospitals and Continuing Care:** Provides acute care services to rural communities and supportive services to adults and seniors in need of continuing care on PEI. Programs and Facilities include the five rural community hospitals, provincial manors, home care, palliative care, dialysis, and adult protection. Administratively, the Director of Community Hospitals and Continuing is responsible for this division and is a member of the Departmental Management Committee.

For each of the five community hospitals, an elected governing board has been put in place. Each board is accountable to the minister, and is responsible for ensuring the completion of annual business plans and reporting on facility performance and results to the Minister and their local communities.

- **Primary Care:** Provides primary health services to citizens of PEI. Programs and facilities includes: Community Mental Health and Addictions including the Provincial Addictions
Treatment Facility, six Family Health Centers, Public Health Nursing, Speech Language / Audiology, Nutrition, Diabetes, and Chronic Disease Prevention and Healthy Living. Administratively, the Director of Primary Care is responsible for this division and is a member of the Departmental Management Committee

- **Population Health**: Provides Public Health and Regulatory Services to the citizens of PEI. Programs and services include the Office of Chief Health Officer, Emergency Health Services, Communicable Disease Control and Immunization, Epidemiology, Environmental Health, Vital Statistics, Community Care / Nursing Home Inspection, Adult Protection, Public Guardian and Dietic Services. Administratively, the Director of Population Health is responsible for this division and is a member of the Departmental Management Committee.

**Support Services**

- Finance: Provides financial management, materials management and business office services to the Department of Health. Administratively, the Director of Finance is responsible for this division and is a member of the Departmental Management Committee

- Medical Programs: Provides support services to medical practitioners; administers medicare and provincial ambulance services; and coordinates out of province hospital placements. Administratively, the Director of Medical Programs is responsible for this division and is a member of the Departmental Management Committee

- Corporate Services: Provide human resource, legislative support, health information management and corporate relations and evaluation services to the Department of Health. Administratively, the Director of Corporate Services is responsible for this division and is a member of the Departmental Management Committee

**Institutional Change/Reform**

**2005 Health and Social Services System Restructuring**

In 2005, the health and social services system underwent a restructuring process. This process resulted in the following structural changes:

- Creation of two new departments, namely the Department of Health, and the Department of Social Services and Seniors, to replace the former Department of Health and Social Services;

- Dissolution of five regional health authorities; and

- Establishment of community hospital boards to govern each of the five small community hospitals in the province.

In line with the structural changes, the following administrative changes occurred:

- The role of the Department of Health changed from responsibility for quality of advice and assistance to line services to a responsibility for direct service delivery;

- Administrative and support services for line services moved from a regional to a departmental model in line with the dissolution of the health authorities;
• Under the previous organizational structure, each of the five regional health authorities had governing boards. Under the new organizational model, each of the five community hospitals have a governing board.

Upon completion of restructuring, departmental responsibility for managing programs and services were realigned as outlined in the table below.

<table>
<thead>
<tr>
<th>Distribution of PEI Department of Health and Social Services Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Department of Health</strong></td>
</tr>
<tr>
<td>Acute Care Services</td>
</tr>
<tr>
<td>Addiction Services</td>
</tr>
<tr>
<td>Adult Protection</td>
</tr>
<tr>
<td>Ambulance Services - Air Ambulance</td>
</tr>
<tr>
<td>Ambulance Services - Ground Ambulance</td>
</tr>
<tr>
<td>Chief Health Officer</td>
</tr>
<tr>
<td>Community Care Facilities</td>
</tr>
<tr>
<td>Diabetes Program</td>
</tr>
<tr>
<td>Environmental Health</td>
</tr>
<tr>
<td>Health Information Resources</td>
</tr>
<tr>
<td>Home Care and Support</td>
</tr>
<tr>
<td>Long Term Care (Nursing Home) Services</td>
</tr>
<tr>
<td>Medical Education / Physician Recruitment Programs</td>
</tr>
<tr>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Nursing Recruitment and Retention Strategy</td>
</tr>
<tr>
<td>Out-of-Province Hospital Services</td>
</tr>
<tr>
<td>Out-of-Province Physician Services</td>
</tr>
<tr>
<td>PEI Dialysis Program</td>
</tr>
<tr>
<td>Physician Payment Services</td>
</tr>
<tr>
<td>Public Health Nursing Programs</td>
</tr>
<tr>
<td>Vital Statistics Program</td>
</tr>
</tbody>
</table>

**Regionalization Activity**

System restructuring resulted in the dissolution of regional health authorities. All health services, with the exception of the five community hospitals, are now managed through a provincial departmental management structure. Each of the five community hospitals are governed by an elected board. These boards are accountable to the minister, and are responsible for completing annual business plans and for reporting on hospital performance and results to the Minister and their local communities.

This is a transition year for the boards. Each board is currently comprised of 5 members appointed by the Minister. In the fall of 2006, board elections will be held with the expectation that each board will be comprised of 7 elected members.

**Support and Innovation in Health Care**

**Human Resources: Physicians**
• A new three-year Master Agreement between the Government of Prince Edward Island and the Medical Society of Prince Edward Island was reached on August 24, 2004. The agreement will be in effect until March 31, 2007.

• The following vacancies currently exist in the physician complement: Anesthesia, Family Medicine, Internal Medicine, Medical Oncology, Psychiatry, and Plastic Surgery. Recruitment to find suitable placements for these positions is ongoing.

• The Medical Education Program of the Department of Health and Social Services works closely with Dalhousie and Memorial Universities to provide clinical rotations for medical students and residents in family medicine and various specialties ranging from two weeks to 12 weeks in duration.

• The Provincial Patient Registry continues to provide assistance to patients in finding family doctors.

**Human Resources - Non-Physicians**

• A total of 66 new Registered Nurses were brought into the health system in 2005/06.

• The (2004-2008) Nursing Recruitment and Retention Strategy continues to provide sponsorship HR Planning and retention resources, as well as the BN Student and Health Care Futures summer employment programs.

• **PEI Health Professionals Registration Database:** The Department approached 20 health professional associations to gauge interest and request participation in this initiative. Participating associations were provided with a system that fully automated their membership registration process. This means improved data collection and reporting capabilities for the associations and the provision of a comprehensive human resources database for the PEI health care system.

• **Nurse Practitioners (NP)** are a new professional health care provider being introduced to PEI. A new Registered Nurses Act was passed in the House in December 2004 and proclaimed in February 2006, which included a provision for recognizing the title of Nurse Practitioner and their scope of practice. Although there are many areas of practice where NPs can add value to the health system, the Department of Health recognizes the need to assess the appropriate allocation of this new health care provider in various areas of health care delivery. A Nurse Practitioner Position Assessment Committee has been established to review proposals for Nurse Practitioner positions and recommend implementation. The Committee will begin reviewing submissions in the spring of 2006.

• **Medical Laboratory Technology Seat Purchase Program:** The Governments of Prince Edward Island and New Brunswick have a new 3 year agreement (expires 2009) whereby three eligible Prince Edward Island residents will be guaranteed access to the Medical Laboratory Technology two-year program offered at the New Brunswick Community College in Saint John New Brunswick.

**Health Information**
**PEI Health Technology**

- The Health System has a standard province-wide approach to health information technology implementation with the development of a provincial information technology infrastructure, the Island Health Information System (IHIS). IHIS is a fully integrated information resource supporting the delivery of health services in Prince Edward Island.

- IHIS is the provincial health separate and secure broadband wide area network that connects all health sites with systems such as email, Office Automation, Payroll, Financials, Human Resource, Medical Records Abstracting, Vital Statistics, etc.

- All physicians are connected and transmit electronic claims on a Physician Payment System. This is accomplished with the assistance of a virtual private network and a PKI security solution.

- All private pharmacies are connected through ISDN lines for submission of claims for government funded drug programs. It is anticipated that by the end of FY06/07 this will be enhanced to include all drugs for all PEI residents.

- There is a state of the art provincial health data centre.

**The following activities and projects were completed in the last three year period and support the development of IHIS as a robust information resource:**

- A Radiology Information System and associated Picture Archive and Communication System (PACS) were implemented province-wide, the first in Canada. This new technology enables X-rays to be electronically captured and distributed between all acute care facilities in PEI, physician offices, emergency rooms and out-of-province facilities. These initiatives are supported by several partnerships, including those with the Queen Elizabeth Hospital Foundation, the Prince County Hospital Foundation, and Health Canada.

- A Common Client Registry (CCR) was implemented. This was based upon data standards that were developed through a collaborative effort with Health Infrastructure Atlantic (HIA) and the Canadian Institute for Health Information (CIHI) with funding from Canada Health Information Partnership Program (CHIP). The application uses HL7 for its messaging and offers a sound foundational component for the province's development of an Electronic Health Record.

- A Children's Dental system was implemented. This provides detail information on all dental services provided through the provincial children's dental program. This program makes dental services available to all PEI children from ages 3 - 16.

- The Health Financial System Upgrade was completed. The PEI Health System has Oracle Financials for its financial information system. This was a very large project that migrated the financials from version 10.7 to version 11i.

- The Integrated Services Management system (ISM) was completed in 2004 establishing standardized case management technology to all community-based health within the PEI health system including home care, addictions, mental health, dental, public health nursing, nutrition services, speech, and audiology. A reporting approach based upon Crystal has been established to enable roll up of standardized provincial statistics in these program areas.
• Implementation of Virtual Interactive Tele-health Assistance Link (VITAL) with New Brunswick to provide cardiac surgery follow-up for Saint John Hospital patients allows a more cost effective and convenient mode of follow-up treatment.

The following major projects & consultations are proposed or ongoing:

• A detailed electronic health record plan is in development to define key components, integration requirements, and viewing features;
• Work on developing a Clinical Information System (CIS) including laboratory, surgery, emergency, pharmacy, ADE, order entry/results reporting, blood bank, admission/discharge/transfer, scheduling, charting, and medical records as part of a provincially integrated system to all hospitals is on-going;
• The Pharmacy Network project will create a database containing prescription information collected from both physicians and retail pharmacies for all individuals receiving prescriptions within PEI. It will involve modifying the existing system and the retail Pharmacy systems to capture the required information. It will also add PIN functionality so that an individual may provide authorization to allow access to their prescription information. The system will be accessed by all retail and institutional pharmacy sites, emergency departments and physician sites;
• The upgrade of the PeopleSoft Human Resource Management System, which includes upgrades to the health payroll system, commenced in January 2006. PeopleSoft HRMS supports all human resource management processes including personnel administration, position management, recruitment, training administration, health and safety, and labour relations. This upgrade will enable the organization to ensure that the system continues to be supported by the vendor as well as provide the opportunity to take advantage of the new processes delivered.
• The Information Management Plan project aims to create an Information Management Plan that will develop a vision for Information Management for the Health System, make recommendations on the need for people, processes and tools required for Information Management in the Health System, and set priorities and gain approval for a plan for addressing these recommendations;
• It is anticipated that the integration of the RIS/PACS, CIS, ISM & CCR systems combined with web viewing functionality will form the basis of the first provincially integrated and functional EHR in Canada;
• Development and implementation of a health surveillance information system in collaboration with Health Canada is on-going;
• Review and redesign of the Wide area network architecture to accommodate remote access and web-enabled transaction traffic continues;
• Consultation and project negotiation with Canada Health Infoway to further Electronic Health Record, Health Surveillance and Telehealth activities continues;
• Collaboration with Health Infostructure Atlantic to identify partnering opportunities and further the development of an Electronic Health Record within Atlantic Canada continues.
Health Programs and Services

Community Health Initiatives

Provincial Addictions

- The Provincial Addictions Treatment Facility provides in-patient residential addiction treatment program services to all persons in the province. Coinciding with treatment programs are one-on-one and group counselling, and educational programs for families of chemically dependent clients. Following treatment, clients are expected to participate in weekly after-care programs. Outpatient detoxification service is also available in all health regions to provide detoxification to clients with less severe addictions.

- The client-centred community-based mobile program for problem and pathological gamblers and their families continues to be delivered across PEI through the Provincial Addiction Treatment Facility and the health regions. The target population is persons who have become harmfully involved in gambling and pathological gamblers.

- A women’s addiction treatment program is available at the Provincial Addictions Treatment Facility and is also a mobile program delivered in the regions on an as needed basis. The focus of the program is improving the quality of life for women and their families.

- Smoking cessation programs are available provincially and are delivered by addiction nurses through outpatient detoxification programs.

Healthy Living

- The Department, in partnership with other government departments and private sectors, released a comprehensive and integrated Provincial Strategy for Healthy Living in June 2003 in order to improve the health of Islanders. Focusing on tobacco reduction, healthy eating and physical activity, promising strategies for promoting population health in PEI include building healthy public policy, creating supportive environments, strengthening community action and developing personal skills. Goals of the Strategy are: to reduce tobacco use and the harm it causes to the population of PEI; to increase the number of Islanders who participate in regular physical activity in sufficient quantity to promote optimal health; to improve healthy eating habits that support good nutritional health with the aim to increase capacity for health promotion and chronic disease prevention. The current focus of the Strategy includes developing networks, internal and external communication strategies, and an evaluation framework.

- The Healthy Eating Strategy, a component of the Healthy Living Strategy, is focused on improving current eating behaviours of Island children and youth through nutrition education, promotion and by creating supportive environments. The goals of the Strategy are to increase nutrition education and promote healthy eating among students, parents, teachers, and all those who work with children; to increase access to safe and healthy foods in every place where children gather; and to increase understanding of how children and youth are currently eating and why, and how best to improve their current eating behaviours through up-to-date and quality research. As part of this strategy, an education program designed to promote
vegetable and fruit consumption was piloted in several schools across the Island. Leadership was provided in the development of the nutrition component of the Elementary School Health Curriculum.

**Tobacco Reduction**

- The PEI Tobacco Reduction Alliance (PETRA) is another component of the Healthy Living Strategy. PETRA has three goals: 1) to help non-smokers stay smoke free, 2) to encourage and help smokers to stop using tobacco, and 3) to promote healthy environments by eliminating exposure to second hand smoke. Several initiatives to reduce tobacco use included:
  - A Smokers Helpline is maintained to provide telephone cessation assistance. Hundreds of Islanders have used it since January 2002.
  - SWITCH (Students Working In Tobacco Can Help), peer-led prevention clubs in high schools, continued developing tobacco reduction activities within their schools and communities such as the numerous awareness raising activities held across the province in high schools during National Non-Smoking Week (Jan 17 - 23).
  - “Staying Smoke Free” was an initiative sponsored by PETRA and in particular the PEI Medical Society whose members went to Grade 6 classes across the province to deliver a tobacco use prevention message. These presentations were revised and a brochure and video was developed to help parents talk to their children about tobacco.
  - The PEI Quit Care program delivered through the Addiction Services Centre’s across the Island continues to provide group cessation counseling combined with assistance in Nicotine Replacement Therapies for participants.
  - The *Smoke-free Places Act* came into effect on June 1, 2003 to protect Islanders from the health risks associated with second hand smoke and to create smoke free public and workplaces. As part of the implementation of this Act, on Sept 29, 2004 all correctional facilities across PEI went totally smoke-free (indoors and all grounds). The smooth implementation of this policy was facilitated by collaboration with Correctional Services staff and administration and the many partners involved in the PEI Tobacco Reduction Alliance. Staffs were trained to deliver stop smoking programs to both staff and inmates using the Quit Care Program currently delivered in Addiction Services Centre’s across the Island. Many other initiatives including subsidized nicotine replacement therapy and increased access to exercise machines, healthy snacks, puzzles, books, etc. for inmates were implemented to assist them in going smoke-free.
  - The Standing Committee on Social Development held hearings on the retail sales of tobacco and their recommendations were incorporated into a revision of the *Tobacco Sales to Minors Act*. The new *Tobacco Sales and Access Act* prohibits the sale of tobacco in pharmacies or retail stores that contain pharmacies and designated places such as hospitals; health care facilities; nursing homes; provincial, municipal government buildings; schools or post secondary education buildings, recreational facilities, theatres, video arcades or amusement parks. The Act also prohibits the sale of tobacco in vending machines. These provisions are aimed at denormalizing tobacco and reducing youth tobacco use.
**Population Health-Based Initiatives**

- In the fall of 2004, over 7000 PEI students aged 7 to 19 years received Adacel as part of a clinical trial. Adacel is a vaccine which provides protection against tetanus, diphtheria, and whooping cough. This study found that Adacel can be safely administered to students in a period as short as 2 years after their last dose of vaccine. PEI students now have the most complete coverage for whooping cough in North America. As a result of this study, it is likely that several jurisdictions in the U.S. and Canada will provide Adacel to students in the 7 to 19 year age range.

**Communicable Disease Control**

- In July 2005, all children born after April 1, 2005 received the pneumococcal conjugate vaccine. This vaccine, effective for 7 strains of pneumococcal disease, is administered at 2 months, 4 months, 6 months and a booster at 12 - 18 months of age.
- The Department continued the dead bird surveillance program for West Nile virus. In addition, the Department conducts ongoing surveys of mosquitoes to identify their species and relative populations from sites across the province.

**Emergency Preparedness**

- The Department of Health began to update the provincial health system pandemic influenza plan to ensure it is consistent with the Canadian Pandemic Influenza plan. It is expected the draft provincial health system pandemic influenza plan will be developed by late fall 2006. Health supplies that may be required in a pandemic influenza, including personal protective equipment and antiviral medication, are being stockpiled in the province.

**Tobacco Sales**

- In December 2005, the Tobacco Sales and Access Act was amended to incorporate many of the recommendations made in the Standing Committee on Social Development Report on Retail Tobacco Sales, including the prohibition of:
  - tobacco sales in designated places such as pharmacies, municipal and provincial government buildings and post-secondary educational institutions;
  - retail display and point of sale signage used to promote tobacco products.

**Maternal - Child Health**

- The PEI Reproductive Care Program Perinatal Database contains information on a number of variables including maternal demographics and lifestyle behaviours, prenatal status and interventions, intrapartum and postnatal status and interventions, births, and perinatal morbidity and mortality statistics.
- The PEI Reproductive Care Program worked with the Pregnancy, Birth and Infancy network of the Healthy Child Development Strategy to develop and distribute resources to increase
awareness of the various opportunities for prenatal/perinatal learning and support in the province.

- Hospitals continued to distribute the booklet "Breastfeeding Your Baby", adapted with permission from Toronto Public Health, to all breastfeeding mothers while in hospital. Public health nurses also distributed the booklet to parents in the prenatal period. In 2004-2005, the French translation of the resource became available.

- A pregnancy resource “Healthy Pregnancy Healthy Baby...A New Life”, developed by the Nova Scotia Department of Health, was adapted with permission for use in the province. The book is available to all pregnant women in the province through their physician or public health nurse. The resource was printed and distributed with assistance from the Department and the PEI Reproductive Care Program.

- The PEI Reproductive Care Program in partnership with Women’s Addiction Services and the Aboriginal Women’s Association of PEI hosted the 2nd 2-day workshop in March 2006. The workshop was attended by professionals from health care and education along with parents and other interested members of the community.

**Primary Care Initiatives**

- Prince Edward Island embarked on a redesign initiative aimed at increasing access to primary care services, and a reduced reliance on the system through continued promotion of wellness, disease prevention and management, and population health strategies.

- The Primary Health Care Redesign project, in response to funding available from the Federal Government, encouraged physicians and nurses and other appropriate health care providers to work in collaborative group practices with shared responsibilities for client outcomes.

- Primary health care redesign focused on population health strategies to promote health, and on reorganization of current primary care services to deliver more cost-effective services, while improving health outcomes, service quality and accessibility. These strategies will help to sustain the current system and ensure a sound balance between activities to improve health over the long term, with effective, essential health services to treat people when they are injured or ill.

- In 2005/2006, Family Health Centres were operational in Charlottetown, Summerside, O’Leary, Hunter River/Rustico, and Souris using newly renovated facilities and expanding existing family physician services to include primary care nurses and other health professionals working in collaborative practices.

- P.E.I., as a member of Primary Health Care Atlantic, partnered with the other Atlantic provinces for the Building a Better Tomorrow initiative. The Building a Better Tomorrow initiative developed and delivered effective (post-basic) continuing education curricula to prepare and provide transitional support for current providers in Atlantic Canada who are willing to or contemplating changing the way they work in the primary health care system. The initiative is timely and appropriate to complement and supplement the other provincial primary health care initiatives that are underway. (Nova Scotia is the lead for this initiative). The program has been very successful in P.E.I. with a great interest by health care providers
to access the learning modules. The modules are being offered to community mental health, public health nursing and addictions staff in addition to family health centres.

**Home Care Initiatives**

- The PEI Home Care and Support program provides both *health care and support services* through five key program areas including general home care, adult protection, integrated palliative care, home and community-based dialysis, and assessment for nursing home placement.
- Specific services include nursing, visiting homemaking for personal care, respite and homemaking, occupational, and physical therapies, dietetics, social work and community support.
- Our case management strategy is critical to providing a coordinated care plan for Home Care and Support clients. Home Care and Support services are provided to individuals based on assessed need and intended to: help individuals achieve and/or maintain health and personal independence in the community; and, supplement the care and support available from family and friends.
- PEI’s Home Care and Support programs partner with the Canadian Council on Health Services Accreditation to pilot standards for Palliative Care, participated in the National Pallium Project.
- New initiative: Reorganizing to a provincial home care program.

**Mental Health Initiatives**

- The PEI mental health system is primarily made up of four parts: hospital services, community mental health, non-governmental organizations like the Canadian Mental Health Association, and primary care practitioners. Hospital services consist of in-patient psychiatric units and Emergency Department crisis response teams in two referral hospitals for people with moderate to severe mental illness, and one larger psychiatric hospital for persons with longer term mental illness.
- The Community Mental Health System in the province includes programs that offered assessment, consultation, treatment, crisis intervention, medication, monitoring, outreach, and ongoing support. These referrals grew in complexity as well as in numbers from previous years. The programs were offered at five sites, three of which also included addictions services:
  - West Prince Community Mental Health & Addictions
  - East Prince Community Mental Health & Addictions
  - Richmond Community Mental Health Centre
  - McGill Community Mental Health Centre
  - Kings Community Mental Health Centre & Addictions
• The goals of the Community Mental Health System are to operationalize mental health in such a way that there is province-wide accessibility to assessment and provincial programs, on site or via tele-mental health; and to increase balance between community- and hospital-based resources.

• A three-year mental health service delivery plan (2001-2004) was implemented to move PEI into a “Best Practice” system. This plan enhanced community mental health services with a number of primary initiatives designed to better meet the mental health needs of Islanders:
  o a provincial mental health crisis response system;
  o enhanced outreach services for persons with serious and persistent mental illness;
  o enhanced clinical services;
  o specialized programs for specific populations such as persons with borderline personality disorders;
  o shared care – mental health staff collaboration with primary care staff in family health centres and physician clinics.

• More recently the mental health system collaborated with the addictions system to provide better care for the large number of people with concurrent disorders including screening, liaison and cross orientation. Mental health continues to partner with non-governmental organizations such as the Canadian Mental Health Association to plan and implement services around suicide prevention and around support needs for persons with serious and persistent mental illness.

**Long-Term Care Initiatives**

• There are 18 long term care facilities in the province in 2005/06 which provides nursing level care; nine public manors/facilities and nine private nursing homes. This level of service is for individuals who are assessed as requiring 24-hour registered nurse supervision and care management (level 4 and 5). Payment for long term care is the responsibility of the individual. When a resident of a facility or a person coming into a facility does not have the financial resources to pay their own cost of care (self pay), they may apply for financial assistance (subsidy) under the Long Term Care Subsidization Act and Regulations. They then undergo a standardized financial assessment.

• Private Nursing Homes are licensed by the Community Care Facilities and Nursing Homes Board under the authority of the Community Care Facilities and Nursing Homes Act and Regulations. The public manors/facilities are accredited by the Canadian Council on Health Services Accreditation.

**Pharmacare Initiatives**

• The provincial Drug Cost Assistance programs provide financial assistance to eligible persons for drug costs, professional pharmaceutical consultation services to clients, government and institutions and programs and as well, an economical source of medications to the provincial health and social services system. The programs include the Diabetes Control Program, Family Health Benefit Program, Financial Assistance Program, Multiple Sclerosis Drug...
Program, Seniors Drug Cost Assistance Plan, Nursing Home Program, and Disease Specific Programs.

- The programs are delivered through community retail pharmacies and the Provincial Pharmacy which is located within the Department of Social Services & Seniors. Program delivery by the retail pharmacies is monitored by the Department through a service delivery agreement with the PEI Pharmaceutical Association.

- In 2005/06, funding for drug programs increased by $3.2 million. Included in this was $400,000 in funding for medications used for the treatment of Alzheimer's disease.

**Other Health System Initiatives**

A process to develop a strategic plan to guide the health system over the next three to five years is being undertaken. This plan will replace the 2001-05 Health and Social Services System Strategic Plan. Once completed, the health system plan will provide direction to middle and front line managers, as well as community hospital boards. As part of this process, the Department will complete an extensive community health needs assessment.

**Newfoundland and Labrador**

**Political Representation:**

Progressive Conservative Party: last election October 2003

- Premier: Danny Williams
- Minister of Health & Community Services: Tom Osbourne
- Deputy Minister of Health & Community Services: John Abbott

**Legislative Amendments**

Bill 20, the Smoke-free Environment Act, 2005, was passed by the Legislature on May 19, 2005 and was proclaimed in force on July 1, 2005. The new Act replaces existing legislation restricting the use of tobacco products in public places and work places. Most public places were required to be smoke free prior to the new legislation. The new Act extended the ban on smoking to bars and bingo halls.

Bill 21, the Medical Act, 2005, was passed by the Legislature on May 19, 2005 and was proclaimed in force on July 1, 2005. The new Act replaces existing legislation governing the practice of medicine and incorporates new discipline procedures, new governance arrangements, and changes the regulatory structure to a College model. The new legislation also responds to recommendations flowing from the OxyContin Task Force respecting measures to strengthen the
ability of the College to investigate allegations of inappropriate prescribing of OxyContin and other narcotic substances.

Bill 51, the Dietitians Act, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of dietetics and incorporates new discipline procedures and new governance arrangements.

Bill 52, the Dispensing Opticians Act, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of dispensing opticians and incorporates new discipline procedures and new governance arrangements.

Bill 53, the Hearing Aid Practitioners Act, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing hearing aid practitioners and incorporates new discipline procedures and new governance arrangements.

Bill 54, the Licensed Practical Nurses Act, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing licensed practical nurses and incorporates new discipline procedures and new governance arrangements.

Bill 55, the Massage Therapy Act, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of massage therapy and incorporates new discipline procedures and new governance arrangements.

Bill 56, the Occupational Therapists Act, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of occupational therapy and incorporates new discipline procedures and new governance arrangements.

Bill 57, the Psychologists Act, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of psychology and incorporates new discipline procedures and new governance arrangements.

Bill 58, the Optometry Act, 2004 (Amendment) was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. This amendment updates existing legislation governing the practice of optometry respecting the discipline procedures and governance arrangements.

Bill 59, the Pharmacy Act, (Amendment) was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. This amendment updates existing legislation governing the practice of pharmacy respecting the discipline procedures and governance arrangements.
Bill 60, the Denturists Act, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of denture technology and incorporates new discipline procedures and new governance arrangements.

**Structure and Finance Updates**

**Fiscal Activity**

The Department of Health & Community Services’ budget for fiscal year 2005/2006 is $1,741,417,000. Of this amount, $1,299,914,000 is budgeted for health authorities and agencies delivering acute care, long-term care, emergency and diagnostic services as well as community-based health services such as public health nursing, continuing care, rehabilitative services, etc. Physician services, budgeted at $280,819,200, accounts for the most significant other current account expenditure item.

$45,486,500 is allocated for construction, repairs and renovations and equipment. Health and community services account for $0.47 of every dollar spent on programs and services by the province.

As a result of Public Sector Reform, the department is part of a government-wide process which is putting a new accountability framework for boards and agencies into place. The new Transparency and Accountability Act was passed in the House of Assembly in December 2004. Full implementation of the Act is targeted for April 2008.

**Governance and Management**

Fourteen health boards were integrated into four Regional Integrated Health Authorities, (RIHA) April 1, 2005. New RIHA Legislation is being prepared.

The Department of Health and Community Services (DOHCS) was reorganized in 2005 to align with the new RIHA structures.

In the fall 2005, annual reports (2004/2005) for the DOHCS, all former fourteen health boards and a number of agencies were tabled in the House of Assembly.

The DOHCS and the RIHAs have drafted strategic plans to ensure compliance to the Transparency and Accountability Act. Four strategic directions have been proposed by the DOHCS: Strengthened public health capacity, population health, improved access to priority services, and achieving accountability and stability in the health care system.

Specific renewal processes continue in the area of primary health care, wellness, and mental health and addictions services. In Oct. 2005 the Provincial policy framework for Mental Health and Addictions Services was released: *Working Together for Mental Health* and in March 2006
the provincial wellness plan was released: *Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador*.


**Institutional Change/Reform**

A major goal of the department is to improve the quality, accessibility and sustainability of health and community services delivered in the system. Creating fewer, more accountable health authorities is necessary to renew our health and community services system and meet client needs. Fewer regions will mean less administration and more opportunities for collaboration. Integrated boards will have the ability to focus on the full continuum of care, from community care to acute and long-term care. This will result in better services for clients.

**Regionalization Activity**

Institutional and community health services were delivered by four Regional Integrated Health Care Boards (RIHAs). The infrastructure in the health and community services system in 2005-06 includes:

- Hospitals 16
- Health Centers 18
- Nursing Homes 21
- Nursing Stations 13
- Community/ clinic offices 106

The Department has devolved a number of services to RIHAs in 2005, ambulance and group home services are two examples.

In addition to the RIHAs, a number of other organizations and agencies offer services to the public such as personal care homes and family resource centers.

**Support and Innovation in Health Care**

**Human Resources: Physicians**

A four-year Memorandum of Agreement was negotiated between Government and the provincial medical association (the NLMA) effective October 01, 2005. The award was valued at $18 - $19 million. The award gave a general sector increase of 0.0/2/.33% over four years with additional
dollars for On-call payments and $1.25 million for salaried physicians who provide after hours and On-call services.

As of March 31, 2005 there were 954 physicians providing medical services in the province – 460 general practitioners and 494 specialists. Sixty-three percent of physicians were fee-for-service, 34.9% were salaried and 1.9% were on alternate payment arrangements. Following completion of a draft provincial Physician Resource Plan which was forwarded to all stakeholders for input and feedback, it remains a priority of the Department of Health and Community Services to have a completed resource plan for physicians during the 2006-07 fiscal year.

**Human Resources - Non-Physicians**

There have been several amendments to existing legislation related to improved regulatory structures for health professionals. (Section 1, Part B)

A new health human resource planning structure is under consideration.

**Nursing**

A Chief Nurse position has been created within the Department of Health and Community Services. A Provincial Nursing Network comprised of key stakeholders from the registered nurse and licensed practical nursing occupations has been formed.

Registered Nurse and Licensed Practical Nurse Supply Reports are in the process of being updated. Existing reports (and other health human resource-related documents) are available at: [www.nlhba.nl.ca/hr](http://www.nlhba.nl.ca/hr).

Work continues related to exploring use of alternative care providers, such as nurse practitioners and midwives, in the delivery of health services. Currently there are approximately 60 nurse practitioners in the province.

The Nurse Practitioner Bursary and Rural Nursing Student Incentive Programs continue to be offered.

**Health Management**

A Graduate Program in Health Administration Scholarship has been made available through the Newfoundland and Labrador Health Boards Association. Leadership and related issues have been identified as a priority among several system stakeholders, and future work will build on analysis completed in 2003.

**Other updates**

NL participated in the Atlantic Health Human Resources Planning Study which was recently completed. This study took a needs-based approach to health human resource planning for
selected occupations, and was focused in particular on the education and training of health professionals in the Atlantic Provinces. The executive summary is available at [www.ahhra.ca](http://www.ahhra.ca).

An initiative to examine employee counts, demographics, earned hours, turnover, and other key workforce statistics is underway, representing the fourth iteration of this exercise with employers.

Quarterly vacancy surveys have been administered to track the number and type of vacant positions occurring in the province at various points in time.

Newfoundland and Labrador continues to participate in several national initiatives related to health human resources including working groups advising on workforce modelling and forecasting, entry-to-practice review, the collection of education-related statistics, and others. Newfoundland and Labrador has been availing of the national funds made available for health human resource related projects, and generated several initiatives in this regard, scheduled for completion by March 31, 2006.

Ongoing initiatives aimed at improving human resource recruitment and retention, especially in rural and specialty areas include:

- Seat purchase and bursary programs for physiotherapy and occupational therapy students as well as other bursaries for speech language; pathologists and audiologists. Pharmacy and psychologists bursaries have been available on occasion;
- Retention incentives for RNs and Social Workers in remote communities in Labrador; and
- Collaborating with key stakeholders to develop primary health care reform.

**Health Information and Telemedicine**

Based on the recommendations of the Provincial Task Force on Health Information, the Department of Health and Community Services (DOHCS) has developed a seven-phase strategic health information plan to develop a comprehensive database responsive to the needs of the health system. The Newfoundland and Labrador Centre for Health Information (NLCHI) was established in 1996.

- NLCHI is developing the Health Information Network that will allow for compatible health information systems to be integrated in to comprehensive province-wide electronic health record (EHR). The first component built specifically as part of the provincial Regional Electronic Health Record (REHR) is the Unique Personal Identifier /Client Registry, a registry of demographic information which was implemented in fall 2002.
- NLCHI has begun the implementation of the provincial Diagnostic Imaging / Picture Archiving and Communications System. This information system will facilitate the sharing of images and reports among the Regional Integrated Health Authorities (RIHA).
- NLCHI will begin implementation in May 2006 of the provincial drug information system the Newfoundland and Labrador Pharmacy Network. This information system will unite pharmacies, hospitals, and physicians and allow for the creation of prescription medication profiles.
The province has implemented Meditech software in all RIHA facilities that provide acute and long-term care services. This software provides administrative and clinical support for the RIHA.

The province has developed a province-wide Client and Referral Management System (CRMS) for use in all RIHA in the provision of community-based services. This supports programs such as public health nursing, continuing care, child, youth and family/rehabilitative services. A new CRMS module to manage payments to clients is currently being developed.

Health Programs and Services

Community Health Initiatives

Federal/Provincial/Territorial Initiatives

**National Child Benefit (NCB)** – This is an ongoing initiative to reduce the depth of child poverty. It provides a direct federal benefit to low and middle income families and provincial/territorial reinvestments/investments. The Department of Health and Community Services (DOHCS) maintains an annual provincial NCB investment of $6.8M which supports family resource programs and healthy baby clubs; a range of child care services – family home child care agencies, the subsidy program, infant care centers in high schools, an Early Childhood Educators certification system, and equipment grants to licensed child centers; intervention services for children with delay and disabilities, including autism; and mental health and residential services for youth at risk.

**Early Childhood Development Initiative (ECD)** – This is a commitment to promote the early childhood period (prenatal period to age six) and to assist families and communities in their role to support children. Commencing in 2001-2002, the five-year funding for NL is $36.6M. Referred to as *Stepping into the Future*, the NL initiative provides support to: family resource programs and healthy baby clubs; child care services-subsidy program, the Educational Supplement for Early Childhood Educators, equipment grants for family home child care providers, and regional and provincial human resources; intervention services, with considerable investment in the delivery of ABA intensive home therapy for preschool children with autism; the Mother Baby Nutrition Supplement (Department of Human Resources, Labor and Employment); and early childhood learning grants and the KinderStart Program (Department of Education).

**Early Learning and Child Care (ELCC) Multilateral Framework**– This initiative was announced by the federal government in March 2003. It involves the transfer of annual sustainable funding to provinces/territories for investment in regulated early learning and child care services. The amount for NL is $16.8 M over five years, with annual funding thereafter of approximately $5.5 M. The funding supports investments in: the child care subsidy program, quality initiatives, and support for children with special needs to fully participate in child care services.

**Early Learning and Child Care Bi-lateral Agreement** – Building on the ELCC Multilateral Framework, the bi-lateral agreement signed on May 13, 2005, provides an additional amount of $21.6 M (one-time funding) in federal funding to the province for further investments in regulated...
early learning and child care. The Department is currently in the process of developing a long-term sustainable plan for implementation of the increased funding.

**Children and Youth Initiatives** - The Youth Corrections Initiative - is a major multi-year initiative by the Department in partnership with the RIHAs. Emphasis is on reducing reliance upon youth custody in favor of less costly, less intrusive and more community-based intervention programs.

*The Model for Coordination of Services for Children and Youth with Special Needs* - is a coordinated, multidisciplinary service to young people with special needs who receive services from one or more of the following departments: Health and Community Services, Education, Justice, and Human Resources Labor and Employment. Two of the primary components of the Model are the Individual Support Services Plan (ISSP) and the Profiling Process. The ISSP allows everyone from any agency / department working with a young person to come together with that young person and their family to design a common plan. Profiling identifies areas of unmet need to assist service providers in resource planning and improved service delivery.

**Family Resource Programs/Healthy Baby Clubs** – Provides direct program and administrative support to 19 family resource programs throughout the province. These community-run, not-for-profit programs provide developmentally appropriate activities, informative workshops and build social networks for parents and young children. Family resource programs offer specialized services such as healthy baby clubs.

**Intervention Services/Autism** – Provides support to individuals and families through three programs including:

- The Direct Home Services Program is a family centered, home based, early intervention program with a focus on child outcomes. It is offered to families of infants and preschool aged children who display development or are at risk for delayed development.
- Autism services provide early intensive applied behavior analysis intervention to pre-school age children up to kindergarten who have a diagnosis of an autism spectrum disorder.
- The Community Behavioral Services Program is a community based behavioral support and training program for school age individuals and adults and their families.

**Wellness Initiative**

*Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador* - was launched in March 2006. Phase 1 will be implemented over the next three years and will focus on initiatives in the wellness priority areas including: healthy eating, physical activity, tobacco control, and injury prevention. Key actions will focus on healthy eating and physical activity for children and youth in school, healthy living community based programs, a provincial wellness grants program, and new resources at the provincial and regional levels.

**Population Health-Based Initiatives**
Changes in the demographic structure of the population, such as healthy young adults leaving the province in search of work, declining rural populations, declining birth rates, and overall aging have major cost implications for all core programs under the jurisdiction of the Department of Health and Community Services (DOHCS). Initiatives to address the changing demographic structure include:

- An increase in long-term and community support services in relation to home support, institutional placement, and rehabilitative services;
- Increase in the financial commitments of the provincial Drug Program and the Medical Care Plan to accommodate the increasing number of eligible beneficiaries and the types of therapies needed, and
- Strategic planning in the provision of primary and secondary services to a declining population over a wide-based geographic base including:
  - recruitment and retention of health professionals in rural and remote areas
  - the use of technology and Primary Health Care teams
  - the establishment of an Aging and Seniors Division within the DOHCS

**Seniors**

The newly established Division of Aging and Seniors, through extensive community consultations and best practice research will be developing a Healthy Aging Framework and Action Plan in the coming year. This plan will provide opportunities for healthy aging by providing a seniors’ lens to policy developers across all provincial government departments. Additional initiatives with a seniors focus are:

- Long-term and community support services to seniors are coordinated through a single entry framework operated by regional health authorities. Services include home care, home support, day care, respite, admission to personal care homes, and nursing homes, as well as equipment and medical supplies for care not provided in nursing homes. A provincial long-term and community support services framework is currently being developed to provide direction related to services for seniors as well as other groups.
- Investments in residential infrastructure are being made in various locations throughout the province to ensure appropriate options in the future.
- The Senior Citizen’s Drug Subsidy Program (Guaranteed Income Supplement Recipients) is within the DOHCS.
- There are also interdepartmental initiatives such as the Provincial Home Repair Program administered by the Newfoundland and Labrador Housing Corporation, which provides grants to financially eligible seniors for repairs and renovations.

**Children and Youth**

The Children and Youth Services division of the DOHCS administers the *Child Youth and Family...*
Services Act (2002), the Adoptions Act (2003) and the Child Care Services ACT (1999). This includes child protective services, children in care, adoptions, supports to families and children, youth services, community youth correction, child care services and family resource centres in the province. The division develops policies, standards and programs for the provision of services to children, youth and families in the province. A Minister's Advisory Committee appointed to review the operations of the Child Youth and Family Services Act delivered its first report to the Minister of Health and Community Services in August 2005. New resources have been designated to carry out the recommendations in this report.

Through Federal/ Provincial/ Territorial (F/P/T) initiatives (Early Childhood Development – ECD, Early Learning and Child Care - ELCC and the National Child Benefit – NCB) the number of subsidized child care spaces available to low income families have been increased, an educational supplement for early childhood educators working within licensed child care centres has been implemented, education grants are provided to licensed child care providers, support to families of children with developmental delay and disability has increased, and family child care agencies have been developed.

The minimum income to access the Child Care Services Subsidy Program has been increasing, allowing more low income families to access the program. Initiative have been instituted to increase the quality of programming in child care and training for child care service staff working with children who have special needs.

Women

The DOHCS works with the Women’s Policy Office and other agencies to address a variety of women’s issues such as the Provincial Strategy Against Family Violence. The Provincial Advisory Council on the Status of Women advises government on matters related to the status of women and gender inclusive policy analysis.

The DOHCS provides funding to Regional Integrated Health Authorities (RIHA) to provide women and their children shelter from violent situations.

Aboriginal People

In 1984, the Government of Canada entered into an agreement (Canada/Newfoundland and Labrador Native Peoples of Labrador Health Agreement) with the Province to provide funding arrangements for the provision of health programs and services to the Innu and Inuit in Labrador. These services include patient transportation, dental services, medical supplies, prosthetic / orthotic devices and the services of Public Health Nurses. This agreement has been signed each year (exchange of letters) since 1984.
In 1997/1998 the management of public health employees and programs was devolved to the Labrador Inuit Association and the Mushuau and Sheshatshiu Band Councils. Labrador/Grenfell Regional Integrated Health Authority retains responsibility for primary acute services in the Aboriginal communities.

Mushuau Innu Health Commission provides health services to the Mushuau Innu of Natuashish (formerly Davis Inlet). The Federal Government provides funding to this Commission to provide health and community services including public health nursing, diabetic education, home support, and addiction/mental health/family services. There are 580 Innu residing in Natuashish.

The Sheshatshiu Health Commission provides health services to the Sheshatshiu Innu. The Federal Government provides funding to this Commission to provide community health programs such as public health nursing, diabetic education, home support services, and addiction/mental health/family services. There are 1,134 Innu residing in Sheshatshiu.

In addition to funding provided by Health Canada, Indian and Northern Affairs Canada (INAC) provides funding to the province to deliver, on its behalf, certain child, youth and family services in Sheshatshiu and Natuashish. INAC’s funding is formula-based and does not cover full delivery costs. INAC does not provide child, youth and family services in the Inuit communities.

INAC has assumed financial responsibility for education and income support to Natuashish and Child, Youth and Family Services (CYFS) in both Innu communities. The Innu are planning for the devolvement of programs and services through the development of an Interim Innu Agency. Eventually, the Agency will administer and provide all provincially mandated health, education and social services. The Province is working with the Innu in the development of capacity for this initiative through an Innu Healing Strategy.

On May 22, 2004 Cabinet gave approval to Ministers of HCS and LAA to negotiate the establishment of a Provincial/Innu Child, Youth and Family Services Board with the Innu Nation to oversee the development and operation of an Innu CYFS Agency. This has not occurred to date. However there is an Agreement between the Province and Canada for the devolvement of CYFS to the Innu in Natuashish and Sheshatshiu. Under this agreement, the Federal Government provides funding to Labrador –Grenfell Health Authority to continue to provide CYFS to the two Innu communities until such time the Innu have developed the capacity to run their own agency.

**Persons with Disabilities**

Disability Related Programs/Services are delivered by the four RIHAs in accordance with provincial standards. Funding is provided to the RIHA by the DOHCS. Services include: special child welfare allowance, home support, residential services, equipment, medical supplies and the support of professional program staff (e.g. behavior management specialists, child management specialists, social workers).

Consultants from the Board Services Division of the DOCHS provide interpretation regarding residential program standards for persons with intellectual disabilities. These programs which include the Co-operative Apartment Program, Alternate Family Care Program and the
individualized living option, support approximately 500 persons living outside their family homes.

Basic income support and employment programs for persons with disabilities remain the responsibility of the Department of Human Resources, Labor and Employment. Policy integration and infrastructural supports continue to require monitoring, evaluation and policy work by DOHCS.

The DOHCS continues its involvement in the F/P/T Benefits and Services for Persons with Disabilities Working Group. The most recent work of this committee has been focused on furthering the analysis of the disability supports and income options as new areas of future investment. In addition the Department is represented on the F/P/T Working Group on Family/Informal Care giving to pursue further analysis of potential funding options to strengthen support to caregivers.

**Primary Health Care**

**Primary Health Care Changes**

In April 2002, the Department of Health and Community Services (DOHCS) established the Office of Primary Health Care (PHC). Their mandate was to engage in widespread dialogue with stakeholder groups, and to develop, implement and evaluate PHC teams’ activities throughout the Province. A PHC Framework, *Moving Forward Together: Mobilizing Primary Health Care*, and Action Plan were developed, with the support of a PHC Advisory Council and external stakeholder consultations. Some of the key elements of the new model of PHC include developing PHC teams, forming PHC networks and establishing PHC physician networks, maximizing scope of practice of professionals, pursuing blended payment models for physicians, moving toward funding models that better reflect population needs and challenges, enhancing support and direction for Chronic Disease Management, and utilizing information technology to enhance communications and linkages.

The province’s target for PHC services is to have 95% of the population within 60 minutes of 24/7 PHC site by 2007.

The Provincial PHC Advisory Council, with association, union and regional representation, was set up to advise the Minister of Health and Community Services regarding PHC renewal.

There are 8 provincial PHC team areas (7 rural and 1 urban). These PHC team areas have developed comprehensive proposals, based on their population needs and a service review. With the leadership team of a coordinator, facilitator (focus on Wellness, Community Capacity Building and Chronic Disease Management) and physician lead, each area is at various stages of implementing all features of the provincial framework.

To assist with provider capacity building and sustainability, leadership teams have been provided with facilitation and change management skill support, formalized team development and Scope
of Practice processes are being implemented for all providers in each of the PHC team areas and where appropriate enhancement of emergency road ambulance services are being pursued.

Provincial Working Groups (Teams, Scope of Practice, Information Management, Physicians Payment Models, Wellness and Community Capacity Building, Chronic Disease Management, Program Planning and Evaluation, and Communication), along with PHC teams and appropriate stakeholder participation, are providing direction and support to PHC team areas, based on best practices.

A Physician Working Group has developed a discussion document on physician funding and payment models, with development of contracts (DOHCS and Regional Integrated Health Authorities (RIHAs), and RIHAs and physician networks) and, based on the funding model proposed, physicians in the PHC team areas are agreeable to trial this model over the next year. Communication regarding PHC activities is occurring in PHC team areas, brochures and posters are available throughout the province, a provincial website is being finalized, and a communication plan regarding PHC is being developed provincially.

Comprehensive needs assessment regarding information required by PHC teams has been completed and electronic applications to enhance information sharing are being evaluated in a rural and an urban setting. This is being done with leadership from Newfoundland and Labrador Centre for Health Information (NLCHI) and linked with any provincial information management activities.

A provincial plan for telehealth is approved, which will provide direction for all aspects of telehealth including clinical video-conferencing (e.g. tele-oncology, tele-diabetes), and interoperability amongst telehealth activities and with provincial Electronic Health Records (HER) plan. The implementation plan is in the final stages and will be initiated in the next fiscal year.

A Request for Proposals for pilot testing an Electronic Medical Record (EMR) in Fee-for-Service Physician Practices is in process, with awarding of a contract planned by the end of this fiscal year.

A provincial plan for Chronic Disease Management Collaboratives is being implemented in all PHC team areas. The associated flow sheet is being used electronically in one of the PHC team areas, and the information from the flow sheet is being supported by a software application that will allow collation of the information and its use for direct client service delivery and planning. Based on evaluation, the diabetes collaborative will be implemented across all regions, and a plan to extend the collaborative model to other diseases will be developed and implemented.

Selfcare / Telecare

Selfcare/Telecare is an Atlantic initiative to develop a system to support increased primary health care access through enhanced communications and linkages for prevention/promotion and surveillance, telephone and on-line direction for direct client/patient advice and tele-homecare. An Atlantic needs assessment and business plan has been completed, and the province is in the
late stages of formalizing and signing a Memorandum of Understanding with New Brunswick to initiate the service.

(BBTI) Building A Better Tomorrow Initiative

Building a Better Tomorrow is an Atlantic initiative to support change. Its purpose is to support and sustain change in PHC services by developing and delivering effective educational and orientation materials (e.g., pamphlets, brochures, manuals) to health care providers who deliver these services.

- Six modules have been developed to support understanding PHC, team development, conflict resolution, adult learning, and community development, and they are being implemented in all PHC team areas through Train the Trainer initiatives.
- Over 300 health care providers in project areas have been involved in some form of team development and scope of practice days.
- Support has been provided for teams in relation to chronic disease management collaborative, with Learning Session # 1 completed.

NL is the lead, with Memorial University of Newfoundland, for the development of team modules.

Facilitation Project

NL, in partnership with Ontario, British Columbia, Manitoba and Saskatchewan, is the lead province in multi-jurisdictional proposal approved through Health Canada Tools for Transition Funds. This project will develop a bilingual Facilitation Manual that can be used by all jurisdictions in managing the change to primary health care, and is in its final stages of completion.

Primary Health Care Nurse Practitioners

A Primary Health Care Nurse Practitioner Education Program has been in place since 1997 and is delivered through the Centre for Nursing Studies. In addition to the education program, the role of nurse practitioners is supported by a legislative framework through amendments to the Registered Nurses Act (1997). An evaluation of the implementation of NP-PHC role was completed. The report has been helpful to inform new directions in PHC renewal in the province.

Home Care Initiatives

(Covered under the long-term community supportive services section)

Mental Health and Addictions

In Oct. 2005, the Province released, Working Together for Mental Health, a comprehensive strategy for the mental health and addictions system that encompasses all age groups and the full
continuum of mental health and addictions services. The policy framework recognizes that addictions services are an essential component of the broader mental health system and emphasizes prevention of addictions and other mental health problems. The framework supports the role of clients/consumers and their families in treatment decisions and promotes greater responsiveness to their changing health and social needs by establishing better connections among all sectors of the health and community services system. Full implementation of the framework is a long-term commitment that will take some years to be realized.

Strategic planning for mental health and addictions services began in 2004 with focus on: identifying long-standing gaps within our mental health system; creating more access to mental health services and treatment; and in time, reduce the stigma that individuals suffering with mental illness face today. In 2005 investments were made in the areas of OxyContin task force recommendations, upgrading infrastructure, enhancing mental health services for home and community supports and enhanced services for gambling addictions. Mental health and addictions services are provided through regional boards.

The importance of consumer involvement in service planning and evaluation is supported through a Consumer Initiative Project with the Canadian Mental Health Association, Newfoundland Branch, and the Consumer Health Awareness Network of Newfoundland and Labrador. The purpose of this project is to develop and maintain a provincial consumer network and local self-help groups.

Cabinet has directed the DOHCS to draft new mental health legislation. A stakeholder group on legislation has been advocating replacement of the current *The Mental Health (1971)* for five years and in 2003, Judge Donald Luther presented recommendations for new legislation as the result of an Inquiry into the Fatal Police Shooting of Norman Reid and Darryl Power.

Government has designed a Video Lottery Terminal Action Plan to address gambling concerns. The plan has two key components: first, government will reduce the number of machines and accessibility to them; and second, government will enhance counseling and addiction services for those who need it.

**Long-Term and Community Support Service Initiatives**

Long-term and community support services are available along the continuum of in-home, community residential and facility-based options such as home support, respite, personal care homes, cooperative apartments and nursing homes. Service is accessed through a single entry system provided by the four Regional Health Authorities. Community support services also include professional services such as nursing, social work, physiotherapy and occupational therapy. Professional services are provided through public funds. Home support services are financially means tested and are primarily provided to seniors and persons with disabilities. Eligible seniors receive a maximum of $2,707/month and persons with disabilities may receive a maximum of $3,875/month.
There are 97 personal care homes located in various communities across the province. These homes have 2,931 beds and provide residential accommodation primarily to persons with low care needs. Some personal care homes that meet provincial design and program standards admit Level II clients. Professional consultation services (i.e., nursing, dietetics) are provided to personal care homes on a visiting basis by staff employed within the regional health authorities. Clients in personal care homes pay a maximum of $1,138.10 a month based on a financial assessment.

Facility-based long-term support is provided in 21 nursing homes, 13 community health centers and four hospitals. Persons admitted to facility-based long-term care pay a maximum of $2800/month based on a financial assessment. Design and construction of three new long-term care facilities in three regions of the province is underway. The models are of a “social” nature to facilitate a home-like environment for residents with the design providing amenities to suit the residents’ particular needs.

Given the demographic structure of an aging population, long term and community support services have been prioritized for development of a new provincial service delivery framework. The framework will be the foundation for new evidenced based policies and a coherent delivery of services across population groups. Investments are currently being made in the areas of infrastructure, new financial and client assessment tools, rate structure reviews, new models of residential support, and increased home supports.

**Pharmacare Initiatives**

The Newfoundland and Labrador Prescription Drug Program assists residents who qualify for benefit coverage to purchase pharmaceutical therapy under the following programs:

- Income Support Drug Program (Income Support recipients and residents who qualify for a drug card only, based on financial assessment).
- Senior Citizen’s Drug Subsidy Program (Guaranteed Income Supplement Recipients)
- Special Needs Program (Cystic Fibrosis, Growth Hormone Deficiency, and Food Bank Program).
- Regional community health boards administer the Special Assistance Program and Medical Equipment and Gases Program.

The Department of Human Resources Labor and Employment determines client eligibility for Income Support clients and the Department of Health and Community Services administers the program.

The delivery/supply of pharmaceuticals is affected primarily through service providers such as physicians, pharmacists, and manufacturers who operate in a free enterprise market system.

Claims to the program are processed in accordance with a service contract with an external claims adjudicator who processes through pharmacies and provides an information data base to
departmental staff to enable better budget, client, physician and pharmacy monitoring, as well as the application support for the processing of special authorization requests. Detailed information is available at: www.gov.nl.ca/health/nlpdp.

In an effort to streamline and reduce duplication in the approval of drugs to be added to provincial drug formularies, Newfoundland and Labrador is collaborating nationally and Atlantically on drug review processes. The National Common Drug Review includes Federal, Provincial, and Territorial jurisdictions and completes reviews for all new chemical entities. The Atlantic Common Drug Review completes class reviews, considers line extensions, and performs other assessments related to existing drugs.

**Other Health System Initiatives**

**Provincial Tobacco Reduction Strategy**

A renewed Provincial Tobacco Reduction Strategy for Newfoundland and Labrador, that outlines priority areas for action for the next three years (2005-2008), was released in June 2005. The strategy, lead by the Alliance for the Control of Tobacco (ACT), in partnership with Department of Health and Community Services (DOHCS) and other key partners, will develop and implement strategies to: decrease smoking rates among youth and young adults, reduce exposure to secondhand smoke and develop a coordinated approach to cessation.

The Department of Health and Community Services, in collaboration with the ACT, the Regional Integrated Health Authorities (RIHAs), other government departments, and numerous community organizations, are working to prevent and reduce the negative impacts smoking continues to have on the people of the province. Throughout 2005-06 the DOHCS collaborated on a number of ongoing activities related to its support of the Provincial Tobacco Reduction Strategy including the Lung Association's Smokers' Help Line and CARE Program – Community Action and Referral Effort (a proactive way of referring smokers to the Smokers’ Helpline services where they can receive services and support to meet their individual needs), Kick the Nic a stop smoking program for teens, and the redistribution of a Grade Seven Tobacco Prevention Resource Kit for teachers and students.

**Amendments to Smoke-Free Environment Act**

The Newfoundland and Labrador amended the *Smoke-Free Environment Act* to further protect the public and workers from the dangers of second-hand smoke. In July 2005, all public spaces, including bars and bingo halls, were designated as smoke-free environments.

**Smoking on School Grounds**

The ACT has been active in raising public awareness about the negative effects of allowing smoking to occur on school grounds. A survey of all school administrators was conducted in May 2005 to determine current policies regarding smoking on school grounds, to list concerns regarding the provision of smoking areas, and to assess the level of support for creating provincial policies or legislation to prohibit smoking on school property. Since the completion of the
survey, three of the five school boards have decided to bring in district-wide policies to ban smoking on school grounds.

**Youth Smoking Prevention Campaigns**

In October 2005, ACT launched a mass media campaign (*You’re a Target: Don’t Let ‘Em Get You*) with funding from Health Canada, to encourage older school aged youth to become more aware of their vulnerability to smoking and the tobacco industry. A second campaign in K-6 schools (*S.P.Y. – Smoking Poisons You*) was also launched in January 2006, to raise elementary students’ awareness about the hazards of smoking. In March 2005, the government increased the tax rates on manufactured cigarettes and fine cut tobacco.

**Public Health Initiative**

Over the next two years government is committing significant additional human resources to Public Health initiatives.

Thirty-nine public health nursing positions to enhance the regional core public health programs and ensure the administration of public health delivered immunization programs with a capacity for mass immunization in the event of a pandemic. Four regional health emergency professionals, along with their required supports, will be hired to develop regional emergency response plans with initial priority on pandemic influenza preparedness planning.

Five positions in the Department of Health and Community Services, including: an epidemiologist, infection control specialist, director of disease control, director of public health information management, and deputy provincial medical officer of health. The creation of these new positions will increase the province’s ability to provide expertise and to support its leadership role in all areas of public health.
**UPDATE BY TOPIC**

**SECTION I: Political Updates**

**Current Political Representation/ La Representation Politique**

**Health Canada**

- Minister of Health: The Honourable Tony Clement, appointed February 6, 2006.
- Associate Deputy Minister of Health: Hélène Gosselin, appointed December 20, 2004.

**Santé Canada**

Gouvernement du Canada : Gouvernement conservateur minoritaire élu le 23 janvier 2006.

**Northwest Territories**

**Part A: Current Political Representation**
- Consensus government: last election November 24, 2003
- Minister of Health and Social Services: J. Michael Miltenberger
- Deputy Minister of Health and Social Services: D.J. (Dave) Murray

**Yukon Territory**
- Yukon Party: in power since October 2002
- Premier: Dennis Fentie
- Minister of Health and Social Services: Brad Cathers (Elected November 2002, became Minister December 2005)
- Deputy Minister of Health and Social Services: John Greschner
British Columbia

- B.C. Liberal Government: next election; May 12, 2009
- Premier: Honourable Gordon Campbell
- Minister of Health: Honourable George Abbott
- Deputy Minister of Health: Dr. Penny Ballem

Alberta

- Progressive Conservative Party: last election November 2004
- Premier: Ralph Klein
- Minister of Health and Wellness: Iris Evans
- Deputy Minister of Health and Wellness: Paddy Meade

Saskatchewan

- New Democratic Party: last election November 2003
- Premier: Lorne Calvert
- Minister of Healthy Living Services: The Honourable Graham Addley (appointed October 14, 2005)
- Deputy Minister of Health: John Wright
- Associate Deputy Minister of Health: Mike Shaw
- Assistant Deputy Minister of Health: Max Hendricks (March 1, 2006) /Lawrence Krahn (retired February 28, 2006)
- Assistant Deputy Minister of Health: Duncan Fisher

Saskatchewan is striving to provide the timely care Saskatchewan residents require through the public Medicare system. We are working to reduce wait times through our surgical care network and through investments in health services, health providers and the health infrastructure.

Manitoba

- New Democratic Party: last election June 2003
- Premier: Hon. Gary Doer
- Minister of Health: Hon. Tim Sale
- Minister of Healthy Living: Hon. Theresa Oswald
• Deputy Minister of Health and Healthy Living: Arlene Wilgosh

**Ontario**

• Last election was in October 2003: Liberal Government was elected
• Premier as of October 23, 2003: Dalton McGuinty
• Minister of Health and Long-Term Care: George Smitherman
• Deputy Minister of Health and Long-Term Care: Ron Sapsford
• Associate Deputy Minister of Health and Long-Term Care & Executive Lead, Health Results Team: Hugh MacLeod

**Quebec**

• Parti libéral, élu en avril 2003.
• Premier ministre : monsieur Jean Charest.
• Ministre de la Santé et des Services sociaux : monsieur Philippe Couillard.
• Ministre déléguée à la Protection de la jeunesse et à la Réadaptation : madame Margaret F. Delisle.
• Sous-ministre de la Santé et des Services sociaux : monsieur Juan Roberto Iglesias.
• Liberal Party, elected in April 2003.
• Premier: Jean Charest.
• Ministre de la Santé et des Services sociaux: Philippe Couillard.
• Ministre déléguée à la Protection de la jeunesse et à la Réadaptation: Margaret F. Delisle.
• Sous-ministre de la Santé et des Services sociaux: Juan Roberto Iglesias.

**New Brunswick**

• Progressive Conservatives re-elected June 9, 1993.
• Liberal party member for Saint John Harbour, elected in November 14, 2005 Bi Election.
• Premier Bernard Lord.
• Minister of Health and Wellness, Elvy Robichaud. As of February 14, 2006, Minister of Health (and Attorney General), Brad Green, Q.C.
• Deputy Minister of Health and Wellness, Nora Kelly. As of February 14, 2006, Deputy Minister of Health, Nora Kelly.
• Family medicine is most often provided through privately owned physicians’ offices; eligible services are funded through Medicare. Some services are also provided in the private offices
of other health professionals. There are no current plans to expand the range of privately provided services.

Nova Scotia

- John Hamm, Progressive Conservative, Premier: August 16, 1999 – February 24, 2006
- Chris A. d’Entremont, Minister of Health: February, 2006 - Rodney MacDonald, Minister of Health Promotion: December 19, 2002- February 2006
- Barry Barnet, Minister of Health Promotion and Protection: February 2006- Cheryl Doiron, Deputy Minister of Health: September 27, 2004-
- Duff Montgomerie, Assistant Deputy Minister of Health Promotion and Protection: January 2006- The Department of Health does not fund privately owned and operated health care service delivery structures

Prince Edward Island

Progressive Conservative Party: last election September 29, 2003

- Premier: Patrick Binns
- Minister of Health: J. Chester Gillan
- Deputy Minister of Health: David B. Ril

New Foundaland and Labrador

Progressive Conservative Party: last election October 2003

- Premier: Danny Williams
- Minister of Health & Community Services: Tom Osbourne
- Deputy Minister of Health & Community Services: John Abbott
 SECTION II: Legislative Initiatives / Mesures Legislatives

Health Canada

Bill C-28, *An Act to amend the Food and Drugs Act (Interim Marketing Authorizations for Food)* was tabled in the House of Commons on May 11, 2005. Bill C-28 died on the Order Paper with the dissolution of Parliament on November 29, 2005.

Bill C-206, *an Act to amend the Food and Drugs Act*, sponsored by Paul Szabo (Liberal Party), was tabled in the House on Commons March 21, 2005. The Standing Committee on Health, in its Eight Report, recommended that the Bill proceed no further.

Bill C-420, *an Act to amend the Food and Drugs Act*, sponsored by Colin Carrie (Conservative Party of Canada), was tabled in the House of Commons on November 23, 2005. The Standing Committee on Health, in its Seventeenth Report recommended that the Bill proceed no further.

The proposed *Regulations Amending the Tobacco Reporting Regulations* was concurred in the House of Commons on March 23, 2005.

Bill S-3 *An Act to Amend the Official Languages Act (promotion of English and French)* received Royal Assent on November 24, 2005, with the support of all political parties except the Bloc Québécois. Under this legislation, all federal institutions have the duty to ensure that positive measures are taken for the implementation of the government's commitment to enhance the vitality of the English and French language minority in Canada.

Committees and Working Groups

*House of Commons Standing Committee on Health*

Over the course of the 38th Parliamentary session, October 4, 2004, to November 29, 2005, the Standing Committee on Health held a total of 57 meetings. The Committee completed the review of two Government bills – Bill C-12, *An Act to prevent the introduction and spread of communicable diseases*, and Bill C-28, *An Act to amend the Food and Drugs Act (Interim Marketing Authorizations)*. The Committee also completed studies of two Private Members’ bills—Bill C-206, *An Act to amend the Food and Drugs Act* (warning labels regarding the consumption of alcohol), and Bill C-420, *An Act to amend the Food and Drugs Act* (definitions of drug and food). In both cases, the Committee tabled reports recommending that the House not proceed with the bills. Both reports died on the Order Paper upon dissolution of Parliament. The Committee also tabled reports on the following issues: Compensation for Hepatitis C victims (Seventh Report tabled on March 22, 2005); Internet Pharmacies (Fourteenth Report tabled on June 6, 2005); Silicone Gel-Filled Breast Implants (Sixteenth Report tabled on November 4, 2005); Tobacco Smuggling (Twelfth Report tabled in the House on May 31, 2005); and, Fetal Alcohol Spectrum Disorder (Ninth Report tabled on April 15, 2005).
**House of Commons Standing Committee on Public Accounts**


**House of Commons Standing Committee on Agriculture and Agri-Food**

On June 16, 2005, the Committee on Agriculture and Agri-Food held a session regarding a bi-annual update on the activities of the Pest Management Regulatory Agency. The Committee also held meetings on other issues of interest to the Health Portfolio including Avian Flu.

**Senate Standing Committee on Social Affairs, Science and Technology**

Throughout Spring 2005, the Senate Standing Committee on Social Affairs, Science and Technology continued its study on mental health, hearing from Health Canada officials, as well as officials from several other government departments. The Committee plans to table its final report in May 2006. On November 1, 2005, the Committee adopted orders of reference to study the state of preparedness for a pandemic on the part of the Canadian Government, and measures that Canadians and Canadian businesses could take to prepare for an epidemic.

**Consultative Committees for English-Speaking and French-Speaking Official Language Minority Communities**

In 2000, Health Canada created two Consultative Committees for English-speaking and French-speaking Official Language Minority Communities. These Committees are made up of community representatives, professionals, health educators and managers, and federal and provincial public servants. The Committees meet regularly to advise the Minister of Health on ways of enhancing the vitality of official language minority communities and supporting their development. The Committees also provide advice to the Health Portfolio on matters relating to the implementation of the federal *Action Plan for Official Languages*.

**Santé Canada**


Le projet de loi C-206, *Loi modifiant la Loi sur les aliments et drogues*, parrainé par Paul Szabo (libéral Mississauga-Sud), a été déposé à la Chambre des communes le 21 mars 2005. Le Comité permanent de la santé, dans son huitième rapport, a recommandé que le projet de loi ne soit pas adopté.
Le projet de loi C-420, *Loi modifiant la Loi sur les aliments et drogues*, parrainé par Colin Carrie (parti conservateur du Canada, Oshawa), a été déposé à la Chambre des communes le 23 novembre 2005. Le Comité de la santé, dans son dix-septième rapport, a recommandé que le projet de loi ne soit pas adopté.

Le projet de *Règlement modifiant le Règlement sur les rapports relatifs au tabac* a été adopté à la Chambre des communes le 23 mars 2005.

Le projet de loi S-3, *Loi modifiant la Loi sur les langues officielles (promotion de l’anglais et du français)*, a reçu la sanction royale le 24 novembre 2005, avec l’appui de tous les partis politiques, à l’exception du Bloc Québécois. En vertu de cette loi, toutes les institutions fédérales ont le devoir de veiller à ce que des mesures positives soient prises pour donner suite à l’engagement des gouvernements de renforcer la vitalité des minorités de langue anglaise et de langue française au Canada.

**Comités et Groupes de Travail**

*Comité permanent de la santé de la Chambre des communes*


Le Comité a également déposé des rapports sur les sujets suivants : indemnisation des victimes de l’hépatite C (septième rapport déposé le 22 mars 2005); pharmacies Internet (quatorzième rapport déposé le 6 juin 2005); implants mammaires au gel de silicone (seizième rapport déposé le 4 novembre 2005); tabac de contrebande (douzième rapport déposé à la Chambre le 31 mai 2005); troubles du spectre de l’alcoolisation fœtale (neuvième rapport déposé le 15 avril 2005).

*Comité permanent des comptes publics de la Chambre des communes*

**Comité permanent de l’agriculture et de l’agroalimentaire de la Chambre des communes**

Le 16 juin 2005, le Comité de l’agriculture et de l’agroalimentaire a tenu une séance sur une mise à jour semestrielle des activités de l’Agence de réglementation de la lutte antiparasitaire. Le Comité a également tenu des rencontres sur d’autres sujets d’intérêt pour le portefeuille de la santé, notamment la grippe aviaire.

**Comité sénatorial permanent des affaires sociales, des sciences et de la technologie**

Le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie a poursuivi son étude sur la santé mentale au cours du printemps de 2005, entendant des responsables de Santé Canada, ainsi que des responsables de plusieurs autres ministères fédéraux. Le Comité prévoit déposer son rapport final en mai 2006. Le 1er novembre 2005, le Comité a adopté des ordres de renvoi afin d’étudier l’état de préparation du gouvernement du Canada à une pandémie et les mesures que peuvent prendre les Canadiens et les entreprises canadiennes pour se préparer à une pandémie.

**Comités consultatifs pour les communautés de langue officielle minoritaire anglaise et française**

En 2000, Santé Canada a créé deux comités consultatifs pour les communautés de langue officielle minoritaire anglaise et française. Ces comités comptent des représentants de la communauté, des professionnels, des éducateurs et des gestionnaires dans le domaine de la santé ainsi que des fonctionnaires fédéraux et provinciaux. Les comités se réunissent régulièrement afin de conseiller le ministre de la Santé sur la façon de renforcer la vitalité des communautés de langue officielle minoritaire et d’appuyer leur épanouissement. Les comités prodiguent également des conseils au portefeuille de la santé sur des questions touchant à la mise en œuvre du plan d’action fédéral pour les langues officielles.

**Northwest Territories**

- **Personal Directives Act**: This new Act was given assent in October 2005. The Act came into effect on January 1, 2006. NWT residents 19 years of age and older may make legally binding personal directives which set out in advance instructions about their health care and personal matters. Further, the Act allows for the designation of an agent of choice to act for an individual in the event of incapacity.
- **Tobacco Control Act**: This Bill was introduced in the House and received second reading in October 2005. The Bill proposes to control where smoking may occur and how cigarettes can be displayed and sold.
- **Tlicho Community Services Agency Act**: This Act came into force on August 4, 2005. The Act establishes the Tlicho Community Services Agency (TCSA) as a Board of Management subject to the provisions of the Hospital Insurance and Health and Social Services Administration Act.
Yukon Territory

- The Yukon completed consultations with owners of large public drinking water systems and bulk water delivery businesses, and is currently undertaking consultations with owners of small public drinking water systems and stakeholders to develop a Drinking Water Regulation under the Public Health and Safety Act.

- September 2005 amendments were made to Communicable Disease Regulations under the Public Health and Safety Act to expand the current list of diseases that must, by law, be reported to the Yukon Communicable Disease Control.

British Columbia

Spring 2005 - No legislative amendments – election writ in effect.

Fall 2005 - Health Statutes Amendment Act, 2005 (Bill 15)

- This Act makes a change to the status of nurse practitioners (NPs) under the Health Authorities Act. Specifically, it excludes NPs from the collective bargaining process that applies to registered nurses.

- Bill 15 also amends the Vital Statistics Act to authorize Cabinet to make an order authorizing the CEO of the Vital Statistics Agency to enter into information sharing agreements with specified public bodies under certain terms and conditions. These agreements must state who will have access to the disclosed information, the circumstances under which information will be disclosed, the limits attached to the disclosure of information, how the information will be stored, how compliance with the agreement will be monitored, and the term of the agreement. Cabinet may make regulations prescribing those bodies with whom the CEO of the Vital Statistics Agency can enter into information sharing agreements.

  [These amendments came into force on Royal Assent November 24, 2005.]

Alberta

In the Spring 2005 Session the Smoke Free Places Act received assent.

The Act protects minors and sets a minimum provincial standard for protection from second-hand smoke for Alberta by defining the types of facilities in which smoking may or may not occur. Subject to specific exceptions, it prohibits smoking in a public place, a workplace and a public vehicle. Offences are also prescribed. The Act and its accompanying regulation came into effect January 1, 2006.

The Smoke Free Places Signs Regulation was also developed to support the provisions of the Smoke-Free Places Act. A sign indicating the status of the establishment must be posted at every entrance to the enclosed public place, including public transportation such as taxis, or indoor workplace so that it is clearly visible to those entering.
During 2005, the Health Care Protection Regulation was amended to remove the list of enhanced medical goods and services and to remove the prescriptive costing formula used to calculate the costs of an enhanced good or service. The changes allow regional health authorities to:

- determine for, within the broad definition provided by the *Health Care Protection Act*, what is an enhanced good or service.
- determine the rates for the enhanced goods or services.

In the summer of 2005 the Hospitalization Benefits Regulation was amended to remove preferred accommodation rates from the regulation and allow regional health authorities to set rates.

In January 2006, the Food and Food Establishment Regulation was amended to:

- better define the application of the regulation to community settings; and
- avoid the application of the regulation in a manner that had an undue negative impact on volunteer community organizations and events.

The existing regulation was repealed and replaced by a new regulation with a new name: the Food Regulation.

In January 2006 the remaining sections of the Blue Cross Amendment Act, were brought into force to amend the ABC Corporation Act. The amendments in conjunction with the revised ABC Benefits Corporation Regulation, establish a payment in lieu of taxes program for the ABC Benefits Corporation to level the playing field with other supplementary health insurance providers.

**Saskatchewan**

*The Osteopathic Practice Repeal Act, 2005*

The Act, which was originally enacted in 1944, was outdated and there are no practicing osteopaths in the province. The Act was granted Royal Assent on May 27th, 2005.

Repeal of the Act enables recently trained Canadian graduates of osteopathy to practice in Saskatchewan, enables freedom to practice in the province as long as they do not engage in any invasive treatment that might encroach on the scope of practice of any regulated health profession.

*The Youth Drug Detoxification and Stabilization Act*

The Act allows for involuntary detoxification and stabilization of youth through an order by two physicians for a period of five days, with the possibility of extension for a maximum of two additional five-day periods. Involuntary detoxification/stabilization will serve as a measure of last resort for parents, legal guardians and judges when it is determined that a youth’s substance use presents a risk to his/her own safety or the safety of others. The Act was given Royal Assent on December 2, 2005 and came into force on proclamation April 1, 2006.
The Hearing Aid Sales and Services Act
The Act came into force in March 2006. Under this legislation, all private sector hearing aid businesses are required to be licensed with Saskatchewan Health. Hearing aid vendors will be required to be compliant with the legislation to ensure consumers receive quality hearing services and hearing aids from trained practitioners who meet the accepted standards of practice. Saskatchewan Health, as the regulatory body responsible for the legislation, will have ability to investigate complaints from consumers and take action if the complaint is found to be valid.


Manitoba

Changes in Health and Health related Legislation

- *The Manitoba Council on Aging Act* (Bill 8) received royal assent and came into force on June 16, 2005
  - This Bill continues the Manitoba Council on Aging. The Council provides advice to government on matters relating to the aging process and the needs of seniors. It also promotes public understanding about the aging process.

- *The Emergency Measures Amendment Act* (Bill 15) received royal assent and came into force on June 9, 2005.
  - This Bill authorizes the province to enter into agreements with other jurisdictions about emergency planning and providing assistance during emergencies. It deals with the qualifications of people from other jurisdictions who provide emergency assistance in Manitoba, as well as liability for their actions while here.

- *The Regional Health Authorities Amendment and Manitoba Evidence Amendment Act* (Bill 17) received royal assent on June 16 and will come into force upon proclamation.
  - This Bill enhances the safety of hospital patients, residents of personal care homes and other people receiving health services. *The Regional Health Authorities Act* is amended to deal with critical incidents. A critical incident is an unintended event that harms a person while he or she is receiving health services. The Bill requires regional health authorities, health corporations and certain health care organizations to report and investigate critical incidents, to keep records about them, and to keep the people affected fully informed. It also permits the patient, a patient’s relative or an employee of a regional health authority, a health corporation or certain health care organizations to report an incident and the incident must be investigated.

  Amendments are made to *The Manitoba Evidence Act* concerning committees that deal with critical incidents, hospital standards, medical staff and research. What happens at those committees cannot be disclosed in legal proceedings, as long as certain information, such as patient records or the facts of a critical incident, is otherwise available to the
The Bill includes a consequential amendment to The Mental Health Act to permit information to be disclosed to a committee formed to look into a critical incident.

- **The Workplace Safety and Health Amendment Act (Needles in Medical Workplaces) (Bill 23)** received royal assent on June 9th and came into force on January 1, 2006.
  - This Bill requires medical workplaces to protect workers by ensuring that safety-engineered needles - such as shielded needle devices or retractable needle systems - are used whenever possible. In addition, they must implement safe work procedures and practices relating to the use of needles.

- **The Health Services Insurance Amendment and Prescription Drugs Cost Assistance Amendment Act (Bill 42)** – This bill received royal assent and came into force on June 16, 2005.
  - This Bill makes several amendments to The Health Services Insurance Act. The key amendments are as follows:
    - the information-gathering powers of the committee that monitors patient use of the health care system, and the limitations on those powers, are clarified;
    - the power to prescribe services for which no benefit is payable is amended; and
    - the powers of inspectors under various provisions of the Act are made consistent.
  - This Bill also amends the powers of inspectors under The Prescription Drugs Cost Assistance Act, making them consistent with those under The Health Services Insurance Act. Other amendments to The Prescription Drugs Cost Assistance Act reflect recent changes in the law allowing "nurse practitioners" to prescribe drugs in certain circumstances.

- **The Regulated Health Professions Statutes Amendment Act (Bill 43)** - This Bill received royal assent on June 16, 2005 and came into force on September 1, 2005 for all health professions statutes except The Medical Laboratory Technologists Act (which is not yet proclaimed) and The Occupational Therapists Act which came into force on December 15, 2005. The amendments for the Medical Laboratory Technologists Act will become effective when the Act does.
  - This Bill amends 19 statutes that regulate the practice of health professionals.
  - Most of the statutes are amended to allow the regulatory bodies to waive registration or licensing requirements if there is a public health emergency and health professionals must be brought in from elsewhere in Canada or from the United States. Amendments to The Denturists Act and The Opticians Act do not include these provisions.
  - The amendments to all statutes require the regulatory bodies to collect certain demographic information about their members and give it to the minister for an electronic registry of health service providers.
The minister may then use the information for limited purposes, and share it, in non-identifying form, with authorized entities such as regional health authorities.

The Medical Act is further amended to clarify what information is to be included in the physician profiles that the College of Physicians and Surgeons will make available to the public.

**The Statutes Correction and Minor Amendments Act – (Bill 50) – This Bill received royal assent and came into force on June 16, 2005.**

This Bill corrects typographical, numbering and other drafting errors. It also makes minor amendments to various Acts and repeals an obsolete Act. The amendments related to health are as follows:

- *The Elderly and Infirm Persons Housing Act* to delete references to personal care homes;
- *The Health Services Insurance Act* to clarify the age description in part of the definition “dependant”;
- *The Human Tissue Gift Act* to add a definition of “minister” and correct a typo;
- *The Mental Health Act* to correct a spelling error;
- *The Personal Health Information Act* to revise the French version of the definition “health”;
- *The Pharmaceutical Act* to remove any restrictions on the ability of a registered nurse (extended practice) to prescribe drugs in accordance with the regulation under *The Registered Nurses Act*;
- *The Non-Smokers Health Protection Act* by changing its number in the Continuing Consolidation from S125 to N92.

**The Medical Amendment Act (Bill 207) – This Bill received royal assent and came into force on June 16, 2005.**

This Bill amends *The Medical Act*. It allows physicians more flexibility to practise non-traditional therapies and other therapies that differ from prevailing medical practice, without the potential for professional discipline unless the non-traditional or differing therapy involves a greater risk to patient health.

**The Dental Hygienists Act (Bill 5) – This Bill received royal assent on December 8th, 2005. The transitional provisions came into force on royal assent. The remainder will come into force on a day fixed by proclamation.**

This Bill defines the practice of dental hygiene and provides for the regulation of the profession.

It includes provisions to

- establish the College of Dental Hygienists of Manitoba;
- establish a governing council with public representatives;
• require the registration of dental hygienists;
• create processes for handling complaints and discipline.

• The Dental Association Amendment Act (Bill 6) – This Bill received royal assent on December 8th, 2005 and was proclaimed on March 24, 2006.
  o The amendments to The Dental Association Act in this Bill allow the Dental Association to regulate dental assistants. They also amend the Act to remove all references to administrative rules since the Association deals with administrative matters by by-laws.

• The Occupational Therapists Act - S.M. 2002 chapter c.05 (was proclaimed on December 15, 2005
  o This Act came into force on December 15, 2005 in order to allow time to develop and adopt regulations that are necessary under the Act. The new act provides for increased public accountability, changing the education standard, requirements for continuing competence and updating of the scope of practice and updated disciplinary procedures.

• The web site for Manitoba Laws is http://web2.gov.mb.ca/laws/statutes/index.php

Updates on Advisory Committees/Working Groups:

• The College of Medical Laboratory Technologists of Manitoba Transitional Council was established in 2003. The Medical Laboratory Technologists of Manitoba Transition Council (MLTMTC) is moving forward with its mandate of transitioning to a College of Medical Laboratory Technologists of Manitoba. The Transitional Council has appointed a Registrar and commenced the registration process. It is anticipated that the College will commence its operations in 2006.

• The Dental Hygienists of Manitoba Transitional Council will be established by May, 2006 to get the new College of Dental Hygienists of Manitoba up and running.

• The Personal Health Information Act (PHIA) Steering Committee, with Government and external representatives, was established in 2002. PHIA requires the Minister of Health to undertake a comprehensive and public review of the legislation. The PHIA Review Steering Committee reviewed feedback received during the public consultation process, and will be proposing amendments to the Act. Recommendations for amendments are currently under review within government. http://www.gov.mb.ca/health/phia/index.html

Ontario

Ambulance Act Amendments 2005 - In 2005, amendments to the Ambulance Act (the Act) were enacted by the Budget Measures Act (No. 2), 2005, S.O. 2005, c. 31, Schedule 1 (Ambulance Act) which was introduced November 2, 2005, received 2nd reading December 12, third reading December 14 and received Royal Assent on December 15, 2005.

Under new section 4(2.1) of the Act, the Minister has the power (but not the duty) to designate one or more corporations without share capital as having the powers and responsibilities now
given to an air or land base hospital under the Act. Where the Minister has made such a designation, all of the provisions of the Act and regulations that apply to a base hospital would also apply to the designated corporation, unless the Act or regulations specifically provide otherwise.

The 2005 amendment also expands the section 22(1)(e.6) regulation-making power to permit the making of a regulation respecting the functions and duties of base hospitals, corporations designated under section 4(2.1) and communication (dispatch) services.

The Local Health System Integration Act, 2005 – This act was introduced November 24, 2005. Second Reading was carried on December 7th, 2005 and it was ordered for third reading on February 15, 2006. Third Reading took place on February 27th and Royal Assent was received on March 28th, 2006.

The purpose of this Act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks.

The Transparent Drug System for Patients Act, 2006 was introduced on April 13, 2006. Second reading was carried on May 10, 2006, third reading June 19, 2006 and Royal Assent granted June 20, 2006.

The Act will strengthen the legislation, ensure the viability of pharmacists, and secure better access to better drugs for patients. The changes include:

- Regulating payments made to pharmacists (“rebates”) and permitting pharmacists to receive defined "professional allowances" under a new Code of Conduct,
- Securing volume discount benefits for government on drugs purchased for the public system
- Including a Pharmacy Council and a Citizen's Council in the legislation
- Instituting an automatic second review of recommendations made to the Executive Officer by the Committee to Evaluate Drugs to designate drug products and decisions made by the Executive Officer not to designate a product as a listed drug product
- Improving transparency by requiring the Executive Officer to prepare an annual report
- A clause in the legislation that specifically prohibits therapeutic substitution.

Amendments to the Business Corporations Act authorizing the Lieutenant Governor in Council to make regulations to exempt classes of health profession corporations from the requirements for professional incorporation and to impose different requirements in their place.

Complementary amendments were also made to the Regulated Health Professions Act, 1991. These amendments were enacted by the Budget Measures Act, 2005, schedule B (Bill 197).
Regulations were made under the *Business Corporations Act* and the *Regulated Health Professions Act, 1991* to permit family members of physicians and dentists to own non-voting shares in physician and dentist corporations respectively. Bill 197 received Royal Assent on December 12, 2005 and Schedule B was proclaimed into force on January 1, 2006. Ontario Regulation 665/05 made under the *Business Corporations Act* and Ontario Regulation 666/05 made under the *Regulated Health Professions Act, 1991* amending O. Reg. 39/02 (Certificates of Authorization) also came into force on January 1, 2006.

Quebec

Le projet de loi no 38 a été adopté en juin 2005, confirmant la création du poste de Commissaire à la santé et au bien-être, qui sera nommé pour cinq ans, renouvelable une fois. Son rôle majeur sera de faire rapport sur la performance du système de santé et de services sociaux, tout en proposant des changements susceptibles d’en améliorer l’efficacité et l’efficience.

Le projet de loi no 112 a également été adopté en juin 2005, apportant ainsi des modifications à la Loi sur le tabac qui intensifient la lutte contre le tabagisme, notamment auprès des jeunes. Il comprend plusieurs mesures qui concernent l’interdiction de fumer dans les lieux publics ou à proximité des établissements de santé et de services sociaux ou de maisons d’enseignement, l’exercice d’un meilleur contrôle de la publicité par les fabricants des produits du tabac et la réduction de l’accès des jeunes à ces produits.

Le projet de révision de la Loi de la protection de la jeunesse, déposé en octobre 2005, propose des ajustements du cadre législatif aux pratiques et aux connaissances d’aujourd’hui. Les modifications visent notamment à améliorer la rapidité d’action du système de protection de la jeunesse et à assurer une plus grande stabilité aux enfants placés.

L’adoption du projet de loi no 83, en novembre 2005, marque une étape importante dans l’organisation et l’administration des soins de santé et des services sociaux au Québec. La nouvelle loi modifie la Loi sur la santé et les services sociaux. Elle permet d’instaurer plusieurs mesures visant à clarifier les responsabilités des différents paliers du réseau de la santé et des services sociaux en soutien à la mise en place des réseaux locaux de santé et de services sociaux. Elle vise à permettre également une circulation de l’information favorisant le travail d’équipe et le partage des connaissances, ainsi qu’à mettre en place des mécanismes devant garantir la qualité des services.

Le projet de Politique du médicament a été soumis à une vaste consultation à la Commission des affaires sociales. Il se déploie autour de quatre grands axes : l’accessibilité des médicaments, l’établissement d’un prix juste et raisonnable, l’usage optimal du médicament et le maintien au Québec d’une industrie pharmaceutique dynamique.

Bill 38, adopted in June 2005, confirmed the creation of the position of *Commissaire à la santé et au bien-être*. The appointee will hold this position for five years and be eligible for one subsequent reappointment. His or her primary role will be to report on the performance of the health and social services system and propose changes to improve the system’s effectiveness and efficiency.
Bill 112, also adopted in June 2005, modified the Tobacco Act and strengthened efforts to fight smoking, especially among youth. It contained several measures related to prohibiting smoking in public places or near health and social service establishments or educational institutions, exercising greater control over advertising by tobacco product manufacturers, and reducing young people’s access to these products.

A review of the Youth Protection Act, tabled in October 2005, was designed to bring the legislative framework into line with current practices and knowledge. The proposed changes focused on making the youth protection system more timely and providing children with greater stability while in care.

The adoption of Bill 83 in November 2005 brought significant changes in how Quebec health and social services are organized and administered. The new legislation modified the Act respecting health and social services and contained several measures designed to clarify the responsibilities of the various levels within the health and social services system and thereby facilitate the implementation of local health and social service networks. It was also designed to facilitate information flow in support of teamwork and the sharing of knowledge, and to establish mechanisms guaranteeing the quality of services.

The Politique du médicament was the subject of extensive consultations conducted by the Commission des affaires sociales, which centred on four main areas: the accessibility of pharmaceuticals, the setting of fair and reasonable prices, the optimal use of pharmaceuticals, and the maintenance of a dynamic Quebec pharmaceutical industry.

New Brunswick

- An Act Respecting Mental Health and Public Health Services was proclaimed on November 28, 2005 (respecting the transfer of public health services and mental health services to the eight Regional Health Authorities).

- An amendment to the Podiatry Act was passed on June 30, 2005.

Nova Scotia

- The Emergency Health Services Act, which came into effect on September 30, 2005, provides the regulatory framework for ambulance services, emergency health services, and related communication services.

- Passed in the Spring 2005 session of the Legislature, the Paramedics Act, regulating the practice of paramedicine in the province, will come into force when proclaimed by Government.

- The Involuntary Psychiatric Treatment Act was passed in the 2005 fall session of the Legislature. It will come into force when proclaimed by Government. The Act focuses primarily on processes for involuntary admissions and also includes provisions for leave certificates, community treatment orders, substitute decision making, and patient rights.
• The Optometry Act came into force on April 1, 2006. It replaces the former Optometry Act which regulated the practice of optometry.

• The Dispensing Opticians Act was passed in the 2005 fall session of the Legislature. It will come into force when proclaimed by Government. The Act replaces the current Dispensing Opticians Act which regulates the practice of dispensing opticians.

• Amendments to the Smoke-free Places Act were passed in the 2005 fall session of the Legislature. The Act will not come into force before December 1, 2006. The Act requires all indoor workplaces, all indoor public places, and all restaurant and bar patios to be smoke free. It does not permit designated smoking rooms in any of these locations with the exception of designated smoking rooms in facilities licensed under the Homes for Special Care Act and in hospital units for veterans.

• The Tobacco Damages and Health-care Costs Recovery Act was passed in the 2005 fall session of the Legislature. It will come into force when proclaimed by Government. The Act is similar to British Columbia’s legislation, which allows the Government to attempt to recover health care costs from the tobacco industry for tobacco related illnesses.

• The Health Protection Act came into force on November 1, 2005

Updates or Reporting of new Advisory Committees Committees/Working Groups

The Health Professions Regulation Review Committee met for the first time in January 2006. This committee has a mandate to:

• Assess all new requests for self-regulation by health professions
• Assess all applications from professions which are currently self-governing to deregulate either in part or from all their professional regulations
• Provide appropriate written advice to the Deputy Minister and to the Minister regarding all regulation or deregulation requests, according to specific criteria
• Advise the Deputy Minister and the Minister on other issues relating to the regulation of health professionals, as directed
• Consult with departmental programme directors, when requests impact on specific programme areas.

A Midwifery Legislation Committee was formed to enable work on midwifery legislation to proceed
Prince Edward Island

A = assent
c.i.f. = came into force

Health and Community Services Reorganization Act [A June 7/05, c.i.f. Jan.1/06]
Dissolves health authorities, transfers assets and liabilities to government, makes consequential amendments to many other statutes.

Community Hospital Authorities Act [A June 7/05, c.i.f. Jan. 1/06]
Designates specific hospitals as community hospitals (c.h.), establishes c.h. authority boards, sets out roles and responsibilities, provides for appointment of administrators, and provides that the c.h. authorities contract with government for the provision of staff.

Health Services Act [A June 7/05, c.i.f. Jan.1/06]
New Act to replace the former Health and Community Services Act following the split of the Department of Health and Social Services into 2 distinct departments (Department of Health, Department of Social Services and Seniors). Sets out the responsibilities of the Minister of Health, provides for protection from liability for the Minister and employees of the Department, and protects the work of quality assurance groups.

Long-Term Care Subsidization Act [A June 7/05, c.i.f. Nov. 8/05]
Replaces what was formerly Part II of the Social Assistance Act, concerns subsidized care in nursing homes.

Act to Amend the Social Assistance Act [A June 7/05, c.i.f. Nov.8/05]
Severs the Act, Part II of former Act moves to new act, above, remainder becomes responsibility of Dep’t of Social Services and Seniors(DSSS).

Act to Amend the Health and Community Services Act [A June 7/05, c.i.f. Nov.8/05]
Deals with the split of the Department, allocates responsibility for health services to Department of Health, and responsibility for social services and services for seniors to DSSS.

Health and Social Services Reorganization Act [A June 7/05 c.i.f. Nov.8/05]
effects various consequential amendments to various Acts in order to reference the appropriate Department once the split occurs.

Health Authorities Employees Act [A June 7/05 c.i.f. June 28/05]
transfers all employees of the health authorities to government, and provides for labour relations dispute resolutions.

Registered Nurses Act [A Dec.16/4, c.i.f. Feb.25/06]
New statute to replace the former Nurses Act, governs the practice of registered nursing in the province.
An Act to Amend the Tobacco Sales to Minors Act [A Dec. 6/05, c.i.f. Aug. 1/05, section 11 June 1/05]
Changes title of the Act to the Tobacco Sales and Access Act, changes primarily concern retail sale of tobacco and designates places where tobacco cannot be sold.

An Act to Repeal the Pre-Marital Health Examination Act [A Dec. 6/05, c.i.f. December 15/05]
Repeals a dated piece of legislation concerning examinations that had been done in an effort to control the spread of syphilis.

An Act to Amend the Tobacco Sales and Access Act [A Dec. 15/05, c.i.f. June 1/06]
Amendments concern ban of display, advertisement and promotion of tobacco in retail premises; exception for tobacconists.

An Act to Amend the Marriage Act [A Dec. 15/05, c.i.f. May 1/05]
Changes provide for marriage commissioners’ licenses; also, wording of pronouncement at the end of civil ceremony changed so as to comply with new federal definition of marriage.

An Act to Amend the Health Authorities’ Employees Act [A Dec. 15/05, c.i.f. retroactive to June 28/05]
Clarified pension issues with respect to some civil service employees.

Hospitals Act [A Dec. 15/05, c.i.f. Jan. 1/06]
New Act replacing prior Act by the same name - reflects the newly reorganized health system.

Regulatory Initiatives:

Public Health Act, Part II, Emergency Medical Services Regulations [c.i.f. Apr. 1/05]
Changed levels of licensing from 2 levels (basic, beyond basic) to 3 levels (EMT Level I, II, and III).

Pharmacy Act, [all of these c.i.f. May 1/05]
- Authorization Regulations
  Generally to update these regulations, and specifically to account for trade mobility requirements
- Drug Schedule Regulations
  New. Specify which drugs are restricted in various categories according to the National Association of Pharmacy Regulatory Authorities (NAPRA), Sets out some prohibitions concerning sale of drugs, and requires pharmacies to follow certain rules, depending on the category of the drugs
- Interchangeable Drug List Regulations
  New - establishes a committee to recommend and maintain an interchangeable prescription drug list for the province; sets out criteria for these drugs, rules for pharmacies, and rights of patients
Standards Regulations
Updates standards for this profession, including rules for labeling and records.

Tobacco Sales and Access Act Regulations [c.i.f. Aug.1/05]
Amendments concern signs to be displayed in premises selling tobacco, and acceptable identification to establish proof of age. Revoke the old regulations under the Tobacco Sales to Minors Act.

Marriage Act Regulations [c.i.f. Aug.18/05]
Revokes an earlier provision; also revises some of the forms under the regulations, mostly to accord with the new federal definition of marriage.

Vital Statistics Act Regulations [c.i.f. Aug.18/05]
Replaces the phrase “bride and groom” with the word “spouses”. Revises some forms.

Public Health Act - Slaughter House Regulations [c.i.f. Dec.3/05]
Amendments concern an exception for processing a dead animal, subject to the special circumstances outlined.

Adoption Act - Supported Adoption Regulations [c.i.f. Jan.1/06]
Amendments to remove references to the health authorities.

Child Protection Act Regulations [c.i.f. Jan.1/06]
Same as above.

Civil Service Act Regulations [c.i.f. Jan.1/06]
Changes clarify which employees are not represented by the Union.

Civil Service Superannuation Act - Participating Employer Regulations [c.i.f. Jan.1/06]
Removed the health authorities from the list of participating employees.

Community Hospital Authorities Act Regulations [c.i.f. Jan.1/06]
New regulations under the new Act - concern the boards of the c.h.a.’s, including the interim appointed boards.

Financial Administration Act - Special Project Funds Regulations [c.i.f. Jan.1/06]
Revoked a reference to a Program no longer in operation.

Health and Community Services Act Regulations [c.i.f. Dec.31/05]
Revoked the regulations under the Act the day before the Act was repealed.

Health Services Payment Act Regulations [c.i.f. Jan.1/06]
Amendments remove references to the health authorities.

Hospital and Diagnostic Services Insurance Act Regulations [c.i.f. Jan.1/06]
Deletes references to health authorities and generally updated the regulations to reflect the reorganized health system.

**Hospitals Act - Hospital Management Regulations** [c.i.f. Jan.1/06]
Same as above.

**Housing Corporation Act - Low Income Assisted Home Ownership Supplement Program Regulations, Provincial Contribution to Senior Home Repair Regulations, and Serviced Lot Subsidy Regulations** [all c.i.f. Jan.1/06]
For the most part, the changes delete references to the “Board” and correct them with references to the “Corporation”.

**Mental Health Act Regulations** [c.i.f. Jan.1/06]
Amendments removed references to the health authorities.

**Public Health Act - Notifiable and Communicable Diseases Regulations** [c.i.f. Jan.1/06]
Clarified to whom the Chief Health Officer provides information.

**Nurses Act - Discipline Regulations Revocation, Registration and Licensing of Nurses Regulations Revocation, and Schools of Nursing Regulations Revocation** [c.i.f. Feb.24/06]
These old regulations under the old Act were revoked the day before the Act was repealed.

**Registered Nurses Act - Nurse Practitioner Regulations, Professional Conduct Review Regulations, Registration and Licensing of Nurses Regulations, and Schools of Nursing Regulations** [c.i.f. Feb.25/06]
New regulations written for the new Act governing the practice of registered nursing in the province.

**Newfoundland and Labrador**

Bill 20, the *Smoke-free Environment Act, 2005*, was passed by the Legislature on May 19, 2005 and was proclaimed in force on July 1, 2005. The new Act replaces existing legislation restricting the use of tobacco products in public places and work places. Most public places were required to be smoke free prior to the new legislation. The new Act extended the ban on smoking to bars and bingo halls.

Bill 21, the *Medical Act, 2005*, was passed by the Legislature on May 19, 2005 and was proclaimed in force on July 1, 2005. The new Act replaces existing legislation governing the practice of medicine and incorporates new discipline procedures, new governance arrangements, and changes the regulatory structure to a College model. The new legislation also responds to recommendations flowing from the OxyContin Task Force respecting measures to strengthen the ability of the College to investigate allegations of inappropriate prescribing of OxyContin and other narcotic substances.
Bill 51, the *Dietitians Act*, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of dietetics and incorporates new discipline procedures and new governance arrangements.

Bill 52, the *Dispensing Opticians Act*, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of dispensing opticians and incorporates new discipline procedures and new governance arrangements.

Bill 53, the *Hearing Aid Practitioners Act*, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing hearing aid practitioners and incorporates new discipline procedures and new governance arrangements.

Bill 54, the *Licensed Practical Nurses Act*, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing licensed practical nurses and incorporates new discipline procedures and new governance arrangements.

Bill 55, the *Massage Therapy Act*, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of massage therapy and incorporates new discipline procedures and new governance arrangements.

Bill 56, the *Occupational Therapists Act*, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of occupational therapy and incorporates new discipline procedures and new governance arrangements.

Bill 57, the *Psychologists Act*, 2005, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of psychology and incorporates new discipline procedures and new governance arrangements.

Bill 58, the *Optometry Act*, 2004 (Amendment) was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. This amendment updates existing legislation governing the practice of optometry respecting the discipline procedures and governance arrangements.

Bill 59, the *Pharmacy Act*, (Amendment) was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. This amendment updates existing legislation governing the practice of pharmacy respecting the discipline procedures and governance arrangements.
Bill 60, the *Denturists Act*, was passed by the Legislature and came into force upon Royal Assent on December 13, 2005. The new Act replaces existing legislation governing the practice of denture technology and incorporates new discipline procedures and new governance arrangements.

**Section III: Structure and Finance Updates**

**Fiscal / Questions Financières**

**Health Canada**


**Santé Canada**


**Northwest Territories**

- There were no changes in funding formulas for 2005/2006.

- In 2005/2006, the Department’s total revised budget, including approved supplementary appropriations was $260,894,000. Significant changes from 2004/05 include:
  - $3,162,000 in additional costs for hospital services from Capital Health Authority of Alberta due to increased utilization and rate changes.
  - $5,272,000 in additional expenses as a result of a collective agreement between the Government of the Northwest Territories and the Union of Northern Workers.
  - $1,000,000 in contribution funding to the Yellowknife Association of Concerned Citizens for Seniors (YACCS) for planning and design of a seniors’ dementia facility.
  - $5,927,000 in savings resulting from the amalgamation of Human Resources to the Financial Management Board Secretariat.

- For 2006/2007, the Department’s opening Main Estimates for Operations Expenses were $265,186,000.

- Expected changes for 2006/2007 include:
  - Compensation and Benefits to be $1,567,000 less than in the 2004-05 fiscal year.
  - Grants and contributions to be $1,610,000 more than in the 2004-05 fiscal year.
Other expenses, including materials, purchased and contract services, fees and payments to be $4,711,000 more than in the 2004-05 fiscal year.

For further information on the Department of Health and Social Services main estimates for 2005/06 and 2006/07 refer to the following web address: http://www.gov.nt.ca/FMBS/documents/mainestimates/MainEstimates.html.

Yukon Territory

- The 2005/06 Operations & Management Budget Estimates for Insured Health & Hearing Services (includes Yukon Hospital Corporation), Community Programs, Community Nursing & Emergency Services, and Continuing Care (includes Home Care) was $108,274,000.
- The Capital Budget Estimate for these programs was $12,790,000.
- The main capital projects for 2005/06 were multi-level care facilities in Dawson City and Watson Lake, Yukon Hospital Corporation equipment, the purchase of 2 new ambulances, Ambulance Services equipment, and increased honorarium, training, clothing and ambulance maintenance in communities.

British Columbia

For further information on the Service Plan for 2005/06 – 2007/08 for the Ministry of Health Services please follow the web address: http://www.bcbudget.gov.bc.ca/2006/sp/hlth/

Alberta

The 2005/2006 spending for Alberta Health and Wellness is forecasted to be $9.208 billion. This is an increase of over $800 million or 10 per cent from the 2004/2005 actuals. Highlights of the 2005/2006 planned spending include:

- $5.644 billion, an increase of $458 million or 9 per cent. The health authorities will also receive $64 million for health capital facilities. This is the first year of a $1.4 billion commitment on 20 new capital projects.
- $1.7 billion for the trilateral agreement between the Alberta Medical Association, the regional health authorities and the department.
- $629 million for a government sponsored non-group benefit program. Over 90 per cent of the spending is for prescription drugs primarily for seniors.

Saskatchewan

- The Department of Health’s 2005-06 budget totalled $2.9B, which was an increase of $192M (7.1%) over the 2004-05 budget. The increase provided for:
increased investment in regional health services through 12 Regional Health Authorities (RHAs);

- significant investments to help recruit and retain valued health professionals;
- new diagnostic and medical equipment to provide health professionals and patients with better information faster;
- improved coordination and efficiency of surgical access through the provincial waitlist strategy;
- continued expansion of primary health care through the development of teams of multi-disciplinary health providers in each region; and
- increased investment in the provincial drug plan.

- Of the total $192M increase, $87M (5.1%) was provided to health regions to:
  - meet labour agreements for 37,000 health care workers;
  - support specialized hospital programs, which benefit all residents of Saskatchewan; and
  - address inflationary pressures.

- $8.1M (14.9%) is designated for cancer programs to address priority operating pressures, predominately the increased costs of providing cancer treatments (i.e. drug costs and the increasing complexity of treatment).

- Other initiatives include:
  - $16.2M in additional funding to cover escalating drug costs of the Saskatchewan Prescription Drug Program and allow for the addition of new drug treatments to the provincial formulary;
  - $20.2M for diagnostic and medical equipment;
  - $8.9M in funding to reduce the number of patients, who have been waiting in excess of 18 months for inpatient surgery and over 12 months for day surgery, and for initiatives to improve system performance and wait list management;
  - $10.5M in funding to increase diagnostic imaging services capacity and new technologically advanced diagnostic equipment; and
  - $9.3M increase to fund the expansion of Primary Health Care and to implement new Care Teams.

**Manitoba**

- The provincial health care budget for 2005/2006 was $3,389,760.2 - an increase from 2004/2005 of 6.3%. The budgeted increase for 2006/07 is 6.4%.

**Ontario**

*Funding Formula*
The Integrated Population Based Allocation (IPBA) is an evidence-based methodology for equitably distributing funding to Ontario hospitals. It ensures that funding allocations weigh consideration for base operations, growth, and hospitals servicing populations with high relative need at an equitable unit cost for care. It simultaneously adjusts for differences in population characteristics such as age, gender, population growth, and morbidity, and for differences in hospital characteristics such as teaching and acute program mix. The methodology was developed in a broad-based stakeholder consultative process, and is widely supported. Recent enhancements to the methodology entrenched the commitment to focus on stability and base operations, in the context of multi-year funding. Ongoing development is planned to broaden the scope of utilization and cost benchmarks to account for the non-acute components of hospital activity (ambulatory, rehabilitation and emergency).

**Budget**

Health care is a top priority for Ontarians. In 2006-07, the government of Ontario will invest a total of $35.0 billion in health care including both operating and capital expenditures. This investment represents an increase of $1.8 billion in funding from the 2005-06 Interim total of $33.2 billion.

**Operating** funding of $34.2 billion includes:

- $12.9 billion in operating support for Ontario’s 152 hospitals
- $8.6 billion in OHIP payments to physicians and other service providers
- $2.8 billion in Drugs programs
- $2.8 billion in Long-Term Care homes
- The remaining $7.1 billion in health care spending supports a wide range of services including funding for community services, devices, cancer care and health human resources.

*(Note: spending figures do not include Ministry of Health Promotion spending of $258M in 2005-06 and $363M in 2006-07).*

Health Care operating spending comprises approximately 44% of total government expenditures excluding public debt interest.

**Capital** spending will be $0.8 billion for health capital investments.

The government’s increased investments in the health care system mean that patients will benefit from access to the health care they need when and where they need it.

**Ontario’s Wait Time Strategy**

*Funding Provided for Additional Procedures*

In 2005/06, the following funding was provided to hospitals:

- $12M for 16,000 additional cataract surgeries;
• $53M for approximately 7,550 additional hip and knee joint replacements;
• $27M for 4,817 additional cancer surgeries;
• $15M for 58,500 additional MRI expansion hours of operation; and
• $47M for 6,998 net new cardiac procedures.

Quebec

Le budget de dépenses 2006-2007 portant sur la période s’étendant du 1er avril 2006 au 31 mars 2007, s’établit à 22,1 milliards de dollars.

Les dépenses gouvernementales, pour 2004-2005, dans le domaine de la santé et des services sociaux s’élèvent à 20,1 milliards de dollars alors que les dépenses probables pour l’exercice 2005-2006 devraient totaliser 20,1 milliards de dollars.

The 2006-2007 budget, for the period April 1, 2006 to March 31, 2007, contains expenditures of $22.1 billion.

New Brunswick

• The budget allocated for the Department of Health and Wellness in 2005-2006 is $1.77 B, up 10.2% from the $1.61 B of 2004-2005. Within this overall budget, funding for Hospital Services rose by 11.1%, Medicare rose by 7.5% and the Prescription Drug Program rose by 8.0%.

Nova Scotia

• The Department of Health’s budget for 2005-2006 exceeds $2.5 billion. The budget for 2004-2005 was approx. $2.38 billion
• Nova Scotia spends approximately $2,500 a year on health care and related services for every man, woman and child in the province. Nova Scotia spends almost 46% of provincial government program spending on health care and related services. A major cost driver is the aging population, which increases expenditures on continuing care and pharmaceutical coverage.

Prince Edward Island

• The Ministry of Health and Social Services & Seniors total expenditures represented more than 45% of the Provincial Government’s program spending in 2005/2006.
• The projected expenditures for the 2005/2006 fiscal year are $453 million, an increase of $8 million over the 2004/2005 fiscal year.
The major cost drivers included acute care hospital services, including increased costs for enhanced services at the QEH related to improving access to services and reduction in wait times, increased cost associated with the new Prince County Hospital, long-term and home care services, information technology initiatives, and increasing rates for our residents requiring out of province hospital services.

As well the delay in the implementation of the organizational restructuring in the health sector has contributed to an inability to reach original targeted savings from the reorganization.

Newfoundland and Labrador

The Department of Health & Community Services’ budget for fiscal year 2005/2006 is $1,741,417,000. Of this amount, $1,299,914,000 is budgeted for health authorities and agencies delivering acute care, long-term care, emergency and diagnostic services as well as community-based health services such as public health nursing, continuing care, rehabilitative services, etc. Physician services, budgeted at $280,819,200, accounts for the most significant other current account expenditure item.

$45,486,500 is allocated for construction, repairs and renovations and equipment. Health and community services account for $0.47 of every dollar spent on programs and services by the province.

As a result of Public Sector Reform, the department is part of a government-wide process which is putting a new accountability framework for boards and agencies into place. The new Transparency and Accountability Act was passed in the House of Assembly in December 2004. Full implementation of the Act is targeted for April 2008.

Governance and Management and Management/Gouvernance Gestion

Health Canada

Health Canada is responsible for helping Canadians maintain and improve their health. The Department monitors health and safety risks and assesses the benefits of drugs, food, chemicals, pesticides, medical devices and certain consumer products. It also works to promote healthy lifestyles and provides health services to First Nations and Inuit. The Department works in partnership with the provinces and territories and other stakeholders to achieve its objectives.

The Department provides advice and support to the Minister on departmental and portfolio issues. The Deputy Minister and the Associate Deputy Minister of Health support the Minister by working with departmental officials and the Ministers’ staff to anticipate the need for strategic advice and information and to ensure that such information is provided in a timely fashion and through the appropriate vehicles. Six Assistant Deputy Ministers manage the Department's programs and administrative Branches. The organizational chart attached in Annex A provides an overview of the Department’s management structure.
**Federal/Provincial/Territorial Advisory Committees**

There are a number of Federal, Provincial and Territorial (F/P/T) Advisory Committees that work collaboratively in various areas of health policy.

- The Advisory Committee on Health Delivery and Human Resources is responsible for developing policy and providing strategic advice to F/P/T Deputy Ministers of Health on the planning, organization and delivery of health services including human resources.

- The Advisory Committee on Information and Emerging Technologies is responsible for developing policy and providing strategic advice to F/P/T Deputy Ministers of Health on health information, technologies and on the effectiveness and utilization of emerging health products and technologies.

- The Advisory Committee on Governance and Accountability is responsible for developing policy and providing strategic advice to F/P/T Deputy Ministers of Health on broad governance, sustainability, quality and accountability issues including performance indicators to enhance reporting by jurisdictions.

All F/P/T Advisory Committees report to the Conference of F/P/T Deputy Ministers of Health, which in turn reports to the Conference of F/P/T Ministers of Health. All Advisory Committees are co-chaired by Health Canada and a province or territory. The Conference of F/P/T Deputy Ministers of Health and F/P/T Health Ministers are co-chaired by the federal Deputy Minister and Minister of Health respectively. The respective provincial/territorial co-chair is designated on a rotating basis.

**Santé Canada**

Santé Canada a pour mission d’aider les Canadiennes et les Canadiens à maintenir et à améliorer leur état de santé. Le Ministère assure la surveillance des risques pour la santé et la sécurité, et évalue les avantages des médicaments, des aliments, des produits chimiques, des pesticides, des matériels médicaux et de certains produits de consommation. Il fait aussi la promotion des modes de vie sains et fournit des services de santé aux Premières nations et aux Inuits. Le Ministère travaille en partenariat avec les provinces et les territoires et d’autres intervenants pour atteindre ses objectifs.


**Comités consultatifs fédéraux-provinciaux-territoriaux**
Un certain nombre de comités consultatifs fédéraux-provinciaux-territoriaux (FPT) travaillent en collaboration dans différents domaines liés à la politique de la santé.

- Le Comité consultatif sur la prestation des soins de santé et les ressources humaines élabore des politiques et donne des conseils stratégiques aux sous-ministres FPT de la Santé en ce qui concerne la planification, l'organisation et la prestation des services de santé, y compris les questions de ressources humaines.

- Le Comité consultatif sur l'information et les nouvelles technologies élabore des politiques et donne des conseils stratégiques aux sous-ministres FPT de la Santé en ce qui concerne l'information en matière de santé, les technologies et l'utilisation des nouveaux produits et technologies de la santé.

- Le Comité consultatif sur la gouvernance et la responsabilité élabore des politiques et donne des conseils stratégiques aux sous-ministres FPT de la Santé en ce qui concerne les questions générales de gouvernance, de viabilité, de qualité et de reddition de comptes, y compris l'établissement d'indicateurs de rendement pour améliorer les rapports présentés par les administrations.

Tous les comités consultatifs FPT rendent des comptes à la Conférence des sous-ministres FPT de la Santé, laquelle rend des comptes à la Conférence des ministres FPT de la Santé. Tous les comités consultatifs sont coprésidés par Santé Canada et une province ou un territoire. La coprésidence fédérale de la Conférence des sous-ministres FPT de la Santé et de la Conférence des ministres FPT de la Santé est assurée respectivement par le sous-ministre et par le ministre de la Santé du gouvernement fédéral. Les coprésidents provinciaux-territoriaux sont désignés à tour de rôle.

**Northwest Territories**

- Under direction of the Minister, eight Health and Social Services Authorities plan, manage and deliver community and institutional-based services.

- The Joint Leadership Council is made up of the Minister, Deputy Minister and Chairs of the Health and Social Services Authorities. This Council:
  - provides advice to the Minister;
  - sets direction for planning system-wide initiatives and issues;
  - reviews and recommends approval of system-wide plans, reports and results information;
  - shares information and discussion of health and social services issues, concerns and best practices;
  - provides direction to the Joint Senior Management Committee; and
  - reviews and recommends approval of reports made by the Joint Senior Management Committee.

- The Joint Senior Management Committee is collectively made up of the Department’s Senior Management Committee and the Chief Executive Officers of the HSS Authorities. This Committee:
- coordinates system-wide activities including service delivery approaches, business and operational planning, and administrative support;
- shares information of relevance to the NWT HSS system;
- provides analytical and planning support to the Joint Leadership Council; and
- coordinates and liaises with other stakeholders at the national and territorial level.

**Health and Social Services System Organization Chart 2005/2006**

![Health and Social Services System Organization Chart 2005/2006](image-url)
Yukon Territory

- The Minister of the Department of Health and Social Services is responsible for the delivery of all insured health care services in the territory. A Director, as appointed by the Commissioner in Executive Council, administers the health care insurance plans. The Yukon Government directly manages the provision of health services other than those managed by the Yukon Hospital Corporation or provided by private business.

- Health-related services managed by the Yukon Government include Insured Health Services (Physician, Hospital) and Yukon government-funded benefit programs including the Chronic Disease and Disability Benefits Program, Children’s Drug and Optical Program, Pharmacare Program, Extended Benefits Program and Travel for Medical Treatment Program.

- Other health programs provided by the Yukon government include hearing services, dental health, environmental health, health promotion, mental health services, communicable disease control, community nursing, (includes Watson Lake Cottage Hospital), emergency medical services, and continuing care (including home care and long-term care facilities).

- The following public boards and committees also provide governance and management:
  - The Yukon Hospital Corporation, Board of Trustees governs the operation of the Whitehorse General Hospital.
  - The First Nations Health Committee, a committee of the Yukon Hospital Corporation Board, governs the First Nations health program offered through the hospital.
  - The Health and Social Services Council provides an advisory function to the Minister.

British Columbia

No change from 2004.

Alberta

- Since April 2003 the Alberta health system structure consists of 11 health boards: nine regional health authorities (RHAs) and two provincial boards – the Alberta Cancer Board and the Alberta Mental Health Board. Board members are appointed and accountable to the Minister of Alberta Health and Wellness for health system performance.

- RHA accountability is managed through four key documents:
  - Health Plan – a three-year planning document, amended annually for approval by the Minister. A health plan must address legislated responsibilities, align with the goals of the Ministry’s business plan, and indicate what accomplishments are intended in respect to stated government expectations. Submission of the health plan is required by December 31, allowing sufficient time for review, amendment and approval, prior to the commencement of the next fiscal year.
  - Business Plan – outlines what specifically will be accomplished in the first year of the health plan and identifies the financial and other resources required to accomplish intended results. A draft business plan is submitted with the health plan and is finalized
once the provincial budget is known, generally in February or March of the subsequent year.

- Two types of quarterly reports: a performance progress report and a financial report. The performance progress report, due 45 days after the end of a quarter, indicates the extent to which the RHA is meeting health plan strategies and business plan objectives. The financial report, due 30 days after the end of a quarter, is prepared and submitted in accordance with requirements set out in the Ministry’s Financial Directives.

- Annual Report – indicates how the RHA has discharged its legislative responsibilities and reports performance accomplishments during the period.

- Performance Agreements form the basis of accountability for the two provincial boards. These agreements set out the Minister’s expectations of the board, the obligations of the Minister, measures to assess performance and the expected results to be accomplished on an annual basis. As appropriate, the agreement may also require the submission of business, financial, capital, health workforce, information management and information technology plans. Agreements link to the provincial fiscal year, may cover two or three years, and are negotiated and approved before commencement of the next performance period. The two provincial boards submit quarterly performance reports and an annual report.

**Saskatchewan**

- In 2002 Saskatchewan proceeded with the development of a new accountability relationship with the Regional Health Authorities (RHAs). The relationship is based on *The Regional Health Services Act*, which was proclaimed on August 1, 2002.

- Regional Health Authorities were created under the *Regional Health Services Act*. The legislation provides the RHAs with a broad range of powers to plan for and manage the regional provision of health services in their regions.

- Regional Health Authorities as well as the Saskatchewan Cancer Agency in collaboration with the Minister /Department are responsible for planning, managing and delivering health services to the residents of Saskatchewan.

- The Minister’s Forum and the Leadership Council have been established. The Minister’s Forum includes all the RHAs and the Saskatchewan Cancer Agency (SCA) Chairs. The Leadership Council is chaired by the Deputy Minister of Health and includes RHA and the SCA CEOs. The two bodies provide advice and make recommendations to the Minister and the Deputy Minister on system-wide issues.

- This new governance structure has resulted in considerable benefits:
  
  - a revised planning cycle for the Regional Health Authorities;
  
  - a new budget planning process provides the regions with input to the budgeting process, allowing for better annual and long range planning; and

  - a new accountability framework that guides the relationship with RHAs and the SCA. This new operational process includes a document for each region that defines program and service expectations and includes the measures by which RHA and the SCA performance will be monitored.
Manitoba

- No material changes in 2005/06.

Ontario

The ministry has overall responsibility for the health care system and ensures the provision of services to the Ontario public through such programs as health insurance, drug benefits, assistive devices, care for the mentally ill, long-term care, home care, community and public health. It also regulates hospitals and nursing homes, operates psychiatric hospitals and medical laboratories, and co-ordinates emergency health services.

Management Structure of the Ontario Ministry of Health and Long-Term Care

Minister of Health and Long-Term Care: George Smitherman
George Smitherman has served as Ontario's Minister of Health since the McGuinty government took office in November of 2003.

Parliamentary Assistants: Dr. Kuldip Kular, Monique Smith, Tim Peterson

Deputy Minister: Ron Sapsford
Ron Sapsford was appointed Deputy Minister of Health and Long-Term Care, effective March 1, 2005.

Associate Deputy Minister & Executive Lead, Health Results Team (HRT):
Hugh MacLeod

Hugh MacLeod was appointed Associate Deputy Minister and Executive Lead of the Health Results Team, effective June 23, 2004.

In his role as Executive Lead of the Ministry’s HRT, Hugh is leading key areas of health system reform, including: Access to Services/Wait Times, Primary Care, System Integration, and Information Management. A team of industry experts have been spearheading the delivery of results in these areas.

On June 29, 2005, the government announced the creation of a new Ministry of Health Promotion with Jim Watson as the Minister. It is the first time Ontario has dedicated a portfolio to promoting healthy living and illness prevention. Currently, transition process and realignment of programs and services between the newly created Ministry and MOHLTC is taking place.

In January 2006, Deputy Minister Ron Sapsford announced that the Ministry of Health and Long-Term Care would be reorganizing to adapt to its new role as health system steward. With the move to place responsibility for operational and funding decisions closer to service providers through the establishment of Local Health Integration Networks (LHINs), and other imperatives, such as health system pressures, the ministry needed to change its focus and embrace a new direction.
In its new role as health system steward, the ministry will provide overall direction and leadership for the system. It will focus on planning, and on guiding resources to bring value to the health system.

The new structure will be organized into five specialized functional divisions:

- Health System Information Management;
- Health System Strategy;
- Health System Investment and Funding;
- Health System Accountability and Performance; and
- Public Health and the Chief Medical Officer of Health.

The ministry's principal functions will be to:

- Establish overall strategic direction and provincial priorities for the health system;
- Develop legislation, regulations, standards, policies, and directives to support those strategic directions; and
- Planning for and establishing funding models and levels of funding for the health care system.

The Ministry reorganization is occurring in three phases, over a two and a half-year period. Phase 1 focuses on strategy — integrating, implementing and supporting the strategy division. Phase 2 will strengthen accountability, and will coincide with the implementation of Local Health Integration Networks (LHINs). In Phase 3, each of the new divisions will be fully functional. It is anticipated that reorganization will be completed by 2008.

On February 15, 2006, the Deputy Minister announced the appointment of five Assistant Deputy Ministers:

- Maureen Adamson, ADM, Health System Investment and Funding;
- Dr. Sheela Basrur, ADM, Public Health and Chief Medical Officer of Health;
- Adalsteinn (Steini) Brown, ADM, Health System Strategy;
- Hugh MacLeod, ADM, Health System Accountability and Performance; and
- Dawn Ogram, ADM, Corporate Support.
Quebec

Au cours de la dernière année, les changements importants qui avaient été initiés il y a quelques années en ce qui a trait à l’organisation générale des services se sont poursuivis. Plusieurs initiatives ont été mises de l’avant pour renforcer les services de première ligne, dont la mise en place des groupes de médecine de famille (GMF) qui s’est poursuivie.

L’instauration des réseaux locaux de services de santé et de services sociaux (RLSSSS) et la création des réseaux universitaires intégrés de santé (RUIS) sont deux autres importantes modifications d’organisation de services qui avaient pour objectif de mieux intégrer et hiérarchiser les services.

Ces changements demandent une grande adaptation dans les pratiques de la part des différents intervenants du réseau. De même, pour assurer une qualité accrue des services, des mesures ont été adoptées, telles la réforme du système des plaintes ou encore le resserrement des obligations des établissements quant à la prestation sécuritaire des services. Ainsi, la dernière année a permis de mieux ancrer ces nouvelles façons de faire.

Le document « Garantir l’accès : un défi d’équité, d’efficience et de qualité » (février 2006) soumet à la consultation trois ordres de solutions dans la recherche d’une plus grande efficience des ressources investies en santé et services sociaux et d’une meilleure qualité de vie des citoyens. La première piste de solution se rapporte à la consolidation et à la poursuite des actions en services préventifs, en services de première ligne et en services médicaux et hospitaliers; d’autres actions s’ajoutent également afin de rehausser la qualité des services de santé et des services sociaux. La deuxième apporte une réponse au jugement de la Cour suprême du Canada dans l’affaire Chaoulli – Zeliotis et prend la forme, principalement, d’une garantie d’accès publique pour certaines procédures médicales et de l’ouverture limitée à l’assurance privée pour les chirurgies de remplacement de la hanche, du genou et de la cataracte. La troisième piste de solution ouvre un questionnement sur les enjeux liés au financement à plus long terme du secteur de la santé et des services sociaux, dans la perspective d’un plus vaste débat sur l’avenir de nos finances publiques. Ce document fait l’objet d’une consultation publique en commission parlementaire, qui a débuté en avril 2006.

The past year saw ongoing implementation of important changes introduced several years ago in the general organization of services. Several initiatives were put forward to strengthen frontline services, including the implementation of groupes de médecins de famille (GMF) (also ongoing).

The inauguration of réseaux locaux de services de santé et de services sociaux (RLSSSSS) and the creation of réseaux universitaires intégrés de santé (RUIS) were two other important organizational changes that were introduced to better integrate and prioritize services.

These changes required the various stakeholders in the system to make major adjustments in their practices. Similarly, to achieve higher quality services, measures such as reforming the complaint system and strengthening establishments’ obligations with respect to the safe delivery of services were adopted. Over the past year, these new ways of doing business became better established.
The document “Garantir l’accès: un défi d’équité, d’efficience et de qualité” (February 2006) put forward for consultation three categories of potential solutions in the effort to achieve more efficient use of the resources invested in health and social services and in enhanced quality of life for people. The first category involved pursuing and strengthening measures in preventive, frontline, and medical and hospital services. This category also included other measures to enhance the quality of health and social services. The second category addressed the Supreme Court of Canada ruling in the Chaoulli-Zeliotis case and consisted primarily of guaranteeing public access to certain medical procedures and establishing a limited role for private insurance in the areas of hip and knee replacement surgeries and cataract surgery. The third category opened a debate on issues related to the longer-term funding of the health and social services sector within a broader debate on the future of our public finances. A parliamentary committee is holding public consultations on this document, which began in April 2006.

New Brunswick

- Effective November 28, 2005, the formal governance structure for the Department of Health and Wellness changed, in accordance with the provisions of the Regional Health Authorities Act (2002), respecting the transfer of Public Health and Mental Health Services to the Regional Health Authorities. Mental Health and Public Health programs and services were transferred from the Department of Health and Wellness to the Regional Health Authorities on November 28, 2005. The Department will continue to fund, monitor and audit these programs and services devolved to the Regional Health Authorities.

- Effective February 14, 2006, the provincial government realigned the structure of government. The Department of Health and Wellness became the Department of Health. The Minister of Wellness, Culture and Sport is now responsible for wellness related initiatives.

- The Department of Health is responsible for policy (development and implementation), monitoring and evaluation, intergovernmental relations, funding, other functions (e.g. provincial drug plan, Medicare etc.) related to health and health care delivery.

- The Department of Health and Wellness hired co-CEOs in 2005 to lead a provincial Cancer Network in the development of a cancer strategy for New Brunswick.

- Regional Health Authorities are responsible for delivering Hospital Services (primary, secondary and tertiary care), Extra-Mural Program (in-home), and Addictions Services, and as of November 28, 2005, Public Health and Mental Health services.

  - Regional Health Authorities are answerable to government (Standing Committee on Crown Corporations) for their level and type of expenditures. Regional Health Authority boards have a combination of appointed and elected members.

  - Regional Health Authority Chief Executive Officers report to the Deputy Minister of Health.

- Since June 2004, the health system has been guided by “Healthy Futures: Securing New Brunswick’s Health Care System,” the Provincial Health Plan for the years 2004-2008.

- Regional Health Authorities developed three-year Regional Health and Business Plans, describing their planned activities, and how these support the priorities in the Provincial Health Plan.
Nova Scotia

- The Department of Health is committed to the ongoing improvement of Nova Scotia’s health care system through planning, legislation, resource allocation, policy and standards development, evaluation and information management.
- District Health Authorities (DHAs) are responsible for governing, planning, managing, delivering, monitoring, evaluating and funding health services within each district and for providing planning support to the province’s 37 Community Health Boards (CHBs). Nova Scotia has 9 DHAs plus the Izaak Walton Killam Health Centre, which has its own board separate from Capital Health. DHAs are accountable to the Minister of Health.
- CHBs are responsible for the development of community health plans, which encompass primary health care, and for the identification of ways to improve the overall health of communities. CHBs are integral to planning and supporting the implementation of a community-based health care system that has primary health care as its foundation. Under the Health Authorities Act, CHBs are responsible for selecting two-thirds of the members of their respective DHAs. CHBs are accountable to their respective DHA.
- DHAs review and integrate community health plans received from their CHBs into their respective district health services business plans.

Prince Edward Island

- The role of the Department of Health is to:
  - provide leadership in innovation and continuous improvement and to provide specific high quality administration and regulatory services to the health system and Islanders.
  - provide leadership in delivering provincial secondary acute and specialized services to improve the health and well-being of citizens.
  - provide leadership in maintaining and improving the health and well-being of its citizens and to provide high quality, client-centred health services consistent with community needs.

The Department of Health fulfills this role through provision of public health services, primary care, acute care, community hospital and continuing care services to Islanders to help ensure their optimal health.

These services are delivered by over 4,000 dedicated professional staff through a large number of facilities and programs across the province, including provincial acute care facilities, community hospitals, provincial manors, a provincial in-patient mental health facility, a provincial additions treatment facility, family health centers, public health nursing, home care, community addictions programs, community mental health, the Chief Health Officer, Vital Statistics, and regulatory services.
Organization

As a department of government, the Department of Health is overseen by a Minister of the Crown, who is ultimately accountable for departmental performance and results to the rest of government and the citizens of the Province.

The Department of Health is managed by a Departmental Management Committee comprised of the Deputy Minister and 8 Senior Directors. This group is responsible for providing overall management direction to the department and for overseeing day to day operations.

An organizational chart and summary of principal roles for each division is outlined below.

Direct “Service Delivery” or “Line” Divisions

- **Acute Care**: Provides regional and provincial secondary, specialty services, and in-patient mental health services to residents of PEI. Facilities include Prince County Hospital, the Queen Elizabeth Hospital and Hillsborough Hospital. Administratively, one Executive Director is responsible for PCH and one Executive Director is responsible for QEIH / Hillsborough Hospital, each of who are members of the Departmental Management Committee.

- **Community Hospitals and Continuing Care**: Provides acute care services to rural communities and supportive services to adults and seniors in need of continuing care on PEI. Programs and Facilities include the five rural community hospitals, provincial manors, home care, palliative care, dialysis, and adult protection. Administratively, the Director of Community Hospitals and Continuing is responsible for this division and is a member of the
Departmental Management Committee.

For each of the five community hospitals, an elected governing board has been put in place. Each board is accountable to the minister, and is responsible for ensuring the completion of annual business plans and reporting on facility performance and results to the Minister and their local communities.

- **Primary Care**: Provides primary health services to citizens of PEI. Programs and facilities include: Community Mental Health and Addictions including the Provincial Addictions Treatment Facility, six Family Health Centers, Public Health Nursing, Speech Language / Audiology, Nutrition, Diabetes, and Chronic Disease Prevention and Healthy Living. Administratively, the Director of Primary Care is responsible for this division and is a member of the Departmental Management Committee.

- **Population Health**: Provides Public Health and Regulatory Services to the citizens of PEI. Programs and services include the Office of Chief Health Officer, Emergency Health Services, Communicable Disease Control and Immunization, Epidemiology, Environmental Health, Vital Statistics, Community Care / Nursing Home Inspection, Adult Protection, Public Guardian and Dietic Services. Administratively, the Director of Population Health is responsible for this division and is a member of the Departmental Management Committee.

**Support Services**

- **Finance**: Provides financial management, materials management and business office services to the Department of Health. Administratively, the Director of Finance is responsible for this division and is a member of the Departmental Management Committee.

- **Medical Programs**: Provides support services to medical practitioners; administers medicare and provincial ambulance services; and coordinates out of province hospital placements. Administratively, the Director of Medical Programs is responsible for this division and is a member of the Departmental Management Committee.

- **Corporate Services**: Provide human resource, legislative support, health information management and corporate relations and evaluation services to the Department of Health. Administratively, the Director of Corporate Services is responsible for this division and is a member of the Departmental Management Committee.

**Newfoundland and Labrador**

Fourteen health boards were integrated into four Regional Integrated Health Authorities, (RIHA) April 1, 2005. New RIHA Legislation is being prepared.

The Department of Health and Community Services (DOHCS) was reorganized in 2005 to align with the new RIHA structures.

In the fall 2005, annual reports (2004/2005) for the DOHCS, all former fourteen health boards and a number of agencies were tabled in the House of Assembly.
The DOHCS and the RIHAs have drafted strategic plans to ensure compliance to the Transparency and Accountability Act. Four strategic directions have been proposed by the DOHCS: Strengthened public health capacity, population health, improved access to priority services, and achieving accountability and stability in the health care system.

Specific renewal processes continue in the area of primary health care, wellness, and mental health and addictions services. In Oct. 2005 the Provincial policy framework for Mental Health and Addictions Services was released: *Working Together for Mental Health* and in March 2006 the provincial wellness plan was released: *Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador*.


**Institutional Change / Reform / Changement/Réforme Sur Le Plan Institutionnel**

**Health Canada**

*Assisted Human Reproduction Agency of Canada*

The *Assisted Human Reproduction Implementation Act*, received Royal Assent on March 29, 2004. The Act is designed to protect the health and safety of Canadians using assisted human reproduction, and establishes the Assisted Human Reproduction Agency of Canada. On May 5, 2005, Orders-in-Council were issued designating Vancouver, British Columbia, as the location of the Agency and fixing January 12, 2006, as the effective date for the establishment of the new Agency.

**Santé Canada**

*Agence canadienne de contrôle de la procréation assistée*


**Northwest Territories**

- In 2005 the Inuvik Regional Health and Social Services Authority (IRHSSA) was divided into two new Authorities: the Beaufort Delta Health and Social Services Authority (BDHSSA) and the Sahtu Health and Social Services Authority (SHSSA). The new Beaufort Delta Authority continues to serve the eight communities of the Beaufort Delta region (Aklavik, Fort McPherson, Holman, Inuvik, Paulatuk, Sachs Harbour, Tsiigehtchic, and
Tuktoyaktuk). The new SHSSA serves the five communities of the Sahtu region (Colville Lake, Délina, Fort Good Hope, Norman Wells, and Tulita).

- The Tlicho Community Services Agency (TCSA) was established on August 4th, 2005, replacing the former Dogrib Community Services Board. The TCSA is unique among health and social services boards, as it is also responsible for education programs. The TCSA consists of five members, one from each community in the Tlicho region, and a Chair. The TCSA serves the communities of Behchoko (formerly called Rae-Edzo), Gameti, Wekweeti and Whati.

Yukon Territory

- No major functional changes within the funding or organization of institutional settings.

British Columbia

In June 2005, the Minister of Health assumed the responsibilities of the Minister of State for Mental Health. The Ministry of Health Services was renamed the Ministry of Health.

Alberta

- In May of 2005, health care experts from around the world gathered in Alberta for The International Symposium on Health. The symposium gave Alberta an opportunity to examine a range of possible solutions to the challenges facing the health care system. From this experience the province learned that there is no single solution to Alberta’s challenges in health care delivery.
- Since then Alberta has continued to develop and implement numerous ideas and improvements that meet patients’ needs, and make a positive difference in the health of Albertans. The goal of this health renewal plan, Alberta’s Third Way in health care, is to improve the public health care system – to make it stronger and better than it is today. In 2005, Alberta announced 13 renewal initiatives as part of a made-in-Alberta approach to health system delivery. This Third Way approach is about unleashing innovation, challenging the status quo and charting a new course to make our health care system among the best in the world. The following actions were identified:
  - Put an overall health policy in place.
  - Improve access and efficiency
  - Get serious about wellness and injury prevention
  - Make children’s health the top priority
  - Improve access to mental health services
  - Implement an electronic health record for all Albertans
  - Expand primary health care
  - Make changes to legislation and regulations
  - Control spiralling drug costs and increase coverage
o Improve quality of long term care
o Increase the supply of health care providers
o Address the health needs of rural communities
o Examine supplementary health insurance

- Some of the innovative initiatives Alberta has recently implemented to improve health care services in the province and the health of Albertans include:
  o The hip and knee replacement pilot project: The first eight months of the pilot resulted in decreased wait times from 35 weeks to six weeks for the first orthopedic consult, and from 47 weeks to 4.7 weeks from the first orthopedic consult to surgery. The length of stay in hospital went from 6.2 to 4.3 days.
  o The implementation of Primary Care Networks: Alberta currently supports 11 Primary Care Networks with 400 physicians and teams of health professionals providing service to 500,000 patients. Another 18 Primary Care Networks are in various stages of development in health regions across the province.
  o The establishment of the Mental Health Innovation Fund: Thirty new projects across Alberta will share in $75 million over three years to provide a wide range of mental health services. These projects will meet the on-going mental health needs of residents in each health region.
Project Hope - On August 4, 2005, Premier Lorne Calvert announced Project Hope, a three-year, $15M (annualized) plan to prevent and treat substance abuse.

Healthy Living - The Hon. Graham Addley, was appointed to Cabinet on October 14, 2005 as Minister of Healthy Living Services. Minister Addley is responsible for initiatives related to the First Ministers’ Accord, Project Hope, Review of the Children’s Mental Health Services, the Cognitive Disabilities Strategy and addictions, as well as broader files including mental health services, health promotion and active living, tobacco reduction, and problem gambling.

Manitoba

- No material changes in 2005/06.
Ontario

Changing Health Care

The Ontario government’s plan for innovation in public health care involves building a system that delivers on three priorities – keeping Ontarians healthy, reducing wait times and providing better access to doctors and nurses.

Key government strategies currently underway include:

The Wait Times Strategy

On November 17, 2004, Minister of Health and Long-Term Care, George Smitherman, officially launched Ontario’s Wait Time Strategy. The strategy is designed to reduce wait times by improving access to healthcare services for Ontarians in five areas: cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements, and MRI and CT scans.

Ontario's Wait Time Strategy is tackling wait times on a number of fronts:

- Significantly increasing the number of procedures to reduce the backlog that has developed over the last decade
- Investing in new, more efficient technology such as MRI machines and extending hours of operations
- Standardizing best practices for both medical and administrative functions in order to improve patient flow and efficiency
- Collecting and reporting accurate and up-to-date data on wait times to allow better decision making and increase accountability

On January 13, 2006, Minister Smitherman allocated $6.8 million to fund an additional 907 hip and knee replacements at 22 Ontario hospitals by March 2006. This “mid-year correction” was over and above the 6,700 additional hip and knee replacement surgeries that were allocated in 2005/06, for a combined total of 7,607 additional procedures. The allocation of additional cases took into account population demographics, surgery rates, current wait times, and hospitals’ ability to complete procedures by the end of March 2006.

On March 23, 2006, the Ontario government announced in its 2006 Ontario Budget that it will continue to shorten wait times in 2006/07 by providing funding for additional procedures.

On April 28, 2006, the government invested $222.5 million for 154,000 more procedures, including:

- 9,000 more hip and knee joint replacements
- 25,850 more cataract surgeries
- 105,200 more MRI exams
- 4,700 more cancer surgeries
• 9,000 more cardiac procedures

Data on the government’s wait times website indicates that, during the last six months, cataract surgery median wait times dropped 21 per cent, times for hip and knee replacements decreased 19 per cent and 17 per cent respectively, and cancer surgery wait times dropped by four per cent.

An important part of the Wait Time Strategy is the development of a single wait time information system for Ontario to collect accurate and timely data. The Wait Times Information System will help doctors and hospitals work together to better understand and prioritize their patients. It will also help hospitals and the government to better target their resources to where they will have the most impact. Patients can also use reports from this system, in consultation with their primary health care provider, to make informed choices about where to be referred for quicker service.

For more information, see the Ontario government’s wait times website at: www.ontariowaittimes.com.

The HealthForceOntario Strategy

In May 2006, the Ontario government launched its HealthForceOntario Strategy. This strategy aims to fill the shortage of health care professionals in Ontario by ensuring the right supply and mix of health care professionals.

The HealthForceOntario Strategy has three components:

Creating four new roles in areas of high need:
• Physician Assistant
• Nurse Endoscopist
• Surgical First Assist
• Clinical Specialist Radiation Therapist

Developing Ontario's workforce by setting up a one-stop centre for internationally educated health professionals to obtain the information they need to work in Ontario.

Better equipping Ontario to compete for scarce health care professionals, in the rest of Canada and throughout the world, by establishing a marketing and recruitment centre including a comprehensive job portal.

This strategy builds on initiatives that are already underway in Ontario to improve access to health care professionals, including:
• A 23 per cent increase in medical school enrolment
• The creation of 150 Family Health Teams
• More than doubling the number of training and assessment positions for international medical graduates
• Developing a comprehensive nursing strategy
• Opening a new school of pharmacy in Waterloo
• Reinforcing the new fully inter-professional curriculum at the Michener Institute, funded by the Ministry of Health and Long-Term Care

**Progress on Family Health Teams**

Progress on the establishment of Family Health Teams in Ontario has been significant. In April 2006, the government announced that it had reached its goal of creating 150 Family Health Teams to be fully implemented by 2007-08. The teams are expected to improve access to health services for more than 2.5 million Ontarians.

**Protecting Public Health**

Additionally, major government initiatives such as **Operation Health Protection** – a three-year action plan to revitalize the public health system – and the development of the **Ontario Health Plan for an Influenza Pandemic**, which provides directions to governments and health care providers on the most effective ways to respond to a pandemic, are contributing to making Ontario a healthier place for Ontarians.

Information on pandemic planning in the health sector, including the Ontario Health Plan for an Influenza Pandemic, is available at [www.health.gov.on.ca/pandemic](http://www.health.gov.on.ca/pandemic). This web site also has information for employers.

**Strengthening the System**

**Integrating the Local Delivery of Care**

Another important part of the government’s plan for change is the creation of 14 Local Health Integration Networks (LHINs). The networks will allow local communities and health care providers to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The government will continue to set strategic directions and provincial standards for high-quality, accessible health care.

**Organizing Information**

Quality patient care requires quality information. This is why strengthening the province’s infrastructure is also part of the government’s plan to build a better health care system.

The province’s Information Management Strategy aims to address the system-wide need for better information, in sectors like acute care and community health. It supports major government initiatives, such as the Wait Times Strategy, the E-Health Strategy, and the establishment of 14 Local Health Integration Networks (LHINs). The strategy lays out a systematic approach for addressing data quality and integration issues. The end goal is not only better quality data, but a more organized, efficient, and ultimately, more sustainable way of managing health system information.
Initiatives that are underway are focused on improving data quality and management, closing information gaps and reducing the burden of data collection on health care providers.

Quebec

Voir la section « Gouverne et gestion ».

See the section “Governance and management.”

New Brunswick

See Political and Regionalization sections.

Nova Scotia

- In February 2006, the Premier, Rodney MacDonald, announced the creation of the Department of Health Promotion and Protection. Nova Scotia Health Promotion and Protection was formed from Nova Scotia Health Promotion, formerly the Office of Health Promotion, Public Health Branch of the Department of Health and the Office of the Chief Medical Officer of Health
- Nova Scotia Health Promotion and Protection’s chief business areas include:
  - Healthy eating
  - Healthy sexuality
  - Physical activity
  - Tobacco control
  - Injury prevention
  - Addictions
  - Chronic disease prevention
  - Health protection and public health
  - Communications and social marketing

Prince Edward Island

2005 Health and Social Services System Restructuring

In 2005, the health and social services system underwent a restructuring process. This process resulted in the following structural changes:

- Creation of two new departments, namely the Department of Health, and the Department of Social Services and Seniors, to replace the former Department of Health and Social Services;
- Dissolution of five regional health authorities; and
• Establishment of community hospital boards to govern each of the five small community hospitals in the province.

In line with the structural changes, the following administrative changes occurred:

• The role of the Department of Health changed from responsibility for quality of advice and assistance to line services to a responsibility for direct service delivery;

• Administrative and support services for line services moved from a regional to a departmental model in line with the dissolution of the health authorities;

• Under the previous organizational structure, each of the five regional health authorities had governing boards. Under the new organizational model, each of the five community hospitals have a governing board.

Upon completion of restructuring, departmental responsibility for managing programs and services were realigned as outlined in the table below.

<table>
<thead>
<tr>
<th>Distribution of PEI Department of Health and Social Services Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Department of Health</strong></td>
</tr>
<tr>
<td>Acute Care Services</td>
</tr>
<tr>
<td>Addiction Services</td>
</tr>
<tr>
<td>Adult Protection</td>
</tr>
<tr>
<td>Ambulance Services - Air Ambulance</td>
</tr>
<tr>
<td>Ambulance Services - Ground Ambulance</td>
</tr>
<tr>
<td>Chief Health Officer</td>
</tr>
<tr>
<td>Community Care Facilities</td>
</tr>
<tr>
<td>Diabetes Program</td>
</tr>
<tr>
<td>Environmental Health</td>
</tr>
<tr>
<td>Health Information Resources</td>
</tr>
<tr>
<td>Home Care and Support</td>
</tr>
<tr>
<td>Long Term Care (Nursing Home) Services</td>
</tr>
<tr>
<td>Medical Education / Physician Recruitment Programs</td>
</tr>
<tr>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Nursing Recruitment and Retention Strategy</td>
</tr>
<tr>
<td>Out-of-Province Hospital Services</td>
</tr>
<tr>
<td>Out-of-Province Physician Services</td>
</tr>
<tr>
<td>PEI Dialysis Program</td>
</tr>
<tr>
<td>Physician Payment Services</td>
</tr>
<tr>
<td>Public Health Nursing Programs</td>
</tr>
<tr>
<td>Vital Statistics Program</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Newfoundland and Labrador

A major goal of the department is to improve the quality, accessibility and sustainability of health and community services delivered in the system. Creating fewer, more accountable health authorities is necessary to renew our health and community services system and meet client needs. Fewer regions will mean less administration and more opportunities for collaboration. Integrated boards will have the ability to focus on the full continuum of care, from community care to acute and long-term care. This will result in better services for clients.

Regionalization / Régionalisation

Health Canada

No developments to report.

Santé Canada

Rien de nouveau à signaler à ce sujet.

Northwest Territories

- The Department is undertaking a Facilities Review. The review will determine an equitable way of allocating resources for facilities, based on nationally recognized benchmarks. A set of recommendations will be made regarding the delivery model for facility-based healthcare in the NWT.

Yukon Territory

- The Yukon does not have a regionalized service structure.
- An appointed Board of Trustees operates the Yukon Hospital Corporation. The Corporation governs the operation of the Whitehorse General Hospital on behalf of all Yukoners.
- The Board of Trustees consists of 14 persons nominated by: Yukon First Nations; councils of rural municipalities; Council of Yukon Indians or its successor; City of Whitehorse; medical staff of the Corporation; non-medical staff of the Corporation; the public at large and the public service of the Yukon.

British Columbia

Health authority accountability

Health authorities sign performance agreements with the Ministry of Health that hold them accountable for the delivery of patient care, health outcomes and how health dollars are spent. A provincial Leadership Council, made up of health authority Chief Executive Officers and Senior
Executives from the Ministry of Health meet regularly to ensure health authorities are meeting the targets set by their performance agreements.

Performance agreements provide a framework against which the overall performance of the system as a whole can be monitored, evaluated and reported. The agreements define performance deliverables and service requirements in broad areas of service and finance and specific areas of reform in emergency care, surgical services, home and community care and mental health services for three fiscal years. Performance targets are meant to challenge each health authority to achieve its maximum potential in key service areas, while taking unique geographic and demographic challenges into account.

In addition to building collaboration across the health care sector, performance agreements have proven to be effective in addressing concerns about accountability in the health care system and in acting as drivers of change and improvement. They have enhanced accountability by setting out mutually defined performance expectations and requiring reports on how expectations are met. In addition, the 2001 consolidation of 52 health authorities to six has created the critical mass within health authorities to support well-functioning internal audit programs. The Office of the Auditor General reports that all six health authorities have set up an internal audit unit.

**Alberta**

Nothing to report at this time.

**Saskatchewan**

- On August 1, 2002, *The Regional Health Services Act* created 12 Regional Health Authorities (RHAs) from the province's existing 32 health districts. The Act not only established new health regions but also fully described the revised approaches to accountability and to program services and standards.

- The establishment of these 12 RHAs has resulted in a new relationship between the key players of the health system and a clear definition of the responsibilities and expectations for each partner.

- Since the RHAs retain responsibility for the expenditure of such a large portion of total provincial expenditures, it was necessary to link the operational and strategic planning of the regions more closely with provincial planning processes.

- 2003-04 was the first full year in the new planning cycle. RHAs submitted plans in the fall based on a defined set of planning and funding guidelines provided to them in early summer. The planning guidelines were based on the overall direction set in the department strategic plan and the funding targets were established for two years.

- Setting out expectations is an important starting point, as Saskatchewan Health seeks to realize the shared vision of “building a province of healthy people and healthy communities”. This will provide a solid foundation for a more effective and cooperative health care system well into the future. In consultation with the RHAs, an Accountability Document was developed in 2003-2004, and this approach continued in 2004-2005 and 2005-2006. The
Accountability Document sets clear goals and service expectations for RHAs, and establishes the indicators and measures required to support RHA accountability and reporting.

- Through the efforts of both an internal and an external committee on indicator development, Saskatchewan has done extensive work over the past several years to define and refine the indicators and measures set out in the Accountability Document. The 2006-07 Accountability Document will continue the process of clarifying expectations of RHAs and supporting more refined reporting to government and the public, ultimately enhancing the accountability of the health system to the people of Saskatchewan.

**Manitoba**

- No material changes in 2005/06.

**Ontario**

*Local Health Integration Networks (LHINs)*

Ontario is moving forward with a distinct, "Made-in-Ontario" model of localized health system management. Ontario’s Local Health Integration Networks (LHINs) are geographically based agencies that will re-orient the health system towards a more patient/client-centered model. These networks will not be responsible for delivering services directly. One of their key jobs will be to ensure that the delivery of local health services is coordinated.

On November 24, 2005, the Honourable George Smitherman, Minister of Health and Long-Term Care, introduced the *Local Health System Integration Act*, (Bill 36). Seven days of public hearings on the Bill were held across the province in late January and early February 2006. On March 28, 2006 the *Local Health System Integration Act, 2006*, received Royal Assent. The legislation will provide LHINs with responsibility and authority for

- local health system planning;
- local health system integration;
- accountability and performance management of certain health service providers;
- local community engagement; and
- funding.

Work is underway for the development and implementation of regulations and policies. The public has been kept informed through regular monthly bulletins posted on the MOHLTC website at www.health.gov.on.ca/transformation.

**Quebec**

Voir la section « Gouverne et gestion ».

See the section “Governance and management.”
New Brunswick

- The Lieutenant-Governor-in-Council proclaimed that November 28, 2005 was the effective date for *An Act Respecting Mental Health and Public Health Services*. Effective that date, 647 full time equivalents (FTEs), reflecting 240 FTEs and 407 FTEs for public health services and mental health services respectively, were transferred to the eight Regional Health Authorities.

Nova Scotia

Provincial programs address health issues across sectors of the health system that are beyond the mandate of any single DHA or health organization. They develop service standards, monitor their achievement, and provide advice to the Department of Health based on best practices, stakeholder input and research-based evidence.

Current Provincial Programs are:
- Cancer Care Nova Scotia
- Nova Scotia Diabetes Care Program
- Reproductive Care of Nova Scotia
- Nova Scotia Breast Screening Program
- Cardiovascular Health Nova Scotia
- Nova Scotia Provincial Blood Coordinating Program
- Nova Scotia Hearing and Speech Program

- A comprehensive demonstration project involving acute and emergency care for, and the prevention and rehabilitation of stroke patients is being piloted by Southwest Nova District Health Authority.

- The Nova Scotia Breast Screening Program has several new fixed mammography sites

- Provincial Infection Control Consultant was hired to work with the District Health Authorities for the next three years

Prince Edward Island

System restructuring resulted in the dissolution of regional health authorities. All health services, with the exception of the five community hospitals, are now managed through a provincial departmental management structure.

Each of the five community hospitals are governed by an elected board. These boards are accountable to the minister, and are responsible for completing annual business plans and for reporting on hospital performance and results to the Minister and their local communities.
This is a transition year for the boards. Each board is currently comprised of 5 members appointed by the Minister. In the fall of 2006, board elections will be held with the expectation that each board will be comprised of 7 elected members.

**Newfoundland and Labrador**

Institutional and community health services were delivered by four Regional Integrated Health Care Boards (RIHAs). The infrastructure in the health and community services system in 2005-06 includes:

- Hospitals 16
- Health Centers 18
- Nursing Homes 21
- Nursing Stations 13
- Community/ clinic offices 106

The Department has devolved a number of services to RIHAs in 2005, ambulance and group home services are two examples.

In addition to the RIHAs, a number of other organizations and agencies offer services to the public such as personal care homes and family resource centers.

**Section IV: Support and Innovation in Health Care**

**Human Resources : Physicians / Ressources Humanines : Médecins**

**Health Canada**

The Health Human Resources Strategies Division has funded several initiatives focusing on improving physician human resources.

- **The Enhancement of Physicians Health Human Resources in Rural Canada** project led by the Society of Rural Physicians of Canada aims to enhance strategies to recruit and retain rural physicians, develop appropriate educational programs, and develop new models of access to rural surgical care. This initiative will improve education for rural physicians and increase access to physicians for rural residents.

- **Increasing Support for Family Physicians in Primary Care and Promotional Strategies to Enhance the Image of Family Medicine to All Canadian** led by The College of Family of Physicians will increase the professional pride of family physicians, as well as enhance the value of the role of the family physicians in the eyes of the public, medical students and to increase support for family physicians in primary health care. To date, this project has supported and established family medicine interest groups in medical schools across the country.
• *Enhancing the Role of Family Medicine in the Undergraduate Medical School Curriculum and Strengthening Links Between Primary and Specialty Care*, also led by the College of Family Physicians, will strengthen the role of family medicine and family physician teachers, mentors and role models in the undergraduate curriculum at Canadian medical schools and explore the roles and relationships between family physicians and specialists. This project is expected to result in an increase in the visibility, credibility, and importance of the discipline of family medicine, increased enrolment into the family medicine program and improved understanding and respect of family physicians and specialists for one another’s roles and responsibilities.

In February 2004, the Canadian Task force on Licensure of International Medical Graduates released a final report with six recommendations that were subsequently supported by the federal/provincial/territorial Ministers of Health. To oversee implementation of these six recommendations, the International Medical Graduate Implementation Steering Committee was established and implementation of initiatives to address the recommendations is nearing completion. A central website of information for international medical graduates on licensure and practice in Canada was launched in April 2005 ([www.img-canada.ca](http://www.img-canada.ca)). The Faculty Development Program for Teachers of International Medical Graduates was developed by the Association of Faculties of Medicine of Canada and launched in Spring 2006. The program enables faculty and preceptors working with international medical graduates to provide a supportive and effective assessment and learning experience.

**Santé Canada**

La Division des stratégies en matière de ressources humaines en santé a financé plusieurs initiatives visant à améliorer les effectifs de médecins.

• Le projet *amélioration des effectifs médicaux dans le Canada rural*, piloté par la Société de la médecine rurale du Canada, vise à renforcer les stratégies de recrutement et de maintien en poste de médecins en région rurale, à mettre au point des programmes éducationnels appropriés et à élaborer de nouveaux modèles d’accès aux soins chirurgicaux en milieu rural. Cette initiative permettra d’améliorer l’enseignement destiné aux médecins des régions rurales et l’accès aux soins médicaux en milieu rural.

• Le projet *Soutien accru aux médecins de famille en soins de santé primaires et stratégies publicitaires pour améliorer l’image de la médecine familiale auprès des Canadiens*, piloté par le Collège des médecins de famille du Canada, accentuera la fierté professionnelle des médecins de famille et valorisera le rôle de ces derniers aux yeux du public et des étudiants en médecine et augmentera le soutien accordé aux médecins de famille dans le secteur des soins primaires. Jusqu’ici, le projet a permis d’appuyer et d’établir des groupes d’intérêt en médecine de famille dans des écoles de médecine un peu partout au pays.

• Le projet *Mise en valeur du rôle de la médecine familiale dans le programme d’enseignement de premier cycle des écoles de médecine et resserrement des liens entre les soins de premiers recours et les soins de spécialité*, lui aussi piloté par le Collège des médecins de famille du Canada, vise à renforcer le rôle de la médecine familiale ainsi que des enseignants, mentors et modèles de comportement en la matière dans le cadre du programme d’enseignement de premier cycle des écoles de médecine du Canada et à explorer les liens entre les médecins de famille et les médecins spécialistes ainsi que leur rôle. Ce projet devrait
se traduire par une amélioration de la visibilité, de la crédibilité et de l’importance de la discipline de la médecine de famille, accroître les inscriptions au programme de médecine familiale et faciliter la compréhension et le respect entre les médecins de famille et les médecins spécialistes au sujet des rôles et des responsabilités qui leur sont propres.


Northwest Territories

- The GNWT offers physicians and specialists a comprehensive salary and benefits package that includes:
  - competitive recruitment and retention bonuses;
  - northern allowance;
  - call-back compensation;
  - moving assistance;
  - special leave;
  - self-funded leave plan;
  - sick leave;
  - maternity leave; and
  - group health benefits

More information on contracts and compensation can be found under Careers at http://www.hlthss.gov.nt.ca

- As of January 2006 there were 56 General Practitioners and 22 specialist positions in the NWT. The following table outlines the breakdown of physician positions by Authority:
<table>
<thead>
<tr>
<th>General Practitioners</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deh Cho</td>
<td>2.5</td>
</tr>
<tr>
<td>Tlicho</td>
<td>2.0</td>
</tr>
<tr>
<td>Fort Smith</td>
<td>4.5</td>
</tr>
<tr>
<td>Hay River</td>
<td>7.0</td>
</tr>
<tr>
<td>Sahtu</td>
<td>2.0</td>
</tr>
<tr>
<td>Inuvik</td>
<td>9.0</td>
</tr>
<tr>
<td>Yellowknife</td>
<td>29.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialists @ STHA</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB/GYN</td>
<td>3.0</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>3.0</td>
</tr>
<tr>
<td>Internist</td>
<td>3.0</td>
</tr>
<tr>
<td>General Surgeon</td>
<td>3.0</td>
</tr>
<tr>
<td>Orthopaedic Surgeon</td>
<td>2.0</td>
</tr>
<tr>
<td>ENT</td>
<td>2.0</td>
</tr>
<tr>
<td>Radiologist</td>
<td>2.0</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>2.0</td>
</tr>
<tr>
<td>Anaesthesiologist</td>
<td>1.0</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>1.0</td>
</tr>
</tbody>
</table>

- A number of recruitment and retention initiatives are ongoing. These include:
  - Physician Recruiter position whose primary focus is attracting and retaining permanent physicians for Stanton Territorial Hospital.
  - Halftime Physician Recruiter position whose primary focus is attracting and retaining permanent physicians for Yellowknife Health and Social Services Authority.
  - Return of Service Bursaries for medical students who agree to reside and work in the NWT upon the completion of their studies.
  - Resident Travel Bursary offered to offset travel costs for a resident who completes a component of their training in the NWT.
Yukon Territory

- A four year funding agreement was negotiated with the Yukon Medical Association, effective April 1, 2004. The agreement provides a 6.5% fee increase over the four year term. The Yukon Physician Recruitment and Retention program was implemented to address related concerns, offering financial bonuses in return for service commitments.

- Agreements typically detail the relationship and flow of funds to fee-for-service and alternative payment physicians; the change to fees; on-call coverage; provisions for recruitment and retention benefits, continuing medical education, medical practice insurance; continuance of service; assurance of cost; dispute resolution; and assurance of a more transparent recruitment process.

- There were 54 resident general and family physicians and eight specialists providing services in the Yukon in 2004/05

- Approximately 10% of physicians in the territory are being remunerated through alternative payment plans. This includes two rural physicians who are required to work in conjunction with Community Nurse Practitioners and five resident specialists in Whitehorse who are remunerated under alternative payment plans.

- In addition to the above services, a Visiting Specialists Program brings itinerate specialists to the territory to provide services not available locally. Further, the Visiting Physician Program provides itinerant services to 10 rural and remote communities that do not have resident physicians.

British Columbia

B.C. medical school expansion

- University of British Columbia (UBC) distributed medical programs are now in place in Prince George and Victoria, and the medical school facilities have expanded under a $134 million commitment announced in March 2002. The expansion included $110 million for a new Life Sciences Centre at UBC Vancouver and about $24 million for new facilities at the University of Northern British Columbia (UNBC) and the University of Victoria (UVic).

- The distributed medical programs focus on rural, geriatric and aboriginal health issues. They will enable undergraduate medical students to study close to home and will help alleviate regional issues over access to physician services by providing a pool of student doctors who will complete residency rotations in hospitals outside of the lower mainland.

- UBC-Okanagan in Kelowna will be home to the province’s fourth medical program. By 2009, this distributed medical program will have first-year spaces for at least 30 students.

More medical school spaces

- BC’s annual intake for medical students was 128 in 2003. The medical school’s expansion doubles the number of first-year spaces to 256 by 2007.

- All undergraduate medical students take the first semester at UBC and then disperse to UBC, UNBC or UVic.
There are now 24 first-year spaces at the Northern Medical Program, UNBC, 24 first-year spaces at the Island Medical Program, UVic, and 176 first-year spaces at Vancouver-Fraser Medical Program, UBC, for a total of 224 potential graduates per year by 2009.

A final 32 first-year medical school spaces will be added in 2007 for a total of 256 potential graduates per year by 2011/12. Of these, eight are expected to go to UNBC, eight to UVic and 16 to UBC Vancouver-Fraser.

The recently announced Okanagan Medical Program will add at least another 30 first-year spaces when the program begins in 2009/10.

More residencies

Postgraduate medical education positions (residencies) will expand to keep pace with the medical school expansions. Since July 2003, the Ministry of Health has approved funding for 89 new postgraduate entry-level (residency) positions.

The number of entry-level residency positions will increase to at least 256 by 2011/12.

Enhanced Infrastructure For Medical Education

The B.C. Government is investing $27.6 million to expand and upgrade academic space in teaching hospitals around B.C. to support the increasing number of undergraduate and postgraduate medical students. The money will go toward renovations and upgrades of academic space, such as seminar rooms, on-call rooms, offices and library space.

Residency spaces increased for International Medical Graduates

In November 2001, the number of IMG family practice entry-level residency positions increased from four to six at St. Paul’s Hospital.

In November 2005, government invested an additional $1.65 million to bring the entry-level residency positions for IMGs from six to 18. For the first time, B.C. is accepting candidates who wish to pursue specialist residencies. Six of the new positions are for family medicine and six are for specialties such as internal medicine, general surgery, psychiatry, pediatrics, pathology, anesthesiology, obstetrics and gynecology. The specialties will be determined by matching the candidate’s assessment results and interests with the specialty program’s readiness to train. (This is no longer a 2-year program for only family medicine.)

Immigration process speeds up for international doctors

Foreign doctors practicing medicine on temporary work permits in B.C. can now gain permanent resident status within six to eight months under a new component of the B.C. Provincial Nominee Program (BC PNP). Previously, foreign doctors waited up to three years for the permanent resident application process to be completed. The new component makes it easier for them to settle their families and set up practice here, helping address pressures in the health care system, especially in rural British Columbia.

Recruiting more doctors to rural and remote areas
• Studies show that doctors tend to practice in the regions where they trained. The new distributed medical programs at UNBC, UVic and UBC-Okanagan will play an important role in recruiting more doctors to rural and remote communities.

• Through physician compensation, government has allocated $58.5 million towards rural programs that encourage physician recruitment, retention and education.

**Total Number of Medical Practitioners by Specialty**

**British Columbia Comparison 2003/04 and 2004/05**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Practitioners 2003/04</th>
<th>Practitioners 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td>4,573</td>
<td>4,629</td>
</tr>
<tr>
<td>Dermatology</td>
<td>66</td>
<td>64</td>
</tr>
<tr>
<td>Neurology</td>
<td>92</td>
<td>96</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>557</td>
<td>584</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>185</td>
<td>197</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>182</td>
<td>180</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>82</td>
<td>79</td>
</tr>
<tr>
<td>General Surgery</td>
<td>190</td>
<td>191</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>160</td>
<td>180</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>63</td>
<td>68</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>21</td>
<td>26</td>
</tr>
<tr>
<td>Urology</td>
<td>71</td>
<td>73</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>206</td>
<td>214</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>536</td>
<td>569</td>
</tr>
<tr>
<td>Radiology</td>
<td>251</td>
<td>263</td>
</tr>
<tr>
<td>Pathology</td>
<td>139</td>
<td>134</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>380</td>
<td>412</td>
</tr>
<tr>
<td>Paediatric Cardiology</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Physical Medicine &amp; Rehab</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>69</td>
<td>39</td>
</tr>
<tr>
<td>Medical Microbiology</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>47</td>
<td>50</td>
</tr>
<tr>
<td>Clinical Immunization and Allergy</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>8,083</strong></td>
<td><strong>8,271</strong></td>
</tr>
</tbody>
</table>
Alberta

- Alberta had 6,279 fully registered physicians as of December 31, 2005. The number of fully registered physicians in Alberta increased by 189 in 2005 and 221 in 2004. The breakdown for specialists and non-specialists was as follows:

<table>
<thead>
<tr>
<th></th>
<th>Specialists</th>
<th>General Practitioners</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>2,549</td>
<td>2,700</td>
<td>5,249</td>
</tr>
<tr>
<td>2001</td>
<td>2,664</td>
<td>2,785</td>
<td>5,449</td>
</tr>
<tr>
<td>2002</td>
<td>2,807</td>
<td>2,882</td>
<td>5,689</td>
</tr>
<tr>
<td>2003</td>
<td>2,884</td>
<td>2,985</td>
<td>5,869</td>
</tr>
<tr>
<td>2004</td>
<td>3,015</td>
<td>3,075</td>
<td>6,090</td>
</tr>
<tr>
<td>2005</td>
<td>3,097</td>
<td>3,182</td>
<td>6,279</td>
</tr>
</tbody>
</table>

- Medical training opportunities have expanded in Alberta in recent years. Alberta’s medical school enrolments totalled 191 seats in 1990/1991 and 228 seats in 2001/2002, an increase of 19 per cent. Seats have been provided for each exiting student to enter medical residency training. Since 2000, Alberta’s medical residency training positions have increased by approximately 16 per cent, from 716 in 2000, to 886 in 2004. There were 20 rural residencies in 2004/2005; this will increase to 30 in 2005/2006.

- Since 2001, Alberta has also provided a number of non-CaRMS (Canadian Resident Matching Service) positions for International Medical Graduates. For July 2005, the Alberta International Medical Graduate Program has made a total of 16 Family Medicine residency entry positions and 12 specialist training positions available. Only 12 Family Medicine and nine specialty places could be filled in 2004. These positions are over and above numbers required to meet demands created by students exiting medical school training.

- Alberta Health and Wellness has implemented a multi-level on-call remuneration program for specialist physicians with a provincial framework and provincial standards. The program has been in place for four years. Rural On-Call covers 87 rural sites, and Specialist On-Call covers approximately 500 approved programs across the province.

- In December 2003, a new tri-lateral master agreement for physician services in Alberta was ratified by Alberta Health and Wellness, the Alberta Medical Association and the nine health authorities. With an unprecedented eight-year term, this agreement extends and expands the Physician Office System Program, creates a new Primary Care Initiative, incorporates the specialist and rural on-call programs, provides fee increases totalling 9.1 per cent over the first three years, and allows for other subsidiary agreements to be added in the future. The tri-lateral parties (Alberta Health and Wellness, Alberta Medical Association and the health regions) are currently negotiating the 2006/2007 and 2007/2008 financial reopener for the Master Agreement.

- The new agreement also makes provision for Alternate Relationship Plans (ARPs, formerly known as alternate payment and alternate funding plans), and for the first time gives them equal standing with fee-for-service expenditures as a spending priority. As of February 2006, Alberta has:
6 academic ARPs in operation involving 472 physicians.
2 additional academic ARPs in development which will involve 121 physicians.
24 non-academic ARPs in operation involving 336 physicians.
59 new non-academic ARPs in development, of which 10 are in the final stages of this process.

Saskatchewan

- The overall supply of physicians has been steadily increasing over the past few years. The head count of all licensed physicians in Saskatchewan, including temporary licensed locums, was 1,622 at the end of March 2001 and was 1,728 at the end of December 2005. This number excludes medical health officers and residents, and allocates non-certified specialists (in transition to certification) to the specialist category.

<table>
<thead>
<tr>
<th>LICENSED</th>
<th>March/01</th>
<th>March/02</th>
<th>March/03</th>
<th>March/04</th>
<th>March/05</th>
<th>Dec/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practitioners</td>
<td>909</td>
<td>897</td>
<td>900</td>
<td>905</td>
<td>927</td>
<td>954</td>
</tr>
<tr>
<td>Specialists</td>
<td>713</td>
<td>725</td>
<td>729</td>
<td>749</td>
<td>753</td>
<td>774</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,622</strong></td>
<td><strong>1,622</strong></td>
<td><strong>1,629</strong></td>
<td><strong>1,654</strong></td>
<td><strong>1,680</strong></td>
<td><strong>1,728</strong></td>
</tr>
</tbody>
</table>

- Saskatchewan continues to have a lower supply of specialists and an average number of general practitioners in comparison to the other provinces.
  - The current negotiated settlement, ratified by the Saskatchewan Medical Association (SMA) in June 2003, covered three years, April 1, 2003 to March 31, 2006. It provided for a combination of fee increases, funding for new fee schedule items, and increased funding for strengthening current initiatives and developing new programs to improve the practice environment. Negotiations are currently underway for a new contract.

- Saskatchewan has a wide range of programs, developed jointly by the Saskatchewan Medical Association and Saskatchewan Health, to assist with the recruitment and retention of physicians. The following programs are provided on an ongoing basis:
  - Medical Student and Resident Bursary Programs;
  - Rural Practice Establishment Grant Programs;
  - Regional Practice Establishment Grant Program;
  - Rural Practice Enhancement Training Program;
  - Re-Entry Training Program;
  - Rural Extended Leave Program;
  - Rural Travel Assistance Program;
  - Rural Emergency Care Continuing Medical Education Program;
Locum Service Program;
Emergency Room Coverage and Weekend Relief Program;
Specialist Emergency Coverage Program;
Specialist Recruitment and Retention Fund Bursary Program;
Specialist Physician Enhancement Training Program;
Long Service Retention Program; and
Physician Incorporation.

- The majority of Saskatchewan physicians work under a fee-for-service reimbursement agreement. A growing number of physicians are exploring alternative payment arrangements as a means to stabilize their income, provide greater practice flexibility, work more directly as members of multi-disciplinary teams, and focus on prevention services. Saskatchewan Health has been developing and piloting alternative payment arrangements with physicians on a voluntary basis since 1992. The majority of alternate payment projects are administered through regional health authorities that contract with or employ the necessary physicians to provide the service. The funding for these projects, particularly in the case of family physician services, is established through a population-based methodology.
- Within Saskatchewan's Action Plan for Primary Health Care, physicians play a role as part of interdisciplinary health care teams. Physician representatives are part of regional health authority planning teams as RHAs develop their plans for primary health care.

**Manitoba**

- Manitoba has enhanced its financial incentive programs to provide conditional financial assistance for family physicians and physicians taking training in a needed specialty such as Emergency Medicine or Anaesthesia. Conditional grants are available to eligible family physicians who have practiced in Manitoba for one year in a rural or urban area, or to physicians who undertake additional training in a needed specialty.
- The Physician Resource Coordination Office was implemented in November of 2005 to assist and support Regional Health Authorities in their physician recruitment and retention efforts and to assist physicians with immigration, licensure and employment in Manitoba.
- A new Master Medical Remuneration Agreement between Manitoba Health and the Manitoba Medical Association (MMA) was reached on June 27, 2005 covering the period April 1, 2005 to March 31, 2008.
- In general, fee-for-service (FFS) and alternately remunerated (ALT) physicians received an overall increase of 7.5% (non-compounded) for the term of the agreement or, 2.5% each year for 3 years beginning April 1, 2005.
Payment Modalities for Manitoba Physicians:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS only</td>
<td>30%</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>ALT only</td>
<td>15%</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>FFS &amp; ALT</td>
<td>55%</td>
<td>55%</td>
<td>61%</td>
</tr>
</tbody>
</table>

- Two new remuneration funds were created with this Agreement; $15 million “Shoring-Up Fund” to be applied to selected tariffs and priority alternately funded physician groups and, $5.5 million “Exceptional Issues Fund” to address outstanding FFS issues to designated blocs of practice. In addition, 4 existing funds were continued and/or enhanced: Professional Liability Insurance Fund, Continuing Medical Education Fund, Maternity/Paternity Benefits Fund and the Physician Retention Fund.

- Concurrent with the Master Agreement, Manitoba Health and the MMA entered into a Memorandum of Understanding (MOU) which sets out the formal process by which physicians, in partnership with Manitoba Health, can develop innovative strategies and initiatives to deliver medical services to the public.

Ontario

2005/06 Initiatives and Previously Announced Initiatives - Physicians

International Medical Graduates (IMGs)

The government continues to further improve access to physicians in Ontario by substantially increasing opportunities for international medical graduates (IMGs), by continuing to make available at least 200 IMG training and assessment positions each year, and funding IMG Ontario, the one-stop centre for access to information and evaluation. In February 2006, the ministry announced that, for the first time, IMGs would be able to participate in the second iteration of the 2006 national physician matching process for postgraduate medical training positions in Ontario. IMGs were offered thirty-five of the 70 positions available through the second iteration.

The ministry is also funding the Registration through Practice Assessment Pilot Program - which is being administered by the College of Physicians and Surgeons of Ontario (CPSO). This pilot project has been assisting experienced physicians from outside Ontario to achieve registration to practice. The pilot was completed in March 2006 and the Ministry is undertaking an evaluation of its effectiveness as a physician supply initiative.

As a result of Ontario’s IMG programs, 218 IMGs were offered training and assessment positions during the 2005/06 selection process for positions that begin in 2006.
**Northern Ontario School of Medicine (NOSM)**

The newly created medical school for Northern Ontario enrolled its charter class of 56 students in September 2005. The school has two main campuses in Thunder Bay and Sudbury, with teaching and research sites distributed across large and small northern communities.

The ministry has also been building post graduate specialty training capacity in the North. To date, 16 positions have been added in the North and by 2009, there will be 26 entry level positions. These positions, in conjunction with the 30 entry level family medicine positions already in place, will accommodate the first graduating class from NOSM.

**Increased Enrolment**

In 2002, a 30% increase in medical school enrollment was completed, adding a total of 160 new positions. A matching increase in the number of postgraduate positions to accommodate graduating medical doctors has been phased in over the last three years with the final addition of 37 new positions in 2006 to bring the total number of new postgraduate positions to 160.

In May 2005, government announced a 15% increase in medical school enrolment by 2009. This will equate to 104 new first year medical school spaces. 32 of these spaces were implemented in September 2005 and the remaining 72 will be implemented over the next three years. These 72 positions will be used to establish four medical education campuses affiliated with three of the province's medical schools in southern Ontario communities that have demonstrated success in the provision of distributed medical education.

This enrolment increase and the opening of the Northern Ontario School of Medicine will equate to a 23% increase in medical school enrolment in Ontario by 2009.

**Distributed Medical Education Programs**

The Ontario government funds a number of Distributed Medical Education Programs (DMEs) to provide clinical learning opportunities outside academic health science centres to improve the supply of health professionals in rural and undersupplied areas of the province. These bring together medical schools, rural and community based physicians, hospitals and communities in need of physician services. The DMEs improve physician recruitment and retention as they provide opportunities for more students and trainees to live and learn in the communities where they may decide to practice once their training is completed.

**Family Medicine Training**

The ministry is investing $45 million between 2004/05 and 2007/08 to expand the province's family medicine training programs by 70%, creating 141 new first-year family medicine residency positions by 2006. This initiative will result in 337 additional family physicians that will be ready for practice in Ontario by 2008.


**Bursary Program**

In 2004, the Ministry developed a 50% cost-shared bursary program for prospective Medical Officers of Health to undertake Masters Level training in public health. The Medical Officers of Health in Training Bursary Program will assist candidates in fulfilling the requirements for appointment, by the Ministry, of a Medical Officer of Health.

**PAIRO Registry**

The Professional Association of Interns and Residents of Ontario (PAIRO) Registry is intended to provide two way access between Ontario's communities, physicians-in-training and established physicians for both recruitment and retention purposes. The PAIRO Registry is meant to provide the communities with an opportunity to disseminate information about job opportunities and to provide physicians with community profiles and availability of work in Ontario.

**Physician Supply in Ontario**

One of the major issues facing health care in Ontario is the availability of appropriate physician resources (i.e., physician supply, mix and distribution in Ontario). In 2004, Ontario ranked 9\textsuperscript{th} in supply of family physicians per 100,000 population, 3\textsuperscript{rd} in the supply of specialists per 100,000 population, and 6\textsuperscript{th} in total physicians per 100,000 population among the provinces and territories according to the CIHI's Supply, Distribution and Migration of Canadian Physicians report released in 2005.

Factors that influence physician supply include socio-demographic characteristics of the area; population health needs of the area; geographic considerations; referral patterns and proximity to an Academic Health Science Center (AHSC).

Ontario continues to move forward on initiatives to improve the supply, distribution, recruitment and retention of physicians in communities. Initiatives such as increasing enrollment in medical schools and improving access to practice opportunities for International Medical Graduates (IMGs) increase the supply of physicians. The expansion of distributed medical education programs, the opening of the Northern Ontario School of Medicine (NOSM) and an increased emphasis on family medicine will improve physician mix, distribution and recruitment. Retention initiatives such as the Underserviced Area Program (UAP) will continue to assist undersupplied communities.

**Health Human Resource Distribution in Ontario**

The Underserviced Area Program helps underserviced communities across the province improve access to health care services by providing a variety of integrated initiatives aimed at attracting and retaining health care providers.

The UAP works closely with underserviced communities and other ministry initiatives (e.g., International Medical Graduates, Rural and Northern Physician Group Agreements, Community Health Centre Program) in matching appropriate programs and optimal benefits to communities.
This "one-stop shop" helps communities recruit doctors, nurse practitioners and other allied health professionals to underserviced areas through financial incentives and other innovative community supports (e.g., Northern Ontario Virtual Library). In addition to recruitment and retention supports, UAP provides operational funding for Nurse Practitioner positions and nursing stations in rural and northern communities whose population cannot support the services of a full-time primary care physician. The UAP also helps ensure access to local health care services (e.g., Visiting Specialist Program).

**Physician Services Agreement**

**Report of fee negotiations**

The Ontario Medical Association and the Ministry ratified a four-year Physician Services Agreement covering the period from April 1, 2004 to March 31, 2008. This Agreement balances targeted investments in specific areas of concern to both the OMA and the Ministry with across-the-board fee increases. The Agreement supports the government's health transformation projects including primary care reform, the wait time strategy, addresses competitiveness with other provinces, as well as addressing fee disparities between general practitioners/ family physicians and specialists.

**Synopsis of the agreements/change with the provincial medical associations**

The 2004 Physician Services Agreement provides for:
- an across-the-board increase effective April 1, 2004 of 2.5% for family practice professional fees, and 2% for specialist professional fee codes
- a 1% increase to technical fees for diagnostic services effective April 1, 2005
- elimination of the billing threshold effective April 1, 2005
- targeted fee code adjustments and fee code changes to address sectional disparities
- targeted fee increases and investments in priority areas, including:
  - in-patient hospital services
  - new fees to ensure patient receives appropriate community care upon hospital discharge
  - investments in mental health, paediatrics, anaesthesia
  - investments in preventative care
  - new fee codes for chronic disease management
  - investments in physician services in Long-Term Care facilities, including funding for an on-call coverage program
- expansion of Primary Care Renewal models
- increased funding for Academic Health Science Centres (AHSCs)
- additional funding for the Hospital On-Call Coverage (HOCC) program in order to expand the program
- incentives for in-hospital anesthesia and emergency room services
• a commitment to formalize an appropriate funding plan for laboratory physicians
• implementation of a clerkship stipend program
• new incorporation benefits

The implementation dates of the Agreement vary depending upon the component of the Agreement.

**Physician Services Committee**

The Physician Services Committee (PSC) is a joint committee of the Ministry of Health and Long-Term Care and the Ontario Medical Association which oversees the implementation of the Physician Services Agreement and ensures that the Agreement commitments are fulfilled.

The PSC which originated in 1997 under a previous Physician Services Agreement has been continued under the current Agreement. The interest-based approach used by the committee has contributed to the development of a strong relationship between Ontario's physicians and the Ministry. The PSC has been successful in addressing a wide range of issues impacting on physician services within the health care system.

The 2004 Agreement has provisions for a number of committees, continuation of existing and creation of new committees. Of significance, two new joint Ministry-Ontario Medical Association committees to support implementation of the Agreement and health system planning have been established, the Primary and Community Care Committee and the Physician Hospital Care Committee.

**Statistical Overview - Physicians**

<table>
<thead>
<tr>
<th>Physicians in Ontario</th>
<th>1999</th>
<th>2004</th>
<th>% Change 1999 - 2004</th>
<th>Physician per 10,000 pop - 1999</th>
<th>Physician per 10,000 pop - 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP/FPs</td>
<td>9,807</td>
<td>10,439</td>
<td>6.4</td>
<td>8.5</td>
<td>8.4</td>
</tr>
<tr>
<td>Specialists</td>
<td>10,673</td>
<td>11,354</td>
<td>6.4</td>
<td>9.3</td>
<td>9.2</td>
</tr>
<tr>
<td>Total Physicians</td>
<td>20,480</td>
<td>21,793</td>
<td>6.4</td>
<td>17.8</td>
<td>17.6</td>
</tr>
</tbody>
</table>

*Source: PIO - OPHRDC*

Data from the Ontario Physician Human Resources Data Centre indicate the following trends from 1999-2004:

• The number of active physicians in Ontario in 2004 was 21,793, a net increase of 6.4% since 1999.
• Almost 48% (10,439) were general practitioners/ family physicians (GP/FPs) and just over 52% (11,354) were specialists.
• Both the number of GP/FPs and the number of specialists increased by 6.4%.
• Rapid population growth (7.7%), however, resulted in a decline in the availability of physicians for every 10,000 people from 17.8 to 17.6.
• The ratio of GP/FPs for every 10,000 people decreased from 8.5 to 8.4, and the ratio of specialists for every 10,000 people decreased from 9.3 to 9.2.

2005/06 Initiatives and Previously Announced Health Human Resources Initiatives - Nurses

Strategies to Stabilize the Nursing Workforce (also see HealthForceOntario initiatives)

The government has been working to address the underlying reasons for the current nursing shortage. Strategies include:

• Increasing the percentage of nurses working full-time;
• Targeting investments to support recruitment and retention of nurses; and
• Improving nursing work environments.

Full Employment of Nurses

Recent investments have supported the creation of full-time nursing positions. Research indicates that many nurses prefer full-time employment, therefore lack of full-time work affects nurses' decision to stay in the province or in the profession. The goal is to see 70% of nurses employed full-time[1].

• The government is continuing to provide targeted funding for full-time nursing positions in hospitals. This funding was first provided in 2004 and allowed hospitals to create new full-time positions or convert existing part-time and/or casual positions to full-time.
• Investments to enhance care standards in long-term care and increased access to community mental health and home care have resulted in increased nursing care hours which have included more full-time nursing positions in these sectors.

Recruitment and Retention

In January 2006, the government announced a fund that will help retain nurses. This fund is intended to assist hospitals with costs associated with orientation training and education so that nurses are prepared to fill vacancies due to hospital service changes. This fund may be used to redeploy a nurse from an area with decreased need for nursing services to another area of the hospital where there are identified or imminent vacancies. It may also be used to provide nurses with opportunities to expand their knowledge and skills so they can work in other clinical areas or nursing roles within the hospital.

In 2005/06, the government provided Nursing Strategy funding to eligible organizations for the second year. The Nursing Strategy provides funding to implement a range of initiatives designed to support nurses at all stages of their careers.

• New nurses often report feeling inadequately prepared for the workplace. Now, every college and university nursing program in the province has been provided with funding to purchase clinical simulation equipment. This funding will help students make the most of their

[1] According to the College of Nurses of Ontario Membership Statistics at January 1, 2004, the rate of full time employment for RNs was 59.3% and for RPNs was 53.4%. Please note that these percentages do not include those nurses who did not indicate their employment status.
clinical placements and ensure that they have the experience they need to transition into the workplace.

- To further support new nurses, to help nurses move to different sectors and to increase capacity for clinical placements for nursing students, funding was provided to long-term care homes, public health units and home care agencies to develop mentorship and preceptorship programs.

- According to a study of Ontario new graduate nurses by McMaster University, only 36.5% of new graduates find full-time work. This can cause new graduates to consider leaving the province to practice, or leaving the profession. The New Graduate Initiative provided funding to employers to create temporary full-time positions for new graduates to support their transition to the workforce.

- Nurses are retiring early: the average retirement age for RNs in 2002 was 58.4 years and for RPNs was 56.7 years. The Late Career Nurse Initiative provided funding to hospitals and long-term care homes so that nurses over 55 could work in less physically demanding alternate roles for part of their work time. This will support these nurses to remain in the workforce and ensure that their knowledge and experience is not lost to the system.

**Improving Nursing Workplaces**

Injuries in healthcare workplaces are a major cause of dissatisfaction among nurses. According to the Health Care Health and Safety Association, since 1998 the health care sector has experienced a 5% increase in lost time injury frequency - but Ontario as a whole has seen an average decrease of 19%.

The government provided funding to long-term care homes and hospitals to purchase patient lifting equipment and provide education programs for the healthcare workers who use the equipment. This will increase the safety of patients, and at the same time reduce the number of musculoskeletal injuries among nurses and other healthcare workers.

Another safety initiative provided funding in 2004/05 for hospitals to move to safer medical equipment such as safety-engineered sharps.

**Supporting Nursing Practice**

**Best Practice Guidelines**

Investments to support nursing practice include providing funding to the Registered Nurses Association of Ontario (RNAO) for the development, implementation and evaluation of evidence-based best practice guidelines.

- Clinical Best Practice Guidelines will improve the quality and consistency of nursing care across the province so that maximum benefits are achieved for patients/clients, nurses and the larger health system.

- Healthy Work Environment Best Practice Guidelines will help employers improve nurse recruitment and retention, reduce nursing staff turnover rates, sick time and employee dissatisfaction; and improve patient care.
Career/Professional Development

The government provides funding for education grants to support the development of skills and specialties that allow nurses to provide quality care in a rapidly changing health care environment. The fund is administered by two professional associations, the Registered Nurses Association of Ontario (RNAO) and the Registered Practical Nurses Association of Ontario (RPNAO).

Nurses who take a course that will enhance the quality of care and services they provide are eligible for up to $1,500 per year for reimbursement. Health care employers who have paid education costs for nursing staff may also apply to have these expenses reimbursed.

Research

Investments in nursing research provide an evidence basis for nursing practice. They also support nurses as researchers.

Nursing research investments support several projects and programs of nursing research, including:

- The Nursing Health Services Research Unit (NHSRU) at McMaster University and the University of Toronto to investigate supply, distribution and deployment of nurses and ways of maintaining quality while realizing funding efficiencies. This information is used in health human resource planning.
- The Nursing and Health Outcomes Project (NHOP) has now become known as the Health Outcomes for Better Information and Care (HOBIC). Its focus is the province-wide, standardized collection of patient health outcomes, staffing and quality of worklife information reflective of nursing, pharmacy, physiotherapy and occupational therapy not only in acute care, complex continuing care, long-term care, rehabilitation, and home care, but also in primary care, mental health and public health.

Nursing Management/Leadership

The Ontario Ministry of Health and Long-Term Care provides funding to inform nursing leadership best practices:

- One of the Healthy Work Environment Best Practice Guidelines developed, implemented and evaluated by the Registered Nurses Association of Ontario will focus on nursing leadership. Additional information is available at: [http://www.rnao.org/projects/hwe.asp](http://www.rnao.org/projects/hwe.asp)

Primary Health Care Nurse Practitioners

Ontario currently invests over $44 million to support 400 Primary Health Care nurse practitioner positions in a variety of communities province-wide.

An additional $3 million is provided to fund the Ontario Primary Health Care Nurse Practitioner Education Program, which is delivered by a consortium of ten universities, and
offers a post-baccalaureate certificate to graduates. The 2004 Budget included a commitment to double the number of education seats for nurse practitioners by 2007. In May 2006, the Minister of Health and Long-Term Care announced plans to expedite this seat expansion, so that 150 learners will be admitted to the program in September 2006, one year ahead of schedule.

In January 2004 the Minister of Health and Long-Term Care announced the Nurse Practitioner Integration Task Team. This Task Team is an action-oriented group established to advise on the implementation of the recommendations in *The Integration of Primary Health Care Nurse Practitioners in the Province of Ontario* report. The team will prioritize the recommendations, establishing short, medium and long-term objectives.

In 2005/06, two initiatives to support recruitment and retention of nurse practitioners were introduced:

- The amount of annual funding for 129 nurse practitioner positions was increased to bring them up to the Ontario average. This will allow these employers to offer more competitive salaries to support recruitment and retention of primary health care nurse practitioners.
- A new, more flexible, policy to support agencies that have been funded for a nurse practitioner position but have had chronic vacancies. Beginning in 2006, organizations will be able to use the funds to sponsor a local registered nurse to pursue his/her primary health care nurse practitioner education. The funds are used to cover education related expenses, including tuition, and to pay the nurse's salary while he or she attends school. In exchange, the new NP must agree to a return-of-service commitment to the position.

**Nursing Education**

As of January 1, 2005, regulations under the *Nursing Act, 1991* were amended to include new entry to practice requirements for the two categories of nurses in Ontario. RNs require a baccalaureate degree and RPNs require a community college diploma.

In 2005/06, colleges and universities will receive up to $72.3 million in operating grants for the nursing degree program. This increase of $26.6 million over the investment in 2004/05 will fund continued enrolment growth in the program. Beginning in 2005/06, this program will also fund Second-Entry degree nursing programs, including programs designed to enable an RPN to upgrade to a B.Sc.N.

In September 2005, a pilot project in community-based nursing education was initiated. This program is offered jointly by Confederation College and Lakehead University in the northern communities of Dryden, Kenora, Sioux Lookout and Fort Frances, and will allow students to study nursing in their home communities.

Recent ongoing investments to support nursing education from the Ontario Ministry of Training, Colleges and Universities include funding to expand enrolment in graduate nursing programs (Masters and PhD), and to provide a tuition waiver for college and university nursing faculty enrolled in the PhD in Nursing.
**RN Education**

RN programs are offered in 20 communities across Ontario:

- Eleven universities offer collaborative baccalaureate programs with 22 community colleges.
- One community college offers a collaborative program with a university in another province.
- Two universities do not offer collaborative programs but grant RN degrees.

**RPN Education**

Twenty-three community colleges in 21 communities across Ontario offer diploma programs.

**Support for Internationally Educated Nurses**

Since 2004, the government's investment is approximately $4 million for bridging programs to support internationally-educated nurses who are preparing to work in Ontario. These projects develop ways for key stakeholders - employers, occupational regulatory bodies and educational institutions to assess existing skills and competencies, provide training and Canadian workplace experience, and help qualified individuals move quickly into the labour market without duplicating what they have already learned.

**Supply of Nurses in Ontario**

Ontario has two categories of nurses, Registered Nurses (RNs) and Registered Practical Nurses (RPNs).

The RN category includes Registered Nurses in the Extended Class (RN(EC)s) who are commonly known as primary health care nurse practitioners (PHCNP).

According to the College of Nurses of Ontario Membership Statistics at January 1, 2005, there were:

- 139,011 nurses registered
- 118,250 employed in nursing
- 2,354 employed in both nursing and non-nursing
- 7,631 employed in non-nursing
- 9,906 not employed
The table below shows nurses by category and employment in the three largest sectors.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number Employed in Nursing</th>
<th>Sector</th>
<th>Number/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
<td>Hospital</td>
<td>11,228 (46%)</td>
</tr>
<tr>
<td>RPN</td>
<td>24,482</td>
<td>Long-Term Care</td>
<td>8,147 (33%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community[2]</td>
<td>3,119 (13%)</td>
</tr>
<tr>
<td>RN</td>
<td>89,054</td>
<td>Community</td>
<td>15,843 (18%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long-Term Care</td>
<td>15,843 (9%)</td>
</tr>
</tbody>
</table>

In 2005, there were 582 RN (EC)s employed in nursing in Ontario. The top five employers for PHCNPs are in the table below.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Number/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Centre</td>
<td>192 (32.3%)</td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>97 (16.3%)</td>
</tr>
<tr>
<td>Physician's Office/Family Practice Unit</td>
<td>78 (13.1%)</td>
</tr>
<tr>
<td>Colleges/Universities</td>
<td>20 (22.5%)</td>
</tr>
<tr>
<td>Other</td>
<td>34 (5.7%)</td>
</tr>
</tbody>
</table>

Quebec

Les travaux de mise à jour du modèle de projection de l’effectif médical ont été complétés au cours de la dernière année. Les premières simulations de projection du nombre de médecins dont disposera le Québec au cours des 10 prochaines années sont terminées. On entrevoit disposer d’un ajout net d’environ 3 000 nouveaux médecins d’ici 2015 (1 500 spécialistes de plus et 1 500 omnipraticiens de plus).

Au cours de la dernière année, l’exercice de révision des plans régionaux d’effectifs médicaux (PREM) en spécialité et en omnipraticité a été complété. En spécialité, le PREM 2006 est en vigueur depuis le 1er décembre 2005. Il couvre la période s’échelonnant du 1er décembre 2005 au 30 novembre 2006. Le PREM est essentiellement constitué des plans d’effectifs médicaux par établissement (PEM) pour toutes les spécialités. Cette année, les Comités techniques des Tables PREM-RUIS ont joué un rôle de premier plan dans la détermination des PREM puisqu’elles se sont vues confier le mandat d’élaborer un scénario de recrutements prioritaires de médecins spécialistes pour l’année 2006 par territoire de RUIS. Une réconciliation des propositions RUIS

\[2\] The community sector includes nurses employed in public health units, community health centres, community home care agencies, Community Care Access Centres, and community agencies.
et de celles du Comité de gestion des effectifs médicaux spécialisés MSSS/FMSQ (COGEMS) a été nécessaire.
Ce plan fixe des cibles d’objectifs de croissance soutenant l’installation de médecins spécialistes en régions éloignées et intermédiaires, particulièrement dans les spécialités locales, et favorise le recrutement de médecins spécialistes dans les établissements connaissant une pénurie chronique de ces médecins.

Afin d’atteindre les objectifs, un ensemble de règles de gestion régissant tous les médecins accompagne ce PREM. Ces règles concernent, entre autres, les médecins de retour de régions, les demandes de dérogation, les approbations de demandes de formation complémentaire ainsi que le recrutement des médecins sélectionnés à l’étranger par les milieux universitaires.

Les PREM en omnipractique ont été obtenus à partir d’une méthodologie qui permet de quantifier les besoins de médecins omnipraticiens pour chacune des régions du Québec. On prévoit la répartition de 358 ajouts bruts entre les différentes régions du Québec. Ce plan est en vigueur depuis le 1er décembre 2005 ; il indique à chacune des régions du Québec les cibles régionales d’ajouts bruts autorisés de médecins omnipraticiens pour la période s’échelonnant du 1er décembre 2005 au 30 novembre 2006. Le plan 2006 prévoit une installation de 51 % des nouveaux médecins en début de pratique, soit 96 des 190 nouveaux médecins attendus dans les régions intermédiaires et éloignées. Notons que le PREM 2006 permet d’accueillir jusqu’à 223 nouveaux facturants puisqu’en régions intermédiaires et éloignées la distinction des cibles, selon la catégorie de médecins (nouveaux médecins ou médecins déjà en exercice), est donnée à titre indicatif. En fonction des opportunités de recrutement qui s'offrent à elle, une région intermédiaire ou éloignée peut modifier la composition de ses cibles (nouveaux médecins ou médecins déjà en exercice) sans toutefois dépasser le recrutement total autorisé.

**Les accords et les ententes avec les fédérations et les associations**

**Les médecins spécialistes**


Les négociations pour le renouvellement de l’Accord-cadre étaient en cours au 1er avril 2006. La FMSQ tenait absolument à conclure une entente sur la correction des écarts de rémunération constatés entre les médecins spécialistes du Québec et ceux des autres provinces avant d’entamer les discussions sur le renouvellement de l’Accord-cadre.

**Les médecins omnipraticiens**


Les amendements n° 89, 90, 91 et 93 (l’amendement n° 92 n’est pas finalisé) comportent surtout des modifications administratives ou ayant trait à des documents déjà en application. Toutefois, certaines de ces modifications sont plus significatives.

L’amendement n° 90 est consacré principalement à l’harmonisation de certains actes dont tous ceux relatifs au système musculo-squelettique avec la nomenclature en vigueur pour les médecins spécialistes. Il introduit également des modifications à l’entente qui couvre la rémunération des médecins omnipraticiens pratiquant dans les unités de soins intensifs et coronariens ; ces modifications permettront, dans les unités les plus lourdes, une rémunération selon un mode mixte à savoir un forfait quotidien plus un pourcentage des actes posés.

De plus, une nouvelle entente particulière sur les cliniques-réseau est en vigueur depuis le 1er juin 2005. Cette entente prévoit des incitatifs monétaires pour les cliniques privées et exceptionnellement les CLSC désignés par les agences de santé et de services sociaux (en moyenne une clinique pour 50 000 personnes). Elles offrent une accessibilité accrue aux services diagnostiques et médicaux sans rendez-vous, selon des horaires étendus, en lien avec les médecins traitants habituels.

**Le mode de rémunération mixte et le pourcentage de médecins non payés à l’acte**

Au cours de la période s’échelonnant du 1er octobre 2004 au 30 septembre 2005, 3272 médecins spécialistes ont été rémunérés en fonction du mode mixte.

La rémunération autre qu’à l’acte représente respectivement 28 % et 22 % des montants versés aux médecins spécialistes et omnipraticiens. Ces données s’appliquent à la période du 1er octobre 2004 au 30 septembre 2005.
Répartition des effectifs médicaux du Québec
au 31 septembre 2005 selon les spécialités

<table>
<thead>
<tr>
<th>SPÉCIALITÉ</th>
<th>Nombre de médecins sept 2005*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omniprofessionnel</td>
<td>7462</td>
</tr>
<tr>
<td>Allergie et immunologie clinique</td>
<td>51</td>
</tr>
<tr>
<td>Anatomopathologie</td>
<td>191</td>
</tr>
<tr>
<td>Anesthesie-Réanimation</td>
<td>583</td>
</tr>
<tr>
<td>Microbiologie médicale et infectiologie</td>
<td>155</td>
</tr>
<tr>
<td>Biochimie médicale</td>
<td>50</td>
</tr>
<tr>
<td>Cardiologie</td>
<td>389</td>
</tr>
<tr>
<td>Chirurgie générale</td>
<td>498</td>
</tr>
<tr>
<td>Chirurgie orthopédique</td>
<td>299</td>
</tr>
<tr>
<td>Chirurgie plastique</td>
<td>96</td>
</tr>
<tr>
<td>Chirurgie cardio-vasculaire</td>
<td>60</td>
</tr>
<tr>
<td>Dermatologie</td>
<td>179</td>
</tr>
<tr>
<td>Gastro-Entérologie</td>
<td>178</td>
</tr>
<tr>
<td>Obstétrique-Gynécologie</td>
<td>394</td>
</tr>
<tr>
<td>Hématologie et oncologie médicale</td>
<td>210</td>
</tr>
<tr>
<td>Santé Communautaire</td>
<td>134</td>
</tr>
<tr>
<td>Pneumologie</td>
<td>196</td>
</tr>
<tr>
<td>Médecine interne</td>
<td>379</td>
</tr>
<tr>
<td>Physiatrie</td>
<td>72</td>
</tr>
<tr>
<td>Neurochirurgie</td>
<td>56</td>
</tr>
<tr>
<td>Neurologie</td>
<td>216</td>
</tr>
<tr>
<td>Ophtalmologie</td>
<td>277</td>
</tr>
<tr>
<td>Oto-Rhino-Laryngologie</td>
<td>184</td>
</tr>
<tr>
<td>Pédiatrie</td>
<td>549</td>
</tr>
<tr>
<td>Psychiatrie</td>
<td>1043</td>
</tr>
<tr>
<td>Radiologie diagnostique</td>
<td>534</td>
</tr>
<tr>
<td>Radio-Onco logical</td>
<td>67</td>
</tr>
<tr>
<td>Urologie</td>
<td>150</td>
</tr>
<tr>
<td>Médecine nucléaire</td>
<td>88</td>
</tr>
<tr>
<td>Néphrologie</td>
<td>145</td>
</tr>
<tr>
<td>Endocrinologie</td>
<td>133</td>
</tr>
<tr>
<td>Rhumatologie</td>
<td>83</td>
</tr>
<tr>
<td>Gériatrie</td>
<td>50</td>
</tr>
<tr>
<td>Neuro-pathologie</td>
<td>0</td>
</tr>
<tr>
<td>Gynécologie médicale</td>
<td>23</td>
</tr>
<tr>
<td>Médecine d’urgence</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sous-total des spécialités</strong></td>
<td><strong>7712</strong></td>
</tr>
<tr>
<td><strong>Total des médecins</strong></td>
<td><strong>15174</strong></td>
</tr>
</tbody>
</table>

Source : Ministère de la Santé et des Services sociaux
* Les effectifs correspondent au nombre de médecins ayant eu une facturation minimale de 5 500 $ durant le
  trimestre visé. Ces effectifs sont attribués à la région où ils ont obtenu la majorité de leur rémunération.
Work to update the physician complement projection model was completed over the past year. The first projections were generated on the numbers of physicians that Quebec will have over the next 10 years. A net gain of approximately 3,000 new physicians is expected by 2015 (1,500 additional specialists and 1,500 additional general practitioners).

Over the past year, the process of reviewing the plans régionaux d’effectifs médicaux (PREMs) in specialties and general practice was completed. The 2006 PREMs have been in effect since December 1, 2005 for specialties, and they cover the period December 1, 2005 to November 30, 2006. The PREMs essentially consist of the plans d’effectifs médicaux par établissement (PEMs) for all specialties. Last year, the Comités techniques des Tables PREM-RUIS played a central role in developing the PREMs, since these committees were mandated to develop a priority recruitment scenario for medical specialists for the year 2006, by RUIS territory. It was necessary to harmonize the proposals put forward by the RUISs and the Comité de gestion des effectifs médicaux spécialisés MSSS/FMSQ (COGEMS).

These plans set growth targets with respect to the number of medical specialists in intermediate and remote regions, especially in local specialties, and promote the recruitment of medical specialists by establishments experiencing chronic shortages of these physicians.

To achieve the objectives, the PREMs come with a series of management rules governing all physicians. These rules address issues such as physicians returning from regions, applications for exemptions, approval of applications for additional training, and the recruitment of foreign physicians by universities.

The PREMs in general practice were developed using a methodology that quantifies the need for general practitioners in each Quebec region. A gross increase of 358 physicians is expected, to be divided among the various regions. These plans have been in effect since December 1, 2005. They include targets for each Quebec region with respect to authorized gross increases in the numbers of general practitioners over the period December 1, 2005 to November 30, 2006. Under the 2006 plans, 51% of the new physicians will be starting their practices, i.e. 96 of the 190 new physicians expected in intermediate and remote regions. The 2006 PREMs allow for up to 223 new physicians, since in intermediate and remote regions, the distinction between the targets by physician category (new physicians versus physicians already in practice) is not binding. Based on the available recruitment opportunities, an intermediate or remote region may shift the makeup of its targets (new physicians versus physicians already in practice). It may not, however, exceed its total authorized recruitment.

Agreements with federations and associations

Medical specialists

The Accord-cadre of October 1, 1995, which was extended for a third time in March 2003, ran out on March 31, 2004. Since on April 1, 2006 the negotiating parties had not yet agreed on terms to renew this framework agreement, it was not possible to set the overall budget envelope for specialists’ remuneration for 2004-2005 and subsequent years.

In the spring of 2006, the parties agreed to amend the aforementioned Accord-cadre. These amendments involved the rules in the General Preamble on medicine and surgery, the rules in the
surgery addendum, and some rules in a few specialties. A certain number of articles were deleted or modified and others were added. Just under 20 of the articles involved fee changes. A few mixed remuneration models for some specialties were modified. In addition, special remuneration conditions were agreed upon for medical specialists in emergency medicine.

Negotiations to renew the Accord-cadre were in process as of April 1, 2006. The FMSQ insisted on reaching agreement on correcting the discrepancies in remuneration between medical specialists in Quebec and the other provinces before entering into discussions on renewal of the Accord-cadre.

**General practitioners**

The general agreement with the Fédération des médecins omnipraticiens du Québec expired on March 31, 2004. Discussions took place with respect to extending this agreement through to March 31, 2010.

Amendments 89, 90, 91 and 93 (amendment 92 has not been finalized) primarily involve administrative modifications or documents that are already being implemented. However, some of these modifications are more significant.

Amendment 90 is primarily devoted to harmonizing some articles. In particular, it harmonizes the nomenclature in all articles involving the musculoskeletal system with the nomenclature in effect for medical specialists. This amendment also introduces modifications to the agreement governing the remuneration of general practitioners who deliver services in intensive care and coronary care units. These modifications mean that, in the busiest units, a mixed remuneration mode, i.e. a daily flat rate and a percentage of fee-for-service, may apply.

In addition, a new special agreement on networked clinics has been in effect since June 1, 2005. This agreement provides monetary incentives for private clinics, and in some cases CLSCs, to be designated by health and social service boards (one clinic per 50,000 people, on average). These clinics provide expanded access to walk-in diagnostic and medical services that are available over extended operating hours and are linked to the usual attending physicians.

**Mixed remuneration mode and percentage of physicians not receiving fee-for-service remuneration**

Over the period October 1, 2004 to September 30, 2005, 3,272 medical specialists were remunerated based on the mixed remuneration mode.

Remuneration other than fee-for-service represented 28% and 22% of the amounts paid to medical specialists and general practitioners, respectively. These data are for the period October 1, 2004 to September 30, 2005.
### Makeup of Quebec Physician Complement As of September 31, 2005, by Specialty

<table>
<thead>
<tr>
<th>Province of Quebec</th>
<th>Number of physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPECIALTY</strong></td>
<td><strong>September 2005</strong></td>
</tr>
<tr>
<td>General practice</td>
<td>7462</td>
</tr>
<tr>
<td>Allergy and clinical immunology</td>
<td>51</td>
</tr>
<tr>
<td>Pathology</td>
<td>191</td>
</tr>
<tr>
<td>Anesthesia-Resuscitation</td>
<td>583</td>
</tr>
<tr>
<td>Medical microbiology and infectious disease</td>
<td>155</td>
</tr>
<tr>
<td>Medical biochemistry</td>
<td>50</td>
</tr>
<tr>
<td>Cardiology</td>
<td>389</td>
</tr>
<tr>
<td>General surgery</td>
<td>498</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>299</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>96</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>60</td>
</tr>
<tr>
<td>Dermatology</td>
<td>179</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>178</td>
</tr>
<tr>
<td>Obstetrics-Gynecology</td>
<td>394</td>
</tr>
<tr>
<td>Hematology and medical oncology</td>
<td>210</td>
</tr>
<tr>
<td>Community health</td>
<td>134</td>
</tr>
<tr>
<td>Respiratory</td>
<td>196</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>379</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>72</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>56</td>
</tr>
<tr>
<td>Neurology</td>
<td>216</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>277</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td>184</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>549</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1043</td>
</tr>
<tr>
<td>Diagnostic radiology</td>
<td>534</td>
</tr>
<tr>
<td>Radio-Oncology</td>
<td>67</td>
</tr>
<tr>
<td>Urology</td>
<td>150</td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>88</td>
</tr>
<tr>
<td>Nephrology</td>
<td>145</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>133</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>83</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>50</td>
</tr>
<tr>
<td>Neuropathology</td>
<td>0</td>
</tr>
<tr>
<td>Medical genetics</td>
<td>23</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sub-total for specialties</strong></td>
<td>7712</td>
</tr>
<tr>
<td><strong>Total physicians</strong></td>
<td>15174</td>
</tr>
</tbody>
</table>

* Physicians who have billed a minimum of $5,500 during the quarter in question. They are assigned to the regions from which they obtained the major part of their remuneration.

Source: Ministère de la Santé et des Services sociaux
New Brunswick

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Physicians with payments of $40,000/year or more, fiscal year 2004-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia</td>
<td>74</td>
</tr>
<tr>
<td>Dermatology</td>
<td>8</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>71</td>
</tr>
<tr>
<td>General Surgery</td>
<td>44</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>116</td>
</tr>
<tr>
<td>Neurology</td>
<td>11</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>7</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>41</td>
</tr>
<tr>
<td>Oncology</td>
<td>14</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>29</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>32</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>18</td>
</tr>
<tr>
<td>Pathology</td>
<td>43</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>44</td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>10</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>14</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>76</td>
</tr>
<tr>
<td>Urology</td>
<td>21</td>
</tr>
<tr>
<td>Vascular and Thoracic Surgery</td>
<td>12</td>
</tr>
<tr>
<td>General Practice</td>
<td>644</td>
</tr>
</tbody>
</table>

- In 2004-2005, 29% of all physicians who were paid $40,000 or more, received at least 51% of this pay through some mechanism, other than fee-for-service. It is expected that this percentage will rise over time.

- In July 2006, the Premier announced the opening of a distributed Medical Education Program. The Université de Sherbrooke will establish a satellite campus in Moncton New Brunswick. The program will be done in collaboration with the Université de Moncton and the various Regional Health Authorities. The first intake of 24 students will be in September 2006. The students would normally have gone to Sherbrooke, where the Province currently purchases the medical seats.

- In October 2006, the Premier also announced the development of a similar program for the city of Saint John. Discussions are underway with universities.

- As part of the Provincial Health Plan, new incentives were introduced to assist with recruitment and retention: bursaries for medical students, business grants and guaranteed minimum income for family practitioners who establish a practice in a designated area.
**Nova Scotia**

The Master Agreement between Doctors Nova Scotia (formerly known as the Medical Society) and the NS Department of Health expires on March 31, 2008. During the fiscal year, April 1, 2004 to March 31, 2005, there were 2,145 physicians registered with the MSI system providing clinical services in Nova Scotia. This represents an increase of 1.3% over the previous fiscal year (903 were GPs/Family Physicians and 1,242 were Specialists). This count includes all physicians with a payment during the fiscal year and is based on functional work distribution rather than licensed speciality.

Since 2000, there has been an increased number of physicians participating in both academic funding plans (AFPs) and community-based alternative payment plans (APPs). The numbers have increased by approx. 30% between 1997 and 2004/5.

Physician resource planning is ongoing to reinforce the efforts of the Department to recruit and retain physicians within the province, and the Maritime region. The Department of Health continues to work with key stakeholders to establish and oversee the processes supporting the development of a comprehensive physician resource plan. The main objectives of this work are to plan for the sustainability of physician resources, and to anticipate future changes that will have an impact on the need for or the availability of physicians.

Recruitment of physicians for the Clinical Assessment for Practice Program (CAPP) began during 2005. This program operated by the College of Physicians and Surgeons of Nova Scotia, in consultation with the Department of Health and Dalhousie Medical School, will assist in streamlining efforts to assess the qualifications of internationally trained specialists.

Policy development work is taking place in several key areas:

- A new framework for AFPs and APPs
- Managing "unattached" patients (patients without a family physician) in the hospital
- Physician on-call expectations, obligations and payments
- Core / foundational physician resources in regional hospital settings
- Ethics in international physician recruitment
- Provincial appeal mechanism
- Comprehensive locum policy

**Prince Edward Island**

- A new three-year Master Agreement between the Government of Prince Edward Island and the Medical Society of Prince Edward Island was reached on August 24, 2004. The agreement will be in effect until March 31, 2007.
- The following vacancies currently exist in the physician complement: Anesthesia, Family Medicine, Internal Medicine, Medical Oncology, Psychiatry, and Plastic Surgery. Recruitment to find suitable placements for these positions is ongoing.
• The Medical Education Program of the Department of Health and Social Services works closely with Dalhousie and Memorial Universities to provide clinical rotations for medical students and residents in family medicine and various specialties ranging from two weeks to 12 weeks in duration.

• The Provincial Patient Registry continues to provide assistance to patients in finding family doctors.

Newfoundland and Labrador

A four-year Memorandum of Agreement was negotiated between Government and the provincial medical association (the NLMA) effective October 01, 2005. The award was valued at $18 - $19 million. The award gave a general sector increase of 0/0/2/.33% over four years with additional dollars for On-call payments and $1.25 million for salaried physicians who provide after hours and On-call services.

As of March 31, 2005 there were 954 physicians providing medical services in the province – 460 general practitioners and 494 specialists. Sixty-three percent of physicians were fee-for-service, 34.9% were salaried and 1.9% were on alternate payment arrangements. Following completion of a draft provincial Physician Resource Plan which was forwarded to all stakeholders for input and feedback, it remains a priority of the Department of Health and Community Services to have a completed resource plan for physicians during the 2006-07 fiscal year.

Human Resources: Non-Physicians / Ressources Humaines: Employés Autres Que Les Médecins

Health Canada

Integration of Internationally Educated Health Professionals

On April 25, 2005, the Government of Canada launched the Internationally Trained Workers Initiative delivering on its commitment to improve the integration of immigrants and internationally trained Canadians into the workforce. The initiative is made up of several integrated components and strategies including the Internationally Educated Health Professionals Initiative. Through this initiative, the government is working with provinces, territories and stakeholders to enable more internationally educated health professionals to put their skills to work in Canada’s health system. This will help address shortages of health professionals and assist efforts to reduce wait times for care. The identified priority professions are: medicine, nursing, medical radiation technology, medical laboratory technology, physiotherapy, occupational therapy, and pharmacy. Pan-Canadian efforts include the development of an orientation program for internationally educated professionals steered by an interdisciplinary working group of representatives from the fields of occupational therapy, physiotherapy, nursing, medical radiation technology, and medical laboratory technology.
Santé Canada

Intégration des professionnels de la santé formés à l’étranger


Northwest Territories

• As of April 1, 2005, Human Resources functions within the GNWT were centralized into one Department, the Financial Management Board Secretariat (FMBS). This includes the centralization of all Human Resources staff and functions previously employed by the Department of Health and Social Services, and all Health and Social Services Authorities with the exception of the Hay River Health and Social Services Authority. The Department released Amended Implementation Plan: A Comprehensive 5 Year Human Resource Strategy in December 2005. The report can be found online at http://www.hlthss.gov.nt.ca/.

Yukon Territory

• The recruitment and retention of nurses to the territory continues to be a high priority.
• A Registered Nurse retention bonus of $3,000 per year was instituted in July 2001.
• A Community Nurse Practitioner retention bonus of an additional $3,000 per year was also instituted in July 2001.
• The Nursing bursary program is under review.
• The recruitment and retention of Speech Language Pathologists, Physiotherapists and Occupational Therapists is a high priority and staffing is currently at a critically low level.
British Columbia

Recruit, retain and educate more nurses

- Since 2001, government has committed more than $84.2 million towards the recruitment, retention and education of nurses in British Columbia.
- Since December 2001, the total increase in nurses with a practicing licence in B.C. is more than 2,100. (More than 1,300 RNs and more than 800 LPNs).
- The Ministry of Health has worked with the Ministry of Advanced Education to expand nursing seats, with 2,500 new nursing seats since 2001.
- As of March 2006, more than 980 nurses had been funded through the Return to Nursing initiative.
- As of March 2006, more than 1,200 LPNs had received funding through the LPN Upgrade Program allowing them to work to their full scope of practice.
- An estimated 6,500 more nurses – including RNs, RPNs and LPNs – are expected to graduate between 2002 and 2006.
- B.C.’s first group of nurse practitioners graduated in May of 2005 and hold key positions on primary health care teams.
- Specialty Education Incentives - More than 10,000 nurses across the province have been funded for continuing and specialty education since 2001
- The Aboriginal Nursing Strategies were established to increase the number of Aboriginal and non-aboriginal nurses working with Aboriginal communities in remote, rural and underserved communities throughout B.C.
- Quality of work life for nurses has been one of the nursing strategy goals since 2003. Funds have been provided for projects related to: increasing front line nurse leaders, innovative schedules and flexible work places; developing creative clinical experiences: encouraging collaborative practice and decreasing aggression towards nurses in long term care settings.

Recruiting more nurses to rural and remote areas

- In 2005, the Northern Health Authority recruited 48 of 58 nursing graduates from UNBC into positions in acute care and public health facilities in Fort St. John, Prince Rupert, Terrace, Smithers, Burns Lake, Fort St. James, Vanderhoof, and Prince George. This year’s nursing influx follows 2004’s recruitment of 33 of 38 UNBC nursing graduates to positions across Northern BC.
- In 2005 health authorities committed to hiring all new RN and RPN graduates. This includes hiring for non-urban settings in NHA and IHA.
- The Ministry of Health provided funds in 2004/05 to translate knowledge learned from the national 2005 *Nursing Practice in Rural and Remote Canada Study* into effective recruitment and retention strategies for rural nurses in BC.
In 2005/06, nursing strategy funds have supported a province-wide education plan that is rural focused and practice driven to meet the needs of nurses working in, or planning to work, in rural communities.

**B.C. registers first nurse practitioners**

British Columbia welcomed its first group of provincially-educated nurse practitioners (NP) in 2005. NPs are registered nurses with advanced education, knowledge and skills. As part of primary health care teams, NPs diagnose common illnesses, order investigations, prescribe medications and provide follow-up.

In May 2003, government announced a total of 30 new spaces for NP education at UBC and UVic. These programs started in September 2003. A third program at UNBC, was funded for 15 seats and started in September 2005.

The *Health Professions Amendment Act*, which was passed on October 22, 2003 allowed for the rollover of the Registered Nurses Association of British Columbia to the College of Registered Nurses of British Columbia (CRNBC) and the recognition of the role of NPs as advanced practitioners within the health profession of registered nurses. The new CRNBC became a reality on August 19, 2005 and the first NPs were registered in early October 2005.

**Government invests in health care professionals’ partnerships**

Government invested $400,000 in a partnership to encourage collaboration among students and practitioners from different health disciplines to improve patient care. The funds, spread over four years, support the Interprofessional Network of British Columbia (In-BC). This network brings together the province’s six health authorities and post-secondary educational institutions to improve health care. In-BC projects involve students and health professionals representing a wide range of disciplines, including medicine, nursing, midwifery, pharmacy, rehabilitation services and social work. In-BC is the first interprofessional network of its kind in North America.

**Expanding loan forgiveness**

B.C.’s student loan forgiveness program was expanded in December 2004 to include four health professions whose graduates are needed to provide support for children in rural and remote areas of the province. Speech language pathologists, audiologists, occupational therapists and physiotherapists became eligible for the program, and can eliminate their B.C. student loans in three years. The loan forgiveness program has been in place for graduates from accredited schools in nursing (including licensed practical nursing), and medical, midwifery and pharmacy schools since August 1, 2000. In October 2005, B.C.’s student loan forgiveness program was further expanded. Nurse practitioners are now eligible to have their B.C. student loans forgiven over three years if they agree to work in a publicly funded facility in an area of the province that is currently underserved.
Alberta

In 2004, Alberta was a signatory to a new Health Accord. Alberta will complete a comprehensive workforce plan and a physician resource plan by December 31, 2005, to meet the obligations of the Health Accord. The plans focus on the overall goal of having the optimal number, mix and distribution of health service personnel required for the provision of accessible, quality, patient-focused health services for Albertans, in a sustainable health care system. The Health Workforce Information Network (HWIN) Initiative, which will provide data on the health work force for policy and planning purposes, is underway. It will be linked to the Alberta Provider Directory.

The Alberta Provider Directory (ABPD) is the Alberta implementation of the Western Health Information Collaborative (WHIC) Provider Registry System. A standardized registry of service providers is one of the fundamental building blocks of the Electronic Health Record and comprehensive health work force planning. (See Section III, Part C)

The Enhancing Clinical Capacity Project Fund (ECCPF) was established to encourage, stimulate and finance innovative projects that enhance the capacity of organizations to provide health disciplines students with clinical learning opportunities in alternative, sustainable ways. The fund will address access to health education programs, including clinical placement problems.

- During the first round, 11 of 13 proposals were approved by the ECCPF Committee for a total of $2,883,900 in funding. These proposals were approved by the Minister and are now receiving their funding.
- During the second round, 13 proposals were approved by the ECCPF Committee for a total of approximately $4.6million in funding.
- The Alberta Government’s Three-Year Plan for the Continuing Care Sector outlined in the document, Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta includes the following major health work force initiatives:
  - A Health Care Aide Provincial Curriculum is currently being distributed to post-secondary educators, employers, and other training agencies. This curriculum is based on the core competencies developed throughout the Continuing Care Workforce Working Group, a multi-stakeholder group comprised of representatives of the regional health authorities (RHAs), non-RHA organizations providing continuing care services and the ministries of Health and Wellness and Advanced Education.
  - Health Care Aide Awareness & Promotion Strategy addresses major challenges faced by employers in recruiting health care aides.
  - A Provincial Alzheimer Disease/Dementia In-Service Training Strategy has been completed. This project will provide a minimum of 7,000 front-line workers who currently provide services in rural and urban areas in the three continuing care streams (facilities, supportive living and home care) with the specialized education and training required for the provision of quality services to individuals with Alzheimer Disease and other types of dementia. A Train-the-Trainer Model is utilized and over 200 health professionals will also be trained through this process.
• The Alberta Government has met the target of a 10 per cent increase in nursing education seats as outlined in Strategy Seven of the Nursing Strategy for Canada (November 2002).

• Between the years 1999/2000 and 2004/2005, there was a total increase of 1,875 seats for all RN nursing programs. That can be broken down as follows
  o Diploma: 457 seat expansion
  o BSc programs (incl. Transfer programs): 1278 seat expansion
  o MA, PhD, advanced training: 140 seat expansion

• Between the years 1990/2000 and 2004/2005, there was a total increase of 857 seats for all LPN nursing programs.

• Between the years 1999/2000 and 2004/2005, there was a total increase of 47 seats for all RPN nursing programs.

• Total increase in nursing numbers from 30,000 in 1998 to over 34,000 in 2004. The 2004 numbers are: 5,700 LPNs; 27,348 RNs; and 1,241 RPNs.

• Strategies to increase work satisfaction and employee retention are being developed by the regional health authorities through their Council of Chairs.

**Saskatchewan**

• A three-year collective agreement was reached with the Saskatchewan Union of Nurses in late 2005, while a four-year collective agreement was reached in early January with the provider unions.

• *Working Together: Saskatchewan’s Health Workforce Action Plan* was released on December 14, 2005. The Plan flows from the First Ministers’ Meeting in the fall of 2004, where a commitment was made to accelerate health human resource planning and make action plans public by December 31, 2005. It also builds upon the 2001 *Action Plan for Saskatchewan Health Care*.

• The Plan contains 5 goals, which are:
  o The health care system has a sufficient number and effective mix of health care professionals who are used fully to provide safe, high-quality care.
  o The health system has safe, supportive, and quality workplaces that help to retain and recruit health care professionals.
  o Aboriginal people fully participate in the health sector in all health occupations.
  o The education and training supply of Saskatchewan health care professionals is aligned with projected workforce requirements and health service needs.
  o The health workforce is innovative, flexible and responsive to changes in the health system.

• There are 82 actions in the plan that focus primarily on: (1) linking young people early and often to health employers, (2) enhancing self-sufficiency within available resources, (3) focusing on Saskatchewan’s competitive advantage – Aboriginal youth population; and (4) strategic and ethical recruitment.
• The Workforce Action Plan sets a direction for a more integrated workforce and includes initiatives to align service and health planning with supply, improve health workplaces and address issues affecting key health professionals.

• Rather than focusing solely on the number of health professionals needed, the plan reflects the value of a workforce responsive to health needs, skill mixes and service delivery.

• Extensive consultations took place with stakeholders in developing the plan, including an October 2005 conference focused on Finding Common Ground, which was hosted by the Canadian Policy Research Network (CPRN). Collaboration and partnership of stakeholders will be vital to the ongoing success of this plan. For this reason, a workforce steering committee will be established, made up of representatives from the health and learning sectors. This committee will guide future actions and help measure progress.

• Health related bursaries are awarded to a wide range of nursing and allied health disciplines, composed of 20 types of allied health bursaries and six categories of nursing bursaries. Approximately 500 bursaries are awarded annually. Upon graduation, bursary recipients are required to provide a specified period of service in a publicly funded position in Saskatchewan. As of December 31, 2005 over 290 new bursaries and 100 continuing bursaries to health (non-physician) students have been awarded. In addition, we have awarded 40 new and 53 continuing physician bursaries.

• The Nursing Education Program of Saskatchewan (NEPS) training capacity is 400. This includes the introduction of nursing as a second-degree option, which began in May 2005 with a planned annual intake of 50 graduates with a degree in other disciplines. The second-degree option is based on a modified NEPS curriculum and will be two calendar years in length.

• RHAs surveyed 37,000 employees in May 2005. The focus of the survey was part of an ongoing commitment to work with employees to improve quality of workplaces. The survey results were officially released on December 12, 2005. Health employers will use these results to develop more specific actions to improve workplaces, and help fulfil regional health authority accreditation requirements.

• Based on the survey company’s (NRC Picker) national database, Saskatchewan healthcare employees on average are more positive than their national counterparts. Survey results showed physical environment, safety and respect were the highest rated topic areas; while learning environment was the lowest rated topic area.

• Just over 100 participants completed a six-module Executive Leadership Program throughout 2005-2006. The program used face-to-face workshops, a series of directed reading components, case studies and group support. The purpose of the program was to provide leaders in the RHAs, Saskatchewan Cancer Agency and Saskatchewan Health with educational opportunities to develop the leadership capabilities and support networks to perform the functions required to effectively run a world-class health care system.

• Saskatchewan Health hosted an Aboriginal representative workforce strategies information session in August 2005. Representatives from federal and provincial departments attended the session. This one-day session will be repeated and expanded. An Aboriginal representative workforce information sharing opportunity is being organized using satellite telecast for health employers, First Nations, Métis health organizations and other
stakeholders. The information session will look at successes with representative workforce initiatives.

On May 30 & 31, 2006, Saskatchewan will be hosting an Aboriginal Health and Human Resources Forum, in partnership with the Government of Canada and the Saskatchewan Association of Health Organizations.

- The province, in partnership with RHAs, expanded the Saskatchewan Immigrant Nominee Program (SINP) to include a health professions category. The province began nominating physicians in 2002 and included nurses the following year. The program allows foreign-educated nurses and doctors practising under a temporary work permit to apply for landed immigrant status in an expedited manner.

In October 2005, the SINP was expanded to include all other skilled health occupations. This includes health occupations requiring at least one academic year of post-secondary education and/or one year of job-specific training.

- The government continues to make investments to create a more representative workforce by helping employers provide cultural awareness training for the current workforce. Health regions have offered this training to over 11,000 health employees as of October 2005.

- To help measure the performance of RHAs and the SCA, a number of human resource indicators are being tracked and reported, as part of the accountability document. These indicators include:
  - The number of sick hours per FTE by union affiliation
  - The number of overtime hours per FTE by union affiliation
  - The number of paid FTEs by region
  - The number of lost time claims per 100 FTEs
  - The number of days (severity) of WCB claims per 100 FTEs
  - Percentage of self-identified aboriginal employees
  - Worked hours (excluding sick hours and claimed lost time) as a percentage of paid hours

**Manitoba**

- The current nursing agreement expires in October 2007. Employers and the union have submitted proposals for a new/revise...
A Community Mental Health Careers website was launched on January 16th, 2006. The website www.workinginmentalhealth.ca will help community mental health agencies recruit more broadly for providers. It will also generate Local Health Integrated network (LHIN) based statistics to assist with future local area planning and complement the Aboriginal Healing and Wellness Initiative by describing the Aboriginal mental health system. The Ministry also funded research into human resources providing mental health services to Aboriginal clients.

**Cancer Care**

Ministry staff continue to work with stakeholders to explore the expansion of career options for radiation therapists that include both entry level and advanced practice roles. Ontario is funding a project to develop, pilot and evaluate five advanced practice Radiation Therapy roles.

**Internationally Educated Health Professionals**

The ministry undertook several projects in 2005/06 to increase access to practice in Ontario for internationally educated health professionals (IEHPs). These projects were funded through Health Canada as part of their five-year, $75 million initiative to increase access for IEHPs in Canada, for which Ontario has been notionally allocated $17.6 million over five years (2005/06 - 2008/09). Projects for 2005/06 included:

- Strategic Planning Project for IEHPs, including the completion of an environmental scan to identify initiatives currently underway for IEHPs, success and gaps, and
- Continued funding for the Michener Institute's Access and Options for Foreign Trained Health Professionals project
- Development of a CD/booklet resource for college guidance counselors advising IEHPs interested in practicing medical radiation technology and medical laboratory technology in Ontario.

**Interprofessional Education**

As interprofessional education facilitates greater collaboration and practice in health care, the ministry approved the development of a curriculum to integrate interprofessional education at the Michener Institute. The funding provided in February 2006 supported the government's commitment to promoting a team approach which will improve access to health care, patient outcomes, and patient satisfaction.

**Clinical Education**

Clinical training is a core aspect of the education of all healthcare students. However, it is becoming increasingly difficult to ensure that all healthcare students receive the appropriate amount of clinical training. The availability of clinical teaching resources and the clinical placements are becoming issues for healthcare students in Ontario. The ministry has provided funds for the enhanced use of simulation at the Michener Institute for magnetic resonance imaging. This will allow students to achieve maximum use of enhanced technological features and improve operational efficiencies in diagnostic imaging in a safe and realistic simulated learning environment.
Magnetic Resonance Imaging (MRI)

The ministry funds the Michener Institute for Applied Health Sciences, which is the only educational institution that offers a formal MRI training program in Ontario. An additional cohort of 25 students was funded in January 2006 to make use of available clinical site. This will support Ontario's Wait Time Strategy, which helps ensure that Ontarians receive timely and appropriate access to five selected services, including MRI scans.

Computerized Tomography Simulation Project

The ministry awarded development costs for the Computerized Tomography (CT) Simulation Project which allows students to acquire and manipulate images without compromising patient safety. This will improve operational efficiencies in diagnostic imaging across the province which is part of the CT Wait Time Strategy in March 2006.

Picture Archiving and Communication System (PACS)

New CT and MR units generate extremely large datasets per examination. Educational opportunities on the Picture Archiving and Communication System (PACS) were funded by the ministry in October 2005 and offered at the Michener Institute to provide knowledge and skill on the efficient management of the information acquired.

Anesthesia Care

The ministry funded the Michener Institute in July 2005 to pilot a new Anesthesia Assistant Program which provides training for respiratory therapists and registered nurses who can participate as part of the anesthesia care team. The first cohort of eleven students entered the Program in January 2006. The introduction of anesthesia assistants will increase patient access to operating rooms, improve wait times for surgical procedures, help address operating room efficiency, and improve working conditions for the province's anesthesiologists.

Medical Laboratory Science

The ministry provided funding in 2002 to the Michener Institute to support an increase of 32 entry-level positions over three years in the Medical Laboratory Science program in response to reports of current and impending shortages in laboratory services The Michener maintained this new enrollment level in 2005/06. The new Medical Laboratory Science program at the University of Ontario Institute of Technology will also increase the supply in 2008 when the first 30 students are expected to graduate.

Midwifery

The Midwifery Education Program (MEP) is a consortium of three universities, Ryerson, McMaster and Laurentian, that offer a 4-year Bachelor degree in midwifery. The MEP has graduated an average of 32 new midwives a year over the past four years. Enrolment in the midwifery program increased to 60 new entrants in 2003, and has remained constant at this number.
Allied Health Human Resource Database (AHHRDB)

It has long been recognized that human resource planning initiatives have been inhibited by inadequate data. There is a critical need for better quality data tailored to meet health human resource planning requirements. The ministry is developing an allied health human resources database to enhance the capacity for integrated health human resource planning, including development of data-driven forecasts. It recently completed a pilot project capturing information from nine allied health regulatory colleges. The next step for the AHHRDB is to transition the project to a long-term operationalization of the database.

As part of the Ontario Government initiative to transform the health care system, an Information Management framework has been established to track and monitor how the health care system serves the public. Through this initiative, key areas of focus will involve producing better data, measuring performance, and supporting evidence-based decisions. As part of this work, supply indicators will be developed for health human resources in various settings such as hospitals, Community Care Access Centres (CCACs), Children's Treatment Centres (CTCs), and Community and Mental Health Facilities.

Quebec


L’adoption, en novembre 2005, de la Loi modifiant la Loi sur les services de santé et les services sociaux et d’autres dispositions législatives (loi n° 83) crée l’obligation pour les agences de réaliser un plan triennal pour la planification de la main-d’œuvre.


La main-d'œuvre infirmière

On dénombrait, au 31 mars 2005, 39 229 infirmières (équivalent temps plein – ETC de 32 591), 12 364 infirmières bachelières (ETC de 10 531), 13 148 infirmières auxiliaires (ETC de 10 721) et 34 893 préposés aux bénéficiaires (ETC de 26 800).

Actuellement, 16 infirmières praticiennes spécialisées sont en poste dans le réseau à titre de candidates et 10 infirmières sont en stage de fin de programme. La planification de la main-d’œuvre prévoit introduire 75 infirmières praticiennes d’ici 2010.

On April 5, 2006, the Conseil des ministres adopted a health workforce renewal strategy. A monitoring committee was established, chaired by the ministère de la Santé et des Services sociaux (MSSS) and made up of representatives from the ministère de l’Éducation, ministère du Loisir et du Sport, ministère de l’Emploi et de la Solidarité sociale, ministère de l’Immigration et des Communautés culturelles, Secrétariat du Conseil du trésor, and Office des professions du Québec.

The Act amending the Act respecting health and social services and other legislative provisions (Bill 83), adopted in November 2005, required agencies to develop three-year workforce plans.

An order-in-council on the working conditions of salaried employees in the health care system, adopted in December 2005, contained special provisions on recruitment and retention and on skills development.

**The nursing workforce**

As of March 31, 2005, Quebec had 39,229 nurses (full-time equivalent—FTE—of 32,591), 12,364 nurses with bachelors degrees (FTE of 10,531), 13,148 licensed practical nurses (LPN) (FTE of 10,721) and 34,893 Patient Service Associates (FTE of 26,800).

An overview and an update concerning the nursing workforce forecast were prepared and presented to the Forum sur la planification de la main-d’œuvre (PMO) infirmière on February 11, 2005. A meeting involving the Forum sur la PMO infirmière and other workforce planning groups in nursing and cardio-respiratory care is scheduled for September 2006. This will provide an opportunity to advance the implementation of the action plan.

There are currently 16 specialized nurse practitioners working in the system as candidates, and 10 nurses are completing their end-of-program placements. According to the workforce planning, 75 nurse practitioners will be added by 2010.

**New Brunswick**

- The 2002 study Health Human Resources Supply and Demand Analysis continues to inform New Brunswick’s health human resources strategy.
- The provincial Health Human Resources Network continues to collaborate on regional and provincial recruitment and retention strategies.
- In April 2005, the province announced an Allied Health Resource Strategy for New Brunswick designed to ensure New Brunswickers have access to appropriate health professionals to meet their health care needs.
Many of the initiatives of the Nursing Resource Strategy unveiled in April 2001 have been maintained, focusing on the recruitment and retention of nurses and licensed practical nurses, as well as their optimum utilization within the health care system.

Ninety-five (95) additional nursing university seats have being approved effective September 2005, as a means to prevent the foreseen nurse shortage.

New Brunswick has made great progress in retaining its nursing resources. In 2005, 86% of the new 2004 graduates re-registered in 2005.

Competitive employment benefits and a phased retirement program for nurses are important initiatives that will help attract candidates to the nursing profession, as well as keep experienced nurses in New Brunswick.

**Nova Scotia**

Launched in 2001, Nova Scotia’s Nursing Strategy continues to make a positive contribution to nursing recruitment, retention and renewal throughout the province. It addresses nursing’s major challenges by providing a comprehensive, coordinated approach to continuing and specialty education, support for recruitment and orientation initiatives, appropriate workforce utilization, and improved quality of work life. By 2007, almost $60 million will have been invested in the Nursing Strategy.

Data shows that the Nursing Strategy is successful. The overall number of employed nurses is higher in than it was in 2001. Of these, significantly more nurses are employed in full-time permanent positions versus casual positions. Nova Scotia is currently retaining over 80% of its new graduates, 90% of whom have found full-time employment. In addition, the Strategy has provided financial support to over 213 nurses re-entering the profession, more than 50 of these in the last year. Since 2001, 398 nurses have accessed relocation allowances to work in Nova Scotia.

Since 2003, government has invested $7.1 million to train an additional 240 nurses each year for four years. In 2005, a total of 238 nurses graduated from Dalhousie University, St Francis Xavier University, and their satellite campuses in Yarmouth and at Cape Breton University. In addition, 140 nurses graduated from the LPN program at the Nova Scotia Community College. The feasibility of further expansion of nursing seats, including the possibility of new education sites is being explored.

Leadership development is a top priority for nursing. In 2004, a provincial working group was established to develop strategies to enhance nursing leadership development in Nova Scotia. In 2005-2006, the Department of Health will receive their report and recommendations, and will identify priorities for implementation.

Recruitment and retention of nurses for rural and remote communities remains a priority. In May 2004, the Provincial Nursing Network released the report, *Rural and Remote Nursing – Recruitment and Retention in Nova Scotia*. The following priorities, aimed at sustaining the rural nursing workforce, were approved:

- Development and implementation of a marketing strategy through partnerships between health providers, educational institutions and communities
- Support for employer initiatives to enhance quality of work life
Support for leadership education for rural managers and nursing staff

Monitoring and evaluating indicators that support planning for recruitment and retention of nurses in rural areas

Implementation of these recommendations, in consultation with stakeholder groups, has begun and will continue into the next fiscal year. New opportunities to promote, support and enhance nursing in rural/remote areas are being explored. The Coperative Learning Experience for BScN students is being expanded. It will fully fund all co-op placements and target long-term care and rural and remote communities for placements in 2005-2006.

- The current and future nursing shortage remains a primary concern. As 30% of Nova Scotia’s nurses near retirement, the retention of older nurses in the workforce is paramount. Government has been working closely with the Colleges of Registered Nurses and Licensed Practical Nurses of Nova Scotia to identify and make recommendations that will assist in the retention of late career nurses in the workforce. The report and recommendations of this committee is forthcoming

- Health Human Resources Branch, Nova Scotia Department of Health completed an environmental scan of planning initiatives across health sectors, jurisdictions and professions. The scan is assisting in the identification of gaps in planning for health human resources at a provincial, regional, national and international level. Planned initiatives for training and recruitment and retention to address the gaps include:
  - Medical Laboratory Technologist education programme, beginning September 2007. The first class will graduate in 2009
  - Internationally Educated Health Professionals and International Medical Graduates Initiative, which provides recruitment and training opportunities, began January 2006. It will continue to 2010 and will increase the number of health care professionals immigrating to Nova Scotia
  - Return to Service bursaries for nurses, medical laboratory technicians, international medical graduates and other health professionals educated outside of Canada.

The Department of Health’s involvement in the Atlantic Health Education Training Study is ongoing in 2005. The Department also participates in the Atlantic Advisory Committee on Health Human Resources.

Prince Edward Island

- A total of 66 new Registered Nurses were brought into the health system in 2005/06.

- The (2004-2008) Nursing Recruitment and Retention Strategy continues to provide sponsorship HR Planning and retention resources, as well as the BN Student and Health Care Futures summer employment programs.

- PEI Health Professionals Registration Database: The Department approached 20 health professional associations to gauge interest and request participation in this initiative. Participating associations were provided with a system that fully automated their membership registration process. This means improved data collection and reporting
capabilities for the associations and the provision of a comprehensive human resources database for the PEI health care system.

- **Nurse Practitioners (NP)** are a new professional health care provider being introduced to PEI. A new Registered Nurses Act was passed in the House in December 2004 and proclaimed in February 2006, which included a provision for recognizing the title of Nurse Practitioner and their scope of practice. Although there are many areas of practice where NPs can add value to the health system, the Department of Health recognizes the need to assess the appropriate allocation of this new health care provider in various areas of health care delivery. A Nurse Practitioner Position Assessment Committee has been established to review proposals for Nurse Practitioner positions and recommend implementation. The Committee will begin reviewing submissions in the spring of 2006.

- **Medical Laboratory Technology Seat Purchase Program:** The Governments of Prince Edward Island and New Brunswick have a new 3 year agreement (expires 2009) whereby three eligible Prince Edward Island residents will be guaranteed access to the Medical Laboratory Technology two-year program offered at the New Brunswick Community College in Saint John New Brunswick.

**Newfoundland and Labrador**

There have been several amendments to existing legislation related to improved regulatory structures for health professionals. (Section 1, Part B)

A new health human resource planning structure is under consideration.

**Nursing**

A Chief Nurse position has been created within the Department of Health and Community Services. A Provincial Nursing Network comprised of key stakeholders from the registered nurse and licensed practical nursing occupations has been formed.

Registered Nurse and Licensed Practical Nurse Supply Reports are in the process of being updated. Existing reports (and other health human resource-related documents) are available at: [www.nlhba.nl.ca/hr](http://www.nlhba.nl.ca/hr).

Work continues related to exploring use of alternative care providers, such as nurse practitioners and midwives, in the delivery of health services. Currently there are approximately 60 nurse practitioners in the province.

The Nurse Practitioner Bursary and Rural Nursing Student Incentive Programs continue to be offered.

**Health Management**

A Graduate Program in Health Administration Scholarship has been made available through the Newfoundland and Labrador Health Boards Association.
Leadership and related issues have been identified as a priority among several system stakeholders, and future work will build on analysis completed in 2003.

**Other updates**

NL participated in the Atlantic Health Human Resources Planning Study which was recently completed. This study took a needs-based approach to health human resource planning for selected occupations, and was focused in particular on the education and training of health professionals in the Atlantic Provinces. The executive summary is available at [www.ahhra.ca](http://www.ahhra.ca).

An initiative to examine employee counts, demographics, earned hours, turnover, and other key workforce statistics is underway, representing the fourth iteration of this exercise with employers.

Quarterly vacancy surveys have been administered to track the number and type of vacant positions occurring in the province at various points in time. Newfoundland and Labrador continues to participate in several national initiatives related to health human resources including working groups advising on workforce modelling and forecasting, entry-to-practice review, the collection of education-related statistics, and others. Newfoundland and Labrador has been availing of the national funds made available for health human resource related projects, and generated several initiatives in this regard, scheduled for completion by March 31, 2006.

Ongoing initiatives aimed at improving human resource recruitment and retention, especially in rural and specialty areas include:

- Seat purchase and bursary programs for physiotherapy and occupational therapy students as well as other bursaries for speech language; pathologists and audiologists. Pharmacy and psychologists bursaries have been available on occasion;
- Retention incentives for RNs and Social Workers in remote communities in Labrador; and
- Collaborating with key stakeholders to develop primary health care reform.

**Health Information / Information en Santé**

**Health Canada**

The *Ten-Year Plan to Strengthen Health Care*, signed by all First Ministers in September 2004, emphasizes accountability by all governments and builds on their previous commitment to report on health system performance to Canadians. In 2005-2006, Health Canada continued to work with provinces and territories, Statistics Canada, and the Canadian Institute for Health Information to improve health statistics and information.

**Santé Canada**

Le Plan décennal pour consolider les soins de santé, signé par les premiers ministres en septembre 2004, insiste sur la responsabilisation de tous les gouvernements et s’appuie sur leur

Northwest Territories

- The Department is working with Canada Health Infoway Inc. (Infoway) to establish an NWT interoperable electronic health record (iEHR) that will enable and support the implementation of the Integrated Services Delivery Model (ISDM), and allow NWT healthcare providers to have instant access to patient medical records. The following initiatives have made the following progress:
  - The Department is developing an Informatics Strategic Plan with Infoway funding support. Infoway is funding the development of a detailed plan for a diagnostic imaging picture archiving computer system. Infoway is also providing funds to develop a high level strategic plan for telehealth, which includes support for the implementation of the Integrated Service Delivery Model;
  - The Department has delivered a high-level project roadmap identifying the required components for an iEHR, and set out the proposed order for implementation over the next 4-5 years;
  - The Department is currently undertaking a project to conduct detailed planning for an iEHR. This phase is expected to be complete in Spring 2006.

- In December 2005, the Department released the *NWT Health Status Report 2005*, an update to the report published in 1999. The report presents information on the health status of NWT residents along with information on some factors known to influence health status.

- In October 2005, the Department released the *2004-05 Community Client Feedback Report*. The report shows the results of the Community Client Feedback Survey done in October 2004. 512 forms were completed, 478 of which were from communities outside of Yellowknife. Overall, 89.3% of respondents were satisfied of very satisfied with the friendliness of staff, and 88.8% were satisfied or very satisfied with the quality of service received. The most common area of improvement cited was accessibility, noted by 41% of respondents. The full report can be found at [http://www.hlthss.gov.nt.ca](http://www.hlthss.gov.nt.ca).

- Telehealth is broadly defined by the Department of Health and Social Services as "the process of using information and communications technologies to deliver health and social service information, services and expertise over short and long distance".

The Department, in partnership with HSS Authorities, specialists and southern hospitals, is using telehealth services to improve access to health services for people in remote communities; support doctors and health care providers to use technology to access peer information and medical education; and improve the efficiency of specialized health services within the NWT.

Yukon Territory

- An assessment of health information management and technology requirements for the department is underway.
• Assessment of the department’s need for access to electronic health and social services research and best practices data bases has been completed, and an evaluation is underway to determine an appropriate vendor to meet these needs.
  o A mental health information system, SYNAPSE, has been implemented; this system is part of an eventual electronic health record.
  o The Tuberculosis module of the iPHIS (Public Health Information System) has been implemented at Yukon Communicable Disease Control, headquartered in Whitehorse. The Immunization module has been implemented in all community health centres.
  o Continuing Care (Home Care and Long term care facilities) has successfully implemented an electronic health care record and case management system that has integrated RAI assessment tools.

British Columbia

**BC Health Guide helps improve access to health care**

• The BC Health Guide Program is one way that government is developing new and creative programs to empower British Columbians to make the right health decisions for themselves and their families. Launched in Spring 2001, the Program provides health information, advice and support 24 hours a day, 7 days a week through an integrated suite of self-care resources (BC HealthGuide handbook, BC HealthGuide OnLine, BC HealthFiles and BC NurseLine).

• BC NurseLine provides confidential health information and advice, enhancing British Columbians' access to health information and assisting them obtain the appropriate care when they need it. Translation services are available in 130 languages, including Mandarin and Cantonese.

• BC NurseLine was enhanced with a Pharmacist Service in June, 2003. Pharmacists are available to answer medication related questions between 5:00 p.m and 9:00 a.m. daily.

• A related telehealth service, Dial-A-Dietitian, provides free nutrition information line for British Columbians Monday to Friday, 9:00 a.m. to 5:00 p.m.

• The BC First Nations Health Handbook, an Aboriginal companion guide to the BC HealthGuide handbook, was distributed in fall 2002.

• In June 2004, the BC HealthGuide handbook was made available in French.

• A redesigned version of BC HealthGuide OnLine (www.bchealthguide.org) was launched in September 2005.


• Translations in Chinese and Punjabi are forthcoming.
Research

Funding to support mental health research

The Province provided $10-million in funding to help establish three new research chairs and a new Institute of Mental Health at UBC. The funding matched a $10-million private gift to UBC and will put B.C. at the forefront of mental health research, training and policy. The $20 million will:

- Create three $5-million endowments to support research chairs in child and adolescent psychiatry, geriatric psychiatry and depression, and psychotherapy.
- Develop fellowships, junior faculty positions, and support for communicating research and clinical findings to clinicians and mental health professionals.

$2 million invested in improving women’s health research

Government invested $2 million through the Women’s Health Research Institute at BC Women’s Hospital & Health Centre to fund investigation into health issues unique to women. The research will provide health care professionals with evidence-based research to support prevention, diagnosis and treatment services for women. New funding will:

- Enable ongoing research on health issues throughout all phases of a woman’s life;
- Improve clinical practices and policy development;
- Develop women’s health research partnerships through sharing technology that will link researchers, women, policy makers and health care providers.

$6.1 million invested in UBC blood research

The Centre for Blood Research officially opened in March 2005 at UBC’s new Life Sciences Centre. The centre focuses on the Canadian blood supply system, including improving transfusion services and developing artificial blood components. Provincial funding of $6.1 million helped create the facilities. The long-term goal of the centre is to make Canada a donor-free society by the year 2025.”

$100 million for Health Research

In February 2005, government committed an additional $100 million to the Michael Smith Foundation for Health Research (MSFHR). MSFHR is British Columbia’s premier health funding agency, supporting BC’s best and brightest health researchers and health research trainees through personnel funding and infrastructure support programs. MSFHR is a third-party, independent organization, working with health research stakeholders across BC to identify, prioritize and respond to provincial priorities. In addition to its funding role, MSFHR acts as a leader, partner and catalyst to advance provincial, inter-provincial and national initiatives that expand health research support and opportunities.
Alberta

- Alberta Health and Wellness continues to provide information technology solutions to help Alberta’s authorized health care providers share relevant patient information. The aim is to improve the health of Albertans, the quality of their care, and the sustainability of Alberta’s health system.

**Electronic Health Record**

- Alberta Netcare Electronic Health Record (EHR) is an Internet portal that today provides health care providers with relevant patient information from systems across the province, such as prescription and dispensing data, allergies and lab test results.

- The EHR began rolling out in August 2003. At the end of 2005, more than 17,000 health care providers had voluntarily signed up to receive access.

- In Alberta, much progress has been made to develop the provincial EHR. Capital Health, Calgary Health Region, and the seven rural regions have developed a strong collaborative approach resulting in a common vision. Capital Health has led the development of the Alberta Netcare portal. Collaborative work between Alberta Health and Wellness, and Calgary and Capital Health regions to develop an information exchange hub will link clinical databases at the regional level, to share information such as laboratory test results, diagnostic images and patient encounters through the portal. To complement this activity, Alberta Health and Wellness is developing patient, provider and facility registries. Security, authorization and access are managed at a provincial level.

- Feedback on the value of the EHR from physicians using the system has been positive. Many have indicated they have changed treatment plans for patients as a result of the information they accessed through Alberta Netcare.

- In addition to valuable patient information, Alberta Netcare includes decision support tools to alert physicians to possible drug-to-drug or drug-to-allergy interactions at the time of prescribing. Research studies conducted in other parts of Canada suggest that tools like the one in Alberta Netcare can significantly reduce the number of inappropriate prescriptions and adverse effects.

- The Provincial HISCA provider data standard was approved in July 2005. The Western Health Information Collaborative (WHIC) provider data standards and definitions were also developed and provided the foundation for the national draft HL7 provider definitions to be balloted.

- Alberta continues to participate in the WHIC provider directory initiative. The Alberta Provider Directory will manage information on providers of 30 registered health professions. The directory tool has been implemented, and there are projects in place to populate the data from the various registration bodies.

- The Alberta Provider Directory will support both the Alberta Netcare EHR and Alberta Health and Wellness services. Detailed requirements have been defined, established and completed for the Alberta Provincial Provider Registry. This key EHR initiative will form the basis for the strategy and implementation of a provincial provider registry. Integration of the Provider Directory to the EHR will be developed in 2006 and 2007.
• Canada Health Infoway is a federal corporation that funds EHR and telehealth initiatives. Infoway is partially funding Alberta’s Electronic Health Record. Canada Health Infoway acknowledges Alberta’s EHR leadership.

Access Services provide access to health information and health services.

• Alberta’s Telehealth Network is one of the largest in Canada and is recognized as a worldwide leader in telehealth. The network continues to experience growth in all areas. Telehealth, through videoconferencing and other leading edge technologies provides Albertans convenient access to specialty health assessment, specialty care and a wide range of health services.
  o Improved access to health services for rural Albertans, including consultations, health promotion and education opportunities for patients and caregivers.
  o Provides improved and cost effective methods for connecting health system staff for continuing education and business meetings, thus greatly reducing travel costs.
  o There are now over 270 telehealth systems in use in all manner of health facilities province-wide.
  o There are telehealth services in approximately 30 clinical areas including diagnosing lung cancer, monitoring heart and dialysis patients, and responding instantly to emergencies.
  o Through this Telehealth network, Albertans from across the province are receiving the specialized care they need without the need to travel far away from their local community support network.

• A number of initiatives are underway to enhance stakeholder infrastructure to enable information exchange. These include:
  o The seven rural health regions, through the Rural Shared Health Information Program (RSHIP) have implemented a common health information system (clinical, financial, and administrative applications).
  o The Physician Office System Program (POSP) is a tri-lateral initiative and an integral component of the province’s electronic health record strategy, technology made available to physicians through POSP means better access to important clinical information and support for decision making. As of March 31, 2006, POSP will have about 3,000 physician participants. This represents about 54 per cent of the 5,521 eligible physicians. Physician intake by fiscal year has been:
    45 in 2001/2002,
    1,108 in 2002/2003,
    193 in 2003/2004,
  o The seven rural regions represent 23 per cent of the participation physician population whereas Capital has 38 per cent and Calgary has 39 per cent.
The physician office systems are working within the boundaries of the clinic; however, there is need to evolve these systems to be integrated with the Provincial Alberta Netcare Electronic Health Record (EHR) and the RHAs. To address the integration need, further inform vendors of mandatory provincial requirements and protect physicians in their purchasing decisions, the Physician Office Vision 2008 project will articulate the information technology vision for Alberta physician offices in the context of Alberta Netcare 2008.

POSP also offers change management support to help physicians assess their needs, choose products and services, and manage the installation and change that accompanies the expansion of computer technology in a physician office.

**Western Health Information Collaborative (WHIC) (with AB perspective)**

- The Western Health Information Collaborative (WHIC) is an initiative sponsored by the Western Premiers and Deputy Ministers of Health to explore collaborative opportunities with respect to health information system development initiatives. This collaborative explores common opportunities that meet western provinces’ and territories’ health information needs and supports the strategic directions and initiatives at the national level. The WHIC process for project initiation and approval involves the following key steps:
  - identifying common opportunities for collaboration;
  - validating with participating jurisdictions;
  - formalizing collaborative projects with lead, participating and supporting jurisdictions;
  - obtaining commitment and funding;
  - undertaking projects within appropriate structures;
  - ongoing facilitation, coordination and process support through the WHIC Secretariat; and
  - project and content leadership throughout the provinces/territories.

- Alberta participates in the majority of WHIC initiatives, which encompass the following EHR projects:
  - Provider Registry
  - Client Registries
  - Pharmacy/PIN
  - Laboratory Information
  - Architecture
  - Telehealth
  - Primary Care

- Alberta is the lead province for Pharmacy/PIN, and Chronic Disease Management as well as a Telehealth Change Management initiative.
The Health Information Solutions Centre (HISC) at Saskatchewan Health is working in consultation with the RHAs and other stakeholders on the implementation of a provincial health sector Information Technology (IT) strategy. This strategy will be delivered through a province-wide health information network. This is a multi-year development, which supports health system priorities at the provincial and local levels.

The provincial IT strategy supports health care professionals in providing quality care by utilizing modern technologies to enable secure and timely access to the health information they require in providing care for their clients, who often receive services at different points across the provincial health system.

HISC delivers secure wide-area networking, application hosting and IT help desk services for health regions; provides electronic health record capabilities to integrate health information from different systems and service locations to support better patient care; supports the implementation of new technologies such as telehealth; and facilitates the use of statistical information to support improvements in the management, planning and evaluation of health services.

In 2005-06 the telehealth network was expanded by 8 sites to bring the total to 26 sites. It allows residents in remote areas access to some specialists without having to leave the community. The telehealth technology uses computers and a sophisticated video conferencing system to allow physicians in urban areas to see patients and provide consultation services to patients in rural remote areas without them leaving their community. It also allows health care providers, patients, and the public to participate in continuing education and health information programs.

HISC’s infrastructure delivers cost-effective information technology solutions such as a common integrated clinical system (ICS) solution for mid-sized health regions in the province. Saskatchewan is working very closely with Canada Health Infoway on electronic health record (EHR) developments and HISC is also implementing innovative technologies to support new provincial Action Plan initiatives such as the Saskatchewan Surgical Care Network and the province’s Health Quality Council.

Privacy protection and information security are key considerations in all developments. In 2003, Saskatchewan Health has implemented new legislation, The Health Information Protection Act (HIPA), to provide the appropriate legislative and policy framework to ensure personal health information is appropriately safeguarded.

Saskatchewan is working very closely with other provinces to coordinate information technology developments in order to avoid duplication of effort and ensure that common IT standards are adopted to facilitate system inter-operability. For example, Saskatchewan has partnered with the other western provinces in a joint project to develop a Provider Registry system, with support from Canada Health Infoway, to enable health care providers to be consistently identified across systems at a regional, provincial and inter-provincial level.

We are participating with Manitoba, Alberta and British Columbia on the Western Health Information Collaborative (WHIC) Chronic Disease Management project to jointly develop and pilot the implementation of common data standards and electronic messages to facilitate
the delivery of care to chronic disease patients by existing regional diabetes and primary health care teams.

- In 2005, Saskatchewan began to implement the first EHR solution, the Pharmaceutical Information Program, which allows clinicians to view complete patient drug profiles thus improving patient safety. Work also continues on a number of other new sector-wide EHR developments such as Lab Results reporting and Diagnostic Imaging systems. In 2006, new technologies for Primary Health Care supporting team based methods of delivery will be introduced as well as a new Surgical Information System, which supports the Action Plan challenge to reduce wait times for surgical procedures.

**Manitoba**

- A privacy impact assessment tool is now in use.
- Government, regional and university stakeholders continue to work together toward a coordinated approach to the development of health information management, reporting, analysis and research capabilities.
- Business case process approach has been established for ICT related initiatives.

**Health Information Standards Council of Manitoba**

- Responsible for identification, development and dissemination of health information and technology standards and guidelines in order to promote the effective use of information and the protection of privacy.
- Formal liaison/networking relationships with the health provincial standards bodies and other standards related entities at the local, national and international level.

**Federal/Provincial/Territorial Collaboration**

- Active participant in Infoway’s EHR Standards Collaboration Process, with representation on the EHR Standards Steering Committee, EHR Standards Advisory Committee and the pan-Canadian Standards Groups, specifically and at this time Client Registry, Provider Registry, Digital Imaging.
- Active participant and/or contributor to other health information standards related activities including HL7 Canada, CIHI’s Partnership for Health Information Standards, and the International Organizational for Standards Health Informatics and Harmonization Working Groups.
- Active participant in the Western Health Information Collaborative (WHIC) where participation on collaborative projects provide opportunities for further development of a personal electronic health record.
- Active participant in the Canadian Integrated Public Health Surveillance (CIPHS) project that is part of the Network for Health Surveillance in Canada, now incorporated as part of the Canada Health Infoway (CHII) mandate.
• Active participant in many Canada Health Infoway initiatives, in particular standards development, architecture blueprint refinement, and specific CHII investment initiatives.

**ICT Strategy & Enterprise Architecture Project**

• A project is underway to develop an ICT Strategy & Enterprise Architecture for Healthcare in Manitoba. Deliverables will be:
  
• An Enterprise Architecture to ensure a common, coherent Target State for all ICT initiatives
• A 5 year ICT Roadmap showing initiatives with high level scope, benefits, dependencies and timeframes for each project
• A sustainable, continuous process to maintain the Enterprise Architecture and, review and amend the 5 Year Roadmap on an annual basis.

**Ontario**

**Managing Wait Times Information**

A significant amount of progress has been made on developing the Wait Time Information System (WTIS) and Enterprise Master Patient Index (EMPI).

The EMPI – or Client Registry – will significantly advance the integration of services by enabling the flow of patient information across organizational silos. The WTIS will provide near real-time access information and alerts when wait time priority targets are being compromised at the physician, hospital, Local Health Integration Network (LHIN) and provincial levels. Furthermore, information will be used to monitor progress made in reducing wait times at these levels and identify where improvements must be made.

Phase 1 of the WTIS and EMPI, implemented by March 31, 2006 at five hospitals: Grand River Hospital, Hamilton Health Sciences Centre, St. Joseph’s Hamilton, Southlake Regional Health Care, and University Health Network. Phase I captures about 18% of the incremental wait time cases in Ontario, and engages over 300 surgical offices that use the WTIS and the patient priority ratings developed by the clinical expert panels.

In Phase 2 (April-December 2006), 50 additional hospitals will implement the provincial system, accounting for about 80% of all wait time funded cases. Hospitals will be divided into five or more groups with implementation efforts targeted at each successive group by December 2006.

The Wait Time Strategy’s information management and technology efforts have also been expanded to support other major access to care initiatives. For example, the University Health Network is leading the development of a provincial Critical Care Performance Measurement System as part of Ontario’s Critical Care Strategy. Performance data, which is being collected through an interim process, will be available in August 2006.

The process of implementing the provincial WTIS is having a number of unintended positive benefits. For example, many surgical offices did not have computers or basic internet access. The
Smart Systems for Health Agency’s connectivity program has now connected surgeons to the internet. This will support the implementation of the WTIS and enable other electronic health initiatives ranging from simple email communication between providers to supporting physician portals into hospital and other information systems.

Managing Health System Information

The province’s Information Management Strategy aims to address the system-wide need for better information in sectors like acute care and community health. It supports major government initiatives, such as the Wait Times Strategy, the e-Health Strategy, and the establishment of 14 Local Health Integration Networks. The strategy lays out a systematic approach for addressing data quality and integration issues. The end goal is not only better quality data, but a more organized, efficient, and ultimately, more sustainable way of managing health system information. Partnerships with health care providers and organizations across the system that are involved in data collection, reporting and storing, have been key to the success of the strategy.

Initiatives that are underway are focused on improving data quality and management, closing information gaps and reducing the burden of data collection on health care providers.

Some of the results achieved so far include the following:

- In June 2005, three metric tonnes of paper were eliminated, and 20,000 person hours were freed up in Ontario’s CCACs, so that the focus can be on the management of care instead of on the production of paper.
- In December 2005, 14 local data management partnerships, made up of health information management officials from hospitals and the community care sector were put in place. They will work together, and with their Local Health Integration Networks, to identify best practices, standards, tools, and policies for better data quality and management.
- In April 2006, the Ministry announced that some Ontario hospitals were no longer mandated to collect and report nursing workload measurement data. Workload measurement data is currently collected by nurses in hospitals across the province, and is used for planning, budgeting and research purposes. Over the years, numerous concerns have been raised with respect to the validity and reliability of this type of data, drawing into question its utility as a measure of nursing productivity, and for cost allocation methodologies.

In the latter part of 2006, as part of the focus on closing information gaps, the ministry will be implementing the Health Outcomes for Better Information and Care (HOBIC) initiative. This initiative will involve the province-wide, standardized collection of patient health outcomes reflective of nursing and other health care disciplines. Implementation is planned to occur in phases, from 2006 to 2009. Collection of information about patient outcomes reflective of the nursing discipline will begin in various sites in acute care, complex continuing care, long-term care and home care. It will subsequently be expanded to additional disciplines (e.g., pharmacy, occupational therapy, physiotherapy) and additional sectors (e.g., rehabilitation, primary care, mental health and public health) across the province. Work is also underway to identify staffing and quality of work life indicators to link with and explain these health outcomes.
Strengthening Health System Information Management for System Stewardship

Good, solid facts about the health of populations, the utilization of services and the allocation of health care dollars will provide the evidence that is needed for health system and local health system planning, decision-making, measurement and reporting activities.

As part of its new role as health system steward, the Ministry of Health and Long-Term Care is putting in place a permanent structure that will be dedicated to managing this critical resource. In 2006, the ministry will be actively working to consolidate its information sources.

Ontario’s e-Health Strategy

To ensure that people in Ontario are benefiting as much as possible from e-Health, the Ontario government is renewing the provincial e-Health strategy.

Ontario’s renewed e-Health strategy will help ensure that the focus is on improving the delivery and management of care in Ontario.

The benefits of e-Health include:

- Providing Ontarians with timely, safe, quality care, and access to their own information and health knowledge to help them manage their own health and health care
- Helping clinical professionals to be well-informed, patient-focused and productive
- Enabling institutions to be more efficient, accountable and focused
- Ensuring managers/planners have the information to support integration, measurement and continuous improvement

The Smart Systems for Health Agency (SSHA) in Ontario was initially established to provide the e-Health technology infrastructure. SSHA is currently delivering the following services in accordance with the e-Health Strategy priorities:

- Secure Hosting
- Network Services
- Portal Services
- Secure Email
- Registration Services
- Contact Centre
- Privacy and Security Training
- Electronic Health Record
- Other critical health care applications
Ontario’s Current e-Health Priorities

Infrastructure

Smart Systems for Health Agency Network Connectivity and Communications

A single electronic network will link all authorized health care providers and allow them to share information within multi-disciplinary primary health care teams, among providers within LHINs and across the health system, and supports Ontario’s telehealth program as well as Cancer Care Ontario, Air Ambulance and the electronic Child Health Network (eCHN). As of March 2006, 100% of all hospitals, CCACs, LHINs and Public Health Units have been connected. In addition, 4% of physicians and 56% of long-term-care homes (currently 56%) were connected.

Smart Systems for Health Agency Secure E-Mail for Health

The Secure Email for Health (SEH) initiative will roll-out email to all health care providers. Where organizations or institutions have an existing email system – and certain criteria are met - an existing system may be integrated with SSHA's system, with directory synchronization. Where there is not an existing email system, or where the existing system is to be replaced, SSHA's SEH will be implemented. As of March 2006, secure e-Mail is being used by all CCACs.

Client Registry/EMPI

Client Registry and an Enterprise Master Patient Index (EMPI) is a cornerstone to the Electronic Health Record (EHR) in Ontario and is fundamental to e-Health services initiatives.

The Client Registry/EMPI is being introduced in 2006 by the Wait Time Information Strategy to support the roll-out of the wait time management system that will, in due course, be rolled out to all health providers

Provider Registry, Identity and Access Management

SSHA’s Registration Management Services (RMS) will:

- provide identity and access management services for all clients using SSHA’s infrastructure
- federate with the identity and access management services of designated institutions in Ontario’s healthcare environment

Business Initiatives

Public Health I&IT Strategy

The Public Health I&IT Strategy provides for the renewal of Public Health I&IT through targeted initiatives in the realm of e-Health Strategy including Communications Tools, Public Health Surveillance solutions, Standards and Architecture, and Transition Support.
Current e-Health initiatives for Public Health I&IT include:

- Integrated Public Health Information System (iPHIS): A communicable disease management and reporting system deployed in all 36 Public Health Units and the Public Health Division

- Public Health I&IT (PHIIT) Communications Portals: Two portals available (one for Public Health professionals and the other for members of the broader health sector), collaboration tools and a publication facility for publishing Important Health Notices

- Integrated Information System for Inspection Activities

- Immunization Information Management

**Drug Information System**

Medication errors will be reduced through electronic prescribing, access to prescription history and drug interaction systems that alert prescribers to potentially dangerous interactions. The Drug Information System is currently comprised of one initiative – Emergency Department (ED) Access to Ontario Drug Benefit Drug History. This access is provided through a drug profile viewer which was deployed to 69 hospitals as of March 31, 2006.

**Ontario Laboratories Information System & Hospital Interface**

OLIS is an integrated province-wide system for the secure electronic exchange of laboratory information among authorized practitioners, laboratories and the MOHLTC.

OLIS will link labs with health providers, ensuring more timely results and helping to reduce the incidence of unnecessary duplicate testing.

As of March 31, 2006, OLIS clinical services (electronic ordering of lab tests and retrieval of results) was available to the early adopters.

**Physician IT Program**

The ePhysician Project was a partnership between the MOHLTC and the Ontario Medical Association (OMA) that developed a comprehensive IT solution for physicians, including office technology and applications for electronic medical records, plus support services. In March 2004 management of ongoing delivery of the Physician IT Program transitioned to the Ontario Medical Association.

A physician portal was launched in August 2005 and, as of March 2006, had 1700 registrants. In addition, over 640 physicians have been engaged by the Transition Support Group – specialists in the field who assist physicians and their staff to improve their medical practice through the use of information technology.

**Continuing Care I&IT Initiatives**

A standardized technology infrastructure has been implemented across the province’s CCACs.
Current e-Health initiatives for the Continuing Care sector include:

- **e-Referrals & Access Tracking**
- **Standardized Common Assessment**
  - Long-Term Care Homes - Resident Assessment: As of March 2006, in use at 15% of Long-Term Care Homes
  - Community - Adult Long Stay Client Assessment: As of March 2006, in use at 100% of CCACs
  - Common Intake Assessment Tool: System completed as of March 2006
- **Business Systems (MIS)**
  - Financial & Statistical Management System

**Telemedicine**

Telemedicine is a service delivery channel that utilizes video and telecommunications technologies for:

- Clinical services (approximately 75% of current services in Ontario): Consists of patient:provider and provider:provider consultation using two-way teleconferencing and electronic medical devices such as digital stethoscopes, exam cameras, endoscopic exam cameras and digital radiography; transmission can be either in real-time or store-and-forward format for later assessment.
- Information Dissemination and Education (approximately 25% of current services in Ontario): Consists of using multi-point video-conferencing and web-casting and can support crisis management, as well as distance education.

**Wait Times Information Management System**

Development of the overall framework and requirements for Ontario’s wait time information system, including:

- reporting wait times on a local, provincial, and eventually LHIN basis;
- implementation of consistent methods for prioritizing patients in the five key service areas, using standardized prioritization tools and technology.

**Diagnostic Imaging Strategy**

Ontario has developed a Diagnostic Imaging (DI) / Picture Archiving and Communications System (PACS) strategy for Ontario. Future steps regarding this strategy will be evaluated as part of the e-Health Strategy renewal process.

**LHIN e-Health Planning Framework**

Local Health Integration Networks (LHIN) have a mandate to plan, coordinate, integrate and fund the delivery of health care services at the community level within their defined geographic regions. The Ministry of Health and Long-Term Care has developed a LHIN e-Health Planning
Framework to guide the LHINs in developing e-Health plans for the sharing of health information.

Quebec

La création ou le renouvellement des comités consultatifs

Plusieurs comités ont poursuivi leurs travaux, notamment:

- le Comité national permanent sur la sécurité et la protection des renseignements personnels, au chapitre de la sécurité et de la protection de ces derniers;
- le Comité de coordination et de concertation des ressources informationnelles. Ce Comité, mis en place en mars 2002, constitue un mécanisme de coordination et de concertation interrégionale MSSS-Sogique pour actualiser la mise en œuvre des priorités ministérielles en ressources informationnelles;
- le Comité aviseur des ressources informationnelles du réseau sociosanitaire. Ce Comité regroupe des représentants d’associations professionnelles, d’associations d’établissements et d’autres organisations spécialement concernées par le sujet;
- le Comité exécutif des ressources informationnelles. Ce Comité, sous la responsabilité de la sous-ministre adjointe à la Direction générale de la planification stratégique, de l’évaluation et de la gestion de l’information au MSSS, regroupe les représentants des principaux acteurs publics impliqués dans la réalisation du plan d’informatisation;
- le Comité de gestion du Fonds d’investissement pour l’informatisation des réseaux locaux de service (RLS).

D’autres comités ont été créés, notamment :

- le Comité Québec – ICIS, réunissant des représentants du MSSS et de l’Institut canadien d’information sur la santé ;
- Le Comité sur l’optimisation des ressources informationnelles. Ce Comité regroupe des représentants du MSSS, de la RAMQ, de la SOGIQUE et des agences. La démarche d’optimisation a pour but d’améliorer l’efficacité des infrastructures matérielles et logicielles, d’accroître la robustesse et la disponibilité des infrastructures et de dégager des bénéfices quantifiables à court et moyen terme.

Par ailleurs, la composition et le mandat du Comité sur la normalisation ont été adoptés et on y a désigné des représentants d’agences, en fonction de volets spécifiques : la sécurité, les systèmes cliniques, l’informatique et la réseautique, ainsi que l’aspect financier.

On a également procédé à la création d’un Forum pour favoriser l’application de la méthodologie ITIL (Information technology infra-structure library).

Les activités

Le projet de loi n° 83 adopté par l’Assemblée nationale du Québec le 25 novembre 2005 envisage des dispositions législatives modifiant les règles sur la circulation de l’information sur
la santé et prévoit notamment la création de services régionaux de conservation. Des travaux sont en cours afin d’assurer la mise en œuvre de ces services.

D’autres activités ont été mises en place ou se poursuivent, notamment:

- l’adoption par le Conseil des ministres, le 22 mars 2006, d’un mémoire portant sur la gouvernance et le financement du plan d’informatisation du réseau de la santé et des services sociaux;
- l’adoption des travaux de mise en place d’une architecture d’ensemble pour les ressources informationnelles du secteur sociosanitaire;
- l’approbation du Plan intégré des ressources informationnelles en santé publique (PIRISP);
- la préparation par les agences de santé et de services sociaux des plans stratégiques d’informatisation arrimés aux projets cliniques régionaux et au plan d’informatisation du réseau;
- la préparation avec Inforoute Santé Canada (ISC) d’une douzaine d’ententes de collaboration;
- la définition d’une grille des projets ministériels prioritaires impliquant une collaboration avec l’Institut canadien d’information sur la santé (ICIS);
- la poursuite de l’évaluation d’alternatives d’évolution du Réseau de télécommunication sociosanitaire (RTSS) et le rehaussement du service de visioconférence;
- une évolution d’Info-santé, à la suite des orientations ministérielles, au sujet de la centralisation des services dans des centres régionaux, une mise à niveau en ce qui a trait à la téléphonie et à l’application informatique, l’ajout des services Info-social et Info-médicaments et la standardisation de certains outils cliniques ;
- la sélection et le financement de projets par le fonds d’investissement partagé (MSSS-réseau) pour l’informatisation des réseaux locaux de services (RLS);
- la poursuite des travaux de mise en vigueur du Cadre global de gestion des actifs informationnels portant sur la sécurité relevant des organismes du réseau de la santé et des services sociaux (RSSS).

**Les systèmes**

On note à ce chapitre :

- la mise en place de l’infrastructure technologique requise pour le déploiement d’un index patient maître;
- la préparation de l’implantation des classifications CIM-10-CA (Classification internationale des maladies, version 10, Canada) et CCI (Classification canadienne des interventions) pour le système d’information Med-Écho;
- l’acquisition d’une application informatique pour l’intégration d’un volet Santé-Société-Mieux-être au portail gouvernemental;
- le développement des systèmes d’information en lien avec la pandémie d’influenza.
Un aperçu des principaux projets à venir

Les travaux se poursuivent en collaboration avec l’ISC sur les projets suivants:

- le dossier de santé électronique interopérable du Québec;
- les systèmes relatifs aux médicaments, à l’imagerie diagnostique et aux laboratoires;
- le répertoire des intervenants et le répertoire des usagers;
- la télésanté;
- la santé publique.

Un appel d’offre a été lancé pour l’acquisition de services électroniques regroupés sous l’appellation de Couche d’accès à l’information de santé (CAIS).

Il y a eu appel d’offre pour le choix d’un outil d’évaluation de la clientèle. Cet outil est un des éléments du système d’information du Réseau de services intégrés aux personnes âgées.

Establishment and renewal of advisory committees

Several committees have continued their work, including:

- The Comité national permanent sur la sécurité et la protection des renseignements personnels, which focuses on the security and protection of personal information;
- The Comité de coordination et de concertation des ressources informationnelles. This committee, established in March 2002, constitutes an MSSS-Sogique inter-regional coordination and cooperation mechanism for implementing the Ministry’s information resource priorities;
- The Comité aviseur des ressources informationnelles du réseau sociosanitaire. This committee brings together representatives of professional associations, establishment associations, and other organizations heavily involved in the information sector;
- The Comité exécutif des ressources informationnelles. This committee, which reports to the ministère de la Santé et des Services sociaux through the sous-ministre adjointe à la Direction générale de la planification stratégique, de l’évaluation et de la gestion de l’information, is comprised of representatives of the main public players involved in implementing the computerization plan;
- The Comité de gestion du Fonds d’investissement pour l’informatisation des réseaux locaux de service (RLS).

Other committees have been created, namely:

- The Quebec-CIHI Committee, comprised of MSSS and Canadian Institute for Health Information representatives;
- The Comité sur l’optimisation des ressources informationnelles. This committee brings together MSSS, RAMQ, SOGIQUE and agency representatives. The goal of the optimization process is to improve the effectiveness of hardware and software infrastructure, to increase the robustness and availability of the infrastructure, and to generate quantifiable short- and long-
In addition, the makeup and the mandate of the Comité sur la normalisation were determined, and its agency representatives were selected based on specific fields: security, clinical systems, computing and networking, and the financial aspect.

A forum promoting application of the ITIL methodology (Information technology infra-structure library) was also created.

**Activities**

Bill 83, adopted by the Assemblée nationale du Québec on November 25, 2005, contained legislative measures that modified the rules governing the sharing of health information and made provision for the creation of regional information retention services. Work is underway to implement these services.

Other activities were performed or are ongoing, namely:

- Adoption by the Conseil des ministres on March 22, 2006 of a report on governance and the funding of the health and social services system computerization plan;
- Adoption of work to establish an overall architecture for information resources in the health and social services sector;
- Approval of the Plan intégré des ressources informationnelles en santé publique (PIRISP);
- Development by health and social service agencies of strategic information technology plans that dovetail with regional clinical projects and the system information technology plan;
- Development with the Canada Health Infoway (CHI) of 12 collaborative agreements;
- Identification of a series of priority ministry projects involving cooperation with the Canadian Institute for Health Information (CIHI);
- Ongoing evaluation of development alternatives for the Réseau de télécommunication sociosanitaire (RTSS) and enhancement of the videoconferencing service;
- Development of the Info-santé program, based on ministerial guidelines, with respect to the centralization of services in regional centres, telephone services, IT solutions and software upgrades, the addition of Info-social (social service) and Info-médicaments (medication) services, and the standardization of some clinical tools;
- Selection and funding of projects by the fonds d’investissement partagé (MSSS-system) for the computerization of the réseaux locaux de services (RLS);
- Ongoing work to implement the Cadre global de gestion des actifs informationnels, which addresses information security within health and social service agencies.

**Systems**

Of note in this area:

- Implementation of the technology infrastructure required to deploy a master patient index;
• Preparation of implementation of the ICD-10-CA (International Classification of Diseases, version 10, Canada) and CCI (Canadian Classification of Interventions) classifications for the Med-Echo information system;
• Acquisition of an IT application required to integrate a Santé-Société-Mieux-être component into the government portal;
• Development of influenza pandemic information systems.

**Overview of major upcoming projects**

Work with the Health Infoway is continuing on the following projects:
• Quebec interoperable electronic health record;
• Systems related to pharmaceuticals, diagnostic imaging and laboratories;
• Health professional directory and user directory;
• Tele-health;
• Public health.

A call for tenders was issued to acquire combined e-services, known as the *Couche d’accès à l’information de santé* (CAIS).

A call for tenders was issued to select a client evaluation tool. This tool is one of the elements in the information system supporting the *Réseau de services intégrés aux personnes âgées*.

**New Brunswick**

• New Brunswick continues to collect health information to support service planning and analysis, report to New Brunswickers, and fulfill intergovernmental commitments. New Brunswick issues an annual Health Care Report Card and a biannual report on comparable health and health system performance indicators.

• Health information is periodically collected and released in issue-specific areas – recent reports include the *Research Project of Deaths by Suicide in New Brunswick between April 2002 and May 2003*, and the *External Review of New Brunswick Cardiac Services*.

**Nova Scotia**

In 2005, the Nova Scotia Minister of Health established the Wait Time Advisory Committee to oversee the province-wide collection and reporting of standardized wait time information and to offer advice on how to address bottlenecks in the system to shorten wait times. The Wait Time Advisory Committee is building on the work of the previous Wait Time Monitoring Steering Committee, which completed its work in 2004.

*The Nova Scotia Hospital Information System*
(NshIS) continues to be implemented across the province in District Health Authorities 1 - 8. The implementation is on target for completion in all 34 hospitals in these districts by March 31, 2006.

**Picture Archiving and Communications System**

PACS is a high-speed, graphical computer system that stores, retrieves and displays diagnostic images (such as MRI, CT scans, ultrasounds and X-rays). Enabled by Nova Scotia’s high-speed, provincial health data network, PACS can provide authorized health care providers with real-time access to diagnostic imaging reports and images across the province.

The Department in cooperation with DHAs 1 to 9 and the IWK, and with support from Canada Health Infoway, is enhancing and expanding the current provincial PACS environment including the capability to store images centrally in a provincial Diagnostic Image Archive. The planning phase is complete and implementation began April 1, 2005. The expected completion date is September 2006.

Client and Provider registries are foundation components of the Electronic Health Record. The detailed Planning Phase for Client Registry started in December 2004 with completion in fall 2005. NS is currently participating in a study with Health Infostructure Atlantic (HIA) to identify Provider Registry collaboration options.

**Health Infostructure Atlantic**

The Secretariat Office has been in operation since May 2003 with approval from the Atlantic Premiers to continue operations until 2006 with the opportunity for a possible extension. The Secretariat, located in Halifax, has a mandate to coordinate and manage common health systems opportunities in Atlantic Canada. HIA is working on:

- Atlantic Diagnostic Imaging A6 (any report, any image, anytime, anywhere, any patient, in any Atlantic Province) Integration Strategy. The project will be completed between March and September 2005.
- Atlantic Provider Registry Business Case. The tentative timeline for completion of the Business Case is October 2005.
- Exploration of collaborative Atlantic opportunities with Infoway in the areas of Telehealth and Public Health Communicable Disease Surveillance and Management Systems.

**The Nova Scotia Telehealth Network (NSTHN)**

NSTHN is a video conferencing communications network, which provides services to 46 healthcare facilities in Nova Scotia. The NSTHN was Canada’s first province-wide Telehealth network. It works in collaboration with a number of partners including the District Health Authorities (DHAs) and the IWK Health Centre to provide health care services closer to home for patients and their families. One of the greatest benefits of the network is improving patient access to health care services close to their home. The network also provides health professionals from across Nova Scotia with access to educational opportunities in their own communities.
In 2005-2006, the Department of Health will be engaging its key stakeholders in the development of a road map for action to increase the utilization of Telehealth technologies to deliver health care services. This planning will involve identifying actions to increase utilization of the current hospital-based Telehealth network and identifying actions required to facilitate access to Telehealth technologies in home, long-term care, and other community settings. In addition, the particular needs of francophone communities and First Nations communities for access to Telehealth services will be examined.

**Primary Health Care Information System**

On March 17, 2005, the Department announced the vendor solutions and implementation phase for its Clinical and Practice Management Systems as part of Nova Scotia’s Primary Health Care Transition funding. A key goal of this project is to increase the use of electronic patient records by primary health care organizations in the province. The Clinical and Practice Management Systems are important components of an electronic patient record.

The preferred vendor solutions are software packages that will allow primary health care providers to record their patient records electronically. This will improve integration, access, quality of care, and the security and privacy of primary health care information. The new systems will provide the capability for linkages to laboratory results, diagnostic imaging records, and hospital discharge summaries all within the electronic media. These linkages will be integrated to the new systems through the Interoperability Initiative.

District Health Authorities will receive funding until September 2006 to cover transition costs of primary health care organizations implementing electronic patient record systems through the Health Canada’s Primary Health Care Transition Fund. The Primary Health Care Information System Program (PHCISP) will begin installation for qualifying clinic sites during Spring of 2005 and plans to have as many as 150 primary health care providers using the new systems by September 2006.

**Privacy**

The Department of Health is working in several key areas to protect the privacy of personal health information and ensure appropriate access to the information to support the provision of health care, research and planning. This work includes:

- Development and implementation of privacy standards for the Nova Scotia Hospital
- Information System and other health information systems
- Implementation of a Privacy Impact Assessment policy for Department of Health programs, services or systems that require personal information
- Stakeholder consultation for a health information privacy framework
- Leading the District Health Authorities and the Department of Health’s Provincial Programs in the development of privacy guidelines and best practices.
Prince Edward Island

**PEI Health Technology**

- The Health System has a standard province-wide approach to health information technology implementation with the development of a provincial information technology infrastructure, the Island Health Information System (IHIS). IHIS is a fully integrated information resource supporting the delivery of health services in Prince Edward Island.

- IHIS is the provincial health separate and secure broadband wide area network that connects all health sites with systems such as email, Office Automation, Payroll, Financials, Human Resource, Medical Records Abstracting, Vital Statistics, etc.

- All physicians are connected and transmit electronic claims on a Physician Payment System. This is accomplished with the assistance of a virtual private network and a PKI security solution.

- All private pharmacies are connected through ISDN lines for submission of claims for government funded drug programs. It is anticipated that by the end of FY06/07 this will be enhanced to include all drugs for all PEI residents.

- There is a state of the art provincial health data centre.

The following activities and projects were completed in the last three year period and support the development of IHIS as a robust information resource:

- A Radiology Information System and associated Picture Archive and Communication System (PACS) were implemented province-wide, the first in Canada. This new technology enables X-rays to be electronically captured and distributed between all acute care facilities in PEI, physician offices, emergency rooms and out-of-province facilities. These initiatives are supported by several partnerships, including those with the Queen Elizabeth Hospital Foundation, the Prince County Hospital Foundation, and Health Canada.

- A Common Client Registry (CCR) was implemented. This was based upon data standards that were developed through a collaborative effort with Health Infrastructure Atlantic (HIA) and the Canadian Institute for Health Information (CIHI) with funding from Canada Health Info structure Partnership Program (CHIPP). The application uses HL7 for its messaging and offers a sound foundational component for the provinces development of an Electronic Health Record.

- A Children's Dental system was implemented. This provides detail information on all dental services provided through the provincial children's dental program. This program makes dental services available to all PEI children from ages 3 - 16.

- The Health Financial System Upgrade was completed. The PEI Health System has Oracle Financials for its financial information system. This was a very large project that migrated the financials from version 10.7 to version 11i.

- The Integrated Services Management system (ISM) was completed in 2004 establishing standardized case management technology to all community-based health within the PEI health system including home care, addictions, mental health, dental, public health nursing,
nutrition services, speech, and audiology. A reporting approach based upon Crystal has been established to enable roll up of standardized provincial statistics in these program areas.

- Implementation of Virtual Interactive Tele-health Assistance Link (VITAL) with New Brunswick to provide cardiac surgery follow-up for Saint John Hospital patients allows a more cost effective and convenient mode of follow-up treatment.

The following major projects & consultations are proposed or ongoing:

- A detailed electronic health record plan is in development to define key components, integration requirements, and viewing features;
- Work on developing a Clinical Information System (CIS) including laboratory, surgery, emergency, pharmacy, ADE, order entry/results reporting, blood bank, admission/discharge/transfer, scheduling, charting, and medical records as part of a provincially integrated system to all hospitals is on-going;
- The Pharmacy Network project will create a database containing prescription information collected from both physicians and retail pharmacies for all individuals receiving prescriptions within PEI. It will involve modifying the existing system and the retail Pharmacy systems to capture the required information. It will also add PIN functionality so that an individual may provide authorization to allow access to their prescription information. The system will be accessed by all retail and institutional pharmacy sites, emergency departments and physician sites;
- The upgrade of the PeopleSoft Human Resource Management System, which includes upgrades to the health payroll system, commenced in January 2006. PeopleSoft HRMS supports all human resource management processes including personnel administration, position management, recruitment, training administration, health and safety, and labour relations. This upgrade will enable the organization to ensure that the system continues to be supported by the vendor as well as provide the opportunity to take advantage of the new processes delivered.
- The Information Management Plan project aims to create an Information Management Plan that will develop a vision for Information Management for the Health System, make recommendations on the need for people, processes and tools required for Information Management in the Health System, and set priorities and gain approval for a plan for addressing these recommendations;
- It is anticipated that the integration of the RIS/PACS, CIS, ISM & CCR systems combined with web viewing functionality will form the basis of the first provincially integrated and functional EHR in Canada;
- Development and implementation of a health surveillance information system in collaboration with Health Canada is on-going;
- Review and redesign of the Wide area network architecture to accommodate remote access and web-enabled transaction traffic continues;
- Consultation and project negotiation with Canada Health Infoway to further Electronic Health Record, Health Surveillance and Telehealth activities continues;
• Collaboration with Health Infostructure Atlantic to identify partnering opportunities and further the development of an Electronic Health Record within Atlantic Canada continues.

Newfoundland and Labrador

Based on the recommendations of the Provincial Task Force on Health Information, the Department of Health and Community Services (DOHCS) has developed a seven-phase strategic health information plan to develop a comprehensive database responsive to the needs of the health system. The Newfoundland and Labrador Centre for Health Information (NLCHI) was established in 1996.

• NLCHI is developing the Health Information Network that will allow for compatible health information systems to be integrated into comprehensive province-wide electronic health record (EHR). The first component built specifically as part of the provincial Regional Electronic Health Record (REHR) is the Unique Personal Identifier/Client Registry, a registry of demographic information which was implemented in fall 2002.

• NLCHI has begun the implementation of the provincial Diagnostic Imaging/Picture Archiving and Communications System. This information system will facilitate the sharing of images and reports among the Regional Integrated Health Authorities (RIHA).

• NLCHI will begin implementation in May 2006 of the provincial drug information system the Newfoundland and Labrador Pharmacy Network. This information system will unite pharmacies, hospitals, and physicians and allow for the creation of prescription medication profiles.

The province has implemented Meditech software in all RIHA facilities that provide acute and long-term care services. This software provides administrative and clinical support for the RIHA.

The province has developed a province-wide Client and Referral Management System (CRMS) for use in all RIHA in the provision of community-based services. This supports programs such as public health nursing, continuing care, child, youth and family/rehabilitative services. A new CRMS module to manage payments to clients is currently being developed.

Health Technology / Technologies de la Santé

Health Canada

Canada Health Infoway

The Canada Health Infoway is an independent, not-for-profit corporation working in collaboration with provinces, territories and other stakeholders to accelerate the development and adoption of electronic health records, telehealth and public health surveillance systems on a pan-Canadian basis. Infoway’s members are the federal/provincial/territorial Deputy Ministers of Health. Systems development and implementation, including part of the funding, is the responsibility of the provinces and territories, while Health Canada’s role is to ensure that
Infoway fulfills its obligations under the funding agreement. In 2005-2006, Health Canada continued to focus on addressing the privacy concerns of Canadians including e-health. The Department also plans to undertake an evaluation of Infoway’s overall performance in 2006.

**Santé Canada**

*Inforoute Santé du Canada*


**Northwest Territories**

See Health Information Section.

**Yukon Territory**

- Telehealth services (video conferencing and store and forward technology) is available in all but four communities. Plans are underway to offer these services to the remaining four communities. The main applications are mental health, therapy services, professional, patient and public health education, family visits, and X-ray support.

- Information technology applications have been implemented in Mental Health (Synapse), Yukon Communicable Disease Control (Tuberculosis module of iPHIS) and Community Nursing (iPHIS, immunization module), supported by funding from Primary Health Care Transition Fund.

- A new Client Registry and a Drug Information System is currently in the process of being developed.

**British Columbia**

*Telehealth*

- Telehealth helps to overcome barriers of geography, transportation infrastructure, or socio-economic disparity by using communications and information technology (such as video conferencing) to deliver health and health care services, information and education where participants are separated. It enables clinical consultation, continuing professional education,
health promotion and healthcare management to be delivered to rural and remote areas. Both broad and low bandwidth infrastructure and technology are used to provide services.

- Telehealth videoconferencing technology is now in place in more than 66 communities in B.C., encompassing nearly 125 dedicated sites in B.C.’s health care facilities, compared to 11 communities in 2001.

- Significant investments are being made across the province in diagnostic imaging systems. Seen as one of several key building blocks of the Electronic Health Record (EHR), diagnostic imaging is one area where the linkage and integration between telehealth and the EHR is very apparent. Transmission of live echocardiogram and ultrasound images for interpretation, along with store-and-forward transfer of digital images for review and assessment, are currently occurring in several health authorities.

- Hand-held devices, the Internet, and other technologies (including transfer of information over regular phone lines) are also being implemented where they provide practical solutions to identified needs. Telehealth services are currently available in approximately 20 clinical program areas. Oncology, mental health/psychiatry, maternal/fetal medicine, medical genetics, orthopedics, pharmacy, thoracic surgery, trauma, and wound care program areas are all applying telehealth technology to service delivery. Services for children are available in the areas of psychiatry, rehabilitation and development, eating disorders/nutrition, neonatology, cardiology, oncology, palliative care, physiotherapy, and speech therapy.

Alberta

See Health Information Section.

Saskatchewan

See Health Information section.

Manitoba

Public Health

- Manitoba Health previously implemented the Public Health Information System (iPHIS), as a seven-month pilot project which was completed in 2004.

- Since then, Canada Health Infoway has been promoting and supporting extensive planning and development of a Pan Canadian Public Health Surveillance System, which has resulted in the completion of detailed requirements definition and planning for the development of an integrated set of components for this system.

- Manitoba is beginning preliminary planning work to assess the implications of the more strategic Pan Canadian Health Surveillance System.
**Chronic Disease Management (CDM)**

- The three diseases selected for this initiative are diabetes, hypertension, and chronic kidney disease. Manitoba will be focusing on diabetes.
- The Western Health Information Collaborative (BC, AB, SK, MB) project team has completed the definition of the core data sets and information exchange messages.
- Manitoba has completed the detailed business and technical requirements for implementation in Manitoba. Two sites have been selected to implement and test the infrastructure. The BC CDM Web Application/Toolkit has been acquired and customized for use in Manitoba. Manitoba is currently working collaboratively with BC and Saskatchewan (also acquired the BC CDM Web Application) to incorporate the CDM core dataset and information exchange messages into the core application for use in all three jurisdictions.

**Hospital Information System Project (HISP)**

- The Hospital Information System Project involves the implementation of a patient-centric information system and will be a source for Electronic Health Record (EHR) clinical data.
- Functions include patient management, admissions, discharges, transfers and scheduling appointments and resources.
- Project scope includes teaching hospitals, community hospitals and long-term care facilities with the initial phases addressing the teaching hospitals.
- A contract was signed in June 2005 for the initial HISP implementation at St. Boniface General Hospital. This project formally commenced in September 2005.
- Manitoba is preparing to launch the next phase of HISP with a planning project focused on Community Hospitals and Long-Term Care facilities. This planning project is expected to begin in late May - early June 2006 and planned to be finished November 2006.
- The expected deliverables for this next project are an overall implementation strategy for HISP in community hospitals and long-term care facilities, as well as a detailed plan for the implementation of Tier 2 software solutions from Momentum Healthware in two regional health authorities - Interlake and Central.

**Client Registry/EMPI (Enterprise Master Patient Index)**

- Manitoba Health has completed the first of four implementation phases of its Provincial Client Registry project, with the financial support of Canada Health Infoway.
- The Provincial Client Registry will be used by Manitoba’s health care sector for identity management and for linking an individual’s identifiers and demographic information from disparate information systems.
- The Implementation Phase started in September 2005 and is planned to be completed by August, 2007. Up to 19 source systems will be connected to the Provincial Client Registry, including Manitoba Health’s Insurance Registry.
Provincial Radiology Information System and Picture Archiving and Communications Systems (RIS/PACS)

- Manitoba has completed its detailed planning for a province-wide RIS/PACS solution.
- The Winnipeg Regional Health Authority (WRHA) has selected a vendor, AGFA, and is working with them in preparation of rolling out the AGFA RIS to WRHA facilities. This region-wide RIS solution is an integral part of the provincial RIS/PACS vision.
- Brandon Regional Health Authority (BRHA) has an established RIS/PACS solution that will be leveraged to accommodate other parts of the province.
- Manitoba Health, WRHA, Diagnostic Services of Manitoba (DSM) and BRHA are working together with Canada Health Infoway to implement a Provincial PACS solution. A component of this project will also address the rural RIS requirements by leveraging existing RIS investments.

Provider Registry

- Original implementation was completed in March 2003.
- Subsequent releases implemented in April 2004 and December 2004.
- Current release implementation planned for May/June 2006.
- Several Provider Data Sources engaged to supply data to the Registry.

Integrated Electronic Health Record (iEHR)

- Manitoba is working with Canada Health Infoway to develop an iEHR Solution that is a combination of people, organizational entities, business and clinical processes, systems, technology and standards that interact and exchange clinical data to provide high quality and effective healthcare.
- Preliminary and detailed planning is underway and expected to proceed over the next 12 months.
- Key areas of focus include:
  - Clinical Data Repositories: Operational data stores that hold and manage clinical data collected from service encounters at the point of service locations.
  - Enterprise Application Integration: Tools and techniques that promote, enable and manage the exchange of information and distribution of business processes across multiple application systems.
  - Clinical Results Viewer: Client Application systems that allows authorized users to access and view patient/person EHR Data in an easily customizable manner.

Cadham Provincial Laboratory

- The objective of this project is to replace the existing laboratory information system (LIS) at Cadham Provincial Lab with a new system that meets current and future business needs.
• The new system must fit within the provincial Electronic Health Record Strategy and provincial lab strategies currently under development in Manitoba. Stakeholder engagement and the documentation of the business requirements are underway.

Primary Data Centre – WRHA

• The major outcome of this project is to acquire appropriate space to accommodate the needs of a new Primary Data Centre and to expand the Provincial Data Network (PDN) connectivity between Health Sciences Centre, St. Boniface General Hospital and the Primary Data Centre.

• Several in-flight projects are dependent on the outcomes of this project e.g. Health Information System Project (HISP), provincial Diagnostic Imaging/Picture Archive Communications System (DI/PACS) and Client Registry (CR).

• The result of this deliverable will be the delivery of healthcare information to users when and where they need it. This space will have the required environmental services to house new and current applications, and to support Electronic Health Record initiatives.

Selkirk Mental Health Centre (SMHC) - Redevelopment Project

• Manitoba Health is proceeding with implementation of a strategic initiative that will see the physical redevelopment of the Selkirk Mental Health Centre and formation of a provincial Acquired Brain Injury program. Construction is slated to be completed in October 2008.

• As part of the redevelopment activities, a detailed assessment of the information technology requirements for the new facilities and associated Extended Treatment and Rehabilitation and Acquired Brain Injury programs will be conducted.

• Preliminary planning is underway to conduct this assessment.

Ontario

In March 2003, a consultation process with representatives from Academic Health Science Centres (AHSCs) and other key Ontario technology assessment stakeholders supported the concept that a single portal of entry process be established for the coordinated uptake and diffusion of new health technologies with evidence of proven effectiveness in improving patient outcomes. A single portal of entry was believed to provide a more consistent, informed, decision-making process for improving equitable access to new health technologies. In response, the Ontario Health Technology Advisory Committee (OHTAC) was created in October 2003 with secretariat and methodological support from the Medical Advisory Secretariat (MAS) of the Ministry of Health and Long Term Care (MOHLTC).

OHTAC is the single portal for providing advice to the health care system, including the Ministry of Health and Long-Term Care (MOHLTC), regarding the uptake, diffusion and distribution for new health technologies and the removal of obsolete health technologies. OHTAC focuses on the effectiveness in improving patient outcomes of new and emerging health technologies that have a significant impact on the health care system. OHTAC does not examine or provide recommendations for pharmaceutical products or information systems, engage in
general disease management reviews but rather the integration of technologies related to specific diseases and conditions and does not infringe upon the important role of innovation through health research.

In February 2005, eighteen months after OHTAC was created, MAS commissioned a review of OHTAC and the MAS processes as part of its ongoing quality improvement initiative. The aim was to identify areas that required different or new processes and methodologies and consisted of a review of documentation and interviews with key informants. Professor Michael Drummond of the Centre for Health Economics, University of York (UK), conducted the review. In brief, he reported broad support for the rational approach to decision-making related to the adoption, diffusion and use of health technologies. He also commented that the Health Technology Assessment (HTA) Program in Ontario was excellent. Recommendations for improved effectiveness processes were made.

The December 2005 OECD report on "Health Technology and Decision Making” examined the MAS/OHTAC process and stated that “The Ontario model systematically incorporates evidence into decision making within the same health system that face similar concerns and patient needs. The Committee has created a process whereby local decision makers’ drive the agenda for HTA and at the same time improve the likelihood that HTA will actually be used. The policy in Ontario is intended to ensure that evidence is examined along the entire development cycle of the technology. It enables better use and dissemination of field evaluations of new (non-drug) technologies to provide needed evidence for decision making. It also enables an early assessment or evaluation of a technology that is based on the specific questions that decision makers have and is aligned to their needs”. The report also favourably examined the Ontario field evaluation of Positron Emission Tomography (PET).

The 2005 OECD report continues the OECDs 2004 interest in Ontario health technology assessment process. In their report of 2004, “Towards High Performance Health Systems”, the OECD stated “the committee (OHTAC) promotes the use of HTA in decision making by bridging the worlds of evidence and decision-making. Under this model, early assessments or evaluations of technology are based on the characteristics of the technology, the evidence available, and the needs of decision makers…The Ontario model is a systematic bottom-up method of incorporating evidence into decision making.”

Since October 2003, OHTAC has made recommendations to the Deputy Minister regarding 3523 health technologies. For more information please visit the MAS website http://www.health.gov.on.ca/english/providers/program/mas/mas_mn.html or the OHTAC website http://www.health.gov.on.ca/english/providers/program/mas/ohtac_about.html

**Health Technology Evaluation and Assessment Program**

The Health Technology Evaluation and Assessment Program (HTEAP) exists to:

- Provide advice to government on the uptake and diffusion of new health technologies based on scientific evidence of effectiveness.
- Ensure a coordinated approach to policy decision-making regarding the introduction of new health technologies and the retirement of obsolete technologies. Technologies examined by HTEAP include diagnostic services and treatment therapies, but exclude pharmaceuticals and information systems.
• Conduct evidence-based analyses of medical scientific research for promising health technologies and combines this with relevant Ontario specific economic, demographic, professional utilization and legal information, and ethical and social considerations to provide decision-makers with policy advice on the health benefits and resource implications of each technology.

MAS works with medical professional bodies, including the Cardiac Care Network, the Clinical Oncology Group of Cancer Care Ontario and the Physician Services Committee Guidelines and Diagnostics Committees, as well as academic research bodies including the Program for Assessment of Technology in Health (PATH) at McMaster University, the Institute for Clinical and Evaluative Sciences (ICES), the Program in Evidence Based Care at McMaster University and the Usability Laboratory at University Health Network. MAS also works closely with clinical experts in the province and engages expert panels from time to time to ensure that its analyses are consonant with practice patterns as appropriate.

MAS initiates field evaluations of promising new health technologies where there is insufficient evidence of effectiveness to warrant investment as an insured health service.

**The Health Technology Research and Evaluation Fund**

This was one-time funding entirely used for research purposes. Established in 2004/05 and running until 2006/07, this Fund:

• Supports third parties to facilitate the Medical Advisory Secretariat and MOHLTC in working closely with appropriate stakeholders and experts in Ontario to achieve the desired objectives.

• Permits the provincial government to obtain credible third party expertise for projects which require arm’s-length standing, particularly where technologies are being field-tested or evaluated or assessed for their cost effectiveness against existing technologies and the government’s credibility must be maintained.

• Consists of the following multi-year projects:
  
  o Positron Emission Tomography (PET) Registry Study for patients with single pulmonary nodule, marker positive thyroid cancer and germ cell cancers.
  
  o The University Health Network Usability Lab which studies the usability of medical devices in the clinical environment and provides information regarding the necessary skill sets and prior knowledge needed to successfully operate the device.
  
  o Development of utilization guidelines for health technologies through Health Technology Utilization Guidelines of Ontario (Health TUGO) based out of the Program for Evidence-Based Care at McMaster University.
  
  o Shared Senior Research Associate based out of McMaster University that brings economic evaluation, decision analytic modeling and budget impact analyses expertise to the MOHLTC.
  
  o Field evaluation study led by PATH, including ICES leadership, to investigate ways of decreasing symptom-to-intervention times for primary angioplasty and thrombolysis.
PET Colorectal Cancer randomized control trial to determine the survival benefit and cost-effectiveness of PET as an additional staging tool.

**Telemedicine in Ontario**

Telemedicine utilizes videoconferencing, telecommunications, and digital store-and-forward technologies to connect patients - particularly those in rural, northern and under-serviced communities to the wide variety of clinical services in Ontario. Ontario is a recognized leader in telemedicine with one of the largest networks of operational sites in North America.

There are three geographically based networks funded by the ministry. These delivery entities use the backbone network infrastructure provisioned by SSHA:

- CareConnect - Serving Eastern Ontario, based in Ottawa
- NORTH Network – Serving Northern and selected regions in the South, based in Toronto
- VideoCare – Serving Southwestern Ontario, based in London

In 2004/05, over 25,000 videoconference events were coordinated across the province, most of which were clinical events. Telemedicine service activity includes the delivery of clinical services involving over 70 subspecialties. Highest users are psychiatry, dermatology, pediatrics, and cardiology. Additional service activity includes telestroke, neurology, burn management, internal medicine, oncology, surgery, anesthesia, dietary encounters, physical medicine rehabilitation, geriatrics, pathology, etc. These clinical applications account for 75% of telemedicine usage in Ontario. The remaining 25% of service activity consists of education and training, consultations between health professionals, and administrative events.

Videoconferencing will be rolled out to Public Health Units across the province because it can play a critical role in preparation, early detection and management of epidemic disease crisis. During the SARS outbreak, a 39-site real-time videoconference for health care professionals was taped and subsequently posted on the internet for province-wide access to breaking news on the management of this crisis.

Satisfaction with telemedicine among patients and providers has consistently been evaluated at over 90%. Reasons for high satisfaction include reduced travel time and cost, decreased waiting times for services and the ease of use of medical peripherals such as high-resolution cameras, digital stethoscopes and otoscopes.

**Telehealth Ontario**

Telehealth Ontario is a free, province-wide, confidential telephone-based health service that offers consumers health advice and information from a registered nurse. Telehealth Ontario is available 24 hours a day, 7 days a week and no health card is necessary to receive the service. Telehealth Ontario nurses help direct callers to appropriate health care options - including taking care of themselves at home, going to their family doctor, going to their local emergency department, or contacting an appropriate community service.
Quebec

La Création ou le renouvellement des comités consultatifs

La table sectorielle télésanté réunissant les RUIS et le MSSS se réunit régulièrement. Dans chaque RUIS, une table télésanté a été créée et une équipe a été mise en place pour lui apporter son soutien.

Le MSSS a confié aux RUIS le mandat de développer les activités de télésanté sur leur territoire. Chacun des RUIS a élaboré un plan de développement des activités de télésanté en relation avec son territoire de desserte. Ces plans ont été déposés au MSSS.

Un aperçu desactivités et des systèmes principaux

Le MSSS a présenté huit projets de télésanté pour le cofinancement d’Inforoute Santé du Canada (ISC). Ces projets ont pour but principal de mettre en place des réseaux de consultation à distance, de téléformation, de télépathologie et de télesoins à domicile sur l’ensemble du territoire québécois. Ils visent la mise à jour du parc actuel d’équipement et son extension ainsi que la mise en place de nouveaux processus cliniques.

Mis à part ces projets d’envergure, plusieurs activités de télésanté sont en cours au Québec. Les domaines d’application sont multiples : téléconsultation par visioconférence dans de nombreuses spécialités médicales telles que la psychiatrie, la génétique, la médecine générale, la néphrologie et la réadaptation. D’autres applications plus spécifiques permettent des consultations et des diagnostics à distance, principalement en cardiologie pédiatrique, en téloorthophonie, en télépathologie, sans oublier la télésurveillance à domicile. Le réseau de visioconférence permet également la téléformation dans de nombreux établissements éloignés.

Le MSSS a également confié aux RUIS, par l’entremise de leur table télésanté, le mandat de gérer des projets de radiologie numérique et de stratégie d’archivage (projet PACS) pour l’ensemble de leur territoire. Ces projets sont en cours dans les quatre RUIS, en collaboration avec ISC. Ils rendront possible la téléradiologie, c’est-à-dire la lecture d’image à distance pour les régions dépourvues de radiologistes.

Le Québec participe également aux travaux pour la mise en place d’un outil de réservation informatisé pour les séances de télésanté. ISC coordonne les activités relatives à ce projet pancanadien.

Un aperçu des principaux projets à venir

Dans les prochains mois, la majorité des efforts seront mis sur la réalisation des projets de télésanté et d’imagerie diagnostique avec Inforoute Santé du Canada.

Creation or renewal of advisory committees

The tele-health sectoral group involving the RUISs and the MSSS is meeting regularly. Each RUIS has established a tele-health roundtable and related support team.
The MSSS has mandated the RUISs to develop tele-health activities within their territories. Each RUIS has devised a tele-health activity development plan tailored to the territory it serves. These plans have been submitted to the MSSS.

**Overview of main activities and systems**

The MSSS submitted eight tele-health projects for co-funding from the Canada Health Infoway (CHI). The primary goal of these projects was to set up networks across Quebec in the fields of remote consultation, tele-training, tele-pathology and tele-homecare. These would be designed to update and expand the current infrastructure and put new clinical processes in place.

In addition to these major projects, several other tele-health activities are underway in Quebec. One of the many fields involved is tele-consultation via videoconference; this is being applied in a number of medical specialties such as psychiatry, genetics, general practice, nephrology and rehabilitation. Other more specific applications allow remote consultations and diagnoses to take place, primarily in pediatric cardiology, tele-speech language pathology and tele-pathology, not to mention tele-home monitoring. The videoconferencing network also allows tele-training to take place in a number of remote establishments.

The MSSS has also mandated the RUISs, through their tele-health roundtable, to manage the digital radiology projects and archiving strategy (PACS project) throughout their territories. These projects, conducted jointly with Health Infoway, are underway in the four RUISs. They will allow tele-radiology to be performed, i.e. remote reading of images in regions that lack radiologists.

Quebec is also involved in work to establish a computerized reservation tool for tele-health sessions. Canada Health Infoway is coordinating the activities related to this Canada-wide project.

**Overview of major upcoming projects**

In coming months, most efforts will focus on completing tele-health and diagnostic imaging projects with the Canada Health Infoway.

**New Brunswick**

- Leadership for e-Health in New Brunswick comes from the Office of e-Health, a collaboration of the Department of Health and the eight Regional Health Authorities, with participation from the NB Medical Society and other key NB Government Departments. The Office of e-Health developed a comprehensive e-Health Strategy for New Brunswick which was approved in November 2005. This strategy identified five strategic directions:
  - **One Patient - One Record:** An ongoing health care record of medical status and care delivery history that is available to authorized health care providers and to the individual, at any time and from any location.
  - **Telehealth:** Bridging distances by bringing quality health services and information to patients who remain in or near their home communities.
Clinical Systems Suite: Full suite of clinical systems for use by physicians and other care providers in day-to-day health care delivery.

Administration and Accountability: Administrative systems to manage programs, and reporting systems to inform and explain how the health system is managed.

Governance and Operating Structures: The work processes to manage the portfolio of development projects and systems.

Within those five directions, the strategy identifies eleven priority projects over the next six years:

- Replacement of Medicare claims payment system
- Replacement of the Hospital Information System at Atlantic Health Sciences Corporation
- Implementation of a common Client Registry
- Implementation of a Provider Registry
- Implementation of a Drug Information System
- Linking Hospital Information Systems through an Interoperability project
- Implement a province-wide Diagnostic Imaging Archive
- Implement a Surgical Access Management system
- Replacement of Addictions Services Information System
- Implementation of Health Surveillance systems for communicable disease
- Evaluation of a Home Health Care Pilot project

Nova Scotia

See Health Information Section.

Prince Edward Island

See Health Information section.

Newfoundland and Labrador

See Health Information section.
Section V: Health Programs and Services

Primary Care / Soins Primaires

Health Canada

Primary Health Care Transition Fund

On November 18, 2005, a one-year extension of the Official Languages Envelope of the Primary Health Care Transition Fund was announced by the Minister for Official Languages, in the amount of $10.6 million, permitting the launch of new initiatives in the 2006-2007 fiscal year.

Santé Canada

Fonds pour l’adaptation des soins de santé primaires


Northwest Territories

The Department and Authorities continued to implement the Integrated Service Delivery Model (ISDM). The ISDM is a team based, client-focused approach to provide health and social services. It focuses on illness and injury prevention and health promotion. Primary community care is one of three key elements to better integrate health and social programs and services. “Primary Community Care” is similar to “primary health care” except it is used to show the need to direct services toward the community level, as close to the client as possible.

The principles of Primary Community Care are:

- Universality: Individuals have access to the services they need and are treated fairly and with respect in the health and social services system.
- Personal Responsibility: Individuals and families have personal responsibilities to address their health and social needs.
- Basic Needs: Publicly funded programs and services will address basic health and social needs in a way when an individual or family cannot meet these needs.
- Sustainability: The health and social services system will operate in a way that does not threaten its ability to meet basic health and social needs over the long-term.
- Continuum of Care: Programs and services will fit together as seamlessly as possible and will be integrated with other services wherever possible.
- Prevention-Oriented System: All activities of the health and social services system will support the maintenance of physical, social and mental health in addition to the treatment of illness and injury.
• People-Oriented System: All activities of the health and social services system will support an approach that places the needs of people first.

Yukon Territory

• The Yukon Government received $4.5 million through the Primary Health Care Transition Fund administered by Health Canada, starting in 2002. Initiatives under the fund will conclude in September 2006. Yukon initiatives focused particularly on meeting the Fund objectives to:
  o increase emphasis on health promotion, disease and injury prevention and management of chronic disease; and
  o facilitate coordination and integration among health services.
• Two core initiatives are underway. These are:
  o to refocus organization structure and processes; and
  o to implement improved technology to support the structure and processes.
• Initiatives have been undertaken to address the following goals:
  o Improving health information to the public;
  o Promoting healthy living;
  o Addressing key health issues; and
  o Improving cooperation and collaboration
• Major activities included information technology projects in mental health, public health, and client registry, initiating a Diabetes Collaborative, undertaking a participatory alcohol and drug research project and making a health guide and web-access information available to the Yukon public. Monies available from the Territorial Health Access Fund will enable some primary care initiatives to be sustained beyond the period of Primary Health Care Transition Fund funding.

British Columbia

Primary health care in British Columbia is undergoing far-reaching modernization. The Ministry of Health Services, regional health authorities, physicians, nurses, midwives, paramedics and all members of the health care team, including patients, have been working together since 2001 to develop a robust primary health care system. Examples of the increased range of integrated primary health care delivery models in the province include:
• Forty-Nine new practice models for improved quality of patient care.
• Forty-Two emerging primary health care networks.
• The addition of pharmacists to the BC Nurseline, who provide after hours advice.
• Establishing Nurse Managed Care/ Nurse First Call practices, where patients receive care from Advanced Practice nurses, in six rural/remote communities.
Province improves chronic disease management

- Traditionally, the health care system has been focused on acute and episodic care. Since 2001, government has taken steps to design the system in a way that will better support patients with chronic diseases.
- A large percentage of health care resources are spent on chronic disease management with 5 per cent of patients using more than 30 per cent of physician services. This 5 per cent consists mainly of patients with chronic disease whose health is likely to decline.
- The MoH developed standards of care for diabetes, hypertension, congestive heart failure, asthma, chronic obstructive pulmonary disease (COPD), kidney disease and depression.
- The province has led a series of collaborative efforts with stakeholders and health experts using the latest research and best practices, setting standards of care and performance targets for physicians caring for patients with chronic diseases. Physicians involved in a provincial congestive heart failure collaborative exceeded targeted outcomes for their patient’s health. Through provincial diabetes collaborative, seven thousand patients were monitored and received optimum care.
- BC Diabetes Guidelines are now available on Personal Digital Assistant (palm pilot) so that doctors can easily access guidelines during office visit.
- Community collaborative efforts focused on diabetes, depression, congestive heart failure and kidney disease have taken place in the Northern Health Authority.
- A provincial kidney disease initiative is helping detect kidney disease earlier and standardize kidney care.
- Through the UVIC Centre on Aging, patients with chronic diseases are being trained to manage their own symptoms and treatment.
- In partnership with the BC College of Family Physicians, BC physicians are receiving professional development on how to help patients set self-management goals (i.e., lifestyle changes such as diet and exercise).
- In partnership with the College of Physicians and Surgeons, GPs are receiving training on how to self-evaluate their practice.
- A CDM Toolkit is providing information technology for physicians to better monitor their patients and provide guidelines based care.

Government encourages British Columbians to protect their health

The Ministry of Health joined the Canadian Diabetes Association to launch Diabetes Awareness Month in November with a strong message to British Columbians that everyone needs to be involved to prevent the onset of this chronic disease. Government supported the Canadian Diabetes Association’s “Get Serious” month-long public awareness campaign.
Alberta

- A key section in the new tri-lateral agreement is a Primary Care Initiative Agreement, supported by $100 million of federal funding, intended to achieve the following objectives:
  - increase the proportion of Albertans with ready access to primary care;
  - coordinate 24/7 management of access to primary care services;
  - increase emphasis on health promotion, disease and injury prevention, care of the medically complex patient and patients with chronic illness;
  - improve coordination and integration with other health services including secondary, tertiary and long-term care through specialty linkages to primary care; and
  - use of multi-disciplinary teams to provide comprehensive primary care.

- These objectives will be addressed through the development of Local Primary Care Initiatives now known as Primary Care Networks (PCNs). PCNs are partnerships between the health regions and physician groups to provide a defined set of primary care services ranging from population health through minor surgery and emergency care, and based on 24/7 management of access to appropriate primary care services, access to diagnostic services and coordination of access to home care, emergency room, long-term care, secondary and public health services.

- A tripartite Primary Care Initiative Committee has responsibility for managing this initiative approving development of PCNs based on a review process including a letter of intent and the development of a business plan. As of March 2005, 14 Networks have begun operation and another 15 are under development.

- Approved Networks will receive up to $50 per informally or formally rostered patient per year to improve primary care services provided by the network.

- Alberta’s Primary Health Care Transition Fund was approved by Health Canada in 2002 to support transitional costs of implementing large-scale primary health care initiatives intended to improve access, accountability and integration of services through fundamental and sustainable change to the organization, funding and delivery of primary health care services.

- To date the Fund has supported:
  - the development and implementation of a province-wide 24/7 nurse-based health information and advice service, Health Link Alberta, which has been operational province-wide since June 2003; and
  - the implementation of a Capacity Building Fund which is funding 10 initiatives intended to develop and integrate:
    - innovative health promotion, disease and injury prevention and chronic disease management programs; and
    - innovative care models based on the use of multi-disciplinary teams and other integrated care models, effective change management strategies, education and training activities for health professionals and infrastructure.
Initiatives include an interdisciplinary primary health care clinical team training initiative, two primary health care centres emphasizing expanded access to primary health care services and use of multi-disciplinary teams, two chronic disease management initiatives, a diabetes initiative, two shared care models, a comprehensive and multi-disciplinary child and youth health network and a mental health diversion project.

- Provincial evaluations are underway for both Health Link Alberta and the 10 initiatives funded through the Capacity Building Fund.
- Additional initiatives focusing on training and inter-disciplinary care have been funded to support the development of the PCNs and leverage off the ten initiatives now well under development.

**Saskatchewan**

- Since the release of the "Action Plan For Saskatchewan Health Care", Saskatchewan Health has been working hard to facilitate a major reorganization of primary health services.
- Milestones in primary health care in Saskatchewan to date are:
  - in August 2003 created HealthLine, a 24-hour telephone health advice line;
  - increased the number of primary health care teams to 37;
  - improved the delivery of primary health care services which are supported through a four-year, $18.6M (in total) federal Primary Health Care Transition Fund until 2005-06;
  - established directors of Primary Health Care and team facilitators in each RHA;
  - developed the Provincial Diabetes Plan;
  - received updated annual primary health care plans and diabetes plans from each RHA;
  - added diabetic supplies such as needles, syringes, lancets and swabs to the Saskatchewan Drug Plan on July 1, 2003;
  - provided funding to two RHAs in 2003 to support consultations for the development of a provincial diabetic foot program;
  - began licensing Registered Nurses (RNs) qualified to practice in an expanded role as Nurse Practitioners (NPs) in 2004;
  - completed a pilot project on team development;
  - partnered with the Réseau Santé en Français on two Primary Health Care Transition Fund (PHCTF) projects ("Setting the Stage" and "Children and Seniors the Heart of a Healthy Community");
  - implemented a national primary health care awareness strategy on behalf of a Federal/Provincial/Territorial partnership to develop;
  - developed a provincial primary health care evaluation framework; and
  - continued to participate in a number of projects funded by Health Canada through the Primary Health Care Transition Fund including development of:
- common evaluation criteria for HealthLines,
- a Chronic Disease Information Technology program,
- common national strategies regarding the nurse practitioner.

Diabetes Prevention and Control

- A Provincial Diabetes Advisory Body was established in 2001 to provide the Department with advice on issues pertaining to successful co-ordination of diabetes programs. Membership includes three representatives from the aboriginal community, one each representing the Federation of Saskatchewan Indian Nations (FSIN), the Métis Nation of Saskatchewan (MNS), and First Nations and Inuit Health Branch (FNIHB); three health region representatives, two physicians, one representative from Canadian Diabetes Association, and five representatives from Saskatchewan Health.

- In February 2004, Saskatchewan Health finalized the Provincial Diabetes Plan, which provided regional health authorities with a framework for a comprehensive and coordinated team approach to diabetes management, recognizing that the person with diabetes is responsible for self-management of the disease.

- Since 2003, RHAs have been asked to submit a diabetes plan and annual update to Primary Health Service Branch (PHSB) that outlines their planned initiatives to address diabetes in their region. These plans are reviewed annually to determine alignment with the direction provided in the Provincial Diabetes Plan.

- The Provincial Diabetes Co-coordinator, and Aboriginal Diabetes Consultant continue to provide support to regional health authorities and Aboriginal communities in addition to facilitating the development of initiatives that are provincial in nature. The following are provincial initiatives developed or under development:
  
  o **Diabetes Education for Health Care Providers program** - Funding was provided by the Department of Health to Saskatchewan Institute of Applied Science and Technology (SIAST) in 2002 for the development of two diabetes education programs. These programs, “Basic” and “Advanced” Diabetes Education for Health Care Providers are offered by distance delivery. The “Basic” program is designed for care providers such as home care aides, emergency service providers as well as community diabetes workers in First Nations communities. The “Advanced” program is designed for nurses, pharmacists, dietitians and others.

  o **Risk Identification of the Foot in Diabetes** - Saskatchewan Health, in partnership with RHA podiatrists and SIAST developed “Risk Identification of the Foot in Diabetes” presentation and training materials. These materials are used in the on-going delivery of workshops aimed at training care providers to identify and classify the diabetic foot at risk to facilitate appropriate care and referrals to minimize or delay the onset of foot complications.

  o **Diabetic Foot Program** (under development) - Funding has been provided to Regina and Saskatoon RHAs to support the consultation process with health professionals and care providers for the development of a provincial diabetic foot program. This program will include clinical practice guidelines for the screening and management of complications associated with the diabetic foot.
o **Provincial Diabetes Symposium** – One-time funding was provided to the Canadian Diabetes Association (CDA) to plan and host a diabetes symposium, which took place on September 15 and 16, 2005. Approximately 350 health care providers from Saskatchewan participated in the event. Continuing education credits were available for physicians, pharmacists and dietitians. Dr. Steven Harris, Dr. Michael Rachlis and Dr. William Osei were key-note speakers.

o **Insulin Adjustment Learning Module** - Funding was provided to develop the Saskatchewan Insulin Adjustment Module” This Module contains an educational component, demonstration of competency process, and guidelines for the development of Regional policies to support Registered Nurses with additional training to perform an insulin dose adjustment service on behalf of physicians for their clients.

- Since November 2001, several new drugs used to treat diabetes have been approved for coverage under the provincial Drug Plan, and are available under Exception Drug Status. The Saskatchewan Prescription Drug Plan was expanded in July 2003 to include coverage of diabetic supplies, including needles, syringes, lancets and swabs. The additional coverage will lower the out-of-pocket expenses for some persons with diabetes, especially those with lower incomes.

- Saskatchewan Health continues to work with the Federal Government and other provinces on the development of a National Diabetes Strategy and the National Diabetes Surveillance System.

- Using information from other databases in Saskatchewan (Personal Registry System, Hospital Separations, Physician Billings), the Population Health Branch has developed a Saskatchewan Diabetes Profile. This profile “Saskatchewan Diabetes Profile 1996/97 to 2000/01” describes diabetes trends in the province and in regional health authorities over a five-year period. This profile is currently being updated to provide data to support program planning and to track progress in reducing the incidence of diabetes over the long term.

- Diabetes is the leading cause of kidney failure. About 45% of the people requiring dialysis are diabetic. The province also has Chronic Renal Insufficiency (CRI) clinics operating in the Saskatoon and Regina Qu'Appelle health regions. The goals of CRI educational sessions are to delay or prevent the need for dialysis and to better prepare patients in making their treatment choices - hemodialysis, peritoneal or home dialysis, or transplant. About 45% of the patients attending these clinics are diabetic as well. At June 30, 2005, there were 875 patients attending CRI clinics, 619 patients on dialysis (hemodialysis and peritoneal dialysis) and 400 patients living with a kidney transplant.

- Dialysis centres in Regina and Saskatoon Health Regions serve about 80% of Saskatchewan’s hemodiaysis patients and acts as “home units” for seven satellite operations in Prince Albert, Lloydminster, Tisdale, Yorkton, Swift Current and North Battleford.

- Saskatchewan Health provides funding to Saskatchewan Health Research Foundation and the Health Quality Council from which grants are awarded. The Health Quality Council is undertaking a Chronic Disease Management Collaborative to support research projects surrounding best practices for the management of diabetes in Saskatchewan. The Collaborative is planned to extend over an 18-month period commencing in November 2005.

- From 1999 to 2003, seven sites received funding as demonstration projects. An evaluation report, “Using a Population Health Approach: Lessons Learned from the Population Health
Promotion Demonstration Sites for the Primary Prevention of Type 2 Diabetes” was released. RHAs are using the evaluation information to develop regional initiatives that focus on primary prevention and health promotion to stop or delay the development of Type 2 diabetes.

Manitoba

Manitoba Approaches to Primary Care (MAPC)

Manitoba has a long history of innovative approaches to the delivery of primary care to its residents. For example, Community Health Centres within Manitoba have been a model of collaborative, community-based service delivery for many decades. In addition, non-physician primary care providers have also been key in northern and isolated communities and, more recently, the Primary Health Care Transition Fund has supported the exploration of many different primary care delivery options. Hence, all of these are Manitoba Approaches to Primary Care (MAPC).

The Physician Integrated Network (PIN) is an approach, currently in development, which focuses on the engagement of autonomous, independently owned fee-for-service physician groups. Interdisciplinary collaboration will be a key feature as this approach evolves. The objectives of the project include: improved access to primary care, improved providers’ access to and use of information systems, improved work environment for providers, and a demonstrated improvement in primary care with specific focus on Chronic Disease Management.

To fully achieve the articulated objectives, it will require a collection of interlinked, yet flexible, elements (structure and practice model, information systems and knowledge, funding and remuneration and monitoring and evaluation). This then becomes the heart of the PIN Project, where all four elements will be implemented in a phased manner.

An Advisory Committee with representation from senior and executive health sector administration has been established to provide input/feedback into the development and implementation of MAPC, including the PIN project.

Primary Health Care Transition Fund (PHCTF)

Manitoba divided its PHCTCF grant into 2 phases. Phase I includes five priority initiatives which were designed to improve Manitobans’ access to a range of appropriate primary health care (PHC) services; facilitate interdisciplinary, integrated delivery of PHC; and enable informed public participation in the discussion and design of PHC reform initiatives. In addition, these initiatives provided a foundation upon which regional health authorities could proceed to reorganize, integrate and enhance primary health care services in partnership with key stakeholders.

Phase II was developed based upon proposals submitted to Manitoba Health by the regional health authorities and CancerCare Manitoba. The seventeen initiatives that make up Phase II build upon Phase I and support the following overarching Primary Health Care.
Ontario

Overview

Primary Health Care has been a foundation of Ontario’s health care system for many years now and is a key element of the government’s priority to ensure “Healthier Ontarians in a Healthier Ontario” in a transformed, results-based health care system. The key goals of the Primary Health Care Transformation Strategy are:

- improved access to primary health care
- improved quality and continuity of primary health care
- increased patient and provider satisfaction
- increased cost-effectiveness of primary health care services
- effective health promotion and disease prevention and chronic disease management strategies.

Ontario is building a strong foundation for primary care by:

- developing new Family Health Teams that consist of interdisciplinary teams providing enhanced comprehensive primary health care
- helping ensure family physicians and other interdisciplinary team members of the primary health care team are practicing in groups with identified (enrolled) populations;
- expanding its network of Community Health Centres to provide improved primary health care access for high-risk populations
- aligning current primary health care models to ensure consistent delivery of core services seen in family health teams
- ensuring 24/7 access to primary health care services is available through extended office hours and a telephone health advisory service.

Initiatives/Projects

Family Health Teams (FHTs) are a central element of Ontario’s primary health care renewal strategy through which the government will provide more Ontarians with access to primary health care. The locally-driven teams will provide interdisciplinary collaborative care so that patients have access to an appropriate health care provider, 24 hours a day, 7 days week through regular office hours, extended hours and a telephone health advisory service. The teams will include physicians, nurses, nurse practitioners, and other health care providers such as pharmacists, dietitians, midwives, social workers, health educators and others that will provide comprehensive care with an increased emphasis on health promotion and disease prevention and chronic disease management.

Family Health Teams will be developed to meet the unique needs of each community and no two teams will function exactly alike. Each FHT will maximize the expertise, preferences and skills
sets of each of its team members and cultivate interdisciplinary collaboration in unique ways. FHTs will not replace existing successful models but will build upon their strengths.

Ontario has committed to the implementation of 150 Family Health Teams by 2007-08. The first 69 Family Health Teams were announced in April 2005 and an additional 31 were announced on December 9, 2005, with the final 50 teams to be announced in spring 2006.

Ontario has several primary health care models. They are the Family Health Networks (FHNs), Primary Care Networks (PCNs), Health Service Organization (HSO), Community Health Centres, Comprehensive Care Model (CCM) and Family Health Groups (FHGs). They all have common elements:

- defined core services
- individual or groups of family physicians working together to provide comprehensive care to patients enrolled to them
- obligations to provide a combination of regular and enhanced office hours
- a telephone health advisory/triage service for after hours, weekends and holidays.

**Family Health Networks (FHNs)** have a minimum of three family doctors working together to provide comprehensive and preventive care management to patients. FHNs receive capitation for all enrolled patients based on a basket of primary care services with additional fee-for-service for some services, and additional premiums, incentives and bonuses. As of February 1, 2006, there were 70 FHNs with signed agreements.

**Health Service Organizations (HSOs)** have individual physicians and groups of physicians providing comprehensive care to enrolled patients. The majority of payments are for defined core services. Some HSOs receive grants for services by allied health professionals for targeted patient groups. As of February 1, 2006 there were 49 HSOs operating in Ontario.

**Primary Care Networks (PCNs):** family doctors work together to provide comprehensive care to enrolled patients. As of February 1, 2006 there were 12 PCNs operational in Ontario.

Per the Memorandum of the Agreement between the Ministry and the Ontario Medical Association, a working group was established to align elements of the HSO and PCN models into one model. This model will provide physicians with payments for common capitated services and some comprehensive care and after-hours care incentives and will be available to all physicians in Ontario by spring 2006.

**Family Health Groups (FHGs)** are fee-for-service group practices with a minimum of three family physicians that receive incentives for providing some core comprehensive and after-hours health care services to enrolled patients and enrolled patients previously without a physician.

In comparison to the FHN, the FHG is a simpler arrangement without specific governance requirements. As of February 1, 2006, there were 330 FHGs operating in Ontario.
**Comprehensive Care Model (CCM)** CCMs are the newest model arising from the 2004 Memorandum of Agreement between the Ontario Medical Association and the Ministry. The model is available to all family physicians in solo practice as of October 2005. Like the FHGs, this is primarily a fee for service model with incentives for providing some core comprehensive and after-hours health care services to enrolled patients and enrolled patients previously without a physician. As of February 1, 2006, there were 341 CCM physicians operating in Ontario.

**Community Health Centres (CHCs)** are a key element of Ontario’s primary care renewal strategy in meeting the needs of high-risk populations and communities. CHCs are community driven and provide primary care through inter-disciplinary teams including physicians, nurse practitioners, nurses, dietitians, therapists, counsellors, chiropodists, health promoters and outreach workers. CHCs develop in response to identified community needs. They identify priority populations for group and community programming. There are currently 54 CHCs and 10 satellite CHCs providing multidisciplinary heath and social services to 330,000 high-risk or disadvantaged Ontario residents. Ontario has announced a three year plan to extend primary care access through an additional 22 CHCs and 17 satellite CHCs by 2007-08.

**Rural and Northern Physician Group Agreements (RNPGA)** (Formerly Northern Group Funding Plan (NGFP) and Community Sponsored Contracts (CSC)) The RNPGA is a new alternate payment plan for physicians that combines both Northern Group Funding Plans (NGFP) for 3 to 7 physicians and the Community Sponsored Contracts (CSC) for 1 to 2 physicians into one agreement.

The RNPGA was negotiated with northern physicians for northern physicians. The purpose of the new RNPGA is to solidify current physician resources and strengthen the recruitment of primary care physicians to Ontario’s most isolated northern communities. The RNPGA retains the complement based physician payment model that was the foundation of the NGFP and CSC and adds to the compensation the bonuses and incentives from other primary health care physician payment models (FHN, PCN, and HSO). A southern based RNPGA model is also being developed. As of February 1, 2006, there were 38 RNPGAs operating in Ontario (24 CSCs and 14 NGFPs).

A compensation element exclusive to the RNPG agreement is a rurality modifier that provides higher compensation to physicians in the most isolated RNPGA communities.

**Group Health Centre (GHC):** The GHC is a multi-specialty, interdisciplinary ambulatory care centre providing primary care, specialist care and outpatient surgery, diagnostics and rehabilitation. The GHC provides multi-specialty ambulatory care to over 58,000 people in Sault Ste Marie.

The GHC enrolls patients, receives capitation payments and funding for services provided by allied health providers and specialists.

**Telephone Health Advisory Service (THAS):** THAS is a vital component of primary health care renewal. This service aids family physicians in providing 24-hour access to primary health care services by providing after-hours advice and triage service for enrolled patients of certain
primary health care models via registered nurses, without charge to patients. THAS is integrated with family physicians via a report-back feature and access to a local on-call physician.

**Primary Health Care Transition Fund (PHCTF):** Ontario has proceeded with the implementation of nine key PHCTF initiatives totaling $213 million over four years (2001/02 to 2005/06). These initiatives include interdisciplinary demonstration, evaluation and research projects; accreditation and leadership training; the integration of mental health and rehabilitation initiatives in primary health care; communications and enrolment; and the development of information and contract management systems for new primary health care delivery models.

These initiatives were initially scheduled to sunset by March 31, 2006, but most have now been granted an extension to summer/fall 2006. The initiatives are transitional in nature and are intended to lead to sustainable change in the organization, funding and delivery of primary health care services. Results generated from PHCTF will inform future primary health care renewal directions.

**Funding**

The Government of Ontario has emphasized the need to strengthen the primary health care models and has allocated $600 million for 2005-2006 for primary health care operations. This includes $100 million for incentives to family physicians for enhanced primary care services including preventive and comprehensive care incentives.

**Quebec**

L’accessibilité est au cœur des préoccupations, notamment pour les soins de première ligne et elle a donné lieu à la poursuite de l’implantation des groupes de médecine familiale (GMF) de même qu’au développement de cliniques-réseau dans la région montréalaise. Après entente avec la Fédération des médecins omnipraticiens du Québec (FMOQ), ces cliniques médicales permettront de répondre à la fois aux caractéristiques de la pratique médicale urbaine et à la nécessité d’offrir aux citoyens un accès à des services médicaux plus complets sur des plages horaires étendues.

Accessibility is a major concern, especially with respect to frontline care, and this has driven the implementation of *groupes de médecine familiale* (GMF) and the development of networked clinics in the Montreal region. After agreement with the *Fédération des médecins omnipraticiens du Québec* (FMOQ), these medical clinics will be tailored to the characteristics of urban medical practice and will meet the need to provide the public with more comprehensive medical services and extended operating hours.

**New Brunswick**

- The range of primary health care services is governed/managed differently, depending on the service. Most fall under the oversight of Regional Health Authorities, while a major proportion of primary health care is also delivered in private physicians’ offices.
• Deriving its mandate from the Provincial Health Plan, the Primary Health Care Collaborative Committee has been formed to focus on a range of primary care issues, including addressing linkages between different aspects of primary health care, and considering a chronic care model for New Brunswick.

• Primary Health Care nurse practitioners are now part of the New Brunswick health care system. At the end of December 2005, 27 nurse practitioners were practising in various primary health care settings: community health centres, family practices, emergency rooms and nursing homes.
  o Consistent with the Provincial Health Plan, the government is supporting more community-based delivery models for primary health care, such as collaborative practices, and community health centres (CHC).
  o One collaborative practice site has been opened.
  o Five Community Health Centres were established with support from the Primary Health Care Transition Fund. Two more have since opened and a third is in planning. These sites are managed by the regional health authority.
  o The Community Health Centres have a provincially approved framework and basket of services. This reflects a conceptual understanding of health, and recognizes the importance of population health in building healthy communities. The following components are core activities:
    - To enhance timely and appropriate access to primary health care services.
    - To ensure a strengthened role for the individual, family and community in health and health care delivery.
    - To develop linkages and collaboration among health services and with social and other community services.
    - To offer a comprehensive range of affordable and reliable primary health care services to a defined population, based on their health needs.
    - To enhance the health status of communities through an increased emphasis on health promotion, disease and injury prevention and the management of chronic diseases in the community.
    - To establish an interdisciplinary approach to the delivery of primary health care services, so that the most appropriate service is provided by the most appropriate provider.

• The Collaborative Practice and the Community Health Centres are currently in the process of establishing an electronic patient record. The record is being coordinated provincially. Key next steps will be to:
  o Maintain consistent implementations;
  o Leverage work of other Regional Health Authorities (economy of effort);
  o Support implementation within any future Community Health Centres.
Nurse practitioners have been included in the service provider mix in the Community Health Centres and collaborative practices. As well, all health care providers are intended to work to full scope of practice within a collaborative and interdisciplinary care model.

A training program, Building a Better Tomorrow, has been developed as part of an Atlantic multi-jurisdictional initiative. A series of training modules have been developed for health care providers working in Community Health Centres or collaborative practices, to enhance the effective implementation of a team approach in primary health care services. Currently being rolled out to all practice sites, the training has been well-received.

There has been significant ongoing effort to develop and implement appropriate data collection and monitoring processes in all primary care sites to improve accountability and evaluation.

There has been a commitment to involve key stakeholders in these initiatives. At the community level, all projects have community advisory committees. At the provincial level, there are ongoing, key steering committees that include government and regional health authority staff.

The Community Health Centres and collaborative practices are funded within the global budget for the Regional Health Authorities. Most providers working within Community Health Centres are salaried under the Regional Health Authority (Doaktown).

The bulk of primary care continues to be delivered by family physicians in private practice, under fee-for-service salary arrangements.

Nova Scotia

Primary Health Care Renewal

The Department is now building on the early work of the Strengthening Primary Care Initiative to develop and implement a community-based primary health care system for Nova Scotia based on a population health approach. The Advisory Committee on Primary Health Care Renewal (ACPHCR) was established in 2001 to advise the Department on the development of a community-based primary health care system. The direction outlined in the final report of ACPHCR was approved by the Department, and this direction now guides the work of District Health Authorities and the Department of Health in Primary Health Care Renewal. The ACPHCR has now evolved into the Primary Health Care Working Group.

$650,000 in funding was provided to support the formation of community-based collaborative primary health care teams. Funding was provided to District Health Authorities and to the Tui’kn initiative in Cape Breton to hire nurse practitioners

Primary Health Care Transition Fund (PHCTF)

In July 2002, the Department of Health submitted a proposal to Health Canada’s PHCTF for Nova Scotia’s share of the per capita portion of the federal funding. This amounted to $17.1M over four years. The proposal was approved by Health Canada in September of 2002. Nova Scotia’s process to undertake transition activities is in keeping with federal funding objectives, and involves:
• implementing enhancements to primary health care services and creating new ways to develop sustainable primary health care networks/organizations

• supporting change costs for primary health care professionals

• transitioning to an electronic patient record.

Since the implementation of the fund, more than 80 initiatives have been supported throughout the District Health Authorities. Federal funding supports the system transition and model implementation costs only. DHAs are required to demonstrate the operation sustainability of funded activities as part of the legislated business planning and accountability requirements.

**Nurse Practitioner and Enhanced Team Implementation**

Nova Scotia introduced the primary health care nurse practitioner in selected primary care practices in 2002. There are currently 19 approved, department-funded primary health care nurse practitioner positions in Nova Scotia. The province also supports an interdisciplinary team at an urban practice, and plans to implement more teams in the future.

**Diversity and Social Inclusion Awareness in Primary Health Care**

Diversity and Social Inclusion in Primary Health Care is an initiative to raise awareness of diversity and social inclusion issues (primarily related to race, language and culture) across a broad range of stakeholders and culturally diverse populations, and to develop guidelines and policies that address diversity and social inclusion issues in primary health care. A final report will be delivered by Spring 2006.

**Primary Health Care Evaluation**

Nova Scotia is building upon its existing capacity to evaluate the impact of changes made as a result of renewal activities. Enhancing primary health care evaluation and research capacity throughout the province will strengthen Nova Scotia’s ability to continue to improve the primary health care system beyond the transition phase. Current activities focus on primary health care indicator development and capacity building within the District Health Authorities.

**Continuing Professional Education for Primary Health Care Providers**

Nova Scotia is the lead province in the Atlantic region’s collaborative initiative, Building A Better Tomorrow. This initiative supports providers’ transition to a renewed primary health care system and complements renewal activities currently underway in the Atlantic provinces. A key area of focus in 2005 was the development of a series of accredited modules (French and English) for face to face and web-based delivery. The goal is to have over 4000 primary health care providers receive the educational program.

**Primary Maternity Care**

A Primary Maternity Working Group was established in 2004 to develop a regulatory framework for the inclusion of midwives in collaborative teams delivering primary maternity care in Nova
Prince Edward Island

- Prince Edward Island embarked on a redesign initiative aimed at increasing access to primary care services, and a reduced reliance on the system through continued promotion of wellness, disease prevention and management, and population health strategies.
- The Primary Health Care Redesign project, in response to funding available from the Federal Government, encouraged physicians and nurses and other appropriate health care providers to work in collaborative group practices with shared responsibilities for client outcomes.
- Primary health care redesign focused on population health strategies to promote health, and on reorganization of current primary care services to deliver more cost-effective services, while improving health outcomes, service quality and accessibility. These strategies will help to sustain the current system and ensure a sound balance between activities to improve health over the long term, with effective, essential health services to treat people when they are injured or ill.
- In 2005/2006, Family Health Centres were operational in Charlottetown, Summerside, O’Leary, Hunter River/Rustico, and Souris using newly renovated facilities and expanding existing family physician services to include primary care nurses and other health professionals working in collaborative practices.
- P.E.I., as a member of Primary Health Care Atlantic, partnered with the other Atlantic provinces for the Building a Better Tomorrow initiative. The Building a Better Tomorrow initiative developed and delivered effective (post-basic) continuing education curricula to prepare and provide transitional support for current providers in Atlantic Canada who are willing to or contemplating changing the way they work in the primary health care system. The initiative is timely and appropriate to complement and supplement the other provincial primary health care initiatives that are underway. (Nova Scotia is the lead for this initiative). The program has been very successful in P.E.I. with a great interest by health care providers to access the learning modules. The modules are being offered to community mental health, public health nursing and addictions staff in addition to family health centres.

Newfoundland and Labrador

Primary Health Care Changes

In April 2002, the Department of Health and Community Services (DOHCS) established the Office of Primary Health Care (PHC). Their mandate was to engage in widespread dialogue with stakeholder groups, and to develop, implement and evaluate PHC teams’ activities throughout the Province. A PHC Framework, Moving Forward Together: Mobilizing Primary Health Care, and Action Plan were developed, with the support of a PHC Advisory Council and external stakeholder consultations. Some of the key elements of the new model of PHC include developing PHC teams, forming PHC networks and establishing PHC physician networks, maximizing scope of practice of professionals, pursuing blended payment models for physicians, moving toward funding models that better reflect population needs and challenges, enhancing
support and direction for Chronic Disease Management, and utilizing information technology to enhance communications and linkages.

The province’s target for PHC services is to have 95% of the population within 60 minutes of 24/7 PHC site by 2007.

The Provincial PHC Advisory Council, with association, union and regional representation, was set up to advise the Minister of Health and Community Services regarding PHC renewal.

There are 8 provincial PHC team areas (7 rural and 1 urban). These PHC team areas have developed comprehensive proposals, based on their population needs and a service review. With the leadership team of a coordinator, facilitator (focus on Wellness, Community Capacity Building and Chronic Disease Management) and physician lead, each area is at various stages of implementing all features of the provincial framework.

To assist with provider capacity building and sustainability, leadership teams have been provided with facilitation and change management skill support, formalized team development and Scope of Practice processes are being implemented for all providers in each of the PHC team areas and where appropriate enhancement of emergency road ambulance services are being pursued.

Provincial Working Groups (Teams, Scope of Practice, Information Management, Physicians Payment Models, Wellness and Community Capacity Building, Chronic Disease Management, Program Planning and Evaluation, and Communication), along with PHC teams and appropriate stakeholder participation, are providing direction and support to PHC team areas, based on best practices.

A Physician Working Group has developed a discussion document on physician funding and payment models, with development of contracts (DOHCS and Regional Integrated Health Authorities (RIHAs), and RIHAs and physician networks) and, based on the funding model proposed, physicians in the PHC team areas are agreeable to trial this model over the next year.

Communication regarding PHC activities is occurring in PHC team areas, brochures and posters are available throughout the province, a provincial website is being finalized, and a communication plan regarding PHC is being developed provincially.

Comprehensive needs assessment regarding information required by PHC teams has been completed and electronic applications to enhance information sharing are being evaluated in a rural and an urban setting. This is being done with leadership from Newfoundland and Labrador Centre for Health Information (NLCHI) and linked with any provincial information management activities.

A provincial plan for telehealth is approved, which will provide direction for all aspects of telehealth including clinical video-conferencing (e.g. tele-oncology, tele-diabetes), and interoperability amongst telehealth activities and with provincial Electronic Health Records (HER) plan. The implementation plan is in the final stages and will be initiated in the next fiscal year.
A Request for Proposals for pilot testing an Electronic Medical Record (EMR) in Fee-for-Service Physician Practices is in process, with awarding of a contract planned by the end of this fiscal year.

A provincial plan for Chronic Disease Management Collaboratives is being implemented in all PHC team areas. The associated flow sheet is being used electronically in one of the PHC team areas, and the information from the flow sheet is being supported by a software application that will allow collation of the information and its use for direct client service delivery and planning. Based on evaluation, the diabetes collaborative will be implemented across all regions, and a plan to extend the collaborative model to other diseases will be developed and implemented.

**Selfcare / Telecare**

Selfcare/Telecare is an Atlantic initiative to develop a system to support increased primary health care access through enhanced communications and linkages for prevention/promotion and surveillance, telephone and on-line direction for direct client/patient advice and tele-homecare. An Atlantic needs assessment and business plan has been completed, and the province is in the late stages of formalizing and signing a Memorandum of Understanding with New Brunswick to initiate the service.

**(BBTI) Building A Better Tomorrow Initiative**

Building a Better Tomorrow is an Atlantic initiative to support change. Its purpose is to support and sustain change in PHC services by developing and delivering effective educational and orientation materials (e.g., pamphlets, brochures, manuals) to health care providers who deliver these services.

- Six modules have been developed to support understanding PHC, team development, conflict resolution, adult learning, and community development, and they are being implemented in all PHC team areas through Train the Trainer initiatives.
- Over 300 health care providers in project areas have been involved in some form of team development and scope of practice days.
- Support has been provided for teams in relation to chronic disease management collaborative, with Learning Session # 1 completed.

NL is the lead, with Memorial University of Newfoundland, for the development of team modules.

**Facilitation Project**

NL, in partnership with Ontario, British Columbia, Manitoba and Saskatchewan, is the lead province in multi-jurisdictional proposal approved through Health Canada Tools for Transition Funds. This project will develop a bilingual Facilitation Manual that can be used by all jurisdictions in managing the change to primary health care, and is in its final stages of completion.
Primary Health Care Nurse Practitioners

A Primary Health Care Nurse Practitioner Education Program has been in place since 1997 and is delivered through the Centre for Nursing Studies. In addition to the education program, the role of nurse practitioners is supported by a legislative framework through amendments to the Registered Nurses Act (1997). An evaluation of the implementation of NP-PHC role was completed. The report has been helpful to inform new directions in PHC renewal in the province.

Community Health / Santé Communautaire

Health Canada

Health Integration Initiative

The Health Integration Initiative, funded from August 2003 to March 2006, was designed to explore, develop, and analyze models for better integration and collaboration in the delivery of health services to First Nations and Inuit in order to: improve access to, and quality of, services; create economies of scale; respond to community priorities; and constitute “win-win” solutions for all partners (federal, provincial, territorial and First Nations communities). This Initiative funded eight integration projects to identify potential mechanisms and models for collaboration and harmonization between First Nations and Inuit and provincial/territorial health systems.

In 2005-2006, all Health Integration Initiative projects were completed, each having undergone an evaluation. The Initiative as a whole also underwent a national evaluation. In terms of next steps, Health Canada is working on the implementation of the Aboriginal Health Transition Fund that was announced at the First Ministers’ Meeting of September 2004. This Fund will support activities for the integration and adaptation of health programs and services in order to better meet the needs of Aboriginal peoples.

Tuberculosis in First Nations Communities

The Tuberculosis Program has undergone a revision of its goals, from the goal of elimination of Tuberculosis to a more realistic target consistent with national and international guidelines. In 2005, the Department commissioned a report to determine whether Tuberculosis elimination should continue to be the goal for the Program, or if a new, evidence-based goal should be developed. In November 2005, subsequent to the review of this report, the Tuberculosis Sub-Working Group endorses that, in accordance with scientific evidence, the following attainable, long-term goal be used: by 2015, reduce Tuberculosis incidence to 3.6 per 100,000 among on-reserve First Nations and Inuit peoples. Regional long-term and short-term goals will be developed by each region and will be congruent with the national goal. While the Department continues to advocate for Tuberculosis elimination in Canadian Aboriginal populations as the ultimate vision for the Program, no time-lines can be attached to this goal.
Aboriginal Diabetes Initiative

The 2005 Federal Budget committed $190 million over five years to enhance the Aboriginal Diabetes Initiative. The enhanced initiative is designed to provide a comprehensive, collaborative and integrated approach to decreasing diabetes and its complications among Aboriginal peoples. A major goal of the initiative continues to be diabetes prevention through community level programs that focus on awareness of risk factors, and the importance of early screening, active living, and good nutrition. Additional resources will be used to increase access to diagnostic and complications screening and care programs, as well as research activities.

National Aboriginal Youth Suicide Prevention Strategy

In 2005, Health Canada began to implement the National Aboriginal Youth Suicide Prevention Strategy. As a national program, the strategy will aim to reduce risk factors and promote protective factors against suicide in Aboriginal communities across Canada. Funding for this new program was allocated in Budget 2005 in the amount of $65 million. The strategy will achieve its objectives through activities in the following areas: primary prevention activities that focus on promoting mental health to increase resiliency and reduce risk; secondary prevention activities that focus on supporting community-based approaches; tertiary prevention activities that focus on increasing the effectiveness of responding to/stabilizing crisis and after-care for survivors. The strategy will also have a knowledge development component.

Maternal and Child Health Program in First Nations Communities

Beginning in 2005, Health Canada invested $110 million over five years to establish a Maternal and Child Health Program in First Nations communities across Canada. The purpose of this program is to improve health and social outcomes for pregnant women, and families with infants and young children. The program provides home visits to pregnant women and families and will aim to better coordinate other health services to increase access where needed. In particular, coordination efforts will focus on families with complex needs. Program activities will be developed in partnership with community representatives and other community health programs such as nursing services, Fetal Alcohol Spectrum Disorder programs, and the Canada Prenatal Nutrition Program. In northern regions, funding will be used to enhance existing health promotion programs for Inuit and other Aboriginal people.

Early Childhood Development in First Nations and Inuit Communities

In 2005, Health Canada’s Early Childhood Development initiatives focussed on integrated service delivery for First Nations and Inuit communities with a view to improving efficiencies and reducing reporting burdens for the following federal programs: Aboriginal Head Start On Reserve (Health Canada); Aboriginal Head Start Urban and Northern Communities (Public Health Agency of Canada); the First Nations and Inuit Child Care Initiative (Human Resources Canada); and Indian and Northern Affairs Canada funded daycares in Alberta and Ontario. Regional engagement sessions to gather input from communities were held across the country in September and October 2005. Partner federal departments continued to work horizontally towards a single window approach for federal Aboriginal children's programming. As this work
progresses, the federal government will continue to collaborate with the Assembly of First Nations and Inuit Tapiriit Kanatami and other key stakeholders.

**Tobacco Use Cessation Practices**

In 2005-2006, the Tobacco Control Program continued its involvements in the ongoing funding of Canadian Smokers' Helplines, as well as in the development, coordination and evaluation activities. Smokers' Helplines or Quitlines offer free telephone support from trained specialists who can help develop a personal quit plan or provide counselling to family and friends of smokers. The Tobacco Control Program is an active participant and funder of the Canadian Network of Smokers' Helplines which conducts training, research and develops specialized protocols for cessation counselling for sub-populations, such as pregnant and postpartum women, based on best practices. The Center for Behavioural Research and Program Evaluation at the University of Waterloo has conducted outcome evaluations over a three year period and found quit rates between 8% and 14%.

The Program is also involved in the coordination and evaluation of a national approach to tobacco use cessation based on a "stepped-care" model. This approach to cessation involves matching smokers to the right quit smoking program based on level of addiction and social support. The updated version of Health Canada's Quit4Life, a smoking cessation program for youth aged 15-19, was evaluated in 2005. Results indicated that 12 to 18 months after participating in the program, youth remained highly satisfied with the program. At follow-up, 16% of participants indicated that they had quit smoking, and between 8% to 16% were long-term quitters one year post-program, compared to 5% of youth in the general population.

**Santé Canada**

**Initiative d'intégration en santé**

La tuberculose dans les communautés des Premières nations

Le programme de la tuberculose a vu son objectif d’élimination de la tuberculose être changé pour un objectif plus réaliste conforme aux lignes directrices nationales et internationales. En 2005, le Ministère a commandé un rapport afin de déterminer s’il convenait de conserver l’élimination de la tuberculose comme objectif, ou s’il ne serait pas préférable d’établir un nouvel objectif, fondé sur des données probantes. En novembre 2005, à la suite de l’examen de ce rapport, le sous-groupe de travail sur la tuberculose a convenu d’utiliser, conformément aux preuves scientifiques, l’objectif suivant réalisable à long terme : d’ici 2015, réduire à 3,6 pour 100 000 l’incidence de la tuberculose chez les Premières nations vivant dans les réserves et chez les Inuits. Des objectifs régionaux à long et à court terme seront élaborés par chaque région; ces objectifs seront en harmonie avec l’objectif national. Le Ministère conserve l’élimination de la tuberculose autochtone comme vision ultime du programme, mais aucune échéance ne peut être rattachée à cet objectif.

Initiative sur le diabète autochtone


Stratégie nationale de prévention du suicide chez les jeunes Autochtones

En 2005, Santé Canada a commencé à mettre en œuvre la Stratégie nationale de prévention du suicide chez les jeunes Autochtones. En tant que programme national, la stratégie visera à réduire les facteurs de risque et à promouvoir les facteurs protecteurs du suicide chez les communautés autochtones de tout le Canada. Une enveloppe pour ce nouveau programme, au montant de 65 millions de dollars, a été prévue dans le budget de 2005. La stratégie réalisera ses objectifs au moyen d’activités dans les domaines suivants : activités de prévention primaire axées sur la promotion de la santé mentale afin d’améliorer la capacité de rebond et de réduire le risque; activités de prévention secondaire axées sur l’appui d’approches communautaires; activités de prévention tertiaire visant à accroître l’efficacité de l’intervention et de la stabilisation en cas de crise et de la postobservation des survivants. La stratégie comportera également un volet d’acquisition de connaissances.

Programme sur la santé des mères et des enfants dans les communautés des Premières nations

Santé Canada a commencé à investir, en 2005, un montant de 110 millions de dollars sur cinq ans afin d’établir un programme sur la santé des mères et des enfants dans les communautés des Premières nations à l’échelle du Canada. Le but de ce programme est d’améliorer les résultats pour la santé et la vie sociale des femmes enceintes et des familles habitant avec des nouveau-nés et de jeunes enfants. Le programme prévoit des visites au domicile des femmes enceintes et de leur famille et visera à mieux coordonner les autres services de santé afin d’améliorer leur
accessibilité en cas de besoin. Les activités du programme seront élaborées en partenariat avec des représentants des communautés et d’autres programmes communautaires, comme les services de soins infirmiers, les programmes sur les troubles du spectre d’alcoolisation foetale et le programme canadien de nutrition prénatale. Dans les régions nordiques, les fonds serviront à rehausser les programmes de promotion déjà en place à l’intention des Inuits et des autres Autochtones.

**Développement de la petite enfance dans les communautés des Premières nations et les communautés inuites**

En 2005, les initiatives de Santé Canada concernant le développement de la petite enfance ont été centrées sur la prestation de services intégrés aux communautés des Premières nations et aux communautés inuites. L’objectif était d’améliorer l’efficience de la prestation des services et de réduire le fardeau des rapports dans le cas des programmes fédéraux suivants : aide préscolaire aux Autochtones vivant dans les réserves (Santé Canada); aide préscolaire aux Autochtones dans les collectivités urbaines et nordiques (Agence de santé publique du Canada); initiative sur les soins aux enfants des Premières nations et des Inuits (Ressources humaines Canada); de plus, Affaires indiennes et du Nord Canada a financé des services de garde d’enfants en Alberta et en Ontario. Des séances régionales ont été tenues en septembre et en octobre afin de recueillir les commentaires des communautés. Les ministères fédéraux partenaires ont continué de travailler horizontalement en vue de l’établissement d’un guichet unique pour tout ce qui concerne les programmes fédéraux destinés aux enfants autochtones. À mesure que ces travaux avanceront, le gouvernement fédéral poursuivra sa collaboration avec l’Assemblée des Premières nations, l’Inuit Tapiriit Kanatami et les autres partenaires clés.

**Pratiques d’arrêt du tabac**

En 2005-2006, le programme de lutte au tabagisme a poursuivi sa participation au financement des lignes téléphoniques d’aide destinées aux fumeurs et ses engagements au chapitre des activités d’élaboration, de coordination et d’évaluation. Les lignes d’aide offrent gratuitement l’accès à des spécialistes formés, qui peuvent aider l’appelant à élaborer un programme personnel d’arrêt du tabac ou fournir des conseils aux amis et à la famille des fumeurs. Le programme de lutte au tabagisme est un participant et un bailleur de fonds actifs du réseau canadien des lignes téléphoniques d’aide. Le réseau offre de la formation, fait de la recherche et élabore des protocoles de counseling spécialisés fondés sur les pratiques exemplaires. Ces protocoles s’adressent à des sous-groupes de la population, comme les femmes enceintes et les nouvelles mères, désireux de renoncer au tabac. Le Center for Behavioural Research and Program Evaluation de l’Université de Waterloo a réalisé des évaluations des résultats sur une période de trois ans et constaté que les taux de sevrage oscillaient entre 8 pour cent et 14 pour cent.

Le programme est aussi impliqué dans la coordination et l’évaluation d’une approche nationale d’arrêt du tabac fondée sur un modèle de soins par paliers. Cette approche d’arrêt du tabac exige que l’on apparie les fumeurs au bon programme de sevrage en se basant sur le niveau de dépendance et le niveau de soutien social. La version actualisée de « Une vie 100 fumer », un programme d’arrêt du tabac destiné aux jeunes de 15 à 19 ans, a été évaluée en 2005. Les résultats montrent que, de 12 à 18 mois après avoir participé au programme, les jeunes demeurent très satisfaits du programme. Lors de l’évaluation de contrôle, 16 pour cent des
participants ont affirmé avoir cessé de fumer, et entre 8 à 16 pour cent des participants étaient encore des abstinents de longue durée un an après avoir suivi le programme, comparativement à 5 pour cent des jeunes dans la population générale.

Northwest Territories

- An integrated service delivery model has been developed to define levels and types of service across the HSS system. This delivery model is used as the basis for determining staffing mix and how funds will be allocated to HSS Authorities.

Yukon Territory

- The provision of insured physician and hospital services in all Yukon communities is administered centrally by the Yukon Government, Department of Health and Social Services.
  - No major health systems projects were initiated. However, the following outlines the basic services available in rural Yukon communities: Four Yukon communities outside Whitehorse have resident physicians and the remainders are served by visiting physicians.
  - Health Centres with Community Nurse Practitioners serve all 12 rural and remote communities.
  - Home support programs are provided in all 12 rural and remote communities and four of the communities have dedicated home care nursing.
  - The Children’s Dental Program provides preventive and restorative services from preschool to Grade 8 in all communities (and up to Grade 12 in communities without a resident dentist).
  - Various other health services (mental health, rehab, home care, hearing services, etc.) are provided by visits from health professionals who travel to the communities. Some elements of mental health and rehab are now part of a telehealth pilot project (see Health Technology).
  - The Healthy Family Initiative for early intervention to improve the quality of life for Yukon children and their families, based on the Hawaiian model, is in place.

British Columbia

Infection Disease Prevention

**B.C. puts in place an HIV/AIDS strategy**

- September 2003, *Priorities for Action in Managing the Epidemics – HIV/AIDS in B.C.: 2003-2007* was released to health authority CEOs and AIDS community service organizations. The directional document serves as a blueprint to guide and support community and health authority efforts to manage the HIV/AIDS epidemic in B.C.
Advances in medical science, improved quality of care and support, have enabled many people living with HIV/AIDS to manage their health more effectively and extend their life expectancy.

In 2003, B.C. made HIV a reportable disease, to better track the course of the disease, to reach those who are not aware of their exposure to HIV and to protect the public from ongoing transmission.

Government’s strategy focuses on sustained effort in four key areas:

- Prevention – achieve a 50% reduction in both the number of people becoming infected each year and the number who are HIV-positive but unaware of their infection.
- Care, Treatment and Support – increase the proportion of HIV-positive individuals who are linked to appropriate services by 25%.
- Capacity – improve the province’s response to B.C.’s current HIV/AIDS epidemics and anticipate and respond to future developments.
- Cooperation and coordination – encourage consensus and co-operation among stakeholders at the federal, provincial, regional and community levels.

Each B.C. health authority has developed, or is developing, an HIV service plan.

The Dr. Peter Centre, in downtown Vancouver, opened September 25, 2003 and is designed to provide comprehensive comfort care for people with HIV and AIDS.

Through BC Housing, government provided $4.3 million in operating subsidies for the Dr. Peter Centre, over 35 years, for the housing component of the project. The Ministry of Health Services and Vancouver Coastal Health provided $3.9 million in capital, Vancouver Coastal Health provides $1.8 million annually for the 24-hour care in the residence and Provincial Health Services Authority provides $1 million in annual operating funding for the day centre.

**Flu doses increase to largest amount ever**

In 2005, the Ministry of Health increased its flu vaccine order by 10% to 1.28 million doses – the largest number ever ordered for B.C. Regional health authorities across British Columbia started their annual influenza vaccination clinics in early November. All eligible British Columbians can access the free flu vaccine from their local public health unit or their doctor.

**Meningitis, chickenpox vaccine programs expanded**

Immunization programs announced in September 2004 were expanded to ensure children and high-risk groups are protected from vaccine preventable diseases. This includes:

- Two-month old infants were eligible for the meningococcal C conjugate vaccine in June 2005, a full seven months ahead of the original implementation date of January 2006;
- Children aged 18 to 48 months were eligible for the chickenpox vaccine beginning April 1, 2005, for one year, to ensure that those who weren’t eligible for the infant and kindergarten vaccine program can now get it.
• Grade 12 students became eligible for the meningococcal C conjugate vaccine in 2005. This is a two-year catch up program to ensure all school age children are protected against meningococcal C disease;

• Susceptible women (those who have not had chickenpox) of childbearing age are now eligible for the varicella vaccine because chickenpox can be fatal for an infant, if the mother contracts the illness while she is pregnant. The chickenpox vaccine is **not** recommended for women who are pregnant.

**Air quality in B.C.**

The 2003 provincial health officer’s annual report found that British Columbians enjoy good air quality by Canadian and world standards, but indoor and outdoor air pollutants can cause harmful health effects. Annual health care costs of treating illness resulting from air pollution are estimated at $167 million. The levels of air pollutants in B.C. vary, with the Interior, the north and the Lower Fraser Valley having more exposure to pollutants. Five priority actions are recommended:

• Reduce exposure to second-hand smoke across the province;

• Decrease exposure to airborne particles in interior and northern regions;

• Reduce aboriginal people’s exposure to indoor air pollutants such as molds and second-hand smoke;

• Reduce vehicle emission and other transportation pollutant exposure in the Lower Fraser Valley;

• Provide public education programs on what individuals can do to improve air quality.

**Alberta**

• Alberta Health and Wellness contributed $2,330,000 to support community-based HIV organizations and community projects through the Alberta Community HIV Fund (ACHF), a joint community/provincial/federal fund disbursement model. ACHF is a collaborative partnership between the Alberta Community Council on HIV (ACCH), Alberta Health and Wellness and the Public Health Agency of Canada. Presently, 14 Alberta community-based HIV organizations and the ACCH receive operational funding. Thirteen projects, sponsored by other community organizations, are also being supported.

• Alberta Health and Wellness issued a report with 99 recommendations aimed at improving Alberta’s organ and tissue donation and transplantation system. Building on those recommendations, the department prepared a document entitled “**Getting Started: Implementation Strategy for an Integrated and Coordinated System for Donation and Transplantation in Alberta**” that outlines implementation activities. Implementation activities already underway or completed include development of policies for new legislation, examination of potential for designated centres, identification of barriers to donation, and improvement of self-sufficiency in accessing tissues for transplantation. The Alberta Strategy will link with the work of the Canadian Council for Donation and Transplantation where appropriate.
Saskatchewan

- Saskatchewan Health provides funding to regional health authorities to provide community services. These services include outpatient mental health services; alcohol, drug and problem gambling services and rehabilitation; inpatient mental health services in selected hospitals and residential care for mental health; and alcohol and drug treatment.

- Saskatchewan Health is responsible for coordinating the delivery of education, prevention and treatment services for problem gambling. Saskatchewan Health initiatives include:
  - Outpatient services in health regions;
  - Funding for in-patient treatment services;
  - Specialized day treatment programs;
  - Problem gambling help line services;
  - Support for community development initiatives, education and learning opportunities;
  - Provincial prevention and public education programs;
  - Training for new counsellors as well as advanced training opportunities for existing health region and help line counsellors; and
  - Research.

- In 2005-06, Saskatchewan Health will provide $4.0M for problem gambling prevention and treatment services. This is the second highest provincial per capita expenditure on problem gambling in Canada.

- Saskatchewan Health is involved with a number of initiatives providing support services to individuals and families affected by Fetal Alcohol Spectrum Disorder (FASD), including

Saskatchewan Prevention Institute: Provincial Fetal Alcohol Spectrum Disorder Prevention Program - The Saskatchewan Prevention Institute Incorporated, a non-profit organization, coordinates and administers a provincial FASD Prevention Program. The provincial departments of Health and Community Resources and Employment fund the program. Initiatives include raising public awareness and providing education across the province; developing and distributing resources and information; providing provincial coordination, and supporting communities in their efforts to address FASD.

Provincial Clinical Teratology Program - Saskatchewan Health has contributed funding since 1999 to support the Provincial Clinical Teratology (the study of malformations or serious deviations) Program within the Department of Paediatrics at the University of Saskatchewan. The clinic is located at the Kinsmen Centre and works with a team of professionals and service providers in making a diagnosis and identifying further needs. The Fetal Alcohol Spectrum (FAS) Clinic is provided one-day per week. A traveling clinic also provides services a few times a year.

Saskatchewan Health is also overseeing a range of initiatives under the Cognitive Disabilities Strategy that will provide individuals and families affected by cognitive disabilities, including
Fetal Alcohol Spectrum Disorder (FASD), with better access to supports and strengthen prevention and early intervention of FASD. These services are not designed to replace existing services or to develop a new service delivery system, but rather are designed to enhance existing supports, fill service gaps and support frontline service providers.

KidsFirst North Program is a key interdepartmental initiative designed to support families in vulnerable circumstances in developing the capacity to nurture their children. Emphasis is also placed on the prevention of FASD.

- Saskatchewan Health has been involved in developing a Provincial Strategy for Individuals with Cognitive Disabilities. A key component of the strategy is to provide supports based on the functional impact of the disability, which will allow for more flexible and individualized responses to individual needs. The Cognitive Disabilities Strategy includes:
  - Increased access to assessment and diagnostic services
    - Additional assessment and diagnostic resources to the regional health authorities of Regina Qu’Appelle, Saskatoon, and Prince Albert Parkland.
    - Development of a telehealth pilot in the north to improve access to FASD diagnosis and assessment.
  - Strengthened access to supports based on need
    - Hiring of four community based Cognitive Disabilities Consultants to provide families, caregivers and service providers with increased knowledge about effective support planning and implementation.
    - New funding for individualized and flexible supports to supplement and extend existing program capacity.
  - Strengthened prevention and early intervention of FASD
    - Hiring of additional home visitors for the KidsFirst North to encourage vulnerable women to have alcohol-free pregnancies.
    - Development of sample curriculum units relating to FASD for secondary school students.
    - Province wide intervention training to enhance the ability of physicians, health care providers and other frontline service providers to support and assist women who are at risk of having an infant with FASD.
  - Support for the Saskatchewan Fetal Alcohol Support Network (SFASN)
    - Funding to provide information and referral services to individuals and families that are impacted by FASD.
    - SFASN assists professionals with specific information and presentations.

Extra-judicial Sanctions Project
- Youth who are suspecting of having FASD are referred to an alternative measures program when they are facing criminal prosecution.
- Youth will receive assessment and diagnosis if necessary, be held accountable for their offence in ways that are meaningful to them, and participate in short and long term intervention plans that have been tailored to their needs.
• The primary objective of the seniors’ portfolio is to promote and enhance the health and well-being of older persons in Saskatchewan by working collaboratively with stakeholders to jointly address issues related to older persons. The Minister Responsible for Seniors' role is to provide a voice and sensitivity to seniors’ issues across program areas and Departments.

• Services provided include the Provincial Advisory Committee of Older Persons (PACOP). This 13-member committee reports directly to the Minister Responsible for Seniors and offers advice and guidance to the Minister on seniors’ issues. The PACOP and Alzheimer Society of Saskatchewan presented _A Strategy for Alzheimer Disease and Related Dementias in Saskatchewan_ to the Minister in January 2005.

• The Saskatchewan Cancer Agency (SCA) provides approximately 38,600 radiation therapy treatments and 16,400 chemotherapy treatments to cancer patients out of its Saskatoon and Regina cancer clinics. In addition, approximately 5,900 chemotherapy treatments are provided to cancer patients in communities across the province through the Community Oncology Program of Saskatchewan (COPS).

• All RHAs have a Quality of Care Coordinator (QCC) or designated person to review concerns about the care of a client. Saskatoon and Regina each have a full time person dedicated to this process. The Saskatchewan Cancer Agency also has a Coordinator for quality of care questions or concerns. The role of the QCC is to:

  o assist individuals and families with questions or concerns about health services in their region;
  o ensure individuals are informed about their rights and options; and
  o recommend changes and improvements to enhance the quality of health services delivered in the region based on their findings and trends of concerns raised.

• The Acquired Brain Injury (ABI) program's mandate is to enhance the rehabilitation outcomes and improve the quality of life of individuals with an acquired brain injury and their families. The ABI Partnership Project is a joint initiative, funded by Saskatchewan Government Insurance and managed by Saskatchewan Health that has worked to provide a coordinated and integrated continuum of community based services across the province for individuals with ABI, their families and communities.

  A provincial advisory group has played an instrumental role in providing ongoing consultation to the project. Consisting of 40 programs, including three outreach teams, the ABI Partnership Project provides services through health regions and community-based organizations throughout the province. The program will also focus on a community injury prevention grant program, and community training and education initiatives.

  The program's most recent evaluation report was released in the 2004-05 fiscal year, which highlighted client outcomes for its service delivery structure. Results included:

    o cost-benefit analyses;
    o a literature review, which indicated that components of the Partnership meet the needs of individuals with moderate to severe acquired brain injury;
    o survey results which indicated that the Partnership strives towards continuous quality improvement in providing client-centred care; and
a good client service match and that Partnership services are responsive to addressing clients’ varied needs.

The program is undertaking a current evaluation with continued focus on client and program outcomes and client, family and community satisfaction with services.

**Manitoba**

- Public Health activities in 2005/06 included:
  - Tabling of a new Public Health Act.
  - Planning for enhanced public health surveillance and a laboratory information system.
  - Promotion of primary prevention and healthy living throughout program areas.
  - Extensive planning for enhancement of storage and distribution of vaccines and other drugs.
  - Planning and research related to c Difficile
  - Completion of implementation of expanded immunizations for children.
  - Implementation of Manitoba Tobacco Strategy and the *Non-Smokers Health Protection Act*, and ongoing measures to discourage access to tobacco products.
  - Implementation of partnership and funding for the Chronic Disease Prevention Initiative.
  - Activities related to prevention of sexually transmitted infections and the promotion of healthy sexuality.
  - Planning activity for the provincial tuberculosis program.
  - Planning activity related to preparedness for pandemic influenza.
  - Management of a comprehensive West Nile Virus Program.
  - Organization of various education events for health professionals – e.g. tuberculosis, diabetes education, travel health, health disparities.
- Manitoba Health/Healthy Living and Regional Health Authorities have agreed to a list of deliverables including: immunization, sexually transmitted infections, injury reduction, breastfeeding initiation and duration, health planning with Aboriginal Manitobans and regional diabetes initiatives in a multi-year process.
- Development of models for inter-jurisdictional partnership in management of diseases
- Further detail on community health initiatives is included in the Population Health-based Initiatives” section of the report.

**Ontario**

*Overview of Governance/Management of Services*

Community health services, including community health centres, diabetes education centres, midwifery services and HIV/AIDS organizations, are governed by incorporated, community-
based, not-for-profit agencies governed by locally elected boards of directors. The MOHLTC administers the organizations’ funding through service agreements.

**Changes of service provision/strategic initiatives**

**Community Health Centres (CHCs)**

- In 2005-06 the government is investing an additional $14.0 million in Community Health Centres over 2004-05 funding levels, to bring the total allocation in 2005-06 to $170.6 million including:
  - $5.0M to add 7 new Community Health Centres and 5 new satellite CHCs to the health care sector
  - $9.0M to annualize the 2004/05 CHC investments, including 10 new satellite CHCs announced in November 2004
- The $5.0 million investment for new CHCs and satellite CHCs will grow to $18.6 million by 2007/08.
- On November 10, 2005, the Minister announced a CHC expansion plan and stated that once fully implemented, we anticipate that the new CHCs and satellite CHCs will serve an additional 200,000 people.

**HIV/AIDS Funding Enhancements**

In 2005-06, the total HIV/AIDS funding for 2005/06 was $27.4M, which comprises $17.7M for AIDS Bureau, $9.7 for Ontario HIV Treatment Network (OHTN). The 2005-06 allocation included $4M in new funding to enhance HIV prevention initiatives and prepare for the 2006 International AIDS Conference in Toronto. The breakdown of the $4M increase is as follows:

- $3.25M for HIV prevention initiatives in priority populations – gay/bisexual men, Aboriginal people, injection drug users, and Ontarians from countries where HIV is endemic;
- $0.75M to support the 2006 International AIDS Conference in Toronto.

**Hepatitis C Secretariat**

The establishment of the Hepatitis C Secretariat was announced by the Minister of Health in October 2004. Responsibilities include:

- Administration of the Ontario Hepatitis C Assistance Plan
- Meeting the Ministry of Health and Long-Term Care's obligations under the Multi-Provincial Territorial Assistance Plan and the 1986 -1990 Class Action Settlement Agreement
- Administrative and policy support to the Ontario Hepatitis C Task Force
The Minister appointed a 16 member Task Force effective April 1, 2005. The mandate of the Hepatitis C Task Force is to provide advice on strategies to improve all aspects of hepatitis C treatment, prevention, education and support in Ontario.

**Collaborations with external organizations**

**Funding Trends**

The Ontario Ministry of Health and Long-Term Care spent over $175 million in 2005-06 to fund Community Health Centres. In recent years, CHCs have benefited from additional funding for nurse practitioners and early childhood development.

The Midwifery Program budget was $6.2 million in 1994. In 2005-06, the Midwifery Program budget was $51 million. Ministry resources have enabled all registered midwives to have the opportunity to provide funded services in Ontario.

The Ontario Ministry of Health and Long-Term Care allocated $54 million in 2005-06 for HIV/AIDS related programs. The Ontario government operates a number of programs and services designed to assist people living with HIV/AIDS and communities at risk for HIV infection.

**Quebec**

Le rapport du directeur national de santé publique sur l’état de santé de la population du Québec « *Produire la santé* » a été publié en avril 2005. Ce rapport dresse le portrait de la société québécoise en matière de santé et fournit des clés pour qu’elle puisse jouir d’une meilleure santé, en décrivant les problèmes évitables les plus criants auxquels elle doit faire face et, surtout, en expliquant comment mieux les prévenir.

Le rapport sur les infections nosocomiales, présidé par M. Léonard Aucoin et publié en juin 2005, recommande plusieurs mesures visant à améliorer la prévention et le contrôle des infections nosocomiales, c’est-à-dire celles qui se transmettent en milieu de soins. Parmi celles-ci, on propose qu’un comité de prévention des infections soit mis en place dans chaque établissement.

Le gouvernement a adopté en juin 2005 le projet de loi no 112, apportant ainsi des modifications à la Loi sur le tabac qui intensifient la lutte contre le tabagisme, notamment auprès des jeunes. Il comprend plusieurs mesures qui concernent l’interdiction de fumer dans les lieux publics ou à proximité des établissements de santé et de services sociaux ou de maisons d’enseignement, l’exercice d’un meilleur contrôle de la publicité par les fabricants des produits du tabac et la réduction de l’accès des jeunes à ces produits.

Le plan québécois de lutte à une pandémie d’influenza a été rendu public en mars 2006. Il présente vingt-quatre stratégies et une série d’activités concrètes à réaliser au niveau provincial. Les agences régionales de la santé et des services sociaux produiront ensuite leur Plan régional de lutte à une pandémie d’influenza pour coordonner les activités dans chaque région. Enfin, au plan local, chaque établissement préparera son plan spécifique en accord avec sa mission. Le plan national se déploie selon cinq grands volets : la santé publique, la santé physique, l’intervention psychosociale, la communication et le maintien des services. Les groupes d’acteurs définis au plan sont les citoyens, les aidants naturels, les divers intervenants et les décideurs, dont les élus au premier chef. Il prévoit des modalités pour assurer le maintien des services du réseau, notamment par le recours à du personnel de relève (retraités, nouveaux diplômés, étudiants, etc.) et à des bénévoles.

A report by the directeur national de santé publique on Quebeckers’ state of health, entitled Produire la santé, was made public in April 2005. This report drew a portrait of health in Quebec and pointed the way to better health by outlining the most pressing preventable health problems and, especially, how to prevent them more effectively.

A report on nosocomial infections, written by Léonard Aucoin and published in June 2005, recommended several measures to improve the prevention and control of nosocomial infections, i.e. infections transmitted in care settings. One of the recommendations was that every establishment set up an infection control committee.

In June 2005, the government adopted Bill 112, which modified the Tobacco Act and strengthened efforts to fight smoking, especially among youth. It contained several measures related to prohibiting smoking in public places or near health and social service establishments or educational institutions, exercising greater control over advertising by tobacco product manufacturers, and reducing young people’s access to these products.

A report entitled L’amélioration des saines habitudes de vie chez les jeunes, submitted by Jean Perrault, Chair of the Équipe de travail pour mobiliser les efforts en prévention, was released in September 2005. He put forward a preventive approach to health among the youth, especially with respect to nutrition and physical activity.

The Plan québécois de lutte à une pandémie d’influenza was made public in March 2006. It contained 24 strategies and a series of concrete activities to be implemented at the provincial level. The regional health and social service boards will produce their Plan régional de lutte à une pandémie d’influenza so as to coordinate efforts in each region. Finally, on the local level, each establishment will prepare its specific plan in accordance with its mission. The national plan is based on five major components: public health, physical health, psychosocial intervention, communication, and the maintenance of services. The groups of players identified in the plan include the public, caregivers, and the various stakeholders and decision makers (especially elected officials). It contains measures to maintain the system’s services, primarily through the use of relief staff (retired people, new graduates, students, etc.) and volunteers.
New Brunswick

- The Community Health Centres recognize the importance of community health in their framework and service delivery models. Work to address community health needs may be provided directly by the Community Health Centre or in partnership with other organizations or health care providers.
- See Primary Health section.

Nova Scotia

The Nova Scotia Department of Health has not adopted a definition of community health. However, it recognizes that integrated, community-based health care is the foundation of the Nova Scotia health system. Community-based health care is generally viewed as health care services based in the community to support individuals and families as close to home as possible. The term implies community involvement in planning for health care services.

Prince Edward Island

Provincial Addictions

- The Provincial Addictions Treatment Facility provides in-patient residential addiction treatment program services to all persons in the province. Coinciding with treatment programs are one-on-one and group counselling, and educational programs for families of chemically dependent clients. Following treatment, clients are expected to participate in weekly after-care programs. Outpatient detoxification service is also available in all health regions to provide detoxification to clients with less severe addictions.
- The client-centred community-based mobile program for problem and pathological gamblers and their families continues to be delivered across PEI through the Provincial Addiction Treatment Facility and the health regions. The target population is persons who have become harmfully involved in gambling and pathological gamblers.
- A women’s addiction treatment program is available at the Provincial Addictions Treatment Facility and is also a mobile program delivered in the regions on an as needed basis. The focus of the program is improving the quality of life for women and their families.
- Smoking cessation programs are available provincially and are delivered by addiction nurses through outpatient detoxification programs.

Healthy Living

- The Department, in partnership with other government departments and private sectors, released a comprehensive and integrated Provincial Strategy for Healthy Living in June 2003 in order to improve the health of Islanders. Focusing on tobacco reduction, healthy eating and physical activity, promising strategies for promoting population health in PEI include building healthy public policy, creating supportive environments, strengthening community action and developing personal skills. Goals of the Strategy are: to reduce tobacco use and the harm it causes to the population of PEI; to increase the number of Islanders who
participate in regular physical activity in sufficient quantity to promote optimal health; to improve healthy eating habits that support good nutritional health with the aim to increase capacity for health promotion and chronic disease prevention. The current focus of the Strategy includes developing networks, internal and external communication strategies, and an evaluation framework.

- The Healthy Eating Strategy, a component of the Healthy Living Strategy, is focused on improving current eating behaviours of Island children and youth through nutrition education, promotion and by creating supportive environments. The goals of the Strategy are to increase nutrition education and promote healthy eating among students, parents, teachers, and all those who work with children; to increase access to safe and healthy foods in every place where children gather; and to increase understanding of how children and youth are currently eating and why, and how best to improve their current eating behaviours through up-to-date and quality research. As part of this strategy, an education program designed to promote vegetable and fruit consumption was piloted in several schools across the Island. Leadership was provided in the development of the nutrition component of the Elementary School Health Curriculum.

**Tobacco Reduction**

- The PEI Tobacco Reduction Alliance (PETRA) is another component of the Healthy Living Strategy. PETRA has three goals: 1) to help non-smokers stay smoke free, 2) to encourage and help smokers to stop using tobacco, and 3) to promote healthy environments by eliminating exposure to second hand smoke. Several initiatives to reduce tobacco use included:
  - A Smokers Helpline is maintained to provide telephone cessation assistance. Hundreds of Islanders have used it since January 2002.
  - SWITCH (Students Working In Tobacco Can Help), peer-led prevention clubs in high schools, continued developing tobacco reduction activities within their schools and communities such as the numerous awareness raising activities held across the province in high schools during National Non-Smoking Week (Jan 17 - 23).
  - “Staying Smoke Free” was an initiative sponsored by PETRA and in particular the PEI Medical Society whose members went to Grade 6 classes across the province to deliver a tobacco use prevention message. These presentations were revised and a brochure and video was developed to help parents talk to their children about tobacco.
  - The PEI Quit Care program delivered through the Addiction Services Centre’s across the Island continues to provide group cessation counseling combined with assistance in Nicotine Replacement Therapies for participants.
  - The *Smoke-free Places Act* came into effect on June 1, 2003 to protect Islanders from the health risks associated with second hand smoke and to create smoke free public and workplaces. As part of the implementation of this Act, on Sept 29, 2004 all correctional facilities across PEI went totally smoke-free (indoors and all grounds). The smooth implementation of this policy was facilitated by collaboration with Correctional Services staff and administration and the many partners involved in the PEI Tobacco Reduction Alliance. Staffs were trained to deliver stop smoking programs to both staff and inmates using the Quit Care Program currently delivered in Addiction Services Centre’s across the
Island. Many other initiatives including subsidized nicotine replacement therapy and increased access to exercise machines, healthy snacks, puzzles, books, etc. for inmates were implemented to assist them in going smoke-free.

- The Standing Committee on Social Development held hearings on the retail sales of tobacco and their recommendations were incorporated into a revision of the *Tobacco Sales to Minors Act*. The new *Tobacco Sales and Access Act* prohibits the sale of tobacco in pharmacies or retail stores that contain pharmacies and designated places such as hospitals; health care facilities; nursing homes; provincial, municipal government buildings; schools or post secondary education buildings, recreational facilities, theatres, video arcades or amusement parks. The Act also prohibits the sale of tobacco in vending machines. These provisions are aimed at denormalizing tobacco and reducing youth tobacco use.

**Newfoundland and Labrador**

**Federal/Provincial/Territorial Initiatives**

*National Child Benefit (NCB)* – This is an ongoing initiative to reduce the depth of child poverty. It provides a direct federal benefit to low and middle income families and provincial/territorial reinvestments/investments. The Department of Health and Community Services (DOHCS) maintains an annual provincial NCB investment of $6.8M which supports family resource programs and healthy baby clubs; a range of child care services – family home child care agencies, the subsidy program, infant care centers in high schools, an Early Childhood Educators certification system, and equipment grants to licensed child centers; intervention services for children with delay and disabilities, including autism; and mental health and residential services for youth at risk.

*Early Childhood Development Initiative (ECD)* – This is a commitment to promote the early childhood period (prenatal period to age six) and to assist families and communities in their role to support children. Commencing in 2001-2002, the five-year funding for NL is $36.6M. Referred to as *Stepping into the Future*, the NL initiative provides support to: family resource programs and healthy baby clubs; child care services-subsidy program, the Educational Supplement for Early Childhood Educators, equipment grants for family home child care providers, and regional and provincial human resources; intervention services, with considerable investment in the delivery of ABA intensive home therapy for preschool children with autism; the Mother Baby Nutrition Supplement (Department of Human Resources, Labor and Employment); and early childhood learning grants and the KinderStart Program (Department of Education).

*Early Learning and Child Care (ELCC) Multilateral Framework* – This initiative was announced by the federal government in March 2003. It involves the transfer of annual sustainable funding to provinces/territories for investment in regulated early learning and child care services. The amount for NL is $16.8 M over five years, with annual funding thereafter of approximately $5.5 M. The funding supports investments in: the child care subsidy program, quality initiatives, and support for children with special needs to fully participate in child care services.
Early Learning and Child Care Bi-lateral Agreement – Building on the ELCC Multilateral Framework, the bi-lateral agreement signed on May 13, 2005, provides an additional amount of $21.6 M (one-time funding) in federal funding to the province for further investments in regulated early learning and child care. The Department is currently in the process of developing a long-term sustainable plan for implementation of the increased funding.

Children and Youth Initiatives

The Youth Corrections Initiative - is a major multi-year initiative by the Department in partnership with the RIHAs. Emphasis is on reducing reliance upon youth custody in favor of less costly, less intrusive and more community-based intervention programs.

The Model for Coordination of Services for Children and Youth with Special Needs - is a coordinated, multidisciplinary service to young people with special needs who receive services from one or more of the following departments: Health and Community Services, Education, Justice, and Human Resources Labor and Employment. Two of the primary components of the Model are the Individual Support Services Plan (ISSP) and the Profiling Process. The ISSP allows everyone from any agency / department working with a young person to come together with that young person and their family to design a common plan. Profiling identifies areas of unmet need to assist service providers in resource planning and improved service delivery.

Family Resource Programs/Healthy Baby Clubs – Provides direct program and administrative support to 19 family resource programs throughout the province. These community-run, not-for-profit programs provide developmentally appropriate activities, informative workshops and build social networks for parents and young children. Family resource programs offer specialized services such as healthy baby clubs.

Intervention Services/Autism – Provides support to individuals and families through three programs including:

- The Direct Home Services Program is a family centered, home based, early intervention program with a focus on child outcomes. It is offered to families of infants and preschool aged children who display development or are at risk for delayed development.
- Autism services provide early intensive applied behavior analysis intervention to pre-school age children up to kindergarten who have a diagnosis of an autism spectrum disorder.
- The Community Behavioral Services Program is a community based behavioral support and training program for school age individuals and adults and their families.

Wellness Initiative

Achieving Health and Wellness: Provincial Wellness Plan for Newfoundland and Labrador - was launched in March 2006. Phase 1 will be implemented over the next three years and will focus on initiatives in the wellness priority areas including: healthy eating, physical activity, tobacco control, and injury prevention. Key actions will focus on healthy eating and physical activity for children and youth in school, healthy living community based programs, a provincial wellness grants program, and new resources at the provincial and regional levels.
Population Health-Based Initiatives / Initiatives Axées sur la Santé de la Population

Health Canada

First Nations and Inuit Health

The First Ministers’ Meeting on Aboriginal Issues held in November 2005 fulfilled commitments made at the previous First Ministers’ Meeting in 2004 to hold a meeting on Aboriginal issues and to table a Blueprint on Aboriginal Health. The 2005 meeting focused on five key priorities: health, education, housing, economic opportunities, and relationships. A commitment was made to close the gap in health status between Aboriginal peoples and other Canadians within ten years. Specific targets were set to reduce infant mortality, youth suicide, childhood obesity and diabetes by 20% in five years, and by 50% in ten years. A commitment to double the number of Aboriginal health professionals within ten years was also made.

Canada’s Food Guide to Healthy Eating

Health Canada is revising Canada’s Food Guide to Healthy Eating for release in the Fall of 2006 to ensure that it reflects current scientific evidence concerning the relationship between diet and health, and continues to promote a pattern of eating that meets nutrient needs and minimizes the risk of nutrient-related chronic diseases such as Type II diabetes. In 2005-2006, Health Canada also continued to be active in providing authoritative information for health choices and informed decision making by supporting the Canadian Food Inspection Agency and the food industry in implementing new nutrition labelling requirements.

Santé Canada

Santé des Premières nations et des Inuits


Guide alimentaire canadien pour manger sainement

Santé Canada procède à la révision du Guide alimentaire canadien pour manger sainement, qui paraîtra à l’automne 2006, afin de s’assurer qu’il reflétera les données scientifiques courantes concernant les rapports entre la nutrition et la santé et continuera à favoriser les habitudes
alimentaires qui répondent aux besoins nutritifs et qui minimisent les risques de maladies chroniques comme le diabète type 2. En 2005-2006, Santé Canada était toujours actif dans le domaine de la prestation d’information faisant autorité en matière de choix sains et de prises de décisions éclairées en aidant l’Agence canadienne d’inspection des aliments et l’industrie alimentaire à mettre en œuvre de nouvelles exigences en matière d’étiquetage nutritionnel.

**Northwest Territories**

- As part of the ongoing Don’t Be a Butthead campaign, The Department of Health and Social Services launched the Create the Smoke Free Future contest in January 2006. Students from grades 3 through 12 are invited to express what they think about smoking through video, music, writing, or through visual arts such as painting, drawing, carving, or dance. Judges will select one junior winner to win $250 or a digital camera, and one senior winner, who will work with a professional artist to turn their artwork into a professionally produced creation.
- In early 2006, the Department launched Smoke Screening, an awareness campaign aimed at youth from grade 6 to 12. A curriculum based on ten anti-smoking commercials from around the world was provided to schools. Students are encouraged to discuss the messages and pick their favourite commercial. Prizes for participation are available.
- Not-for-profit non-government organizations can apply for up to $10,000 in projects under the Health Promotion Fund. Projects must promote healthy lifestyles and practices. Details on accessing the program may be found in the document *Guide to GNWT Grants & Contributions Program* on-line at [http://www.hlthss.gov.nt.ca](http://www.hlthss.gov.nt.ca).
- The Social Program Departments published the report *Homelessness in the NWT: Recommendations to Improve the GNWT Response* in November 2005. Further work on homelessness includes the development of a Policy Framework to strengthen collaboration between the Social Program Departments, and the continued funding of emergency and transitional shelters in the territory.
- In response to the worldwide concern about Avian Influenza, the Chief Medical Health Officer published four Fact Sheets. The first contains general health information for the public, the second is intended for physicians and health care workers, the third provides information on the NWT’s approach to surveillance and monitoring of birds, and the fourth answers frequently asked questions.
- The NWT offered free influenza vaccinations to all residents in the fall of 2005. To encourage uptake, the Department published a brochure titled *Myths and Facts about Influenza Vaccine*.

**Yukon Territory**

- The population has been experiencing a growth in the number of seniors in recent years. This has had a significant impact on the seniors’ drug and extended benefit programs, home care service levels, and the demand for facility based long term care services.
- A major initiative is the Active Living Strategy, a collaborative effort of several government departments and community partners.
• The Yukon Government, in partnership with the Recreation and Parks Association Yukon, has undertaken a mass media tobacco reduction campaign with funding from Health Canada directed to young adult smokers (ages 18-34 years). This campaign includes the distribution of QuitPacks, a slingback which contains tools and resources to assist young smokers in becoming smoke-free.

• At the same time, there are many initiatives underway to prevent or reduce smoking among youth. These activities include awareness raising about the tobacco industry and engaging in a range of activities intended to stimulate discussion and debate among youth in schools and youth-serving organizations.

• Making sense and moving forward: Report on the 2003 Yukon Youth Smoking Survey was distributed in October 2005 throughout the Yukon.

• A revised Questions and answers on sexual health has been printed and distributed, training on the use of Choices and Changes, a sexual health education curriculum, a toll-free sexual health information line, YK-STYLE, continues to operate, a fulsome condom distribution campaign continues, and a sexual health promotion strategy is being developed.

• Governmental and non-governmental organizations collaborate to promote breast health awareness on an annual basis.

• A prostate health awareness campaign was launched in September 2005, and there are plans to do a similar awareness campaign this fall.

• Drop the Pop, a school-based program directed at primary school students and Drink to your health! a public education campaign were launched in March 2006 to increase awareness and knowledge about healthier drink choices.

• Yukon joined the Joint Consortium on School Health, and has undertaken a number of initiatives to promote healthier school communities.

• Prevention and management of communicable disease continues to be a priority, especially in relation to food, water and blood-borne illnesses. Outreach nursing services to high-risk groups, and a dedicated Hepatitis C nurse are examples of specific activities.

• Changes to the Yukon Immunization Schedule include the introduction of vaccines for varicella for infants, pertussis for adolescents, pneumococcal for infants and toddlers, and meningitis for infants and adolescents.

**British Columbia**

**B.C. communities get healthier**

Premier Gordon Campbell proclaimed March 19, 2005 as the first annual ActNow BC day, with the goal of making the province the healthiest jurisdiction ever to host an Olympic and Paralympic Games in 2010. ActNow BC combines cross-government and community-based approaches to address common chronic disease risk factors through programs and initiatives that support healthier eating, physical activity, ending tobacco use and promoting healthy choices during pregnancy. In the 2005 throne speech, government made healthy living one of B.C.’s five Great Goals for a Golden Decade.

Act Now funding includes:
\begin{itemize}
  \item $500,000 in 2005/06 to develop the Action Schools! BC Healthy Eating Module;
  \item $450,000 in 2004/05 and 2005/06 for an electronic professional services database to provide up-to-date nutrition information to dietitians;
  \item $1.5 million in 2005/06 in grants to communities via health authorities for community kitchens, gardens, good food boxes, and other local activities;
  \item $1.5 million in 2005/06 to support municipal governments, health districts and partner organizations promote healthy lifestyles;
  \item $285,000 to support communities develop healthy public policy and encourage public leaders to talk about healthy planning in their communities.
\end{itemize}

**B.C. expands early childhood health screening**

The launch of a new $73 million program to provide universal hearing, dental and vision screening for every child under age six will give B.C. children the best possible start on a healthy, happy life. The Province will invest the money over the next three years in new infant and early childhood screening and intervention programs including:

\begin{itemize}
  \item A Sound Start, a program to ensure children born with congenital hearing loss will receive early screening, diagnosis and treatment ($19 million).
  \item Vision screening, including increased coverage for eyeglasses for children from low-income families and families on income assistance ($19 million).
  \item Dental screening and support programs, including increased dental coverage for children in families on income assistance and those receiving MSP premium assistance ($35 million).
  \item Increased dental and eyeglass coverage represents a $7.5 million annual commitment to the health of over 203,000 children in low-income families and took effect April 1, 2005.
\end{itemize}

**Healthier eating in B.C. schools**

A new pilot program was launched in September 2005 to promote healthy eating and increase access to healthier snacks in schools. The School Fruit & Vegetable Program will provide one serving of BC-grown fruits or vegetables to children twice a week at ten elementary schools. The ministry provided $300,000 to fund the study, which will be administered and delivered by the BC Agriculture in the Classroom Foundation.

**First forum to promote health in B.C. schools**

Educators, health professionals, parents, students and municipal leaders met in Vancouver in January 2005 for the first-ever forum to promote health in B.C. schools. A panel of educators and students helped to develop a framework for health-promoting schools for all students in B.C. Completion of the framework is expected by spring 2005.

**Province invests in community health promotion fund**

The Province announced a $5-million grant in April 2005 to the Union of BC Municipalities to help kick start local government involvement in building healthier communities throughout the
province. This investment will help UBCM members get to work at the local level to establish proactive health promotion and prevention programs that will help achieve B.C.’s health and fitness goals. As one of the nine organizations that make up the BC Healthy Living Alliance, UBCM has been an active member of the province’s efforts to establish the goals of ActNow BC.

Food guidelines to help schools improve student health

The Province introduced guidelines in November 2005 for food and beverage sales in schools to help eliminate junk food and improve student health and achievement. In B.C., one in four children between the ages of two and 17 is overweight or obese. Through ActNow BC, B.C.’s goal is to lead the way in North America in healthy living and physical fitness. A report on food sales and policies in B.C. public schools found:

- At elementary schools, 33% of beverage vending machine slots and 30% of snack machine slots contain “more healthy” choices.
- At secondary schools, 26% of beverage vending machine slots and 19% of snack machine slots contain “more healthy” choices.
- Less than 18% of schools have a policy or guideline in place that calls for competitive pricing of food and beverages to promote healthy choices.

Clean win for B.C. in tobacco ruling

The Supreme Court of Canada in September 2005 ruled unanimously in favour of B.C.’s effort to hold the tobacco industry to account for practices that have harmed British Columbians. The province is proceeding with its case to recover the costs that are owed to the taxpayers of B.C. The lawsuit alleges that, since the 1950s, the tobacco industry failed to warn consumers about the harmful and addictive nature of tobacco.

Alberta

The December 2001 report of the Premier’s Advisory Council on Health identified 44 recommendations for health reform, the first of which was “to stay healthy”. In response, Alberta Health and Wellness, working in collaboration with other government departments and organizations, developed the Framework for a Healthy Alberta that outlined 10-year objectives and targets to improve healthy behaviours and reduce the risk of chronic disease. The Framework is intended to guide government departments, regional health authorities and community organizations in the development of policies, programs and services to decrease the incidence of heart disease, cancer, lung disease, diabetes and other chronic diseases, and the number of injuries in Alberta.

A working group has been established to review the Framework to identify targets that need to be revised based on current evidence. They will also identify next steps in implementation and monitoring progress. Alberta Health and Wellness’ three year Healthy U initiative, focuses on raising awareness among Albertans about the importance of healthy eating and active living through key components:

- A media campaign communicates the Healthy U message to all Albertans.
• Healthy U @ work provides more targeted information to employees and employers.

• The Community Choosewell Challenge challenges communities to compete to become one of the healthiest communities in Alberta.

• Healthy U Crew, a group of young individuals, share information at local events around the province.

• A website provides access to credible information and weekly tips.

• Phase II of Healthy U is underway and has a primary focus on children and their parents and caregivers. The Snactivity Box, a resource kit for registered day home and day care providers is being distributed in stages. It provides information and activities for them to use with young children in their care.

• The Premier’s Award for Healthy Workplaces has been introduced. It recognizes the efforts of employers to promote healthy workplaces including healthy eating and active living programs.

• In July 2003, a Memorandum of Understanding was signed between Alberta Health and Wellness and Health Canada to participate in the World Health Organization (WHO) Countrywide Integrated Non-communicable Disease Intervention Program (CINDI). The WHO CINDI Program is a cooperative international effort to promote activities that focus on risk factors (such as smoking, alcohol abuse, inadequate dietary intake and sedentary lifestyles) that are common to major non-communicable diseases. This memorandum officially recognizes Alberta, via the Alberta Healthy Living Network (AHLN), as a demonstration site for an integrated approach to chronic disease prevention and health promotion. The Healthy Alberta Communities project will link evaluation outcomes for the AHLN to CINDI.

• Alberta Health and Wellness is an active participant of the Coordinating Committee of the Alberta Healthy Living Network, which provides leadership for an integrated approach to chronic disease prevention and health promotion. The activities of the Network supplement Alberta Health and Wellness prevention initiatives, for example, the Framework for a Healthy Alberta, Healthy U, the Alberta Diabetes Strategy and participation in the Integrated Pan Canadian Healthy Living Strategy.

• The Alberta Blood Borne Pathogens (BBP) and Sexually Transmitted Infections (STI) Strategy 2005-2011 is in development to provide direction for the prevention, care and management of BBPs and STIs in Alberta.

• Alberta Health and Wellness is taking the lead in facilitating a Population Health Provincial Non-Prescription Needle Use (NPNU) Consortium to prevent the transmission of blood-borne pathogens and to reduce the harm associated with non-prescription needle use. The NPNU Project is advised by a broad-based, 39-member, multi-sectoral, provincial consortium that addresses emerging issues and policy recommendations from seven task groups regarding priority themes including: surveillance, public awareness, Aboriginal groups, prisons, mental health services, addiction services, and community and professional development. An Opioid Dependency Treatment Coordinating Committee has also been established to assume central leadership for the delivery of opioid dependency services in the province.
The *Alberta Diabetes Strategy* (2003-2013) focuses on both primary prevention and management of diabetes. Key components of the strategy include:

- Financial assistance for low-income Albertans without private insurance to help them purchase the supplies that assist them to manage their disease.
- The community based *Keep Your Body in Check Program*, developed in May 2004 in partnership with the Canadian Diabetes Association (CDA) was launched in three communities (Norwood/Edmonton city center communities, St. Paul/Bonnyville and Medicine Hat). The program targets families, youth and Aboriginal youth and aims to educate Albertans on how to reduce their risk of developing type 2 diabetes. There have been 8,036 registrations to date.
- Educational tools for people with diabetes and for health professionals, based on the Canadian Diabetes Association 2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada, were recently developed. Dissemination of these resources will take place this spring to many stakeholders including regional health authorities.
- A mobile team of health professionals visit off-reserve Aboriginal communities to screen individuals for diabetes and its complications. A total of 16 communities have been visited since November 1, 2003.

New cross-ministry initiatives have been established for the province which includes a project to develop a comprehensive provincial strategy to promote health, well-being and mental health of all children and youth.

Alberta Health and Wellness has lead responsibility to facilitate the development of this strategy, which will be built by addressing the determinants of health that will improve the wellness of children and youth. The project was launched in January 2006. Nine ministries, the Alberta Alcohol and Drug Abuse Commission (AADAC), Alberta Mental Health Board and the Public Health Agency of Canada are involved.

Three priorities for immediate (18 months to 3 years) action have been identified: healthy eating and active living, building resiliency (the capacity to respond positively to life’s challenges) and healthy choices (in areas of risk taking such as sexuality, use of alcohol, tobacco and other substances, sports and vehicle use).

Actions to address these priorities will be further advanced in the longer term (10 year) strategies along with additional priorities that will be identified as the strategy continues to develop.

The *Alberta Cervical Cancer Screening Program* is a new program operated by the Alberta Cancer Board. The program provides a population-based approach to cervical cancer screening targeting Alberta women 18 to 69 years of age with the goal to reduce the incidence and mortality from cervical cancer through enhanced prevention, early detection and treatment of precursor conditions.

The *Alberta Breast Cancer Screening Program* was announced in October 2004. The collaborative program will be coordinated by the Alberta Cancer Board and includes radiologists and health regions as key partners. Alberta women 50 to 69 years of age will be targeted for screening mammography. The goal is to decrease mortality from breast cancer.
The Alberta Perinatal Health Program was established on July 1, 2004, to promote maternal health, positive birth outcomes and healthy infancy by providing provincial leadership and enhanced support to health regions, health professionals, Alberta Health and Wellness and other stakeholders. This provincial program is administered through a partnership between two health regions and the Alberta Medical Association.

Alberta Health and Wellness will provide over $6.5 million for a managing obstetrical risk program over five years to be administered through the Alberta Perinatal Health Program.

Alberta Pandemic Influenza Contingency Plan advancements included an internal exercise for emergency preparedness, an estimate of funds required for supplies to be stockpiled and completion of a strategy to encourage self care when ill with influenza during the annual influenza season and in the time of a pandemic. A provincial stockpile of 2.6 million doses of antiviral medications has been secured for administration to Albertans, according to specific priority groups, during an influenza pandemic.

A provincial Smallpox Emergency Response Plan has been developed in the event of accidental or purposeful release of the smallpox virus. The plan provides a public health response to any smallpox threat in Alberta and provides a model for regional health authorities to build regional smallpox plans.

Alberta Health and Wellness facilitated the development of the Environmental Health Field Manual for Private, Public and Communal Drinking Water Systems in Alberta. Membership on the committee included representatives from regional health authorities; the Provincial Laboratory of Public Health; Alberta Environment; Health Canada; Prairie Farm Rehabilitation Administration; Alberta Infrastructure and Transportation; and Alberta Health and Wellness. It is estimated that approximately 600,000 Albertans do not have access to drinking water provided by an approved municipal water treatment facility. Untreated, uninspected and unmonitored systems are a potential concern to public health and occasionally present conditions that warrant an emergency public health response. The manual is designed as a reference guide for public health inspectors of regional health authorities and includes an emergency response protocol that the health authorities can apply in the event of a laboratory confirmation of bacteriologically failed or otherwise unsafe drinking water. The manual is in its second revision and has been distributed throughout Canada.

**Immunization Program**

Alberta Health and Wellness is leading the development of a province wide immunization strategy that will address immunization rates currently below target for all Albertans. This strategy will encompass the results of a literature review; local, provincial, national and international environmental scan; and extensive consultation with stakeholders. The Alberta Immunization Strategy will recommend evidence based strategies that will be implemented over a 10 year period and address all age groups within Alberta’s population. The target release date for the strategy is June – September 2006.

Alberta Health and Wellness provides provincial recommendations and guidelines to assist with implementing the provincial immunization program in the form of an Alberta Immunization Manual (AIM). The last revision to the AIM was in 2001. The format of this manual will be completely revised which provide a comprehensive program guidelines that
will be used by public health staff in the health regions who operationalized Alberta’s Immunization Program. The final draft of this manual is targeted for September 2006. Extensive consultation with public health staff in the health regions will occur at that time.

- Work continues to promote routine childhood immunization by practicing physicians in Alberta by discussing immunization with the parents and referring them to their local public health office. Specific print items are available on the public government website under the logo “Prevention in Practice” for physicians to order or download.

- New pamphlets have been developed for some of the routine childhood vaccines to be used by public health staff in the health regions and work continues to develop the remaining pamphlets for all routine childhood vaccines.

**Saskatchewan**

- Regional Health Authorities (RHAs) have the authority to identify and address specific health needs and issues at the regional level. In addition to region-specific strategies, numerous province-wide projects are underway.

- Province-wide health initiatives include:
  
  o Saskatchewan Health, in collaboration with the Public Health Agency of Canada and the RHAs, has continued work on the contingency plan for pandemic influenza and supports other government departments and crown corporations to incorporate pandemic influenza preparedness into their business continuity plans. Tabletop exercises have been organized for some RHAs, and a joint planning day for all RHAs was held in February 2005. Saskatchewan Health has prepared and distributed fact sheets on influenza/pandemic/avian flu as well as influenza prevention and self-care to all media and the general public. The province is also participating in a national stockpile of antiviral medication.
  
  o Saskatchewan Health, in co-operation with Regional Public Health Services and First Nations jurisdictions, with assistance of federal funding, introduced three new vaccines into the routine publicly funded immunization program:
    
    - meningococcal conjugate vaccine program was initiated in October 2004 for infants at 12 months of age, preschool (age 4) and an adolescent catch-up dose at Grade 6;
    
    - varicella immunization, commonly known as chickenpox, started on January 1, 2005 for all infants 12 months of age, and an adolescent catch-up dose at Grade 6. The vaccine is provided to children who have not had chickenpox disease;
    
    - beginning April 1, 2005, pneumococcal conjugate immunization will be provided universally to all infants 2 months of age (born on or after February 1, 2005);
    
    - in the fall of 2005, influenza vaccine was added to the publicly funded immunization program for all children 6 - 23 months of age.
  
  o The Saskatchewan West Nile Virus Working Group, a multi-disciplinary group of representatives from government and external stakeholders formed in 2000, developed the Provincial West Nile Virus Response Framework. The provincial program has focused on a number of surveillance systems and an integrated pest management
approach to mosquito control, as well as public education. It provided municipalities with grants for approved mosquito control programs to reduce the risk of West Nile Virus to humans. Communities were eligible for grants of up to $1.50 per capita, with the province contributing $2.00 for each $1.00 of approved municipal expenditure. Saskatchewan Health contracted an entomologist to coordinate the provincial response plan including mosquito surveillance and public communications and to help the municipal governments develop local mosquito control programs.

**Provincial Population Health Promotion Strategy**

- *Healthier Places to Live, Work and Play...A Population Health Promotion Strategy for Saskatchewan* was released in April 2004. The four priority areas for action defined in the Strategy are:
  - Mental Well-Being;
  - Accessible Nutritious Food;
  - Decreased Substance Use and Abuse; and
  - Active Communities.

- Saskatchewan Health hosted an evaluation workshop in October 2005 for the RHAs and their inter-sectoral partners. The purpose of the workshop was to build knowledge and skills for evaluation of their local regional population health promotion plans.
- Health regions submitted updated Regional Population Health Promotion Plans in December 2005. Saskatchewan Health reviewed plans and is providing feedback to health regions.
- The Health Promotion Unit conducted a workshop at the Moving Forward Conference on upstream strategies to prevent substance use and abuse. The workshop highlighted evidence based strategies and the need to work inter-sectorally.
- Saskatchewan Health provided funding for new staff (one full time equivalent in each Regional Health Authority) to support the health promotion and primary prevention of substance use/abuse as outlined in the Population Health Promotion Strategy and Project Hope.

**Tobacco Use Reduction**

- The smoke-free enclosed public place provisions of *The Tobacco Control Act* came into effect on January 1, 2005. Saskatchewan Health oversaw the implementation of the new provisions and worked with public health inspectors in Regional Health Authorities to enforce the Act.
- In January, the Supreme Court upheld the display ban provisions of *The Tobacco Control Act* and tobacco enforcement officers began enforcing the ban.
- The Minister of Healthy Living Services issued a challenge to all grade 12 classes to graduate tobacco free.
• Saskatchewan Health provided Regional Health Authorities funding to enhance their public health capacity, including enforcement of *The Tobacco Control Act*.

**Manitoba**

Examples of current activities that promote healthy living and lifelong health of all Manitobans include:

- **Nutrition Initiatives** – provision of expertise and capacity for identifying and responding to current and emerging food and nutrition issues, and provides interdepartmental representation on food and nutrition issues.

- **Healthy Schools** - Works with partners (Healthy Child Manitoba, Manitoba Education, Citizenship and Youth, school divisions, and regional health authorities) to promote the physical, emotional, and social health of school communities, including children, youth, their families and school staff.

- **Injury Prevention** - Working with regional health authorities and other departments and stakeholders on an Injury Prevention Strategy and on regional injury prevention frameworks which include targets and activities to reduce leading causes of death and hospitalization. Best practice documents have been produced on four injury causes to assist in planning responses. Initiatives are being developed to promote bicycle helmet use, increase children’s safety on farms and promote water safety to reduce drowning.

- **Increasing Physical Activity** - Manitoba Health and Healthy Living, is co-leading with Manitoba Culture, Heritage and Tourism, the physical activity health promotion strategy, *Manitoba in motion*. *In motion* is a provincial strategy to help all Manitobans make physical activity part of their daily lives for health benefits and enjoyment. The goal is to increase physical activity in Manitoba by 10% by the year 2010. *Manitoba in motion* joins with community partners, in the health, (including RHAs) healthy living, recreation, sport and education to raise activity levels and reduce barriers to physical activity.

Toward strengthened health for children, examples of current activities include:

- **Nutrition/Breastfeeding Initiatives** – A Food and Nutrition web site to provide education/prevention information as well as electronic resources about nutrition; infant feeding resources, developed by a partnership of government and service providers; partnership with Manitoba Council on Child Nutrition to promote healthy school eating policies and practices and a school Healthy Vending project; partnership with Manitoba Education, Citizenship & Youth and Dietitians of Canada to develop provincial guidelines to support implementation of school nutrition policies; analysis of national and provincial child nutrition survey data to produce reports on obesity and child nutrition in Manitoba; a *Baby Friendly Manitoba* Committee, including RHA as well as independent expert members, plans and coordinates activities to support breastfeeding as the best first source of nutrition for babies. Healthy Living has developed a Breastfeeding Strategy and Framework with RHAs and other stakeholders to increase breastfeeding initiation, increase breastfeeding duration and increase exclusive breastfeeding to six months as recommended by Health Canada.

- **Infant Hearing Screening** – As part of the Children’s Therapy Initiative, “I HEAR Manitoba” (acronym for Infant Hearing Screening Early Assessment and Referral) screens infant hearing at birth. Led by Brandon RHA, and operating in Brandon and Assiniboine health
regions, it is being expanding to include other rural and northern regions on a phased-in basis.

- **Sexually Exploited Children and Youth** - Working with interdepartmental partners to address the issue of sexual exploitation of vulnerable children. Resources have been produced to increase awareness for professionals working with high-risk vulnerable children. Funding has been provided to develop training for front line workers to recognize at-risk children and youth and to intervene effectively with youth involved in the sex trade.

**To address health issues of particular importance to women, activities include:**

- **Women’s Health Profile** - One of the initiatives proposed in the Strategy was a Women’s Health Profile to identify useful indicators of women’s and teen girls’ health. Toward the Profile, Health has partnered with the Women’s Health Clinic and the Prairie Women’s Health Centre of Excellence to provide a report on existing women’s and teen girls’ health profiles in other jurisdictions and health indicator information. Funding to conduct the profile has been secured through a partnership with Healthy Living, Health Canada and Women’s Health Bureau. The profile will review over 100 indicators of women’s health.

- **Reproductive Health Strategy** to enhance reproductive health promotion and improve reproductive health services including teen clinics, increasing access to reproductive health supplies, and unintended pregnancy services. A new Reproductive Health Clinic to provide a range of reproductive health services is in the planning stages. The clinic will be operated by Women’ Health Clinic and the WRHA.

- **Emergency Contraception** - Emergency contraception also known as Plan B has been added as a benefit under Pharmacare.

- **Applied Behavior Analysis (ABA) for Children with Autism**. In partnership with Manitoba Family Services and Housing and Manitoba Education, Citizenship and Youth, Manitoba Health provides funding to St. Amant Centre to provide clinical psychology supports to school-age children with autism whose families are implementing an ABA program.

**To address health priorities related to seniors, current activities include:**

- Falls Prevention Strategy and Safety Aid Initiative – A falls prevention strategy is near completion to identify activities to reduce hospitalizations and deaths due to falls. Several initiatives have been developed including supports to promote bone health, improved vision to reduce falls, and increased awareness about falls risks. The SafetyAid program home safety and crime prevention program was expanded to include a falls prevention component for senior homeowners. Home safety and falls prevention audits are conducted by a visiting team and home safety and falls prevention supplies (e.g. non-slip bathmats) are provided. Operates in Winnipeg, Brandon and Portage la Prairie and further expansion is planned.

**Aboriginal Health**

A myriad of initiatives related to the Aboriginal community in Manitoba underway include but are not limited to the following:
• Aboriginal Strategy on HIV/AIDS – Aboriginal Health Branch staff took the lead in the development of “As Long as the Waters Flow,” an Aboriginal Strategy on HIV/AIDS. An Implementation Advisory Committee was established to undertake an environmental scan of existing HIV/AIDS services available to Aboriginal people. The scan is expected to be completed in 2006.

• Multi Governmental Working Group on First Nations (formerly Romanow Joint Working Group) - Branch staff participate in the multi-sectoral working group involving both levels of Federal Government (First Nations and Inuit Health Branch, Indian and Northern Affairs Canada), Province of Manitoba and First Nations. Priority areas include: Health Human Resources, Exploration of Fiscal Frameworks, Jurisdiction, Integration of Services and Governance and Primary Health Care.

• Traditional Aboriginal Wellness Policy (TAWP) - The policy recognizes the importance of Aboriginal values, traditions and practices as a compliment to mainstream systems to build healthy Aboriginal communities.

• First Nation Personal Care Homes (PCH) - Indian and Northern Affairs Canada (INAC) directed the six unlicensed PCHs on reserve to become eligible for provincial licensing by March 31, 2006. Branch staff participates in the First Nation PCH Networking Group meetings and provide relevant information related to provincial standards, licensing and capital guidelines. Work is ongoing with INAC, Manitoba Health and First Nations toward licensing on an interim basis until a First Nation licensing and monitoring mechanism is in place.

• Norway House Health Integration Initiative - First Nations and Inuit Health Branch committed $750K for a two-year period to integrate and provide a continuum of health services for on-reserve residents of Norway House First Nation as well as those in the adjacent Northern Affairs community of Norway House. Partners include Manitoba Health, INAC, Norway House Cree Nation, Norway House Mayor and Council, BRHA and FNIHB (Manitoba region) & Aboriginal Affairs.

• Role of First Nation People with Regional Health Authorities - In 2005, a second forum “The Role of First Nation People with Regional Health Authorities” took place. Participants included: RHAs, FNIHB, INAC and First Nations. The summary report and matrix of issues is in process of being sent to forum participants. The second forum provided an opportunity for the RHAs to present on their structures, processes and initiatives and action issues identified in the matrix.

Aboriginal Health Deliverable - Staff acts as a contact for RHAs and CancerCare Manitoba as they work towards meeting the Aboriginal Health Deliverable as part of the Performance Agreements signed in 2003 between the Minister of Health and the RHAs. Eight RHAs are engaging with Aboriginal communities and will identify elements for an Aboriginal specific Health Strategy while BRHA, Winnipeg and Nor-Man RHAs have advanced beyond engagement and are continuing implementation of Aboriginal specific health strategies. The RHAs & CancerCare MB are at various stages of implementation.

Manitoba Metis Project - The Manitoba Metis Federation (MMF) is involved in a tripartite government process that has identified health as a priority. Manitoba Health contributed $25K in 2004/05 for the MMF to consult with their
constituents and identify priority areas. The MMF has now established a Health Secretariat and hired staff and is undertaking work on ways to improve health services for Metis people.

- **National Aboriginal Health Blueprint** - Staff participates with the objective of improving the health status of Aboriginal people and services delivery in Canada through concrete initiatives:
  - Improving delivery and access of services
  - Measures to ensure Aboriginal people benefit fully from improvements in the Canadian health care system,
  - A forward-looking agenda of prevention, health promotion and other upstream approaches.

- **Aboriginal Issues on Suicide** - Suicide has been identified as one of the most urgent problems facing Aboriginal communities. Aboriginal Health and ANA co-chair the Aboriginal Committee for Suicide Prevention providing a network between jurisdictions, stakeholders and services and develop processes to assist Aboriginal communities mobilize and tackle the complex issue of suicide. A provincial suicide framework has been developed with an Aboriginal component.

- **Manitoba First Nation Disability Multi Sectoral Working Group** - Aboriginal Health Staff participate in this multi-sectoral working group that is attempting to address service delivery issues faced by First Nation persons with disabilities in Manitoba.

- **Island Lake Regional Primary Health Care Centre Inc.** - Aboriginal Health staff participates as a member on the committee. The Renal Health Program has been implemented, serving four Aboriginal communities and is located in Garden Hill.

**Ontario**

**Operation Health Protection**


Since June 2004, significant steps have been taken to implement the Action Plan:

- In December, 2004, amendments to the Health Protection and Promotion Act to increase the independence of the Chief Medical Officer of Health received Royal Assent.
- In January 2005 the Ministry initiated and launched the following:
  - The creation of the Agency Implementation Task Force (AITF). The AITF is supporting the design and development of Ontario’s Health Protection and Promotion Agency.
  - The Ontario Health Protection and Promotion Agency is expected to be established by 2006/07. The Agency Implementation Task Force (AITF) presented a Phase One report to the Ministry in October 2005 and the final report was released March 20, 2006.
• An operational review of public health laboratories was completed in October 2005.

• The Government announced in the 2006 Budget, an investment of $31M over three years to support the relocation of the Central Public Health Laboratory and upgraded infrastructure for regional health laboratories.

• The Ministry announced the creation of the Local Public Health Capacity Review Committee (CRC). The CRC will advise the Ministry on options to improve the configuration and function of the local Public Health Unit system.

• The Ministry initiated 4 subcommittees to support the Provincial Infectious Diseases Advisory Committee (PIDAC): Infection Control (within healthcare facilities); Surveillance; Immunization and Communicable Diseases.

• The Ministry announced the implementation of the Integrated Public Health Information System (iPHIS). iPHIS is a web-based integrated database for all health units to use for case and outbreak management and for the reporting of communicable and reportable disease information. Information on infectious disease can be analyzed quickly, allowing health units to identify and track unusual and unexpected instances of infectious diseases.

• The Ministry has struck a Steering Committee to develop core competency training in infection, prevention and control for front-line healthcare workers. This is ongoing and a small pilot has been done in 3 acute care settings in the Spring of 2006.

• Implementation of ten (10) initial Regional Infection Control Networks is underway. The mandate of networks is to maximize coordination and integration of activities related to the prevention, surveillance and control of infectious diseases across the healthcare spectrum on a regional basis, including promoting a common and standardized approach to infection prevention and control activities, based upon best practices. Additional networks will be implemented throughout Ontario in the upcoming years.

**Overview of Governance/Management of Services**

The Chief Medical Officer of Health/Assistant Deputy Minister who reports jointly to the Deputy Minister of Health Promotion and the Deputy Minister of Health and Long-Term Care (MOHLTC) has overall responsibility for the Mandatory Health Programs and Services Guidelines (MHPSG).

The MHPSG, last published in December 1997, are province-wide standards that steer the local planning and delivery and services by boards of health. They set minimum requirements for fundamental public health programs and services targeting the prevention of disease, health promotion, and health protection. As of November 2005, four of the Program Standards were transferred to the Ministry of Health Promotion. The Minister of Health Promotion now has the authority under section 7 for these programs.

The MHSPG published by the Minister of Health and Long-Term Care under the authority of section 7 of the *Health Protection and Promotion Act* (HPPA), which also obliges the boards of health to comply with them. As of November 2005, four of the Program Standards were transferred to the Ministry of Health Promotion. The Minister of Health Promotion now has the authority under section 7 for these programs.
The MOHLTC/PHD and Ministry of Health Promotion assist boards of health in implementing the mandatory programs through the provision of professional, technical and administrative consultation and financial resources.

As part of the 2004 Ontario Budget, the government made a commitment to increase the provincial share of public health funding to 75% by 2007. Effective January 1, 2006, the provincial share of public health costs for the delivery of mandatory health programs and services increased to 65 per cent and will rise to 75 per cent by January 2007.

In addition, the MOHLTC and the MHP provide additional funding for specific public health programs (e.g., West Nile virus).

**Transfer to Ministry of Health Promotion (MHP)**

Effective November, 2005, a number of Ministry of Health and Long-Term Care programs were transferred to the new MHP. The following mandatory programs were transferred from the Public Health Division:

**Chronic Disease Prevention and Health Promotion**

Chronic Disease Prevention and Health Promotion provides public health, population health, health promotion and epidemiologic leadership and expertise to Boards of Health, the Ontario Health Promotion Resource System and other agencies. Programs and services include: chronic disease prevention (e.g., heart health, tobacco free living, healthy eating, healthy weights and regular physical activity); early detection of cancer; injury prevention including substance abuse prevention; reproductive health and child health. Key initiatives in 2005 included:

**Mandatory Health Programs and Services Guidelines**

- Chronic Disease Prevention
- Injury Prevention Including Substance Abuse Prevention
- Child Health
- Reproductive Health

**Smoke- Free Ontario/Ontario Tobacco Strategy (OTS)**

The Ministry of Health and Long-Term Care currently provides $50 million for tobacco control including funding for youth prevention programs, cessation, Aboriginal programs, Public Health Units, public education, evaluation and surveillance and provincial support programs. $1.0 million goes to the resource centres within the Ontario Health Promotion Resource Centres System.

The goals of the Strategy are prevention of tobacco use - helping youth not start to smoke, cessation - helping people quit smoking, and protection - helping Ontarians avoid second-hand smoke.
Healthy Weights

In 2004, the Chief Medical Officer of Health report was *Healthy Weights, Healthy Lives*. The report sets out a plan to promote healthy weights in Ontario. The goal is to help all Ontarians understand the factors that affect their weight and find the right balance between the food they eat and how physically active they are and to create environment – child learning and care centres, schools, workplaces; recreation centres, and communities – that promote physical activity and healthy eating. The report call on all levels of government, the health sector, the food industry, workplaces, schools, families and individuals to become part of a comprehensive province-wide effort to change all the factors that contribute to unhealthy weight.

The Ontario Heart Health Program

Phase II of the program has been implemented in 36 communities and will continue until 2008. This community-based program implements activities to address the modifiable risk factors (physical inactivity, unhealthy eating, and tobacco use) to support the prevention of cardiovascular disease. Phase II of the program will be enhanced by including chronic disease prevention as part of the program implementation. Activities will target the general population with special emphasis on children, youth, and women.

The FOCUS Community Program

Phase II of the program has been implemented in 22 communities and will continue until 2008. This community-based program implements activities to address problems including injuries associated with the misuse of alcohol and other drugs. The mandate for Phase II of the program was expanded to include alcohol as a risk factor for chronic disease prevention as part of the program implementation. Activities of the program will target the general population with a special emphasis on youth.

Stroke Strategy

Through the Ontario Stroke Strategy, a series of health promotion/prevention projects have been funded to address stroke prevention, especially in the population of 45 years and up. These projects include a public awareness campaign on the early warning signs of stroke; web-based tools for individuals to assess their risk for hypertension, production of an Implementation Guidebook to enable local communities to provide community-wide health promotion activities related to stroke prevention; continuation of building community capacity through work with health professionals in primary health care, secondary and tertiary care facilities; and the implementation of identified Best Practices/Promising Practices in stroke prevention in five communities in Ontario.

Ontario Health Promotion Resource System (OHPRS)

The OHPRS was established in 2000 as a consortium of health resource centres that support health promoters across Ontario. Currently, there are 23 resource centres, providing training, consultation services, print and electronic resources, referrals, network building opportunities and referral to health practitioners in public health units, community health centres, other health organizations.
Environmental Health Services

West Nile Virus

The Ontario government continues its commitment to the surveillance, prevention and control of this virus. The Ministry’s WNV program budget totals approximately $20M, comprising cost-sharing of the 36 public health units’ WNV programs, labs, and the Ministry’s own public communication and education program. This substantial programming has been in place since 2003. While the Ministry is the lead on West Nile Virus for the government the support of provincial partners is extremely important. Ministries of Agriculture, Food and Rural Affairs, Environment, Natural Resources, and Transportation, and the Ontario Realty Corporation are in continual communication with the Health Units. Other active partners include the Canadian Public Health Agency; Health Canada’s First Nations and Inuit Health Services, the Canadian Cooperative Wildlife Health Centre and the Canadian Blood Services.

Through O. Reg. 199/03 (Control of West Nile Virus Regulation), the local Medical Officer of Health carries out a WNV risk assessment in the community, and upon determining those required activities (if any) to control WNV in the community, is empowered to require municipality to take the required actions.

Safe Water

The Safe Water Unit of the Ministry has responsibility for drinking water protection, and recreational water protection:

- To ensure the community drinking water systems meet the health-related chemical, physical, microbiological and radionuclide objectives as published in the Ontario Drinking Water Standards and the Guidelines for Canadian Drinking Water Quality.
- To reduce communicable disease transmission from waters used for bathing at public: pools, spas, whirlpools, hot tubs, wading pools, and beaches.

Infectious Disease Control

In response to a recommendation by the Expert Panel on SARS and Infectious Disease Control (the Walker Panel) the Ministry established the Provincial Infectious Diseases Advisory Committee (PIDAC) to provide a single standing source of expert advice on infectious diseases for Ontario.

PIDAC advises the Chief Medical Officer of Health (CMOH) on prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases. PIDAC provides the CMOH with advice on issues such as guidelines and best practices for infection control, protocols to prevent and control infectious diseases, and immunization programs.

PIDAC brings together a high level of expertise from relevant fields across Ontario’s healthcare sector, including respected experts in infection prevention and control, infectious diseases, medical microbiology, public health, epidemiology, and occupational health and safety.
**Vaccines**

Three new publicly funded vaccines – pneumococcal conjugate, meningococcal C-conjugate and varicella vaccines.

The program expansion began in July of 2004. The following is an outline of the eligible age and risk groups by vaccine:

- **Pneumococcal Conjugate Vaccine:**
  - Routine infant program for infants under 2 years of age, born on or after Jan. 1/04
  - High-risk program expanded to children 24 to 59 months of age inclusive

- **Meningococcal – C Conjugate Vaccine:**
  - Routine infant program for 1-year-old infants born on or after Sept. 1/03
  - Catch-up program for children 12 years of age (grade 7) and youth ages 15 to 19 years
  - High-risk program for high-risk persons of all ages

- **Varicella (Chicken Pox) Vaccine:**
  - Routine infant program for 1-year-old infants born on or after Sept. 1/03
  - Catch-up program for susceptible (who have not had chicken pox) children 5 years of age
  - High-risk program for susceptible high-risk person of all ages

**Research Activity**

**Walkerton Health Effects Study**

- The London Health Sciences Centre and McMaster University receive funding for research that studies, reviews and makes a determination of the long-term health implications arising from the Walkerton *E.coli* outbreak. This study responds to the concerns of the people in Walkerton and the medical community about the implications of the outbreak. Some of the research questions that the study is exploring include:
  - the long-term health implications as a result of the Walkerton outbreak;
  - the physical and psycho-social impact of the outbreak;
  - a prospective cohort study of the characterization and management of long-term medical complications resulting from *E.coli* infection;
  - the incidence of, risk factors for, and genotypes associated with irritable bowel syndrome following bacterial gastroenteritis, as well as the effect of acute bacterial gastroenteritis on gut permeability;
  - permeability.
**PHRED**

The Public Health Research, Education and Development (PHRED) program is funded by the Ministry on a cost-shared basis to support two areas important to the public health system:

- applied research in public health practice
- leadership in the undergraduate and graduate education of future health and public health professionals.

**Quebec**

**Les autochtones**

En mai 2005, une entente sur les soins de santé et les services sociaux, dans la foulée de la Paix des Braves, a été signée avec le Grand Conseil des Cris. Ainsi, le budget annuel de fonctionnement du Conseil cri de la santé et des services sociaux de la Baie-James augmentera de 40 millions de dollars en cinq ans. Cette entente permettra la mise en œuvre des dispositions relatives à la santé de la Convention de la Baie-James et du Nord québécois et les sommes additionnelles investies seront utiles pour renforcer les activités de prévention et les services de base à l’intérieur des différentes communautés autochtones.

**Les jeunes**

Le projet de révision de la Loi de la protection de la jeunesse, déposé en octobre 2005, propose des ajustements du cadre législatif aux pratiques et aux connaissances d’aujourd’hui. Les modifications visent notamment à améliorer la rapidité d’action du système de protection de la jeunesse et à assurer une plus grande stabilité aux enfants placés.


**Les personnes âgées**

En septembre 2005 s’est tenu à Québec le Forum franco-québécois sur le vieillissement et la santé. Cet événement d’envergure a regroupé environ trois cents experts et invités représentant différents secteurs des sociétés françaises et québécoises. Il a donné une occasion privilégiée d’analyser certaines idées préconçues quant aux réalités liées au vieillissement, de débattre de leurs fondements et de dégager des idées nouvelles sur ces questions.

En novembre 2005, le plan d’action 2005-2010 sur les services aux aînés en perte d’autonomie a été lancé. Sous le thème « Un défi de solidarité », le plan présente des pistes d’action en relation avec les grands principes directeurs prévoyant le respect de la liberté de choisir de la personne, la volonté de permettre le maintien dans la communauté, la solidarité à l’égard de la personne proche aidante, la disponibilité de l’information et une prestation de services fondée sur les besoins réels des personnes, plutôt que d’être liés à un milieu de soins en particulier.
**La santé des femmes**

Les maisons d’hébergement pour les femmes victimes de violence conjugale et leurs enfants recevront en cours d’année une somme de 3 millions de dollars, annualisée à 5 millions de dollars et une aide financière de 1,5 millions de dollars, annualisée à 2,5 millions de dollars est allouée aux centres de femmes. Le financement qui leur est accordé totalisera 49 millions de dollars. Il existe actuellement 122 centres de femmes au Québec.

**La toxicomanie**

Le *plan d’action interministériel en toxicomanie 2006-2011* a été également rendu public en mars 2006. Le Ministère a coordonné les travaux menant à la réalisation de ce plan, en collaboration avec les ministères de l’Éducation, du Loisir et du Sport; de la Justice ; de la Sécurité publique ; de l’Emploi et de la Solidarité sociale ; de la Famille, des Aînés et de la Condition féminine ; de l’Immigration et des Communautés culturelles ; le Secrétariat à la jeunesse ; le Secrétariat aux affaires autochtones ; la Société de l’assurance automobile du Québec et le Comité permanent de lutte à la toxicomanie. Il propose 41 actions concertées visant à prévenir, à réduire et à traiter la toxicomanie au sein de la société québécoise.

**First Nations**

In May 2005, an agreement on health and social services reached under the *Paix des Braves* was signed with the Grand Council of the Crees. This agreement will see the annual operating budget of the Cree Board of Health and Social Services of James Bay increase by $40 million over five years, which will allow the health provisions contained in the James Bay and Northern Quebec Agreement to be implemented. The additional funding will be used to strengthen prevention efforts and core services within the various First Nations’ communities.

**Youth**

A review of the *Youth Protection Act*, tabled in October 2005, was designed to bring the legislative framework into line with current practices and knowledge. The proposed changes focused on making the youth protection system more timely and providing children with greater stability while in care.

The 2e *Colloque sur la maltraitance envers les enfants et les adolescents — Conter la maltraitance: un défi de société* was held on October 24 and 25, 2005. It gave all stakeholders in the various sectors the opportunity to meet and discuss the issue of child abuse and thereby improve their practices and approaches.

**Seniors**

In September 2005, the *Forum franco-québécois sur le vieilissement et la santé* was held in Quebec City. This major event on aging brought together approximately three hundred experts and guests representing various sectors of society in France and Quebec. It was an ideal opportunity to analyse some preconceived ideas about aging, discuss the underlying assumptions, and generate new ideas on these issues.
In November 2005, the plan d’action 2005-2010 sur les services aux aînés en perte d’autonomie was launched. Under the theme Un défi de solidarité, this plan contains potential solutions addressing the major, guiding principles governing a person’s freedom of choice, the desire to allow people to remain in the community, caregiver support, the availability of information, and service delivery that is based on people’s real needs rather than being linked to a particular care setting.

Women’s health

This year, women’s shelters, which serve women who are victims of marital violence and their children, will receive funding of $3 million (annualized at $5 million), and women’s centres will receive financial assistance of $1.5 million (annualized at $2.5 million). Total funding of $49 million will be provided. There are currently 122 women’s centres in Quebec.

Addiction

The Plan d’action interministériel en toxicomanie 2006-2011 was also made public in March 2006. The Ministry coordinated the work that led to completion of this plan, in collaboration with the following entities: the ministère de l’Éducation; ministère duLoisir et du Sport; ministère de la Justice; ministère de la Sécurité publique; ministère de l’Emploi et de la Solidarité sociale; ministère de la Famille, des Aînés et de la Condition féminine; ministère de l’Immigration et des Communautés culturelles; Secrétariat à la jeunesse; Secrétariat aux affaires autochtones; Société d’assurance automobile du Québec; and Comité permanent de lutte à la toxicomanie. The plan proposes 41 joint measures designed to prevent, reduce and treat addictions within Quebec society.

New Brunswick

Management/governance of Public Health programs and services in New Brunswick

- Public Health programs and services were transferred from the Department of Health and Wellness to the Regional Health Authorities in November 2005. The Department will continue to fund, monitor and audit the programs and services devolved to the Regional Health Authorities. The Medical Officers of Health will remain with the Department and will continue to be responsible to enact the Health Act and regulations. Environmental Health/Protection programs and services will remain within the Department.

Communicable Disease: Prevention, Management and Control

- By fiscal year 2005-06, children entering Grade 4 will have been vaccinated against hepatitis B as infants, and therefore the Grade 4 hepatitis B vaccine program that is now provided in schools will conclude.
- As part of the Department’s Provincial Health Plan, four new vaccines were incorporated into the routine childhood immunization schedule and the eligibility criteria for flu vaccine was expanded to include healthy infants, aged six to 23 months. Vaccines providing protection against chicken pox, meningococcal type C disease and whooping cough in
adolescents were introduced into the schedule, followed by a vaccine providing protection against invasive pneumococcal disease in January 2005.

- Planning for pandemic influenza is ongoing among the health care sectors and other sectors of business and society. Public Health has been working collaboratively with Regional Health Authorities and other stakeholders to develop plans in preparation for a pandemic at the local level. Departmental representatives have collaborated with the Public Health Agency of Canada, in the continued development of national and provincial plans. New Brunswick, along with all provinces and territories, as well as Health Canada, have participated in the purchase of a national stockpile of antiviral medication to be used, as per the nationally agreed upon priorities during the pandemic response.

**Environmental Health/Community Protection**

- There are two emerging zoonotic diseases of concern for New Brunswick– rabies and the mosquito borne West Nile virus.
- For the fourth year, wildlife rabies control measures were conducted, where cases of raccoon strain rabies had been detected previously. The department continued its rabies education and awareness campaign with pamphlets, radio and newspaper advertisements.
- Surveillance for West Nile virus focussed on testing wild birds and mosquitoes. The department continued the West Nile virus education and awareness campaign with pamphlets, radio and newspaper advertisements.

**Promotion of Health Lifestyles/Healthy Families**

- The Department of Health and Wellness recognizes the many benefits of breastfeeding, and promotes the Baby Friendly Initiative (BFI) within the province. BFI is a global initiative of the World Health Organization/UNICEF to promote, support and protect breastfeeding in hospitals and within communities. Public Health contributes to BFI by participating in the Provincial Breastfeeding Committee and Regional Committees.
- The Healthy Learners in School (high school pilot project) continued during the 2004-05 year in high schools in four districts, with efforts directed at the promotion of healthy lifestyles (stress reduction, physical activity and healthy eating), drug/tobacco use prevention/reduction, and sexual health.
- In October 2004, the province implemented the *Smoke-free Places Act* (SFPA). The legislation includes a complete ban on smoking in all enclosed public places and indoor workplaces in the province, with the exception of group living facilities and tourist accommodation facilities who can designate smoking rooms. The Act is enforced through a coordinated approach between Public Health Inspectors, Liquor License Inspectors, and Health and Safety Inspectors. A toll-free information line was established in mid-September 2005, which expanded to become a single entry point for people to report violations of the Act.
Nova Scotia

Overview

- Services are delivered through nine District Health Authorities (DHAs) and the IWK Health Centre with input from Community Health Boards (CHBs). Public Health Services and Addiction Services are two of the shared services within the DHA structure. As shared services, they are responsible for the delivery of services in one or more of the DHAs.

- District Public Health and Addictions Services are responsible for the operational delivery of health services, operational planning and management of services, monitoring and evaluation of services, and providing health information data.

- Funding for Public Health and Addictions Services is non-portable at the DHA level.

- In February 2006, a new department was formed bringing together the priorities of the former Nova Scotia Health Promotion (NSHP) with the Public Health areas of both NSHP and the Department of Health and the Office of the Chief Medical Officer of Health. NSHPP’s functions include: addictions prevention, chronic disease prevention which includes healthy eating, tobacco control, injury prevention and control, and chronic disease prevention, public health, health protection, physical activity and sport and recreation, and communications and social marketing. The Department of Health Promotion and Protection is responsible for funding, setting directions, providing provincial policy advice, developing standards, and monitoring and evaluation.

- Environmental Health Services are provided through the Departments of Agriculture and Fisheries, Environment and Labour, and Health.

Funding trends

In the 2003 *Blueprint for Building a Better Nova Scotia*, the Nova Scotia Government committed to doubling the budget of the then Office of Health Promotion.

Population Health Programs or Strategies

Addiction Prevention

*Alcohol Strategy*

A provincial addiction prevention and community education coordinator has been hired to work with provincial and regional partners and stakeholders to support the development of a comprehensive alcohol strategy designed to reduce alcohol-related harms.

*A Better Balance: Nova Scotia’s First Gaming Strategy*

In April 2005, *A Better Balance: Nova Scotia’s First Gaming Strategy* was released by government. This strategy includes seven initiatives that are being led by NSHPP, along with $3 million in funding to accomplish the goals outlined in the strategy.
Problem Gambling Strategy

Although A Better Balance outlines an overall gambling strategy for the province, a more detailed strategy is needed to address the full range of gambling related prevention and treatment needs. Led by NSHPP, the development of a provincially coordinated problem gambling strategy begun in 2005 continues.

Enhanced Services for Rural Women and Youth

NSHPP directed funding to Addictions services in the DHAs to improve health outcomes for rural women and youth throughout the province. The funding provides resources to facilitate and evaluate a range of addictions services for women and youth based on current evidence of best practice and cost-effectiveness. This initiative places an emphasis on enhancing services and eliminating barriers to treatment for women and youth, and their families, who may be harmfully involved in substance use and/or gambling.

Public Health

HIV/AIDS Strategy

Nova Scotia’s Strategy on HIV/AIDS was released in 2003. An update, focusing on strategic initiatives to increase accessibility to and/or expand services, particularly to those who are most vulnerable to HIV infection, was released on World AIDS Day, December 1, 2005.

Standards for the Prevention of Blood-Borne Pathogen Infections

Standards for preventing blood-borne pathogen infections were completed in 2004 with the participation/contribution of many community stakeholders.

Vaccine Schedule

A vaccine schedule consistent with the National Immunization Strategy is being implemented.

Public Health Review

Following the SARS outbreak in Ontario and the Naylor Report on the public health system’s response, the Federal/Provincial/Territorial Ministers of Health decided to “make public health a top priority by improving health infrastructure, and increasing international, provincial, territorial and federal capacity across the country”. In response, Nova Scotia embarked on an external review of the coordination, integration and comprehensiveness of its public health system.

The Renewal of Public Health in Nova Scotia: Building a Public Health System to Meet the Needs of Nova Scotians was released in Spring 2006. The result will be a strengthened public health system that builds on the success of Nova Scotia Health Promotion and the public health functions. It will create a system that is coordinated, responsive and integrated. A transition team has been formed to oversee a multi-year undertaking aimed at the renewal of the public health system.
National Collaborating Centre for the Social Determinants of Health

The Government of Canada’s commitment to renew and strengthen public health included the establishment of six National Collaborating Centres (NCC) for public health. The NCC for the Social Determinants of Health was assigned to Atlantic Canada. Although located regionally, it is intended to provide a national focal point as one key component of the overall pan-Canadian public health strategy, drawing on regional, national and international expertise.

Fluoride Mouthrinse Program Review

The Fluoride Mouthrinse Program Review Committee has developed policy recommendations for standard calibration, community participation, monitoring and evaluation, and maintenance of professional competencies in relation to the provincial school-based Fluoride Mouthrinse Program. This program uses a population-based tool to identify schools eligible to participate. An evaluation of the tool is currently being undertaken.

Nova Scotia Round Table for Youth Sexual Health

Nova Scotia Round Table for Youth Sexual Health is a diverse group of community and government partners whose mission is to work collaboratively for the promotion and protection of sexual health for all youth within the province through policy development, advocacy and evaluative research. A framework for action has been developed and will be released in 2006.

Youth Health Centres

The Department of Health completed an evaluation of community-based Youth Health Centres in the province to provide policy makers and funding organizations with the evidence needed to make informed decisions and policies as well as to provide the Centres with information to support programming and to document the impact of their work. Standards have been developed. Provincial work related to clinical guidelines, orientation, partnership, informed consent and evaluation is underway.

Injury Prevention and Control

Nova Scotia Injury Prevention Strategy

In 2003, Nova Scotia became the first province in Canada to adopt a government funded and led injury prevention strategy. The Strategy addresses the leading causes of injury in the province eg. falls among the elderly, motor vehicle collisions and suicide. It also addresses improvements to policy, collection of injury statistics and cooperation amongst injury prevention partners.

Preventing Falls Together

NSHPP continued funding and supporting the partnership with Community Links for the Preventing Falls Together Initiative, which promotes the development of a network for falls prevention to work with seniors, caregivers, health professionals, government and community agencies.
**Injury Prevention Knowledge and Capacity Building**

NSHPP supports and delivers opportunities for the development of injury prevention knowledge and capacity at the community level. In November 2005, NSHPP co-hosted the Canadian Injury Prevention Conference held in Halifax.

**Road Safety Communications Strategy**

NSHPP maintains a partnership with Transportation and Public Works (TPW) and the Road Safety Advisory Committee (RSAC) composed of members from the Departments of Transportation and Public Works, Health Promotion and Protection, Service Nova Scotia and Municipal Relations, Justice and Health and the Nova Scotia Safety Council, the RCMP, Association of Police Chiefs of Nova Scotia, Insurance Bureau of Canada and Mount Saint Vincent University. Working with TPW and RSAC, NSHPP led the development of a comprehensive strategy for road safety communications.

**Suicide Prevention Strategy**

NSHPP led the development of a suicide prevention strategy, working collaboratively with Mental Health Services, Department of Health. The partnership will identify evidence-based approaches to the development and enhancement of societal, policy and individual supports to reduce suicide in Nova Scotia.

**Injury Prevention in Schools**

During the 2005-2006 fiscal year, HPP Launched the Prevent Alcohol and Risk Related Trauma in Youth (P.A.R.T.Y), an evidence-based resource designed to educate teenagers (ages 15 and 16) about the consequences of risk and serious injury. HPP’s goal is to deliver PARTY to 15,000 grade 10 students in Nova Scotia. Partnering with Emergency Health services, the Departments of Education and Transportation and Public Works and with Dalhousie University, PARTY will expand in 2006-2007.

**Healthy Eating**

This strategy was released in March 2005. Developed by the Healthy Eating Action Group of the Alliance for Healthy Eating and Physical Activity, NSHPP has the lead in the implementation of the strategy. Its purpose is to promote an increase in the initiation and duration of breast feeding, increase consumption of vegetables and fruit, promote healthy, affordable food choices for children and youth and increase the availability and affordability of healthy food for all Nova Scotians.

**Provincial School Food and Nutrition Policy**

There were public consultations on the draft Provincial School Food and Nutrition Policy in September/October 2005. HPP supported the development of the Department of Education’s School Food and Nutrition Policy, which addresses a variety of issues including: foods offered at school cafeterias, vending machines, canteens, fund-raising, portion sizes, nutrition education,
vulnerable children and time to eat. The policy will be phased in over time, beginning in the 2006-2007 school year.

**Food Security**

NSHPP provided funding to the Atlantic Health Promotion Research Centre (AHPRC), in collaboration with the Nova Scotia Nutrition Council, to develop the Working Together for Ongoing Food Costing & Policy Solutions to Build Food Security report. In October 2005, in addition to the food costing model, NSHPP received the draft Food Security Policy Discussion Paper and policy lens.

**Health Promoting Schools**

Comprehensive School Health (Health Promoting Schools) is an approach to school-based health promotion involving programs, activities and services that take place in schools and their surrounding communities. NSHPP provided funding for partnerships of school boards and district health authorities to implement Health Promoting Schools programs with a focus on healthy eating and physical activity.

**Breakfast Program**

NSHPP committed $750,000 to enhance and expand breakfast programs for elementary school children in Nova Scotia.

**Provincial Breastfeeding and Baby-Friendly Initiative**

The Provincial Breastfeeding and Baby-friendly Initiative (BFI) Committee provides leadership for the protection, promotion and support of breastfeeding, and for the implementation of the Initiative in the province. This involves collaboration between hospitals and community health services across the province. In October 2005, Nova Scotia became the second province in Canada to adopt a provincial breastfeeding policy following the Department of Health’s and NSHPP’s approval of the document, Breastfeeding in Nova Scotia: Responsibilities of the Nova Scotia Department of Health and Nova Scotia Health Promotion.

**Physical Activity, Sport and Recreation**


**Health Living Incentive**

Announced in 2005, the Healthy Living Incentive is a non-refundable $150 tax credit per child, which can be used for physical activity, sport and recreation activities that are registered with NSHPP.
**Sport Opportunities for Children and Youth in Nova Scotia**

This collaborative program provides structured and unstructured school and community-based programs to increase current levels of physical activity in children. The three year program, a comprehensive approach by all levels of government, began during 2005.

**Sport Futures Leadership Program**

This program focuses on increasing physical activity by assisting provincial sports organizations to provide fun, safe and inclusive activities for children and youth, regardless of gender, socio-economic status, disability, ethnic background or culture. Sport Futures Leaders work with volunteers to improve sport programming and increase recruitment of participants.

**Physical Activity Grants Program**

This annual program provides financial assistance to Nova Scotian organizations whose mandate promotes physical activity in inactive populations.

**Physical Activity Children and Youth 2 Accelerometer Study**

This 2005-2006 study surveys students in grades 3, 7, and 11 to gauge their physical activity levels. Results will be available by fall 2006.

**Active Transportation Framework**

Beginning in 2005, a framework to support active transportation initiatives and action plans for the implementation of these initiatives is being developed.

**Provincial Walking Initiative**

This initiative, a collaborative relationship with the Heart and Stroke Foundation of Nova Scotia, builds on the results of a consultation held in August 2005. It supports local-level initiatives to improve walking environments in the community, workplace and school. The project provides information, resources, social marketing activities, education, pedometer access and a recognition programme for individuals, schools, workplaces and communities to encourage participation at many levels.

**Tobacco Control**

**Tobacco Strategy Update**

A second progress report will be released, and a review of the strategy will take place during 2006/2007. Activities to date include:

- **Legislation** - Enforcement of the Smoke-Free Places Act continued. During 2006, this Act will be amended to no longer permit designated smoking rooms except for designated rooms in facilities licensed under the Homes for Special care Act and in hospital units for veterans. Outdoor restaurant and bar patios will become smoke free.
• **Treatment/cessation** - Funding was provided to Addictions Services in the District Health Authorities to hire staff dedicated to nicotine treatment programming and to cover pharmacological cessation aids.

• **Community-based Programs** - Funding was provided to Public Health Services in the District Health Authorities to support community-based tobacco control initiatives.

• **Youth Prevention** - *You Choose*, a tobacco media literacy curriculum supplement for high schools continued to be used during 2005.

• **Media/Public Awareness** - Year 4 of the tobacco public awareness campaign was implemented including: provincial dissemination of *Smoke-Free Around Me*, a smokefree homes campaign *Great Reasons to Smoke* TV ads were re-aired. New print *Great Reasons to Smoke* ads were developed, and the Great Reasons To Smoke speakers’ booth toured provincial university campuses.

**Chronic Disease Prevention**

*Comprehensive Workplace Strategy*

NSHPP led the development of the strategy. The strategy will build on HealthWorks: a National Strategy for Comprehensive Workplace Health to provide a provincial approach to workplace health which encompasses organizational health, personal health practices and occupational health and safety workplace initiatives.

*Social Marketing*

*Social Marketing Campaign for Parents: momsanddads.ca*  A three-year, multi-media, social marketing campaign, targeting parents of young children aged 0-12 years was launched. The campaign focuses on healthy eating, physical activity, car seats/booster seats, and second hand smoke in the home.

**Prince Edward Island**

• In the fall of 2004, over 7000 PEI students aged 7 to 19 years received Adacel as part of a clinical trial. Adacel is a vaccine which provides protection against tetanus, diphtheria, and whooping cough. This study found that Adacel can be safely administered to students in a period as short as 2 years after their last dose of vaccine. PEI students now have the most complete coverage for whooping cough in North America. As a result of this study, it is likely that several jurisdictions in the U.S. and Canada will provide Adacel to students in the 7 to 19 year age range.

*Communicable Disease Control*

• In July 2005, all children born after April 1, 2005 received the pneumococcal conjugate vaccine. This vaccine, effective for 7 strains of pneumococcal disease, is administered at 2 months, 4 months, 6 months and a booster at 12 - 18 months of age.
The Department continued the dead bird surveillance program for West Nile virus. In addition, the Department conducts ongoing surveys of mosquitoes to identify their species and relative populations from sites across the province.

**Emergency Preparedness**

The Department of Health began to update the provincial health system pandemic influenza plan to ensure it is consistent with the Canadian Pandemic Influenza plan. It is expected the draft provincial health system pandemic influenza plan will be developed by late fall 2006. Health supplies that may be required in a pandemic influenza, including personal protective equipment and antiviral medication, are being stockpiled in the province.

**Tobacco Sales**

In December 2005, the Tobacco Sales and Access Act was amended to incorporate many of the recommendations made in the Standing Committee on Social Development Report on Retail Tobacco Sales, including the prohibition of:

- tobacco sales in designated places such as pharmacies, municipal and provincial government buildings and post-secondary educational institutions;
- retail display and point of sale signage used to promote tobacco products.

**Maternal - Child Health**

The PEI Reproductive Care Program Perinatal Database contains information on a number of variables including maternal demographics and lifestyle behaviours, prenatal status and interventions, intrapartum and postnatal status and interventions, births, and perinatal morbidity and mortality statistics.

The PEI Reproductive Care Program worked with the Pregnancy, Birth and Infancy network of the Healthy Child Development Strategy to develop and distribute resources to increase awareness of the various opportunities for prenatal/perinatal learning and support in the province.

Hospitals continued to distribute the booklet "Breastfeeding Your Baby", adapted with permission from Toronto Public Health, to all breastfeeding mothers while in hospital. Public health nurses also distributed the booklet to parents in the prenatal period. In 2004-2005, the French translation of the resource became available.

A pregnancy resource “Healthy Pregnancy Healthy Baby…A New Life”, developed by the Nova Scotia Department of Health, was adapted with permission for use in the province. The book is available to all pregnant women in the province through their physician or public health nurse. The resource was printed and distributed with assistance from the Department and the PEI Reproductive Care Program.

The PEI Reproductive Care Program in partnership with Women’s Addiction Services and the Aboriginal Women’s Association of PEI hosted the 2nd 2-day workshop in March 2006. The workshop was attended by professionals from health care and education along with parents and other interested members of the community.
Newfoundland and Labrador

Changes in the demographic structure of the population, such as healthy young adults leaving the province in search of work, declining rural populations, declining birth rates, and overall aging have major cost implications for all core programs under the jurisdiction of the Department of Health and Community Services (DOHCS). Initiatives to address the changing demographic structure include:

- An increase in long-term and community support services in relation to home support, institutional placement, and rehabilitative services;
- Increase in the financial commitments of the provincial Drug Program and the Medical Care Plan to accommodate the increasing number of eligible beneficiaries and the types of therapies needed, and
- Strategic planning in the provision of primary and secondary services to a declining population over a wide-based geographic base including:
  - recruitment and retention of health professionals in rural and remote areas
  - the use of technology and Primary Health Care teams
  - the establishment of an Aging and Seniors Division within the DOHCS

Seniors

The newly established Division of Aging and Seniors, through extensive community consultations and best practice research will be developing a Healthy Aging Framework and Action Plan in the coming year. This plan will provide opportunities for healthy aging by providing a seniors’ lens to policy developers across all provincial government departments. Additional initiatives with a seniors focus are:

- Long-term and community support services to seniors are coordinated through a single entry framework operated by regional health authorities. Services include home care, home support, day care, respite, admission to personal care homes, and nursing homes, as well as equipment and medical supplies for care not provided in nursing homes. A provincial long-term and community support services framework is currently being developed to provide direction related to services for seniors as well as other groups.
- Investments in residential infrastructure are being made in various locations throughout the province to ensure appropriate options in the future.
- The Senior Citizen’s Drug Subsidy Program (Guaranteed Income Supplement Recipients) is within the DOHCS.
- There are also interdepartmental initiatives such as the Provincial Home Repair Program administered by the Newfoundland and Labrador Housing Corporation, which provides grants to financially eligible seniors for repairs and renovations.
Children and Youth

The Children and Youth Services division of the DOHCS administers the Child Youth and Family Services Act (2002), the Adoptions Act (2003) and the Child Care Services ACT (1999). This includes child protective services, children in care, adoptions, supports to families and children, youth services, community youth correction, child care services and family resource centres in the province. The division develops policies, standards and programs for the provision of services to children, youth and families in the province. A Minister's Advisory Committee appointed to review the operations of the Child Youth and Family Services Act delivered its first report to the Minister of Health and Community Services in August 2005. New resources have been designated to carry out the recommendations in this report.

Through Federal/ Provincial/ Territorial (F/P/T) initiatives (Early Childhood Development – ECD, Early Learning and Child Care - ELCC and the National Child Benefit – NCB) the number of subsidized child care spaces available to low income families have been increased, an educational supplement for early childhood educators working within licensed child care centres has been implemented, education grants are provided to licensed child care providers, support to families of children with developmental delay and disability has increased, and family child care agencies have been developed.

The minimum income to access the Child Care Services Subsidy Program has been increasing, allowing more low income families to access the program. Initiative have been instituted to increase the quality of programming in child care and training for child care service staff working with children who have special needs.

Women

The DOHCS works with the Women’s Policy Office and other agencies to address a variety of women’s issues such as the Provincial Strategy Against Family Violence. The Provincial Advisory Council on the Status of Women advises government on matters related to the status of women and gender inclusive policy analysis.

The DOHCS provides funding to Regional Integrated Health Authorities (RIHA) to provide women and their children shelter from violent situations.

Aboriginal People

In 1984, the Government of Canada entered into an agreement (Canada/Newfoundland and Labrador Native Peoples of Labrador Health Agreement) with the Province to provide funding arrangements for the provision of health programs and services to the Innu and Inuit in Labrador. These services include patient transportation, dental services, medical supplies, prosthetic / orthotic devices and the services of Public Health Nurses. This agreement has been signed each year (exchange of letters) since 1984.

In 1997/1998 the management of public health employees and programs was devolved to the Labrador Inuit Association and the Mushuau and Sheshatshiu Band Councils. Labrador/Grenfell
Regional Integrated Health Authority retains responsibility for primary acute services in the Aboriginal communities.

Mushuau Innu Health Commission provides health services to the Mushuau Innu of Natuashish (formerly Davis Inlet). The Federal Government provides funding to this Commission to provide health and community services including public health nursing, diabetic education, home support, and addiction/mental health/family services. There are 580 Innu residing in Natuashish.

The Sheshatshiu Health Commission provides health services to the Sheshatshiu Innu. The Federal Government provides funding to this Commission to provide community health programs such as public health nursing, diabetic education, home support services, and addiction/mental health/family services. There are 1,134 Innu residing in Sheshatshiu.

In addition to funding provided by Health Canada, Indian and Northern Affairs Canada (INAC) provides funding to the province to deliver, on its behalf, certain child, youth and family services in Sheshatshiu and Natuashish. INAC’s funding is formula-based and does not cover full delivery costs. INAC does not provide child, youth and family services in the Inuit communities. INAC has assumed financial responsibility for education and income support to Natuashish and Child, Youth and Family Services (CYFS) in both Innu communities. The Innu are planning for the devolvement of programs and services through the development of an Interim Innu Agency. Eventually, the Agency will administer and provide all provincially mandated health, education and social services. The Province is working with the Innu in the development of capacity for this initiative through an Innu Healing Strategy.

On May 22, 2004 Cabinet gave approval to Ministers of HCS and LAA to negotiate the establishment of a Provincial/Innu Child, Youth and Family Services Board with the Innu Nation to oversee the development and operation of an Innu CYFS Agency. This has not occurred to date. However there is an Agreement between the Province and Canada for the devolvement of CYFS to the Innu in Natuashish and Sheshatshiu. Under this agreement, the Federal Government provides funding to Labrador –Grenfell Health Authority to continue to provide CYFS to the two Innu communities until such time the Innu have developed the capacity to run their own agency.

Persons with Disabilities

Disability Related Programs/Services are delivered by the four RIHAs in accordance with provincial standards. Funding is provided to the RIHA by the DOHCS. Services include: special child welfare allowance, home support, residential services, equipment, medical supplies and the support of professional program staff (e.g. behavior management specialists, child management specialists, social workers).

Consultants from the Board Services Division of the DOCHS provide interpretation regarding residential program standards for persons with intellectual disabilities. These programs which include the Co-operative Apartment Program, Alternate Family Care Program and the individualized living option, support approximately 500 persons living outside their family homes.
Basic income support and employment programs for persons with disabilities remain the responsibility of the Department of Human Resources, Labor and Employment. Policy integration and infrastructural supports continue to require monitoring, evaluation and policy work by DOHCS.

The DOHCS continues its involvement in the F/P/T Benefits and Services for Persons with Disabilities Working Group. The most recent work of this committee has been focused on furthering the analysis of the disability supports and income options as new areas of future investment. In addition the Department is represented on the F/P/T Working Group on Family/Informal Care giving to pursue further analysis of potential funding options to strengthen support to caregivers.

**Mental Health / Santé Mentale**

**Health Canada**

*Canadian Mental Health Commission*

An Interdepartmental Task Force on Mental Health was created in July 2005. The Task Force is co-led by Health Canada and the Public Health Agency of Canada, and brings together representatives from approximately twenty federal departments to study federal activities in mental health, mental illness and addiction, with the goal of strengthening policy collaboration and coherence in these areas.

On November 24, 2005, the previous government proposed that a Canadian Mental Health Commission be established, in consultation with provinces/territories, stakeholders and Aboriginal leaders, as a first step in national efforts to address mental health and mental illness issues. The proposed Commission would act as a national (not federal) focal point in Canada for knowledge exchange and increasing public awareness regarding mental health and mental illness, and operate at arms-length from all governments and mental health stakeholders.

*Aboriginal Mental Wellness Advisory Committee*

In 2005, Health Canada established the Aboriginal Mental Wellness Advisory Committee to develop a strategic action plan to improve First Nations and Inuit mental wellness outcomes. The strategic action plan will build on collaborative efforts that have examined Aboriginal mental health and wellness issues in recent years. The Committee process includes a number of key stakeholders including the Assembly of First Nations, Inuit Tapiriit Kanatami, provincial and territorial governments, professional organizations and other knowledgeable groups such as the Aboriginal Healing Foundation. It is anticipated that the Committee’s strategic plan will be finalized in 2006.
Santé Canada

Commission Canadienne de la Santé Mentale

Le 24 novembre 2005, l’ancien gouvernement a proposé d’établir une commission canadienne de la santé mentale en collaboration avec les provinces et les territoires, les intervenants et les dirigeants autochtones. Il s’agirait là d’une première d’un ensemble de mesures nationales pour faire face aux questions de santé mentale et de maladies mentales. La commission agirait comme centre de coordination national (et non fédéral) pour l’échange de connaissances et la sensibilisation du public relativement à la santé mentale et aux maladies mentales. De plus, elle serait indépendante des gouvernements et des intervenants en santé mentale.

En juillet 2005, nous avons mis sur pied un groupe de travail interministériel sur la santé mentale. Le groupe, qui est dirigé conjointement par Santé Canada et l’Agence de santé publique du Canada, rassemble des représentants d’environ 20 ministères fédéraux. Ensemble, ils étudient les activités fédérales relatives à la santé mentale, aux maladies mentales et à la toxicomanie en vue de consolider la collaboration stratégique et la cohésion dans ces secteurs.

Comité consultatif sur le mieux-être mental chez les Autochtones

En 2005, le comité consultatif sur le mieux-être mental chez les Autochtones a été mis sur pied afin d’élaborer un plan d’action stratégique destiné à améliorer les résultats en mieux-être mental dans les collectivités autochtones. Le plan d’action mettra à profit le fruit des efforts qui ont été engagés pour examiner les problèmes de santé mentale et de mieux-être au cours des récentes années. Le processus du comité comprend un certain nombre d’intervenants clés, notamment l’Assemblée des Premières nations, l’Inuit Tapiriit Kanatami, les gouvernements provinciaux et territoriaux, des organismes professionnels et d’autres groupes bien au fait des dossiers, comme la Fondation autochtone de guérison. On prévoit que le comité pourra mettre la touche finale à son plan d’action stratégique au début de 2006.

Northwest Territories

- The Department continued implementation of Mental Health and Addiction Services in the NWT, including the addition of the following positions:
  - Community Wellness Workers;
  - Mental Health/Addiction Counsellors; and
  - Clinical Supervisors.
- The Community Wellness Worker provides communities with education, prevention and awareness initiatives in the areas of addictions, mental health issues and family violence.
- The Mental Health/Addiction Counsellors are the clinical piece of the program. The position provides communities with therapeutic counselling services and also provides support to the Community Wellness Workers.
- The Clinical Supervisor supervises the Mental Health/Addiction Counsellors and Community Wellness Workers. They also serve as consultants for the rest of the Primary Community Care team for any mental health or addiction case.
Yukon Territory

- A full-time psychiatrist was recruited to the Yukon in October 2002. In addition, a child psychiatrist and a geriatric psychiatrist provide services to Yukoners during itinerant clinics and via televideoconferencing.
- Monitoring of in-patient care and emergency services provided by Whitehorse General Hospital is now done through the hospital’s Patient Care Team.
- Outreach services to persons with serious mental illnesses have been expanded in Whitehorse and rural Yukon, and a healthy living partial day program developed.
- Mental Health Services, Yukon Family Services Association (a non-profit organization) and Alcohol and Drug Services recently completed a project, funded through the inter-jurisdictional envelope of the Primary Health Care Transition Fund to improve services to individuals with concurrent (mental health and substance abuse) disorders.
- Education, case consultation and direct clinical services have been provided using televideoconferencing technology.
- Assessment of the housing needs of persons with serious mental illnesses will be undertaken this fiscal year.

British Columbia

The Province of British Columbia envisions a comprehensive, integrated, evidence-based system of mental health and addictions services. These services focus on health promotion, prevention, treatment and recovery and support individuals' and families' resiliency and self-care. B.C. has developed various strategies and initiatives to improve health outcomes for individuals with mental disorders and/or substance use disorders, their families and the communities in which they live.

The province-wide delivery of addictions and mental health services is provided through the health authorities. The recent alignment of addictions services with mental health services offers new opportunities for improving access and responsiveness.

New funding to fight crystal meth

B.C. announced $7 million in September 2005 in additional funding and new initiatives to continue the fight against crystal meth. That funding included:

- $2 million for treatment programs similar to Meth Kickers program in Kamloops;
- $3 million on a public awareness campaign including $1 million for school-based initiatives and $2 million on a public advertising campaign;
- $2 million to help communities by providing $10,000 seed grants.

An additional $8 million was announced in February 2005 to increase bed capacity for youth with addictions and build crystal meth treatment programs and support.
Expanding assessment services for children with FASD

Government funded $3.5 million to expand diagnostic and assessment services for children with special needs, including those with Fetal Alcohol Spectrum Disorder. The funding is a part of government’s commitment to strengthen services for children and youth with special needs. Through the Provincial Health Services Authority, funding is being directed to enhance assessment and diagnostic services for children with possible FASD and other complex developmental-behavioural conditions at the regional and provincial levels. These services will build on the existing network of diagnostic and assessment services for Autism Spectrum Disorder.

Patients to benefit from neuropsych move to Kamloops

Patients will receive expert care in a state-of-the-art setting when provincial neuropsychiatric beds from Riverview Hospital are transferred to a new mental health facility in Kamloops. As part of the Riverview Hospital Redevelopment Project, 25 acute neuropsychiatric beds will transfer from Riverview Hospital to a new mental health facility scheduled to open in Kamloops in winter 2005/06. The new facility is adjacent to Royal Inland Hospital, which will provide improved access to diagnostic and treatment services, including an expanded emergency department, MRI and CT scanners, laboratory and pharmacy services, speech pathology and neurosurgery. The care for the patients in Kamloops will be supported through the Provincial Neuropsychiatry Program at UBC, which provides central intake, screening and referrals through assessment and treatment beds operated by Vancouver Coastal Health.

Premier’s Task Force on Homelessness, Mental Illness and Addictions

The Premier announced the formation of the Task Force at the Union of British Columbia Municipalities annual convention in September 2004. The Task Force is working to enhance BC’s system of housing and support services to help people break the cycle of homelessness. Twelve projects are underway in nine cities, with a total of 533 new units and shelter beds created.

New funding to target youth addictions treatment

In 2005/2006, the Ministry of Health provided an additional $6 million in annual funding to develop specialized youth addictions treatment services in the health authorities.

Alberta

Mental health services were transferred from the Alberta Mental Health Board (AMHB) to the regional health authorities on April 1, 2003. A steering committee comprising the AMHB, regional health authorities, Alberta Alliance on Mental Illness and Mental Health, Alberta Medical Association, Alberta Psychiatric Association and Alberta Health and Wellness guided the development of Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta through an extensive consultation process. The Provincial Mental Health Plan released in May 2004 sets out a new direction for mental health in Alberta.
Each health authority now has an approved regional mental health plan aligned with the Provincial Mental Health Plan. These plans outline how they will enhance the capacity of the system, address gaps and improve access to mental health services.

A Mental Health Innovation Fund, which will provide $25 million in each of the next three years, was announced as part of Budget 2005 to facilitate implementation of the Provincial Mental Health Plan and regional mental health plans. Thirty projects approved for funding were announced in November 2005. Two health authorities were requested to re-submit proposals, so additional projects will be announced.

The approved projects cover a broad spectrum of priority areas (e.g., crisis; case coordination; shared care; tele-mental health; prevention, promotion and public awareness; supportive housing) and population groups (e.g., children, youth, seniors, Aboriginals) across the three key strategic directions of the Provincial Mental Health Plan – support and treatment, risk reduction and capacity building.

**Saskatchewan**

- The Mental Health program funds mental health services to residents of individual Regional Health Authorities (RHAs) in Saskatchewan, including Child and Youth Services, Adult Community Services, Psychiatric Rehabilitation Services, Mental Health Inpatient Services and residential services. Provincial rehabilitation and forensic services are located at Saskatchewan Hospital North Battleford (SHNB). Saskatchewan Health reviews mental health services on an annual basis, producing a document called the *Mental Health, Alcohol and Drug Services, Problem Gambling and Acquired Brain Injury Program Review* that is used to assist with regional health authority and department planning for mental health services. Additionally, in-depth reviews are carried out in individual RHAs. Currently, a review is being undertaken in Prairie North, with Sunrise RHA almost complete. Reviews have been completed for Sun Country, Cypress and Kelsey Trail RHAs.

- The Saskatchewan Mental Health Advisory Council advises the Minister and senior officials at Saskatchewan Health on policies, priorities and resources aimed at meeting the mental health needs of the people of Saskatchewan.

- A stakeholder consultation in May 2005, followed by a final report completed in September 2005 outlines the development of a provincial vision for Children’s Mental Health Services. The project aims to promote effective health and disease prevention through the development of a children’s mental health strategy, which arose out of the Child Advocate Report.

- Saskatchewan Health also provides funding to Regional Health Authorities for the rehabilitation and reintegration of youth under the Youth Criminal Justice Act. Services include community-based programs that provide treatment, supervision and other services.
Manitoba

Overview of the governance/management of services:

- Manitoba Health is responsible for developing provincial policies and coordinating planning across the full continuum of mental health and addiction services. Responsibility for the delivery of mental health services was devolved to Regional Health Authorities in 1997. Addiction services are provided by eight agencies that are funded directly by Manitoba Health including the Addictions Foundation of Manitoba. Only a few addictions programs are funded directly by Regional Health Authorities.

- Manitoba Health continues to be guided by Mental Health Renewal which was announced in 2001 to raise the profile of mental health within the health system. Mental Health Renewal also reflects a continued shift towards prevention, early intervention and community based service and support whenever possible.

- In 2001, a high level mental health renewal vision document was developed and made public. This document included a vision statement, principles, values, goals and objectives.

- Addictions and mental health have been identified as one of thirteen strategic priorities in 05/06 by Manitoba Health. Included in the strategic priorities is mental health promotion and substance abuse reduction as part of an overall healthy living strategy for the province.

Update on new strategies, programs and the outreach services for certain groups:

- **Selkirk Mental Health Centre** – The Selkirk Mental Health Centre is a provincial psychiatric facility in Manitoba. In 2004 the redevelopment of Selkirk Mental Health Centre was announced. The first phase of the redevelopment will include a new Psychogeriatric facility and an Acquired Brain Injury Program. The new facilities and the enhanced programming will better serve clients and will provide a more respectful environment.

- **Manitoba Crystal Meth Strategy** – This is a comprehensive government initiative aimed at restricting the supply and reducing the demand for crystal meth in Manitoba. The Manitoba Meth Task Force which is co-led by representatives from Manitoba Health and Justice, oversee the development and implementation of the Crystal Meth Strategy. Seven committees and working groups have been formed to develop successful strategies to combat meth use and production. Training for front-line workers in identification and treatment of crystal meth as well as a public awareness campaign and public forums are key aspects to the strategy. In addition, the Government of Manitoba is working on legislation that would provide the ability for the court to mandate youth into custody for a seven-day stabilization period. The goal is to provide a seven day period where the child is not under the acute influence of drugs so that they can make a sober decision regarding treatment. As part of the overall Crystal Meth Strategy approximately $6.7M was added to mental health and addictions services in part because of growing concerns regarding timely access to addictions and mental health services and the growing concerns related to crystal meth.

- **Provincial co-occurring mental health and substance use disorders initiative** - The co-occurring disorders initiative began in 2002 and continues to progress. Consumers in both systems are now screened for a co-occurring disorder, assessed and with informed consent, an integrated treatment plan is developed. This initiative treats both the substance abuse
issue and the mental health issue as primary and therefore no longer requires the individual to
deal with each separately, or to deal with one prior to the other.

• **Winnipeg Drug Treatment Court** – This specialized court, which is funded by the Federal
  Government and the Province is led by a working group including Health, Justice,
  Addictions Foundation of Manitoba, Behavioural Health Foundation, RCMP, the Winnipeg
  Police Service and several community agencies. The court provides an opportunity for
treatment rather than incarceration for those who have committed non-violent criminal acts
motivated by an addiction to drugs. The purpose is to help addicts break their cycle of
dependency and become more productive members of their community. This initiative
commenced operation on January 10, 2006.

• **Development of a provincial eating disorders and disordered eating strategy** - Manitoba
  Health has been leading a process to develop a framework for enhancing resources for
  Manitobans living with eating disorders and disordered eating. This work is intended to
inform and guide planning for effective prevention of disordered eating, enhance capacity for
early identification and intervention, and ensure accessible supports and services for
individuals with eating disorders. A number of activities have been completed including the
development of a comprehensive list of body image/eating disorder prevention resources for
schools, development of information for physicians and health professionals, and training in
eating disorders for mental health workers. A working group has also been formed to make
recommendations for the future development of community-based eating disorders treatment
in Manitoba.

• **Development of a provincial suicide prevention strategy** – Manitoba Health is
  implementing a provincial suicide prevention strategy. This strategy was developed in
  collaboration by the Provincial Committee on Suicide Prevention led by Manitoba Health.
The Committee’s work included a literature search, jurisdictional review and 11 focus groups
with consumers, service providers and specific at-risk groups, including the Aboriginal
community. A final document was created by the Committee called the Framework for
Suicide Prevention Planning in Manitoba that will guide the implementation of the strategy.
One of the key recommendations of the strategy is that each region will develop a regional
suicide prevention committee to organize suicide prevention work at the community level
and that each committee be comprised of cross-representation from community sectors, (i.e.
health, education, justice, etc. and relevant levels of government). In addition the report
recommends that specific high risk groups, i.e. the Aboriginal community, youth and seniors
develop suicide prevention committees to implement work plans using the Framework as a
template and using the suggested activities as a guide for their work.

• **Development of a provincial drug strategy** – Manitoba Health is leading a process to
develop a provincial drug strategy that will provide the framework upon which to develop
activities that are coordinated and aimed at reducing the harms associated with alcohol and
other drug use. This strategy will provide the framework for a coordinated approach which
recognizes the importance of involving the community in developing responses to alcohol
and drug use issues. Objectives of the strategy will be broad, long term and complimentary to
those of Canada’s Drug Strategy - such as:
  o To decrease the number of young people who become harmfully involved with alcohol
    and other drugs;
  o To delay the age at which youth experiment with alcohol and other drugs;
o To explore the use of innovative criminal justice measures for those harmfully involved with alcohol and other drugs;
o To decrease the availability of illegal drugs and address new and emerging drug trends;
o To decrease the incidence of communicable diseases related to substance use;
o To decrease avoidable health, social and economic costs.

- **Acquired Brain Injury Planning** – A Community-Based Acquired Brain Injury Services Planning Committee was convened by Manitoba Health to develop a detailed model of community-based acquired brain injury services for Manitoba, including structure, governance, service components, working partnerships and funding mechanisms with a corresponding action plan to implement the model. A primary focus of the model is the establishment of a continuum of community-based services for individuals with acquired brain injury. A draft of the report outlining the proposed model will be distributed for stakeholder feedback before it is finalized.

**Funding Trends**

- Since 1999, funding for mental health services in Manitoba has increased by more than 40%. This increase has been driven by mental health reform which sought to reduce the institutionalization of people with mental illness by increasing the availability of community-based programs.
- At the same time, the scope of mental health services has expanded to include populations that were traditionally not served by community mental health programs such as acquired brain injury, eating disorders, suicide prevention, co-occurring addictions, Pervasive Developmental Disorders, etc.
- Funding to addiction agencies has also increased significantly since 1999. Most significantly, funding to the Addictions Foundation of Manitoba increased by 41% between 1999 and 2006.

**Ontario**

**Mental Health – Number of Adults and Children Served**

The 2005 Provincial Budget provided that community mental health services will be expanded to serve an additional 33,989 patients in 2005/06 - rising to 78,000 new patients annually by 2007-08 and include increased access to assertive community treatment, case management, crisis response and early intervention services. The Province will be providing $531.9M in 2005-06, growing to $627.1M in 2007-08, for these services.

In April 2004, the Ministry of Children and Youth Services (MCYS) became the lead ministry responsible for programs and services that serve children, youth, and their families. To aid in the delivery of more seamless, coordinated service, the Ministry of Health and Long-Term Care transferred 17 of its 21 hospital-based children’s mental health outpatient programs to the MCYS. In 2004-05, the MCYS invested $25M in 2004-05 in community-based children’s
community mental health programs, growing to $38M by 2005-06. This has allowed the community-based children’s mental health sector to treat an additional 7,000 children per year.

**Mental Health**

Total 2005/06 funding for Mental Health is $1,488.7M (Community Mental Health $531.9M, Addictions $141.2M, Ontario Mental Health Foundation $0.4M, Specialty Psychiatric Hospitals $653.1M, Provincial Psychiatric Hospitals $161.8M, and Municipal Taxation-Psychiatric Hospitals $0.3M).

The government is investing $27.5 million annually in community mental health agencies across the province that will provide services to an additional 12,000 people. Mental health services will be provided to non-violent offenders. People with mental illness who commit serious crimes will continue to be prosecuted under the Criminal Code.

The investment, the first of its kind in Ontario, will be used to expand services in the five following key areas:

- Crisis response and outreach, to provide access to a range of services and supports on a 24/7 basis to individuals experiencing a mental health crisis.
- Short-term residential crisis support beds, which are often referred to as "safe beds," that can be used as an alternative to custody or hospital beds.
- Court support services, located in the courts, to assist with cases involving the mentally ill.
- Intensive case management, to identify and provide the services required to keep people in the community with adequate supports.
- Supportive housing services, which provide longer-term housing with mental health services.

Since 1995, there has been a 27% increase in the number of mentally ill people who have been admitted to correctional facilities in Ontario.

The $27.5 million is part of the government's $65 million increase in 2004/05 to improve access to services for people with mental illness, announced on June 14, 2004. This funding brings the government's total annual investment in community mental health to $531.9 million in 2005-06. The government will add another $95.2 million over the next few years, reaching $627.1 million annually by 2007/08.

**Community Support Investment**

Total 2005/06 funding for CSS is $295.4 million.

Total new funding contained in two announcements, is $30.5 million;

- $24.9 million for community support and assisted living services in supportive housing, announced July 19, 2005, and
- $5.6 million for acquired brain injury services announced July 29, 2005.
Community support services expanded through this initiative include adult day programs, meal programs, community transportation, homemaking and personal support services and special services persons who are deaf or blind or have sensory impairments and will serve over 9,000 additional clients.

Acquired Brain Injury service expansion will provide immediate support to 25 persons identified as being in urgent need and implement new services benefiting 136 new clients in Durham, Simcoe, Ottawa and the District of Cochrane.

$6 million from Ontario’s end-of-life strategy funding has been allocated for volunteer hospice and other Community Support Service agencies.

In January 2006, a 1.5% one-time increase to base funding for Elderly Persons Centres (EPC) was distributed as a Special Grant under Section 5 of the Elderly Persons Centres Act for the 2005/06 fiscal year.

Quebec

Le plan d’action en santé mentale 2005-2010 a été rendu public en juin 2005. Intitulé « La force des liens », il vise à doter le Québec d’un système efficient de santé mentale qui reconnaît le rôle des personnes utilisatrices et qui offre l’accès à des services de traitement et de soutien pour les enfants, les jeunes et les adultes de tout âge ayant un trouble mental, ainsi que pour les personnes présentant un risque suicidaire.

The plan d’action en santé mentale 2005-2010 was made public in June 2005. Entitled La force des liens, it strives to give Quebec an efficient mental health system that acknowledges the role of users and provides access to treatment and support services for children, youth, and adults of all ages with mental health problems and for people at risk of suicide.

New Brunswick

See Regionalization and Homecare.

Nova Scotia

The Department of Health, Mental Health, Children’s Services & Addiction Treatment is responsible for policy, standards, monitoring and funding mental health services. Mental Health services for children, youth and adults are delivered through nine District Health Authorities and the IWK Health Centre. Core programs, across the life span, include: secondary prevention and promotion; outpatient and outreach services; acute, short stay and long-term psychiatric in-hospital treatment; specialty mental health services and community supports. Services are consumer and family focused and community-based where possible. Some mental health services are delivered through a shared care approach in collaboration with primary care services. All DHAs and the IWK Health Centre provide outpatient and outreach services through a network of more than 50 community-based mental health clinics. In-patient psychiatric units are located in eight of nine health districts. In addition, there are a number of day treatment
programs, psychosocial rehabilitation programs, and specialty mental health services available throughout the province.

In 2003-2004, the Department of Health provided $2 million in funding to the DHAs and the IWK Health Centre to implement core service standards in key areas including community supports, crisis services and child and youth services. During 2005-2006, the Department of Health worked with teams of mental health clinicians and consumers to continue the implementation of core service standards as well as to begin the implementation of specialty service standards for: eating disorders; concurrent services for persons with mental health and chemical dependency disorders; neurodevelopmental disorders; early psychosis services; and services to seniors.

A plan for monitoring the quality, appropriateness and effectiveness of mental health services was initiated in 2003-2004. Included in this plan is a mental health profile for each DHA and the IWK Health Centre utilizing information from Statistics Canada’s Community Health Surveys, from the department’s ambulatory mental health information system (MHOIS) and from hospital discharge abstracts (CIHI). Pilot testing of standardized outcome (HoNOS) and satisfaction measures was also initiated in 2003-2004 with further development planned for 2005-2006.

In 2002, the Government provided $2 million for an Early Identification and Intervention Service (EIIS) for children up to their 6th birthday, diagnosed with Autistic Spectrum Disorder (ASD). A portion of this funding was permanently allocated to the Departments of Education and Community Services for support and transition to school services. In 2004, the Government announced an additional $4 million was being provided for the development and implementation of an Early Intensive Behavioral Intervention (EIBI) Program for young children with ASD. The treatment model is in the final stages of development. Province wide training is in process. It is estimated for full implementation it will take up to 3 years. An external evaluation is also in place, with the final report due in 2007.

In 2005 the Department of Health initiated a 3-5 year provincial depression strategy to raise awareness for early detection and intervention. Phase one targeted adolescents and seniors and approx. 6,000 information packages were disseminated.

A 6-month Youth at High Risk project has also been initiated through the joint efforts of the Department of Health and the Department of Community Services. A project manager is in place to develop recommendations and an implementation plan to move the project forward if government approval is granted.

**Prince Edward Island**

- The PEI mental health system is primarily made up of four parts: hospital services, community mental health, non-governmental organizations like the Canadian Mental Health Association, and primary care practitioners. Hospital services consist of in-patient psychiatric units and Emergency Department crisis response teams in two referral hospitals for people with moderate to severe mental illness, and one larger psychiatric hospital for persons with longer term mental illness.
The Community Mental Health System in the province includes programs that offered assessment, consultation, treatment, crisis intervention, medication, monitoring, outreach, and ongoing support. These referrals grew in complexity as well as in numbers from previous years. The programs were offered at five sites, three of which also included addictions services:

- West Prince Community Mental Health & Addictions
- East Prince Community Mental Health & Addictions
- Richmond Community Mental Health Centre
- McGill Community Mental Health Centre
- Kings Community Mental Health Centre & Addictions

The goals of the Community Mental Health System are to operationalize mental health in such a way that there is province-wide accessibility to assessment and provincial programs, on site or via tele-mental health; and to increase balance between community- and hospital-based resources.

A three-year mental health service delivery plan (2001-2004) was implemented to move PEI into a “Best Practice” system. This plan enhanced community mental health services with a number of primary initiatives designed to better meet the mental health needs of Islanders:

- a provincial mental health crisis response system;
- enhanced outreach services for persons with serious and persistent mental illness;
- enhanced clinical services;
- specialized programs for specific populations such as persons with borderline personality disorders;
- shared care – mental health staff collaboration with primary care staff in family health centres and physician clinics.

More recently the mental health system collaborated with the addictions system to provide better care for the large number of people with concurrent disorders including screening, liaison and cross orientation. Mental health continues to partner with non-governmental organizations such as the Canadian Mental Health Association to plan and implement services around suicide prevention and around support needs for persons with serious and persistent mental illness.

Newfoundland and Labrador

In Oct. 2005, the Province released, Working Together for Mental Health, a comprehensive strategy for the mental health and addictions system that encompasses all age groups and the full continuum of mental health and addictions services. The policy framework recognizes that addictions services are an essential component of the broader mental health system and emphasizes prevention of addictions and other mental health problems. The framework supports the role of clients/consumers and their families in treatment decisions their and promotes greater responsiveness to their changing health and social needs by establishing better connections.
among all sectors of the health and community services system. Full implementation of the framework is a long-term commitment that will take some years to be realized.

Strategic planning for mental health and addictions services began in 2004 with focus on: identifying long-standing gaps within our mental health system; creating more access to mental health services and treatment; and in time, reduce the stigma that individuals suffering with mental illness face today. In 2005 investments were made in the areas of OxyContin task force recommendations, upgrading infrastructure, enhancing mental health services for home and community supports and enhanced services for gambling addictions.

Mental health and addictions services are provided through regional boards.

The importance of consumer involvement in service planning and evaluation is supported through a Consumer Initiative Project with the Canadian Mental Health Association, Newfoundland Branch, and the Consumer Health Awareness Network of Newfoundland and Labrador. The purpose of this project is to develop and maintain a provincial consumer network and local self-help groups.

Cabinet has directed the DOHCS to draft new mental health legislation. A stakeholder group on legislation has been advocating replacement of the current *The Mental Health (1971)* for five years and in 2003, Judge Donald Luther presented recommendations for new legislation as the result of an Inquiry into the Fatal Police Shooting of Norman Reid and Darryl Power.

Government has designed a Video Lottery Terminal Action Plan to address gambling concerns. The plan has two key components: first, government will reduce the number of machines and accessibility to them; and second, government will enhance counseling and addiction services for those who need it.

**Home Care / Soins à Domicile**

**Health Canada**

No developments to report.

**Santé Canada**

Rien de nouveau à signaler à ce sujet.

**Northwest Territories**

- Depending on a patient’s needs, home care is provided by doctors, nurses, home support workers, social services workers and many other health and social services workers. Anyone can access home care support if they have a need identified by an assessment.
• Coordinated home care programs in most regions in the NWT have continued to expand into outlying communities. Approximately 90% of communities have, at a minimum, home support services available to residents.

• All home care programs are assessed using a standard Continuing Care Assessment and Placement Package to ensure clients are cared for in their homes and communities for as long as possible before being admitted to long-term care facilities.

Yukon Territory

• Home care has experienced significant volume increases in all areas of service provision over the last fiscal year. The challenge remains to meet this demand over large, isolated geographic areas.

• Program expansion to remote, rural communities has been increased through a traveling outreach therapies team. All Yukon communities are visited on a regular rotational basis.

• Additional nursing resources have been added to meet the increased client need in the communities.

• Implementation of an integrated electronic health care record system, including the MDS home care assessment tool (integrated throughout continuing care which includes home care, day programs, therapy services and long-term care facilities.

British Columbia

B.C. is expanding its home and community care sector to provide more independent housing options, modernize residential care, improve home care/support and provide for end-of-life care.

Home and community care services provide a range of health care and support services for eligible residents who have acute, chronic, palliative or rehabilitative health care needs. These services are designed to complement and supplement, but not replace, the efforts of individuals to care for themselves with the assistance of family, friends and community.

Home and community care services:

• support clients to remain independent and in their homes as long as possible;

• provide residential services and independent living services to clients who can no longer be supported in their homes;

• provide services at home to clients who would otherwise require admission to hospital or would stay longer in hospital; and

• provide respite for the client’s unpaid caregivers.

Since 2001, BC Housing and health authorities have been working in partnership with for profit and non-profit housing and care providers to give British Columbia seniors more options that provide the right care in the most appropriate setting.

Advancements in clinical practice, home technology and housing options mean more people can and want to live in their own homes and communities. B.C. is upgrading residential care beds to
improve the quality of care for seniors and people with disabilities. Assisted living units are being developed for seniors and people with disabilities who can no longer live at home but do not require the 24/7 nursing care provided in residential care facilities. Enhanced home care, independent living, adult day care and hospice beds are part of the continuum of services that will be available to seniors and people with disabilities.

B.C.’s Seniors’ Housing and Care Strategy – 2001 to 2008:

- Research and evidence from international and national seniors’ care planners – and the experiences of seniors themselves – indicate that B.C. is taking the right approach to improving seniors’ care.
- In the fall of 2004, government concluded a dialogue on health and aging that gave us the benefit of the best evidence available today, in Canada and in the world, about actions that have been shown to improve seniors’ care.
- The province will be following up on that dialogue to refine the next phase of our strategy to create the best system of support for seniors in Canada.
- We look forward to hearing from the new Premier’s Council on Aging and Seniors’ Issues to ensure B.C. seniors have the housing and care services they deserve.

Key health achievements for B.C. seniors and those with disabilities:

- Reduced average wait times for residential care from up to one year to an average of 60 to 90 days between 2001 and 2005.
- Government is working to provide at least 5,000 new residential and assisted living beds by 2008.
  - Modernized and replaced outdated residential care beds.
  - Updated and modernized the Community Care and Assisted Living Act to protect the health and safety of seniors and people with disabilities in licensed community care facilities and registered assisted living residences.
  - Since 2001, government spending on seniors’ housing and care has increased by about $100 million more annually.
  - The actual, average cost in 2004 of operating a residential care bed is approximately $4,500 a month. The lowest-income seniors continued in 2005 to pay only $854 per month. Government subsidizes more than half the operating costs for the highest-income seniors.
  - Health authorities are working to enhance home care and home support services throughout their communities.
  - An expanded toll-free telephone information line is giving seniors one-stop access to a range of information – including health services – on government services.

Facilities updated/constructed in 2005 for Seniors/Persons With Disabilities

- Burns Lake - 17 new Assisted Living (AL) units (construction began Aug. 2005)
- Salt Spring Island – 30 new AL units (construction began July 2005)
• Surrey – 165 AL units as part of Fleetwood Villa, a Campus of Care (construction began July 2005)

• Powell River – 40 AL units (construction began July 2005)

• Abbotsford – 104 AL units at the Tabor Home’s Campus of Care (construction began July 2005)

• Lake Country – 25 AL units (construction began August 2005)

• Morgan Heights – 70 new residential care beds, 18 AL units at The Residence (opened July 2005)

• South Surrey Seniors Village – 85 new residential care beds, 42 new AL units (opened July 2005)

• White Rock – 84 new AL units at Evergreen Heights Baptist (construction began July 2005)

• Vancouver – 36 AL units and 154 residential care beds at Haro Park Campus of Care (opened March 2005)

• Ladysmith – 75 residential care beds, 12 geriatric mental health beds (construction began March 2005)

• Ucluelet – 10 new AL units at Sea View (construction began October 2005)

• Chilliwack – 66 new AL units (opened October 2005)

• Fort St. James – 2 new AL units (construction started October 2005)

• Rose Manor – 70 refurbished AL units (opened October 2005)

• Richmond – 10 hospice/end-of-life care beds at Salvation Army Rotary Hospice House (opened September 2005).

• Chilliwack – 10 bed hospice (construction began July 2005)

• Mission – 10 bed hospice (opened July 2005)

• Surrey – 10 bed hospice (opened July 2005)

• Langley – 10 bed hospice (opened July 2005)

• Maple Ridge – 10 bed hospice (construction began August 2005)

Alberta

See Long-Term Care Initiatives.

Saskatchewan

• The Home Care program provides help to people who need acute, palliative and supportive care to remain independent at home. Home Care provides the following services: assessment and care coordination, nursing supervision and nursing care, personal care, homemaking, meals, respite services, home maintenance and therapies.

• A Home Care Program Review was completed and includes an assessment regarding program design and vision; the range and mix of services; the capacity to meet need; and
financial resources. The review has also identified strengths and weaknesses and recommended potential change and future direction to improve program effectiveness and efficiency.

**Manitoba**

No material changes in 2005/06.

**Ontario**

*Our Investment in Home Care*

- The total funding for home care services is $1.46 billion in 2005-06, increasing to $1.65 billion in 2007-08.
- In 2005-2006, $156.1 million net increase in funding for home care.

*Number of Clients Receiving Care*

- It is expected that 45,100 additional acute hospital replacement clients will receive home care services in 2005-06 as a result of our investments.
- By 2007-08, enhancements to home care will provide an additional 95,700 acute hospital replacement Ontarians with care in their homes.
- Formal linkages between CCAC case management and Family Health Teams will help to avoid hospital admissions and improve health care management of mutual clients, especially those dealing with chronic illness.
- Joint initiative between Home Care and Community Support Branch and Hospitals Branch will orient more hospitalized patients with end-stage-renal disease and new to dialysis treatment, to in-home peritoneal dialysis instead of in-hospital hemodialysis.
- In 2005/06, in addition to the 45,100 acute hospital replacement clients, CCACs are relieving pressure on hospitals by taking 7,600 post-hospital hip and/or knee total joint replacement client referrals from hospitals.

*End-of-Life Care Strategy*

- On October 4, 2005 the government announced a $115.5 million investment over three years in the End-of-Life Care Strategy to improve care services at home and in the community by:
  - Funding CCACs to provide more and better end-of-life care, including nursing and personal support services for people in their own homes.
  - Funding support for nursing and personal support services in residential hospices will be available to over 30 communities by 2007-08. Residential hospices offer care, compassion and dignity to those who are in their last stages of life while providing needed support to their families.
• Strengthening the role of hospice volunteers. Volunteers are trained and supervised by paid staff to provide emotional, social and spiritual support to individuals and their families.

• Through Ontario’s End-of-Life Care Strategy, over 6,000 more Ontarians will receive compassionate, end-of-life care in their homes by 2007-08.

• In 2005-06, $39 million in new funding will improve end-of-life care services that are provided at home and in the community, so an additional 4,300 adults and children can receive the care that they need.

• The End-of-Life Care Strategy will help shift care of persons in last stages of life from hospitals to home or another appropriate setting of their choice; will enhance an interdisciplinary team approach to care in the community; and will work towards better co-ordination and integration of local services.

**CCACs: Ratio between Not-for-Profit and Profit**

Ratio of contracts as of August 24, 2004:

• A basic review was done approximately 8 years ago and it was then determined that there were 51% not-for-profit and 49% for-profit

• The Ministry last looked at this approximately 2 years ago and the numbers were inverted (49% not-for-profit and 51% for-profit)

**CCAC: Review of Competitive Bidding Process**

• On May 30, 2005, the government received the report by the Honourable Elinor Caplan, who was commissioned by the Ontario government to do an independent review of the competitive bidding process used by Community Care Access Centres (CCACs) to select home care providers.

• The Caplan report contains 70 recommendations on a range of issues related to the competitive bidding process including continuity and quality of care, better integration of home care in the health care system, research, accountability and workforce stability.

• On December 7, 2005, the ministry provided the CCACs with the Contract Management Guidelines to Resume the Competitive Procurement Process Used by Community Care Access Centres. The guidelines support continuity in home care services delivered to clients and provide directions to CCACs on the resumption of the procurement of client services and contract extensions where necessary. CCACs can extend contracts no later than March 31, 2010. However, contracts can be extended for services provided in schools to no later than June 30, 2010 to ensure continuity of services throughout the school year. During the review the competitive bidding process was only used when absolutely necessary. CCACs were requested to extend contracts where possible. CCACs are not expected to issue revised RFPs until the ministry has reviewed contract template documents.

• Currently the ministry is developing a plan to implement the report and the government plans to respond to the report shortly.
CCAC and Community Support Services (CSS): Diagnostic and Medical Equipment Fund

- On March 4, 2005, the government announced an investment of $9.1 million to purchase diagnostic medical equipment for clients accessing services through Community Care Access Centres (CCACs) and Community Support Services (CSS) around the province.
- The money was used to purchase medical equipment to assist people in their own homes, in supportive housing and adult day programs in the community.
- The equipment includes mechanical lifts, bathing equipment, intravenous and feeding pumps, as well as devices designed to increase mobility such as door openers and wheelchairs.

Quebec

Un investissement de 15 millions de dollars a été accordé en avril 2005 dans le cadre de l’application de la Politique de soutien à domicile. Ce montant permettra l’achat de matériel utilisé auprès des différents groupes de personnes qui bénéficient de services de soutien à domicile.

An investment of $15 million was made in April 2005 in support of the Politique de soutien à domicile. This amount will allow materials to be purchased for use with the various groups of people receiving home support services.

New Brunswick

- New Brunswick’s Extra Mural Program (EMP) provides comprehensive home health care services to all New Brunswickers in their homes and in their communities. The service is administered by the Regional Health Authorities following provincial standards and policies.
- Services are provided by physicians and EMP health professionals (nurses, dieticians, respiratory therapists, occupational therapists, physiotherapists, social workers and speech language pathologists).
- Under the auspices of the Provincial Health Plan, significant enhancements have been made to the EMP to enhance the provision of acute and palliative care services in the home. Enhancements have included funding for human resources and short-term personal support services. The Program is also piloting telemonitoring in the home, as a mechanism to improve service delivery for patients with chronic diseases and those that live in rural areas.
- Within Addiction and Mental Health Services, two home care initiatives were undertaken. The implementation of a provincial Telemental Health system will allow more individuals to receive psychiatric consultation within their home communities. As well, mobile crisis response services will be enhanced within three Regional Health Authorities. This will increase capacity to provide community-based interventions to consumers in crisis, effectively decreasing the need for hospitalization.
Nova Scotia

- Continuing Care consists of a range of services to support individuals with identified health needs. Care is provided in a manner that enables the individual to live as independently as possible in the community, or in a residentially based service.

- Continuing Care services include home care, self-managed care, long term care, adult protection and care coordination. The Department of Health manages these services directly. Services are coordinated through a single entry access system. Assessment, care coordination and ongoing case management are a responsibility of the Continuing Care branch. The Branch works directly with approximately 140 provider organizations, including non-profit home support agencies, the Victorian Order of Nurses, and municipal, private for profit, and non-profit residentially based organizations.

- Home care programs provide support to approximately 12,000 Nova Scotians at throughout the year. Services include short term (acute) and longer term professional nursing care provided by registered nurses and licensed practical nurses. Home support services include personal care, respite, nutritional care, and essential housekeeping. Home oxygen services are provided through contracted oxygen vendors. Although not funded or regulated by the Department of Health, community supports such as adult day and volunteer programs, meals on wheels, and limited community rehabilitation services are available.

- Self Managed Care helps Nova Scotians with physical disabilities to increase control of their lives. The program provides funds to eligible individuals so that they may directly employ people who provide home support and personal care services.

- Residentially based programs provide support to approximately 6,600 Nova Scotians. These services include licensed nursing homes, licensed residential care facilities and a number of community-based options that provide services for up to three clients, and operate under interim standards.

- Adult Protection Support services are extended, under the authority of the Adult Protection Act, to adults 16 years of age or older who are abused or neglected (including self-neglect and/or neglect by a caregiver) and who cannot physically or mentally protect themselves. There are approx. 1,300 referrals for assistance annually. 75% of the referrals are for individuals over the age of 65 years.

- The 2005-2006 budget for continuing care was approximately $427 million. Home Care services cost $128 million, residentially based services $296 million, and administration $3 million. The budget for the previous fiscal year (2004-2005) was $376 million. The increase reflects the introduction of government funding for the health care costs of residents in long term care facilities.

- During 2006, a strategic framework for continuing care in the province will be released.

- Beginning in 2006, a planned approach to the recruitment of continuing care assistants will be implemented.

Further information on Continuing Care is available at [http://www.gov.ns.ca/health/ccs/default.htm](http://www.gov.ns.ca/health/ccs/default.htm)
Prince Edward Island

- The PEI Home Care and Support program provides both health care and support services through five key program areas including general home care, adult protection, integrated palliative care, home and community-based dialysis, and assessment for nursing home placement.

- Specific services include nursing, visiting homemaking for personal care, respite and homemaking, occupational, and physical therapies, dietetics, social work and community support.

- Our case management strategy is critical to providing a coordinated care plan for Home Care and Support clients. Home Care and Support services are provided to individuals based on assessed need and intended to: help individuals achieve and/or maintain health and personal independence in the community; and, supplement the care and support available from family and friends.

- PEI’s Home Care and Support programs partner with the Canadian Council on Health Services Accreditation to pilot standards for Palliative Care, participated in the National Pallium Project.

- New initiative: Reorganizing to a provincial home care program.

Newfoundland and Labrador

See Long Term Care section.

Long-Term Care / Soins de Longue Duree

Health Canada

No developments to report.

Santé Canada

Rien de nouveau à signaler à ce sujet.

Northwest Territories

- A review of long-term care facilities was completed in 2005-06. Renovations and upgrades will begin in 2006-07.

- In January 2006, the Department allocated multi-year funding for 2005-2007 to the Yellowknife Association of Concerned Citizens for Seniors (YACCS) for the design of a 24-unit seniors dementia facility. The next phase of the project will be the tender for and construction of the building.
Yukon Territory

- Work on the development of Continuing Care regulations and standards is currently underway.
- Implementation of an integrated electronic health management system (home care and long-term care facilities) includes MDS assessment tool.
- Case management and assessment training is complete.
- Consent to care training is underway for all care providers
- $400,000 in funding to open 7 Intermediate care beds.

British Columbia

See Homecare section.

Alberta

Alberta continues to collaborate with regional health authorities to facilitate the shift to community based continuing care options that will enable aging in place by providing support to seniors in their own communities. The promotion of standards for quality of care remains a priority of continuing care reform.

Expand community care options

- Continue the shift so more Albertan over 75 years of age receive community-based continuing care services, reducing the ratio of those in institutions from 70.5 per thousand in 2003/2004 to 69 per thousand in 2005/2006.
- A Home/Community Care Innovation Project is underway. An assessment of the strategic innovations required to modernize home/community care services has been completed. The proposed strategic innovations will support the expansion of home/community based health care services and development of an integrated community care system. Examples include: collaboration between regions, collaboration between and integration of the various components of the care continuum, and implementation of common assessment tools across the regions.
- Regional health authorities continue to expand community based health care options, such as supportive living settings, allowing seniors to maintain their independence and remain in the community with the support services they need, rather than entering long-term facility based care prematurely.
- Currently, there are an estimated 20,000 supportive living spaces in Alberta.
**Improve access to continuing care services**

- Coordinated access policies have been developed which require regions to provide care management and seven day access to continuing care services. These policies are now in the process of being implemented, with full implementation targeted for 2007.
- Alberta Health and Wellness, in collaboration with the regional health authorities has developed and implemented policies on inter-regional transfers for continuing care.

**Enhance skill of front-line workers**

- The provincial Alzheimer’s in-service training initiative has been completed. The goal of training 3,000 front line care workers was exceeded as over 7,000 front line care workers have now completed the training program.
- Core competencies for Health Care Aides have been developed for use by educational institutions and employers. All Health Care Aides working in long-term care are expected to have achieved these core competencies in 2008.

**Implement the interRAI suite of assessment and care planning tools**

- The interRAI tools will facilitate standardized, comprehensive assessment and care planning for all continuing care clients and will provide quality indicator and resource utilization information for use by health regions and Alberta Health and Wellness.
- It is anticipated that the interRAI tools and the systems to support the tools will be fully implemented and functional by December, 2007.

**Finalize and implement the continuing care health service and accommodation standards**

- The MLA Task Force on Continuing Care Health Service and Accommodation Standards gathered feedback from a variety of stakeholders and the public on a new set of draft continuing care standards.
- It is anticipated that the new continuing care health service and accommodation standards will be finalized and released in the spring of 2006 for implementation in the 2006/2007 fiscal year.

**Saskatchewan**

- The purpose of special-care homes (SCH) is to provide long-term care (LTC) to meet the needs of individuals, usually with heavy care needs (Level 3 and 4), that cannot be met through home-based/community services. These homes are publicly funded facilities that provide 24-hour, supervised, institutional long-term care services to individuals.
- Minimum Data Set/Resource Utilization Groupings (MDS/RUGS), the classification system for residential long-term care, is fully implemented in all long-term care facilities in Saskatchewan. It facilitates better care planning, quality indicators and outcome measurements, which will improve client care. It also provides increased efficiency in record keeping and facilitates program monitoring and evaluation at the facility and regional health
authority level. MDS/RUGS results in improved quality of information, which can be used for identifying resident needs as well as areas to target for program development and staff education.

- Personal Care Homes provide an alternative residential option for individuals who neither need nor wish to use the services of the publicly funded home care, public housing or special-care home systems. These homes are privately owned and operated facilities that do not receive public funding and which offer accommodation, meals and assistance or supervision for adults aged 18 and over.
- Initiatives include making personal care homes more accessible to those with limited income and the development of improved standards.

**Manitoba**

- Manitoba Health introduced a Personal Care Home Standards Regulation under *The Health Services Insurance Act* in 2005.
- Regular monitoring of standards is now an important part of Manitoba’s patient safety initiative. This monitoring is led by Manitoba Health with the participation of the local regional health authority.
- Standards monitoring now informs the annual personal care home licensing process, along with the results of other departmental monitoring of personal care homes.

**Ontario**

*Our Investment in LTC*

- The 2005 Provincial Budget announced an investment in LTC homes of $2.75 billion in 2005/06. This represents a $264M increase over 2004/05 interim actuals which will fund improvements to the safety and quality care provided to residents, the opening of new LTC beds and a freeze in co-payment rates for the second year in a row. This fiscal year’s investment includes the announced increase to the Raw Food and Other Accommodation envelopes: as of July 1, 2005, funding to the Raw Food Envelope increased by $0.10 per resident/day, and an increase of $0.66 per resident/day for the Other Accommodation Envelope was also made.

The government is committed to:

- $191M over two years beginning in 2004/05 to hire 2000 new staff including at least 600 new nurses and ensure a higher standard of care, such as having around-the-clock, on-site registered nursing care, and offering residents two baths a week. The Alternative Level of Care (ALC) strategy is also supported by this funding (see ALC section below).
- $340 million over two years to support system growth.
- 700 new LTC beds will be open within the 2005/06 fiscal year.
Staffing Report

- To track the sector’s progress in meeting the target of 2000 new staff and other new resident care requirements, all LTC homes are required to complete a multi-phase staffing report.
- The 2000 new staff target will be met over a two-year period. The ministry is continuing to collect staffing information to track the sector’s progress in reaching the staffing target.

Status of 2000 New Staff

Based on the data reported by 528 LTC homes (which represents about 90% of the sector), there were a total of 36,810 Full-Time Equivalent (FTE) staffing positions during the baseline period. The sector reported a total of 39,144 FTE staffing positions during Phase 3. This translates to an increase of 2334 FTEs, including an increase of 472 nursing FTE’s when Phase 3 (January to June 2005) is compared to Phase 1 baseline period (January to June 2004).

Alternative Levels of Care

- The Government is investing $42.8 million in its Alternative Levels of Care (ALC) strategy. The strategy incorporates three complementary programs:
  - the Interim LTC Bed Program: $19.25M to create up to 500 interim LTC beds for people who are waiting in hospital for a permanent LTC bed in their community.
  - the New Convalescent Care Program: $11.7 million to establish up to 340 convalescent care beds in LTC homes for people who no longer need intensive hospital care but are not yet ready to return home.
  - the High Intensity Needs Fund (HINF): $11.85 million to purchase equipment and supplies needs for the care of residents who require the highest levels of care in a LTC setting.

Stabilization Factor Funding

- The increase of $1.01 per diem stabilization factor funding—$0.92 in Nursing and Personal Care (NPC), and $0.09 in Program and Support Services (PSS)—to support care requirements, was implemented in August 2005 and is retroactive to April 1, 2005.

Increase to the Accommodations Envelope

- In July 2005, the per diems were increased for the Raw Food and Other Accommodations by $0.10 and $0.66 respectively.

Resident Co-Payment Freeze

- In July 2005, the resident co-payment freeze was extended for a second year until July 31, 2006.
Diagnostic Medical Equipment and Patient Lifts

In 2005/2006, there has been an investment of $7.2M for diagnostic medical equipment in LTC Homes.
- In 2004/05, the investment for diagnostic/medical equipment in LTC Homes was $38.8M.
- For fiscal year 2005/06, the amount for mechanical patient lifts is $29M for both hospitals and long-term care homes.

Physician On-Call Coverage

- As of October 1, 2005, LTC homes are eligible to receive $100 per bed (with a minimum of $10,000 per home and a maximum of $30,000 per home) to support after-hours physician on-call coverage for LTC homes.

LTC Home Reform Strategy

- To improve the overall quality of life in long-term care homes, the Long-Term Care Home Reform Strategy supports:
  - a strong role for Family Councils and Resident Councils within LTC homes
  - making it easier for couples to live together in LTC homes
  - toughen enforcement by mandating reporting of suspected abuse, introducing whistleblower protection and targeted surprise inspections of homes with poor track records (all annual inspections are now unannounced)
  - strengthen accountability through a public website that provides information to seniors and their families about individual homes and their records of care. The ministry will also be kept accountable through the Staffing Report, which monitors the progress towards achieving staffing targets.

Public Reporting

- The public reporting website was first launched in Fall 2004
- The website was enhanced to identify ministry sanctions imposed on LTC homes, e.g. suspension of admissions, in real time.
- The reporting website can be accessed through the ministry’s website; while those without internet access can phone the LTC Action Line at 1-866-434-0144. The website is the first of its kind in Canada.
- The public reporting website was most recently updated in October 2005. Currently, the site reflects the record of care from April 1, 2004 to March 31, 2005.

Seniors Health Research Transfer Network

- In August 2005, the government invested $2.7 million to build a Seniors’ Health Research Transfer Network that will support putting health research into practice with all health care providers who work in geriatric care and involve front line providers in setting research
priorities, and to hire eight regional coordinators to implement RNAO Best Practice Guidelines in LTC homes.

New Regulations

• New regulations took effect January 2005 including:
  o That a registered nurse who is a member of the regular nursing staff of the home be onsite 24 hours a day, seven days a week in LTC homes
  o That each resident be given at least two baths or showers per week
  o That all planned food menus and menu cycles must be reviewed and approved in writing by each home’s dietician at least once a year (effective January 1, 2005).

Sector Communication

• In addition to the “LTCH Program news” bulletin, which is sent monthly to the Regions and LTCH Branch, in October 2005, the ministry launched the first issue of the quarterly “Program Brief”. The “Program Brief” updates the sector on key developments affecting LTC homes. The French version of these bulletins is distributed to homes that provide services in French.

Quebec

Un investissement de 16,9 millions de dollars a été accordé en août 2005 pour la construction et le réaménagement de résidences dédiées à l’hébergement de longue durée.

An investment of $16.9 million was made in August 2005 for the construction and renovation of long-term care residences.

New Brunswick

• Long term care homes fall within the responsibility of New Brunswick’s Department of Family and Community Services.

Nova Scotia

See Homecare section.

Prince Edward Island

• There are 18 long term care facilities in the province in 2005/06 which provides nursing level care; nine public manors/facilities and nine private nursing homes. This level of service is for individuals who are assessed as requiring 24-hour registered nurse supervision and care management (level 4 and 5). Payment for long term care is the responsibility of the individual. When a resident of a facility or a person coming into a facility does not have the financial resources to pay their own cost of care (self pay), they may apply for financial
assistance (subsidy) under the Long Term Care Subsidization Act and Regulations. They then undergo a standardized financial assessment.

- Private Nursing Homes are licensed by the Community Care Facilities and Nursing Homes Board under the authority of the Community Care Facilities and Nursing Homes Act and Regulations. The public manors/facilities are accredited by the Canadian Council on Health Services Accreditation.

Newfoundland and Labrador

Long-term and community support services are available along the continuum of in-home, community residential and facility-based options such as home support, respite, personal care homes, cooperative apartments and nursing homes. Service is accessed through a single entry system provided by the four Regional Health Authorities. Community support services also include professional services such as nursing, social work, physiotherapy and occupational therapy. Professional services are provided through public funds. Home support services are financially means tested and are primarily provided to seniors and persons with disabilities. Eligible seniors receive a maximum of $2,707/month and persons with disabilities may receive a maximum of $3,875/month.

There are 97 personal care homes located in various communities across the province. These homes have 2,931 beds and provide residential accommodation primarily to persons with low care needs. Some personal care homes that meet provincial design and program standards admit Level II clients. Professional consultation services (i.e., nursing, dietetics) are provided to personal care homes on a visiting basis by staff employed within the regional health authorities. Clients in personal care homes pay a maximum of $1,138.10 a month based on a financial assessment.

Facility-based long-term support is provided in 21 nursing homes, 13 community health centers and four hospitals. Persons admitted to facility-based long-term care pay a maximum of $2800/month based on a financial assessment. Design and construction of three new long-term care facilities in three regions of the province is underway. The models are of a “social” nature to facilitate a home-like environment for residents with the design providing amenities to suit the residents’ particular needs.

Given the demographic structure of an aging population, long term and community support services have been prioritized for development of a new provincial service delivery framework. The framework will be the foundation for new evidenced based policies and a coherent delivery of services across population groups. Investments are currently being made in the areas of infrastructure, new financial and client assessment tools, rate structure reviews, new models of residential support, and increased home supports.
Pharmacare

Northwest Territories

- There were no substantial changes to drug plan coverage during 2005/2006.

Yukon Territory

- Nothing to report at this time.

British Columbia

PharmaCare subsidizes eligible prescription drugs and designated medical supplies, protecting British Columbians from high drug costs. PharmaCare provides financial assistance to British Columbians under Fair PharmaCare and other specialty plans.

B.C. pushes for national PharmaCare program

Premier Gordon Campbell was instrumental in Federal Provincial Territorial discussions in 2004 for the federal government to accept a national Pharmacare program. Canada’s premiers support the development of a national pharmaceuticals strategy to improve access to safe, affordable and effective drug therapies, protect Canadians from catastrophic drug costs and ensure the sustainability of the health care system. British Columbia is co-leading the National Pharmaceutical Strategy.

BC first to fund drug to benefit breast cancer patients

B.C. was the first province to approve and cover the cost of the drug Herceptin for all eligible breast cancer patients. Breast cancer patients in British Columbia gained access to the promising drug therapy through an $8-million commitment from the Ministry of Health, the PHSA and the BC Cancer Agency. In clinical trials, patients treated with Herceptin after completing chemotherapy had their rate of cancer recurrence cut by more than half, and had improved survival rates. It is expected that about 160 women in B.C. can benefit from the drug each year, at an annual cost of up to $8 million.

Patients benefit from new drugs under PharmaCare

Patients with rheumatoid arthritis, glaucoma, migraines and high blood pressure are among those who will benefit from improved health and quality of life through access to eight new drugs under PharmaCare. Decisions about drug coverage are based on scientific evidence that clearly shows a medication is safe, cost-effective and improves patient outcomes. In July and August 2005, PharmaCare listed the following prescription medications for coverage:

- Humira, used to treat rheumatoid arthritis.
- Combigan, for glaucoma and ocular hypertension.
• Axert, for migraine.
• Teveten Plus, for high blood pressure.
• Avodart, for enlarged prostate (prostatic hyperplasia).
• VFEND, for invasive fungal infections in immune-compromised patients.
• Keppra, for epilepsy.
• Xalacom, for glaucoma and ocular hypertension.

More than 10,000 patients will receive coverage for these drugs in 2006.

**PharmaCare makes program improvements to benefit British Columbians**

- BC’s PharmaCare program increased the number of drugs reviewed over the past year by 293%. In 2004, PharmaCare completed 14 drug reviews and approved five. In contrast, in 2005, PharmaCare completed 55 drug reviews and approved 29. This includes only the brand name drugs, not generics.
- PharmaCare expenditure has increased 25% from $635 million in 2000/01 to almost $793 million in 2004/05.

**PharmaNet**

- PharmaNet is an innovative, province-wide network linking all pharmacies into a central set of data systems which, in turn, provide improved data and services to support drug dispensing, drug monitoring and claims processing. Australia is now considering the B.C. model as a prototype for a similar initiative. PharmaNet was cited in a 2004 CIHI report as an example of innovation in patient safety.
- Government is improving patient care and safety by making medication histories available to authorized medical practices through PharmaNet. Expansion of access to PharmaNet is being supported by a change in the proper legislation with amendments to the Access to PharmaNet Patient Record Information Regulation. PharmaNet is the secure computer network that links all community pharmacies in B.C. and many hospital pharmacies, to a central database. The computer network protects British Columbians from potentially dangerous medication interactions and duplications.

**Modernize and Improve Administration of Medical Services Plan and PharmaCare**

Government has contracted with MAXIMUS BC to modernize and improve the administration of MSP and PharmaCare. This is intended to improve services to British Columbians:

- reduced wait time for phones and correspondence;
- quicker processing times;
- faster and more user friendly automated services.

Measures have been taken to ensure the confidentiality of the public's information is protected. B.C. leads Canada in privacy protection. The agreement protects employee jobs and working conditions for current staff.
**Alberta**

**Alberta Electronic Health Record**

- Alberta Netcare is the new name to describe all activities related to the Alberta Electronic Health Record (EHR). Various projects, products, programs and services continue to emerge across the province. Alberta Wellnet, the name of the branch within Alberta Health and Wellness responsible for developing and delivering the EHR, has been changed to the Information Systems Delivery branch.

- The Alberta EHR is an electronic clinical health information network that links community physicians, pharmacists, hospitals, and other authorized health care providers from across the province. It helps health care providers quickly see, and in some cases update, health information such as patients’ allergies, prescriptions and laboratory results. To do this, the Alberta EHR brings together three technology applications in one view to make it easy to access the information: the Pharmaceutical Information Network (PIN), the Person Directory, and the Laboratory Test Results History.

- Physician office and pharmacy system vendors are working with the Information Services Delivery branch to complete revisions to their software to interoperate with the Alberta EHR. This means that health care providers will soon be able to benefit from the Alberta EHR without changing the management software tools they have become familiar with, such as electronic medical records and the pharmacy dispensing systems.

**Common Drug Review**

- The Common Drug Review (CDR) is a single process for undertaking reviews and providing recommendations for new drugs and new drug combinations to participating federal, provincial, and territorial drug benefit plans in Canada. The CDR consists of a critical appraisal of the best available clinical and pharmo-economic evidence, and listing the recommendations made by the Canadian Expert Drug Advisory Committee.

- The Canadian Coordinating Office for Health Technology Assessment is responsible for delivery of the CDR to participating drug plans. As of February 23, 2006, reviews and recommendations have been completed for 36 drugs.

- Alberta Health and Wellness has integrated the CDR process into its decision-making processes. Alberta has retained drug review processes for products other than those reviewed by CDR. The Minister continues to make all formulary listing decisions based on advice from the Expert Committee on Drug Evaluation and Therapeutics.

**National Pharmaceutical Strategy**

- The federal, provincial and territorial governments are working together to develop a National Pharmaceuticals Strategy (NPS) to address challenging drug issues in an integrated, comprehensive and collaborative approach.

- Alberta is actively engaged in the NPS.
Saskatchewan

- The governance/management of the Saskatchewan Prescription Drug Plan follows *The Prescription Drugs Act*. Financial benefits provided by the Drug Plan follow *The Prescription Drugs Regulations, 1993*. The plan is structured to assist families with low incomes, families with high drug costs and those with a combination of both.

- The Special Support Program is designed to help those whose drug costs are high in relation to their income. Based on the information provided on the application form along with Drug Plan records, the Drug Plan determines the amount of benefit for which the beneficiary is eligible. A family may qualify for Special Support based on the family's annual adjusted income. Income adjustments are made by deducting $3,500 for each dependent under 18 years of age. The family's co-payment is determined by the amount that the family drug costs exceed 3.4 percent of the adjusted combined family income from the most recent tax year. If the annual benefit drug cost exceeds 3.4 percent of the adjusted income, the family qualifies for a lower co-payment to reduce their share of drug costs and spread the cost over the six-month deductible period.

- All Saskatchewan residents except those covered by other agencies (i.e. Registered Indians, Veterans, RCMP, Canadian Forces and Workers Compensation Board) are eligible for coverage under the Drug Plan. During the 2004/2005 fiscal year, in excess of 119,000 families received financial assistance with their prescription costs. This represents 25.3% of families that receive prescription drugs. As of February 28, 2006, 86,826 families were registered in the Income Based Special Support program. Of these families 61,530 had family drug costs greater than 3.4% of their family income. The Special Support Program provides additional financial support (i.e. decreased deductibles and/or co-payments) to help those whose drugs costs are high in relation to their income.

- The Drug Plan budget increased from $170.9M in 2004/05 to $187.1M in 2005/06.

- The Pharmaceutical Information Program (PIP) medication profile electronic viewer became operational in October 2005. PIP provides authorized health care professionals (e.g. pharmacists and physicians) with confidential access to a medication profile containing all prescription drugs dispensed by Saskatchewan community pharmacies. A full production rollout is underway in 2006 to extend the medication profile viewer to as many pharmacies, emergency rooms, physician clinics, long-term care and home care facilities in the province as possible. PIP will be broadened in future phases to include electronic prescribing and integration with pharmacy computer systems. PIP is a key component of the Electronic Health Record strategy for Saskatchewan. The costs of the project are being shared with Canada Health Infoway.

Manitoba

- The Pharmacare program in Manitoba operates under the legislative authority of *The Prescription Drugs Cost Assistance Act*. It is wholly administered by Manitoba Health.

- Pharmacare is an income-based drug benefit program. Coverage is based on a family’s adjusted total income. It provides 100% financial assistance for eligible prescription drug costs in excess of a pre-set deductible. The minimum deductible is $100.
• Published Estimates of Expenditures for Pharmacare for 2003/2004 are $160.8M. This is a 17.6% increase over 2002/2003 estimated expenditures for Pharmacare.

• Effective April 1, 2005, the Pharmacare deductible was adjusted. For families with incomes of $15,000 and under, the new deductible rate is 2.44%, up from 2.32%. For families with incomes above $15,000, the deductible rate rose from 3.48% to 3.65%, and 4.2% from 4.0% for adjusted incomes greater than $40,000 and less than or equal to $75,000, as well as, 5.25% from 5.0% for adjusted incomes greater than $75,000.

Ontario

The Ontario Drug Benefit (ODB) program provides coverage to the following eligible recipients with a valid Ontario Health Card:

• Ontario residents aged 65 and over,
• Ontario residents receiving social assistance (Ontario Disability Support Program and/or Ontario Works)
• Ontario residents receiving professional services under the Home Care Program,
• residents of homes for special care and long-term care facilities, and
• all other Ontario residents who have registered in the Trillium Drug Program (TDP). The TDP is intended to provide catastrophic drug coverage for those Ontario residents who have high out-of-pocket drug costs relative to their net household income.

In addition, certain high cost outpatient drugs used to treat specific diseases/conditions are covered under the Special Drugs Program (SDP). The ODB program is funded by both the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services.

Under ODB, the government provides coverage for over 3,300 prescription drug products (including some nutrition products and diabetic testing agents) listed as benefits in the Ontario Drug Benefit Formulary/Comparative Drug Index (Formulary).

Quebec

À la suite d’une vaste consultation à la Commission des affaires sociales, le projet de loi n° 130 a été déposé en novembre 2005, visant à modifier et à bonifier l’actuelle Loi sur l’assurance médicaments.

After extensive consultations conducted by the Commission des affaires sociales, Bill 130, designed to amend and enhance the current Act respecting prescription drug insurance, was tabled in November 2005.

New Brunswick

• The New Brunswick Prescription Drug Program (NBPDP) is a provincially-funded program which provides drug coverage to eligible New Brunswick residents. They include seniors
who receive the Guaranteed Income Supplement, qualify through an income test, residents of
nursing homes, clients of the Department of Family and Community Services, and others
with certain medical conditions. Information regarding eligibility requirements for the
various beneficiary groups and the list of drug benefits can be found at
www.gnb.ca/0051/0212/index-e.asp

- The NBPDP budget increased from $132,003,000 in 2004/2005 to $142,600,000 in

**Nova Scotia**

*Nova Scotia Seniors’ Pharmacare Program*

- Pharmacare provides prescription drug insurance to eligible residents 65 years of age or older
  who are registered under the Medical Services Insurance (MSI) program and who do not
  already have prescription drug coverage through Veteran Affairs, or first Nations and Inuit
  Health or private drug plans.

- Pharmacare was established in 1974 under the authority of the Insured Programs Branch,
  Department of Health under Section 17 of the Health Services and Insurance Act. The
  Prescription Drug Plan Regulations became effective October 1, 1974 and were revised in
  January 1991. Additional regulations for the Seniors’ Pharmacare Program were approved
  June 27, 1995. There have been several revisions

- The following revisions to the co-payment and premium maximums for Pharmacare becomes
  effective in April 2006:
  - premium paid by each eligible senior changes from $390 to $400 a year. The co-payment
    changes from an annual maximum of $350 to $360. The co-payment of 33% of the total
    cost of each drug prescribed to a maximum of $30 for each drug prescribed remains the
    same.

- Based on their annual income, over 50% of seniors are exempted from the payment of
  premiums. Other seniors may qualify for reduced premiums.

- The estimated cost of the program for 2006/7 is $172 million.

- Further information on Nova Scotia’s Pharmacare Program is available at
  http://www.gov.ns.ca/health/pharmacare/default.htm

*Nova Scotia Diabetes Assistance Program (NSDAP)*

- The NSDAP is a provincial drug plan which covers the medications and supplies, necessary
  to manage diabetes, including insulin, oral blood glucose lowering drugs (antihyperglycaemics),
  blood glucose test strips, needles, lancets, and syringes

- Eligibility for the program is based on:
  - Permanent residency in Nova Scotia
  - Valid Nova Scotia health card
  - Under age 65
Confirmed medical diagnosis of diabetes
Agreement to verification of family income
Agreement to provide changes in size of family on an annual basis
No drug coverage through private insurance, Veterans Affairs, or First Nations and Inuit Health
Agreement to provide information about their diabetes when registering for assistance

- The amount of assistance provided by the Government of Nova Scotia is based on a deductible, calculated January 1st each year. The deductible is based on family size and income of the participant in the program.
- Everyone registered in the program is required to pay a co-payment of 20% for each prescription.

Further information on the NSDAP is available at http://www.gov.ns.ca/health/pharmacare/dap/default.htm

Prince Edward Island

- The provincial Drug Cost Assistance programs provide financial assistance to eligible persons for drug costs, professional pharmaceutical consultation services to clients, government and institutions and programs and as well, an economical source of medications to the provincial health and social services system. The programs include the Diabetes Control Program, Family Health Benefit Program, Financial Assistance Program, Multiple Sclerosis Drug Program, Seniors Drug Cost Assistance Plan, Nursing Home Program, and Disease Specific Programs.
- The programs are delivered through community retail pharmacies and the Provincial Pharmacy which is located within the Department of Social Services & Seniors. Program delivery by the retail pharmacies is monitored by the Department through service delivery agreement with the PEI Pharmaceutical Association.
- In 2005/06, funding for drug programs increased by $3.2 million. Included in this was $400,000 in funding for medications used for the treatment of Alzheimer's disease.

Newfoundland and Labrador

The Newfoundland and Labrador Prescription Drug Program assists residents who qualify for benefit coverage to purchase pharmaceutical therapy under the following programs:

- Income Support Drug Program (Income Support recipients and residents who qualify for a drug card only, based on financial assessment).
- Senior Citizen’s Drug Subsidy Program (Guaranteed Income Supplement Recipients)
- Special Needs Program (Cystic Fibrosis, Growth Hormone Deficiency, and Food Bank Program).
- Regional community health boards administer the Special Assistance Program and Medical Equipment and Gases Program.
The Department of Human Resources Labor and Employment determines client eligibility for Income Support clients and the Department of Health and Community Services administers the program.

The delivery/supply of pharmaceuticals is affected primarily through service providers such as physicians, pharmacists, and manufacturers who operate in a free enterprise market system. Claims to the program are processed in accordance with a service contract with an external claims adjudicator who processes through pharmacies and provides an information data base to departmental staff to enable better budget, client, physician and pharmacy monitoring, as well as the application support for the processing of special authorization requests. Detailed information is available at: www.gov.nl.ca/health/nlpdp.

In an effort to streamline and reduce duplication in the approval of drugs to be added to provincial drug formularies, Newfoundland and Labrador is collaborating nationally and atlantically on drug review processes. The National Common Drug Review includes Federal, Provincial, and Territorial jurisdictions and completes reviews for all new chemical entities. The Atlantic Common Drug Review completes class reviews, considers line extensions, and performs other assessments related to existing drugs.

Other / Autres Questions

Health Canada

International Collaboration

In 2005-2006, Health Canada completed a strategic framework for its international activities. This framework will guide the Department’s decisions on international involvement, advance domestic health priorities, and contribute to Canada’s foreign policy. The Department also contributed to the World Health Organization’s negotiations to revise the International Health Regulations, and continued to advance work on key international issues such as HIV/AIDS, tobacco control, and international trade and health.

Santé Canada

Collaboration internationale

En 2005-2006, Santé Canada a mis au point un cadre stratégique pour ses activités internationales. Ce cadre orientera les décisions du Ministère concernant son engagement international, fera progresser les priorités canadiennes en matière de santé et contribuera à la politique étrangère du pays. Le Ministère a également contribué aux négociations de l’Organisation mondiale de la Santé concernant la révision du Règlement sanitaire international et poursuivi l’examen des principaux dossiers internationaux, comme le VIH/sida, la lutte contre le tabagisme ainsi que le commerce international et la santé.
Northwest Territories

Nothing to report at this time.

Yukon Territory

Nothing to report at this time.

British Columbia

No other updates to report at this time.

Alberta

Nothing to report at this time.

Saskatchewan

Acute & Emergency Care

Emergency Medical Technician Training and Dispatch Initiatives

- In 2002-03 a three-year Emergency Medical Technician (EMT) training initiative began with a goal of training new or existing emergency medical service providers to the EMT-Basic Level and in future implementing a service standard of having at least one EMT on every ambulance call provided in the province. To date, training was provided or arrangements are in place for a total of 106 students.

- Emergency medical services dispatch continued to improve. All ambulance services in the province are now dispatched through one of five wide-area dispatch centers. This ensures appropriate service for patients and better coordination and use of ambulances.

Surgical Wait List Initiatives

- The Saskatchewan Surgical Care Network (SSCN) was established in March 2002. This is an advisory committee to Saskatchewan Health dedicated to creating a more reasonable, fair surgical system for all Saskatchewan people. The SSCN has been working with key health partners to improve the system’s effectiveness, organization and efficiency, so that those who require surgery receive it within appropriate time frames.

- The SSCN has overseen the following actions:
  - Established a Registry Office and developed a province-wide computerized Surgical Patient Registry. This Registry tracks all patients needing surgery in the province who go through the operating room;
  - Developed target time frames for surgery to allow the health regions to better monitor and track patients and help ensure they receive care according to their level of need;
In March 2004, Target Time Frames for Surgery were announced as “performance goals” for the surgical care system;

Provision of better public information through a surgical web site launched in January 2003. This site provides information on wait times and how to access surgical services in the province. Contacts in each health region have been established so that patients can call to inquire about their own waits for surgery;

Implementation of a new Patient Assessment Process to increase consistency and fairness by standardizing the factors physicians will use to assess their patients’ level of need for surgery. This will help to ensure those with the greatest need for surgery to receive it first.

**Diagnostic Imaging Strategy**

- In June 2004, a Steering Committee of key stakeholders was established to obtain expert assistance in the development of a diagnostic imaging strategy.

- On January 31, 2004 the Minister of Health announced the establishment of a Diagnostic Imaging Network. Through collaboration with participating partners, the Network will act as a provincial advisory body to assist in province-wide strategic planning and coordination of the diagnostic imaging system.

- The Diagnostic Imaging Network members acknowledge the importance of standardizing wait time definitions and priority levels province-wide, and are therefore, currently studying preliminary information relating to a common wait time definition and priority groupings for diagnostic imaging procedures.

**Family Health Benefits**

- The Family Health Benefits Program provides extended health benefits to lower income working families to assist with costs of raising healthy children. The plan includes coverage for child dental services, eyeglasses, medical supplies and appliances, prescription drugs, and ambulance services.

- Adults in these families receive additional coverage for eye examinations, chiropractic services, as well as a semi-annual Drug Plan deductible of $100.

- During 2004-2005 the average number of families eligible for Family Health Benefits was 20,189. This includes 26,303 adults and 35,321 children.

**Healthy Living / Project Hope**

- Under the portfolio of Healthy Living, Project Hope’s initiatives include:
  - the expansion of HealthLine to provide information and referrals on addictions issues;
  - a crystal methamphetamine (crystal meth) media campaign targeted at parents and youth;
  - education and prevention through the Alcohol and Drug Prevention and Education Directorate of Saskatchewan Health;
o the provision of resource officers in schools, who can directly help young people at risk of substance abuse;
o regional recruitment of Prevention Coordinators;
o the establishment of a Research Chair in Substance Abuse at the University of Saskatchewan;
o the Youth Drug Detoxification and Stabilization Act, passed in December 2005;
o enhanced methadone services;
o the successful recruitment of a Health, Enforcement and Education in Partnership (HEP) Coordinator;
o expanding the ability to treat addiction, by developing more detox beds, creating and expanding more outreach services, developing a mobile treatment service and recruiting more addictions counsellors;
o “going after the source” through supply reduction, by recruiting drug enforcement and Safer Communities and Neighbourhoods Act (SCAN) officers, urging the federal government to strengthen drug possession penalties and building on “MethWatch”, a coalition of retail and wholesale businesses that restricts the supply of ingredients used in crystal meth;
o Restrictions were put in place regarding the sale of certain cold remedies containing pseudoephedrine, one of the ingredients used to make crystal meth. Cough and cold remedies, containing only pseudoephedrine, are now kept behind pharmacy counters. As well, the volume of pseudoephedrine that may be sold at any transaction is now limited at 3,600 milligrams; and
o coordination through the Community Development Framework, which amalgamates and empowers communities to battle substance abuse issues and the development of a treatment database with updated information about treatment options.

Aboriginal health

- Saskatchewan Health provides health care services to Aboriginal people through Regional Health Authorities and provincial programs. Regional Health Authorities plan for and manage the provision of health services in their regions, which includes understanding the population within their region and responding to the health care needs of Saskatchewan’s diverse populations.

- Aboriginal people tend to have specific health care needs and lower health status than other Canadians. The 2004 First Ministers Communiqué on Aboriginal Health and the 2005 Aboriginal Blueprint to Strengthen Health Care include commitments to take action to improve the health status of Aboriginal people. The national Aboriginal health blueprint was released as a “work in progress” and will lead to the development of plans at the provincial level.

- The Saskatchewan health blueprint approach document is built on the priorities that emerged from provincial blueprint engagement sessions and submissions. This document was developed as a starting point and does not represent a final blueprint plan for the province.
Manitoba

Nothing to report at this time.

Ontario

Performance Indicators

*Measuring Health System Performance*


The Ontario Health Quality Council, one of the main components of the *Commitment to the Future of Medicare Act*, was launched on September 12, 2005. The Council is an independent body with the mandate to monitor Ontario’s health care system and report to the public on how well the health system is performing. The Council submitted its first yearly report (as required under S.5 of the Act) to the Minister of Health and Long-Term Care on March 30, 2006. The Minister tabled the report in the Legislature on April 26, 2006.

In developing its first report, the Council examined indicators of health system performance from many sources. The Ministry of Health and Long-Term Care was a source for validated indicators linked to provincial strategic goals. The Ministry also contributed data and other information.

A copy of the report and more information about the Council and its mandate are available at [http://www.ohqc.ca](http://www.ohqc.ca).

*Measuring Wait Times Performance*

In *A 10-Year Plan to Strengthen Health Care*, the Federal-Provincial-Territorial Ministers of Health agreed to establish evidence-based benchmarks for medically acceptable wait times by December 31, 2005 starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration. The pan-Canadian benchmarks for selected procedures were announced on December 12, 2005. As a follow-up to this announcement, Minister George Smitherman announced Ontario-specific targets for each of the five service areas with priority levels and wait time targets for each level. This information is based on advice from five clinical expert panels, and from subsequent advice from the expert panel chairs on a common and consistent approach to priority levels and targets. The table below highlights the targets that have been set.
The public can follow progress on wait times in Ontario by going to the Ontario government’s wait times website at www.ontariowaittimes.com.

This website allows Ontarians to get information on wait times for key surgical procedures at local hospitals, and to see whether a procedure is available sooner at other hospitals. It is also designed to help professionals set priorities based on patients’ needs.

### Measuring Hospital Performance in Ontario

The Ministry of Health and Long-Term Care and the Ontario Hospital Association (OHA) jointly sponsor the Hospital Report Card Series. The primary goal of the hospital reports is to improve health care by annually measuring hospital performance. Hospital reports provide hospital administrators and planners with a valuable evaluation tool to guide their future decision-making and assist in improving hospital performance.

The hospital reports follow a balanced scorecard approach reporting on cost management, clinical outcomes, patient satisfaction and the impetus for change at the hospital and system level.
In 2005, Ontario produced hospital reports in the following areas:

- Acute Care
- Complex Continuing Care
- Emergency Department Care
- Rehabilitation Services

In July 2006, an Acute Care report was released. Each report includes a Women’s Health Perspective section. Copies of all reports are available at www.hospitalreport.ca

Quebec

Le Comité de travail sur la pérennité du système de santé et de services sociaux, présidé par M. Jacques Ménard, a publié son rapport en juillet 2005. Cette démarche s’inscrit dans le grand débat qui vise à améliorer et à maintenir à long terme notre système de soins de santé et de services sociaux accessible à tous. Le rapport Ménard brosse d’abord un portrait de la situation démographique du Québec et de la croissance des coûts liés à la santé. Ensuite il propose différentes mesures dont la création d’un régime d’assurance contre la perte d’autonomie et souligne l’apport que pourrait apporter le secteur privé dans le système de santé québécois.


The Comité de travail sur la pérennité du système de santé et des services sociaux, chaired by Jacques Ménard, published its report in July 2005. This process was part of a larger debate around the long-term improvement and maintenance of a health and social services system that is accessible to all. The Ménard report draws a portrait of Quebec’s demographic situation and the growth of health-related costs, then proposes various measures, including the creation of an insurance plan against loss of independence, and highlights the contribution that the private sector could make to the Quebec health care system.

The Bilan des progrès accomplis à l’égard de l’entente bilatérale intervenue à l’issue de la rencontre fédérale-provinciale territoriale des premiers ministres sur la santé de septembre 2004 was published in October 2005. This report summarizes the progress made in the wake of the bilateral agreement entitled Asymmetrical Federalism that Respects Quebec’s Jurisdiction, under which Quebec will implement its own wait time reduction plan, based on its own objectives, standards and criteria, and the Government of Quebec will report to Quebeckers on the results obtained. The Quebec government summary primarily addresses wait times
reductions, access enhancements, health human resources, primary care reform, pharmaceuticals, and public health.

New Brunswick

The Provincial Health Plan provided a mandate for the establishment of four committees, to report to the Minister on health system issues.

- The *Provincial Programs Steering Committee* was established in 2004 to ensure New Brunswickers have access to specialized clinical programs, by ensuring full collaboration amongst Regional Health Authorities. This committee is chaired by the Minister of Health, and receives the reports of the following committees.

- The *Patient Safety and Clinical Collaboration Committee* was established in 2005, with a mandate to ensure New Brunswickers have access to safe, quality clinical programs in a timely manner. Representatives from all of the Regional Health Authorities and stakeholders are focusing on three areas: clinical programs; surgical access management; and best practices for patient safety.

- The *Primary Health Care Collaborative Committee*, as described in the section on primary health care was established in 2005 to develop and implement new ways of improving access and delivering primary health care to New Brunswickers.

- The *Non Clinical Support Services Committee* was established in 2005 with a mandate to review and recommend consolidation of appropriate Regional Health Authority non-clinical support services.

Nova Scotia

*Healthcare Safety*

Leading safety practices are being identified for application in Nova Scotia. The Department of Health is contributing to the *Safer Healthcare Now!* Campaign in the Atlantic Region. This campaign offers Canadian hospitals the opportunity to implement six (6) practices demonstrated to improve patient safety. All district health authorities and the IWK Health Centre are participating in the campaign by implementing one or more of the practices.

Some other provincial activities in progress include:

- Development of guidelines and tools for conducting meaningful quality review aimed at preventing things from going wrong or rectifying factors which contribute to adverse events;

- Implementation of a multi-phased disclosure policy which requires healthcare organizations to have processes in place to support clients and staff when disclosing adverse treatment/care events to clients;

- Expansion of opportunities to increase awareness of health care safety and safety practices through education sessions, participation in national patient safety week and establishment of stakeholder networks;
• Involvement by health system stakeholders and Department of Health staff on national patient safety initiatives such as the Canadian Medication Incident Reporting and Prevention System and committees of the Canadian Patient safety Institute.

**Prince Edward Island**

A process to develop a strategic plan to guide the health system over the next three to five years is being undertaken. This plan will replace the 2001-05 Health and Social Services System Strategic Plan. Once completed, the health system plan will provide direction to middle and front line managers, as well as community hospital boards. As part of this process, the Department will complete an extensive community health needs assessment.

**Newfoundland and Labrador**

*Provincial Tobacco Reduction Strategy*

A renewed Provincial Tobacco Reduction Strategy for Newfoundland and Labrador, that outlines priority areas for action for the next three years (2005-2008), was released in June 2005. The strategy, lead by the Alliance for the Control of Tobacco (ACT), in partnership with Department of Health and Community Services (DOHCS) and other key partners, will develop and implement strategies to: decrease smoking rates among youth and young adults, reduce exposure to secondhand smoke and develop a coordinated approach to cessation.

The Department of Health and Community Services, in collaboration with the ACT, the Regional Integrated Health Authorities (RIHAs), other government departments, and numerous community organizations, are working to prevent and reduce the negative impacts smoking continues to have on the people of the province. Throughout 2005-06 the DOHCS collaborated on a number of ongoing activities related to its support of the Provincial Tobacco Reduction Strategy including the Lung Association's Smokers' Help Line and CARE Program – Community Action and Referral Effort (a proactive way of referring smokers to the Smokers’ Helpline services where they can receive services and support to meet their individual needs, Kick the Nic a stop smoking program for teens, and the redistribution of a Grade Seven Tobacco Prevention Resource Kit for teachers and students.

*Amendments to Smoke-Free Environment Act*

The Newfoundland and Labrador amended the *Smoke-Free Environment Act* to further protect the public and workers from the dangers of second-hand smoke. In July 2005, all public spaces, including bars and bingo halls, were designated as smoke-free environments.

*Smoking on School Grounds*

The ACT has been active in raising public awareness about the negative effects of allowing smoking to occur on school grounds. A survey of all school administrators was conducted in May 2005 to determine current policies regarding smoking on school grounds, to list concerns regarding the provision of smoking areas, and to assess the level of support for creating provincial policies or legislation to prohibit smoking on school property. Since the completion
of the survey, three of the five school boards have decided to bring in district-wide policies to ban smoking on school grounds.

**Youth Smoking Prevention Campaigns**

In October 2005, ACT launched a mass media campaign (*You’re a Target: Don’t Let ‘Em Get You*) with funding from Health Canada, to encourage older school aged youth to become more aware of their vulnerability to smoking and the tobacco industry. A second campaign in K-6 schools (*S.P.Y. – Smoking Poisons You*) was also launched in January 2006, to raise elementary students’ awareness about the hazards of smoking.

In March 2005, the government increased the tax rates on manufactured cigarettes and fine cut tobacco.

**Public Health Initiative**

Over the next two years government is committing significant additional human resources to Public Health initiatives.

Thirty-nine public health nursing positions to enhance the regional core public health programs and ensure the administration of public health delivered immunization programs with a capacity for mass immunization in the event of a pandemic.

Four regional health emergency professionals, along with their required supports, will be hired to develop regional emergency response plans with initial priority on pandemic influenza preparedness planning.

Five positions in the Department of Health and Community Services, including: an epidemiologist, infection control specialist, director of disease control, director of public health information management, and deputy provincial medical officer of health. The creation of these new positions will increase the province’s ability to provide expertise and to support its leadership role in all areas of public health.
Part E Updates from National Research Institutes

Canadian College of Health Service Executives

Executive Forum: Cross-Canada Check-up highlights

As part of Executive Forum hosted by the College on April 19-21, a session called “Cross Canada Check-up” provided an opportunity for representatives from each of the provinces and territories to report on the most important developments affecting the health system over the past year. Nearly every jurisdiction included health human resources, wait lists, governance and accountability.

British Columbia is in the second year of a ten-year capital plan and the public sector unions have finalized four year agreements. Health care continues to be a priority, especially in terms of long term care, recruitment and retention.

Alberta has Primary Care Networks in place, but these are still primarily physician-driven, rather than interdisciplinary. The province has made progress on introducing electronic health records and access standards, and implemented a wait list registry. With increased growth and prosperity, Alberta forecasts that 93,000 new health care employees will be required over the next ten years.

Four years ago, Saskatchewan amalgamated 32 health districts into 13 health regions, with boards appointed by the Ministry of Health. The collective bargaining process has concluded which is expected to result in relative stability over the next two to three years.

Manitoba’s regionalization process is continuing. A key priority is the wait list initiative where the focus is on involving primary care to track patients moving through the health care system.

In Ontario, regionalization is still on the health transformation agenda in the form of a “made in Ontario” model that will retain its regional boards but also includes 14 Local Health Integration Networks. The model is unique in terms of separating the planning and operational functions. The province has also introduced signed performance agreements between the government and hospitals as well as home care.

Quebec has seen significant changes in health and social services to address inequities and issues of access and wait lists. The decentralized system is comprised of 95 local networks in 18 regions. There is still a human resource shortage throughout the province.

New Brunswick established Regional Health Authorities in 2002. The province is creating a provincial cancer network, and is integrating public and mental health into its Regional Health Authorities. There is also a focus on wait lists and issues around patient safety.

Newfoundland has four integrated boards (down from 52), which has improved coordination and access. The Newfoundland Centre for Health Information is responsible for connecting them. The province introduced a provincial-client registry, the first of its kind in Canada.
Prince Edward Island’s government abolished the four health regions and is centralizing the supervision of health delivery. There has increased centralization on all fronts, including administration and human resources.

Nova Scotia has developed a physician incentive framework, established a clinical assessment program and created a single entity for public health. A number of initiatives related to human resources and administration have been introduced and a nursing strategy was developed to improve recruitment and retention.

The Northwest Territories consists of eight Regional Health Authorities, seven of which have regional boards. The Joint Leadership Council sets out the basic directions for the Territories and the provincial government is part of an “Integrated Service Delivery Model.” Physicians are employed under contract, to avoid problems with recruitment. The Department of Health and Social Services is, among other things, working on an informatics blueprint which will serve as the basis for establishing electronic health records.

The Canadian Armed Forces is predominantly a primary care system and, as such, is involved in many of the associated primary care initiatives across the country. Health human resources continues to be a key issue and work is continuing to develop electronic health records.

From the presentations, it was clear that the provinces and territories continue to face many challenges associated with health human resources in terms of recruitment and retention, exploring new models of care and managing shortages with increased demands. There continues to be a focus on wait list management, new practices in the areas of information technology and patient safety as well as evolving governance structures and accountability.
Canadian Institute for Health Information

CIHI—Taking health information further

The Canadian Institute for Health Information (CIHI) is an independent, not-for-profit organization that produces essential, pan-Canadian health information to improve Canadians’ health and their health system.

To do this, CIHI works with provincial governments, regional health authorities, hospitals, the federal government, researchers and associations representing health care professionals.

What does CIHI do?

CIHI collects, analyzes and disseminates data and information on the performance of the Canadian health system, the delivery of health care, and the status of Canadians’ health.

It is CIHI’s mandate to provide accurate and timely information that can be used to develop sound health policies, manage Canada’s health system, and increase public awareness of the factors affecting good health. Specifically, CIHI’s data focuses on:

- Health care services
- Health human resources
- Health spending
- Population health

CIHI also identifies and promotes national health indicators—measures such as life expectancy or what we spend on health per capita—that are used to compare health status and health-system performance and characteristics. To make sure these measurements are comparable and meet the same quality requirements, CIHI also coordinates national health information standards.

CIHI’s research and data are published in reports, analytical documents, and special studies. CIHI also coordinates and leads education sessions and conferences.

Our role in Canada’s future

CIHI collects and synthesizes a vast amount of high-quality, comparable data to track what is happening in Canada’s health system and how healthy Canadians are. CIHI’s data provides snapshots of how Canada’s health system worked in the past and how it’s working now.

This information has become a resource that is routinely called upon by the nation’s many health care providers, organizations, associations and governmental bodies as they make decisions on the future of Canada’s health care system.
**How is CIHI measuring up?**

CIHI is increasingly being recognized as a national and world leader for achievements in health information—as well as a great place to work!

- In 2003, CIHI was chosen as the recipient of the Conference Board of Canada/Spencer Stuart National Awards in Governance.
- In both 2004 and 2005, CIHI was listed as one of Canada’s top 100 employers in *MacLean’s Magazine.*

Interested in joining the team? Learn more about CIHI’s career opportunities by visiting www.cihi.ca/careers

**A Selection of Current and Upcoming Reports from CIHI**

The following are only a few of the analytical reports that were recently published or about to be released. Please refer to our web site at www.cihi.ca for more comprehensive information.

**Health Care in Canada:** A report produced in collaboration with Statistics Canada, each year this report examines health care issues that are of importance to Canadians, using the most recent data available to explore what we know and don’t know about health care in Canada. *Health Indicators,* a companion report, includes selected indicators measuring health status, non-medical determinants of health, health system performance, and community and health system characteristics.


**Health Indicators:** A compilation of selected indicators measuring health status, non-medical determinants of health, health system performance, and community and health system characteristics. The information is provided for Canada's largest health regions, encompassing approximately 95% of the population, as well as provinces and territories.

**Funding of Health Services in Canada:** A special report that explores the variations in funding for health care services across Canada.


**Improving the Health of Canadians:** Three part series focusing on the following priority themes: healthy transitions to adulthood, healthy weights, and place and health.


**Nursing Workforce Trends in Canada:** Information on the number of nurses in Canada by various demographic, practice and education characteristics.


**Supply, Distribution and Migration of Canadian Physicians:** Information on physicians in Canada by various demographic and practice characteristics.

**National Health Expenditure Trends:** Updated health expenditure data by source of funds (sector) and use of funds (category) at the provincial/territorial level and for Canada.  
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=spend_nhex_e

**Emergency Department Wait Times:** A series of reports focusing on Canadian Emergency Departments, specifically who is using them, how sick they are, how long they wait to see a physician and how long their visits take.  
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=reports_e

**Medical Imaging in Canada:** An annual report tracking the number and distribution of selected imaging technologies and the cost of medical imaging services in Canada.  

**Drug Expenditures in Canada:** This report updates trends in drug spending in Canada primarily from retail establishments, in total, by public and private payers, and by type of drug (prescribed and non-prescribed).  
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_80_E&cw_topic=80

**Strategic Directions 2005–2006 to 2007–2008:** CIHI’s vision for the future is mapped out by a three-year strategic plan (2005–2006 to 2007–2008). This strategic plan was developed in response to changes in Canada’s health care landscape and the insights gained from a cross-country dialogue with a wide range of stakeholders. The plan outlines how CIHI, working with our partners throughout the country, will focus our efforts to meet current and emerging health information needs.  
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=profile_e#strategic

**Waiting for Health Care in Canada, What We Know and Don’t Know:** This special report explores wait times across the spectrum of care. It highlights findings from a range of surveys, provincial data, and other sources. Given the patchwork of information available, this report provides useful insights and a starting point for collective efforts to understand and reduce wait times.

For more information, please feel free to contact CIHI:

495 Richmond Road  
Ottawa, Ontario  
(613) 241-7860; (613) 241-8120 (fax)  
communications@cihi.ca

CIHI--Taking health information further
Institut canadien d'information sur la santé

ICIS – À l'avant-garde de l'information sur la santé

L'Institut canadien d'information sur la santé (ICIS) est un organisme pancanadien autonome et sans but lucratif dont l’objectif est d’améliorer la santé des Canadiens et le système de santé en offrant une information de qualité sur la santé.

Pour atteindre son objectif, l’ICIS collabore avec les gouvernements fédéral et provinciaux, les régies régionales de la santé, les hôpitaux, les chercheurs et les associations de professionnels de la santé.

Que fait l'ICIS?

L’ICIS recueille, analyse et diffuse des données sur le rendement du système de santé canadien, la prestation de soins de santé et l’état de santé des Canadiens.

Son mandat consiste à diffuser une information précise et opportune utile à l’établissement de politiques de santé avisées, à la gestion du système de santé canadien et à la sensibilisation du public aux facteurs déterminants pour la santé.

Les données de l’ICIS portent particulièrement sur :

- Les services de soins de santé
- Les ressources humaines de la santé
- Les dépenses de santé
- La santé de la population

De plus, l’ICIS définit et fait la promotion des indicateurs nationaux de la santé – mesures telles que l’espérance de vie et les dépenses de santé par habitant – qui permettent de comparer l’état de santé avec le rendement et les caractéristiques du système de santé. Afin de s’assurer que ces mesures sont comparables et conformes aux mêmes exigences en matière de qualité, l’ICIS coordonne également les normes nationales d’information sur la santé.

L’Institut publie des rapports, des bulletins analytiques et des études spéciales portant sur ses résultats de recherche et données. Il coordonne des séances de formation et des conférences.

Rôle de l'ICIS dans l'avenir du Canada

L’ICIS recueille et résume une vaste gamme de données comparables et de haute qualité qui portent sur l’état du système de santé canadien et de la santé des Canadiens. Ces données fournissent également un aperçu de l’évolution du fonctionnement du système de santé canadien.

Plusieurs dispensateurs de soins, organismes, associations et organismes gouvernementaux à l’échelle nationale se basent régulièrement sur ces données dans leurs prises de décisions sur l’avenir du système de santé canadien.
L'ICIS à la hauteur

L'ICIS est de plus en plus reconnu comme un chef de file national et international pour ses réalisations dans le domaine de l'information sur la santé – et comme un excellent employeur!

- En 2003, l'ICIS a reçu le prix national en gouvernance décerné par le Conference Board du Canada et Spencer Stuart.
- En 2004 et en 2005, l'ICIS a été classé parmi les 100 meilleurs employeurs au Canada par le magazine *MacLean's*.

Vous aimeriez vous joindre à l'équipe? Visitez le site Web [www.icis.ca/emploi](http://www.icis.ca/emploi) pour vous renseigner au sujet des perspectives d’emploi à l’ICIS.

Liste des rapports publiés par l’ICIS

Les rapports suivants font partie des rapports analytiques qui ont été publiés récemment ou qui seront publiés prochainement. Veuillez visiter notre site Web ([www.icis.ca](http://www.icis.ca)) pour en savoir davantage.


*Indicateurs de santé*: regroupe des indicateurs précis permettant de mesurer l’état de santé, les déterminants non médicaux de la santé, le rendement du système de santé, ses caractéristiques ainsi que celles de la collectivité. Les données portent sur les plus grandes régions sanitaires au Canada, représentant environ 95 % de la population, ainsi que sur les provinces et les territoires.


Nombre, répartition et migration des médecins canadiens : ce rapport fournit des renseignements sur les médecins au Canada selon diverses caractéristiques démographiques et de pratique
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=hhrdata_f

Tendances des dépenses nationales de santé : ce rapport inclut des données mises à jour sur les dépenses de santé par source (secteur) et affectation (catégorie) de fonds à l'échelle provinciale, territoriale et nationale.
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=spend_nhex_f

Comprendre les temps d'attente dans les services d'urgence : une série de rapports sur les services d'urgence au Canada, particulièrement sur les utilisateurs de ces services, la gravité de leur maladie, le temps qu'ils doivent attendre pour voir un médecin et la durée de leur visite.
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1266_F&cw_topic=1266

L'imagerie médicale au Canada : un rapport annuel sur le nombre et la répartition de certains appareils d'imagerie, et le coût des services d'imagerie médicale au Canada.

Dépenses en médicaments au Canada : comprend des données à jour sur les tendances des dépenses en médicaments au Canada, principalement celles qui proviennent des points de vente, globalement, selon le type de financement (public ou privé) et selon le type de médicaments (prescrits ou non prescrits).

http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=profile_f

Temps d'attente au Canada : ce que nous savons et ce que nous ignorons : ce rapport spécial explore les temps d’attente au sein des différents services de santé. Il souligne les résultats d’une vaste gamme d’enquêtes, de données provinciales et d’autres sources de données. Il donne, compte tenu de l’ensemble de l’information offerte, un aperçu pertinent et sert de point de départ dans nos efforts communs visant à comprendre et à réduire les temps d’attente.

Pour de plus amples renseignements, veuillez communiquer avec l’ICIS :

495, chemin Richmond, bureau 600
Ottawa (Ontario) K2A 4H6
Télécopieur : (613) 241-8120
communications@icis.ca
www.icis.ca

ICIS — À l'avant-garde de l'information sur la santé

599
Canadian Institutes of Health Research

Canadian Institutes of Health Research (CIHR) is the major federal agency responsible for funding health research in Canada. It aims to excel in the creation of new health knowledge, and to translate that knowledge from the research setting into real world applications. The results are improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system. CIHR’s thirteen institutes identify, coordinate, focus and integrate health research and knowledge translation priorities for Canada by supporting individuals, groups and communities of researchers pursuing common goals.

CIHR Institute of Health Services and Policy Research

The vision of CIHR's Institute of Health Services and Policy Research (IHSPR) is of a vibrant community of excellent researchers who conduct outstanding health services and policy research that informs Canadians about their health care system, is used by decision-makers to strengthen Canada's health care system, and influences health and social policy in Canada and abroad.

Since its inception, IHSPR has attempted to respond to the myriad of challenges entailed in its broad mandate. This has meant moving rapidly and simultaneously to address problems and opportunities relating to health services and policy research capacity; the research resources needed to undertake high quality, relevant research; research gaps and emerging issues; and the CIHR-wide priority placed on timely knowledge translation.

Selected CIHR-IHSPR Funding Programs and Activities - 2005/06

Partnerships for Health System Improvement

CIHR’s Partnerships for Health System Improvement (PHSI) is an annual competition designed to support teams of researchers and decision makers interested in conducting applied health research useful to health system managers and/or policy makers. Funded teams conduct health services, systems and policy research projects of up to three years in length, in high-priority thematic areas identified by IHSPR and its partners. This funding program relies heavily on the participation of partners and stakeholders to promote effective knowledge translation and to match CIHR's financial contributions. The first PHSI competition in 2004 funded 20 teams, representing an investment of over $8 million in cash and in-kind contributions from CIHR and all partners. The third PHSI competition will be launched in fall 2006.

Healthcare Policy

Healthcare Policy, a new quarterly journal for health services and policy, was launched by Longwoods Publishing in September 2005. Healthcare Policy features original scholarly and research papers that support health policy development and decision making in spheres ranging from governance, organization and service delivery to funding and resource allocation. This journal marks the culmination of much effort over many years by committed individuals and organizations, including IHSPR, to establish a Canadian health services, management and policy journal. The journal is available electronically at www.longwoods.com. Print and electronic copies of the journal are free to members of the Canadian Association for Health Services and Policy Research.
Research Syntheses

IHSPR, in partnership with other CIHR Institutes and CIHR’s Knowledge Translation Branch, continues to support competitions dedicated to funding syntheses of health services and systems research in high priority areas that can be used by health care and public health policy makers, administrators, managers and the research community. IHSPR has also launched an RFA dedicated to supporting training initiatives designed to educate health services and policy researchers in methods of conducting syntheses. Funding for these initiatives will commence in 2007.

Toward Canadian Benchmarks for Health Services Wait Times

In February 2005, IHSPR, in partnership with the Conference of Provincial/Territorial Deputy Ministers of Health and the CIHR Institutes of Cancer Research and Musculoskeletal Health and Arthritis funded eight research teams under the “quick response” RFA Toward Canadian Benchmarks for Health Services Wait Times - Evidence, Application and Research Priorities. This RFA was designed to fund initiatives that would inform the work of the Provincial/Territorial Deputy Ministers of Health in meeting commitments in the Ten-Year Plan to Strengthen Health Care to establish evidence-based benchmarks for medically acceptable wait times, the first set of which were announced in December 2005. In late 2005, a second RFA was launched to fund teams to conduct synthesis work in clinical areas not funded in this initial RFA. Syntheses from both these competitions will continue to inform future research investments in priority clinical areas for improving timely access to quality care.

Knowledge Translation Casebook

In early 2006, IHSPR published its first Knowledge Translation Casebook, featuring first-hand cases of health services and policy knowledge translation experiences that illustrate examples of the collaborative development and practical use of health services and policy research evidence. Submissions from across Canada illustrate successful, and less than successful knowledge translation experiences, including interactions, collaborations, uses and impacts of research. The cases provide insight into critical success factors for KT in the health services and policy community. CIHR’s Institute for Population and Public Health has also produced a KT Casebook targeted to the population and public health community.

For more information on any of these programs, please visit the CIHR-IHSPR website at www.cihr-irsc.gc.ca/ihspr.html.

CIHR Knowledge Translation Branch

CIHR's mandate is to create new knowledge and to translate that knowledge into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system. CIHR's KT activities are focused on areas where we can make a unique contribution on the basis of our recognized core competencies: researcher training and research funding; our close relationship with the health research community; our ability to develop integrated, strategic national research agendas; and our credibility as a forum for consideration of complex health research issues. Above all, it is CIHR's reputation as an independent, credible and objective source of knowledge that positions us as an influential organization in the KT world.

CIHR, its Institutes and its Knowledge Translation Branch are guided in KT by the strategic plan Innovation in Action – Knowledge Translation Strategy 2004-2009 and by the Governing
Council Knowledge Translation Working Group. There are four main strategic areas identified in the KT Strategy to lead CIHR towards achieving its knowledge translation mandate. They are:

- Support KT Research;
- Contribute to Building KT Networks;
- Strengthen and Expand KT at CIHR; and
- Support and Recognize KT Excellence.

Selected Knowledge Translation (KT) Branch Funding Programs and Activities - 2005/06

Grants Funded through the KT Branch
In fiscal year 2005/06, the CIHR KT Branch funded 96 KT grants (on-going and new) totaling approximately $4.5 million, through the open competition, the strategic initiatives, and the workshops and symposia program. This excludes awards like the KT Award and the Health Research Communications Award which are described below in more detail.

Knowledge to Action (KTA), Phase 1: Development Grants for Local Researcher-User Interaction
The purpose of this initiative is to build and strengthen teams engaged in KT at the community, local or regional level by funding KT activities of researchers and users of research situated in the same community or region. This investment is expected to position recipients with the ability to accelerate the translation of knowledge to strengthen Canada's health care system and/or improve the health of Canadians.

This initiative constituted Phase 1 of a long-term commitment to promote and sustain linkages between the generation of new knowledge and its application, to meet the needs of community partners for innovation. Phase 2 of this program will build on the successes of Phase 1. Examples of funded projects from Phase 1 include:

- Dr. Alix Adrien – Direction de la Santé Publique Montréal-Centre: Transfert et échange de connaissances entre chercheurs et décideurs pour une meilleure prévention des infections transmises sexuellement dans les communautés ethnoculturelles au Québec
- Dr. Grace Warner – Dalhousie University: Applying knowledge translation theory to transfer stroke prevention and treatment knowledge to rural health professionals

Doctoral Research Awards - Continuing Health Education
The purpose of this doctoral research award is to advance the field of continuing health/medical education (CME/CHE) and continuing professional development (CPD) in Canada. It is expected that this targeted investment will develop a future generation of CME/CHE/CPD researchers and practitioners.

This award was developed in collaboration with the AXDEV Group, the Continuing Education of the Faculty of Medicine at the University of Toronto, the University of British Columbia Department of Family Practice, The College of Family Physicians of Canada, and The Royal
College of Physicians and Surgeons of Canada. One Doctoral Research trainee is expected to be funded for three years.

**Knowledge Translation Award**

This award honors and supports teams or organizations that make an outstanding contribution to the health of Canadians or to the health system through exemplary knowledge translation. Nominated teams or organizations will be assessed on innovative and significant achievements in knowledge translation activities relevant to any area of health research (e.g., biomedical, clinical, health services and policy, and population and public health). The *CIHR Knowledge Translation Award* consists of a certificate of recognition and a grant of $100,000 for achievements with an impact at a national or international level and $20,000 for achievements at a local or regional level.

In 2005/06, there were 3 awards:

- National Award Recipient: Dr. Jack Tu - Canadian Cardiovascular Outcomes Research Team (CCORT)
- Regional Award Recipient: Dr. Patricia Martens - The Need to Know Team & Manitoba Centre for Health Policy
- Regional Award Recipient: Dr. Réjean Hébert - Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA)

**Health Research Communications Awards**

For the fifth consecutive year, CIHR's Health Research Communications Awards helped promising Canadian science communicators develop their careers. These opportunities are available to those who have applied or those who are enrolled in journalism or communication programs with a human health and/or science backgrounds. The purpose of this initiative is to build capacity in science journalism and biomedical communications. By increasing the number of Canadians engaged in communicating the results of health research, in a variety of formats, CIHR hopes to raise the level of understanding of health research across a variety of audiences through more effective communications.

Five awards were made in 2005/06.

**Cochrane Collaboration**

The Cochrane Collaboration is an international non-profit and independent organization, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide. The major product of the Collaboration is the Cochrane Database of Systematic Reviews, which is published quarterly as part of the Cochrane Library. Recognizing the importance of the systematic reviews produced by the Cochrane Collaboration, CIHR has recently approved 5 years of funding for the Canadian Cochrane Network and Centre.
**CIHR Institutes**

The CIHR Institutes are all involved in KT activities. The majority are creating and partnering on KT specific Request for Applications (RFAs) and/or embedding KT components into their RFAs. They are all increasing the linkages and exchanges between stakeholders including researchers, community, policy makers and government.

Institute specific examples of KT activity include:

- The Institute of Gender and Health commissioned 12 synthesis papers summarizing key research areas in both Canadian and international contexts on ‘Gender, Sex and Health’, ‘Globalization, Gender and Health Synthesis’ and ‘Reducing Health Disparities and Promoting Health for Vulnerable Populations’.

- The Institute of Musculoskeletal Health and Arthritis established a Knowledge Exchange Task Force. They also created and implemented a KT Strategic Model and a pyramid of research excellence (from research community/stakeholders to open grants to training programs through to international consortia) with KT moving through each level of the pyramid.

For more information on these programs, please visit the CIHR KT Branch website: [http://www.cihr-irsc.gc.ca/e/29529.html](http://www.cihr-irsc.gc.ca/e/29529.html)
Instituts de recherche en santé du Canada

Les Instituts de recherche en santé du Canada (IRSC) sont le principal organisme fédéral responsable du financement de la recherche en santé au Canada. Ils ont pour mission d'exceller dans la création de nouvelles connaissances sur la santé et leur application dans le monde réel en vue d'améliorer la santé de la population canadienne, d'offrir de meilleurs produits et services de santé et de renforcer le système de santé au Canada. Les 13 instituts des IRSC déterminent, coordonnent, mettent en évidence et intègrent des priorités de recherche et d'application des connaissances en matière de santé pour le Canada par le soutien de chercheurs et de groupes de chercheurs poursuivant des objectifs communs.

L'Institut des services et des politiques de la santé des IRSC

La vision de l'Institut des services et des politiques de la santé (ISPS) des IRSC consiste en une collectivité active d'excellents chercheurs menant d'importantes recherches sur les services et les politiques de la santé qui informent les Canadiens et les Canadiennes sur leur système de soins de santé, qu'utilisent les décideurs afin de renforcer le système de soins de santé au Canada, et qui ont une incidence sur les politiques de la santé et les politiques sociales du Canada et à l'étranger.

Depuis sa création, l'ISPS des IRSC s'est efforcé de répondre aux nombreux défis que sous-entend son vaste mandat. Il lui a donc fallu agir rapidement et simultanément sur un certain nombre de fronts pour s'attaquer aux problèmes et saisir les possibilités concernant la capacité de recherche sur les services et les politiques de la santé au pays; les ressources de recherche nécessaires pour entreprendre des recherches pertinentes et de grande qualité; les lacunes dans la recherche et les questions émergentes ainsi que la priorité accordée à l'application opportune des connaissances à la grandeur des IRSC.

ISPS des IRSC – Activités et programmes de financement choisis

Partenariats pour l'amélioration du système de santé

L’initiative de partenariats pour l’amélioration du système de santé (PASS) des IRSC est un nouveau concours annuel qui a pour but d'appuyer les équipes de recherche et les décideurs intéressés à effectuer de la recherche appliquée utile aux gestionnaires du système de santé et aux responsables des politiques. Les équipes financées mènent des projets de recherche d'une durée maximale de trois ans sur les services de santé ainsi que sur les systèmes et les politiques dans des secteurs jugés hautement prioritaires par l'ISPS des IRSC et leurs partenaires. Ce programme de financement mise fortement sur la participation de partenaires et d'intervenants pour favoriser l'application effective des connaissances et égaler les contributions financières des IRSC. Le premier concours des PASS en 2004 a permis de financer 20 équipes, ce qui représente un investissement de plus de 8 millions de dollars (contributions en espèces et en nature) des IRSC et de tous les partenaires. Le troisième concours des PASS sera annoncé en automne 2006.

Politiques de santé

Politiques de santé, une nouvelle revue trimestrielle sur les services et les politiques de la santé, a été lancée par Longwoods Publishing en septembre 2005. Politiques de santé publie des
articles savants et des rapports de recherche inédits qui appuient l'élaboration de politiques et la prise de décision en matière de santé dans des sphères allant de la gouvernance, de l'organisation et de la prestation des services au financement et à l'affectation des ressources. Cette revue est l'aboutissement de nombreuses années d'efforts déployés par des personnes et des organisations dévouées, dont l'ISPS, afin de créer une revue canadienne sur les services, la gestion et les politiques de la santé. La revue est disponible sous forme électronique à www.longwoods.com. Les membres de l'Association canadienne pour la recherche sur les services et les politiques de la santé peuvent obtenir gratuitement cette revue, en version imprimée et en version électronique.

**Synthèses de recherche**

L’ISPS, en partenariat avec d’autres instituts des IRSC et la Direction de l'application des connaissances des IRSC, continue d'appuyer les concours visant le financement de synthèses de recherche sur les services et les systèmes de santé dans des domaines hautement prioritaires qui pourraient aider les chercheurs, les gestionnaires, les administrateurs et les responsables des politiques du domaine de la santé publique et des soins de santé. L’ISPS a aussi lancé un appel de demandes pour soutenir des initiatives de formation conçues pour donner aux chercheurs spécialisés dans les services et les politiques de la santé de la formation sur les méthodes de synthèse. Le financement de ces initiatives débutera en 2007.

**Établir des points de repère canadiens concernant les temps d'attente dans les services de santé**

En février 2005, l’ISPS, en partenariat avec la Conférence des sous-ministres de la santé des provinces et des territoires, l'Institut du cancer et l'Institut de l'appareil locomoteur et de l'arthrite des IRSC, a financé huit équipes de recherche dans le cadre d’un appel de demandes d’intervention rapide intitulé « Établir des points de repère canadiens concernant les temps d'attente dans les services de santé – Preuves, application et priorités de recherche ». Le but de cet appel de demandes était de financer les initiatives conçues dans le but de guider les sous-ministres de la santé des provinces et des territoires dans leur travail afin qu'ils remplissent les engagements énoncés dans le Plan décennal pour consolider les soins de santé, en ce qui a trait à l'établissement de points de repère fondés sur des preuves concernant les temps d'attente médicalement acceptables, dont le premier ensemble a été annoncé en décembre 2005. À la fin de 2005, un deuxième appel de demandes a été lancé pour financer des équipes qui effectueront des travaux de synthèse dans des domaines cliniques qui n’ont pas été subventionnés dans le cadre du premier appel de demandes. Les synthèses de ces deux concours continueront de guider les futurs investissements en recherche dans les domaines cliniques prioritaires en vue d’améliorer l'accès en temps opportun à des soins de qualité.

**Recueil de cas d'application des connaissances**

Au début 2006, l’ISPS a publié le premier recueil de cas d'application des connaissances, présentant des exemples concrets d'application des connaissances sur les services et les politiques de la santé, où l’on a eu recours à la création en collaboration et à l'utilisation pratique de données de recherche sur les services et les politiques de la santé. On a reçu de partout au Canada des exemples d’expériences réussies ou non en application des connaissances, illustrant aussi les différentes interactions et collaborations, ainsi que l’utilisation et les répercussions de la recherche. Le recueil nous permet d’avoir une meilleure idée des « facteurs de réussite
critiques » en matière d’application des connaissances dans les milieux des services et des politiques de la santé. L'Institut de la santé publique et des populations des IRSC a aussi produit un recueil d'application des connaissances s’adressant aux groupes des milieux de la santé publique et des populations.


**La Direction de l'application des connaissances des IRSC**

Le mandat des IRSC consiste notamment en la *création de nouvelles connaissances et leur application* en vue d'améliorer la santé de la population canadienne, d'offrir de meilleurs produits et services de santé et de renforcer le système de santé du Canada. Les activités des IRSC en matière d'application des connaissances (AC) mettront l'accent sur des secteurs où les instituts peuvent apporter une contribution unique grâce à leurs compétences clés reconnues : la formation de chercheurs et le financement de la recherche; leurs relations étroites avec la communauté de la recherche en santé; leur capacité d'élaborer des projets de recherche nationaux intégrés et stratégiques; et leur crédibilité en tant que tribune permettant l'examen de questions complexes associées à la recherche en santé. Mais avant tout, c'est la réputation des IRSC, source indépendante, crédible et objective de connaissances, qui fait d'eux un organisme faisant autorité dans le monde de l'AC.

Les IRSC, leurs instituts et leur Direction de l’application des connaissances sont guidés dans l’AC par le plan stratégique *L'innovation à l'œuvre – Stratégie d'application des connaissances 2004-2009* et par le Groupe de travail sur l'application des connaissances du conseil d'administration. Il y a quatre principaux domaines stratégiques dans la stratégie d’AC en vue d’aider les IRSC à remplir leur mandat d’application des connaissances. Les voici :

- soutenir la recherche sur l'AC;
- contribuer à l'établissement de réseaux relatifs à l'AC;
- renforcer l'AC et en assurer l'expansion aux IRSC;
- soutenir et reconnaître l'excellence dans le domaine de l'AC.

**Direction de l'application des connaissances des IRSC – Activités et programmes de financement choisis**

**Subventions financées par l’intermédiaire de la Direction de l’AC**

Durant l’exercice 2005-2006, la Direction de l’AC a financé 96 subventions liées à l’AC (en cours et nouvelles) d’une valeur totale d’environ 4,5 millions de dollars, dans le cadre du concours ouvert, des initiatives stratégiques et du programme d’ateliers et de symposiums. Cela ne comprend pas les bourses, comme les prix de l’AC et les bourses en communications dans le domaine de la recherche en santé qui sont décrits ci-dessous.
Des connaissances à la pratique (CAP), phase 1 : Subventions de développement favorisant l'interaction chercheurs-utilisateurs à l'échelon local

L'objectif de cette initiative est de constituer et de consolider des équipes dédiées à l'application des connaissances aux échelons communautaire, local ou régional en finançant les activités d'application des connaissances des chercheurs et des utilisateurs de la recherche qui se trouvent dans une même collectivité ou région. L’investissement devrait permettre de donner aux bénéficiaires les moyens d'accélérer l'application des connaissances afin de renforcer le système de santé canadien et/ou d'améliorer la santé des Canadiens.

Cette initiative constituait la phase 1 d'un engagement à long terme envers la promotion et le maintien de liens entre la production de nouvelles connaissances et leur application, pour répondre aux besoins des partenaires du milieu de l’innovation. La phase 2 de ce programme se fondera sur les succès de la phase 1. Voici des exemples de projets financés dans la phase 1 :

Dr Alix Adrien – Direction de la santé publique de Montréal-Centre : Transfert et échange de connaissances entre chercheurs et décideurs pour une meilleure prévention des infections transmises sexuellement dans les communautés ethnoculturelles au Québec.

Dre Grace Warner – Université Dalhousie : Mettre en pratique la théorie de l’application des connaissances pour transférer les connaissances sur la prévention et le traitement des accidents vasculaires cérébraux aux professionnels de la santé en région.

Bourses de recherche au doctorat – Formation continue en santé

Cette bourse de recherche au doctorat a pour but de faire avancer le domaine de la formation continue en santé/médecine (FCS/FCM) et le perfectionnement professionnel continu (PPC) au Canada. Cet investissement ciblé devrait permettre de former une génération future de chercheurs et de praticiens en FCS/FCM/PPC.

Cette bourse a été élaborée en collaboration avec le groupe AXDEV, le service de formation continue de la faculté de médecine de l’Université de Toronto, le département de médecine familiale de l’Université de la Colombie-Britannique, le Collège des médecins de famille du Canada et le Collège royal des médecins et chirurgiens du Canada. On s’attend à subventionner un stagiaire de recherche au doctorat pendant trois ans.

Prix de l'application des connaissances des IRSC

Ce prix rend hommage aux équipes ou aux organismes qui contribuent de façon exceptionnelle à la santé des Canadiens ou au système de santé par l'entremise d'activités exemplaires d'application des connaissances. Les équipes ou les organismes mis en candidature seront évalués selon leurs réalisations marquantes et innovatrices au chapitre de l'application des connaissances dans n'importe quel secteur de la recherche en santé (p. ex. biomédicale, clinique, sur les services et les politiques de santé, et sur la santé publique et des populations). Le Prix de l’application des connaissances des IRSC consiste en un certificat de reconnaissance et en une subvention de 100 000 $ pour des réalisations qui ont eu un rayonnement au niveau national ou international, et de 20 000 $ pour des réalisations au niveau local ou régional.

En 2005-2006, il y a eu 3 bourses :
• Lauréat du prix national : Dr Jack Tu – Équipe canadienne d'analyse de résultats en matière de maladies cardiovasculaires (CCORT)

• Lauréat d’un prix régional : Dr Patricia Martens – L’Équipe qui a besoin de savoir et le Centre d’élaboration de la politique des soins de santé du Manitoba

• Lauréat d’un prix régional : Dr Réjean Hébert – Programme de recherche sur l'intégration des services de maintien de l'autonomie (PRISMA)

**Bourses en communications dans le domaine de la recherche en santé des IRSC**

Pour la cinquième année consécutive, les bourses en communications dans le domaine de la recherche en santé des IRSC aideront les communicateurs scientifiques dans le développement de leur carrière. Ces possibilités sont offertes à ceux qui ont fait une demande ou qui sont inscrits dans un programme de communication et/ou de journalisme et qui ont des antécédents en science ou en santé humaine.

Le but de cette initiative est de renforcer les capacités en journalisme scientifique et en communications biomédicales. En augmentant le nombre de Canadiens participant à la communication, sous toutes formes, des résultats de la recherche en santé, les IRSC souhaitent accroître le niveau de compréhension de la recherche en santé au sein d’auditoires variés au moyen de communications plus efficaces.


**Collaboration Cochrane**

La Collaboration Cochrane est une organisation internationale indépendante à but non lucratif, vouée à la diffusion de renseignements précis et d'actualité sur les effets des soins de santé, auxquels on peut facilement accéder des quatre coins de la planète. Le plus important produit de la Collaboration Cochrane est la base de données Cochrane des revues systématiques (Cochrane Database of Systematic Reviews), qui est publiée chaque trimestre et qui se trouve dans la bibliothèque Cochrane. En reconnaissance de l’importance que revêtent les revues systématiques produites par la Collaboration Cochrane, les IRSC ont récemment accordé un financement de 5 ans au Réseau-centre canadien Cochrane.

**Instituts des IRSC**

Les Instituts des IRSC participent tous à des activités d’AC. La majorité d’entre eux créent des appels de demandes portant spécifiquement sur l’application des connaissances dans lesquels ils sont partenaires et/ou intègrent le volet application des connaissances dans leurs appels de demandes. Ils accroissent tous les liens et les échanges entre les intervenants, notamment les chercheurs, la collectivité, les responsables des politiques et le gouvernement.

Voici des exemples d’activités d’AC propres à des instituts :

L’Institut de la santé des femmes et des hommes a commandité 12 documents de synthèse résumant les principaux domaines de recherche dans les contextes tant canadien qu’international sur les thèmes suivants : « Genre, sexe et santé », « Synthèses sur la mondialisation, le genre et la santé » et «Réduire les disparités sur le plan de la santé et promouvoir la santé chez les populations vulnérables ». 
L’Institut de l’appareil locomoteur et de l’arthrite a formé un Groupe de travail sur l’échange des connaissances. Il a aussi créé et mis en œuvre un modèle stratégique d’AC et une pyramide d’excellence en recherche (du milieu de la recherche ou des intervenants aux concours ouverts en passant par les consortiums internationaux jusqu’au programmes de formation) avec un volet application des connaissances à chaque niveau de la pyramide.

APPENDIX A National Health Expenditure Trends 1975 – 2006

Figure 1—Total Health Expenditure, Canada, 1975 to 2006

Figure 2—Total Health Expenditure, Annual Growth Rates in Constant 1997 Dollars, Canada, 1978 to 2006

Figure 3—Total Health Expenditure per Capita, Canada, 1975 to 2006

Source: Canadian Institute for Health Information.
Figure 5—Total Health Expenditure as a Percentage of Gross Domestic Product, Canada, 1975 to 2006

Sources: Canadian Institute for Health Information; Statistics Canada.

Figure 6—Health Expenditure and GDP Trends, Constant Dollar Indices (1975 = 100), Canada, 1975 to 2006

Sources: Canadian Institute for Health Information; Statistics Canada.

Figure 7—Health Expenditure by Source of Finance, Canada, 1975 to 2006

Source: Canadian Institute for Health Information.
Figure 8—Health Expenditure by Source of Finance, Constant Dollar Indices (1975 = 100), Canada, 1975 to 2006

Source: Canadian Institute for Health Information.

Figure 9—Growth in Real per Capita Public and Private Health Expenditure and the Private Share, Canada, 1976 to 2006

Sources: Canadian Institute for Health Information; Statistics Canada.
APPENDIX B  Number of Registered Health Personnel in Canada


### Table: Number of Health Personnel in Selected Professions, by Registration Status, 2005

<table>
<thead>
<tr>
<th>Profession</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>% Female</th>
<th>% Male</th>
<th>% Unknown</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Registered: Represents all individuals who are registered with an organization. The count may include individuals in all registration categories (active, inactive, honorary, etc).</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiologists</td>
<td>514</td>
<td>761</td>
<td>1,241</td>
<td>141</td>
<td>75</td>
<td>20</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>4,485</td>
<td>6,077</td>
<td>7,113</td>
<td>59</td>
<td>58</td>
<td>28</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>12,662</td>
<td>15,803</td>
<td>18,403</td>
<td>45</td>
<td>96</td>
<td>2</td>
<td>0</td>
<td>57</td>
</tr>
<tr>
<td>Dietitians</td>
<td>6,367</td>
<td>6,975</td>
<td>8,135</td>
<td>48</td>
<td>83</td>
<td>2</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Health Information Management Professionals</td>
<td>3,143</td>
<td>2,412</td>
<td>2,674</td>
<td>-9</td>
<td>-2</td>
<td>-</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>5,670</td>
<td>6,484</td>
<td>7,635</td>
<td>25</td>
<td>68</td>
<td>18</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Social Workers</td>
<td>13,700</td>
<td>22,648</td>
<td>20,800</td>
<td>118</td>
<td>73</td>
<td>16</td>
<td>12</td>
<td>92</td>
</tr>
<tr>
<td>Speech-Language Pathologists</td>
<td>2,883</td>
<td>4,311</td>
<td>3,331</td>
<td>119</td>
<td>92</td>
<td>4</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td><strong>Active registered: Represents all registered/licensed individuals who are legally able to work under the title of the specified health profession. Individuals may or may not be currently employed in the profession.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>15,867</td>
<td>17,091</td>
<td>18,080</td>
<td>18</td>
<td>20</td>
<td>72</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td>Medical Laboratory Technologists</td>
<td>18,847</td>
<td>19,936</td>
<td>20,039</td>
<td>6</td>
<td>81</td>
<td>14</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>Medical Physicists</td>
<td>214</td>
<td>277</td>
<td>313</td>
<td>46</td>
<td>-2</td>
<td>-</td>
<td>100</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>Medical Radiation Technologists</td>
<td>14,260</td>
<td>14,583</td>
<td>18,036</td>
<td>13</td>
<td>23</td>
<td>4</td>
<td>74</td>
<td>49</td>
</tr>
<tr>
<td>Midwives</td>
<td>164</td>
<td>370</td>
<td>520</td>
<td>217</td>
<td>90</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>7,235</td>
<td>9,434</td>
<td>11,378</td>
<td>57</td>
<td>70</td>
<td>5</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>Optometrists</td>
<td>3,016</td>
<td>3,493</td>
<td>3,853</td>
<td>27</td>
<td>45</td>
<td>66</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>22,787</td>
<td>25,443</td>
<td>26,471</td>
<td>9</td>
<td>20</td>
<td>8</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>Physicians (excl. residents)</td>
<td>94,018</td>
<td>98,940</td>
<td>112,022</td>
<td>12</td>
<td>32</td>
<td>37</td>
<td>0</td>
<td>190</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>12,657</td>
<td>14,471</td>
<td>15,772</td>
<td>24</td>
<td>76</td>
<td>20</td>
<td>4</td>
<td>49</td>
</tr>
<tr>
<td>Psychologists</td>
<td>11,258</td>
<td>12,836</td>
<td>14,716</td>
<td>31</td>
<td>65</td>
<td>32</td>
<td>3</td>
<td>45</td>
</tr>
<tr>
<td><strong>Employed active registered: Represents personnel who are registered/licensed with an organization and currently working in the specified health profession.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>78,859</td>
<td>73,306</td>
<td>64,951</td>
<td>23</td>
<td>93</td>
<td>7</td>
<td>0</td>
<td>200</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>220,670</td>
<td>231,612</td>
<td>261,676</td>
<td>19</td>
<td>94</td>
<td>6</td>
<td>0</td>
<td>778</td>
</tr>
<tr>
<td>Registered Psychiatric Nurses</td>
<td>5,016</td>
<td>4,910</td>
<td>4,904</td>
<td>NC</td>
<td>77</td>
<td>23</td>
<td>0</td>
<td>19</td>
</tr>
</tbody>
</table>


Notes:
1. Data provided in this table were requested of various HRDB data providers based on the registration status definitions indicated. Data in this table and a viewer-viewed select health professions, which can be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1995 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
2. Data not available.
3. Percentages may not sum to 100 percent due to rounding.
4. Total may not sum to 100 percent due to rounding.
5. Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
6. Data were submitted to CIHI from an organization in which membership is voluntary.
## Newfoundland and Labrador

### Number of Health Personnel in Selected Professions, by Registration Status, 2005

<table>
<thead>
<tr>
<th>Profession</th>
<th>First Year of Regulation</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>N.L. as % of Canada Total</th>
<th>% Female</th>
<th>% Male</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiologists</td>
<td>NR</td>
<td>..</td>
<td>19</td>
<td>16</td>
<td>..</td>
<td>1,241</td>
<td>1</td>
<td>81</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>1992</td>
<td>20</td>
<td>43</td>
<td>49</td>
<td>145</td>
<td>7,113</td>
<td>&lt; 1</td>
<td>39</td>
<td>61</td>
<td>10</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>1988</td>
<td>63</td>
<td>79</td>
<td>92</td>
<td>46</td>
<td>18,403</td>
<td>&lt; 1</td>
<td>91</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Dietitians</td>
<td>1965</td>
<td>101</td>
<td>123</td>
<td>144</td>
<td>43</td>
<td>8,135</td>
<td>2</td>
<td>90</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Health Information Management Professionals</td>
<td>NR</td>
<td>56</td>
<td>38</td>
<td>48</td>
<td>-18</td>
<td>2,874</td>
<td>2</td>
<td>..</td>
<td>..</td>
<td>9</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>NR</td>
<td>71</td>
<td>70</td>
<td>74</td>
<td>4</td>
<td>7,036</td>
<td>&lt; 1</td>
<td>69</td>
<td>32</td>
<td>14</td>
</tr>
<tr>
<td>Social Workers</td>
<td>1984</td>
<td>678</td>
<td>973</td>
<td>1,062</td>
<td>57</td>
<td>29,066</td>
<td>4</td>
<td>86</td>
<td>14</td>
<td>208</td>
</tr>
<tr>
<td>Speech-Language Pathologists</td>
<td>NR</td>
<td>..</td>
<td>64</td>
<td>86</td>
<td>..</td>
<td>6,331</td>
<td>2</td>
<td>96</td>
<td>5</td>
<td>19</td>
</tr>
</tbody>
</table>

### Active registered: Represents all registered/licensed individuals who are legally able to work under the title of the specified health profession. Individuals may or may not be currently employed in the profession.

<table>
<thead>
<tr>
<th>Profession</th>
<th>First Year of Regulation</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>N.L. as % of Canada Total</th>
<th>% Female</th>
<th>% Male</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentists</td>
<td>1993</td>
<td>143</td>
<td>163</td>
<td>167</td>
<td>17</td>
<td>18,688</td>
<td>&lt; 1</td>
<td>21</td>
<td>77</td>
<td>32</td>
</tr>
<tr>
<td>Medical Laboratory Technologists</td>
<td>NR</td>
<td>325</td>
<td>349</td>
<td>415</td>
<td>28</td>
<td>20,039</td>
<td>2</td>
<td>77</td>
<td>23</td>
<td>81</td>
</tr>
<tr>
<td>Medical Physicists</td>
<td>NR</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>50</td>
<td>313</td>
<td>&lt; 1</td>
<td>..</td>
<td>..</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>Medical Radiation Technologists</td>
<td>NR</td>
<td>202</td>
<td>279</td>
<td>294</td>
<td>12</td>
<td>16,030</td>
<td>2</td>
<td>..</td>
<td>..</td>
<td>57</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>1997</td>
<td>..</td>
<td>..</td>
<td>68</td>
<td>..</td>
<td>1,020</td>
<td>7</td>
<td>..</td>
<td>..</td>
<td>13</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>1987</td>
<td>103</td>
<td>137</td>
<td>129</td>
<td>25</td>
<td>11,378</td>
<td>1</td>
<td>..</td>
<td>..</td>
<td>25</td>
</tr>
<tr>
<td>Optometrists</td>
<td>1929</td>
<td>34</td>
<td>35</td>
<td>41</td>
<td>21</td>
<td>3,853</td>
<td>1</td>
<td>29</td>
<td>71</td>
<td>8</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1910</td>
<td>483</td>
<td>526</td>
<td>586</td>
<td>21</td>
<td>29,471</td>
<td>2</td>
<td>..</td>
<td>..</td>
<td>114</td>
</tr>
<tr>
<td>Physicians (excl. residents)</td>
<td>1993</td>
<td>924</td>
<td>945</td>
<td>994</td>
<td>9</td>
<td>81,622</td>
<td>2</td>
<td>29</td>
<td>67</td>
<td>193</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1970</td>
<td>184</td>
<td>196</td>
<td>209</td>
<td>21</td>
<td>15,772</td>
<td>1</td>
<td>77</td>
<td>23</td>
<td>38</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1988</td>
<td>30</td>
<td>210</td>
<td>197</td>
<td>557</td>
<td>14,715</td>
<td>1</td>
<td>64</td>
<td>36</td>
<td>38</td>
</tr>
</tbody>
</table>

Employed active registered: Represents personnel who are registered/licensed with an organization and currently working in the specified health profession.

<table>
<thead>
<tr>
<th>Profession</th>
<th>First Year of Regulation</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>N.L. as % of Canada Total</th>
<th>% Female</th>
<th>% Male</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Practical Nurses</td>
<td>1983</td>
<td>2,938</td>
<td>2,899</td>
<td>2,696</td>
<td>NC</td>
<td>64,951</td>
<td>4</td>
<td>87</td>
<td>13</td>
<td>524</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>1954</td>
<td>5,261</td>
<td>5,439</td>
<td>5,496</td>
<td>4</td>
<td>251,075</td>
<td>2</td>
<td>96</td>
<td>4</td>
<td>1,068</td>
</tr>
</tbody>
</table>


### Notes:
- Data provided in this table were requested of various HPOS data providers based on the registration status definitions indicated. Data in this table are an overview of selected health professions, which can be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1995 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
- Data not available.
- NC Data not comparable.
- NR Not registered as of 2004.
1. Gender unknown excluded; as a result, totals may not sum to 100%.
2. Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
3. Profession not regulated in all provinces. The Canada total for each profession includes some provincial data in which registration is required by the regulatory authority may not be a condition of practice.
4. Data were submitted to CHI from an organization in which membership is voluntary.

Last updated 2006-11-7.
### Prince Edward Island

**Number of Health Personnel in Selected Professions, by Registration Status, 2005**

<table>
<thead>
<tr>
<th>Profession</th>
<th>First Year of Regulation</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>P.E.I. as % of Canada Total</th>
<th>% Female¹</th>
<th>% Male¹</th>
<th>Per 100,000 Population²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Registered:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiologists</td>
<td>NR</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td>1,241</td>
<td>&lt; 1</td>
<td>100</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>1992</td>
<td>4</td>
<td>7</td>
<td>8</td>
<td>100</td>
<td>7,113</td>
<td>&lt; 1</td>
<td>25</td>
<td>75</td>
<td>6</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>1974</td>
<td>30</td>
<td>46</td>
<td>58</td>
<td>93</td>
<td>18,403</td>
<td>&lt; 1</td>
<td>100</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>Dietitians</td>
<td>1994</td>
<td>47</td>
<td>54</td>
<td>63</td>
<td>34</td>
<td>8,136</td>
<td>&lt; 1</td>
<td>97</td>
<td>3</td>
<td>48</td>
</tr>
<tr>
<td>Health Information Management</td>
<td>Professionals</td>
<td>NR</td>
<td>20</td>
<td>15</td>
<td>17</td>
<td>2,074</td>
<td>&lt; 1</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>NR</td>
<td>11</td>
<td>14</td>
<td>16</td>
<td>45</td>
<td>7,030</td>
<td>&lt; 1</td>
<td>56</td>
<td>44</td>
<td>12</td>
</tr>
<tr>
<td>Social Workers</td>
<td>1988</td>
<td>180</td>
<td>198</td>
<td>198</td>
<td>10</td>
<td>29,866</td>
<td>&lt; 1</td>
<td></td>
<td></td>
<td>143</td>
</tr>
<tr>
<td>Speech-Language Pathologists</td>
<td>NR</td>
<td>17</td>
<td>26</td>
<td></td>
<td></td>
<td>6,331</td>
<td>&lt; 1</td>
<td>92</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td><strong>Active registered:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>1891</td>
<td>48</td>
<td>61</td>
<td>62</td>
<td>29</td>
<td>18,688</td>
<td>&lt; 1</td>
<td>26</td>
<td>74</td>
<td>45</td>
</tr>
<tr>
<td>Medical Laboratory Technologists</td>
<td>NR</td>
<td>107</td>
<td>102</td>
<td>109</td>
<td>2</td>
<td>20,038</td>
<td>&lt; 1</td>
<td>78</td>
<td>22</td>
<td>79</td>
</tr>
<tr>
<td>Medical Physicists</td>
<td>NR</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>300</td>
<td>313</td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Medical Radiation Technologists</td>
<td>NR</td>
<td>65</td>
<td>57</td>
<td>72</td>
<td>11</td>
<td>15,030</td>
<td>&lt; 1</td>
<td></td>
<td></td>
<td>52</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>1979</td>
<td>31</td>
<td>35</td>
<td>33</td>
<td>6</td>
<td>11,378</td>
<td>&lt; 1</td>
<td>91</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>Optometrists</td>
<td>1922</td>
<td>11</td>
<td>12</td>
<td>18</td>
<td>64</td>
<td>3,053</td>
<td>&lt; 1</td>
<td>44</td>
<td>56</td>
<td>13</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1905</td>
<td>111</td>
<td>131</td>
<td>160</td>
<td>44</td>
<td>29,471</td>
<td>&lt; 1</td>
<td></td>
<td></td>
<td>116</td>
</tr>
<tr>
<td>Physicians (excl. residents)</td>
<td>1871</td>
<td>170</td>
<td>180</td>
<td>199</td>
<td>17</td>
<td>81,022</td>
<td>&lt; 1</td>
<td>24</td>
<td>76</td>
<td>144</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1973</td>
<td>48</td>
<td>50</td>
<td>49</td>
<td>2</td>
<td>15,772</td>
<td>&lt; 1</td>
<td></td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1991</td>
<td>15</td>
<td>22</td>
<td>27</td>
<td>80</td>
<td>14,716</td>
<td>&lt; 1</td>
<td>59</td>
<td>41</td>
<td>20</td>
</tr>
<tr>
<td><strong>Employed active registered:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>1959</td>
<td>586</td>
<td>634</td>
<td>606</td>
<td>NC</td>
<td>64,951</td>
<td>&lt; 1</td>
<td>92</td>
<td>8</td>
<td>439</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>1949</td>
<td>1,340</td>
<td>1,270</td>
<td>1,443</td>
<td>8</td>
<td>261,676</td>
<td>&lt; 1</td>
<td>97</td>
<td>3</td>
<td>1,044</td>
</tr>
</tbody>
</table>

**Data Sources:** Health Personnel Database, CHI. Population estimates from Quarterly Demographic Statistics, Statistics Canada, vol. 19, no. 4, 2005.

**Notes:**

- Data provided in this table were requested of various HPIS data providers based on the registration status definitions indicated. Rita in this table are derived from the annual HPIS data providers' database on selected health professions, which can be used for some purposes, but should be used within the limitations noted. Please refer to Health Personnel Trends in Canada, 1895 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.

- Data not available.
- NC Data not comparable.
- NR Not regulated as of 2004.
- ¹ Gender unknown excluded, as a result, totals may not sum to 100%.
- ² Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
- ³ Profession is not regulated in all provinces. The Canada total for each profession includes some provincial data in which regulation is on a regulatory body may not be a condition of practice.
- ⁴ Data were submitted to CHI from an organization in which membership is voluntary.
## Nova Scotia

### Number of Health Personnel in Selected Professions, by Registration Status, 2005

<table>
<thead>
<tr>
<th>Registered: Represents all individuals who are registered with an organization. The count may include individuals in all registration categories (active, inactive, honorary, etc.)</th>
<th>First Year of Regulation</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>N.S. as % of Canada Total</th>
<th>% Female</th>
<th>% Male</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiologists</td>
<td>NR</td>
<td>..</td>
<td>50</td>
<td>53</td>
<td>..</td>
<td>1,241</td>
<td>4</td>
<td>68</td>
<td>32</td>
<td>6</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>1972</td>
<td>30</td>
<td>73</td>
<td>98</td>
<td>227</td>
<td>7,113</td>
<td>1</td>
<td>42</td>
<td>58</td>
<td>10</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>1973</td>
<td>396</td>
<td>408</td>
<td>511</td>
<td>29</td>
<td>18,403</td>
<td>3</td>
<td>99</td>
<td>1</td>
<td>56</td>
</tr>
<tr>
<td>Dietitians</td>
<td>1998</td>
<td>318</td>
<td>365</td>
<td>436</td>
<td>37</td>
<td>8,136</td>
<td>5</td>
<td>98</td>
<td>2</td>
<td>47</td>
</tr>
<tr>
<td>Health Information Management Professionals</td>
<td>NR</td>
<td>198</td>
<td>155</td>
<td>144</td>
<td>-27</td>
<td>2,874</td>
<td>5</td>
<td>..</td>
<td>..</td>
<td>15</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>NR</td>
<td>172</td>
<td>152</td>
<td>141</td>
<td>-18</td>
<td>7,036</td>
<td>2</td>
<td>..</td>
<td>..</td>
<td>15</td>
</tr>
<tr>
<td>Social Workers</td>
<td>1984</td>
<td>1,074</td>
<td>1,471</td>
<td>1,531</td>
<td>43</td>
<td>29,686</td>
<td>5</td>
<td>..</td>
<td>..</td>
<td>163</td>
</tr>
<tr>
<td>Speech-Language Pathologists</td>
<td>NR</td>
<td>..</td>
<td>156</td>
<td>171</td>
<td>..</td>
<td>6,331</td>
<td>3</td>
<td>99</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Active registered: Represents all registered/licensed individuals who are legally able to work under the title of the specified health profession. Individuals may or may not be currently employed in the profession.</td>
<td>First Year of Regulation</td>
<td>1996</td>
<td>2001</td>
<td>2005</td>
<td>% Change 1996-2005</td>
<td>Canada Total</td>
<td>N.S. as % of Canada Total</td>
<td>% Female</td>
<td>% Male</td>
<td>Per 100,000 Population</td>
</tr>
<tr>
<td>Dentists</td>
<td>1991</td>
<td>428</td>
<td>461</td>
<td>499</td>
<td>17</td>
<td>16,688</td>
<td>3</td>
<td>29</td>
<td>71</td>
<td>53</td>
</tr>
<tr>
<td>Medical Laboratory Technologists</td>
<td>2004</td>
<td>799</td>
<td>792</td>
<td>883</td>
<td>11</td>
<td>20,039</td>
<td>4</td>
<td>85</td>
<td>15</td>
<td>94</td>
</tr>
<tr>
<td>Medical Physicists</td>
<td>NR</td>
<td>9</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>313</td>
<td>3</td>
<td>..</td>
<td>..</td>
<td>1</td>
</tr>
<tr>
<td>Medical Radiation Technologists</td>
<td>1999</td>
<td>498</td>
<td>496</td>
<td>522</td>
<td>5</td>
<td>15,030</td>
<td>3</td>
<td>..</td>
<td>..</td>
<td>50</td>
</tr>
<tr>
<td>Midwives</td>
<td>NR</td>
<td>..</td>
<td>2</td>
<td>10</td>
<td>..</td>
<td>520</td>
<td>2</td>
<td>..</td>
<td>..</td>
<td>1</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>2002</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>1,202</td>
<td>4</td>
<td>..</td>
<td>..</td>
<td>5</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>REG</td>
<td>172</td>
<td>239</td>
<td>309</td>
<td>80</td>
<td>11,378</td>
<td>3</td>
<td>93</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Optometrists</td>
<td>1921</td>
<td>66</td>
<td>74</td>
<td>86</td>
<td>26</td>
<td>3,063</td>
<td>2</td>
<td>34</td>
<td>66</td>
<td>9</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1978</td>
<td>636</td>
<td>931</td>
<td>1,065</td>
<td>29</td>
<td>29,471</td>
<td>4</td>
<td>..</td>
<td>..</td>
<td>114</td>
</tr>
<tr>
<td>Physicians (excl. residents)</td>
<td>1928</td>
<td>1,744</td>
<td>1,885</td>
<td>2,039</td>
<td>17</td>
<td>61,622</td>
<td>3</td>
<td>32</td>
<td>67</td>
<td>218</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1959</td>
<td>373</td>
<td>449</td>
<td>529</td>
<td>42</td>
<td>15,772</td>
<td>3</td>
<td>..</td>
<td>..</td>
<td>56</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1981</td>
<td>297</td>
<td>383</td>
<td>414</td>
<td>39</td>
<td>14,715</td>
<td>3</td>
<td>72</td>
<td>27</td>
<td>44</td>
</tr>
<tr>
<td>Employed active registered: Represents personnel who are registered/licensed with an organization and currently working in the specified health profession.</td>
<td>First Year of Regulation</td>
<td>1996</td>
<td>2001</td>
<td>2005</td>
<td>% Change 1996-2005</td>
<td>Canada Total</td>
<td>N.S. as % of Canada Total</td>
<td>% Female</td>
<td>% Male</td>
<td>Per 100,000 Population</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>1957</td>
<td>3,180</td>
<td>3,369</td>
<td>3,127</td>
<td>..</td>
<td>64,951</td>
<td>5</td>
<td>95</td>
<td>5</td>
<td>334</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>1985</td>
<td>8,738</td>
<td>8,504</td>
<td>8,733</td>
<td>..</td>
<td>251,075</td>
<td>3</td>
<td>97</td>
<td>3</td>
<td>932</td>
</tr>
</tbody>
</table>


Notes:
- Data provided in this table were requested of various HPDB data providers based on the registration status definitions indicated. Data in this table are a snapshot view of selected health professions, which may be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1995 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
- Data not available.
- NC Data not comparable.
- NR Not regulated as of 2004.
- REG Registered in 2005, but initial year of registration is unknown.
- Gender unknown excluded; as a result, totals may not sum to 100%.
- 1 Profession is not regulated in all provinces. The Canada total for each profession includes some provincial data in which registration with a regulatory authority may not be a condition of practice.
- 2 Data were submitted to CIHI from an organization in which membership is voluntary.
New Brunswick
Number of Health Personnel in Selected Professions, by Registration Status, 2005

<table>
<thead>
<tr>
<th>Profession</th>
<th>First Year of Regulation</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>% Female</th>
<th>% Male</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered: Represents all individuals who are registered with an organization. The count may include individuals in all registration categories (active, inactive, honorary, etc.)</td>
<td>First Year of Regulation</td>
<td>1996</td>
<td>2001</td>
<td>2005</td>
<td>% Change 1996-2005</td>
<td>Canada Total</td>
<td>% Female</td>
<td>% Male</td>
<td>Per 100,000 Population</td>
</tr>
<tr>
<td>Audiologists</td>
<td>1987</td>
<td>36</td>
<td>41</td>
<td>47</td>
<td>31</td>
<td>1,241</td>
<td>4</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>1998</td>
<td>36</td>
<td>57</td>
<td>63</td>
<td>75</td>
<td>7,113</td>
<td>&lt; 1</td>
<td>33</td>
<td>67</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>1980</td>
<td>202</td>
<td>245</td>
<td>288</td>
<td>43</td>
<td>18,403</td>
<td>2</td>
<td>99</td>
<td>1</td>
</tr>
<tr>
<td>Dietitians</td>
<td>1989</td>
<td>211</td>
<td>278</td>
<td>318</td>
<td>51</td>
<td>8,136</td>
<td>4</td>
<td>96</td>
<td>2</td>
</tr>
<tr>
<td>Health Information Management Professionals</td>
<td>1990</td>
<td>111</td>
<td>94</td>
<td>108</td>
<td>-5</td>
<td>2,874</td>
<td>4</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>1989</td>
<td>169</td>
<td>213</td>
<td>221</td>
<td>31</td>
<td>7,036</td>
<td>3</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>Social Workers</td>
<td>1989</td>
<td>1,082</td>
<td>1,224</td>
<td>1,463</td>
<td>35</td>
<td>29,986</td>
<td>5</td>
<td>82</td>
<td>18</td>
</tr>
<tr>
<td>Speech-Language Pathologists</td>
<td>1987</td>
<td>120</td>
<td>147</td>
<td>173</td>
<td>-44</td>
<td>6,331</td>
<td>3</td>
<td>93</td>
<td>7</td>
</tr>
<tr>
<td>Active registered: Represents all registered/licensed individuals who are legally able to work under the title of the specified health profession. Individuals may or may not be currently employed in the profession.</td>
<td>First Year of Regulation</td>
<td>1996</td>
<td>2001</td>
<td>2005</td>
<td>% Change 1996-2005</td>
<td>Canada Total</td>
<td>% Female</td>
<td>% Male</td>
<td>Per 100,000 Population</td>
</tr>
<tr>
<td>Dentists</td>
<td>1990</td>
<td>257</td>
<td>266</td>
<td>298</td>
<td>16</td>
<td>18,688</td>
<td>2</td>
<td>29</td>
<td>71</td>
</tr>
<tr>
<td>Medical Laboratory Technologists</td>
<td>1992</td>
<td>662</td>
<td>647</td>
<td>654</td>
<td>-1</td>
<td>20,098</td>
<td>3</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>Medical Physicists</td>
<td>1992</td>
<td>5</td>
<td>6</td>
<td>10</td>
<td>100</td>
<td>313</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Medical Radiation Technologists</td>
<td>1998</td>
<td>451</td>
<td>453</td>
<td>501</td>
<td>11</td>
<td>10,030</td>
<td>3</td>
<td></td>
<td>67</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>2002</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,026</td>
<td>2</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>1997</td>
<td>147</td>
<td>204</td>
<td>245</td>
<td>67</td>
<td>11,378</td>
<td>2</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>Ophthalmists</td>
<td>1921</td>
<td>85</td>
<td>94</td>
<td>96</td>
<td>15</td>
<td>3,053</td>
<td>3</td>
<td>45</td>
<td>56</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1994</td>
<td>511</td>
<td>554</td>
<td>625</td>
<td>22</td>
<td>29,471</td>
<td>2</td>
<td></td>
<td>83</td>
</tr>
<tr>
<td>Physicians (excl. residents)</td>
<td>1967</td>
<td>1,121</td>
<td>1,179</td>
<td>1,295</td>
<td>16</td>
<td>61,622</td>
<td>2</td>
<td>30</td>
<td>68</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1960</td>
<td>290</td>
<td>363</td>
<td>428</td>
<td>48</td>
<td>15,772</td>
<td>3</td>
<td>84</td>
<td>16</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1967</td>
<td>215</td>
<td>213</td>
<td>265</td>
<td>23</td>
<td>14,715</td>
<td>2</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>Employed active registered: Represents personnel who are registered/licensed with an organization and currently working in the specified health profession.</td>
<td>First Year of Regulation</td>
<td>1996</td>
<td>2001</td>
<td>2005</td>
<td>% Change 1996-2005</td>
<td>Canada Total</td>
<td>% Female</td>
<td>% Male</td>
<td>Per 100,000 Population</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>1980</td>
<td>2,427</td>
<td>2,743</td>
<td>2,633</td>
<td>NC</td>
<td>64,951</td>
<td>4</td>
<td>90</td>
<td>10</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>1984</td>
<td>7,381</td>
<td>7,385</td>
<td>7,507</td>
<td>2</td>
<td>251,075</td>
<td>3</td>
<td>96</td>
<td>4</td>
</tr>
</tbody>
</table>


Notes:
- Data provided in this table were requested of various HPDB data providers based on the registration status definitions indicated. Data in this table are a cross-section view of selected health professions, which can be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1995 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
- Data not available.
- NC Not comparable.
- NR Not registered as of 2004.

1. Gender unknown excluded; as a result, totals may not sum to 100%.
2. Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
3. Profession is not regulated in all provinces. The Canada total for each profession includes some provincial data for which registration with a regulatory authority may not be a condition of practice.
4. Data were submitted to CHI from an organization in which membership is voluntary.

### Quebec

#### Number of Health Personnel in Selected Professions, by Registration Status, 2005

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>First Year of Regulation</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>% Female</th>
<th>% Male</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Registered:</strong> Represents all individuals who are registered with an organization. The count may include individuals in all registration categories (active, inactive, honorary, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiologists†</td>
<td>1973</td>
<td>145</td>
<td>197</td>
<td>239</td>
<td>65</td>
<td>1,241</td>
<td>19</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>1974</td>
<td>872</td>
<td>1,017</td>
<td>1,112</td>
<td>28</td>
<td>7,113</td>
<td>16</td>
<td>35</td>
<td>65</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>1975</td>
<td>3,105</td>
<td>3,667</td>
<td>4,145</td>
<td>33</td>
<td>18,403</td>
<td>23</td>
<td>99</td>
<td>1</td>
</tr>
<tr>
<td>Dietitians</td>
<td>1974</td>
<td>1,892</td>
<td>1,916</td>
<td>2,266</td>
<td>20</td>
<td>8,136</td>
<td>28</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>Health Information Management Professionals†</td>
<td>NR</td>
<td>105</td>
<td>22</td>
<td>21</td>
<td>-80</td>
<td>2,874</td>
<td>&lt; 1</td>
<td>..</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>1985</td>
<td>2,354</td>
<td>2,651</td>
<td>3,047</td>
<td>29</td>
<td>7,036</td>
<td>40</td>
<td>84</td>
<td>16</td>
</tr>
<tr>
<td>Social Workers†</td>
<td>1958</td>
<td>4,088</td>
<td>4,765</td>
<td>6,424</td>
<td>57</td>
<td>29,866</td>
<td>21</td>
<td>84</td>
<td>16</td>
</tr>
<tr>
<td>Speech-Language Pathologists†</td>
<td>1973</td>
<td>727</td>
<td>969</td>
<td>1,318</td>
<td>61</td>
<td>6,331</td>
<td>21</td>
<td>90</td>
<td>4</td>
</tr>
<tr>
<td><strong>Active registered:</strong> Represents all registered/licensed individuals who are legally able to work under the title of the specified health profession. Individuals may or may not be currently employed in the profession.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>1969</td>
<td>3,779</td>
<td>3,994</td>
<td>4,035</td>
<td>7</td>
<td>18,888</td>
<td>22</td>
<td>36</td>
<td>64</td>
</tr>
<tr>
<td>Medical Laboratory Technologists†</td>
<td>1973</td>
<td>2,596</td>
<td>2,810</td>
<td>3,972</td>
<td>68</td>
<td>20,039</td>
<td>20</td>
<td>88</td>
<td>12</td>
</tr>
<tr>
<td>Medical Physicists†</td>
<td>NR</td>
<td>34</td>
<td>44</td>
<td>49</td>
<td>44</td>
<td>313</td>
<td>18</td>
<td>..</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>Medical Radiation Technologists†</td>
<td>1973</td>
<td>3,089</td>
<td>3,579</td>
<td>4,128</td>
<td>12</td>
<td>16,036</td>
<td>20</td>
<td>86</td>
<td>10</td>
</tr>
<tr>
<td>Midwives†</td>
<td>1999</td>
<td>37</td>
<td>56</td>
<td>84</td>
<td>127</td>
<td>520</td>
<td>16</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>2003</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>1,026</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>1973</td>
<td>1,968</td>
<td>2,618</td>
<td>3,288</td>
<td>67</td>
<td>11,378</td>
<td>29</td>
<td>93</td>
<td>7</td>
</tr>
<tr>
<td>Optometrists</td>
<td>1909</td>
<td>1,119</td>
<td>1,163</td>
<td>1,201</td>
<td>3</td>
<td>3,853</td>
<td>31</td>
<td>58</td>
<td>42</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1973</td>
<td>5,367</td>
<td>6,141</td>
<td>6,790</td>
<td>26</td>
<td>29,471</td>
<td>23</td>
<td>..</td>
<td>89</td>
</tr>
<tr>
<td>Physicians (excl. residents)</td>
<td>1948</td>
<td>15,232</td>
<td>15,866</td>
<td>16,354</td>
<td>43</td>
<td>61,622</td>
<td>27</td>
<td>37</td>
<td>63</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1973</td>
<td>2,865</td>
<td>3,210</td>
<td>3,677</td>
<td>28</td>
<td>15,772</td>
<td>23</td>
<td>78</td>
<td>22</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1982</td>
<td>5,602</td>
<td>6,271</td>
<td>7,523</td>
<td>34</td>
<td>14,715</td>
<td>51</td>
<td>71</td>
<td>29</td>
</tr>
<tr>
<td><strong>Employed active registered:</strong> Represents personnel who are registered/licensed with an organization and currently working in the specified health profession.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>1974</td>
<td>18,572</td>
<td>16,203</td>
<td>16,293</td>
<td>NC</td>
<td>64,951</td>
<td>25</td>
<td>92</td>
<td>8</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>1946</td>
<td>57,291</td>
<td>58,462</td>
<td>63,827</td>
<td>11</td>
<td>251,075</td>
<td>25</td>
<td>91</td>
<td>9</td>
</tr>
</tbody>
</table>


Notes:
- Data provided in this table were requested of various HPDB data providers based on the registration status definitions indicated. Data in this table represents an overview of selected health professions, which can be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1995 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
- .. Data not available.
- NC Data not comparable.
- NR Not regulated as of 2004.
- 1 Gender unknown excluded; as a result, totals may not sum to 100%.
- 2 Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
- 3 Profession is not regulated in all provinces. The Canada total for each profession includes some provincial data in which registration with a regulatory authority may not be a condition of practice.
- 4 Data were submitted to CHI from an organization in which membership is voluntary.
## Ontario

### Number of Health Personnel in Selected Professions, by Registration Status, 2005

| Registered: Represents all individuals who are registered with an organization. The count may include individuals in all registration categories (active, inactive, honorary, etc.) | First Year of Regulation | 1996 | 2001 | 2005 | % Change 1996-2005 | Canada Total | Ont. as % of Canada Total | % Female | % Male | Per 100,000 Population
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiologists&lt;sup&gt;2&lt;/sup&gt;</td>
<td>1994</td>
<td>287</td>
<td>406</td>
<td>497</td>
<td>73</td>
<td>1,241</td>
<td>40</td>
<td>78</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>1925</td>
<td>2,171</td>
<td>2,884</td>
<td>3,538</td>
<td>63</td>
<td>7,113</td>
<td>50</td>
<td>30</td>
<td>70</td>
<td>28</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>1951</td>
<td>5,393</td>
<td>6,756</td>
<td>8,252</td>
<td>53</td>
<td>18,403</td>
<td>45</td>
<td>98</td>
<td>2</td>
<td>68</td>
</tr>
<tr>
<td>Dietitians</td>
<td>1994</td>
<td>2,047</td>
<td>2,256</td>
<td>2,629</td>
<td>28</td>
<td>8,139</td>
<td>32</td>
<td>99</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Health Information Management Professionals&lt;sup&gt;2&lt;/sup&gt;</td>
<td>NR</td>
<td>1,324</td>
<td>1,894</td>
<td>1,325</td>
<td>&lt; 1</td>
<td>2,674</td>
<td>48</td>
<td>...</td>
<td>...</td>
<td>11</td>
</tr>
<tr>
<td>Respiratory Therapists&lt;sup&gt;1&lt;/sup&gt;</td>
<td>1991</td>
<td>1,628</td>
<td>1,846</td>
<td>2,290</td>
<td>41</td>
<td>7,036</td>
<td>30</td>
<td>70</td>
<td>30</td>
<td>18</td>
</tr>
<tr>
<td>Social Workers&lt;sup&gt;3&lt;/sup&gt;</td>
<td>2000</td>
<td>2,977</td>
<td>6,886</td>
<td>10,189</td>
<td>242</td>
<td>29,986</td>
<td>34</td>
<td>83</td>
<td>17</td>
<td>81</td>
</tr>
<tr>
<td>Speech-Language Pathologists&lt;sup&gt;1&lt;/sup&gt;</td>
<td>1994</td>
<td>1,403</td>
<td>1,954</td>
<td>2,385</td>
<td>70</td>
<td>6,331</td>
<td>38</td>
<td>96</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Active registered: Represents all registered/licensed individuals who are legally able to work under the title of the specified health profession. Individuals may or may not be currently employed in the profession.</td>
<td>First Year of Regulation</td>
<td>1996</td>
<td>2001</td>
<td>2005</td>
<td>% Change 1996-2005</td>
<td>Canada Total</td>
<td>Ont. as % of Canada Total</td>
<td>% Female</td>
<td>% Male</td>
<td>Per 100,000 Population</td>
</tr>
<tr>
<td>Dentists</td>
<td>1967</td>
<td>6,361</td>
<td>7,351</td>
<td>7,905</td>
<td>24</td>
<td>18,688</td>
<td>42</td>
<td>74</td>
<td>26</td>
<td>63</td>
</tr>
<tr>
<td>Medical Laboratory Technologists&lt;sup&gt;2&lt;/sup&gt;</td>
<td>1994</td>
<td>8,139</td>
<td>6,846</td>
<td>7,217</td>
<td>-11</td>
<td>20,039</td>
<td>36</td>
<td>82</td>
<td>18</td>
<td>57</td>
</tr>
<tr>
<td>Medical Physicists&lt;sup&gt;1&lt;/sup&gt;</td>
<td>NR</td>
<td>105</td>
<td>127</td>
<td>147</td>
<td>40</td>
<td>313</td>
<td>47</td>
<td>...</td>
<td>...</td>
<td>1</td>
</tr>
<tr>
<td>Medical Radiation Technologists&lt;sup&gt;2&lt;/sup&gt;</td>
<td>1980</td>
<td>5,260</td>
<td>5,388</td>
<td>5,939</td>
<td>13</td>
<td>16,030</td>
<td>37</td>
<td>...</td>
<td>...</td>
<td>47</td>
</tr>
<tr>
<td>Midwives&lt;sup&gt;1&lt;/sup&gt;</td>
<td>1994</td>
<td>87</td>
<td>190</td>
<td>266</td>
<td>206</td>
<td>520</td>
<td>51</td>
<td>100</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>1991</td>
<td>...</td>
<td>...</td>
<td>653</td>
<td>...</td>
<td>1,020</td>
<td>64</td>
<td>...</td>
<td>...</td>
<td>5</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>1993</td>
<td>2,668</td>
<td>3,375</td>
<td>4,002</td>
<td>50</td>
<td>11,378</td>
<td>35</td>
<td>94</td>
<td>6</td>
<td>32</td>
</tr>
<tr>
<td>Optometrists</td>
<td>1919</td>
<td>1,001</td>
<td>1,218</td>
<td>1,386</td>
<td>38</td>
<td>3,853</td>
<td>36</td>
<td>42</td>
<td>58</td>
<td>11</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1971</td>
<td>7,852</td>
<td>8,790</td>
<td>10,385</td>
<td>32</td>
<td>29,471</td>
<td>35</td>
<td>...</td>
<td>...</td>
<td>93</td>
</tr>
<tr>
<td>Physicians (excl. residents)</td>
<td>1795</td>
<td>20,209</td>
<td>21,482</td>
<td>22,237</td>
<td>10</td>
<td>61,622</td>
<td>36</td>
<td>31</td>
<td>68</td>
<td>176</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1953</td>
<td>4,727</td>
<td>5,223</td>
<td>5,314</td>
<td>12</td>
<td>15,772</td>
<td>34</td>
<td>81</td>
<td>19</td>
<td>42</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1960</td>
<td>2,190</td>
<td>2,665</td>
<td>2,990</td>
<td>37</td>
<td>14,715</td>
<td>20</td>
<td>62</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>Employed active registered: Represents personnel who are registered/licensed with an organization and currently working in the specified health profession.</td>
<td>First Year of Regulation</td>
<td>1996</td>
<td>2001</td>
<td>2005</td>
<td>% Change 1996-2005</td>
<td>Canada Total</td>
<td>Ont. as % of Canada Total</td>
<td>% Female</td>
<td>% Male</td>
<td>Per 100,000 Population</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>1947</td>
<td>35,392</td>
<td>32,513</td>
<td>24,458</td>
<td>NC</td>
<td>64,951</td>
<td>38</td>
<td>94</td>
<td>6</td>
<td>194</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>1922</td>
<td>80,188</td>
<td>80,590</td>
<td>89,429</td>
<td>12</td>
<td>251,075</td>
<td>36</td>
<td>96</td>
<td>4</td>
<td>710</td>
</tr>
</tbody>
</table>

**Data Sources:** Health Personnel Database, CHI. Population estimates from Quarterly Demographic Statistics, Statistics Canada, vol. 19, no. 4, 2005.

**Notes:**
- Data provided in this table were requested by various HPDB data providers based on the registration status definitions indicated. Sites in this table are an answer to the selection of health professions, which can be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1995 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
- ... Data not available.
- NC Data not comparable.
- NR Not registered as of 2004.
- 1 Gender unknown excluded; as a result, totals may not sum to 100%.
- 2 Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
- 3 Profession is not regulated in all provinces. The Canada total for each profession includes some provincial data in which registration with a regulatory authority may not be a condition of practice.
- 4 Data were submitted to CHI from an organization in which membership is voluntary.
### Number of Health Personnel in Selected Professions, by Registration Status, 2005

<table>
<thead>
<tr>
<th>Registered: Represents all individuals who are registered with an organization. The count may include individuals in all registration categories (active, inactive, honorary, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2005</strong></td>
</tr>
<tr>
<td><strong>Audiologists</strong></td>
</tr>
<tr>
<td><strong>Chiropractors</strong></td>
</tr>
<tr>
<td><strong>Dental Hygienists</strong></td>
</tr>
<tr>
<td><strong>Dietitians</strong></td>
</tr>
<tr>
<td><strong>Health Information Management Professionals</strong></td>
</tr>
<tr>
<td><strong>Respiratory Therapists</strong></td>
</tr>
<tr>
<td><strong>Social Workers</strong></td>
</tr>
<tr>
<td><strong>Speech-Language Pathologists</strong></td>
</tr>
<tr>
<td><strong>Active registered: Represents all registered/licensed individuals who are legally able to work under the title of the specified health profession. Individuals may or may not be currently employed in the profession.</strong></td>
</tr>
<tr>
<td><strong>Dentists</strong></td>
</tr>
<tr>
<td><strong>Medical Laboratory Technologists</strong></td>
</tr>
<tr>
<td><strong>Medical Physicians</strong></td>
</tr>
<tr>
<td><strong>Medical Radiation Technologists</strong></td>
</tr>
<tr>
<td><strong>Midwives</strong></td>
</tr>
<tr>
<td><strong>Nurse Practitioners</strong></td>
</tr>
<tr>
<td><strong>Occupational Therapists</strong></td>
</tr>
<tr>
<td><strong>Optometrists</strong></td>
</tr>
<tr>
<td><strong>Pharmacists</strong></td>
</tr>
<tr>
<td><strong>Physicians (excl. residents)</strong></td>
</tr>
<tr>
<td><strong>Physiotherapists</strong></td>
</tr>
<tr>
<td><strong>Psychologists</strong></td>
</tr>
<tr>
<td><strong>Employed active registered: Represents personnel who are registered/licensed with an organization and currently working in the specified health profession.</strong></td>
</tr>
<tr>
<td><strong>Licensed Practical Nurses</strong></td>
</tr>
<tr>
<td><strong>Registered Nurses</strong></td>
</tr>
<tr>
<td><strong>Registered Psychiatric Nurses</strong></td>
</tr>
</tbody>
</table>

**Notes:**
- Data provided in this table were requested from various HPRD data providers based on the registration status definitions indicated. Data in this table provides an overview of selected health professions, which can be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1985 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
- Data not available.
- Value suppressed in accordance with CII privacy policy; cell value from 1 to 4.
- NC: Data not comparable.

1. Gender unknown excluded; as a result, totals may not sum to 100%.
2. Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
3. Professional practice is regulated in all provinces. The Canada total for each profession includes some provincial data in which registration with a regulatory authority may not be a condition of practice.
4. Data were submitted to CII from an organization in which membership is voluntary.

---

### Saskatchewan

**Number of Health Personnel in Selected Professions, by Registration Status, 2005**

<table>
<thead>
<tr>
<th>Professions</th>
<th>First Year of Regulation</th>
<th>1996</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>Sask. as % of Canada Total</th>
<th>% Female</th>
<th>% Male</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiotherapists</td>
<td>1996</td>
<td>...</td>
<td>...</td>
<td>30</td>
<td>...</td>
<td>1,241</td>
<td>2</td>
<td>93</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>1943</td>
<td>129</td>
<td>183</td>
<td>184</td>
<td>43</td>
<td>7,113</td>
<td>3</td>
<td>24</td>
<td>76</td>
<td>19</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>1950</td>
<td>242</td>
<td>300</td>
<td>347</td>
<td>43</td>
<td>18,403</td>
<td>2</td>
<td>98</td>
<td>2</td>
<td>35</td>
</tr>
<tr>
<td>Dietitians</td>
<td>1969</td>
<td>170</td>
<td>224</td>
<td>251</td>
<td>40</td>
<td>8,135</td>
<td>3</td>
<td>96</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Health Information Management Professionals</td>
<td>NR</td>
<td>262</td>
<td>224</td>
<td>248</td>
<td>-6</td>
<td>2,674</td>
<td>9</td>
<td>...</td>
<td>...</td>
<td>25</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>NR</td>
<td>94</td>
<td>98</td>
<td>97</td>
<td>3</td>
<td>7,036</td>
<td>1</td>
<td>52</td>
<td>48</td>
<td>10</td>
</tr>
<tr>
<td>Social Workers</td>
<td>NR</td>
<td>452</td>
<td>976</td>
<td>1,161</td>
<td>157</td>
<td>29,808</td>
<td>4</td>
<td>83</td>
<td>17</td>
<td>117</td>
</tr>
<tr>
<td>Speech-Language Pathologists</td>
<td>1982</td>
<td>...</td>
<td>...</td>
<td>240</td>
<td>...</td>
<td>6,331</td>
<td>4</td>
<td>96</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Dentists</td>
<td>1908</td>
<td>351</td>
<td>357</td>
<td>364</td>
<td>4</td>
<td>18,688</td>
<td>2</td>
<td>24</td>
<td>76</td>
<td>37</td>
</tr>
<tr>
<td>Medical Laboratory Technologists</td>
<td>1996</td>
<td>961</td>
<td>967</td>
<td>984</td>
<td>3</td>
<td>20,038</td>
<td>5</td>
<td>...</td>
<td>...</td>
<td>99</td>
</tr>
<tr>
<td>Medical Physicists</td>
<td>NR</td>
<td>8</td>
<td>12</td>
<td>9</td>
<td>12</td>
<td>313</td>
<td>3</td>
<td>...</td>
<td>...</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Medical Radiation Technologists</td>
<td>1982</td>
<td>418</td>
<td>450</td>
<td>453</td>
<td>8</td>
<td>16,032</td>
<td>3</td>
<td>...</td>
<td>...</td>
<td>46</td>
</tr>
<tr>
<td>Midwives</td>
<td>NR</td>
<td>6</td>
<td>5</td>
<td>10</td>
<td>67</td>
<td>520</td>
<td>2</td>
<td>100</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>2003</td>
<td>...</td>
<td>...</td>
<td>75</td>
<td>...</td>
<td>1,026</td>
<td>7</td>
<td>...</td>
<td>...</td>
<td>8</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>1971</td>
<td>148</td>
<td>201</td>
<td>217</td>
<td>49</td>
<td>11,378</td>
<td>2</td>
<td>88</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>Optometrists</td>
<td>1907</td>
<td>110</td>
<td>109</td>
<td>117</td>
<td>6</td>
<td>3,863</td>
<td>3</td>
<td>32</td>
<td>68</td>
<td>12</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1911</td>
<td>1,049</td>
<td>1,129</td>
<td>1,177</td>
<td>12</td>
<td>29,471</td>
<td>4</td>
<td>...</td>
<td>...</td>
<td>119</td>
</tr>
<tr>
<td>Physicians (excl. residents)</td>
<td>1985</td>
<td>1,472</td>
<td>1,549</td>
<td>1,545</td>
<td>5</td>
<td>61,022</td>
<td>3</td>
<td>26</td>
<td>73</td>
<td>156</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1945</td>
<td>406</td>
<td>524</td>
<td>534</td>
<td>31</td>
<td>15,772</td>
<td>3</td>
<td>80</td>
<td>20</td>
<td>54</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1962</td>
<td>78</td>
<td>73</td>
<td>418</td>
<td>NC</td>
<td>14,715</td>
<td>3</td>
<td>64</td>
<td>36</td>
<td>42</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>1956</td>
<td>2,277</td>
<td>2,122</td>
<td>2,194</td>
<td>NC</td>
<td>64,951</td>
<td>3</td>
<td>97</td>
<td>3</td>
<td>221</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>1967</td>
<td>8,508</td>
<td>8,198</td>
<td>8,549</td>
<td>&lt;1</td>
<td>251,675</td>
<td>3</td>
<td>97</td>
<td>3</td>
<td>863</td>
</tr>
<tr>
<td>Registered Psychiatric Nurses</td>
<td>1948</td>
<td>1,109</td>
<td>1,038</td>
<td>933</td>
<td>NC</td>
<td>4,064</td>
<td>19</td>
<td>80</td>
<td>10</td>
<td>94</td>
</tr>
</tbody>
</table>

**Data Sources:** Health Personnel Database, CHI. Population estimates from Quarterly Demographic Statistics, Statistics Canada, vol. 19, no. 4, 2005.

**Notes:**
1. Data provided in this table were requested of various HPB data providers based on the registration status definitions indicated. Data in this table are from a survey of selected health professions, which can be used for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1985 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
2. Data not available.
3. Data not comparable.
4. Data not reported as of 2004.

---

# Alberta

## Number of Health Personnel in Selected Professions, by Registration Status, 2005

<table>
<thead>
<tr>
<th>Registered: Represents all individuals who are registered with an organization. The count may include individuals in all registration categories (active, inactive, honorary, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Year of Regulation</strong></td>
</tr>
<tr>
<td><strong>Audiologists</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Chiropractors</strong></td>
</tr>
<tr>
<td><strong>Dental Hygienists</strong></td>
</tr>
<tr>
<td><strong>Dietitians</strong></td>
</tr>
<tr>
<td><strong>Health Information Management Professionals</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Respiratory Therapists</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Social Workers</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Speech-Language Pathologists</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Active registered: Represents all registered/licensed individuals who are legally able to work under the title of the specified health profession. Individuals may or may not be currently employed in the profession.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Year of Regulation</strong></td>
</tr>
<tr>
<td><strong>Dentists</strong></td>
</tr>
<tr>
<td><strong>Medical Laboratory Technologists</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Medical Physicians</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Medical Radiation Technologists</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Midwives</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Nurse Practitioners</strong></td>
</tr>
<tr>
<td><strong>Occupational Therapists</strong></td>
</tr>
<tr>
<td><strong>Optometrists</strong></td>
</tr>
<tr>
<td><strong>Pharmacists</strong></td>
</tr>
<tr>
<td><strong>Physicians (exc. residents)</strong></td>
</tr>
<tr>
<td><strong>Physiotherapists</strong></td>
</tr>
<tr>
<td><strong>Psychologists</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employed active registered: Represents personnel who are registered/licensed with an organization and currently working in the specified health profession.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Year of Regulation</strong></td>
</tr>
<tr>
<td><strong>Licensed Practical Nurses</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Registered Nurses</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Registered Psychiatric Nurses</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>


Notes:

- Data provided in this table were requested of various HPDB data providers based on the registration status definitions indicated. Data in this table provide a summary view of selected health professions, which can be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1985 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
- .. Data not available.
- NC Data not comparable.
- NR Not required as of 2004.
- 1 Gender unknown excluded; as a result, totals may not sum to 100%.
- 2 Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
- 3 The data reflects the most recent registration data available for each profession, which may vary across the country.
- 4 Data were submitted to CIHI from an organization in which membership is voluntary.

**British Columbia**

**Number of Health Personnel in Selected Professions, by Registration Status, 2005**

<table>
<thead>
<tr>
<th>Profession</th>
<th>First Year of Regulation</th>
<th>1995</th>
<th>2001</th>
<th>2005</th>
<th>% Change 1996-2005</th>
<th>Canada Total</th>
<th>% Female</th>
<th>% Male</th>
<th>Per 100,000 Population</th>
</tr>
</thead>
</table>
| **Registered:**  
| Audiologists 2                    | NR                       | 167  | 1241 | 564  | -15                | 13          | 78      | 24     | 4                     |
| Chiropractors                     | 1934                     | 576  | 826  | 946  | 64                 | 63          | 71      | 32     | 22                    |
| Dental Hygienists                 | 1952                     | 1,593| 1,910| 2,224| 40                 | 18          | 40      | 72     | 52                    |
| Dietitians                        | 2004                     | 630  | 647  | 910  | 10                 | 0           | 10      | 91     | 11                    |
| Health Information Management Professionals 1 | NR | 431  | 351  | 366  | -15                | 12          | 17      | 3      | 4                     |
| Respiratory Therapists 1          | NR                       | 303  | 523  | 73   | 7                  | 0           | 0       | 0      | 9                     |
| Social Workers 1                  | REG                      | 1,203| 1,361| 1,732| 44                 | 29          | 67      | 10     | 12                    |
| Speech-Language Pathologists 1    | NR                       | 0    | 0    | 0    | 0                 | 0           | 0       | 0      | 0                     |
| **Active registered:**  
| Dentists                          | 1886                     | 2,354| 2,643| 2,857| 21                | 18          | 67      | 18     | 8                    |
| Medical Laboratory Technologists 1| NR                       | 2,630| 2,443| 2,482| -6                | 17          | 44      | 11     | 19                    |
| Medical Physicists 1              | NR                       | 22   | 33   | 64   | 6                 | 11          | 25      | 0      | 5                    |
| Medical Radiation Technologists 1 | NR                       | 1,004| 1,675| 1,623| 14                | 10          | 53      | 1      | 9                    |
| Midwives                          | 1994                     | 66   | 94   | 520  | 18                | 100         | 0       | 0      | 2                    |
| Nurse Practitioners               | 2005                     | 1029 | 1,299| 1,634| 39                | 10          | 34      | 0      | 4                    |
| Occupational Therapists 1         | 2000                     | 290  | 367  | 423  | 46                | 13          | 46      | 10     | 2                    |
| Optometrists                      | 1921                     | 2,846| 3,406| 3,941| 34                | 1           | 25      | 37     | 192                   |
| Pharmacists                       | 1991                     | 2    | 30   | 36   | 46                | 11          | 36      | 12     | 4                    |
| Physicians (ass. residents)       | 1997                     | 7,002| 1,010| 507  | 13                | 14          | 50      | 0      | 9                    |
| Physicians                        | 1946                     | 2,093| 2,306| 2,606| 30                | 16          | 76      | 22     | 59                    |
| Psychologists                     | 1977                     | 977  | 934  | 933  | -5                | 4           | 56      | 44     | 22                    |
| **Employed active registered:**   |                          |      |      |      |                   |             |         |       |                       |
| Licensed Practical Nurses         | 1988                     | 5,667| 5,045| 4,884| -11               | 11          | 91      | 9      | 114                   |
| Registered Nurses                 | 1918                     | 27,379| 27,317| 27,814| > 1              | 251          | 17      | 10     | 650                   |
| Registered Psychiatric Nurses     | 1951                     | 2,212| 2,181| 1,954| -12               | 4           | 77      | 23     | 46                    |

**Data Sources:** Health Personnel Database, CIHI. Population estimates from Quarterly Demographic Statistics, Statistics Canada, vol. 19, no. 4, 2005.

**Notes:**
- Data provided in this table were requested of various HPDO data providers based on the registration status definitions indicated. Data in this table represent views of selected health professions, which can be useful for some purposes, but should be used within the limitations noted. Please consult Health Personnel Trends in Canada, 1995 to 2004 for more detailed methodological notes, data quality issues and profession-specific information.
- **Not available**
- **Value suppressed to ensure confidentiality; cell value greater than 5.**
- NC Not comparable.
- REG Regulated in 2005, but initial year of regulation is unknown.
- 1 Gender unknown excluded; as a result, totals may not sum to 100%.
- 2 Due to the variation in regulatory requirements, interprofessional comparison should be interpreted with caution.
- 3 Profession is not regulated in all provinces. The Canada total for each profession includes some provincial data in which registration with a regulatory authority may not be a condition of practice.
- 4 Data were submitted to CIHI from an organization in which membership is voluntary.
APPENDIX C  Potential Impacts of the Electronic Health Record (EHR)

<table>
<thead>
<tr>
<th>EHR ELEMENT</th>
<th>POTENTIAL IMPACT OF EHR ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WAIT TIMES</td>
</tr>
<tr>
<td>Electronic Medical Record (MD/clinic) for patient encounters</td>
<td>• Automatic call reminders can prevent delays</td>
</tr>
<tr>
<td></td>
<td>• Increases provider productivity allowing more encounters per day</td>
</tr>
<tr>
<td>Laboratory data</td>
<td>• Faster results</td>
</tr>
<tr>
<td></td>
<td>• Abnormal results can trigger automatic call-back and recommended intervention</td>
</tr>
<tr>
<td></td>
<td>• Can trigger automatic consultation with and/or referral to specialist</td>
</tr>
<tr>
<td>E-prescribing with decision support built in</td>
<td>• Instant transmission to pharmacy</td>
</tr>
<tr>
<td></td>
<td>• Builds in reminders for follow-up consultations to check effectiveness, prompt refills</td>
</tr>
<tr>
<td></td>
<td>• Can enhance greater cooperation among provider groups with prescribing authority</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EHR ELEMENT</th>
<th>WAIT TIMES</th>
<th>PRIMARY HEALTH CARE DEVELOPMENT</th>
<th>SAFETY</th>
<th>QUALITY</th>
<th>EFFICIENCY/VALUE FOR MONEY</th>
</tr>
</thead>
</table>
| Diagnostic imaging (PACS)   | - Reduces delays caused by redundant imaging  
                           |                                 | - Can reduce referrals                   | - Allows views of comparative images for more accurate interpretation  
                           | - Can obtain faster interpretation for remote sites  
                           |                                 | - Can enhance team understanding of imaging results | - Faster consultation with specialists and sub-specialists  
                           | - Avoids travel                  |                                 | - Can reduce exposure to radiation by avoiding repeat tests   | - Reduces repeat investigations  
                           | - Faster follow-up and treatment of patients  |                                 |                                             | - Reduces cost of transmission  
                           |                                     |                                 |                                             | - Reduces archiving costs |
| Hospital data (ER, inpatient, outpatient) | - Faster assessments reducing time to treatment  | - PHC team can provide better follow-up care with complete data | - Reduced risk of medication errors  
                           |                                     |                                 | - Reduced risk of inadequate discharge planning | - Better integration of community and hospital care  
                           |                                     |                                 |                                             | - Improved continuity of care  
                           |                                     |                                 |                                             | - Better coordination allows earlier discharges  
                           |                                     |                                 |                                             | - Reduces need for telephone and fax communication  
                           |                                     |                                 |                                             | - Reduces repeat tests and procedures  
                           |                                     |                                 |                                             |                                     |
| Home care                   | - Can reduce demand for LTC and lower wait times  
                           |                                 | - Expands PHC team to include home support, home nursing  
                           | - Can trigger appointments with PHC or specialists  
                           | - Integrates medical and social aspects of care  | - Reduced medication errors  
                           |                                 |                                 | - Can alert PHC team to changing care needs | - Facilitates communication with PHC and specialist care  
                           |                                     |                                 |                                             | - Can reduce demand for LTC  
<pre><code>                       |                                     |                                 |                                             | - Early detection of problems can reduce referrals, hospitalizations |
</code></pre>
<table>
<thead>
<tr>
<th>EHR ELEMENT</th>
<th>POTENTIAL IMPACT OF EHR ON:</th>
<th>WAIT TIMES</th>
<th>PRIMARY HEALTH CARE DEVELOPMENT</th>
<th>SAFETY</th>
<th>QUALITY</th>
<th>EFFICIENCY/VALUE FOR MONEY</th>
</tr>
</thead>
</table>
| Long Term Residential Care | • Can prevent some visits to ER, freeing up capacity for others  
• Expands PHC team to include facility personnel  
• Facilitates electronic and in-person team meetings  
• Integrates medical and social aspects of care  | • Reduces medication errors  
• Can alert need for all prevention and other preventive measures  | • Can promote more individualized care plans  
• Facilitates consultations with PHC, specialists  | • Can reduce ER visits  
• Can reduce hospitalizations  
• Can reduce need for specialists by strengthening PHC |
| User access to own record | • Can trigger timely appointments  
• Can enhance self-care, reducing need and freeing up clinic time  
• E-mail can replace some visits  | • Facilitates communication with various team members  
• Encourages patient-centred approach  | • Greater awareness of medication risks  
• Potential to alert care team of errors and unforeseen risks of treatment  | • Potential to enhance chronic disease management  
• Improves communication with providers  | • Can reduce need for visits  
• Improved self-management can reduce complications |
APPENDIX D  Provincial Drug Subsidy Programs


Comparison of Provincial and Territorial Drug Subsidy Programs

Table 10 gives an overview of provincial and territorial drug subsidy programs. The table was verified for accuracy with provincial/territorial programs. Information is also available from the following Web sites:

British Columbia Pharmacare—
www.healthservices.gov.bc.ca/pharme

Alberta Prescription Drug Program—

Saskatchewan Drug Plan—
www.health.gov.sk.ca/ps_drug_plan.html

Manitoba Pharmacare Program—
www.gov.mb.ca/health/pharmacare/index.html

Ontario Drug Benefits—
http://www.health.gov.on.ca/english/providers/program/drugs/odbf_mn.html

Régime général d’assurance-médicaments du Québec (RGAM)—

New Brunswick Prescription Drug Program—
http://www.gnb.ca/0212/intro-e.asp

Nova Scotia Pharmacare—
http://www.gov.ns.ca/health/pharmacare/default.htm

Prince Edward Island Pharmacy Services—
www.gov.pe.ca/infopei/Government/GovInfo/Health/Pharmacy_Services

Newfoundland and Labrador Prescription Drug Program—
www.gov.nf.ca/health/nlpdp

Yukon Pharmacare—
www.hss.gov.yk.ca/programs/insured_hearing/pharmacare

Northwest Territories—
www.hlhss.gov.nt.ca/content/About_HSS/about_index.htm

Nunavut Planning Commission—
<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Program/Plan</th>
<th>Beneficiary</th>
<th>Premium</th>
<th>Deductible</th>
<th>Co-Pay</th>
<th>Maximum Annual Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>Fair PharmaCare</td>
<td>All families in which one or more family members were born before 1940 and are not covered by other plans</td>
<td>None</td>
<td>Based on family net income: $0 &lt; $33K 1% $33K to $450K 2% &gt; $450K</td>
<td>PharmaCare pays 75%</td>
<td>1.25% &lt; $33K 2% $33K to $50K 3% &gt; $50K</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Families in which all family members were born after 1940 and are not covered by other plans</td>
<td>None</td>
<td>Based on family net income: $0 &lt; $15K 2% $15K to $40K 3% &gt; $40K</td>
<td>PharmaCare pays 70%</td>
<td>2% &lt; $15K 3% $15K to $30K 4% &gt; $30K</td>
</tr>
<tr>
<td>PharmaCare Plan B</td>
<td>Residents of long-term care facilities</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>PharmaCare Plan C</td>
<td>BC Benefits Recipients</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>PharmaCare Plan D</td>
<td>Cystic FibrosisPatients</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>PharmaCare Plan F</td>
<td>Severely-Handicapped Children-at-Home Program</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>PharmaCare Plan G</td>
<td>Mental Health Centre Clients</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>PharmaCare Plan P</td>
<td>Palliative residents treated at home</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Alberta</td>
<td>Seniors</td>
<td>Seniors aged 65 and older and their eligible dependants</td>
<td>None</td>
<td>None</td>
<td>30% of prescription to a max of $25.00 per prescription plus additional cost if highercost-product is selected</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Widows</td>
<td>Residents aged 55 to 64 who qualify for Alberta Widows' Pension and eligible dependants</td>
<td>None</td>
<td>None</td>
<td>30% of prescription to a max of $25.00 per prescription plus additional cost if higher-cost-product is selected</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 10 (cont’d)—Comparison of Provincial and Territorial Drug Subsidy Programs as of December 2005

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Program/Plan</th>
<th>Beneficiary</th>
<th>Premium</th>
<th>Deductible</th>
<th>Co-Pay</th>
<th>Maximum Annual Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta (cont’d)</td>
<td>Palliative</td>
<td>Palliative residents treated at home</td>
<td>None</td>
<td>None</td>
<td>30% of prescription to a max of $25.00 per prescription plus additional cost if higher-cost-product is selected</td>
<td>The maximum amount palliative patients pay out-of-pocket is $1,000</td>
</tr>
<tr>
<td></td>
<td>Group 1</td>
<td>A universal plan available to all residents under the age of 65</td>
<td>Quarterly (3-month) rate is $61.50 for singles and $123 for families. Subsidized rates are available at $43.05 for singles and $86.10 for families</td>
<td>None</td>
<td>30% of prescription to a max of $25.00 per prescription plus additional cost if higher-cost-product is selected</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Province Wide Services</td>
<td>Residents with specific conditions may be eligible for high-cost drugs, mostly transplant and HIV drugs</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Income Support</td>
<td>Residents receiving social assistance and eligible dependants</td>
<td>None</td>
<td>None</td>
<td>$2.00 per prescription for first three prescriptions each month</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Assured Income for the Severely Handicapped (AISH)</td>
<td>Residents receiving AISH (an income support program for adults with a permanent disability that severely impairs their ability to earn a living) and eligible dependants</td>
<td>None</td>
<td>None</td>
<td>$2.00 per prescription for first three prescriptions each month</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Alberta Adult Health Benefit</td>
<td>Qualified clients leaving Income Support for work</td>
<td>None</td>
<td>None</td>
<td>$2.00 per prescription for first three prescriptions each month</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Alberta Child Health Benefit</td>
<td>Children in low-income families</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Province/Territory</td>
<td>Program/Plan</td>
<td>Beneficiary</td>
<td>Premium</td>
<td>Deductible</td>
<td>Co-Pay</td>
<td>Maximum Annual Co-Pay</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
<td>-------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>Saskatchewan Drug Plan</td>
<td>All residents with Saskatchewan Health Coverage</td>
<td>None</td>
<td>Income-tested (annual threshold based on 3.4% of adjusted family income)</td>
<td>Income-tested (based on benefit drug costs, to help spread cost out evenly over the year)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seniors receiving the Saskatchewan Income Plan supplement or receiving the federal Guaranteed Income Supplement and residing in a special care home (automatically receive this deductible and co-pay but may also apply for income-tested coverage)</td>
<td>None</td>
<td>$100 semi-annual family deductible</td>
<td>35% consumer co-payment after deductible has been paid</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seniors receiving the Guaranteed Income Supplement and living in the community (automatically receive this deductible and co-pay but may also apply for income-tested coverage)</td>
<td>None</td>
<td>$200 semi-annual family deductible (may apply for income-tested coverage)</td>
<td>35% consumer co-payment after deductible has been paid</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Emergency Assistance Program</td>
<td>Residents who require immediate treatment with covered prescription drugs and are unable to cover their share of the cost. This is a one-time benefit, and individuals are encouraged to apply for income-tested coverage for future assistance.</td>
<td>None</td>
<td>None</td>
<td>The level of assistance provided is in accordance with the consumer’s ability to pay</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 10 (cont’d)—Comparison of Provincial and Territorial Drug Subsidy Programs as of December 2005

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Program/Plan</th>
<th>Beneficiary</th>
<th>Premium</th>
<th>Deductible</th>
<th>Co-Pay</th>
<th>Maximum Annual Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saskatchewan</td>
<td>Family Health Benefits</td>
<td>Eligibility is established by the Department of Social Services, based on the number of children in the family and the family’s annual income. (automatically receive this deductible and co-pay but may also apply for income-tested coverage)</td>
<td>None</td>
<td>$100.00 semi-annual family deductible</td>
<td>No charge for benefit prescriptions for children; 35% consumer co-payment after deductible has been paid for adult benefit prescriptions</td>
<td>N/A</td>
</tr>
<tr>
<td>Supplementary Health</td>
<td></td>
<td>Persons nominated by Saskatchewan Social Services for special coverage, including persons on Social Assistance, wards, inmates, etc.</td>
<td>None</td>
<td>None</td>
<td>Up to $2.00 per prescription (some drugs covered at no charge; individuals under 18 and certain other categories receive benefit prescriptions at no charge)</td>
<td>N/A</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>Aids to Independent Living (SAIL)</td>
<td>Persons registered under the following SAIL programs receive Formulary and approved non-Formulary drugs at no charge: Paraplegia Program, Cystic Fibrosis Program, and Chronic End Stage Renal Disease Program</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Drug Plan Palliative Care Program</td>
<td>Residents who are in the late stages of a terminal illness</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Province/Territory</td>
<td>Program/Plan</td>
<td>Beneficiary</td>
<td>Premium</td>
<td>Deductible</td>
<td>Co-Pay</td>
<td>Maximum Annual Co-Pay</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------</td>
<td>-------------</td>
<td>---------</td>
<td>------------</td>
<td>--------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Manitoba</td>
<td>Pharmacare</td>
<td>All provincial residents who are eligible for benefits under Manitoba Health's Provincial Drug Program, with the exception of residents covered under other Statutes.</td>
<td>None</td>
<td>Based on total Adjusted family income; 2.32% of ≤ $15,000; 3.48% of $15,000–$40,000; 4% of $40,000–$75,000; 5% of &gt; $75,000; credit of $3,000 for a spouse and each dependent under 18 years; minimum of $100 deductible is applicable to everyone</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Family Services</td>
<td>Individual Manitobans that are receiving drug benefits pursuant to the Social Assistance Health Services Drug Program</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Personal Care Home</td>
<td>Manitoba residents of Personal Care Homes</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Palliative Care</td>
<td>Residents who are terminally ill and wish to remain at home</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 10 (cont’d)—Comparison of Provincial and Territorial Drug Subsidy Programs as of December 2005

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Program/Plan</th>
<th>Beneficiary</th>
<th>Premium</th>
<th>Deductible</th>
<th>Co-Pay</th>
<th>Maximum Annual Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>Ontario Drug Benefit Program</td>
<td>Seniors (aged 65 and older)</td>
<td>None</td>
<td>$100.00</td>
<td>After deductible, up to $6,11 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residents of long-term care facilities</td>
<td>None</td>
<td>None</td>
<td>Up to $2.00 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residents of Homes for Special Care</td>
<td>None</td>
<td>None</td>
<td>Up to $2.00 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residents receiving professional services under the Home Care program</td>
<td>None</td>
<td>None</td>
<td>Up to $2.00 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residents receiving social assistance</td>
<td>None</td>
<td>None</td>
<td>Up to $2.00 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Trillium Drug Program</td>
<td>Residents with high drug costs in relation to income</td>
<td>None</td>
<td>Income-based</td>
<td>Up to $2.00 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Special Drugs Program</td>
<td>Residents with valid Ontario Health Insurance. Coverage is product specific for a limited number of diseases or conditions.</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Quebec</td>
<td>Régime général d’assurance-médicaments du Québec (RGAMI)</td>
<td>Employment assistance (welfare) recipients (EAR) and other holders of a carnet de réclamation (claim slip)</td>
<td>None</td>
<td>$8.33 per month</td>
<td>25% of prescription costs</td>
<td>$16.66 per month (No deductible or co-pay for EAR with severe employment constraints)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seniors (65 and over) receiving at least 94 % of the maximum GIS</td>
<td>None</td>
<td>$8.33 per month</td>
<td>25% of prescription costs</td>
<td>$16.66 per month (No deductible or co-pay for seniors who receive the maximum GIS (100%))</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seniors (65 and over) receiving less than 94 % of the maximum GIS (partial GIS)</td>
<td>$0 to $521.00 per adult per year, depending on income[41]</td>
<td>$11.90 per month</td>
<td>28.5% of prescription costs</td>
<td>$46.67 per month</td>
</tr>
</tbody>
</table>

41. Although, in theory, the maximum premium is $521, the highest premium actually paid by people in this beneficiary group is $20, because it depends on income.
### Table 10 (cont’d)—Comparison of Provincial and Territorial Drug Subsidy Programs as of December 2005

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Program/Plan</th>
<th>Beneficiary</th>
<th>Premium</th>
<th>Deductible</th>
<th>Co-Pay</th>
<th>Maximum Annual Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quebec (cont’d)</td>
<td>Prescription Drug Program—Plan A</td>
<td>Seniors with GIS</td>
<td>None</td>
<td>None</td>
<td>$9.05 for each prescription</td>
<td>$250.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seniors without GIS who qualify for benefits based on an annual income as follows: a single senior with an annual income of $17,198 or less; a senior couple (both age 65) with a combined annual income of $26,955 or less; a senior couple with one spouse under 65, with a combined annual income of $32,390 or less</td>
<td>None</td>
<td>None</td>
<td>$15.00 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Prescription Drug Program—Plan B</td>
<td>Cystic fibrosis patients or patients with juvenile or infant sclerosis of the pancreas</td>
<td>None</td>
<td>$50.00 yearly registration fee</td>
<td>20% prescription cost up to a maximum of $20.00</td>
<td>$500 per family</td>
</tr>
<tr>
<td></td>
<td>Prescription Drug Program—Plan E</td>
<td>Individuals residing in a licensed residential facility who hold a valid health card for prescription drugs issued by the Department of Family and Community Services</td>
<td>None</td>
<td>None</td>
<td>$4.00 for each prescription</td>
<td>$250.00</td>
</tr>
</tbody>
</table>


Table 10 (cont'd)—Comparison of Provincial and Territorial Drug Subsidy Programs as of December 2005

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Program/Plan</th>
<th>Beneficiary</th>
<th>Premium</th>
<th>Deductible</th>
<th>Co-Pay</th>
<th>Maximum Annual Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Brunswick (cont'd)</td>
<td>Prescription Drug Program—Plan F</td>
<td>Individuals holding a valid health card for prescription drugs issued by the Department of Family and Community Services</td>
<td>None</td>
<td>None</td>
<td>$4.00 per prescription for adults (18 and over) and $2.00 for children (under 18 years)</td>
<td>$250.00 per family</td>
</tr>
<tr>
<td></td>
<td>Prescription Drug Program—Plan G</td>
<td>Special needs children and children under the care of the Minister of Family and Community Services</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Prescription Drug Program—Plan H</td>
<td>Residents in possession of a prescription written by a neurologist for the medications Avonex, Rebif, Betaseron or Copaxone are eligible to apply for assistance</td>
<td>$50.00 yearly registration fee</td>
<td>None</td>
<td>Income-tested Ranges from 0-100%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Prescription Drug Program—Plan R</td>
<td>Organ transplant recipients who are registered and qualify with the NBPD</td>
<td>$50.00 yearly registration fee</td>
<td>None</td>
<td>20% prescription cost up to a maximum of $20.00</td>
<td>$500.00 per family</td>
</tr>
<tr>
<td></td>
<td>Prescription Drug Program—Plan T</td>
<td>Individuals with growth hormone deficiency who are registered and qualify with the NBPD</td>
<td>$50.00 yearly registration fee</td>
<td>None</td>
<td>20% prescription cost up to a maximum of $20.00</td>
<td>$500.00 per family</td>
</tr>
<tr>
<td></td>
<td>Prescription Drug Program—Plan U</td>
<td>Individuals who are HIV positive and are registered with the NBPD</td>
<td>$50.00 yearly registration fee</td>
<td>None</td>
<td>20% prescription cost up to a maximum of $20.00</td>
<td>$500.00 per family</td>
</tr>
<tr>
<td></td>
<td>Prescription Drug Program—Plan V</td>
<td>Individuals who reside in a registered nursing home</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Province/Territory</td>
<td>Program/Plan</td>
<td>Beneficiary</td>
<td>Premium</td>
<td>Deductible</td>
<td>Co-Pay</td>
<td>Maximum Annual Co-Pay</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
<td>------------</td>
<td>---------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Seniors Pharmacare Program</td>
<td>Seniors (65 and older) receiving GIS and covered by MSI (Medical Services Insurance) and not having coverage through Veterans Affairs Canada, First Nations and Inuit Health, or a private drug plan</td>
<td>None</td>
<td>None</td>
<td>33% prescription cost ($30.00 maximum)</td>
<td>$350.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seniors (65 and older) not receiving GIS and covered by MSI (Medical Services Insurance) and not having coverage through Veterans Affairs Canada, First Nations and Inuit Health, or a private drug plan</td>
<td>Up to $390.00 per year</td>
<td>None</td>
<td>33% prescription cost ($30.00 maximum)</td>
<td>$350.00</td>
</tr>
<tr>
<td></td>
<td>Department of Community Services Programs</td>
<td>Eligible clients and their dependents in receipt of Income Assistance, any client and/or dependent having access to another drug plan, be it from a public or private entity, will be required to use that plan and will not be eligible for the Pharmacare program</td>
<td>None</td>
<td>None</td>
<td>All income assistance clients and dependents are required to co-pay a flat fee of $5.00 per prescription, unless the client or dependent is eligible for co-pay exemption</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Drug Assistance for Cancer Patients</td>
<td>Residents having a gross family income no greater than $15,720 per year, and not eligible for coverage under other drug programs</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Multiple Sclerosis Drug Funding Assistance</td>
<td>Residents who meet established MS criteria and who do not have other drug coverage</td>
<td>None</td>
<td>None</td>
<td>$9.35 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td>Province/ Territory</td>
<td>Program/Plan</td>
<td>Beneficiary</td>
<td>Premium</td>
<td>Deductible</td>
<td>Co-Pay</td>
<td>Maximum Annual Co-Pay</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------</td>
<td>-------------</td>
<td>---------</td>
<td>------------</td>
<td>--------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Nova Scotia (cont’d)</td>
<td>Diabetic Assistance Pharmacare Program</td>
<td>Residents aged under 65 with a valid Nova Scotia Health Card and who do not have drug coverage through Veterans Affairs Canada, First Nations and Inuit Health, or any private drug plans that cover diabetes supplies, that have a confirmed diagnosis of diabetes</td>
<td>None</td>
<td>Income-based</td>
<td>20% of the total prescription cost</td>
<td>N/A</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>Seniors Drug Cost Assistance Plan</td>
<td>Seniors 65 years of age or older and eligible for PEI Medicare</td>
<td>None</td>
<td>None</td>
<td>First $11.00 of the medication cost plus the pharmacy professional fee for each prescription</td>
<td>N/A</td>
</tr>
<tr>
<td>Financial Assistance Program</td>
<td>Persons whose eligibility is determined by the Social Assistance Act and Regulations</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Family Health Benefit Program</td>
<td>Families eligible for PEI Medicare, with one or more children under 18 years of age, a total annual net family income of $20,000 or less, and approved by the program</td>
<td>None</td>
<td>None</td>
<td>The pharmacy professional fee for each prescription</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Children-In-Care Program</td>
<td>Persons under 18 years of age in temporary or permanent custody of the Director of Child Welfare</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Province/Territory</td>
<td>Program/Plan</td>
<td>Beneficiary</td>
<td>Premium</td>
<td>Deductible</td>
<td>Co-Pay</td>
<td>Maximum Annual Co-Pay</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
<td>------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Prince Edward Island (cont’d)</td>
<td>Diabetes Control Program</td>
<td>Persons with diabetes eligible for PEI Medicare and who are registered with the program</td>
<td>None</td>
<td>None</td>
<td>Insulin: $10.00 per 10mL vial of insulin or box of 1.5 mL insulin cartridges; $20.00 per box of 3.0 mL insulin cartridges. Oral Medications and Urine Testing Materials: $11.00 per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Multiple Sclerosis Medications Program</td>
<td>Persons eligible for PEI Medicare, diagnosed with relapsing-remitting or secondary progressive multiple sclerosis, and approved by the program</td>
<td>None</td>
<td>None</td>
<td>Income tested copay plus the pharmacy professional fee for each prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Remicade and Enbrel Program</td>
<td>Persons eligible for PEI Medicare, diagnosed with severe Rheumatoid Arthritis or Crohn’s Disease, and approved by the program.</td>
<td>None</td>
<td>None</td>
<td>Income tested copay plus the pharmacy professional fee for each prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Sexually Transmitted Diseases (STD) Program</td>
<td>Persons diagnosed with sexually transmitted disease or identified contacts of a person with a sexually transmitted disease</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Nursing Home and Institutional Pharmacy Programs</td>
<td>Residents in government Manors and private nursing homes eligible for coverage under the Social Assistance Act and Regulations</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 10 (cont’d)—Comparison of Provincial and Territorial Drug Subsidy Programs as of December 2005

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Program/Plan</th>
<th>Beneficiary</th>
<th>Premium</th>
<th>Deductible</th>
<th>Co-Pay</th>
<th>Maximum Annual Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prince Edward Island (cont’d)</td>
<td>Disease Specific Programs (e.g. AIDS/HIV, Cystic Fibrosis, Growth Hormone, Hepatitis, and Transplant Drug Programs delivered through the Provincial Pharmacy)</td>
<td>Persons diagnosed with specific medical conditions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>The Senior Citizens Drug Subsidy Program</td>
<td>Seniors’ (65 and older) who are in receipt of the Guaranteed Income Supplement and who are registered for the Old Age Security benefits</td>
<td>None</td>
<td>None</td>
<td>Mark-up and Professional Fee for identified benefits</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>The Income Support Program</td>
<td>Residents of the province who qualify for full benefit coverage under the Department of Humans Resources and Employment</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residents who, due to the high cost of their medications, may qualify for drug card only benefits</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>The Special Needs Program</td>
<td>Residents patients with Cystic Fibrosis or Growth Hormone deficiency</td>
<td>None</td>
<td>None</td>
<td>None, for identified benefits</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 10 (cont’d)—Comparison of Provincial and Territorial Drug Subsidy Programs as of December 2005

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Program/Plan</th>
<th>Beneficiary</th>
<th>Premium</th>
<th>Deductible</th>
<th>Co-Pay</th>
<th>Maximum Annual Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yukon Territory</td>
<td>Pharmacare</td>
<td>Seniors 65 years of age or older (and seniors’ spouses aged 60 years and older) registered with Yukon Health Care Insurance Plan (YHCIP) and not having coverage through First Nations and Inuit Health. Program may also include clients receiving Palliative Care.</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Chronic Disease Program</td>
<td></td>
<td>Residents who have a chronic disease or a serious functional disability as provided under the Chronic Disease and Disability Benefits Regulations and not having coverage through First Nations and Inuit Health. (Residents must use private insurance plans first). Program may also include clients receiving Palliative Care.</td>
<td>None</td>
<td>Maximum $250 per individual and $500 per family (deductible may be waived depending on income)</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Children’s Drug and Optical Program</td>
<td></td>
<td>Children under the age of 19 years from low-income families and not having coverage through First Nations and Inuit Health.</td>
<td>None</td>
<td>Maximum $250.00 per child and $500.00 per family (deductible may be waived depending on income)</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Province/Territory</td>
<td>Program/Plan</td>
<td>Beneficiary</td>
<td>Premium</td>
<td>Deductible</td>
<td>Co-Pay</td>
<td>Maximum Annual Co-Pay</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
<td>------------</td>
<td>--------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>Extended Health Benefits Program for Specified Diseases</td>
<td>Resident, Non-Native or Metis and have a specified disease condition</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Senior’s Benefit Program</td>
<td>Metis and Non-Native residents who are 60 years of age and older</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Metis Health Benefits</td>
<td>Eligible Metis 59 years old and younger</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Indigent Health Benefits Program</td>
<td>Indigent individuals or families resident of the Northwest Territories, who meet the eligibility requirements according to the Indigent Health Benefits Policy</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Nunavut</td>
<td>Extended Health Benefits Program</td>
<td>All Metis and Non-Aboriginal residents, including Seniors’, who have a specific chronic condition or have reached the age of 60</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Indigent Health Benefits Program</td>
<td>All residents who do not have access to other programs</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>N/A</td>
</tr>
</tbody>
</table>
APPENDIX E  References and Internet Sources

National Web Sites

Health Canada / Santé Canada
http://www.hc-sc.gc.ca/

Canadian Institute for Health Information / Institut canadien d’information sur la santé
http://www.cihi.ca

Canadian Health Network / Réseau canadien de la santé
http://www.canadian-health-network.ca/

Canadian Institutes of Health Research / Instituts canadiens de la recherche de la santé
http://www.cihr.ca

Canadian Society for International Health / Société canadienne de la santé internationale
www.csih.org

Statistics Canada / Statistique Canada
www.statisticcanada.ca

Canadian Nurses Association / Association des infirmières et infirmiers du Canada
http://www.cna-nurses.ca/

Ontario Hospital Association
www.oha.ca

Provincial/Territorial Web Sites

Nunavut Ministry of Health & Social Services
http://www.gov.nu.ca/hss.htm

NWT Ministry of Health & Social Services
http://www.hlthss.gov.nt.ca/

Yukon Ministry of Health & Social Service
http://www.hss.gov.yk.ca/

British Columbia Ministry of Health and Ministry Responsible for Seniors
http://www.gov.bc.ca/healthservices/

Alberta Health & Wellness
http://www.health.gov.ab.ca/

Saskatchewan Health
http://www.health.gov.sk.ca/

Manitoba Health / Manitoba – Ministère de la Santé
http://www.gov.mb.ca/health/index.html

Ontario Ministry of Health and Long-Term Care / Ontario – Ministère de la santé et des soins de longue durée
http://www.health.gov.on.ca/

Québec Ministry of Health and Social Services / Québec – Ministère de la santé et des services sociaux
http://www.msss.gouv.qc.ca/

New Brunswick Ministry of Health and Community Services / Nouveau-Brunswick – Minitère de la santé et des services communautaires
http://www.gnb.ca/0051/

Nova Scotia Ministry of Health
http://www.gov.ns.ca/health/

Prince Edward Island

Newfoundland & Labrador Ministry of Health & Community Services
http://www.gov.nf.ca/health/

Newspapers

National Post
www.nationalpost.com

Toronto Star
www.torontostar.com

Globe and Mail
http://www.globeandmail.com/