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LEGISLATIVE SESSION – ESTIMATES NOTE

Canada Health Transfer and Bilateral Funding Agreements

Topic: Status of the Canada Health Transfer and other bilateral funding agreements, including the Working Together to Improve Health Care in Canada Agreement, Aging with Dignity Agreement, Drugs for Rare Diseases Agreement, and National Pharmacare Agreement.

Key Messaging and Recommended Response:

- Federal funding for health care is partially provided by the Canada Health Transfer, through which B.C. will receive $7.548 billion for 2025/26.
- In 2025/26, B.C. will receive approximately $697.6 million in federal funding through health bilateral agreements.
    - $407.3 million under the Working Together to Improve Health Care for Canadians Agreement;
    - $208.3 million under the Aging with Dignity Agreement (including $45.3 million from the Personal Support Workers Addendum); and
    - Approximately $64.6 million under the Drugs for Rare Diseases Agreement (final allocation to be calculated March 31, 2025).
    - $17.4 million under the Universal Access to Contraception and Diabetes Medications and Increased Access to Diabetes Devices and Supplies, Canada-British Columbia Funding Agreement (National Pharmacare Agreement).
- B.C. and Health Canada signed the Drugs for Rare Diseases bilateral agreement on July 12, 2024, which includes $194 million over three years.
- On March 6, 2025, B.C. and Health Canada signed a bilateral agreement for National Pharmacare, which includes federal funding for diabetes and contraception drugs in the amount of $17.4 million in 2025/26 and $204.9 million per year for three years starting April 1, 2026, until March 31, 2029. The agreement also includes a one-time payment in November 2026 of approximately $37.8 million for diabetes devices and supplies.
- As part of the bilateral agreement for National Pharmacare, B.C. will begin funding medications for menopausal symptoms on March 1, 2026.
- The Province is grateful for these contributions towards the health and wellbeing of British Columbians, however, the federal share of funding has not kept up with the increasing demands on BC's health care system.
- As our government continues to make historic investments in BC's health system, we will also continue our advocacy with Federal partners to catch up, and keep up, with future increases to the Canada Health Transfer.-

NOTE: COPIES OF THE BILATERAL AGREEMENTS ARE PROVIDED IN THE ASSOCIATE DM, HSO SUPPLEMENTAL BINDER.

CURRENT SITUATION

- Between October 2023 and March 2025, B.C. and Health Canada have signed the following bilateral federal funding agreements:
    - CAN-BC Agreement to Work Together to Improve Healthcare for Canadians (**Working Together Agreement**);
    - CAN-BC Aging with Dignity Funding Agreement (**Aging with Dignity Agreement**);
    - National Strategy for Drugs for Rare Diseases Initiative Funding Agreement (**Drugs for Rare**

Diseases Agreement); and
  - CAN-BC Universal Access to Contraception and Diabetes Medications and Increased Access to Diabetes Devices and Supplies Agreement (**National Pharmacare Agreement**).
- The **Working Together Agreement** was signed on October 10, 2023, and includes approximately $1.22 billion over three years, with approximately $407.3 million remaining for 2025-26. (See **Table 1** for funding details).
  - $82 million of the agreement funding targeted to mental health and addictions is drawn from the previously-announced Home and Community Care and Mental Health and Addictions Services (HCCMHAS) funding from 2017.
  - The remaining funding ($325 million) is targeted to supporting the health workforce, including the implementation of nurse patient ratios; addressing diagnostic and treatment backlogs; and/or assisting with modernizing health data systems.
  - Intergovernmental Communications

- The **Aging with Dignity Agreement** was signed on February 12, 2024, and includes $733 million over five years until March 31, 2028. This was followed by the Personal Support Worker (PSW) Addendum on July 22, 2024, which provides additional funding for B.C. of approximately $232.5 million over five years until March 31, 2029. (See **Table 2** for funding details).
  - Intergovernmental Communications

  - The Aging with Dignity funding is being used to expand home and community care services; improve long-term care (LTC), including through stronger oversight and reporting; and improve the availability and quality of dementia care, palliative care, and end-of-life care.
  - The PSW Addendum funding will allow B.C. to work towards a broader provincial compensation standard for health care assistants across all publicly funded LTC and assisted living facilities. This will further bolster and enhance LTC workforce stabilization initiatives included in the Aging with Dignity agreement and in B.C.'s Health Human Resources Strategy.
- The **Drugs for Rare Diseases Agreement** was signed on July 12, 2024, and includes $194 million over three years until March 31, 2027. B.C. has agreed to:
  - Improve patient access to drugs on the "common set," referring to a list of 12 drugs listed under the agreement. The full list of the "common set" of drugs is confidential until price negotiations are completed on a drug-by-drug basis, with five drugs from the "common set" now covered in B.C.
  - Improve access to other new or existing drugs for rare diseases.
  - Work towards improving screening and diagnostics for rare diseases.
- The **National Pharmacare Agreement** was signed on March 6, 2025, to improve access to prescription drugs through step-by-step implementation of a national universal pharmacare plan. The agreement includes $670 million over the four years, ending March 31, 2029. (See **Table 3** for funding details).
  - The $17.4 million in funding for 2025/26 and $204.9 million per year beginning in 2026/27 will support 100% coverage of diabetes and contraception drugs beginning March 1, 2026, improving coverage of diabetes drugs and transitioning B.C.'s existing 100%-paid BC PharmaCare coverage of contraception to federal funding.
  - Because B.C. has been a leading jurisdiction in the country for the coverage of contraception medication, with the receipt of federal funding for contraception, the province intends to repurpose existing provincial funding for contraception to provide free treatment of menopausal symptoms with hormone replacement therapy (HRT) beginning March 1, 2026.
  - B.C. will also receive a one-time payment in November 2026 of approximately $37.8 million for diabetes devices and supplies that can be spent over the agreement term. Expanded coverage of diabetes devices and supplies will follow B.C. PharmaCare policy and is planned to begin April 1, 2026, with details to be confirmed closer to that date.

- Further details regarding federal plans for the Indigenous Health Equity Fund are being communicated directly to Indigenous organizations by Indigenous Services Canada, including to the First Nations Health Authority, with limited information being shared by Health Canada.

FINANCIAL IMPLICATIONS

- The revenue assumptions for the Canada Health Transfer (CHT) and other health related federal government transfers total over **$8.246 billion** for 2025/26, which accounts for just over 24% of health spending. This includes the following incremental funding:[1]
  - $7.548 billion for the CHT.
  - $407.300 million for the Working Together agreement.
  - $208.300 million for the Aging with Dignity agreement.
  - $64.570 million for the Drugs for Rare Diseases agreement.
  - $17.407 million for the National Pharmacare agreement.
  - In 2024/25, HLTH received $7.6 million through the Workforce Development Agreement, which was signed by the Minister of Advanced Education, Skills, and Training. HLTH is expecting to receive more funding through the agreement in 2025/26, though the amount has not been confirmed as of March 19, 2025.
- Through the bilateral agreements, B.C. is expected to receive bilateral funding of over $2.000 billion between 2023/24 and 2028/29.
- **Table 1**, **Table 2, and Table 3** provide specific funding details on the Working Together, Aging with Dignity, and National Pharmacare Agreements. Future year funding for the Drugs for Rare Diseases agreement will be recalculated each year and a comparable table is not available. Annual funding amounts are expected to be approximately $64.570 million over the agreement term for Drugs for Rare Diseases.

KEY BACKGROUND

- Federal funding for health care is primarily provided through the CHT.
- Since 2017, the CHT growth rate/escalator has been based on Gross Domestic Product growth (with a floor of 3%).
- On February 7, 2023, Premiers were presented with a ten-year plan for federal health care spending (for 2023/24 through to 2032/33), which includes both adjustments and increases to the CHT, and $25 billion in funding through tailored bilateral agreements for all provinces and territories. Premiers accepted the offer on February 13, 2023, subject to final bilateral agreements.
- Over the 10-year period 2023/24 to 2032/33 for which the federal government has proposed changes, B.C.'s CHT funding is forecast to include growth of $21.158 billion under the existing formula, calculated against the 2022/23 funding.[2]

Working Together and Aging with Dignity Bilateral Agreements

- The Working Together and Aging with Dignity Agreements were part of a February 2023 federal funding announcement of $25 billion over 10 years (2023/24 to 2032/33), with funding on a "base plus" model with a minimum amount of funding based on jurisdiction size then the balance distributed across PTs on a per-capita basis.[3]
- The bilateral agreement funding incorporated the remaining four years of HCCMHAS funding.
  - The HCCMHAS 10--year Agreement started in 2017/18 and, in August 2021, B.C. and Canada agreed to amend the HCCMHAS to allow for a one-time payment of approximately $135 million in Safe Long-Term Care funding.[4]

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[1] Does not account for any funding carried forward from 2023/24 or incremental funding due to population adjustments.
[2] Government of Canada, February 7, 2023
[3] See "Provincial and Territorial Funding Allocation Table", Government of Canada, February 7, 2023. https://www.canada.ca/en/health-canada/news/2023/02/working-together-to-improve-health-care-for-canadians.html
[4] https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/home-community-care-mental-health-addictions-services-bilateral-agreements.html

  - The first five -year term of the HCCMHAS Agreement was set to expire on March 31, 2022. To ensure continuity of existing programs, Health Canada and PTs negotiated a one-year extension of the HCCMHAS, with $163.966 million in B.C. funding for 2022/23.
- The targeted funding will be used in some or all of the following priority areas:
  - Reducing backlogs and better support B.C.'s healthcare workers.
  - Modernizing how we track and report health data.
  - Improving access to mental health and addictions services.
  - Helping Canadians age with dignity through home and community health services.
  - Stabilizing the LTC and assisted living workforce.
- As part of the Agreements, B.C. is required to report on spending progress and key indicators outlined in the Action Plans.

Drugs for Rare Diseases Bilateral Agreement

- On March 22, 2023, the Government of Canada announced a total investment of up to $1.500 billion over three years to support the National Strategy for Drugs for Rare Diseases, which is aimed at increasing access to, and affordability of, effective drugs for rare diseases. As part of this overall investment, the Government of Canada made up to $1.400 billion available over three years to provinces and territories through bilateral agreements.
- The Drugs for Rare Diseases funding agreement identifies the new and emerging drugs that will be cost-shared under the agreement (known under the agreement as the "common set"). As part of the agreement, B.C. is required to keep the "common set" list of drugs confidential to maintain the integrity of the drug price negotiation and drug product listing agreement processes.
- A minimum of 50% of total federal funding allocated to B.C. in year three of the agreement (2026/27) must be used to enhance access to drugs on the "common set." In years one (2024/25) and two (2025/26) of the agreement, B.C. will have flexibility to use the funding toward improving access to both existing drugs and new and emerging drugs that are not on the "common set".
- In year three of the agreement, of the eligible expenditures related to the drugs on the "common set" incurred by B.C., the Province must pay a minimum of 10% from sources other than the DRD Funding Agreement, with the balance (up to 90%) eligible to be paid using the funds under the agreement.

National Pharmacare Agreement

- The funding is part of the federal government's broader work to provide coverage for select contraception and diabetes medications under the federal *Pharmacare Act*, passed October 10, 2024. In addition to providing access to a number of contraception and diabetes medications, the federal government has also established a fund for diabetes devices and supplies to help Canadians manage and monitor their diabetes and administer their medication.
- B.C. will receive federal funding in two streams:
  - Stream 1 will include funding allocations over four years to provide universal, single-payer, first-dollar coverage for the list of products for contraception and diabetes medication that are covered in B.C. and belong to categories identified in the agreement.
  - Stream 2 includes a one-time payment of $37.8 million in 2026/27 that can be spent throughout the term of the agreement, with B.C. intending to implement improved coverage for April 1, 2026. Stream 2 funding is provided to increase access by expanding coverage to support hybrid closed-loop blood glucose monitor and insulin delivery systems; to include lancets for diabetic use; and to include additional supplies for insulin pump and glucose monitor users, with all expanded coverage using existing coverage plans and adjudication rules.
- B.C. will then repurpose existing provincial funding for contraception to provide free treatment of menopausal symptoms with hormone replacement therapy (HRT) beginning March 1, 2026.

LEGISLATIVE SESSION – ESTIMATES NOTE

Table 1: Working Together Funding Allocation

Initiative ($ millions)	Incremental Investments		
	2023-24	2024-25	2025-26
Family Health Services			**N/A**
Health Workforce and Backlogs			
Implementation of transformative staffing model to better support nurses and patients.	200.0	250.0	300.0
Create incentive programs to support recruitment and retention of healthcare workers.	18.0	-	-
Improve outcomes for patients by addressing diagnostic and treatment backlogs and reducing pressure on acute care services.	78.0	45.0	0.0
Total	**296.0**	**295.0**	**300.0**
Mental Health and Substance use			
Strengthen the capacity of primary care to respond to mental health and addictions, with a focus on prevention/early intervention and children/youth.	23.0	23.0	22.0
Expand access to culturally safer and trauma informed mental health and addictions services for Indigenous communities.	14.0	14.0	15.0
Improve seamlessness across systems of care so that people can ask once and get help fast.	11.0	11.0	11.0
Increase access for students to mental health and addictions prevention and early intervention services.	4.0	4.0	4.0
Expand access to evidence-based prevention, early intervention, treatment, and recovery options for vulnerable populations.	30.0	30.0	30.0
Total	**82.0**	**82.0**	**82.0**
Modernizing Health Systems			
Modernizing health data systems to support the full continuum of care and empower patients to engage in their health care.	29.3	30.3	25.3
Total	**29.3**	**30.3**	**25.3**
Total Funding Available	**407.3**	**407.3**	**407.3**

Table 2: Actual Funding Allocations Based on Signed Aging with Dignity Agreement and PSW Addendum

Initiative ($ millions)[5]	Incremental Investments						
	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	Total
Incremental Funding	163	207	208	209	129	49	965
Total Available with Carry Forward	*163*	*296*	*294*	*268*	*158*	*49*	*N/A[6]*
Home and Community Care Planned Expenditure	74	90	82	82	N/A	N/A	328
Long-term Care Planned Expenditure	-	76	108	111	110	N/A	405
Personal Support Workers	-	44	45	46	48	49	232
Total Planned Carry Forward into Next Fiscal Year	*89*	*86*	*59*	*29*	-	-	*N/A[6]*

Table 3: Funding Allocations based on signed National Pharmacare Agreement

Funding Streams	Federal Financial Contributions				
	2025-26	2026-27	2027-28	2028-29	Total
Stream 1	17.4	204.9	204.9	204.9	632.1
Stream 2	N/A	37.8	N/A	N/A	37.8
Total	17.4	242.7	204.9	204.9	669.9

LAST UPDATED

The content of this estimates note is current as of March 19, 2025, as confirmed by Darlene Therrien.

APPROVALS

March 19, 2025 – Rob Byers, Finance and Corporate Services Division
March 19, 2025 - Darlene Therrien, Intergovernmental Relations

[5] B.C.'s published Aging with Dignity Action Plan shows that for Personal Support Workers, B.C. would spend $5.000 million in 2024/25 and carry forward the remaining $39.200 million of the 2024/25 allocation into 2025/26. Subsequently, pursuant to the spending plan approved by Treasury Board, B.C.'s revised plan was to spend the full $44.200 million allocation in 2024/25. To reflect this change, for Personal Support Workers this table then shows the Total Available Funding per year as published in Table 2 of Annex 4 of the amended agreement.

[6] The total amount is not included as it would result in double counting.

LEGISLATIVE SESSION – ESTIMATES NOTE
In Plain Sight Report Recommendations – Implementation

Topic: The report 'In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health Care' (IPS) was released publicly on November 30, 2020, identifying 24 recommendations to address systemic Indigenous-specific racism in the health system[1].

Key Messaging and Recommended Response:

- Everyone in British Columbia deserves to feel safe and supported when accessing health services.
- Indigenous health concerns and experiences of racism in the health system continue to be reported as a barrier to accessing care in B.C.
- That's why the ministry commissioned and completed the In Plain Sight report to address Indigenous-specific racism and discrimination in health care, in June 2020.
- Since the report's release in November 2020, the 24 recommendations to address systemic Indigenous-specific racism have been accepted and most of the deliverables and milestones have completed the initiation stage.
    - In addition: 5 new Indigenous health liaison positions have been funded in each health authority with 2 additional positions at Providence Health Care, for a total of 32 net new positions.
    - Medical bylaws are under review by the Ministry, and revisions will be implemented collaboratively, for consistent cultural safety and humility standards for medical staff privileges.
    - The implementation of the Anti-Racism Act, introduced in 2024, holds public bodies accountable for addressing systemic racism in policy and programs.
    - We remain dedicated to ending Indigenous-specific racism and discrimination, and improving cultural safety and quality of care for Indigenous Peoples throughout the province.
- Our government is working in partnership with Indigenous health service organizations to transform how the health system serves Indigenous Peoples in B.C. by addressing critical gaps in the provision of culturally safe, inclusive health care.

CURRENT SITUATION

Recommendation #1

- The Minister of Health issued an apology statement to Indigenous people on November 30, 2020. On December 1, 2020, a joint written apology on behalf of all Board Chairs and CEOs from the health authorities was issued. On May 11, 2021, written apologies were also issued by the BC College of Nurses and Midwives, the College of Physicians and Surgeons of BC, the College of Dental Surgeons of BC, and the College of Pharmacists of BC.
- In 2022-2025 collective agreements, health employers and health sector unions and bargaining associations agreed to a new Memorandum of Agreement (MOA) acknowledging the pervasive harms of colonialism faced by Indigenous peoples and committed to working together to take a comprehensive system-wide approach to confronting Indigenous specific-racism and cultural safety.
- A provincial Indigenous-specific anti-racism (ISAR) forum with the health sector unions as well as a physician-specific committee on ISAR and cultural safety and humility (CSH) has been established and the next round of collective bargaining begins in February 2025.

Recommendation #2

- The ***Health Professions and Occupations Act*** passed royal assent on November 22, 2022, and in June 2024, a new independent Superintendent position has been created to provide oversight to the regulatory colleges. The position is currently filled.
- On June 2, 2022, the ***Anti-Racism Data Act*** **(ARDA)** became law in BC.

[1] https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report-2020.pdf.

- In Summer 2023, the Ministry of Attorney General conducted community-led public engagement sessions for the ***Anti-Racism Act***. In March 2024, the Anti-Racism Legislation Community Engagement Report was released, summarizing engagement feedback. The *Anti-Racism Act* passed committee stage on May 9, 2024.
- 2021 – ***Human Rights Code*** amended to include Indigenous identity as a ground for discrimination.
- The ***Public Interest Disclosure Act*** became applicable to all health authorities on June 1, 2023, supporting whistleblower protections and a "Speak Up Culture". Health authorities are instituting appropriate policies or procedures to support application and implementation of the Act.

Recommendation #5

- In October 2022, Health Quality BC (HQBC) hosted a workshop and public lecture on restorative processes in quality improvement and complaints-focused learning, which resulted in a collaborative 'Restorative Circle' working group. The Circle hosted a Leadership Symposium in November 2023 to advance structural changes to BC's patient care and quality processes.
- HQBC in partnership with the In Plain Sight Task Team published the "Sharing Concerns: Principles to Guide the Development of an Indigenous Patient Feedback Process." This publication identifies core principles of a safe, accessible, and meaningful patients' complaint process. Final revisions are underway for an updated "Sharing Concerns 2024".
- Fraser Health, in collaboration with the Ministry of Health, First Nations Health Authority, Métis Nation BC, and other regional health system partners, have worked in partnership to develop a draft blueprint for gathering Indigenous feedback and complaints, entitled Xwélalà:m Xwelá Ye Xwexwílmexw (Listening to Indigenous Peoples). The draft blueprint serves to advance the patient feedback systems with a comprehensive, culturally safe process with clear accountability and is governed by Indigenous leadership and health authority board executive.
- The draft Blueprint was approved in principle by the former Minister of Health in September 2024 in support of the continued work to draft a comprehensive implementation plan to deliver and embed the new Indigenous feedback process in Fraser Health Authority.

Recommendations #6, #17 – The signatories to the 2018 Memorandum of Understanding: Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness have extended the implementation period to April 2, 2025, and are collaborating on a plan to implement the 10 Year Strategy on the Social Determinants of Health.

Recommendation #7 – Métis Nation BC (MNBC) and the Ministry have bi-monthly bilateral meetings. A Health, Mental Health, and Harm Reduction Table has been established between MNBC, MoH, MHA, and MIRR to support the implementation of In Plain Sight as well as the Ministry's DRIPA Action Plan commitments. MNBC has signed Letters of Understanding with all six provincial health authorities. The renewed Fraser Partnership Accord, signed on February 1, 2024, for the first time included MNBC as a signatory. This marked a renewed commitment with the Fraser Salish Regional Caucus, Fraser Health, Ministry of Health and, for the first time, Métis Nation BC to improve health outcomes for Indigenous Peoples in the region.

Recommendation #8 The HSO (Health Standards Organization) BC Cultural Safety and Humility Standard was published in June 2022, co-developed with the First Nations Health Authority (FNHA). The CSH Standard is currently being used to help guide health system organizations as they work towards improved cultural safety and humility, with the intent that this standard will subsequently become part of the suite of standards that Accreditation Canada uses to assess and accredit health care organizations. In January 2023, the Ministry of Health established an internal working group to develop an implementation approach for operationalizing the Cultural Safety and Humility Standard within the Ministry and have begun to embed elements of the standard in the Ministry's strategic plan. Work continues to hardwire cultural safety and humility across the Ministry as a key organization in the provincial health system.

Recommendation #9

- The Tripartite Data Quality & Sharing Agreement (TDQSA) will be extended through October 2024 and FNHA and the Ministry are collaborating on the development of a new agreement to replace the TDQSA, in alignment with DRIPA.
- A provincial Indigenous Cultural Safety Measurement working group (ICSWG) has been established to improve data sharing across the system, determine a balanced indicator set to measure cultural safety across the system, and develop a standardized systemic performance monitoring dashboard.
    - Given the endorsement of the working group to leverage the Canadian Institute for Health Information Measuring Cultural safety in Health Systems[2], significant progress in advancing the goal of defining a

[2] https://www.cihi.ca/sites/default/files/document/measuring-cultural-safety-in-health-systems-report-en.pdf

framework for measuring cultural safety across the province. A final draft report is currently being reviewed by partners to bring to the VPs of Indigenous Health, then to the Ministry for endorsement.

Recommendation #13 - In January 2021, the role of Associate Deputy Minister of Indigenous Health and Reconciliation was created to lead the implementation of the recommendations in collaboration with Indigenous, health system, and provincial ministry partners. This was the first time an Indigenous person had been appointed as an Associate Deputy Minister in the BC public service. The role is currently filled.

Recommendation #14 - All health authorities have at least 2 Indigenous Board members and each, including PHSA and Providence Health Care, have established and filled Vice President, Indigenous Health leadership positions and have built up Indigenous health and cultural safety teams. Through the Ministry's collaboration with the VPs of Indigenous Health, BC's Health Human Resources Strategy (HHR) includes targeted strategies to support and protect Indigenous people as both patients and providers, with the goal of eliminating Indigenous-specific racism. The HHR strategy is taking action to increase the representation of Indigenous health workers in health care a core action underway is to develop a provincial Indigenous-specific recruitment strategy.

Recommendation #15 – As part of the established response to the COVID-19 pandemic, the collaboratively developed *Rural, Remote, First Nations, and Indigenous COVID-19 Response Framework* continues to support medical transportation and ambulance services for communities.

Recommendations #18, 20, 21, 22 and 23

- The Ministry of Health is working with the Ministry of Advanced Education and Skills Training (AEST) on a collaborative process to advance implementation of the recommendations specific to post-secondary education institutions.
- In March 2023, Health Quality BC and the MoH hosted a provincial dialogue on cultural safety and humility training and education to develop a guide with standardized learning expectations and outcomes at a provincial level. This guide is currently being reviewed by the VPs of Indigenous health and will be brought forward for endorsement by the Ministry in early 2025.
    - A draft of the Cultural Safety and Indigenous-specific Anti-Racism Education and Training Framework is complete. A 'calibration tool' was developed to aid the implementation of the Framework, with specific criteria and measures designed to support the development and review of curricula.
    - Through use of the 'calibration tool' three health authorities are piloting the Framework in a review of their training programs: Island Health, Northern Health, and Provincial Health Services Authority, the latter of which has put forward both their internal Anti-Racism Response training program and all three levels of San'yas ICS training. This process is intended to assess each program against its own stated goals, while also providing feedback on the Framework and calibration tool for further application across the health system.
- A new medical school is being established at SFU and curriculum will be designed to embed and equalize Indigenous knowledge systems.

Recommendation #19 - The Ministry provided $0.550 million in 2021/22 for 5 years of support to the National Collaborating Center for Indigenous Health (NCCIH) as a centre for anti-racism, cultural safety and trauma-informed standards, policy, tools, and leading practices. Approximately twelve tools and resources have been developed to support health authorities and organizations to better understand and to implement the BC Cultural Safety and Humility Standard, including: a framework to guide cultural safety measurement, an environmental scan of cultural safety resources and initiatives in BC, and a series of tools (videos, podcasts, and a webinar) to support learning, self-reflection, and action. The current agreement with NCCIH is being extended in duration to provide time for NCCIH to conclude some of the funded initiatives.

Recommendation #24 - A Task Team was formed and launched on May 12, 2021, with MNBC, FNHA, First Nations Health Council, First Nations Leadership Council, and system partners who hold expertise in the BC health care system, cultural safety and humility, experience with Indigenous engagement, and addressing Indigenous-specific anti-racism. The task team's mandate was for a minimum 24-month term. The Task Team concluded on June 27, 2023, and a full report on progress towards implementation of the 24 recommendations was released in October 2023. Monitoring progress towards full implementation of the IPS recommendations will now happen under the Declaration Act Action Plan, which includes annual progress reporting to ensure accountability for this work going forward.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- Budget 2021 provided $15 million annually to support the work of the In Plain Sight Task Team, culturally safe health services and more Indigenous liaisons in each regional health authority to improve health access and services for Indigenous peoples.

KEY BACKGROUND

- In June 2020, the Minister of Health commissioned an independent review into allegations of racism in the BC emergency department setting, as well as the broader health system. The review concluded with both a full and summary report in November 2020, and a data report released in February 2021.
- Additional steps taken, in alignment with IPS and provincial response, included:
    - 5 new Indigenous health liaison positions funded in each HA with 2 additional positions at Providence Health Care, for a total of 32 net new positions.
    - Medical bylaws are under review by the Ministry, and revisions will be implemented collaboratively, for consistent cultural safety and humility standards for medical staff privileges.
- The independent review toll-free number and email address had been transferred to the Office of the Ombudsperson and maintained as a reporting resource while processes for effective system complaints processes were strengthened. In December 2024, the phone line was transitioned to the Ministry with plans to work with the Anti-Racism Branch to align the resource with the provincial approach to anti-racism under the *Anti-Racism Act*.

LAST UPDATED

The content of this estimates note is current as of February 11, 2025, as confirmed by Dillon Halter, Executive Director, Indigenous Health and Reconciliation Division.

APPROVALS

March 4, 2025, Diana Clarke, Assoc. DM, Indigenous Health and Reconciliation
February 26, 2025, Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services

LEGISLATIVE SESSION – ESTIMATES NOTE

Title: Indigenous Health Funding

Topic: The Ministry provides annual funding to health authorities, the First Nations Health Authority (FNHA), the BC Association of Aboriginal Friendship Centres (BCAAFC), and Métis Nation BC (MNBC) to support the advancement of Indigenous health and wellness initiatives.

Key Messaging and Recommended Response[1]:

- Government is committed to addressing and eliminating Indigenous-specific racism in health care and acknowledges that Indigenous health concerns and experiences of racism continue to be reported as a barrier to accessing care in B.C. That's why the Ministry of Health continues to invest in, and support a range of Indigenous led, culturally safe health and wellness initiatives, including:
    - Annual funding to health authorities, the First Nations Health Authority, BC Association of Aboriginal Friendship Centres and Métis Nation BC;
    - A commitment to open 15 First Nations-led primary care centres throughout B.C., with two open and the remaining 13 in various stages of planning, implementation and completion;
    - Renovating six and building two new First Nations-run treatment centres;
    - Establishing additional Indigenous patient support positions, Indigenous patient navigators and cultural competency training; and
    - Supporting virtual care through the First Nations Health Authority's First Nations Virtual Doctor of the Day, and Virtual Substance Use and Psychiatry Service.
- We will continue to invest in the time and collaborative work needed to help improve health outcomes for Indigenous Peoples throughout B.C.

CURRENT SITUATION

Health Authorities

$10.4 million annual base funding was allocated to health authorities ($4.9 million beginning in 2020/21 and $5.5 million beginning in 2021/22) for priorities aligned with the IPS Sight recommendations including: 1) Indigenous recruitment and retention, 2) improving the complaints system, 3) furthering Cultural Safety and Humility and, 4) an additional 32 Indigenous Health Liaison positions.

First Nations Health Authority (FNHA)

- The Ministry supported the *Tripartite Framework Agreement on First Nations Health Governance* (2011) with contributions to FNHA of $100 million from 2006/07 - 2019/20. The Ministry provided $33 million ($11M per year) in supplemental funding from 2020/21 through 2022/23 to further support the FNHA for costs related to the Rural Remote Collaborative Framework.
- The Ministry commits $15.33 million annually to support 27 Nation-based projects through a Joint Ministry-FNHA Project/Priorities Board.
- Action 6 of B.C.'s HHR Strategy expanded prototype rural retention incentives in Northern, Interior, and Island Health and the Ministry has also included eligible FNHA employees in the program for 2023/24. Total costs for FNHA employees are estimated between $1M and $1.3M.
- The FNHA funding letter supports the partners' annual Letter of Mutual Accountability (LMA). The Ministry and FNHA will be exploring development of a new LMA for 2025/26.
- The Ministry provided $2.74 million to FNHA in 2024/25 for virtual physician services, including the Virtual Doctor of the Day, and the Virtual Substance Use and Psychiatry Services programs.

1 First Nations Primary Care Centres information as perhttps://www.fnha.ca/about/news-and-events/news/improved-access-to-first-nations-led-primary-care-on-the-way-to-communities-province-wide retrieved February 23, 2025.

- For 2024/25, the Ministry provided $63.733 million dollars in base funding including: 1) Climate Preparedness and Adaption Strategy, 2) Cultural Safety and Humility, 3) Health Human Resources Strategy, 4) Mental Health and Addictions Services, 5) Primary Care Strategy, 6) Shared Recovery Mandate and, 7) Traditional Healing and Wellness.
- In 2024/25, the Ministry provided $1.0 million in funding to support the Cancer Care Action Plan, and $0.1 million to support strategic Innovation Pathway development.
- BC Association of Aboriginal Friendship Centres (BCAAFC)
- The Ministry provides BCAAFC with a grant of $0.25 million to support projects and initiatives benefiting urban and off-reserve Indigenous populations.
- Métis Nation BC (MNBC)
- The Ministry provides MNBC with an annual $0.825 million grant through 2024/25 to support health and wellness initiatives benefiting Métis peoples and communities in BC including partnership development, supporting the Métis Public Health Surveillance Program, facilitating Métis participation across the spectrum of Indigenous engagement, working relationships with health partners, and collaboration on implementing In Plain Sight recommendations.
- The Ministry provided MNBC with a $1 million one-time grant in 2022/23 to support the development of a Métis Health and Wellness Strategy and Plan to advance Métis health and wellness priorities and support collaboration with the Province on the DRIPA Action Plan.
- National Collaborating Centre for Indigenous Health (NCCIH)
- $0.550 million in 2020/21 to support NCCIH's work with health system partners to develop tools, strategies, training, and resources to enhance culturally safe service delivery practices across the BC health system. Support for the NCCIH aligns with Rec. #19 from the IPS report.
- $1.050 million in 2021/22 to NCCIH through the University of Northern BC to work with health authorities and health system partners to advance initiatives related to the Cultural Safety and Humility standard, Indigenous Cultural Safety measurement, and education and training. The current agreement expires March 31, 2025 and NCCIH has requested an extension in time to conclude the initiatives.
- Memorandum of Understanding on the Determinants of Health and Wellness
- The 2018 tripartite MoU – Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness (2018 MoU) provides provincial support through the Ministry, MMHA, Children and Family Development (MCFD), and Indigenous Relations and Reconciliation (MIRR).
- BC provided $10 million ($5 million/year for 2018/19 and 2019/20) through the 2018 MoU as part of the tripartite commitment to support planning and implementation of Nation-based plans and initiatives.
- In 2019, the Province provided $20 million (matched by FNHA) to build and revitalize First Nations treatment centres across the Province. Federal Budget 2021 provided an additional $20 million from the Government of Canada to support this initiative, for a final tripartite allocation of $60 million.2
    - As of February 2025, one centre is open (Tsow-Tun-Le-Lum Society Helping House on Vancouver Island), and four centres are in the construction phase including the recent groundbreaking for the Seven Nations Soaring Eagle Centre in the Interior.
    - The treatment centres will support up 131 mental health and substance use treatment beds.
- The 10-Year Strategy on the Social Determinants of Health was approved at Gathering Wisdom XII (2023) with four key priorities: Healing approaches; Cultural Infrastructure; Nation-Based Governance; and Sustainable Funding.
- The 10-Year Strategy draft implementation plan calls for $5 million/year from each of the tripartite partners to directly support Nations in meeting local social determinants-related needs and priorities. The former Ministry of Mental Health and Addictions (MMHA), now the Mental Health Portfolio in the Ministry of Health, secured the first two years of funding through its Indigenous Fund of $5 million/year in 2024/25-2025/26 as the provincial allocation for this initiative.

[2] Indigenous Services Canada. (2021, August 14). *Government of Canada highlights funding for Indigenous communities to support critical infrastructure*. Retrieved February 5, 2025, from: https://www.canada.ca/en/indigenous-services-canada/news/2021/08/government-of-canada-highlights-funding-for-indigenous-communities-to-support-critical-infrastructure.html

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- In 2024/25, the Ministry committed the following funding as identified above to support Indigenous Health.
    - $98.153 million to FNHA, with an additional $104.273 million in deferred contributions, for total available funding of $202.426 million.
    - $0.2 million to the BC Association of Aboriginal Friendship Centres.
    - $0.825 million to Métis Nation BC.

KEY BACKGROUND

- The Ministry provides ongoing financial supports for Indigenous-specific health and wellness initiatives through mandated Ministry service planning and for prior obligations, including:
    - Funding to health authorities/other organizations for Indigenous health services and initiatives.
    - Implementation of the In Plain Sight (IPS) recommendations and collaboration on the Declaration on the Rights of Indigenous Peoples Act (DRIPA) Action Plan.

LAST UPDATED

The content of this estimates note is current as of February 11, 2025, as confirmed by ED Dillon Halter.

APPROVALS

2025 03 21 – Associate DM, Diana Clarke, Indigenous Health and Reconciliation Division
2025 02 23 – Health Sector Information, Analysis & Reporting Division
2025 03 04 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Ministry Declaration Act Action Plan Commitments

Topic: The Declaration Act Action Plan (2022-2027) outlines significant actions the province will undertake over five years to achieve the objectives of the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) in consultation and cooperation with Indigenous Peoples. The Ministry is responsible for 10 health-specific actions, leading 8, and supporting 2.

Key Messaging and Recommended Response:

- BC is the first jurisdiction in Canada to have passed legislation to formally adopt the internationally recognized standards of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).
- BC passed the Declaration on the Rights of Indigenous Peoples Act (DRIPA) in November 2019 to establish UNDRIP as a framework for true and lasting reconciliation as per the Truth and Reconciliation Commission of Canada.
- Following two years of intensive engagement to ensure it aligned with the priorities of Indigenous Peoples in BC, the DRIPA Action Plan was developed to achieve the objectives of the UNDRIP in consultation and co-operation with Indigenous Peoples.
- The first of its kind, the DRIPA Action Plan (2022-2027) was released in March 2022, with a five-year timeline and includes 89 tangible, achievable actions in the areas of self-determination and self-government, rights and title, ending anti-Indigenous racism, and enhancing social, cultural and economic well-being.
- Eight actions are being led by multiple divisions within the Ministry, including Mental Health and Addictions, Primary Care, and Indigenous Health and Reconciliation. The Ministry is supporting two actions with the Ministry of Public Safety and Solicitor General.
- The health-specific actions aim to enhance access to care, improve cultural safety and quality of health and mental health services, address Indigenous-specific racism, and support Indigenous-led initiatives.
- Through this work, B.C. is building a province where Indigenous Peoples' excellence, leadership, governance, and self-determination is recognized and respected.
- Our ongoing work seeks to address those inequities and support the health and well-being of Indigenous Peoples. Reconciliation is a shared responsibility, and when we all do our part, we all feel the benefits.

CURRENT SITUATION

- Section 5 of the Declaration on the Rights of Indigenous Peoples Act requires an annual report on progress made towards the alignment of provincial laws with the United Nations Declaration on the Rights of Indigenous Peoples and the implementation of the Declaration Act, all to be done in consultation and co-operation with Indigenous Peoples.
    - The 2022/23 Declaration Act Annual Report was delivered through a digital first approach and reflected partnership with Indigenous leaders, experts and artists, and was responsive to feedback from Indigenous leaders for reporting that is more accessible, accountable, transparent, co-operative and impactful.
    - The 2023-24 Declaration Act Annual Report[1] details progress made on 60 actions that demonstrated substantial progress or were completed in the first two years of the Declaration Act Action Plan, as well as work to align provincial laws.

[1] https://declaration.gov.bc.ca/annual-report/

- The 2024/25 Declaration Act Annual Report (Year 3) is currently in development and will be publicly released by June 30th, 2025.
- The following DRIPA Action Plan actions are being led by the Ministry of Health. Several actions were led or supported by the former Ministry of Mental Health and Addictions, now part of the Ministry of Health as the new Mental Health and Addictions Portfolio (MHA). Ministry divisions leading or supporting health-specific actions are noted (*lead; support*):
    - **3.7** - Implement recommendations made in the In Plain Sight: Addressing Indigenous-specific racism and discrimination in B.C. health care report, striving to establish a health care system in BC that is culturally safe and free of Indigenous-specific racism (*Indigenous Health and Reconciliation – IHR*).
    - **4.7** - Demonstrate a new and more flexible funding model and partnership approach that supports First Nations to plan, design and deliver mental health and wellness services across a full continuum of care and to address the social determinants of health and wellness (*IHR; MHA*).
    - **4.8** - In alignment with the tripartite health plans and agreements, continue to strengthen and evolve the First Nation health governance structure in BC to ensure First Nations are supported to participate as full and equal partners in decision-making and service delivery at local, regional, and provincial levels, and engage First Nations and the Government of Canada on the need for legislation as envisioned in the tripartite health plans and agreements (*IHR; MHA*).
    - **4.10** - Prioritize the implementation of Primary Care Networks, the First Nations-led Primary Health Care Initiative, and other primary care priorities, embedding Indigenous perspectives and priorities into models of care to increase Indigenous Peoples' access to primary care and other health services, and to improve cultural safety and quality of care (*Primary Care Division [PCD]*).
    - **4.12** - Address the disproportionate impacts of the overdose public health emergency on Indigenous Peoples by: applying to the Government of Canada to decriminalize simple possession of small amounts of illicit drugs for personal use, and continuing campaigns and other measures to help end the stigma and shame associated with addiction; expanding prescribed safer supply and other harm reduction measures; and ensuring accessibility of recovery beds, and evidence-based, culturally relevant and safe services to meet the needs of Indigenous Peoples, including youth (*MHA; Ministry of Public Safety and Solicitor General [PSSG] and Attorney General [AG]*).
    - **4.13** - Increase the availability and accessibility of culturally safe substance use services, including through the renovation and construction of Indigenous-run treatment centres and the integration of land based and traditional approaches to healing (*MHA; IHR*).
    - **4.14** - Increase the availability and accessibility of resources to Indigenous partners in COVID-19 pandemic health and wellness planning and response, including the implementation of the Rural, Remote, First Nations and Indigenous COVID-19 Framework[2] to ensure access for all Indigenous Peoples to immediate and culturally safe and relevant care closer to home (*PCD; MHA*).
    - **4.26** - Strengthen the health and wellness partnership between Métis Nation BC, the Ministry of Health and the Ministry of Mental Health and Addictions, and support opportunities to identify and work to address shared Métis health and wellness priorities. *(IHR; MHA)*.
- The Ministry is a supporting partner for the following actions being led by PSSG:
    - **3.11** - Develop and implement comprehensive policing reforms to address systemic biases and racism. This will include: updating the Police Act, BC Provincial Policing Standards and mandatory training requirements; enhancing independent oversight; clarifying the roles and responsibilities of police officers in the context of complex social issues such as mental health, addiction and homelessness; and contributing to the modernization of the federal First Nations Policing Program (*PSSG; MHA and AG*).
    - **4.11** - Increase the availability, accessibility and the continuum of Indigenous-led and community-based social services and supports that are trauma-informed, culturally safe and relevant, and address a range of wholistic wellness needs for those who are in crisis, at-risk or have experienced violence, trauma and/or significant loss (*PSSG; MHA and IHR*).

[2] https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/emergency-preparedness-response-recovery/gdx/rural-and-remote-covid-19- response-framework.pdf

- The Declaration Act Engagement Fund (DAEF) program was announced in July 2023. To reduce barriers for First Nations to fully participate in implementing UNDRIP, the Province has dedicated $200 million in funding and partnered with the New Relationship Trust to administer the Fund.
    - Declaration Act Engagement Fund (DAEF) provides multi-year (4 year) non-repayable funding contributions to First Nations to support their capacity to engage with the Province of B.C. on the implementation of the DRIPA Action Plan and alignment of Provincial laws with UNDRIP. DAEF reflects a significant shift in how engagement funding is provided, as First Nations are able to self-determine their engagement priorities based on their distinct needs and interests.
    - To date, there are 131 government-to-government engagement interests from 34 BC First Nations for the 10 DRIPA health-specific actions, as many Nations expressed interest in multiple actions.
- The Declaration Act Secretariat is working on Consultation and Cooperation Guidance for government which will inform the Ministry's consultation and cooperation approaches on DRIPA Action implementation.

FINANCIAL IMPLICATIONS

- Financial implications for specific actions (e.g., implementing In Plain Sight recommendations) are detailed in the Indigenous Health Funding Fact Sheet.

KEY BACKGROUND

- The Ministry is a party to several commitments, partnerships and activities that support the achievement of elements of the DRIPA Action Plan:
    - The renewed Métis Nation Relationship Accord (2016).
    - Collaborative implementation of the British Columbia *Tripartite Framework Agreement on First Nations Health Governance* (2011).
    - 2015 *Protocol on the Social Determinants of Health* with the First Nations Leadership Council.
    - 2015 *Declaration of Commitment to Cultural Safety and Humility in Health Services.*
    - 2016 bilateral Memorandum of Understanding – *A Regional Engagement Process and Partnership to Develop a Shared Ten-Year Social Determinants Strategy for First Nation Peoples in BC*.
    - 2018 Tripartite MoU – *Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness,* supporting community-driven, Nation-based initiatives to improve mental health and wellness.
    - Aligning B.C.'s Health Human Resources Strategy (HHR) with UNDRIP, the Declaration Act, IPS and B.C.'s Cultural Safety and Cultural Humility Standard. This includes the following HHR strategic actions:
        - Action 10 - Provincial Organizational Standard for Cultural Safety and Cultural Humility
        - Action 11 - Indigenous Employee Experience Advisors and Development Funding
        - Action 45 - Indigenous Leader Recruitment and Support Initiative
        - Action 46 - Indigenous-Specific Recruitment Strategy
        - Action 54 - Cultural Safety and Humility Training Expansion
        - Action 66 - Master of Nursing in Indigenous Health Implementation

LAST UPDATED

The content of this estimates note is current as of February 11, 2025, as confirmed by Dillon Halter, Executive Director, Indigenous Health and Reconciliation.

APPROVALS

2025 02 14 – Diana Clarke, Associate Deputy Minister, Indigenous Health and Reconciliation Division
2025 02 21 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Decision

LEGISLATIVE SESSION – ESTIMATES NOTE

2025/26 to 2027/28 Ministry of Health Service Plan Overview

Topic: The Ministry of Health 2025/26 – 2027/28 Service Plan makes public the Ministry's goals, objectives, and performance targets for the three-year period, and includes the Ministry's financial information as required under the Budget Transparency and Accountability Act.

Key Messaging and Recommended Response:

- In BC, and around the world, health system pressures are increasing and becoming more complex, which is putting additional strain on the health system.
- That is why we lay out our service plan and set specific objectives and performance targets to ensure we're focused on making a difference throughout B.C. towards our goal of strengthening the health care system.
- We know we're making progress. For example, we are tracking improvements in a variety of areas people can see and feel, including:
  - Increasing the numbers of people attached to a primary care provider
  - Increasing ambulance in-service hours throughout the province
  - Increasing the total number of operating room hours and overall number of surgeries performed in BC
  - Shorting the waits between client referral and accessing service for community bed-based treatment and recovery services
- While we have more work to do, these are just some of the areas making progress throughout the health sector in our province.

CURRENT SITUATION

- The 2025/26 Ministry Service Plan was tabled on Budget Day, March 4, 2025.

KEY BACKGROUND

- The Ministry service plan is intended to provide the public a high-level overview of the Ministry's purpose, strategic direction, key priorities, and the results it expects to achieve with the use of its financial resources.
- The 2025/26 Ministry of Health Service Plan reflects government's strategic direction, and the integration of the mental health and addictions programs from the former Ministry of Mental Health and Addictions (MMHA).
- This years' plan outlines the Ministry's priorities, and highlights work underway that supports the new Minister's Mandate Letter of January 16, 2025.
- The following performance measure (PM) changes are included:
  - A new primary care PM (1a), which considers the current Longitudinal Family Physician (LFP) payment model, while reflecting the Mandate Letter deliverable of primary care for all;
  - Updated targets for the inappropriate use of antipsychotics PM (1b), to set attainable targets with consideration of evolving resident complexity and rising rates of dementia;
  - Removed *Number of people admitted to hospital for a chronic disease per 100,000 people aged 75 years and older* as a PM, as targets were consistently surpassed;
  - Two new performance measures from MMHA's service plan (1c and 1d);
  - Updated targets for the nursing overtime hours PM (3a) to set attainable targets with consideration of the HHR challenges, and
  - Updated methodology for the patient portal registrations PM (3b), to enable a stable measurement of progress.
- This years' Service Plan contains the same three goals, and nine objectives:
  - **Goal 1:** Primary and community care services are integrated, accessible, and well-coordinated within the health system

- **Objective 1.1:** Timely access to team-based, culturally safe, and comprehensive primary care services
- **Objective 1.2:** Expand and improve home and community care services to ensure people living in B.C. can access the care they need, from health promotion and prevention to complex care supports, in their homes and local communities
- **Objective 1.3:** Expand with key partners an accessible system of care for mental health and substance use

- **Goal 2:** Regional and provincial health care services meet the diverse needs of all in B.C.
  - **Objective 2.1:** Timely access to hospital, surgical and diagnostic services throughout the province
  - **Objective 2.2:** Improve access to cancer care services across the entire continuum of cancer care
  - **Objective 2.3:** Provide timely access to ambulance services to meet the needs of all in B.C.
- **Goal 3:** A high-quality sustainable health system supported by a skilled and diverse workforce, and effective and efficient systems and structures
  - **Objective 3.1:** A sustainable, skilled and diverse health sector workforce supported by a healthy, safe and engaging health care setting
  - **Objective 3.2:** Enable sustainable health sector innovation for quality population and patient health care
  - **Objective 3.3:** Modernize digital care services and tools to provide a connected, safe, and trusted system

The 8 performance measures stated below **exactly as presented** in the 2025/26 – 2027/28 Ministry Service Plan

Performance Measure	Baseline[1]	2024/25 Forecast	2025/26 Target	2026/27 Target	2027/28 Target
[1a] Number of people newly attached to a primary care provider	N/A	222,000	250,000	250,000	250,000
[1b] Potentially inappropriate use of antipsychotics in long-term care	25.4% (2017/18)	29.0%	28.0%	27.0%	26.0%
[1c] Percentage of people on Opioid Agonist Treatment (OAT) who have continued on OAT for 12 months	N/A	43.8%	45.0%	46.0%	47.0%
[1d] Median number of days between client referral and accessing service for community bed-based treatment and recovery services	N/A	31 days	30.5 days	30 days	TBD
[2a] Ambulance In-Service hours	N/A	2,979,000	2,800,000	2,800,000	2,800,000
[2b] Total Operating Room Hours	545,419 (2016/17)	665,500	696,700	703,900	710,900
[3a] Nursing and allied health professionals' overtime hours as a percentage of productive hours[2]	N/A	8.5%	8.5%	8.4%	8.3%
[3b] Number of British Columbians registered with Health Gateway, the provincial patient portal	N/A	1.695M	1.8M	1.9M	2M

[1] Baseline values were not used this year for measures where baselines were not informing target setting.

[2] The indicator *Nursing and allied health professionals' overtime hours as a percentage of productive hours* is a calendar year indicator: 2024 Forecast, 2025 Target, 2026 Target, and 2027 Target respectively.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this estimates note is current as of March 3, 2025, as confirmed by Holly Moulton.

APPROVALS

2024 03 26 – Rob Byers, ADM, Finance & Corporate Services
2025 02 28 Heather Richards obo ADM Martin Wright – Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Budget 2025 Overview

Topic: Health care is a top priority for the province and the government will continue to make significant investments to support the public health system in British Columbia and ensure people can access the care they need when they need it.

Key Messaging and Recommended Response:

- *Budget 2025* provides new funding of $4.903 billion over the next three years to support health care services.
- This funding is focused on the services people need – hiring more health care workers, increasing access to primary care, providing care to seniors, providing more surgeries and continuing the expansion and building of hospitals to support our growing and ageing population.

CURRENT SITUATION

- *Budget 2025* provides new funding of **$4.903 billion** over the next three years to support health care services. These investments support meaningful health outcomes and quality health services for British Columbia's population.

Operating ($ millions)	2024/25	2025/26	2026/27	2027/28
***Budget 2024* Restated**	**$ 32,885.059**	**$ 33,779.381**	**$ 34,622.049**	**$ 34,622.049**
Budget 2025		**35,144.178**	**35,905.567**	**36,876.837**
Budget 2025* vs *Budget 2024				
Plan over Plan $ Change		**$ 1,364.797**	**$ 1,283.518**	**$ 2,254.788**
Plan over Plan % Change		4.04%	3.71%	6.51%
Year over Year $ Change		**$ 2,259.119**	**$ 761.389**	**$ 971.270**
Year over Year % Change		6.587%	2.17%	2.71%

KEY BACKGROUND

IMPROVING HEALTH SERVICES – *BUDGET 2025* FISCAL PLAN INCREMENTAL INCREASES:

- *Budget 2025* provides new funding of **$4.903 billion over three years** to support improved health care. This includes:

Operating ($ millions)	2025/26	2026/27	2027/28	Total
Caseload – Pop/Dem/Inf	$ 702.746	$ 613.817	$ 1,585.087	$ 2,901.650
Caseload – HHR Strategy	26.821	-	-	26.821
Caseload – Primary Care	147.600	147.600	147.600	442.800
Major Capital Operating	268.455	302.926	302.926	874.307
Minister's Office	0.123	0.123	0.123	0.369
Shared Recovery Mandate	219.052	219.052	219.052	657.156
HLTH Total	**$ 1,364.797**	**$ 1,283.518**	**$ 2,254.788**	**$ 4,903.103**

LEGISLATIVE SESSION – ESTIMATES NOTE

Key Messages

Caseload – Population, Demographics, Inflation

- *Budget 2025* provides **$2.902 billion** over the fiscal plan to respond to rising health care costs and sustain services.
- This funding will ensure the system is able to respond to the needs of B.C.'s growing, aging population, as well as inflationary costs.

Caseload – Health Human Resources Strategy

- *Budget 2025* provides **$26.821 million** in 2025/26 to sustain existing initiatives and investments under B.C.'s Health Human Resources Strategy, which is focused on optimizing the health system, expanding training, and improving recruitment and retention.

Caseload – Primary Care

- *Budget 2025* provides incremental funding of **$442.800 million** over the fiscal plan to meet primary care demand.
- This funding will ensure British Columbians can continue to access care from their family physician, supporting consistent and reliable health care.

Major Capital Project Operating Costs

- *Budget 2025* provides **$874.307 million** over the fiscal plan to develop and operationalize major capital projects in the Ministry's capital plan aimed at expanding and upgrading health facilities.
- Government has made historic investments in the expansion and upgrading of our health facilities and this operating funding is essential to ensuring a smooth transition to full operations.

Minister's Office

- *Budget 2025* includes an increase of **$0.369 million** over the fiscal plan to increase the Minister's Office budget in accordance with staffing levels and allocations as approved by the Office of the Premier.

Share Recovery Mandate

- *Budget 2025* provides incremental funding of **$657.156 million** over the fiscal plan for compensation increases related to public-sector collective agreements in the health sector.

Health Sector Spending (Blue Book)

- Health authority and hospital society spending is projected to increase from **$29.011 billion** in 2024/25 to **$31.586 billion** in 2027/28, an increase of **$2.575 billion** over the fiscal plan period.
- This spending is expected to improve the quality of long-term care, support recruitment and retention of personal support workers, fund drugs for rare diseases; and to cover staffing and operating costs incurred to meet the projected volume and service growth in health-care services delivered by these organizations.

Cost Drivers in Health Care

BC's healthcare system faces increasing demand due to a growing and aging population:

- From 2015 to 2024, B.C.'s population grew from 4.76 million to 5.68 million, representing a 19% increase, or an average of 1.9% per year).
- Population growth is expected to continue to grow over the fiscal plan period, though at a slower rate due to reduced immigration targets set by the federal government.
- B.C. seniors, referring to those aged 65 and older, are currently the fastest growing age group in the province.
- B.C. seniors' population is projected to increase by 27% over the next decade, from 1,127,346 persons in 2024 to 1,431,675 persons by 2034.
- Technology - advancement in technology and testing expands the ability to treat more people for existing conditions (e.g. hip replacements for older patients), and new and expensive treatments for previously untreatable conditions.
- Chronic disease – managing incidents of chronic disease (e.g. diabetes, renal failure, congestive heart failure).
- Drug costs – rapidly rising drug prices, especially cancer drugs and increased utilization.
- Developmental conditions - expanding treatment for developmental conditions (e.g. autism, fetal alcohol syndrome).
- Compensation pressures – negotiated compensation agreements covering six health sector bargaining units (e.g. resident doctors of BC, nurses, ambulance paramedics).

- Public health emergencies – preparing for and managing critical situations of a temporary nature that seriously endanger the lives, health and/or safety of the population.
- The 2025/26 budget for health is $35.144 billion, which represents an almost $15.390 billion increase since 2017/18.

LAST UPDATED

The content of this estimates note is current as of February 28, 2025, as confirmed by Blaine Ferguson.

APPROVALS

2025 03 02 Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Extra Billing – Audits and Canada Health Transfer Penalties

Topic: Several private health clinics and Medical Services Plan enrolled physicians are privately charging patients for services in contravention of the *Medicare Protection Act* (MPA) and the *Canada Health Act* (CHA). This is referred to as "extra-billing" and is prohibited under the MPA and CHA.

Key Messaging and Recommended Response:

- The Province is committed to maintaining the integrity of the public health care system.
- We changed the *Medicare Protection Act (MPA)* in 2018, bringing in new protections for patients to ensure they would not be liable for extra-billing and clarified rules around extra-billing for medical practitioners.
- The Medical Services Commission (MSC) routinely reviews entities brought to their attention and takes appropriate action if they're billing patients or their employers for services in contravention of the MPA.
- To demonstrate B.C.'s ongoing commitment to uphold the principles of the CHA and eliminate extra-billing, B.C. has taken several actions, including contracting private surgical clinics to bring private surgical services back into the public system, reducing wait times and increasing access.
- As a result of B.C.'s corrective actions to eliminate extra-billing and user charges, in March 2025, Health Canada issued B.C. a total reimbursement in the amount of $20.98M of the penalties assessed.
- Our focus remains on building and investing in the public system, including bringing more private clinics under public control.
- We remain steadfast in our commitment in ensuring equal access to quality health care, and that healthcare is not based on a person's ability to pay – and we will continue to defend it.

CURRENT SITUATION

- In accordance with Health Canada requirements, the Province will continue extra-billing audits with the expectation the Province will receive the Canada Health Transfer (CHT) funds previously withheld by the Federal Government.
- CHA's Reimbursement Policy requires that any reimbursement must occur within two years of the date of the original deduction, otherwise B.C. will permanently forfeit a portion of its deduction.
- On April 1, 2020, the federal Diagnostics Services Policy came into effect. Commencing December 2022, the Province is required to report on extra-billing and user charges associated with medically necessary diagnostic services to Health Canada.
- Advice/Recommendations Section 18.1 expands the current prohibition against approved facilities charging for medically necessary diagnostic services that are benefits under the MPA or the *Hospital Insurance Act* to include unapproved facilities.Advice/Recommendations

Advice/Recommendations

FINANCIAL IMPLICATIONS

- If B.C. is subject to a CHT deduction in the amount reported in this filing, B.C. will have been assessed:

Fiscal Year	Payment Date	Total Penalties Assessed Since Mar -18	Total Reimbursement to Mar-20	Total Reimbursement to Mar-21	Total Reimbursement to Mar-22	Total Reimbursement to Mar-23	Total Reimbursement to Mar-24	Total Reimbursement to Mar-25	Net Penalties Assessed Since Mar-18
2022/23	25-Mar	23,520,110						(20,312,449)	3,207,661
2021/22	24-Mar	18,118,721					(15,743,338)	(616,365)	1,759,017
2020/21	23-Mar	23,110,531				(13,933,354)	(6,542,928)	(53,507)	2,580,741
2019/20	22-Mar	13,275,823			(11,948,241)	(1,194,824)	(119,482)		13,276
2018/19	21-Mar	13,949,979		(9,188,971)	(4,284,907)	(428,491)			47,610
2017/18	20-Mar	16,753,833		(11,992,825)	(4,284,907)				476,101
2016/17	19-Mar	16,177,259	(8,088,630)	(3,327,622)					4,761,007
2015/16	18-Mar	15,861,818	(7,930,909)						7,930,909
Totals		**140,768,073**	**(16,019,539)**	**(24,509,418)**	**(20,518,055)**	**(15,556,669)**	**(22,405,748)**	**(20,982,322)**	**20,776,323**

- In January 2025, B.C. reported $23.52M in extra-billing and user charges for 2022/23. This includes $17.1M in respect of patient charges levied for medically necessary diagnostic services.
- As a result of B.C.'s corrective actions to eliminate extra-billing and user charges, in March 2025, Health Canada issued B.C. a total reimbursement in the amount of $20.98M. This amount represents an 85% reimbursement of the March 2025 deduction in respect of patient charges for diagnostic services and a 90% reimbursement of the 2025 deduction in respect of patient charges for other medically necessary services. The reimbursement amount also comprises a 90% reimbursement of the remaining March 2023 and March 2024 CHT deductions in respect of patient charges for other medically necessary services.

KEY BACKGROUND

- Each year, B.C. is required to submit a report to Health Canada, quantifying the total extra-billings for a prior fiscal year. Health Canada assesses CHT penalties based on the reported extra-billings, and federal funding is reduced in the following fiscal year as a CHA compliance deduction.
- In October 2018, B.C. brought the remaining provisions of the *Medicare Protection Amendment Act* Bill 92 (2003) into force to address the province's ability to respond to extra-billing and to bring B.C. into compliance with the CHA.
- The enforceability of the Bill 92 provisions was challenged in Court in Cambie Surgeries Corporate v. British Columbia (Attorney General).
- In September 2010, the province saw a successful outcome in the landmark case. The appeal was heard in June 2021, with a decision rendered by the B.C. Court of Appeal in July 2022, upholding that of the B.C. Supreme Court in favour of the Province. In July 2022 B.C. Court of Appeal dismissed Cambie's appeal, upholding the original judgement.
- B.C. has seen success in curbing extra-billing through government contracts with private clinics to provide publicly insured services instead of private-pay services. As a requirement of these contracts, clinics and physicians are required to sign compliance statements acknowledging that they will not engage in extra-billing.
- On April 1, 2020, the Federal Diagnostics Services Policy came into effect. This policy aims to ensure patients do not face charges for medically necessary diagnostic services such as (but not limited to) magnetic resonance imaging (MRI) and computed tomography (CT) scans, regardless of where the services are provided. As of April 1, 2020, any province that has not eliminated patient charges for medically necessary diagnostic scans is subject to mandatory deductions under the terms of the CHA.
- In December 2022, the Province commenced reporting on extra-billing and user charges associated with medically necessary diagnostic services to HC.
- B.C. has been assessed approximately $20.78M in net penalties since March 2018.

<u>Audit Activity</u>

- Audits identify the extent of patient charges by physicians and private clinics for insured health services in B.C. Audits of private clinics assess compliance with the principles set out in sections 18 and 19 of the CHA, and more specifically sections 17 and 18 of the MPA with respect to extra-billing.
- In August 2021 the HLTH conducted an audit of Cambie's compliance with the Injunction Order. The audit report was submitted to the MSC in January 2022.
- HLTH has completed twelve extra-billing audits as part of the initial reporting requirements to HC.
- The MSC issued the final audit report, accompanied by a letter from the MSC Chair to each facility. No recovery is expected.
- An audit plan for diagnostic facilities has been developed Advice/Recommendations

Advice/Recommendations

- Advice/Recommendations

<u>Relevant Legislation</u>

- The CHA explicitly prohibits user fees and extra-billing of patients for insured services.
- Sections 17 and 18 of B.C.'s MPA prohibit enrolled physicians from charging patients for Medical Service Plan insured services, as outlined in the MPA's Payment Schedule.
- Under the MPA, the HLTH has authority to audit enrolled physicians. HLTH delegates this authority to the MSC.
- The Audit Inspection Committee (AIC) approves audit referrals based on delegated authority from the MSC. Approved audits are conducted by HLTH. Completed audit reports are presented to AIC, which provides recommendations and forwards the reports to the MSC for approval.

LEGISLATIVE SESSION – ESTIMATES NOTE
Health Authority Corporate Expenditures

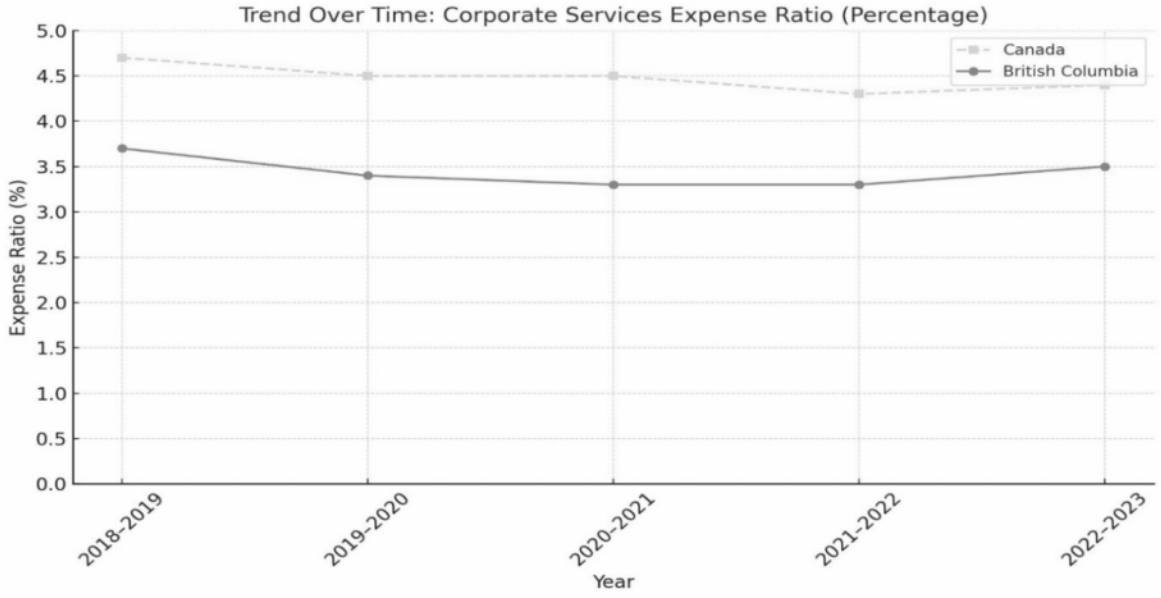
Topic: An overview of Health Authority Corporate Expenditures

Key Messaging and Recommended Response:

- In order to protect key services that British Columbians rely on, we will be working with the Ministry of Finance to review all existing Ministry of Health programs and initiatives to ensure programs support the health of British Columbians while keeping costs manageable.
- We are prioritizing reducing the cost of administration of the health care system to focus resources on the front line, including a review of the Regional Health Authorities, and incorporating an active role for doctors, nurses, and health science professionals in designing and implementing healthcare solutions.
- This is especially important in the context of current Provincial budget constraints, our growing and aging population, and emerging technologies.
- Right now we need every available dollar directed to front line patient care and we're committed to conducting a thoughtful review that ensures health system sustainability, in a sustainable way.
- I have been meeting with healthcare workers since day one – hearing about the challenges and opportunities in the health authorities.
- It's important to recognize the crucial role the health authorities play in understanding the context of the communities they serve and the delivery of services.
- I'll have more to say on this work as it moves forward.
- Our goal is to drive down administration costs and put those savings to work delivering frontline services for British Columbians.

CURRENT SITUATION

- The Canadian Institute for Health Information (CIHI) monitors a metric called "Corporate Services Expense Ratio" (CSER) which provides a measure of what jurisdictions across Canada are spending on administration as a percentage of total health costs.
- In 2022/23, B.C.'s CSER was 3.5%, compared to Canada's 4.4%. CIHI information for 2023/24 is not currently available.
- B.C. has the second lowest CSER in the country (behind Alberta).[1]
- B.C.'s CSER has generally trended downward since 2016/17.



[1] Health spending: Indicators | CIHI

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

Table 1: Corporate Services Expenditures by Health Authority

Health Authority	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
FHA	253.985	275.907	288.736	339.836	370.735	479.820	549.248
IHA	145.294	153.436	163.374	180.032	201.684	221.842	264.085
NHA	66.231	71.061	74.834	80.277	90.431	107.398	120.417
VCHA	319.165	340.300	366.000	381.000	414.200	539.800	597.793
VIHA	186.635	187.047	195.033	213.319	240.838	293.518	323.989
PHSA	282.899	707.090	735.453	983.380	1,022.961	1,311.684	1,196.196
Totals	**1,254.209**	**1,734.841**	**1,823.430**	**2,177.844**	**2,340.849**	**2,954.062**	**3,051.728**

Notes:
1. Significant 2018/19 increase in the Corporate Sector is a result of BCCSS reported under PHSA, effective April 1, 2018.
2. Per health authority audited financial statements.

KEY BACKGROUND

- Health authorities are required to comply with annual government reporting requirements under the Budget Transparency & Accountability Act, including publication of annual budgets and estimates, public accounts, quarterly reports, services plans, annual reports, and major capital plans.
- Corporate expenditures on the health authority financial statements include a wide range of "overhead" expenses, including administration, human resources, financial services, capital planning, communications, information management, technology, risk management, medical administration, and emergency service planning.
- Corporate expenditure increases are driven by many factors, including inflation and targeted investments in clinical information systems, virtual health infrastructure, new hospital development projects, and health human resource initiatives.
- The Canadian Institute of Health Information (CIHI) calculated B.C.'s 2022/23 corporate services expense ratio (i.e., administrative costs relative to total expenses) at 3.5% - the second lowest in the country (behind Alberta).
- Annual increases in corporate service expenditures are linked to several factors, including changes in healthcare technology and service delivery (e.g., virtual care and IT services), infrastructure planning and development, wage increases for unionized and other staff providing corporate services, and accounting transactions from year to year (actuarial adjustments).
- All of these investments, particularly those in the construction and maintenance of IT systems, cybersecurity, and communication networks, are crucial for ensuring the delivery of modern, high-quality healthcare services.
- In the 2023/24 fiscal year, approximately $1.160 billion, representing around 40% of the total corporate expenditures across all health authorities, was allocated to information systems, support services, and Information Management and Information Technology (IMIT), as summarized in **Table 2**.

Table 2: Corporate Services Expenditures in 2023/24 by Health Authority

Health Authority	2023/24 ($millions)	Description
FHA	245.535	Examples: $85.442 million went toward Meditech Advance Project; $60.360 million to Clinical information management and Information Technology Services; $53.193 million to Technology Services; $22.356 million to Desktop Management Services; $13.447 million to Information Management Projects; $6.528 million to Telecommunications (Wireless, data and voice services); and $4.208 million to Cybersecurity.
IHA	118.059	Various IM/IT services, including telecommunications.
NHA	38.706	Examples: $12.030 million to Clinical Information Systems (CIS); $7.800 million to Core technology; $6.500 million to Safercare, Remote Access Services (RAS), Human Capital Management (HCM), and Desktop Management Services

		(DMS); $4.600 million on Client Services; and $3.920 million on Telecommunications.
VCHA	189.559	Examples: Approximately $45.000 million to CIS.
VIHA	137.025	Various information systems.
PHSA	430.855	Examples: $132.000 million on Core Provincial Digital Health & Information Services (PDHIS); $46.761 million on Clinical Systems Transformation (CST); $48.219 million on Ministry-driven Initiatives; and $22.990 million on contractual obligations.
Total	**1,159.739**	

- Health authorities are also planning and managing more major capital projects than ever before. Government is investing billions into new and expanded infrastructure including hospitals, long-term care, and more to support healthcare delivery. *Budget 2024* provided for capital funding of $13.000 billion over three years to support the health sector.
- Other health authority corporate cost drivers in 2023/24 included:
    - $529.405 million - Commercial Services Supply Chain, Employee and Financial Services (PHSA only)
    - $479.676 million - Finance and Administration
    - $213.566 million - Human Resources
    - $121.056 million - Support Services and other corporate overhead
    - $107.920 million ($99.090 million for VCHA Amortization) - Equipment, Information Systems and Buildings
    - $84.200 million - Material Management

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Brenda Rafter.

APPROVALS

2025 03 07– Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Authorities Executive Compensation – Top 5

Topic: Public sector employers are required to disclose annually all compensation paid to the Chief Executive Officer (CEO) and the next four highest ranking or paid executives with decision making authority.

Key Messaging and Recommended Response:

- Executive Disclosure Statements for each health authority and Providence Health Care are posted in conjunction with the release of the Public Accounts.
- The statements disclose the annual compensation paid to the CEO and the next 4 highest ranking/paid executives with decision-making authority.

CURRENT SITUATION

- The 2023/24 Executive Disclosure Statements were posted by the Public Sector Employers' Council Secretariat (PSEC) and each of the health organizations in conjunction with the release of the Public Accounts and Service Plan Reports.
- The disclosure statements provide the base salary, employer contributions for statutory, pension, and health benefits and any other personal benefits provided, such as severance and sick leave payouts at retirement or conclusion of employment and vacation payouts. The objective is to disclose everything that a reasonable person would view as compensation.

FINANCIAL IMPLICATIONS

- Appendix A reflects 23/24 compensation and 2021/22-2022/23. Compensation information for 2024/25 will be made public in coordination with the release of the province's Public Accounts.

KEY BACKGROUND

- As part of the BC government's economic recovery plan, the Minister of Finance determined that employers subject to compensation plans under the Public Sector Employers Act will be required to amend their Compensation Reference Plans (CRPs) to indicate that there will be no performance increases or adjustments paid to executive-level employees for the 2020/21 performance year.
- In 2016, under Phase 2 of the *BC Public Sector Compensation Review*, employers received approval to adjust executive and excluded management compensation within approved ranges.
- In 2015, under Phase 1 of the *BC Public Sector Compensation Review*, compensation reference plans and benchmarking were revised to ensure alignment with a common public sector compensation philosophy.
- In 2014, under the *BC Public Sector Compensation Review*, Government adopted a common public sector compensation philosophy, implemented new taxpayer accountability principles, and revised disclosure guidelines to further clarify and enhance transparency.
- In 2007/2008, the *Public Sector Employers Act* was amended requiring the disclosure of the salaries of public sector CEOs and the next 4 highest-ranking executives earning $125,000 or more in base pay.
- In 2002, the *Public Sector Employers Act* (Bill 66) was introduced, which required Ministerial approval of compensation plans, strengthened standards for severance payments, accumulated sick leave and vacation payouts.
- The *Public Sector Employers Act* requires that current contracts of senior executives be filed with the PSEC and available to the public.

LAST UPDATED

The content of this estimates note is current as of February 26, 2025 as confirmed by Blaine Ferguson.

APPROVALS

2025 03 07 – Rob Byers, ADM and EFO, Finance and Corporate Services Division
2025 02 26 – Blaine Ferguson, ED, Finance and Corporate Services Division

Appendix A

Name	Principle Position	Base Salary	Pension	Benefits	All Other Comp	Total 2023/24	Total 2022/23	Total 2021/22
Fraser Health								
Lee, Dr. Victoria	President & CEO	$381,621	$35,529	$34,087	$1,894	$453,131	$447,181	$410,012
Belle, Dr. Ralph	VP, Medicine	$319,469	$29,742	$25,603	$1,182	$375,996	$357,609	$338,228
Leith, Laurie	VP, Regional Hospitals & Communities	$290,255	$27,023	$30,174	$915	$348,367	$346,234	$300,076
Kelly, Dermot	VP, Community Hospitals & Health Services	$281,278	$26,187	$29,453	$1,121	$338,039	$299,953	
Dempster, Linda	VP, Patient Experience	$273,772		$15,731	$1,023	$290,526	$282,026	$266,301
Tyler, Ingrid	VP, Population & Public Health and Chief Medical Health Officer (effective Jan 29, 2024)	$323,603	$30,079	$39,232	$1,320	$394,234		
Interior Health								
Brown, Susan	President & CEO	$387,186	$36,656	$28,093	$20,672	$472,607	$449,647	$441,445
Lavoie, Martin	Chief Medical Officer (effective January 19, 2024; was seconded to IHA from MoH prior to this date)	$48,951	$3,418	$7,668		$60,037		
Weir, Sylvia	CFO & VP Corporate Services	$278,659	$30,562	$25,046	$8,241	$342,508		
Letwin, Shallen	VP, Clinical Operations, IH South	$283,708	$28,273	$24,224	$12,991	$349,196	$326,714	$315,644
Smith, Douglas	VP, Medicine & Quality (effective May 10, 2023)	$288,569	$28,273	$20,736	$10,669	$348,247		
Northern Health								
Ulrich, Cathy	President & CEO (retired effective Jan 10, 2024)	$298,059		$11,396	$221,026	$530,481	$399,841	$406,906
Panessa, Ciro	President & CEO (effective Sept 5, 2023)	$303,301	$21,872	$19,287	$6,831	$351,291		
Chapman, Dr. Ronald	VP, Medicine	$330,848	$30,768	$16,771		$378,387	$354,395	$355,608
Kim, Dr. Jong Woan	Chief Medical Health Officer	$319,332	$30,650	$15,241	$9,885	$375,108	$340,463	$348,674
Anguish, Penny	Chief Operating Officer, NI HSDA (seconded to MoH effective Sept 5, 2023)	$114,782	$10,686	$5,740		$131,208	$296,460	$297,748
De Croos, Mark	VP, Financial & Corporate Services/CFO	$283,177	$26,364	$18,080		$327,621	$274,270	$273,940
De Smit, Angela	Acting VP, Clinical Operations (effective Dec 5, 2023)	$257,186	$23,944	$15,245	$2,123	$298,498		
Providence Health Care								
Dalton, Fiona	President & CEO	$371,049	$34,545	$15,796		$421,390	$395,808	$381,548
Simmers, Brian	CFO & VP, Health Informatics & Corporate Development	$323,177	$30,088	$18,848	$6,056	$378,169	$355,487	$338,146
Ingram, David	VP, Major Capital Projects	$314,351	$29,266	$18,671	$19,476	$381,764	$347,013	$328,874
Peters, Norman	Chief Operating Officer	$270,444	$25,178	$17,846	$7,105	$320,573	$233,596	
Palmer, Becky	Chief People, Nursing and Health Professions Officer (effective Aug 1, 2022)	$259,838	$24,191	$18,277	$7,267	$309,573		
Provincial Health Services								
Byres, David	President & CEO	$394,025	$36,684	$21,783	$14,689	$467,181	$429,952	$221,011
Wong, Jason	Chief Medical Officer and B.C.'s Deputy Provincial Health Officer (effective May 8, 2023)	$381,737	$35,495	$16,325	$721	$434,278	$357,087	
Heppell, Leanne	Executive VP, BC Emergency Health Services and Chief Ambulance Officer	$320,776		$39,614	$6,000	$366,390	$348,354	
MacNair, Scott	Executive VP, Business Operations	$316,330	$29,450	$21,839	$953	$368,572	$342,115	$340,851
Wannamaker, Susan	Executive VP, Clinical Service Delivery, PHSA	$331,302		$20,694		$351,996	$326,343	$342,209
Malovec, Shannon	Executive VP, Digital Health, Information Services and Innovation	$302,882	$28,258	$21,808		$352,948	$320,405	
Chi, Kim	Executive Vice President and Chief Medical Officer, BC Cancer (effective Nov 1, 2023)	$458,700	$45,928	$20,426	$953	$526,007		
Vancouver Coastal Health								
Eliopoulos, Vivian	President & CEO	$405,884		$16,935	$13,383	$436,202	$417,788	$391,031
Daly, Patricia	VP, Public Health and Chief Medical Health Officer	$326,551	$30,395	$16,781	$21,109	$394,836	$383,697	$387,493
Pica, Fernando	CFO & Vice President, Strategic Business Services	$337,902	$31,452	$18,402	$3,600	$391,356	$378,219	$376,732
Jetha, Yasmin	VP, Community Services	$244,711	$22,773	$16,978	$3,600	$288,062		
Blashin, Wayne	Interim VP, People	$259,827	$24,183	$18,034	$21,101	$323,145	$274,325	$241,873
Vancouver Island Health								
MacNeil, Kathryn E	President & CEO	$382,170	$35,580	$20,002	$13,980	$451,732	$423,003	$403,791
Williams, Dr. Ben	VP Medicine and Quality & Chief Medical Executive	$299,789	$27,910	$20,820	$20,972	$369,491	$382,537	$334,257
Kerrone, Kim	VP & CFO	$302,356	$28,149	$6,590	$26,575	$363,670	$353,082	$334,085
Bjarnason, Lilja Elin	VP, Clinical Operations (retired effective May 11, 2023)	$40,608	$3,781	$3,696	$198,979	$247,064	$344,712	$306,190
Hanson, James	VP, Clinical Operations	$269,061	$25,050	$19,685	$11,769	$325,565	$304,798	$305,354
Gustafson, Dr. Reka	VP Island Health	$318,969	$30,158	$20,201	$11,769	$381,097	$187,360	
Peljhan, Marko	VP Island Health	$269,061	$25,050	$22,988	$12,807	$329,906		

LEGISLATIVE SESSION – ESTIMATES NOTE
Health Authority Overview (Financial Positions)
Fraser Health Authority

Topic: The Fraser Health Authority (FHA) is 1 of 6 health authorities created in 2001. The Ministry of Health (the Ministry) provides annual operating funding directly to the FHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- It is Government's direction that health authorities (HAs) operate within balanced budgets.
- As at Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing FHA $5.669 billion in Regional Services funding.
- 2024/25 financial results are expected to be finalized in July 2025 and published in August 2025.

CURRENT SITUATION

- FHA had a surplus of $3.799 million in its 2023/24 Audited Financial Statements excluding affiliates, creating a surplus of $3.211 million with Menno Hospital and St. Michael's Centre included.
- Menno Hospital reported a 2023/24 deficit of $0.588 million (revenues of $16.624 million, less expenditures of $17.212 million). $14.368 million of the revenue was provided by FHA.
- St Michael's Centre reported a 2023/24 balanced account (revenues of $18.916 million less expenditures of $18.916 million). $18.101 million of the revenue was provided by FHA.
- At Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing FHA $5.669billion in Regional Services funding.

FINANCIAL IMPLICATIONS

- 2023/24 Audited Financial Statements of FHA (excluding Menno and St. Michael's)

Total Revenues:	$6,383.253 million
Total Expenses:	$6,379.454 million
Surplus (Deficit):	$ 3.799 million

2023/24 Breakdown of Total Revenues by Major Funding Source
Year Ended March 31, 2024
($ Millions)

	Budget 2023/24	Actuals 2023/24	Actuals 2022/23
Revenues			
Ministry of Health Contributions	4,542.400	5,204.619	4,620.214
Medical Services Plan	240.800	295.980	265.777
Recoveries from other health authorities and BC government	149.700	157.415	134.401
Patients, clients and residents	104.288	149.699	127.860
Amortization of deferred capital contributions	112.900	261.220	109.743
Other contributions	94.800	102.265	97.192
Other	40.764	182.691	111.500
Interest income	2.848	29.364	20.217
Total Revenues	**5,288.500**	**6,383.253**	**5,486.904**

Note: Amounts as per 2023/24 audited financial statements

LEGISLATIVE SESSION – ESTIMATES NOTE

- Regional Services Funding Allocation (to FHA from Ministry)
  - 2021/22 - $4.509 billion (per 2021/22 Post Final Funding Letter)
  - 2022/23 - $4.629 billion (per 2022/23 Post Final Funding Letter)
  - 2023/24 - $5.184 billion (per 2023/24 Post Final Funding Letter)
  - 2024/25 - $5.669 billion (per 2024/25 Funding Letter Update #3)

- Estimated Full-Time Equivalents (FTEs)
  - According to Health Sector Compensation Information System 2023 Quarter 4 data, the estimated number of FTEs (excluding Menno Hospital, St. Michael's, and Other Contracted Agencies) is as follows:
    - Union – 22,534
    - Non-Union/Management – 2,726

- FHA Population
  - BC Stats forecasts FHA's catchment area population and growth rate will be:
    - 2024/25 – 2.237 million, 1.9% growth
    - 2025/26 – 2.273 million, 1.6% growth
    - 2026/27 – 2.321 million, 2.1% growth
    - As of July 2024, approximately 16.8% of FHA's population is age 65 and over.

KEY BACKGROUND

- This Ministry's Regional Services funding represents most of FHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, and preferred accommodation).
- Working in co-operation with the FHA to provide health services within the FHA region are 2 denominational affiliates or hospital societies established per the *Hospital Act* (i.e., Menno Hospital and St. Michael's Centre). These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements.
- The Ministry does not provide operating funding directly to the denominational affiliates; the FHA is responsible for allocating operating funding to the denominational affiliates. The financial results of the FHA and the denominational affiliates are consolidated in the Government Reporting Entity.

LAST UPDATED

The content of this estimate note is current as of February 12, 2025, as confirmed by Brenda Rafter, Executive Director, Financial Analysis and Decision Support.

APPROVALS

2025 02 20 - Brenda Rafter, Finance and Corporate Services Division
2025 02 25 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Health Authority Overview (Financial Positions)
Interior Health Authority

Topic: The Interior Health Authority (IHA) is 1 of 6 health authorities created in 2001 that the Ministry of Health (the Ministry) provides annual operating funding directly via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- It is Government's direction that health authorities (HAs) operate within balanced budgets.
- At Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing $3,482.442 million to IHA in Regional Services funding.
- 2024/26 financial results are expected to be finalized in July 2025 and published in August 2025.

CURRENT SITUATION

- IHA had a surplus of $2.395 million in its 2023/24 Audited Financial Statements.
- At Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing $3.482 billion to IHA in Regional Services funding.

FINANCIAL IMPLICATIONS

- 2023/24 Audited Financial Statements of IHA

Total Revenues	$3,885.485 million
Total Expenses	$3,883.090 million
Surplus/(Deficit)	$ 2.395 million

2023/24 Breakdown of Total Revenues by Major Funding Source
Year ended March 31, 2024
($ Millions)

	Budget 2023/24	Actuals 2023/24	Actuals 2022/23
Revenues			
Ministry of Health contributions	2,925.714	3,188.298	2,739.831
Medical Services Plan	231.119	260.737	221.651
Patients, clients and residents	127.528	131.579	123.905
Amortization of deferred capital contributions	102.181	104.970	100.593
Recoveries from other health authorities and BC Government reporting entities	72.230	78.399	69.250
Other contributions	47.745	48.092	46.814
Other revenues	41.208	57.034	43.650
Investment income	10.000	16.376	9.839
	3,557.725	3,885.485	3,355.533

Note: Amounts as per the 2023/24 audited financial statements.

- Regional Services Funding Allocation (To IHA from Ministry)
  - 2018/19 - $1.859 billion (per 2018/19 Final Funding Letter)
  - 2019/20 - $2.028 billion (per 2019/20 Final Funding Letter)
  - 2020/21 - $2.383 billion (per 2020/21 Post-Final Funding Letter)
  - 2021/22 - $2.586 billion (per 2021/22 Post-Final Funding Letter)
  - 2022/23 - $2.781 billion (per 2022/23 Post-final Funding Letter)
  - 2023/24 - $3.193 billion (per 2023/24 Post-Final Funding Letter)
  - 2024/25 - $3.482 billion (per 2024/25 Funding Letter Update #3)

LEGISLATIVE SESSION – ESTIMATES NOTE

- Estimated Full-Time Equivalents (FTEs)
  - According to Health Sector Compensation Information System 2023 Quarter 4 data, the estimated number of FTEs is as follows:
    - Unionized – 15,622
    - Non-unionized/Management – 1,650

- Central Deposit Program
  - The IHA participates in the Ministry of Finance/Provincial Treasury Central Deposit Program (see Health Authority Cash Management and Central Deposit Program Fact Sheet). The Central Deposit Program was created by the Provincial Treasury in response to a recommendation by the Office of the Auditor General to better manage cash holdings by health authorities.
  - At Quarter 3, IHA forecasts a 2024/25 year-end cash position of $244.767 million, comprised of:
    - Cash Balance in the Central Deposit Program – $110.118 million
    - Cash and Cash Equivalents on Hand (Unrestricted) – ($56.652) million
    - Cash and Cash Equivalents on Hand (Restricted) – $191.301 million
    - Portfolio Investments on Hand - $0

- IHA Population
  - According to BC Stats, IHA's population forecast, and rate of growth is as follows:
    - 2024/25 – 0.909 million, 1.08% growth
    - 2025/26 – 0.917 million, 0.89% growth
    - 2026/27 – 0.930 million, 1.37% growth

KEY BACKGROUND

- The Ministry's Regional Services funding represents the vast majority of the IHA's annual operating revenue. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, and preferred accommodation).

LAST UPDATED

The content of this fact sheet is current as of February 5, 2025, as confirmed by Brenda Rafter, Executive Director, Financial Analysis and Decision Support.

APPROVALS

2025 02 05 - Brenda Rafter, Finance and Corporate Services Division
2025 02 12 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Authority Overview (Financial Positions)
Northern Health Authority

Topic: The Northern Health Authority (NHA) is 1 of 6 health authorities created in 2001. The Ministry of Health (the Ministry) provides annual operating funding directly to the NHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- It is Government's direction that health authorities (HAs) operate within balanced budgets.
- As at Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing $1.247 billion to NHA in Regional Services funding.
- 2024/25 financial results are expected to be finalized in July 2025 and published in August 2025.

CURRENT SITUATION

- NHA had a surplus of $4.695 million in its 2023/24 Audited Financial Statements.
- At Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing $1.247 billion to NHA in Regional Services funding.

FINANCIAL IMPLICATIONS

- 2023/24 Audited Financial Statements of NHA

Total Revenues:	$1,446.403 million
Total Expenses:	$1,441.708 million
Surplus/(Deficit):	$ 4.695 million

2023/24 Breakdown of Total Revenues by Major Funding Source
Year Ended March 31, 2024
($ Millions)

	Budget 2023/24	Actuals 2023/24	Actuals 2022/23
Revenues			
Ministry of Health Contributions	1,151.000	1,133.360	956.002
Medical Services Plan	128.600	126.543	112.679
Recoveries from other health authorities and BC government	17.400	23.764	16.163
Patients, clients and residents	48.700	54.585	47.771
Amortization of deferred capital contributions	47.500	54.171	46.950
Other contributions	17.100	23.107	16.402
Other	13.500	18.405	18.690
Investment income	10.200	12.468	6.249
Total Revenues	**1,434.000**	**1,446.403**	**1,220.906**

Note: Amounts as per 2023/24 audited financial statements

LEGISLATIVE SESSION – ESTIMATES NOTE

- Regional Services Funding Allocation
  - 2021/22 - $0.910 billion (per 2021/22 Post-final Funding Letter)
  - 2022/23 - $0.952 billion (per 2022/23 Post-final Funding Letter)
  - 2023/24 - $1.117 billion (per 2023/24 Post-final Funding Letter)
  - 2024/25 - $1.247 billion (per 2023/24 Funding Letter Update #3)

- Estimated Full-Time Equivalents (FTEs)
  - According to Health Sector Compensation Information System 2023 Quarter 4 data (2024), the estimated number of FTEs is as follows:
    - Union – 5,246
    - Non-Union/Management – 968

- NHA Population
  - According to BC Stats, the NHA's population forecast, and rate of growth is as follows:
    - 2024/25 – 0.304 million, 0.2% growth
    - 2025/26 – 0.304 million, 0.1% growth
    - 2026/27 – 0.305 million, 1.2% growth
  - As of July 2024, approximately 17% of NHA's population is age 65 and over.

KEY BACKGROUND

- This Ministry's Regional Services funding represents the vast majority of the NHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (fees for services provided to non-residents of Canada, parking, preferred accommodation, etc.).
- Wrinch Memorial Hospital in Hazelton became part of the NHA on April 1, 2016, and was included in the NHA's audited financial statements in 2016/17. Wrinch Memorial Hospital was previously a denominational affiliate. Denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements. The Ministry does not provide Regional Services operating funding directly to the denominational affiliate; the NHA is responsible for allocating operating funding to the denominational affiliate. The financial results of the NHA and the denominational affiliates are consolidated in the Government Reporting Entity.

LAST UPDATED

The content of this estimates note is current as of February 22, 2025, as confirmed by Brenda Rafter.

APPROVALS

2025 02 22– Brenda Rafter, Finance and Corporate Services Division
2025 02 25 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Health Authority Overview (Financial Positions)
Provincial Health Services Authority

Topic: The Provincial Health Services Authority (PHSA) is 1 of 6 health authorities created in 2001, and the only health authority not limited to a particular region. The Ministry of Health (the Ministry) provides annual operating funding directly to the PHSA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- It is Government's direction that health authorities (HAs) operate within balanced budgets.
- At Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing $4,215.119 million to PHSA in Regional Services funding.
- 2024/25 financial results are expected to be finalized in July 2025 and published in August 2025.

CURRENT SITUATION

- PHSA had a surplus of $3.192 million in its 2023/24 Audited Financial Statements.
- At Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing $4.215 billion to PHSA in Regional Services funding.

FINANCIAL IMPLICATIONS

- 2023/24 Audited Financial Statements of PHSA

Total Revenues	$5,838.693 million
Total Expenses	$5,835.501 million
Surplus/(Deficit)	$ 3.192 million

2023/24 Breakdown of Total Revenues by Major Funding Source
Year ended March 31, 2024
($ Millions)

	Budget 2023/24	Actuals 2023/24	Actuals 2022/23
Revenues			
Ministry of Health contributions	3,609.587	4,170.315	3,510.480
reporting entities	749.615	818.847	775.830
Medical Services Plan	261.053	324.288	274.805
Other contributions	112.080	124.519	118.620
Amortization of deferred capital contributions	136.700	143.778	125.927
Research and designated contributions	98.273	142.448	116.179
Other revenues	38.763	56.032	41.355
Patients, clients and residents	14.980	35.561	24.635
Pharmacare	5.550	2.529	4.082
Investment income	2.238	20.376	12.875
Total Revenues	**5,028.839**	**5,838.693**	**5,004.788**

Note: Amounts as per the 2023/24 audited financial statements, and do not include Operating Summary (revenues and expenses) for PHSA Agencies.

- Regional Services Funding Allocation
  - 2021/22 – $3.192 billion (per 2021/22 Post Final Funding Letter)
  - 2022/23 – $3.456 billion (per 2022/23 Post Final Funding Letter)
  - 2023/24 – $4.071 billion (per 2023/24 Post Funding Letter)
  - 2024/25 – $4.215 billion (per 2024/25 Funding Letter #3)

- Estimated Full-Time Equivalents (FTEs)
  - According to Health Sector Compensation Information System 2023 Quarter 4 data, the estimated number of FTEs is as follows:
    - Union – 13,710
    - Non-Union/Management – 5,167

KEY BACKGROUND

- The Regional Services funding represents the vast majority of the PHSA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, other health authorities, foundations, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking and preferred accommodation).
- The PHSA is responsible for:
  - Planning in conjunction with regional health authorities, and in some cases providing direct funding, for specialized services, including cardiac services and programs; thoracic surgery; trauma services; Centre for Excellence in HIV/AIDS; and BC Autism Assessment Network.
  - Providing leadership and coordination, in conjunction with the Ministry on several system improvements in emergency care, surgical services, and specialized neonatal care.
  - Corporate governance and management for provincial agencies and services, including BC Cancer; BC Centre for Disease Control; BC Renal; BC Transplant; BC Mental Health and Substance Use; BC Women's Hospital and Health Centre; BC Children's Hospital and Health Centre; BC Children's Hospital and Sunny Hill Health Centre; and PHSA Cardiac Services BC.

LAST UPDATED

The content of this fact sheet is current as of February 22, 2025, as confirmed by Brenda Rafter, Executive Director, Regional Grants and Decision Support.

APPROVALS

2025 02 22 - Brenda Rafter, Finance and Corporate Services Division
2025 02 24 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Health Authority Overview (Financial Positions)
Vancouver Coastal Health Authority

Topic: The Vancouver Coastal Health Authority (VCHA) is 1 of 6 health authorities created in 2001. The Ministry of Health (the Ministry) provides annual operating funding directly to the VCHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- It is Government's direction that health authorities (HAs) operate within balanced budgets.
- As at Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing VCHA with $5.002 billion in Regional Services funding.
- 2024/25 financial results are expected to be finalized in July 2025 and published in August 2025.

CURRENT SITUATION

- VCHA reported a $1.067 million surplus in its 2023/24 Audited Financial Statements excluding affiliates, creating a surplus of $2.142 million with Providence Health Care (PHC) and Louis Brier Hospital included. Affiliate organizations receive funding from VCHA.
- Providence Health Care (PHC) reported a 2023/24 surplus of $1.384 million (revenues of $1,443.188 million less expenditures of $1,441.804 million). VCHA provided $934.689 million of their revenue.
- Louis Brier Hospital reported a 2023/24 loss of $0.309 million (revenues of $29.423 million less expenditures of $29.732 million). VCHA provided $21.982 million of their revenue.
- At Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing VCHA with $5.002 billion in Regional Services funding.

FINANCIAL IMPLICATIONS

- 2023/24 Audited Financial Statements of VCHA (excluding PHC and Louis Brier)

Total Revenues:	$6,164.843 million
Total Expenses:	$6,163.776 million
Surplus (Deficit):	$ 1.067 million

2023/24 Breakdown of Total Revenues by Major Funding Source
Year Ended March 31, 2024
($ Millions)

	Budget 2023/24	Actuals 2023/24	Actuals 2022/23
Revenues			
Ministry of Health Contributions	4,400.926	4,868.550	4,164.789
Medical Services Plan	349.928	396.389	345.413
Recoveries from other health authorities and BC government	241.349	244.181	236.902
Patients, clients and residents	156.899	182.565	156.041
Amortization of deferred capital contributions	154.403	164.774	129.490
Other contributions	188.196	206.738	190.973
Other	32.193	58.017	45.243
Research and designated revenue	20.000	21.273	18.024
Investment income	8.160	16.584	9.275
PharmaCare	5.502	5.772	6.505
Total Revenues	**5,557.556**	**6,164.843**	**5,302.655**

Note: Amounts as per 2023/24 audited financial statements

LEGISLATIVE SESSION – ESTIMATES NOTE

- Regional Services Funding Allocation (to VCHA from Ministry)
  - 2021/22 - $3.918 billion (per 2021/22 Post Final Funding Letter)
  - 2022/23 - $4.174 billion (per 2022/23 Post Final Funding Letter)
  - 2023/24 - $4.833 billion (per 2023/24 Post Final Funding Letter)
  - 2024/25 - $5.002 billion (per 2024/25 Funding Letter Update #3)

- Estimated Full-Time Equivalents (FTEs)
  - According to Health Sector Compensation Information System 2023 Quarter 4 data, the estimated number of FTEs (including PHC, but excluding other denominational affiliates and contracted agencies) is as follows:
    - Union – 23,622
    - Non-Union/Management – 3,219

- VCHA Population
  - According to BC Stats, VCHA's population forecast, and rate of growth are as follows:
    - 2024/25 – 1.365 million, 0.8% growth
    - 2025/26 – 1.374 million, 0.6% growth
    - 2026/27 – 1.390 million, 1.2% growth
  - As of July 2024, approximately 17.8% of VCHA's population is aged 65 and over.

KEY BACKGROUND

- This Ministry's Regional Services funding represents the vast majority of the VCHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, preferred accommodation, etc.).
- Working in co-operation with the VCHA to provide health services within the VCHA region are two denominational affiliates or hospital societies established per the Hospital Act, namely PHC and Louis Brier Hospital in Vancouver. These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements (two former denominational affiliates or hospital societies, R. W. Large Memorial Hospital in Bella Bella and Bella Coola General Hospital were absorbed by VCHA as of April 1, 2014).
- The Ministry does not provide Regional Services operating funding directly to the denominational affiliates; the VCHA is responsible for allocating operating funding to its denominational affiliates. The financial results of the VCHA and the denominational affiliates are consolidated in the Government Reporting Entity.

LAST UPDATED

The content of this estimate note is current as of February 12 2025, as confirmed by Brenda Rafter, Executive Director, Financial Analysis and Decision Support.

APPROVALS

2025 02 20 - Brenda Rafter, Finance and Corporate Services Division
2025 02 24 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Authority Overview (Financial Positions)
Vancouver Island Health Authority

Topic: The Vancouver Island Health Authority (VIHA) is 1 of 6 health authorities created in 2001. The Ministry of Health (the Ministry) provides annual operating funding directly to the IHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- It is Government's direction that health authorities (HAs) operate within balanced budgets.
- As at Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing VIHA with $3.718 billion in Regional Services funding.
- 2024/25 financial results are expected to be finalized in July 2025 and published in August 2025.

CURRENT SITUATION

- VIHA had a surplus of $3.089 million in its 2023/24 Audited Financial Statements excluding affiliates, creating a surplus of $3.118 million with Mount St. Mary Hospital included, which reported a surplus of $0.029 million (revenues of $26.188 million, less expenditures of $26.159 million).
- At Quarter 3 of fiscal year 2024/25, the Ministry has committed to providing $3.718 billion to VIHA in Regional Services funding.

FINANCIAL IMPLICATIONS

- 2023/24 Audited Financial Statements of VIHA (excluding Mount St. Mary Hospital)

Total Revenues	$4,222.939 million
Total Expenses	$4,219.850 million
Surplus/(Deficit)	$ 3.089 million

2023/24 Breakdown of Total Revenues By Major Funding Source
Year Ended March 31, 2024
($ Millions)

	Budget 2023/24	Actuals 2023/24	Actuals 2022/23
Revenues			
Ministry of Health Contributions	3,373.451	3,545.887	3,085.944
Medical Services Plan	238.162	267.087	238.505
Recoveries from other health authorities and BC government	138.424	161.338	148.510
Patients, clients and residents	69.279	87.540	83.965
Amortization of deferred capital contributions	88.090	89.633	88.091
Other contributions	4.815	2.726	3.801
Other	36.299	62.806	61.769
Investment income	1.535	5.922	3.654
Total Revenues	**3,950.055**	**4,222.939**	**3,714.239**

Note: Amounts as per the 2023/24 audited financial statements.

- Regional Services Funding Allocation (to VIHA from Ministry)
  - 2021/22 – $2.905 billion (per 2021/22 Post Final Funding Letter)
  - 2022/23 – $3.097 billion (per 2022/23 Post Final Funding Letter)
  - 2023/24 – $3.554 billion (per 2023/24 Post Final Funding Letter)
  - 2024/25 – $3.718 billion (per 2024/25 Funding Letter Update #3)

- Estimated Full-Time Equivalents (FTEs)
  - According to Health Sector Compensation Information System 2023 Quarter 4 data, the estimated number of FTEs – excluding Mount St. Mary Hospital, St. Joseph's General Hospital and other contracted agencies – is as follows:
    - Unionized – 17,062
    - Non-unionized/Management – 2,033

- VIHA Population
  - According to BC Stats, VIHA's population forecast, and rate of growth is as follows:
    - 2024/25 – 0.938 million, 0.8% growth
    - 2025/26 – 0.944 million, 0.7% growth
    - 2026/27 – 0.955 million, 1.2% growth
  - As of July 2024, approximately 25.9% of VIHA's population is age 65 and over.

KEY BACKGROUND

- This Ministry's Regional Services funding represents the vast majority of VIHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (fees for services provided to non-residents- of Canada, parking, and preferred accommodation, etc.).
- Working in cooperation with the VIHA to provide health services within the VIHA region are two denominational affiliates or hospital societies established per the *Hospital Act*, namely Mount St. Mary Hospital in Victoria and St. Joseph's General Hospital in Comox. These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements.
- St. Joseph's General Hospital transferred its acute care services to the VIHA on October 1, 2017, through the North Island Hospital, Comox Valley, Courtenay. St. Joseph's General Hospital continues to operate 117 residential care beds and 4 hospice beds at its Comox site. St. Joseph's General Hospital reached an agreement with Providence Residential and Community Care Services Society (PRCC) to transfer ownership and operation of St. Joseph's General Hospital to PRCC effective April 1, 2019, at which time was superseded by PRCC as an affiliate of the VIHA.
- The Ministry does not provide Regional Services operating funding directly to the denominational affiliates; the VIHA is responsible for allocating operating funding to its denominational affiliates. The financial results of the VIHA and the denominational affiliates are consolidated in the Government Reporting Entity.

LAST UPDATE

The content of this fact sheet is current as of February 20, 2025, as confirmed by Brenda Rafter, Executive Director, Financial Analysis & Decision Support

APPROVALS

2025 02 20 - Brenda Rafter, Finance and Corporate Services Division
2025 02 24- Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Physician Supply Numbers

Topic: An overview of BC's current complement of physicians, recent trends, and comparison with other Canadian jurisdictions.

Key Messaging and Recommended Response:

- There's a global shortage of health workers, which is why we're making B.C. an attractive place to work, with fair pay, better working conditions and faster credential recognition – so we can deliver the care people need.
- Our government's record investments and improvements to physician supply include:
  - Increasing the University of B.C.'s medical school intake by 40 -seats, with an additional 162 residency positions by 2028. These efforts mean BC will have a total intake of up to 613 residents, including 205 family medicine, 219 first year- specialty, and 189 subspecialty intake positions. This is a 35% increase since 2017;
  - Expanding the Practice Ready Assessment BC program from 32 to 96 seats annually, which helps internationally trained family physicians get to work more quickly in B.C.;
  - Recruiting doctors internationally, and launching campaigns targeting countries like the USA and UK where the process for foreign credential recognition and transferring credentials is more compatible compared to other jurisdictions; and
  - Launching the first new medical school in Western Canada in over 50 years at Simon Fraser University, with the aim of welcoming its first students in 2026.
- We are starting to see the impact of our work; B.C. has an increasing supply of physicians compared to other provinces, and supply growth continues to outpace population growth.
- We will continue work hard to strengthen our health-care system, so that people in B.C. get the health care they need, when and where they need it. That's our focus every day.

CURRENT SITUATION

- In January 2025, Health Canada released *Caring for Canadians: Canada's Future Health Workforce – The Canadian Health Workforce Education, Training and Distribution Study.* The report was commissioned by the federal, provincial, and territorial Health Ministers to identify and support pan-Canadian approaches to meet future healthcare demands.
  - BC has already made progress in key areas including workforce modelling and forecasting of physicians.
- Compared to other provinces, BC has a good supply of physicians, and supply growth continues to outpace population growth; over the last 5 fiscal years (2018/19 – 2022/23), the number of physicians providing MSP services grew by 13.6%[1], while the BC population grew by 6.7%[2].
- In 2022/23, the Ministry of Health (HLTH) counted 14,357 physicians under all payment sources.[3] Physicians receive payments through fee-for-service, alternative payments, capitation, or a combination of modalities.
  - In February 2023, BC implemented the Longitudinal Family Physician (LFP) payment model. As of January 31, 2025, 4,474 Family Physicians are active working under the model.
  - Out of all family physicians who previously practiced longitudinal primary care (2021/2022), 72% have switched to the LFP model.[4]
- The College of Physicians and Surgeons of BC reported 15,502 registrants in 2022/23 and 15,993 in 2023/24. This count differs from HLTH's as there is a subset of practicing physicians in the province who are not compensated

[1] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, Health Sector Information, Analysis & Reporting Division (HSIAR), HLTH. Data from VT4, as of February 2024
[2] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, HSIAR, HLTH. Data from PEOPLE_LHA, as of February 2024
[3] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, HSIAR, HLTH. Data from HSPP: Physician Compensation Dashboard, as of January 2025
[4] HSIAR, HLTH. LFP Payment Model Dashboard, as of February 2025

through the public health system.[5]

- The CIHI estimates that BC has 272 physicians per 100,000 population (2023).
  - 138 Family Medicine physicians per 100,000; and,
  - 134 Specialists per 100,000.
- BC's figures are higher than the Canadian rate of 243 per 100,000 and ahead of all other provinces.[6]
- BC is increasing self-sufficiency in physician training while remaining an attractive destination for physicians relocating from other jurisdictions (total net migration of 122 in 2023[7]).
- As outlined in HLTH's Provincial Health Human Resource Strategy, BC's PRA-BC program for internationally educated family physicians increased intake from 32 to 96 annual seats in2024. PRA-BC program participants complete a
  3-year return of service (ROS) in a health authority-identified underserved community upon successful completion of the assessment. As of February 2025, 318 participants have been placed into 77 communities in BC[8].

KEY BACKGROUND

Challenges

- Discussion of physician shortage is not only related to the total number of physicians needed, but also related to changes in physician working preferences, productivity and distribution.
- In 2022/23 the average physician age in BC was 48.7 years compared to 49.3 years 5 years prior in 2018/19. In 2018/19, there were 1,652 physicians aged 65 or older and in 2022/23 there were 1,806. Therefore, despite the decrease in average physician age, the absolute number of retirees may still rise in the future due to the aging population of physicians. [9]

Training

- To train more doctors in BC, UBC expanded its medical school intake by 40 seats and will expand postgraduate residency intake by up to 162 residency positions by 2028.
- In 2025, BC will have a total intake of up to 613 residents, including 205 family medicine, 219 first-year specialty, and 189 subspecialty intake positions. This is a 35% increase since 2017 (i.e., 453).
- As part of the expansion, UBC's family medicine expands from 170 (2017) to 205 by 2025 – an increase of 35 new positions. UBC now has the single largest family medicine intake in Canada.
- HLTH continues to support the Ministry of Post Secondary Education and Future Skills to establish a second medical school at SFU within Surrey.
- Residents selected into International Medical Graduates – BC (IMG-BC) positions are required to complete a ROS in a health authority-identified underserved community upon finishing their residency program.
  - 52 of the 58 entry-level IMG-BC positions are in family medicine; the other 6 intake positions are in priority specialties that include psychiatry, internal medicine, and pediatrics.
  - An IMG-BC resident completing Family Medicine is required to complete a 2-year ROS; and a 3-year ROS if practicing in a specialty.
  - Inclusive of upcoming 2025 confirmed placements, 583 family physicians and 82 specialists have been placed in 101 communities, since the program started in 2006[10].

LAST UPDATED

The content of this estimates note is current as of March 24, 2025, as confirmed by Rhiannon Pretty.

APPROVALS

2025 03 26 – Martin Wright, Health Sector Information, Analysis & Reporting Division

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[5] Annual Report 2022/23, British Columbia College of Physicians and Surgeons, https://www.cpsbc.ca/about-us/annual-report - Verified by HSIAR
[6] CIHI. Supply, Distribution and Migration of Physicians in Canada, 2023 — Data Tables. Ottawa, ON: CIHI; 2024.
[7] *Ibid*, 6 – Verified per HSIAR
[8] Physician Services ROS Participant Data, March 22, 2024
[9] *Ibid*, 1 – Verified per HSIAR
[10] Physician Services, ROS Participant Data, February 13, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

Summary of Family Physician Supply in BC

Topic: An overview of family physicians (FPs) supply in BC, including programs to educate, recruit and retain FPs.

Key Messaging and Recommended Response:

- There's a global shortage of health workers, which is why we're making B.C. an attractive place to work, with fair pay, better working conditions and faster credential recognition.
- We are making it easier for international medical graduates (IMGs) to practice in B.C., such as expanding the Practice-Ready Assessment BC program in 2024 from 32 to 96 seats annually, which helps internationally trained family physicians get to work more quickly in B.C .
    - As of February 2025, 318 family physicians have successfully completed the -program and have been placed in 77 communities throughout the province.
- We are recruiting internationally, and specifically targeting the United Kingdom since the college process for foreign credential recognition and transferring credentials is more compatible compared to other jurisdictions.
- As well, the University of B.C.'s family medicine residency program has increased from 170 (2017) to 205 annual entry-level positions in 2025.
- Not only are we recruiting and training more family doctors, but we are also helping more of them start or continue their practices through the Longitudinal Family Physician Payment Model, which gives them greater flexibility and better compensation.
    - As of Jan. 31, 2025, 4,474 family physicians have signed on to the new model. [1]
- We will continue work hard to strengthen our health-care system, so that people in B.C. get the health care they need, when and where they need it.

CURRENT SITUATION

- In the 2022/23 fiscal year, 7,301 FPs received payment from the Ministry of Health (HLTH) for providing patient care services.[2] FPs make up approximately 50% of all physicians and this number corresponds closely to the number of FPs registered through College of Physicians and Surgeons of BC during the same period.[3]
- In most years, BC's number of FPs grows faster than the population: Between 2018/19 and 2022/23, the number of FPs grew by 12.1%, while BC's population grew by 6.7%[4].
- BC compares favourably with other Canadian provinces in per population supply of FPs: according to the Canadian Institute for Health Information (CIHI), in 2023, BC had 138 FPs per 100,000 population, behind only the Yukon and New Brunswick and well above the Canadian rate of 120 per 100,000[5].
- That ratio for BC grew from 131 per 100,000 in 2019 to 138 per 100,000 in 2022[6].
- BC continues to train and qualify more FPs to practice:
    - Since 2017, UBC's family medicine postgraduate education residency intake has increased from 170 to 205 annual entry-level positions offered in 2025 – an increase of 35 positions during this time.
    - PRA-BC program for internationally trained FPs increased annual seats from 32 to 96 in March 2024.

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[1] LFP Payment Model Uptake Report – February 21, 2024.
[2] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, Health Sector Information, Analysis & Reporting Division, HLTH. Data from VT4, as of February 2024.
[3] CPSBC, 2022/23 Annual Report. Retrieved on February 7, 2023, from https://www.cpsbc.ca/files/pdf/2022-23-Annual-Report.pdf
[4] From July 1, 2018, to July 1, 2022. PEOPLE 2023. BC Stats Population Estimates and Projections; updated February 22, 2024.
[5] CIHI. Supply, Distribution and Migration of Physicians in Canada, 2023 — Historical Data. Ottawa, ON: CIHI; 2024.
[6] *Ibid 3.*

- Table 1 illustrates the distribution of FPs providing patient care services across payment models over the last 5 fiscal years for which there is complete data. FP remuneration is trending away from fee-for-service as the exclusive payment modality to other models, e.g., such as service contracts, salary, sessional or capitation.

Table 1. Family Physician Headcounts that Provided Patient Care Services by Payment Modality[7]

Modality	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Fee-for-Service Only (FFS)	4,210	4,081	3,629	3,496	3,716
Mixed FFS/Other Payments	1,968	2,234	2,726	3,158	3,003
Other Payments Only	336	346	468	617	582
Total	**6,514**	**6,661**	**6,823**	**7,271**	**7,301**

- Table 2 provides detail on the number of FPs working under various payment arrangements, as of February 2024. FPs are counted in each payment model under which they worked, but only once in the total.

Table 2. Family Physician Headcounts by Payment Modality, Detail, 2022/2023[8]

Modality	Family Physicians
Fee-for-Service	6,794
Longitudinal Family Practice	2,558
Alternative Payments Program	2,214
Group Contract	119
Northern Model (capitation)	30
New-to-practice Contracts	214
Population-Based Funding (capitation)	132
Primary Care Strategy Funded APP	52
Total	**7,334**

KEY BACKGROUND

Postgraduate Medical Education (PGME)

- Family medicine residency positions continue to be expanded:
  - Aligned with HLTH's key priorities and BC's workforce needs, UBC continues to maintain a strong focus on training family medicine physicians to help support increased access to primary care.
  - As a result of expansion since 2017, UBC's family medicine intake will increase from 170 to 205 annual entry-level positions offered by 2025 – an increase of 35 total new positions during this time period.
  - As new family medicine residents move through their residency training programs, BC will continue to realize the benefits of HLTH's significant investment into PGME training.
- UBC's family medicine PGME program is distributed at 23 regionally based training sites across BC to:
  - Expose and prepare medical residents for the challenges and benefits of practicing in rural, remote, and other underserved communities.
  - Enhance health care service capacity across the province; note that medical residents also provide direct patient care while they train.
  - Upon completion of PGME, encourage these newly licensed physicians to establish a practice within the communities where they have been educated and trained.
- Residents selected into BC's IMG-BC family medicine positions are required to complete a 2-year return of service (ROS), in a health authority-identified underserved community upon finishing their residency program.
  - 52 of the 58 entry-level IMG-BC positions are in family medicine; the other 6 intake positions are in priority specialties that include psychiatry, internal medicine, and pediatrics.

[7] *Ibid* 2.

[8] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, Health Sector Information, Analysis & Reporting Division, HLTH. Data from HSPP: Physician Compensation Dashboard; VT4; and SCRUBS, as of January 2025.

- ROS placements in rural, remote, and other underserved communities support equitable access to patient care across BC.
- By end of 2025, 583 FPs and 82 specialists will have been placed in 101 communities since 2006, when the program was established [9].

PRA-BC Program[10]

- The PRA-BC program provides a pathway to licensure in BC for internationally trained FPs in exchange for a three-year ROS commitment within a community of need as identified by a health authority.
- As of February 2025, 318 PRA-BC FPs will have been placed in 77 communities in BC.[11]

LAST UPDATED

The content of this estimates note is current as of March 24, 2025, by Rhiannon Pretty.

APPROVALS

2025 03 25 – Martin Wright, Health Sector Information, Analysis & Reporting Division

[9] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, HLTH. IMG-BC Community Placements. Data as of February 13, 2024.
[10] For more information on PRA, please refer to the PRA-BC for Family Physicians Fact Sheet
[11] Physician Services; Health Sector Workforce and Beneficiary Services Division. PRA Participant Placements Data. Data as of March 21, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

Virtual Care – Physician Payment Growth

Topic: Virtual care provided by physicians paid under fee-for-service models.

Key Messaging and Recommended Response:

- **Demand for health-care services is growing at an unprecedented rate because of B.C.'s growing and aging population.**
- **Virtual care, which played a critical role in providing access to health care during the COVID-19 pandemic, continues to be used by many health-care professionals to help meet the care needs of British Columbians.**
- **Our government is working closely with the Doctors of BC and physicians to ensure the right balance of virtual and in-person care delivers high-quality public health care to people throughout the province.**
- **These different health service delivery models help people in B.C. access the care they need, when and where they need it.**

CURRENT SITUATION

- Virtual care has played a critical role in facilitating access to care during the COVID-19 pandemic. In 2020/21, virtual care visits rose by 691.8% over the previous year.
- Since then, utilization and expenditures of virtual care have decreased[1]:
  - Total virtual care expenditures in 2023/24 were $580.8M, a decrease of 16.2% ($112.4M) from 2022/2023 ($693.2M).
  - Total virtual care services in 2023/24 were 13M, a decrease of 10.5% from 2022/23.
- In the first 2-quarters of 2024/25[2]:
  - Virtual care fee item visits and consultations, as a proportion of all visits and consultations, decreased from 42.8% to 41.6%.
  - Virtual care visits and consultation services decreased from 5.8M to 5.4M.
  - Total in-person visits and consultations services were 7.5M; family practitioner in-person visits and consultations decreased from 4.5M to 4.3M.
  - Among family practitioner virtual care services:
    - Services decreased by 8.6%, from 4.8M to 4.4M.
    - The number of patients decreased by 5.9%, from 2.2M to 2.0M.
    - The number of participating physicians decreased by 7.8%, from 5.7K to 5.3K.

Virtual Care Fee Items Expenditures and Services Totals by Fiscal Year for 5 Fiscal Years[3] [4]

Metric	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024
Expenditure ($M)	83.28	896.69	810.43	693.29	580.89
% change		976.7%	-9.6%	-14.5%	-16.2%
Services (M)	2.34	18.53	17.11	14.55	13.0
% change		691.8%	-7.7%	-15.0%	-10.5%

[1] Ministry of Health Data are for fiscal years with the paid date as of the following September 30th for each fiscal year.
[2] HSIAR Integrated Analytics: Primary & Acute Care and Workforce Branch, Medical Services Plan Database, updated January 22, 2025.
[3] HLTH data are for fiscal years 2019/2020 to 2023/2024 inclusive, with the paid date as of the following September 30th for each fiscal year (RMS 3533).
[4] Data are for medical, nurse practitioner and midwives claims only.

Virtual and In-Person Patient Visits and Consultations

Specialty	Care Type	2020/2021	2021/2022	2022/2023	2023/2024
Family Practice	Virtual Care	13,897,611	12,494,228	10,369,557	9,603,342
	In-Person Care	5,634,626	7,009,936	8,211,626	9,087,719
	Total	19,532,237	19,504,164	18,581,183	18,691,061
	% Virtual Care	71.15%	64.06%	55.81%	51.38%
Specialists	Virtual Care	2,837,865	2,496,841	2,104,960	2,017,096
	In-Person Care	4,880,116	5,631,743	6,086,889	6,588,519
	Total	7,717,981	8,128,584	8,191,849	8,605,615
	% Virtual care	36.77%	30.72%	25.70%	23.44%

FINANCIAL IMPLICATIONS

- Total virtual care expenditures in 2023/24 were $580.89M.[5]

KEY BACKGROUND

- "Telehealth Service" is a specifically defined term in the Medical Services Commission (MSC) Payment Schedule: "a medical practitioner delivered health service provided to a patient via live image transmission of those images to a receiving medical practitioner at another approved site, using video technology."
- In response to the pandemic, the General Preamble has been changed temporarily to include telephone calls in the definition of telehealth and where there is no telehealth fee for consultations, office visits, and non-procedural interventions, to allow a virtual care service to be claimed under the face-to-face fee, with a claim note record that the service was provided via telehealth.
- Initially, the delivery of telehealth services payable under the MSC Payment Schedule was restricted to a health authority facility. To support physicians and patients that were not physically close to a health authority facility, that requirement was removed in 2011.
- Since then, the Ministry of Health has seen significant increases in utilization across all specialties, but particularly in Family Physician telehealth fees.
- Prior to the pandemic, most physician virtual care visits were delivered through use of private, internet-based providers.
- Currently there are 259 virtual care fees[6] for medical specialties in the MSC Payment Schedule[7]. These include telehealth (206 fees) and services using other platforms (i.e., telephone, e-mail, text, fax).
- 10 fees originally established under the General Practice Services Committee and 8[8] fees originally established under the Specialist Services Committee transferred to the MSC Payment Schedule April 1, 2020, per the Physician Master Agreement.
- 25 new virtual care fees were temporarily approved to support access to healthcare during the pandemic and 6 virtual care fees temporarily deleted.

LAST UPDATED

The content of this estimates note is current as of March 24, 2025, as confirmed by Rhiannon Pretty.

APPROVALS

2025 03 25 – Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 13 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

[5] HSIAR Integrated Analytics: Primary & Acute Care and Workforce Branch, Medical Services Plan Database, updated January 22, 2025.
[6] Include temporary fees to support access to healthcare during COVID-19 pandemic.
[7] Ministry of Health. Health*ideas* fee item database.
[8] Ministry of Health. Health*ideas* fee item database.

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Gateway

Topic: Health Gateway is the provincial patient portal that gives BC residents secure online access to their health information and services from anywhere in the province.

Key Messaging and Recommended Response:

- Health Gateway is making it easier and more convenient for people to access their health records online safely and securely.
- Health Gateway helps people stay on top of their health and wellness needs, so they can actively make decisions about their and their families' health needs.
- Connecting people to health information including lab results, immunization history and health visits in one place is a priority for government, supporting quality care by allowing people to easily share their health history with providers across care settings.
- Health Gateway is making proactive self-care and health management easier, more equitable and accessible. It brings key health priorities—like immunization and cancer screening reminders—directly to people
- Health Gateway is built with robust security standards, using the BC Services card for secure authentication, ensuring people in BC can conveniently and confidently access their health information.

CURRENT SITUATION

- As of January 24, 2025, Health Gateway has 1,655,406 registered users[1].
- Health Gateway enables secure login and registration using the BC Services Card.
- The portal gives users access to their personal health information and online services, including:
  - Prescription history
  - Lab result history
  - Immunization schedule & history (including COVID-19)
  - Reminder and result letters for BC Cancer Cervix, Lung, Breast, and Colon Screening programs
  - Special authority drug request status
  - Hospital visits
  - Healthcare visits billed to the Medical Services Plan
  - Organ donor registration status
  - Diagnostic imaging reports
  - Clinical documents cc'd to patients where health authorities permit
  - The ability for users to capture information about their own health care experiences with notes and comments
- More clinical records and online services are planned for patients using the Health Gateway. For example: a calendar of appointments, notifications and reminders, patient summaries and information from primary care providers, and discharge summaries from hospital visits.
- The Health Gateway team works closely with patients, families, health care providers, HealthLink BC and health authorities to ensure that the information available in the Health Gateway supports patients to better manage their health through safe and equitable access to their personal information and relevant services.
- The Health Gateway team works with health sector partners to align patient portals across the province, creating a more unified and connected patient experience for British Columbians.
- Health Gateway is listed as a key initiative in BC's Digital Health Strategy and continues to promote its presence by aligning with provincial communication campaigns and with key placement on the HealthLink BC website to increase access and awareness.

[1] Program data source, Jelena Kalyvas. Project Manager, Health Gateway Team, Provincial Health Services Authority. January 24, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- In 2022/23 the Ministry received capital funding of $1.667 million from the OCIO through the HIE funding request, and a further $2.200 million from OCIO through the Health Gateway 2.0 funding request.
- In 2023/24 the Ministry received capital funding of $2.681 million from OCIO through the Health Gateway 2.0 funding request.
- In 2024/25 the Ministry received capital funding of $2.480 million from OCIO through the Health Gateway 2.0 funding request.

KEY BACKGROUND

- In 2019, the Health Gateway project was approved as a cross-sector initiative led by the Ministry of Health in partnership with the OCIO and Government Digital Experience, Ministry of Citizens' Services.
- In December 2019, Health Gateway launched as a web-based application. Health Gateway immediately began to respond and adapt to the needs of British Columbians. For instance, during the COVID-19 pandemic, Health Gateway provided a critical service as the provincial distributor of proof-of-vaccination QR codes.
- In Summer 2022, the Provincial Deputy Ministers' Committee on Digital and Data further endorsed Health Gateway with an additional 3-year funding commitment to continue to expand to meet the needs of British Columbians.
- In November 2023, the Deputy Ministers' Committee on Digital and Data endorsed Health Gateway to expand functionality and expand into interactive digital services, such as allowing patients to track referrals, securely communicate with healthcare providers, or view and manage medical appointments; and shift to a new technology platform to do so.
- In August 2024, Health Gateway gained a new look and powerful functionality readiness on a new platform that aligns with partner programs, taking another step toward to a connected patient experience provincewide.
- In December 2024, Health Gateway launched digital access to more BC Cancer Screening Reminder and Result letters which supported people with these important health activities during the Canada Post mail strike.

LAST UPDATED

The content of this estimates note is current as of February 3, 2025, as confirmed by Danton Remacle.

APPROVALS

2025 02 13 – Jeff Aitken, Health Sector Information Management Information Technology
2025 02 24 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 02 26 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Agency Staffing

Topic: Agency utilization by health authorities and provincial actions to manage expenditures.

Key Messaging and Recommended Response:

- Private agency nurses are used as a last resort to fill shift vacancies and prevent services disruptions.
- Our priority is to ensure the public has access to health care services, particularly in rural and remote communities, that often see challenges in recruiting staff.
- The Ministry of Health is taking action to reduce reliance on private staffing agencies. These actions include:
    - A standardized provincial contract for staffing agencies, with language that improves financial transparency and prioritizes patient safety
    - The expansion of GoHealth BC (the provincial travel resource pool) that deploys health authority employed nurses to rural and remote communities.
    - Competitive wage increases, premiums, and incentives, as well as policy changes (such as minimum nurse to patient ratios) to attract nurses and other health care workers to work in the public sector.

CURRENT SITUATION

- Agency utilization has increased in each of the last five fiscal years; however, the rate of increase has slowed.
    - Total agency hours increased by 30% from 2022/23 to 2023/24 (compared with 153% increase from 2020/21 to 2021/22 and 98% increase from 2021/22 to 2022/23).
    - In 2023/24, agencies supplied 3.6% of all nursing productive hours, up from 2.9% in 2022/23.

Table 1. Agency hours total and as a % of total nursing productive hours, by health authority (HA)[1]

	Total Agency Hours (in thousands)		Agency Nursing Hours as a % of Total Nursing Productive Hours	
	2022/23	2023/24	2022/23	2023/24
Fraser	152	112	1.1%	0.8%
Interior	281	317	3.3%	3.5%
Island	407	584	4.7%	6.4%
Northern	306	392	10.4%	12.6%
Providence	23	23	0.9%	0.9%
Vancouver Coastal	178	322	2.9%	3.2%
Total	**1,346**	**1,750**	**2.9%**	**3.6%**

- Through B.C's Health Human Resources Strategy, Ministry of Health (HLTH) has implemented several actions to bolster our public sector nursing workforce – ensuring appropriate staffing levels and reducing our overall demand for agency staffing, including:
    - Implementing and expanding GoHealth BC – a travel nursing program that deploys health authority employed nurses to rural and remote communities across the province.
    - Funding generational wage increases and premiums for unionized nurses through the 2022-2025 Nurses Bargaining Association collective agreement.
    - Implementing minimum Nurse to Patient Ratios.
    - Offering a suite of public-sector incentives in Fiscal Year 2024/25, including signing bonuses for former agency nurses who accept regular positions in the public sector.
    - Reducing barriers for internationally educated nurses to work in public sector healthcare settings.
    - Establishing a provincial framework with wraparound supports for new graduates during their first

[1] Health Employers Association of BC (HEABC) Data provided to Workforce Planning and Results Management (WPRM). September 2024.

years of practice.
- Developing a peer support and mentoring program to help new entrants transition into the public sector nursing workforce.

FINANCIAL IMPLICATIONS

Table 2. Agency Expenditures by HA, 2022/23 and 2023/24 in millions ($M) [2]		
Health Authority	**2022/23**	**2023/24**
Fraser	$14.73M	$15.40 M
Interior	$33.65M	$57.89 M
Island	$37.46M	$53.22 M
Northern	$52.03	$70.7 M
Provincial Health Services Authority	$0.12M	$1.51M
Providence	$2.60M	$2.64 M
Vancouver Coastal	$24.05M	$39.26 M
Total	**$164.65M**	**$240.6 M**

KEY BACKGROUND

- During the COVID-19 pandemic, there emerged a concerning trend of nurses leaving HA positions, joining or starting a private agency, and then providing private care at the sites where they were previously employed. In some cases, these nurses would also recruit their former teammates to follow suit.
  - In response to the proliferation of new agencies, HLTH placed a moratorium on new agencies in 2022 and began work on a suite of provincial initiatives to reduce reliance on agencies and improve accountability.
  - The new provincial contract (launched in 2024) includes terms to reduce churn from HAs to agencies and to ensure patient safety:
    - requiring agencies to wait 6 months from the employees' last day of work for an HA prior to their deployment into an HA site by the agency
    - prohibiting agency staff from simultaneously being "on call" for an HA and an agency
    - prohibiting agencies from hiring new graduates
  - In spring 2024, HLTH permitted Northern Health to contract with six new agencies to support emergency department stabilization efforts in rural and remote areas.

LAST UPDATED

The content of this estimates note is current as of March 10,2025 as confirmed by Lynn Hancock.

APPROVALS

2025 03 10 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 28 – Finance and Corporate Services Division

[2] Finance and Corporate Services Division (FCS) Data provided to Workforce Planning and Results Management (WPRM). September 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE
Amalgamation of Health Profession Regulatory Colleges

Topic: On June 28, 2024, 11 health profession regulatory colleges were amalgamated to create two new multi-profession regulators, decreasing the total number of health profession regulatory colleges in BC from 15 to 6.

Key Messaging and Recommended Response:

- As of June 2024, all health profession regulatory college amalgamations recommended by the Steering Committee on Modernization of Health Professional Regulation have been completed.
- Having fewer regulatory colleges will directly support patients and families in BC:
    - Reducing the colleges from 15 to 6 will make it easier for the public to determine who they should contact regarding concerns about the care received by a health professional.
    - For example, as a result of the amalgamation of the three nursing regulatory colleges, there is now a single point of contact for concerns about the professional practice or behavior of any nurse.
- Amalgamating the regulatory colleges from 15 to 6 increases public protection and improves the efficiency and effectiveness of regulatory colleges.

CURRENT SITUATION

- As of June 28, 2024, the College of Complementary Health Professionals of BC (CCHPBC) now regulates the professions of massage therapy, chiropractic, naturopathic physicians, and traditional Chinese medicine practitioners and acupuncturists.
- As of June 28, 2024, the College of Health and Care Professionals of BC (CHCPBC) now regulates the professions of physical therapy, occupational therapy, dietetics, optometry, opticianry, psychology, and the speech and hearing professions.
- While these colleges are legally amalgamated, they continue to work on operational amalgamation, including alignment of the previous colleges' information technology systems and registration processes.
- Additionally, all colleges are preparing for the transition from the *Health Professions Act* (HPA) to the *Health Professions and Occupations Act* (HPOA).

FINANCIAL IMPLICATIONS

- To support the work required to complete the legal amalgamations by June 28, 2024, the Ministry of Health (HLTH) awarded the 11 amalgamating colleges a $4.0 million grant on May 30, 2023, and an additional grant of $1.125 million on April 11, 2024.

KEY BACKGROUND

- On August 27, 2020, the Steering Committee on Modernization of Health Professional Regulation (the Steering Committee) released its final recommendations report. Included within the report is a recommendation to reduce the number of regulatory colleges in BC from 20 (at the time) to 6 to increase public protection and improve efficiency and effectiveness of regulation.
- Since the report was released, three amalgamations, in addition to the two that occurred in June 2024, have taken place:
    - On September 1, 2020, the former nursing and midwifery regulators were amalgamated to form the British Columbia College of Nurses and Midwives (BCCNM).
    - On August 31, 2020, the former physicians/surgeons and podiatric surgeon regulators were amalgamated to form the College of Physicians and Surgeons of British Columbia (CPSBC).
    - On September 1, 2022, the former oral health regulators (dentistry, dental hygiene, dental technology and denturist) were amalgamated to form the British Columbia College of Oral Health Professionals (BCCOHP).

- The two amalgamations that occurred on June 28, 2024, were the last amalgamations recommended by the Steering Committee on Modernization of Health Professional Regulation. In total, there are six health profession regulatory colleges operating under the HPA and these will continue under the HPOA once it is brought into force:
    - The College of Physicians and Surgeons of British Columbia;
    - The British Columbia College of Nurses and Midwives;
    - The College of Pharmacists of British Columbia;
    - The British Columbia College of Oral Health Professionals;
    - The College of Health and Care Professionals of British Columbia; and
    - The College of Complementary Health Professionals of British Columbia.
- The amalgamations were intended to create larger and better resourced regulatory colleges that have a greater ability to effectively fulfil their public protection mandates under the HPA.
- While previous amalgamations were funded by the amalgamating colleges, the two recent amalgamations creating the CCHPBC and CHCPBC involved the amalgamation of BC's smallest and least well-resourced regulators who did not have the financial resources to independently support amalgamation. Given this, HLTH provided $5.125 million in grant funding to support amalgamation.

LAST UPDATED

The content of this estimates note is current as of February 19, 2025 as confirmed by Brian Westgate, Acting Executive Director.

APPROVALS

2025 03 12 – Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 02 22 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Associate Physicians

Topic: Expansion of the 'Associate Physician' class of restricted licensure for international medical graduates (IMGs) who are not eligible for a full or provisional license.

Key Messaging and Recommended Response:

- With a global shortage of health-care workers, this is another way we are strengthening our health-care system to deliver the care people in B.C. need.
- To make it easier for internationally trained doctors to receive credential recognition in the province, we introduced the associate physician classification.
- As associate physicians, international medical graduates who are not eligible for licensure as independent medical practitioners can work under an attending physician – finding meaningful employment and helping to meet the workforce needs of B.C.'s health-care system.
- As of early February 2025, 78 associate physicians were working throughout B.C., with health authorities expanding this capacity in a wide range of clinical settings.

CURRENT SITUATION

- Expansion of Associate Physician (AP) deployment is included as Action 23 in BC's Health Human Resources (HHR) Strategy, and the Ministry of Health (HLTH) has committed direct funding for salary, benefits, and other costs to accelerate AP program development and hiring across the province.
- Health authorities have responded with the launch of 116 AP programs accredited by the College of Physicians and Surgeons of BC (CPSBC). A further 37 programs are in the planning or accreditation phases.
- **92 APs have been licensed** to date:
  - **78 APs hold an active license** and are working in BC.
  - **14 APs have an inactive license**, meaning they are in the process of changing positions, did not pass their initial 12-week assessment, or have resigned.
- Provincially, there are **58 open job opportunities** posted to Health Match BC (HMBC).
- The AP role is active in or planned in a wide range of clinical settings. Current accredited programs target Inpatient Care, Emergency Medicine, Surgery, Perinatal, Medical Oncology, General Internal Medicine, Critical Care, Obstetrics and Gynecology, and many other areas.
- HMBC has identified 243 potential candidates who appear to meet CPSBC requirements for the AP Acute or AP Community Primary Care license and are already authorized to work in Canada.
  - Candidates not yet meeting CPSBC requirements are often missing English language testing, completion of the Medical Council of Canada (MCC) Qualifying Exam, or demonstration of clinical currency.
- With the exception of a small pilot project in Northern Health, AP deployment has been limited to acute care settings.

FINANCIAL IMPLICATIONS

- In 2023/24, HLTH allocated $3.127 million in HHR Strategy Action 23 funding to health authorities (HAs) for APs.
- With additional HHR Strategy funding of $7.151 million for 2024/25, HLTH has committed to reimbursing HAs for actual expenses incurred in 2024/25 and 2025/26 for APs hired before March 31, 2025.

KEY BACKGROUND

- APs are physician extenders who work under an associate physician class of licensure available to qualified IMGs who are unable to meet the requirements for full or provisional licensure through the CPSBC and would not otherwise be able to contribute to patient care in BC.
- APs work as health authority employees in team-based settings under physician direction and supervision to increase health care quality, access, and the patient experience.

- To become licensed as an AP in BC, an IMG must have:
    - Completed a medical degree outside of Canada at a school listed in the World Directory of Medical Schools;
    - Undertaken at least one year of post-graduate training for work in community primary care or surgical assist and two years for work in acute care settings;
    - Passed Part 1 of the MCC Qualifying Exam and be a licentiate of MCC (or CPSBC-defined equivalent);
    - Maintained clinical currency to the satisfaction of CPSBC by working at least 24 months in the prior three years; and
    - Obtained an offer of employment and sponsorship by a health authority.
- Prospective APs must also demonstrate that they meet general English language proficiency requirements of CPSBC. They can do this by showing that the primary language of their medical education and prior patient care was English or by taking a standardized proficiency test (IELTS Academic, OET Medicine, or CELPIP General).
- Health authorities that employ APs must do so within a program that has been accredited by CPSBC to ensure program quality, provide an objective means of assessment, and enable CPSBC to provide guidance as programs are developed.
    - Specific accreditation requirements include defined oversight and supervision models, a comprehensive job description, a performance evaluation system, and continuing professional development monitoring and support processes.
- CPSBC first amended their bylaws to create a registration category for APs on May 29, 2020. Since then, the Ministry has worked collaboratively with CPSBC, health authorities and other partners to develop the policies, process and structures needed to integrate AP within acute and community primary care settings.
- HMBC maintains a pool of candidates who have expressed interest in becoming an AP, profiles all vacancies, provides pre-screening for prospective applicants, works with eligible candidates to apply for open positions, and assists those who are successful to submit a registration package to CPSBC.

LAST UPDATED

The content of this estimates note is current as of February 9, 2025 as confirmed by Kevin Brown.

APPROVALS

2025 03 05 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 28 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

BC's Health Human Resources Strategy

Topic: Progress to implement 70 actions under four cornerstones: retain, redesign, recruit, and train.

Key Messaging and Recommended Response

- The Health Human Resources (HHR) Strategy, announced in Fall 2022, is comprised of 70 actions to recruit, train and retain health-care workers, while redesigning the health-care system to foster workplace satisfaction and innovation.
- Government launched the strategy and committed roughly $1 billion in new funding over three years to support the transformational change proposed throughout the strategy's 70 actions.
- It's already making a difference and throughout the health car system we're starting to see signs of improvement despite the challenges experienced across the country and around the world in health sector staffing.
- 58 of 70 actions are already complete or substantially underway – up from 39 in December 2023.
- This year we will evaluate our progress and refresh the strategy to align with current provincial priorities and emerging fiscal realities.
- Government remains committed to ensuing a robust health human resources strategy is in place in this province so that people in B.C. have access to the health services they need in every corner of the province.

CURRENT SITUATION

- Across the world, health needs are becoming more complex and demand for healthcare services is growing.
  - Demand pressures are being compounded by supply shortages driven by an ageing workforce, increased competition from other sectors, inconsistent uptake of health sector training, and other factors.
- Under the **retain** cornerstone, 12 of 17 actions are underway or complete. Including:
  - Implementation of a relational security model at 26 sites, 320 RSOs and 14 Violence Prevention (VP) Leads hired.
  - Increased psychological and occupational health and safety support for healthcare workers,
  - Expanded the Provincial Rural Retention Incentive (PRRI) to 80 communities across BC, and
  - Partnered with the Vice Presidents of Indigenous Health to develop resources for Indigenous employees.
- Under the **redesign** cornerstone, 14 of 18 actions are underway or complete. Including:
  - minimum Nurse to Patient ratios in hospitals across BC,
  - Introduction of the Associate Physician and Physician Assistant roles,
  - Expansion of the GoHealth BC program – providing more than 300,000 hours of nursing in 34 rural and remote communities across the province, and
  - Expanded scopes of practice for key professions including emergency medical assistants and pharmacists.
- Under the **recruit** cornerstone, 15 of 16 actions are underway or complete, including:
  - Registering more than 1,600 internationally educated nurses (IENs) and hiring nearly 1,500 IENs into health authority nursing positions,
  - Signing bonuses and other incentives for 211 new-to-practice family physicians, 1459 nurses, and 765 allied health and other healthcare workers by December 31, 2024.

  - Deployed the nurse new graduate transition program with a streamlined hiring process, a guaranteed offer of regular employment, time with a clinical mentor, and a $500 exam bursary, and
  - Increased dual credit opportunities to attract more high school students to health sector careers.
- Under the **train** cornerstone, 17 of 19 actions are underway or complete, including:
  - Added 40 undergraduate medical education seats and over 160 post-graduate residencies at the University of British Columbia (UBC) by 2028 (including 40 undergraduate seats and 67 residencies already added),
  - Made progress towards opening the Simon Fraser University Medical School which is expected to welcome 48 students in 2026 and grow to approximately 120 by 2035,
  - Added more than 700 new employed student nurse placement opportunities per year, and
  - Funded tuition credits and bursaries for nursing students, priority allied health students, and Indigenous students in select health education programs.

FINANCIAL IMPLICATIONS

- Budget 2023 allocated three-year funding of $995 million to the Strategy, including $273.6 million in FY2023/24, $349.6 million in FY2024/25, and $372.7 million in FY2025/26.

KEY BACKGROUND

- The Strategy received Cabinet and Treasury Board approval in 2022.
- HLTH released a public report in December 2023 – highlighting 39 actions that were complete or underway.

LAST UPDATED

The content of this estimates note is current as of March 10, 2025 confirmed by Lynn Hancock.

APPROVALS

2025 03 16 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 26 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Designation of New Health Professions and Occupations

Topic: Regulating new Health Professions

Key Messaging and Recommended Response:

- Government recognizes some currently unregulated health professionals would like to become regulated under the *Health Professions Act HPA*.
- This was formerly a complex and arduous process with potentially significant new costs in the form of College fees to those wanting to become a regulated profession.
- That's why Government launched a robust engagement initiative to consult health professionals throughout B.C. as the HPA was being developed with intentions to streamline and amalgamate the current Colleges while creating a future where regulating new professions is more efficient and successful.
- At the moment, the Ministry is no longer conducting designation assessments under the *Health Professions Act* (HPA) and instead focusing on bringing the *Health Professions and Occupations Act* (HPOA) into force.
- Under the HPOA the Superintendent of Health Professions and Occupations will conduct assessments and make a recommendation to the Minister on whether a group of health providers should become regulated as a designated health profession.
- This will better enable the Minister to make decisions whether to designate, based on the recommendation provided by the Superintendent.

CURRENT SITUATION

- Under the *Health Professions Act* (HPA), the Ministry of Health is responsible for conducting assessments to determine whether a group of health providers should become regulated as a designated profession.
- Currently, there are 25 health professions designated and regulated by a regulatory college.
- Under the HPA, whenever a new health profession is designated and regulated, a new regulatory college must be established.
- On August 27, 2020, the Steering Committee on Modernization of Health Professional Regulation (the Steering Committee) released its final recommendations report: Recommendations to modernize the provincial health profession regulatory framework (PDF, 669KB)[1].
    - The report recommended reducing the number of regulatory colleges in BC from 20 to 6 through amalgamation to increase public protection and improve efficiency and effectiveness of regulation.
    - The report also recommended that an oversight body conduct assessments into whether any more professions should become regulated.
- These recommendations informed the *Health Professions and Occupations Act* (HPOA), which received Royal Assent on November 24, 2022.
- The Ministry has been working towards reducing the overall number of regulatory colleges. As of June 28, 2024, following the amalgamation of 11 colleges into 2 (College of Health and Care Professionals of British Columbia and College of Complementary Health Professionals of British Columbia) there are now 6 regulatory colleges.
- The HPOA also creates the Office of the Superintendent of Health Profession and Occupation Oversight (Superintendent's Office).
- The Superintendent's Office is an independent office that will conduct designation assessments into whether any unregulated health provider should become regulated. The Superintendent's recommendation

[1] Steering Committee on Modernization of Health Professional Regulation, *Recommendations to modernize the provincial health profession regulatory framework*, August 2020, https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/recommendations-to-modernize-regulatory-framework.pdf. Last accessed February 11, 2025.

will inform a Ministerial decision whether to regulate and in what form.

- The HPOA also enables the designation of health occupations, a lighter-touch approach to regulating health providers, who do not meet the test of becoming health professionals, but provide services that present a risk of harm to the public.
- There are currently no designated health occupations.

FINANCIAL IMPLICATIONS

- Cabinet Confidences

- Health allocated $2.9 million in 2024 to support the work of Superintendent Office.

KEY BACKGROUND

- On October 18, 2023, parts of the HPOA were brought into force to stand up the Superintendent Office.
- In June 2024, Sherri Young was appointed Superintendent (by Cabinet) and in July Benson Cowan was appointed Director of Discipline (by the Minister).
- The Superintendent's Office will take on the responsibility of conducting designation assessments and making recommendations on designating professions and occupations to the Minister.
- Recommendations will be based on the level of risk of the profession or occupation's activities on public health, considering both the likelihood of harm and the severity if harm should occur. It will also include which form of regulation is most appropriate.
- The Minister will make the final determination on whether to designate the profession or occupation, and the form of regulation.
- Several health professions have been designated under the HPA but are not yet regulated, as the Ministry has prioritized the amalgamation of regulatory colleges and the development and implementation of the HPOA.
    - 4 Diagnostic and Therapeutic (D&T) occupations (respiratory therapists, radiation therapists, clinical perfusionists and medical laboratory technologists) were designated by Cabinet as health professions in 2017.
    - Psychotherapists were designated by Cabinet as a health profession in July 2024.
- The D&T and psychotherapy professions will be regulated once the HPOA is in force by an existing regulatory college, which will be responsible for establishing, monitoring, and enforcing educational requirements.

There is currently no timeline for when the HPOA will be bought into force, or when the D&T professions and psychotherapists will be regulated.

LAST UPDATED

The content of this estimates note is current as of February 10, 2025, as confirmed by Christopher Bennett.

APPROVALS

2025 03 04 – Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 02 14 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Extra Billing – Canada Health Act

Topic: Management of extra billing charges within the public healthcare system in B.C.

Key Messaging and Recommended Response:

- The Province is committed to maintaining the integrity of the public health care system.
- We changed the *Medicare Protection Act* (MPA) in 2018, bringing in new protections for patients to ensure they would not be liable for extra billing and clarified rules around extra billing for medical practitioners.
- In September 2020, we saw a successful outcome in the landmark Cambie Surgeries Corporation litigation. The appeal was heard in June 2021, and a decision was rendered by the BC Court of Appeal in July 2022, upholding that of the BC Supreme Court, in favour of the province. In April 2023, the Supreme Court of Canada denied Cambie's application for leave to appeal, bringing this ongoing proceeding to a successful conclusion.
- Since 2022, the Medical Services Commission (MSC) has been in contact with numerous entities alleged to be charging beneficiaries in B.C. for insured medical services, including corporations, brick and mortar health care clinics, and independent practitioners. Results have varied, from immediate steps to come into compliance with the MPA to continued challenge about the intent of the fees and services. The MSC continues to contact new entities brought to its attention.
- Health Canada issued a CHA Interpretation Letter on January 9, 2025, expanding the policy of prohibition against patient charges to include any "physician equivalent services" (e.g., NP, pharmacists, midwives). The *Canada Health Act Services Policy* will come into effect on April 1, 2026. Provinces and territories will be required to report patient charges under the new policy in December 2028.
- We remain steadfast in our commitment to ensuring equal access to quality health care, and that health care is not based on a person's ability to pay – and we will continue to defend it.
- The Province continues to build a robust public system where primary care services are comprehensive and free at the point of care, and where patients are not liable for extra billing.

CURRENT SITUATION

- The CHA requires the submission of a financial statement by provinces each December which shows the amount charged to patients through extra billing and/or user charges for the fiscal year ending 21 months previously (e.g., December 2023 for 2021/22).
- Advice/Recommendations
-
- On April 1, 2020, the Federal Diagnostics Services Policy came into effect. Similar to the Federal Services Policy, this policy was result of a CHA Interpretation Letter. The Federal Diagnostics Services Policy aims to ensure patients do not face charges for medically necessary diagnostic services such as, but not limited to, magnetic resonance imaging (MRI) and computed tomography (CT) scans, regardless of where the services are provided.
- As of April 1, 2020, any province that had not eliminated patient charges for medically necessary diagnostic scans was subject to mandatory deductions under the terms of the CHA. Reports to Health

[1] March 11, 2025 email from Jocelyne Voisin (Health Canada) to Mark Armitage (BC Ministry of Health).

Canada on extra billing and user charges in respect of medically necessary diagnostic services began in the 2021/22 report, which was prepared December 2022.

- Advice/Recommendations
- Advice/Recommendations
    - Section 18.1 of the MPA expands the current prohibition against approved diagnostic facilities charging for medically necessary diagnostic services that are benefits under the MPA or the *Hospital Insurance Act* to include unapproved facilities. Advice/Recommendations
    Advice/Recommendations
- On January 9, 2025, HC released a CHA Interpretation Letter, expanding the policy prohibiting patient charges to include any "physician equivalent services" (e.g. Nurse Practitioners, pharmacists, midwives). The *Canada Health Act Services Policy* will come into effect on April 1, 2026, and reporting of patient charges under the new policy will be required by provinces and territories in the in December 2028 *Extra Billing and User Charges Information Regulations* report.

FINANCIAL IMPLICATIONS

- The requirement for B.C. to report annually to HC on extra billing and/or user charges results in a reduction of the federal government CHT payments to the province.

KEY BACKGROUND

Advice/Recommendations

LAST UPDATED

The content of this estimates note is current as of March 12, 2025 as confirmed by Kate Puckett.

APPROVALS

2025 02 14 – Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 02 27 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Health Career Access Program

Topic: The Government announced the Health Career Access Program (HCAP) on September 9, 2020[1] to provide a flexible pathway to rewarding careers in healthcare while taking decisive action to address persistent staffing challenges in the long-term care, assisted living, and home support sectors.

Key Messaging and Recommended Response:

- The Health Career Access Program was launched in September 2020 to recruit entry-level health care workers into the health sector in long-term care (LTC) homes, assisted living (AL) facilities, health authority-owned and operated home health services, and acute care including Emergency Departments across the province.
- The Health Career Access Program is a publicly funded, work-integrated learning pathway that provides people in B.C. flexible pathways to a rewarding career in health care, allowing them to begin working as health care support workers while upgrading their skills to become licensed health care assistants.
- The program was expanded in May 2022 to include Indigenous communities, and again in November 2023 to include mental health and addiction support workers.
- The program is a part of the Provinces' Health Human Resources Strategy which works to strengthen BC's health workforce through retention, recruitment and training, as well as redesigning the health-care system.
- As more HCAP participants are hired into the workforce they help to support health care professionals spend more time with patients, resulting in better care.
- Since the program was announced on September 9, 2020, 9,709 positions in the Health Career Access Program have been filled across all initiatives.[3]

CURRENT SITUATION

- On September 9, 2020, Provincial Government announced the launch of the HCAP, a program aimed at hiring 3,000 net new Health Care Support workers per year (HCSW) Full-time Equivalents (FTEs).[2]
- As of December 31, 2024, a total of 9,709 HCAP positions have been filled[2]:

Table 1 HCAP Hiring Activity as of December 31, 2024

	Allocation	Total Hires
LTC/AL Sites	**7,738**	**7,235**
Health Authority Sites	*2,999*	*3,076*
Private/Affiliate	*4,739*	*4,159*
Home Support	**2,238**	**1,990**
Acute Care	**814**	**351**
Mental Health/Substance Use	**139**	**133**
Total	**10,929**	**9,709**

- As of December 31, 2024, 7,065 HCAP participants have started their training at a post-secondary institution, with 5,336 graduated from their education program and 4,346 moved to Return of Service (ROS) stage. [3]

[1] BC Government News Release Sept.9, 2020: https://news.gov.bc.ca/releases/2020PREM0050-001694

[2] On September 9, 2020, Government announced the hiring of 7,000 individuals into the health sector over three initiatives including: (1) 3,000 net new Health Care Support Worker (HCSW) FTEs (2) 2,000 net new FTEs to support visitation in long-term care and assisted living and (3) 2,000 existing vacancies filled through the Provincial Recruitment campaign. Program aimed at hiring 3,000 net Health Care Support Worker (HCSW) FTEs per year. As of December 31, 2024, 9,709 positions have been filled across all initiatives.

[3] Health Career Access Program (HCAP) Portal, December 31, 2024.

- An expansion into acute care, supporting a new team-based care model in Emergency Departments, is being prototyped across all Health Authorities as of April 1, 2023. An early prototype in the Fraser Health Authority hired 184 participants.[3] An additional 74 HCAP acute participants have been hired to the Interior Health Authority followed by 42 in Northern region and 51 in Vancouver Island.[3]
- During 2023, the Ministry of Health and former Ministry of Mental Health and Addictions (MMHA) softly launched an HCAP expansion into Mental Health and Substance Use (MHSU) settings.
    - A formal announcement of this expansion was made in July 2024[4].
    - The MHSU pilot program aims to recruit up to 500 participants over 3 years. With participation from all Health Authorities, the program has hired 133 participants as of December 2024.[3]
- The first prototype expanding HCAP into Indigenous communities was initiated in May 2022. Several additional First Nations communities have expressed interest in participating with hires planned throughout 2023.

FINANCIAL IMPLICATIONS

- Budget 2021 provided $585 million over three years to continue support of the HCAP program.
- Budget 2023 and Budget 2024, each provided $117 million to the health authorities for wage and benefit supports and $900,000 for administrative supports while individuals train as health-care workers in long-term care homes and assisted-living facilities throughout BC.
- A further $3 million was provided in 2020/21, $4.2 million in 2021/22, $2.7 million in 2022/23, $4.1 million in 2023/24, and a forecast of $4.1 million in 2024/25 to the Ministry of Post-Secondary Education and Future Skills (PSFS) to support direct program funding to post-secondary institutions.
- Ministry of Post Secondary and Future Skills (PSFS) received funding for 600 HCAP training seats in 2020/21 (914 seats were funded into 21/22) and a further 2,400 through Budget 2021 (3,020 seats were funded into 22/23). PSFS received additional funding through Budget 2022 to support 1,950 HCAP seats.

KEY BACKGROUND

Program Overview

- HCAP provides a publicly funded, work-integrated learning pathway for participants wanting to become health care assistants (HCAs) and Mental Health & Addiction Workers (MHAWs). Participants begin the program as HCSWs with an employer in LTC, AL or home health / Acute care setups and MHASWs in Mental Health setups. They alternate between the work setting and formal study through an approved post-secondary institution. Upon completion of the program, participants will be qualified as HCAs and MHAWs and HCAs are able to register with the BC Care Aide and Community Health Worker Registry.
- The purpose of HCAP is to:
    - Increase the provincial supply of HCAs/MHAWs by providing participants a low barrier pathway to careers in the health care sector.
    - Stabilize and augment staffing in LTC and AL facilities and home health locations by increasing the supply of HCAs/MHAWs while engaging HCSWs/MHASWs in a supportive role focused on non-clinical duties.
    - Initially due to COVID 19 and other factors, the program aimed to facilitate labour market transitions for British Columbians who face unemployment or underemployment.
- All education and employment costs are funded through the program.

LAST UPDATED

The content of this estimate note is current as of February 24, 2025, as confirmed by Michelle Perren.

APPROVALS

2025 03 12 – Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 02 27 – Health Sector Information, Analysis & Reporting Division
2025 02 24 – Finance and Corporate Services Division

[4] BC Government News Release July 31, 2024: https://news.gov.bc.ca/releases/2024MMHA0042-001231

LEGISLATIVE SESSION – ESTIMATES NOTE
Health Education Expansion

Topic: Outlining the most recent comprehensive investments in health education expansion.

Key Messaging and Recommended Response:

- We know that there is a global shortage of healthcare workers, which is why we're expanding health education seats in BC.
- We also know that people trained in BC are more likely to stay in BC, so we are increasing healthcare education seats to grow our workforce and meet demand for health services.
- Since 2017, this government has invested in education expansions for more than 20 different health occupations, including:
    - Midwives, nurses, psychiatric nurses, practical nurses, and nurse practitioners.
    - Allied health including physiotherapists, social workers, and medical lab technologists.
    - Family and specialist physicians.
- For example, we recently doubled the number of nurse practitioner seats at the UNBC School of Nursing from 20 to 40 seats. The first cohort started in fall 2024.
- Similarly, we have taken action to ensure that more family doctors will be trained in B.C.
    - The new medical school at Simon Fraser University (SFU) will be the first new medical school in Western Canada in over 50 years.
    - SFU plans to welcome 48 students in Fall 2026 and to have as many as 120 seats by 2036.

CURRENT SITUATION

- Since 2021, BC has added 687 new **nurse, nurse practitioner, and midwife** training seats, including: [1]
    - 362 additional registered nursing (RN) seats
    - 40 additional registered psychiatric nursing (RPN) seats
    - 180 additional licensed practical nursing (LPN)
    - 85 additional nurse practitioner (NP) seats
    - 20 additional midwifery seats

- Since 2021, BC has added 238 of the 322 announced seats for **allied health providers**:
    - 41 pharmacy technician seats
    - 40 respiratory therapist seats
    - 28 med lab tech and 24 med lab assistant seats
    - 25 social worker seats
    - 20 rehabilitation assistant seats
    - 16 occupational therapist seats
    - 12 MRI tech seats
    - 12 dietitian seats
    - 10 anesthesia assistant seats
    - 8 radiation therapist seats
    - 2 genetic counsellor seats
- Additional allied health expansions in planning include 20 rehabilitation assistant seats, 40 physiotherapist seats, 8 speech/language pathologist seats, and 16 occupational therapist seats.

[1] Based on the length of the training program, there is always a lag between a seat being funded/opened and the expanded cohort graduating. Seats may also be expanded over several years as post-secondary institutions recruit instructors and build training capacity.

- Since 2021 we have added more than 2,500 **health care assistant** training seats per year for participants in the Health Career Access Program, with additional funding available to add seats as needed.

- In 2025, BC will have a total intake of 613 **medical residents** (a 35% increase since 2017, +453):
    - 205 family medicine residents (including 31 added since 2023 through BC's Health Human Resources (HHR) Strategy)
    - 219 first-year specialty residents
    - 189 residents in a combination of subspecialties, re-entry into medical residency, and family medicine enhanced skills
- Between 2022 and 2028, UBC will add more than 160 new residency positions.

- With funding through BC's HHR Strategy, UBC has also added 40 new **undergraduate medical school** seats (18 in 2023 and 22 in 2024).

- The **new Simon Fraser University medical program** plans to welcome its first cohort of 48 students in Fall 2026.

FINANCIAL IMPLICATIONS

- Budget 2021 included $96 million over three years for health education expansions.
- Budget 2023 included $302.664 over three years for 19 actions under the "Train" cornerstone of BC's HHR Strategy, including $18.205 million in capital funding. Much of this funding is managed by the Ministry of Post Secondary Education and Future Skills (PSFS).
- Over two fiscal years (FY2023/24 and 2024/25) the Ministry of Health (HLTH) has allocated a total of $65.084 million to support nursing education expansions including tuition waivers through the minimum Nurse to Patient Ratios budget.

KEY BACKGROUND

- PSFS collaborates with HLTH and Post-Secondary Institutions to make sure the supply of seats aligns with demand.

LAST UPDATED

The content of this estimates note is current as of March 14, 2025, as confirmed by Lynn Hancock.

APPROVALS

2025 03 25 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 03 19 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Health Professions and Occupations Act

Topic: New legislation called the Health Professions and Occupations Act (HPOA) received royal assent on November 24, 2022, and work is underway to prepare for the legislation coming fully into force through regulation.

Key Messaging and Recommended Response:

- The purpose of the HPOA is to better protect the public and promote an accountable and transparent health system. This legislation is about ensuring patients are kept safe from harm and discrimination.
- Government continues to make progress to bring the HPOA into force and will continue to communicate key milestones towards an implementation date.
- To make the HPOA comes into force, it is crucial that all partners, including the regulatory colleges, the newly established Superintendent's Office, and the Discipline Tribunal, are fully prepared to fulfill their legislative responsibilities.
- Progress has been made in several key areas:
  - Enacting Order in Council regulations which brought sections of the HPOA into force to stand up the Superintendent's Office;
  - Hiring of a Superintendent and Director of Discipline to lead the Office and discipline tribunal; and,
  - To modernize health professional regulation, the number of regulatory colleges has been reduced from 21 to 6. The last amalgamations on June 28, 2024, combined 11 colleges into two: the College of Complementary Health Professionals of BC and the College of Health and Care Professionals of BC.
  - Issuing of grants to the BC Health Regulators totaling $4.5 million to support regulatory college preparation for implementation of the HPOA;

CURRENT SITUATION

- The HPOA received royal assent on November 24, 2022.
  - The *Health Professions and Occupations Act* is not yet fully in force. It will come fully into force by regulation of the Lieutenant Governor in Council at a future date.
- Bringing the HPOA into force will:
  - Introduce a legislative framework committed to cultural safety and humility by taking a proactive approach to discrimination in BC's healthcare system.
  - Create a safer complaints system for patients with a new independent disciplinary hearing process with trauma-informed practices.
  - Enable the Superintendent's Office to begin its oversight mandate through increased transparency and accountability in public interest.
  - Allow new health professions, such as Diagnostic and Therapeutic (D&T) professions (medical laboratory technologists, radiation therapists, perfusionists and respiratory therapists) and psychotherapists, to become regulated by an existing college.
  - Require regulatory colleges to remove barriers for foreign trained health professionals to practice in BC.

FINANCIAL IMPLICATIONS

- The Ministry provided the BC Health Regulators (BCHR) with $4.5 million in 2023/24 to support the regulatory colleges' work in preparation for implementation of the HPOA.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

Development of the HPOA

- The HPOA was drafted in response to recommendations of an all-party steering committee on Modernization of Health Professional Regulation, which were made public in August 2020, following over three years of consultation.
- The HPOA implements several key recommendations of the report, which will:
    - Commit to cultural safety and humility by taking a proactive approach to addressing discrimination in B.C.'s healthcare system.
    - Improve governance of regulatory colleges, moving to a merit and competency-based appointment process for board members.
    - Strengthen oversight of regulatory colleges by creating an independent Superintendent's Office to ensure regulatory colleges are focused on patient safety and the public interest.
    - Create a safer complaints system with a new independent disciplinary hearing process.
    - Improve information sharing and transparency for enhanced patient safety.
- Part of modernizing how health professionals are regulated in the province included finalizing the amalgamation of regulatory colleges, reducing the total number from 21 down to six. The last amalgamations were completed on June 28, 2024, amalgamating 11 regulatory colleges into two, forming the College of Complementary Health Professionals of BC and the College of Health and Care Professionals of BC.
- Sections of the HPOA to establish the Office of the Superintendent of Health Profession and Occupation Oversight (The Superintendent Office) were brought into force in October 2023, which enabled the appointment of Sherri Young as the first Superintendent in June 2024, and Benson Cowan as the first Director of Discipline in July 2024.
- A $4.5 million grant was issued to the BC Health Regulators (BCHR, an organization comprised of the Registrars/CEOs of all six college) to support regulatory college preparation for implementation of the HPOA.
- There is continued engagement to dispel false and misleading information about the HPOA. More than 75 presentations with stakeholders and partners such as regulatory colleges, associations, health authorities, licensed health professionals, and others have already been completed.
- The Ministry of Health continues to work alongside the regulatory colleges, to complete the work required to fully implement the HPOA. There is currently no timeline for when the HPOA will come into force.
- Advice/Recommendations

LAST UPDATED

The content of this estimates note is current as of February 10, 2025 as confirmed by Christopher Bennett.

APPROVALS

2025 02 26 – Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 02 14 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

International Medical Graduates – BC Return of Service Program

Topic: BC funds a designated number of postgraduate medical education (PGME) residency positions for International Medical Graduates (IMGs) in exchange for a return of service (ROS) – a practice commitment - in an identified community of need through the International Medical Graduate-BC (IMG-BC) Program.

Key Messaging and Recommended Response:

- We are working hard to make it easier for healthcare workers to receive faster credential recognition in B.C.
- For physicians, we have implemented the Postgraduate Medical Education International Medical Graduate Program (PGME-IMG), which provides international medical graduates with an opportunity to train and qualify as a practicing physician in the province.
- The PGME-IMG program at UBC has expanded substantially from 6 annual entry positions in 2003 to 58 today.
- We are also funding UBC residency positions that are protected for international medical graduates (IMG).
- The 58 IMG positions include 52 in family medicine and 6 positions across internal medicine, pediatrics, and psychiatry.
- After completing residency at UBC, family medicine participants complete a 2-year return of service, while specialist participants complete a 3-year return of service and they're expected to practice in identified communities of need in B.C.
- By the of 2025, approximately 583 family physicians, and 82 specialists, will have started their return of service since the program was established in 2006, having brought much needed health care services to 101 communities throughout B.C.

CURRENT SITUATION

- In 2024, 56 IMG-BC physicians (48 family medicine (FM) and 8 specialty) started practicing in their ROS community. In 2025, it is expected that 67 IMG-BC physicians (61 FM (including delayed participants from previous cohorts) and 6 specialty) will start their ROS.[1]
- By the end of 2025, 665 physicians (583 FM and 82 Specialty) will have started their ROS in 101 communities across BC since 2006, when the ROS program was established.[2]
- A new Medical Residency (Competitive) Stream introduced in 2024 provides opportunities for IMGs and Canadian Medical Graduates (CMGs) to apply to 20 UBC residency specialist medicine seats in a variety of specialties. These seats come with a 3-year ROS commitment in BC.
- There are a number of other recent initiatives launched to support IMG licensure (see Pathways to Practice for Internationally Educated Physicians Estimates Note).

FINANCIAL IMPLICATIONS

- In 2024/25, the Province provided:
  - $222.6 million to UBC Faculty of Medicine to support PGME residency training, up from $135 million in 2017/18.[3]
  - Of this total, $19.8 million to UBC Faculty of Medicine is to support IMGs through their PGME training in FM, psychiatry, general pediatrics, and internal medicine.[4]

KEY BACKGROUND

- UBC's IMG-BC program provides IMGs with an opportunity to train and qualify as a practicing physician in BC.

[1] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health, Return of Service Data. Data as of January 29, 2025.
[2] Ibid.
[3] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division. Cost per FTE 2024_25_FINAL. Data as of July 25, 2024. FY2024/25 PGME Funding letter for UBC FoM. Data as of October 31, 2024.
[4] Ibid.

- The IMG stream seats have expanded substantially from 12 annual seat intake with ROS in 2006 to 58 today including 52 FM positions and 6 specialist positions (2 each in psychiatry, internal medicine and pediatrics)[5].

Return of Service

- FM participants are required to complete a 2-year ROS and specialist physician participants complete a 3-year ROS practicing medicine in a health authority-identified community of need after completing training.
- The Ministry provides governance for ROS programs and the contractual agreement is between the Province and the physician participating in the UBC IMG stream with a ROS.

Medical Education and Residency

- IMGs are a diverse group of Canadian citizens or permanent residents who complete their medical education outside of Canada or the United States as listed in the World Directory of Medical Schools.
- Medical education varies among IMGs due to the different evaluation and credentialing processes at international schools. As a result, IMGs must pass a series of examinations by regulatory authorities that test knowledge, skills, and aptitude to assess their readiness for entrance into a Canadian residency program including the:
    - Medical Council of Canada's Qualifying Examination Part 1 – a summative examination assessing critical medical knowledge and clinical decision-making ability. [6]
    - National Assessment Collaboration Examination – an objective structured clinical exam which is a series of mock clinical situations with standardized patients in designated stations.[7]
- IMGs applying to PGME positions in BC through the Canadian Resident Matching Service (CaRMS) must pass UBC's one-day Clinical Assessment Program. The program assesses candidates' clinical experience, potential for success in residency and suitability for working in BC.[8]
- To attain an IMG residency position through CaRMS, IMGs must also meet the basic eligibility criteria and have no prior PGME training in Canada or the United States. This does not preclude individuals with PGME training from non-approved jurisdictions from applying (approved jurisdictions are determined by the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada and have been assessed against the national college's standards).
- IMGs compete for entry-level (1st year) dedicated IMG residency positions in the first iteration of CaRMS and for unfilled IMG and CMG positions in the second iteration of the match.
- In 2024, 1,602 IMGs applied for 407 IMG-dedicated residency positions in Canada through CaRMS.[9]

Reducing Barriers to PGME

- IMG entry-level PGME positions at UBC increased from 6 in 2003 to 58 (52 FM and 6 specialty) currently, including 40 new positions since 2011.[10]
- IMGs who obtain a residency position at UBC take part in an orientation on the Canadian medical system and are introduced to tools and resources to help them succeed in residency.
- Students from international medical schools can apply to UBC's Visiting Electives Program in their final year of study if their school has a "Canada" designation on the World Directory of Medical Schools. Clinical electives provide IMGs with an opportunity to gain practical experience in BC's health care system and demonstrate their clinical skills.[11]

LAST UPDATED

The content of this estimates note is current as of February 4, 2025 as confirmed by Kevin Brown.

APPROVALS

2025 03 05 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 10 – Health Sector Information, Analysis & Reporting Division
2025 02 21 – Finance and Corporate Services Division

[5] CaRMS (2023). R-1 Match Reports Tables 1 and 14. http://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 29, 2025.
[6] Medical Council of Canada (2024). https://mcc.ca/examinations/mccqe-part-i/ Last accessed January 29, 2025.
[7] Medical Council of Canada (2024). https://mcc.ca/examinations/nac-overview/ Last accessed January 29, 2025.
[8] UBC Faculty of Medicine (2024). https://imgbc.med.ubc.ca/clinical-assessment/ Last accessed January 29, 2025.
[9] CaRMS (2024). R-1 Match Reports Tables 1 and 14. http://www.carms.ca/data-reports/r1-data-reports/ Last accessed February 4, 2025.
[10] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division. (2024). Master Tracker. Data as of January 29, 2025.
[11] AFMC Student Portal (2022). https://afmcstudentportal.ca/. Last accessed January 29, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Internationally Educated Allied Health Providers (IEAHP) Support Program

Topic: Update on the status of Action 37 of BC's Health Human Resources (HHR) Strategy which streamlines licensure and offsets costs associated with language proficiency, exams, education, and registration/certification in BC for select IEAHPs.

Key Messaging and Recommended Response:

- There's a global shortage of healthcare workers, which is why we're making B.C. an attractive place to work, with fair pay, better working conditions and faster credential recognition – so we can deliver the care people need.
- This government has funded a bursary support program for Internationally Educated Allied Health Providers (IEAHPs). Bursaries are available for eligible internationally educated physiotherapists, medical laboratory technologists, and occupational therapists.
- We are also taking action by removing roadblocks for IEAHPs who want to work in B.C. For example, Action 37 of B.C.'s HHR Strategy works to expedite credential assessment pathways for IEAHPs.
- Ultimately, these actions mean more allied healthcare professionals to relieve pressures and reduce staff shortages in B.C.

CURRENT SITUATION

- To be eligible for bursaries through the IEAHP support program, as an initial step in the bursary process IEAHPs must commit to a return of service (ROS) with a publicly funded health employer for one to two years, depending on their full time equivalent (FTE) of their employment.
- **As of January 30, 2025,** programs have been launched for IE Physiotherapists (Jun. 1, 2023), IE Medical Laboratory Technologists (Jan. 1, 2024), and IE Occupational Therapists (Jan. 1, 2024).
    - **IE Physiotherapists**:
        - 423 ROS signed, 318 unique applicants are in receipt of bursaries (over $554,000), and 22 have commenced work
    - **IE Medical Laboratory Technologists**:
        - 432 ROS signed, 67 unique applicants have received bursaries (over $114,000), and 8 have commenced work
    - **IE Occupational Therapists**: Launched Jan 1, 2024
        - 81 ROS signed, 54 unique applicants have received bursaries (over $159,000), and 13 have commenced work
    - Factors such as costly and time-consuming credential assessment pathways , lack of provisional licenses for Physiotherapists and the cost and barriers associated with immigration significantly contribute to the low commencement rates.
- In addition to the bursaries, the Ministry of Health (HLTH) has issued targeted funding through Action 37 of BC's HHR Strategy to expedite credential assessment pathways and reduce overall timelines from application to licensure/certification and commencement of work.
    - One-time funding to the Canadian Alliance of Physiotherapy Regulators to develop a pre-approved pathway for IEPTs from select jurisdictions, has lowered average processing timelines for these applicants from 16 to 2 weeks,[1] freeing up resources to process other applicants, reducing timelines for all applicants.
    - Advice/Recommendations

[1] Canadian Alliance of Physiotherapy Regulators (2025). CAPR Introduces New Pre-Approved Credentialling Pathway to Address Physiotherapy Shortage. https://alliancept.org/capr-introduces-new-pre-approved-credentialling-pathway-to-address-physiotherapy-shortage/. Accessed 2025-02-05.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- In FY2022/23, HLTH allocated $4.5 million in one-time surplus funding from the Health Career Access Program (HCAP) to Health Employers Association of BC (HEABC) to seed the IEAHP Support program.[2]
- IEAHP Support Program (Action 37) is funded through BC's HHR Strategy for $11.310 million over three years (2023/24-2025/26) and $5.870 million ongoing.

KEY BACKGROUND

- On July 19, 2022, HLTH announced a range of new training, recruitment, and retention initiatives to help meet the increasing demand for allied health workers in BC, including $4.5 million in seed funding for the IEAHP support program.
- HLTH further expanded these efforts with funding through *BC's Health Human Resources Strategy* (the Strategy). The Strategy includes, under Action 37, the implementation of an IEAHP assessment support program to facilitate access to public-sector careers in allied health that includes:
    - Bursaries for internationally educated (IE) physiotherapists, medical laboratory technologists, and occupational therapists, and
    - Client-focused navigation services to guide IEHPs through registration and certification.
- Each allied health occupation (over 70) has its own specific qualifying process, including credential evaluation, bridging or refresher courses, and often followed by certification or licensing examinations.
- Registration and certification pathways for IEAHPs can cost thousands of dollars and prevent IEAHPs from seeking a credential assessment to practice in BC. Bursary funds will help reduce these financial barriers and allow individuals to practice in BC.
    - These costs can drive many IEAHPs into the private sector where wages are generally higher.
- To help target efforts, the following criteria were applied to identify the three IEAHP bursary streams (IE physiotherapist, medical laboratory technologist, and occupational therapist):
    - Occupations utilized within the Ministry's priority service areas;
    - Occupations that have known high vacancy rates; and
    - Occupations with substantial credential assessment costs but a defined pathway to licensure and registration/certification.
- IEAHPs are currently supported with the credentialing, job finding, and immigration processes through several other programs funded by BC's provincial government:
    - **BC Health Careers and the Integrated Provincial Recruitment Initiative (Action 44):** supports IE physiotherapists, occupational therapists, clinical pharmacists, medical laboratory technologists, diagnostic medical sonographers, and medical radiation technologists.
    - **Career Paths for Skilled Immigrants**: IEAHPs can access financial support for language and skills upgrading, career planning and coaching that assist with pathways to BC employment.[3]
    - **BC Provincial Nominee Program (BCPNP)**: IEAHPs who meet requirements for licensure and/or certification and have a formal job offer in BC may be eligible for immigration support with the PNP (health care occupation category).[4]

LAST UPDATED

The content of this estimates note is current as of March 20, 2025 as confirmed by Lorrie Cramb.

APPROVALS

2025 03 25 – Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 02 28 – Finance and Corporate Services Division

[2] HLTH (2022). British Columbia trains, recruits more allied health professionals. https://news.gov.bc.ca/27203. Accessed 2025-02-05.
[3] Province of British Columbia. Career Paths for Skilled Immigrants. https://www.welcomebc.ca/Work-in-B-C/Career-Paths-for-Skilled-Immigrants. Accessed 2025-02-05.
[4] Province of British Columbia. About the Provincial Nominee Program. https://www.welcomebc.ca/immigrate-to-b-c/about-the-bc-provincial-nominee-program Accessed 2025-02-05.

LEGISLATIVE SESSION – ESTIMATES NOTE

Internationally Educated Nurse and Nurse Re-entry Support Program

Topic: Reducing barriers for Internationally Educated Nurses (IENs) to enter BC's health workforce and supporting nurses to re-enter practice will help meet growing labour demand.

Key Messaging and Recommended Response:

- We worked closely with the BC College of Nurses and Midwives (BCCNM) to develop a more efficient process that simultaneously assesses Internationally Educated Nurses (IENs) for healthcare designations including HCA, LPN, & RN.
- This new process helps determine where IENs best fit in B.C.'s health workforce and allows them to start work sooner.
  - Between January 1, 2023 and March 1, 2025, 1,759 IENs have been registered in BC.
  - As of December 31, 2024, 1,497 IENs and 142 HCAs have been hired into the BC health system.
- Actions like these result in more nurses in B.C. to relieve pressures and reduce staff shortages in our hospitals.
- This government has also invested in financial support to IENs (up to $16,840) and for nurses that want to return to practice after a period of absence (up to $14,429).
- We are taking new steps to attract more nurses from the US by fast-tracking credential recognition and launching a coordinated, targeted recruitment campaign.

CURRENT SITUATION

- On April 19, 2022, the Ministry of Health (HLTH) announced new funding available to offset IEN licensure costs[1] – including up to $16,840 in bursaries for credential recognition, assessments, application fees, and transitional education. Eligibility criteria apply and bursaries are subject to IENs signing a return of service (ROS) with a designated publicly funded health employer for one to two years, depending on the Full-time Equivalent (FTE) of their employment.
- On January 9, 2023, HLTH further expanded these efforts with funding through *BC's Health Human Resources Strategy* (the Strategy). As a result, IENs can now access:
  - Credential recognition services through five different agencies (previously restricted to the National Nursing Assessment Service which took up to two years).
  - The triple-track assessment process through Inspire Global Assessments (Inspire). IENs can have their competency assessed as a Health Care Assistant (HCA), Licensed Practical Nurse (LPN), and Registered Nurse (RN) at the same time rather than waiting for consecutive assessments.
  - Self-scheduling for the triple-track assessment (computer-based and simulation lab assessments).
  - Advice/Recommendations

- As of April 2024, Inspire has made further improvements to the pathway for IENs to increase intake volumes, including a multi-role integrated bilingual (English/French) nursing competency assessment, new website[3], and new, integrated Customer Resource Management (CRM) system.
- On March 11, 2025, HLTH announced new work underway through the BC College of Nurses and Midwives to make it faster and easier for US-registered nurses to work in BC by leveraging common registration systems and similarities in education and practice.

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[1] Province of B.C. (2022). Supporting international nurses into B.C.'s health system. https://news.gov.bc.ca/releases/2022HLTH0120-000589. Accessed on February 4, 2025.
[2] BCCNM (2024). Internationally Educated Nurses (IENs) Pathway Pilot & Nursing Workforce Monthly Report for August 2024. September 2024.
[3] https://www.inspireassessments.org/

- From January 1, 2023 to March 1, 2025:
    - There have been 3,871 BCCNM registration decisions for IENs in the bursary program:
        - 1,759 IENs registrations have been approved for full or provisional registration.
        - 2,112 decisions have been rendered for 1,272 IENs (simultaneously assessed for HCA/LPN/RN designations) who have been referred to transitional education.
    - 313 IENs have registered as health care assistants (IE HCAs) with B.C.'s Care Aide and Community Health Worker Registry[4]
- From January 1, 2023, to December 31, 2024:
    - 1,497 IENs and 142 IE HCAs have been hired by health authorities and Providence Health Care (HAs/PHC).

FINANCIAL IMPLICATIONS

- In April, 2022, the Ministry announced $12 million in funding to support the development and hiring of nurse navigators and for IEN application, assessment, and educational bursaries.
- IEN and Nurse Re-entry Support Program (Action 36) is funded through B.C.'s HHR Strategy for $28.079 million over three years (2023/24- 2025/26), and $9.107 million ongoing.
- In Fiscal Year 2023/24 $1.900 million was allocated from the Minimum Nurse-to-Patient (mNPR) ratio program to the Ministry of Post-Secondary and Future Skills (PSFS) to support the Action 36 IEN Bridging Program Expansion.

KEY BACKGROUND

- Registering as a nurse or HCA in BC as an IEN is complicated and lengthy, costing approximately $6,000 if a competency assessment is required. This excludes language test costs (if required)[5], document translation fees, travel, license fees and national exam fees. IENs who require remedial education also must pay an additional $500 to $10,000.
- Historically, it had taken IENs approximately 2-6 years to obtain nursing registration in BC.[6] [7]
- A business case to reduce IEN barriers to entry into the healthcare system was developed in 2021, in collaboration with health partners. This led to:
    - The development of a single assessment intake and fee for IENs seeking multiple registrations (i.e., RN, LPN, and/or HCA) – known as 'Triple Track'.
    - The addition of system navigators at Health Employers Association of BC (HEABC) to support IENs through the registration process.
    - An expedited process for IENs from countries with education and training aligned with the requirements in B.C. (i.e., US., AUS, NZ, and the UK).
    - Process improvements reducing time to receive a registration decision to 4-9 months.
- The January 9, 2023 announcement extended the IEN bursaries to provide the same supports to eligible Return to Practice nurses.

LAST UPDATED

The content of this estimates note is current as of March 17, 2025, as confirmed by Meghann Brinoni.

APPROVALS

2025 03 17 – Stephanie Power obo Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 27 – Finance and Corporate Services Division

[4] As per BC Care Aide Registry on February 28, 2025.
[5] BCCNM (2021). English proficiency. https://www.bccnm.ca/RN/applications_registration/Pages/English_proficiency.aspx. Accessed September 10, 2021.
[6] NNAS (2020). Frequently Asked Questions, The Advisory Report – How long does it take to get an Advisory Report and how long does the application process take? https://www.nnas.ca/faqs/ Accessed on October 8, 2020.
[7] BCCNM (2021). Applying to BCCNM. https://www.bccnm.ca/RN/applications_registration/how_to_apply/InternationalEN/Pages/Applying.aspx. Accessed on September 10, 2021.

LEGISLATIVE SESSION – ESTIMATES NOTE

Longitudinal Family Physician (LFP) Payment Model

Topic: Overview of the new Longitudinal Family Physician (LFP) Payment Model

Key Messaging and Recommended Response:

- We heard concerns from family doctors loud and clear – something needed to be done to improve how family doctors are compensated and supported for their time with patients.
- That's why our government brought in the Longitudinal Family Physician (LFP) Payment Model two years ago in collaboration with Doctors of BC and BC Family Doctors.
- This was our response to an urgent need to retain and attract family doctors and revolutionize the long-standing fee-for-service model that wasn't working in today's complex primary care environment.
- Naturally, the new model was developed in collaboration with Doctors of BC, BC Family Doctors and took feedback from community-based family doctors into consideration.
- The LFP Payment Model recognizes the complexity of long-term patient care, compensating family doctors for their time, patient interactions, and the number and complexity of patients in their practice.
- As of Dec. 31, 2024, there were 4,418 family physicians actively working under the LFP Payment Model.
- The payment model is one of many actions B.C. is taking through its primary care strategy to strengthen our health-care system so that people in B.C. get the health care they need, when and where they need it.

CURRENT SITUATION

- The LFP Payment Model covers almost all clinic-based primary care services and in June 2024, was expanded to allow family physicians that provide LFP clinic services, to also bill under LFP for pregnancy and newborn, inpatient, and long-term and palliative care services provided in facilities.
- There are three payment components: time, patient interactions, and a panel payment based on the number and complexity of attached patients.
- Most locum physicians providing care on behalf of a longitudinal physician are eligible to enroll as an LFP locum.
- As of December 31, 2024, 4,418 physicians are active registrants under the LFP Payment Model, 71.7% of whom were longitudinal family physicians in BC in 2022[1]. Of those who have enrolled:
    - 139 had not previously identified themselves as longitudinal physicians
    - 703 are new to practice or MSP
    - 403 were previously locum family physicians
- Payment for on-call availability is provided under separate mechanisms (Medical On-call Availability Program for pregnancy and newborn services and the Family Practice Services Committee for long-term care and inpatient care).

FINANCIAL IMPLICATIONS

- As of December 31, 2024, 71.7% of existing longitudinal family physicians have enrolled in LFP as longitudinal providers, locums in longitudinal practices, or both. These figures are based on existing longitudinal family physicians and family physician locums in BC in 2022.
- Financial risks include higher than forecasted costs due to suboptimal pricing and/or higher than anticipated volumes, and challenges making appropriate adjustments due to limited service data.

[1] Source: Longitudinal Family Physician (LFP) Payment Model HSPP dashboard

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- The LFP Payment Model was developed in collaboration with Doctors of BC (DOBC) and BC Family Doctors (BCFD) in response to family physician concerns with the fee-for-service model.
- To be eligible for the LFP Payment Model, a longitudinal family physician must meet the eligibility criteria, including: provide timely, accessible, comprehensive and relationship-based care to patients; contribute to the rent, lease, or ownership costs, and other operating costs of their longitudinal clinic; have a panel of at least 250 patients; work at least one day per week in clinic; provide at least 70% of their clinic services to longitudinal patients (unless exempt); and upload their panel to the Provincial Attachment System (PAS).
- There are four time codes billable within clinic and facility settings (direct patient care, indirect patient care, travel time, and clinical administrative). Indirect patient care, travel time, and clinical administration are valued at $130 per hour. Direct patient care is valued at $130 per hour within clinic, and $170 to $230 per hour within facility settings, with applicable after-hours premiums.
- Within the clinic setting, there are eight interaction codes, ranging from $10 to $110.
- Within the facility settings, there are seven to eleven interaction codes per setting, ranging from $15 to $270.
- Panel payments vary depending on panel size and complexity but are paid at approximately $53.52 per patient of average complexity per year. A physician with a panel of 1250 active patients of average complexity will receive an annual amount of approximately $66,900.
- Once the Provincial Attachment System is fully established, it will be utilized for panel payments. In the interim, the methodology used by the Family Practice Services Committee to make annual panel payments to longitudinal family physicians is being used to calculate LFP panel payments.
- The LFP Payment Model is subject to Plan-Do-Study-Act (PDSA) cycles with DOBC and BCFD.
- The Ministry of Health, DoBC, and BCFD are working to improve and adapt the LFP Payment Model on an ongoing basis.

LAST UPDATED

The content of this estimates note is current as of February 12, 2025 as confirmed by Marie Ty.

APPROVALS

2025 03 05– Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 13 – Health Sector Information, Analysis & Reporting Division
2025 02 22 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Minimum Nurse-to-Patient Ratio (mNPR)

Topic: Update on the implementation of mNPRs in B.C. – a first in Canada initiative to improve nurse satisfaction while strengthening B.C.'s health care system.

Key Messaging and Recommended Response:

- Minimum nurse-to-patient ratios (mNPRs) are a policy solution that creates better working environments for nurses and improves the quality of patient care.
- The Ministry of Health (HLTH) worked with the BC Nurses' Union (BCNU)to adopt these new minimum nurse-to-patient ratios.
- B.C. is the first jurisdiction in Canada to implement ratios for nurses; this will help ensure that our province is the best place to be a nurse in this country.
- These ratios represent the minimum number of nurses deemed necessary to care for a maximum number of patients on a unit.
- mNPRs are being designed and implemented in close partnership with nurse and operations leaders throughout the province to ensure implementation achieves the greatest impact with the best possible outcomes for nurses and patients.
- Implementation is ongoing and is expected to continue over a four-year period.
- We know that additional vacancies will be created by the implementation of mNPRs. However, both HLTH and the BCNU are confident that mNPRs will help with the recruitment and retention of nurses.

CURRENT SITUATION

- Per the Minister of Health's Mandate Letter issued on January 16, 2025, it is a priority to make progress on working collaboratively with partners on initiatives to strengthen nurse ratios.
- mNPRs are aligned with Action 18 of B.C.'s Health Human Resources (HHR) Strategy to develop workload standards to balance workload and staffing levels, and to optimize quality of care.
- On August 15, 2024, HLTH published a policy directive and implementation framework for hospital sector ratios to be used by health employers to support implementation.
    - The directive and framework are supported by the mNPR Executive Steering Committee (ESC), including HLTH, the BCNU, Nurses' Bargaining Association (NBA), Health Employers Association of BC (HEABC), and health employers. The package includes an instruction manual, planning template, and terms of reference for regional committees to ensure standardization and consistency in implementation.
- The policy for mNPR:
    - Outlines the necessary actions, expected benefits, and goals for introducing ratios, providing a clear roadmap for improving care quality and nursing practice.
    - Promotes safer, more effective nursing practices by improving supervision, including expanding the role of charge nurses for better oversight and support.
    - Implements and evaluates ratios to improve care, based on evidence from other jurisdictions where similar ratios have enhanced patient outcomes and nurse satisfaction.
- Since November 2024, direct care nurse and staff engagement sessions have been hosted by health employers to ensure fulsome opportunities for dialogue and questions.
- On December 20, 2024, HLTH released the Rural and Remote Hospital Sector ratios, specifically tailored to address the needs of nurses and patients in these areas, ensuring the successful implementation of mNPR across the province.
- The Implementation Plans for Phase 1 were endorsed in principle by the provincial ESC and activation is currently underway.
    - Health employers are using a sequencing approach that best aligns with their organizational needs, such as unit, geography, care-based or a combination.

- Vancouver Coastal Health, Providence Health, and Fraser Health have developed a Lower Mainland strategy to align implementation across the Lower Mainland to avoid staff turnover.

FINANCIAL IMPLICATIONS

- mNPRs are supported by three-year funding of $750 million through the Canada-British Columbia Agreement to Work Together to Improve Health Care for Canadians (2023/24 to 2025/26), including: $200 million in 2023/24, $250 million in 24/2025, and $300 million in 2025/26.[1]
- One-time funding of $242.692 million – in alignment with B.C.'s HHR Strategy – was announced on March 1, 2024, to retain, recruit, and train nurses in support of mNPRs.
- $207.289 million has been distributed to the health employers in 2024/25 to support mNPR implementation, including funding to hire nursing leadership/support positions.
- Full costing for acute care mNPR implementation is still underway, as is policy work for long-term care and community / non-hospital settings. In both cases, additional funding will likely be required.

KEY BACKGROUND

- On April 03, 2023, HLTH and the BCNU signed a Memorandum of Understanding (MOU) to work together on validating and implementing mNPRs through four objectives[1]. The MOU was reached alongside but separate from negotiations for 2022-2025 NBA Collective Agreement.
- Pursuant to the MOU, the ESC was established in 2023 and includes leadership from HLTH, BCNU, NBA, HEABC, and health employers.
- Several working groups with shared representation from HLTH, NBA, HEABC, and health employers support mNPR – which are supported through a centralized program office.
- On April 04, 2023, HLTH and BCNU conducted their first joint public announcement.[2]
- On March 01, 2024, HLTH and the BCNU jointly announced[3] ratios for ten hospital-based care settings.
- On September 18, 2024, HLTH and the BCNU jointly announced ratios covering 90% of the hospital practice areas.[4] Health Authorities are prioritizing Phase 1 ratios announced in the March announcement. All mNPR partners are committed to continuous improvement, ensuring that as mNPR is planned and implemented, the lived experiences of direct care nurses are considered, and updates will be made to better serve nurses and patients across the system.

LAST UPDATED

The content of this estimates note is current as of March 12, 2025, as confirmed by Melissa Murdock.

APPROVALS

2025 03 14 – Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 03 07 – Finance and Corporate Services Division

1 HLTH (2023). Memorandum of Understanding, Process for Establishing, Reviewing/Amending mNPRs. https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/minimum-nurse-to-patient-ratios/moh_nba_nurse_patient_ratios_mou.pdf
2 HLTH (2023), Province announces minimum Nurse-to-Patient Ratio initiative news.gov.bc.ca/releases/2023HLTH0019-000446
3 HLTH (2024) Province announces minimum nurse-to-patient ratios, retention and recruitment investments https://news.gov.bc.ca/30389.
4 HLTH (2024), Better patient care, more nurses coming to B.C. https://news.gov.bc.ca/releases/2024HLTH0044-001553

LEGISLATIVE SESSION – ESTIMATES NOTE

Medical Services Commission - Public Healthcare System in BC

Topic: Efforts taken to defend the public healthcare system in B.C.

Key Messaging and Recommended Response:

- In accordance with the *Medicare Protection Act* (MPA), the responsibilities of the Medical Services Commission (MSC) are twofold: to ensure that all B.C. residents have reasonable access to medical care; and to manage the provision and payment of medical services in an effective and cost-efficient manner.
- In 2018, the British Columbia government strengthened the MPA to include new protections for patients to prevent extra billing (private billing for Medical Services Plan (MSP) insured benefits), clarify the billing rules for medical practitioners, and establish consequences for those who break the rules.
- In September 2020, the province saw a successful outcome in the landmark Cambie Surgeries Corporation litigation. The appeal was heard in June 2021, with a decision rendered by the B.C. Court of Appeal in July 2022, upholding that of the B.C. Supreme Court in favour of the province. On April 6, 2023, the Supreme Court of Canada denied Cambie's application for leave to appeal, bringing this ongoing proceeding to a successful conclusion.
- In April 2023, as a result of an injunction filed by the MSC, TELUS Health demonstrated to the satisfaction of the MSC that it would make the necessary changes to the LifePlus program to come into compliance with the MPA.
- In June 2024, as a result of an injunction filed by the MSC, Harrison Healthcare made the necessary changes to their service offerings to come into compliance with the MPA.
- The MSC and the Ministry continue to demonstrate commitment to upholding the principles of public healthcare in accordance with the *Canada Health Act* and the MPA. The focus remains on building and investing in the public system, including bringing more private clinics into the publicly managed health care system.

CURRENT SITUATION

- B.C. continues to demonstrate a rigorous commitment to defending public healthcare.
- In April 2023, B.C. saw a successful outcome in the Supreme Court of Canada in the landmark Cambie Surgeries Corporation (Cambie) litigation; a decision which upheld all sections of the MPA.
- Operational processes are in place to protect patients from extra billing. The B.C. Ministry of Health (the Ministry) and the Medical Services Commission (MSC) process patient complaints and investigate allegations of extra billing to determine whether extra billing has taken place.
- Since 2017, the Ministry has completed twelve audits of private surgical clinics. The results of these audits were shared with Health Canada.
- B.C. has seen success in curbing extra billing through government contracts with private clinics to provide publicly insured services instead of private-pay services. As a requirement of these contracts, clinics and physicians are required to sign compliance statements acknowledging that they will not engage in extra billing.
    - In 2024/25, Health Authorities contracted with 8 facilities to perform surgeries.
- The Ministry has also brought more private surgical centres under public control. In 2022/23, the Island Health Authority purchased Seafield Surgical Centre (now Centre Island Surgical Centre) and View Royal Surgical Centre (now South Island Surgical Centre). In May 2023, Northern Health Authority (NHA) purchased Prince George Surgery Centre.
- MSC filed two injunctions in 2022/23 against private clinics/companies providing patient care in B.C.: TELUS Health and Harrison Healthcare Inc. Both entities have since altered their service offerings to the satisfaction of the MSC. The MSC continues to hold these providers accountable through review of patient data.

- The Commission continues to have contact with numerous entities brought to its attention, through referral and investigation, that offer patient care through 'bundled services', that is, monthly or annual charges for health services which are often marketed as preventative or supplementary (e.g. dieticians, kinesiologists, etc.). Where these charges offer access to MSP insured services, or expedited access to a physician to receive insured services, the charges would contravene the *Canada Health Act* and the MPA.

FINANCIAL IMPLICATIONS

- In last year's report for 2021/22, the amount of extra billing and user charges reported to Health Canada was $18.118 million. B.C.'s March 2024 Canada Health Transfer (CHT) payment was reduced by this amount.
- In March 2024, under Health Canada's Reimbursement Policy, a $22.406 million[1] reimbursement was applied to B.C.'s March 2024 CHT payments, which represents a partial reimbursement of B.C.'s March 2022, March 2023, and March 2024 CHT deductions.
- In this year's report for 2022/23, the amount of extra billing and user charges reported to Health Canada was $23.520 million; including $17.113 million in extra billing related to diagnostic services.
- In March 2025, under Health Canada's Reimbursement Policy, a $20.982 million[2] reimbursement was applied to B.C.'s March 2025 CHT payments, representing a partial reimbursement of the March 2023, March 2024, and March 2025 CHT deductions for the province.

KEY BACKGROUND

- The purpose of the MPA is to preserve a publicly managed insurance plan and a fiscally sustainable health care system in which access to necessary medical care is based on need and not an individual's ability to pay.
- The MSC pays for insured medical services (benefits) provided to eligible residents of BC under the Medical Services Plan (MSP) in accordance with the MPA. The MPA establishes rules regarding billing for services provided by physicians who are enrolled with MSP. In general, patients (or their representatives) must not be charged for benefits. The MPA also prohibits anyone from charging patients for *"materials, consultations, procedures, use of an office, clinic, or other place, or for any other matters that relate to the rendering of a benefit",* unless specifically permitted by the Commission.
- In 2018, the Government brought into force outstanding provisions of the Act, which enhanced the Commission's authority around extra billing (Bill 92).
- Private companies are attracting physicians and other primary healthcare practitioners away from the public health care system compounding existing, underlying challenges with the provision of primary care in B.C.

LAST UPDATED

The content of this estimates note is current as of March 13, 2025, as confirmed by Kate Puckett.

APPROVALS

2025 03 14– Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 02 18 – Finance and Corporate Services Division

[1] March 5, 2023, email from Jocelyne Voisin (Health Canada) to Mark Armitage (B.C. Ministry of Health).
[2] March 11, 2025, email from Jocelyne Voisin (Health Canada) to Mark Armitage (BC Ministry of Health).

LEGISLATIVE SESSION – ESTIMATES NOTE
Number of Health Professional Registrants by College or Registry

Topic: Update on the current number of health professional registrants in B.C.

Key Messaging and Recommended Response:

- There has been a steady increase in the number of health professionals practicing in BC over the last several years.
    - Since 2020, approximately 2000 additional Medical Doctors, 5,000 additional Registered Nurses, 500 additional Registered Psychiatric Nurses, 3000 additional Licensed Practical Nurses, and 300 additional Dentists have been registered to practice in British Columbia.
- On June 28, 2024, 11 regulatory colleges amalgamated into two: the College of Health and Care Professionals of BC and the College of Complementary Health Professionals of BC. This brings the number of regulatory colleges in BC down to 6. There are no more planned amalgamations.
    - The first annual report for the amalgamated colleges is expected to be issued in 2025.

CURRENT SITUATION

Health Professions		**Reporting Cycle**	**Practicing Only**	**Total** (incl. non-practicing)
Chiropractors[1]		2024	1,472	1,537
Dental Hygienists[2]		2023/24	4,550	4,928
Dental Surgeons[2]	Dentists	2023/24	4,177	4,313
	Certified Dental Assistants	2023/24	6,292	6,746
Dental Technicians[2]		2023/24	298	305
Denturists[2]		2023/24	254	259
Dietitians[3]		2024	1,617	1,668
Licensed Practical Nurse[4]		2023	16,284	16,738
Massage Therapists[5]		2023	6,622	6,803
Midwives[4]	Midwives	2023	~400	~500
	Employed student midwife	2023	95	95
Naturopathic Physicians[6]		2024	774	787
Occupational Therapists[7]		2024	3,251	3,340
Opticians[8]		2023/24	957	1,027
Optometrists[9]		2023	961	963
Pharmacists[10]	Pharmacists	2023/24	-	6,915
	Technicians	2023/24	-	1,822
Physical Therapists[11]		2024	-	5,607

[1] Email, Plischke, Carin. Registrar of College of Complementary Health Professionals of BC. February 10, 2025.
[2] British Columbia College of Oral Health Professionals. *2023/24 Annual Report*. (p. 2) https://oralhealthbc.ca/wp-content/uploads/2024/08/BCCOHP-Annual-Report-2023-24.pdf. Last accessed February 13, 2025.
[3] Email, Millette, Dianne. Registrar of College of Health and Care Professionals of BC. February 10, 2025.
[4] BC College of Nurses and Midwives. *2023 Annual Report*.(p. 17) https://www.bccnm.ca/Documents/governance/annual_reports/BCCNM_2023_Annual_Report.pdf. Last accessed February 13, 2025.
[5] College of Massage Therapists of BC. *2023 Annual Report*.(p. 10)
[6] Email, Plischke, Carin. Registrar of College of Complementary Health Professionals of BC. February 10, 2025.
[7] Email, Millette, Dianne. Registrar of College of Health and Care Professionals of BC. February 10, 2025.
[8] College of Opticians of BC. *2023/24 Annual Report*.(p. 10)
[9] College of Optometrists of BC. *2023 Annual Report*.(p 10).
[10] College of Pharmacists of BC. *2023/24 Annual Report*. (p. 14) https://library.bcpharmacists.org/2_About_Us/2-6_Annual_Reports/CPBC-Annual_Report_2023_24.pdf. Last accessed February 13, 2025.
[11] Email, Millette, Dianne. Registrar of College of Health and Care Professionals of BC. February 12 2025.

Health Professions		Reporting Cycle	Practicing Only	Total (incl. non-practicing)
Physicians and Surgeons[12]	Family practitioners	2023/24	7,685	15,993[13]
	Specialists	2023/24	7,532	
Podiatric Surgeons[14]		2023/24	71	
Psychologists[15]		2023	1,381	1,493
Registered Nurses[4]	Registered Nurses	2023	48,182	49,583
	Employed student nurses	2023	1,410	1,410
Registered Psychiatric Nurses[4]	Registered Psychiatric Nurses	2023	3,524	3,630
	Employed student psychiatric nurses	2023	84	84
Speech and Hearing Health Professionals[16]	Audiologists	2024	319	323
	Hearing Instrument Practitioners	2024	590	605
	Speech Language Pathologists	2024	1,553	1,592
	Total	2024	2,462	2,520
Traditional Chinese Medicine Practitioners and Acupuncturists[17]		2024	2,481	2,563
Emergency Medical Assistants[18]	Paramedics	January 7, 2025	-	5,771
	First Responders	January 7, 2025	-	7,290
Health Care Assistants[19]		December 31, 2024	N/A	56,223

LAST UPDATED

The content of this estimates note is current as of February 11, 2025 as confirmed by Christopher Bennett.

APPROVALS

2025 03 04 – Stephanie Power, Health Sector Workforce and Beneficiary Services
2025 02 23 – Health Sector Information, Analysis & Reporting Division

[12] College of Physicians and Surgeons of BC, *2023/24 Annual Report*. (p 14). https://www.cpsbc.ca/files/pdf/2023-24-Annual-Report.pdf. Last accessed February 13, 2025. Last accessed February 13, 2025.
[13] This number includes a small number of podiatric surgeons as the total number of registrants outlined in the college's annual report includes both physicians and podiatric surgeons.
[14] College of Physicians and Surgeons of BC, *2023/24 Annual Report*. (p 14). https://www.cpsbc.ca/files/pdf/2023-24-Annual-Report.pdf.. Last accessed February 13, 2025.
[15] College of Psychologists of BC. *2023 Annual Report*.(p. 34)
[16] Email, Millette, Dianne. Registrar of College of Health and Care Professionals of BC. February 10, 2025.
[17] Email, Plischke, Carin. Registrar of College of Complementary Health Professionals of BC. February 10, 2025.
[18] Emergency Medical Assistants Licensing Board (2025), Retrieved from https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/colleges-boards-and-commissions/emergency-medical-assistants-licensing-board/emergency-medical-assistants-licensing-branch. Last accessed February 13, 2025.
[19] BC Care Aide & Community Health Worker Registry 2024 Year-End Update Report to MOH (confidential), January 15, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Nursing Supply

Topic: A summary of BC's supply of nurses, including registered nurses (RNs), registered psychiatric nurses (RPNs), and licensed practical nurses (LPNs).

Key Messaging and Recommended Response:

- There's a global shortage of healthcare workers, which is why we're making BC an attractive place to work, with fair pay, better working conditions and faster credential recognition – so we can deliver the care people need.
- We are starting to see the impact of our work; BC is adding nurses at an increasing pace.
- To address supply-demand challenges, we continue to develop and implement actions supporting retention, redesign, recruitment, and training – the four cornerstones of BC's Health Human Resources Strategy.
- HLTH has and will continue to invest in these areas through 2025/26 via minimum Nurse-to-Patient Ratios, investments in Relational Security Officers, and the introduction of the Psychological Health and Safety Positions.

CURRENT SITUATION

- In 2024, 74,186 nurses were registered with BC College of Nurses and Midwives (BCCNM) including:
  - 17,193 LPNs (15,578 practicing, 90.6%)
  - 51,296 RNs (46,955 practicing, 91.5%)
  - 3,757 RPNs (3570 practicing, 95.0%)
  - 1,940 Employed Student Nurses/Psychiatric Nurses (ESNs/ESPNs)
- From 2018 to 2024, nursing (RNs, RPNs, and LPNs) registrants in all categories grew by 26% compared with population growth of 13% in the same period.
  - From 2023 to 2024, the number of net new nurses registered in BC grew by 4% compared with population growth of 3% in the same period.
- In 2023, an estimated 73% of nurses registered with the BC College of Nurses and Midwives (BCCNM) worked one or more hours in the public sector (52,343 regular and casual nurses worked one or more hours in 2023 of the 71,444 total registrants in 2023).

- Health authorities (HAs) employ 47,240 regular nurses of whom 39,150 (83%) worked at least one hour between October 1 and December 31, 2024 (Q3 2024/25).
  - HAs also report 17,980 casual nurses, of whom 6,890 (38%) worked at least one hour in Q3 2024/25.[1]
- From 2018 to 2023, nursing Full-time Equivalents (FTEs) delivered in BC's public health sector grew by 10%, keeping pace with population growth of 10% in the same period.
  - Nurses in BC worked 36,030 full-time equivalents (FTEs) in 2023 (+2% from 2022).[2, 3]
  - Regular FTE contributions have grown. In 2023, 89.6% of health authority nursing FTEs were delivered by regular full and part time employees compared with 85% in 2018.
  - Casual FTE contributions have fallen both as a percentage of total FTEs (from 15% to 10.4% but also in terms of total FTEs – from 4,906 in 2018 to 3,747 in 2023).

- In the first three quarters of fiscal year 2024/25 (April 1 – December 31, 2024), health authorities recruited 5,360 nurses through external competitions and 14,400 nurses through internal competitions.[5]

1 The provincial casual number likely double counts nurses on casual roles in multiple health authorities.
2 Ministry of Health. Report ID: 3455. Health Human Resources, Allied Health and Nursing. Retrieved from: https://hspp.hlth.gov.bc.ca/Human Resources/Health Human Resources, Allied Health and Nursing. Last accessed on 2/3/2025 4:26:34 PM 2023.
3 FTEs were estimated as straight-time hours divided by the annual standard work hours (1950 hours) for a full-time employee according to bargaining group.

- In 2023[4] 47% of BC's nurses were aged under 40, 90% were female, and 11% were internationally educated.
- In 2023: 63% of RNs worked in hospitals, 19% in community settings, and 6% in nursing homes/long term care. 36% of LPNs worked in hospitals, 15% in community settings, and 38% in nursing homes/long term care.[4]
- In 2024/25, approximately 1,500 RNs, 120 RPNs and 500 LPNs will graduate in BC.
    - Most nurse graduates from BC remain in BC (92% of LPNs, 78% of RPNs, 77% of RNs).[4]

- Despite recent growth, significant challenges with the nursing workforce persist, including: [4, 5]
    - An estimated vacancy rate of 17%.
        - Vacancy rates of up to 30-40% are often reported in rural and remote communities.
    - 29% of nurses in BC's current workforce are aged over 50 and likely to retire within the next decade.
    - A significant portion of young nurses leave the profession, although rates in BC are below the national average and have been declining in recent years.
        - Data from the Canadian Institute of Health Information (CIHI) demonstrates that for each 100 nurses under the age of 35 joining BC's workforce, only 32 leave.[6]
        - BC's performance according to CIHI data compare favorably to other provinces including Ontario (35 leave for every 100 joining), Saskatchewan (38 leave for every 100 joining), Quebec (42 leaving for every 100 joining), and Alberta (48 leave for every 100 joining).
        - BC has also improved its entry to exit ratio since 2013 (47 exits to every 100 entries) whereas every other province has seen their ratio of entries to exits increase (except for Prince Edward Island which saw a smaller improvement than BC.

FINANCIAL IMPLICATIONS

- The total compensation estimated to the Nursing Bargaining Association members is $6.781 billion in FY2024/25.
- Budget 2021 included $96 million for seat expansions to add 602 new nursing seats across BC and 1000 new specialty nursing training opportunities.

KEY BACKGROUND

- Burnout and workload challenges resulting from the COVID-19 pandemic and toxic drug crisis have been persistent, resulting in nurses taking more time off. As a result, recent increases in the number of nurses have not directly translated to corresponding increases in worked hours.
- Education and Training
    - Nursing education takes up to 4 years. As a result, the effects of seat expansions announced in Budget 2021 have yet to be fully realized in the number of annual RN graduations.
    - The nursing New Graduate Transition Program is supporting BC graduates with guaranteed regular employment with mentorship in the public sector and one-time bursaries for licensing fees.

LAST UPDATED

The content of this estimates note is current as of March 14, 2025 as confirmed by Lynn Hancock.

APPROVALS

2025 03 14 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 12 – Health Sector Information, Analysis & Reporting Division
2025 02 27 – Finance and Corporate Services Division

4 Canadian Institute for Health Information. Nursing in Canada, 2023 — Data Tables. Ottawa, ON: CIHI; 2024.
5 Vacancy data submitted by HAs/PHC to HLTH, data as of Q2 FY24/25.
6 Canadian Institute for Health Information. Nursing in Canada, 2023 — Data Tables. Ottawa, ON: CIHI; 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

Pathways to Practice for Internationally Educated Physicians

Topic: Internationally educated physicians or International Medical Graduates (IMGs) who received their medical training outside of Canada have several pathways to licensure in BC.

Key Messaging and Recommended Response:

- We are working hard to make it easier for healthcare workers to receive faster credential recognition in the province. Approval timelines for credentials can often take longer than six weeks.
- The Ministry continuously works with the College of Physicians and Surgeons of BC and national partners to identify barriers and take steps to make the licensing process more accessible for IMGs.
- The College of Physicians and Surgeons of BC (CPSBC), in partnership with the Ministry of Health, is taking **two key steps** through proposed Bylaw changes to reduce barriers for internationally trained physicians, including U.S. physicians:
    - Creating a pathway to full licensure for U.S. trained and board certified physicians
    - Removing the Medical Council of Canada qualifying examination requirement for IMGs
- Ongoing strategies include tripling the Family Medicine Practice Ready Assessment seats, introducing the Associate Physician class of licensure for IMGs, and expanding residency training opportunities.
- We have implemented the Postgraduate Medical Education International Medical Graduate Program (PGME-IMG), which protects UBC residency positions for IMGs and provides an opportunity for IMGs to train and qualify as a practicing physician in the province.
- The PGME-IMG program at UBC has expanded from 6 annual entry positions in 2003 to 58 today.
- The Practice-Ready Assessment BC (PRA-BC) program provides internationally trained family physicians with an alternative route to full licensure in B.C. PRA-BC was expanded from 32 to 96 seats annually in 2024, supporting more IMGs to practice across the province.
- As of February 2025, 78 Associate Physicians (APs) have been hired and are contributing to patient care across the province.
- The introduction of the AP class of restricted licensure provides a pathway for some IMGs who do not meet the eligibility requirements for provisional licensure or the the PRA-BC program.
- 907 IMGs were registered between January 1, 2024 and December 31, 2024.
- We know there is more work to do, that is why we will be working with the colleges to further improve and expedite the credentialing process so we can get internationally trained healthcare workers on the front lines as fast as possible.

CURRENT SITUATION

- **BC averages 40 days for licensure with the College of Physicians and Surgeons of BC** (CPSBC) after basic licensing requirements are confirmed by the Medical Council of Canada and the relevant national college - College of Family Physicians of Canada (CFPC) or Royal College of Physicians and Surgeons (RCPSC).

The following changes have been introduced to streamline licensure processes in BC:

- **Practice Ready Assessment-BC** (PRA-BC) – IMGs who completed their residency and practiced independently abroad as a family physician can apply to complete the PRA-BC program. PRA-BC expanded intake from 32 to 96 seats annually starting in 2024. Successful candidates complete a return of service (ROS) practicing medicine in communities across BC. (See PRA-BC Fact Sheet)
- **Residency Training** – IMGs who have not completed postgraduate training or who have completed postgraduate training outside of Canada and are willing to retrain may apply to residency positions in UBC's IMG Stream or new Competitive Stream through the Canadian Residency Matching Service (CaRMS). These positions come with an attached ROS to benefit communities across the province while providing a route to full licensure in BC. (See IMG-BC Fact Sheet)

- **Associate Physicians** – Health authorities have implemented the associate physician role in a wide range of service settings, creating job opportunities for IMGs who would not otherwise be able to contribute to patient care in BC. (See Associate Physicians Fact Sheet)
- **USA Certified** – In March 2025, the CPSBC proposed bylaw changes that would eliminate the USA Certified class of restricted licensure and instead create a direct pathway to full unrestricted licensure for all U.S. trained family or specialist physicians who hold certification from the American Board of Medical Specialties (ABMS), the American Board of Family Medicine, or the American Osteopathic Board of Family Physicians without the need for further assessment, examination or training.
- **American Osteopathic Board of Family Physicians** – In October 2023, the CPSBC introduced a route to provisional licensure in the family medicine class for physicians who have obtained certification with the American Osteopathic Board of Family Physicians.
- **Alternatives to national certification exams** – In October 2023, the CPSBC amended their bylaws to provide new alternatives to the CFPC and RCPSC national certification exams.
    - Summative assessment – physicians in the provisional class of registration can transfer to the full class after successfully completing an assessment of competency.
    - Restricted licensure (family and specialty) – physicians in the provisional class who have not obtained the CFPC or RCPSC certification exam but have completed 5 years of practice in BC can move to a new class of restricted licensure (with health authority sponsorship).

KEY BACKGROUND

- Medical education varies widely among IMGs due, in part, to the varied selection, evaluation and credentialing processes in place at different international medical schools.
- Physicians wanting to practice medicine in BC must be registered and licensed with the CPSBC as the provincial medical regulatory authority. The role of the CPSBC is to ensure physicians meet expected standards of practice and conduct and the over-riding interest is protection and safety of patients.
- The CPSBC relies on the national regulatory bodies, the CFPC and the RCPSC, to determine if IMGs meet the appropriate national standards for certification.
- In BC, there are a variety of licensure categories available for IMGs depending on their educational background and clinical experience:
    - **Provisional (family and specialty)** – Permits a registrant to practice medicine with limits and conditions granted by the CPSBC. An IMG granted a provisional license must have a sponsoring organization (e.g., health authority) and a supervisor approved by the CPSBC.
    - **Clinical observer** – For IMGs seeking to enter a postgraduate (residency) training program in BC. Clinical observers are not authorized to practice independently and function at the level of a fourth-year medical student.
    - **Assessment** – For qualified internationally trained family physicians selected to participate in the PRA-BC program.
    - **Associate Physician (acute and community primary care) –** For IMGs, who do not meet the requirements for any other class of licensure, to practice under the supervision of a fully licensed physician in accredited structured team-based care settings.
    - **USA Certified** – Permits ABMS certified physicians in emergency medicine, internal medicine, pediatrics, and psychiatry to practice independently within the limits and conditions granted by the CPSBC Registration Committee. The proposed CPSBC bylaw changes will eliminate this category and instead allow all U.S. trained and certified physicians to apply directly to the full licensure class.
    - **American Osteopaths** – allows US trained physicians with certification from the American Osteopathic Board of Family Medicine to become provisional registrants. The CFPC has recognized these physicians through the practice eligibility route, and they may sit the CFPC certification examination after two years of practice in a Canadian jurisdiction.

LAST UPDATED

The content of this estimates note is current as of March 17, 2025 as confirmed by Kevin Brown.

APPROVALS

2025 03 17 – Stephanie Power obo Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 14 – Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Pharmacist Scope of Practice

Topic: BC's Health Human Resources Strategy includes commitments to optimize and expand pharmacy services to support primary care.

Key Messaging and Recommended Response:

- Expanding and optimizing the scope of practice of pharmacists is one of the key actions in B.C.'s Health Human Resources Strategy.
- Beginning in 2022, the Ministry introduced changes to pharmacist scope of practice in collaboration with the College of Pharmacists of BC and other partners to add new services to the scope of offering pharmacists could offer. The intent was reducing pressure on primary care and increase access to addressing minor ailments. Through this work pharmacist scope of practice was:
  - optimized to enable pharmacists to adapt and renew prescriptions for a wider range of drugs and conditions, and to administer, further to a prescription, a wider range of drugs by injection or intranasally.
  - expanded to enable pharmacists to perform assessments and prescribe for minor ailments and contraception.
  - broadened to enable pharmacists to adapt prescriptions for controlled drugs and substances (in alignment with Health Canada's policy guidance).
- B.C. pharmacists can help patients by:
  - Assessing and treating 21 minor ailments;
  - Prescribing and dispensing birth control;
  - Renewing or changing some prescriptions;
  - Administering immunizations and drugs by injection; and
  - Helping patients understand and manage medications.
- The ministry continues to explore the feasibility of other options to enhance pharmacy services in B.C. and improve access to health care.

CURRENT SITUATION

- Advice/Recommendations
-
-
-

FINANCIAL IMPLICATIONS

The financial implications of further changes to pharmacist SOP and/or pharmacy services will be determined as part of policy work.

KEY BACKGROUND

- The practice of pharmacy is a designated health profession under the *Health Professions Act* (HPA) and is regulated by the CPBC in accordance with the HPA, the Pharmacists Regulation, and the bylaws of the CPBC.

- On September 29, 2022, the Province launched BC's Health Human Resources Strategy, which included actions related to the optimization and expansion of pharmacy services to improve healthcare access for British Columbians.
- In October 2022, the CPBC made changes to Professional Practice Policy-58 Adapting a Prescription[1] (PPP-58) that optimized SOP by enabling pharmacists to:
    - renew and adapt existing prescriptions for a wider range of medication types and conditions, including chronic diseases;
    - renew prescriptions for narcotics, controlled drugs and targeted substances, for the same duration as originally prescribed (as permitted by a Health Canada temporary exemption to the federal Controlled Drugs and Substances Act [CDSA]).
    - administer a wider range of prescribed drugs by injection and intranasal route.
- At that time, the valid period for prescriptions was extended to two years, instead of one year.
- In 2023, the Ministry worked with the CPBC on changes to the Pharmacists Regulation that expanded SOP to authorize pharmacists to perform assessments and prescribe for 21 minor ailments and contraception. This is now known as the Minor Ailments and Contraception Service (MACS)[2].
- In August 2024, the CPBC made further changes to PPP-58 that optimized SOP by enabling pharmacists to adapt prescriptions for controlled drugs and substances (aligning with Health Canada's policy on "Prescription management by pharmacists with controlled substances under the Controlled Drugs and Substances Act and its regulations"[3]).
- The federal government regulates which health practitioners in Canada may prescribe controlled drugs and substances (including OAT) in regulations under the CDSA. The list of authorized health practitioners does not include pharmacists.
    - In August 2023, the Ministry, in collaboration with the CPBC, submitted to Health Canada a formal expression of interest in the event that consideration is given to authorizing pharmacists to prescribe controlled drugs and substances (i.e., by designating pharmacists as a practitioner or issuing a section 56 exemption under the CDSA).

LAST UPDATED

The content of this estimates note is current as of March 27, 2025 as confirmed by Christopher Bennett.

APPROVALS

2025 02 26 – Stephanie Power, Health Sector Workforce and Beneficiary Services

[1] https://library.bcpharmacists.org/6_Resources/6-2_PPP/5003-PGP-PPP58.pdf
[2] https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/initiatives/ppmac
[3] https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/prescription_management_pharmacists_controlled_substances.html

LEGISLATIVE SESSION – ESTIMATES NOTE

Physician Assistants

Topic: To provide an overview of integrating physician assistants (PA) into the BC healthcare system.

Key Messaging and Recommended Response:

- Across Canada and around the world, jurisdictions are struggling with health sector recruitment.
- That's why B.C. launched a health human resource strategy and started thinking differently about recruiting, retaining, training and redesigning the health system – to preemptively stabilize staffing wherever possible.
- Working alongside physicians as physician extenders, physician assistants can help improve patient flow, shorten wait times and enhance team-based care, however, they were previously not approved to work in B.C.
- Considering emergency department stabilization is a critical issue right now, government worked with the colleges and health authorities to add physician assistants to the mix of health care providers who could help stabilize staffing.
- In early January 2025, two Physician Assistants joined the Emergency Department team at the Saanich Peninsula Hospital, the first to work in B.C. history, and one more is anticipated to begin in spring 2025.
- Northern Health has four physician assistant positions posted: two each in Prince George and Dawson Creek with hopes to have them filled in spring 2025.
- Other health authorities are in process of identifying emergency department sites where they could introduce physician assistants and while they're currently only permitted to practice in emergency departments, the role may eventually be expanded to other clinical settings.

CURRENT SITUATION

- The first two PAs began working at the Saanich Peninsula Hospital on January 8, 2025. One more is expected to begin in March.
- Island Health is actively recruiting up to six PAs, and Northern Health is actively recruiting up to four PAs.
- Health authorities have indicated a demand for PAs in hospital EDs and for expanding the profession into other clinical settings.
- BC does not currently have a PA training program.
- Canada has five established programs (University of Manitoba, McMaster, Toronto, Dalhousie, and Calgary), with the University of Saskatchewan expected to launch in 2025.
- By 2027, approximately 193 new PAs will graduate annually from these programs (103 in 2025).
- The Ministry of Post-Secondary Education and Future Skills has confirmed that a PA training program could be established through the UBC Faculty of Medicine with the approval of net new capital and operational funding.
- PAs are not currently designated as a health profession in BC under the Health Professions Act.
- All activities a PA can perform are to be assigned, supervised, or delegated by a supervising physician and must be set out in the College of Physicians and Surgeons of BC Bylaws.

KEY BACKGROUND

- In 2023, the College of Physicians and Surgeons of BC developed a licensing and regulatory framework to enable PAs to work under the delegation and supervision of physicians in emergency departments in BC
- A "toolkit" of materials has been created by HTLH and Island Health to establish a provincial process for integrating PAs into hospital emergency departments and has been shared with all regional health authorities.

- PAs are employed by health authorities and compensation in BC is approximately $98,000 to $120,000 per year, depending on years of experience.
- The Health Employers Association of BC and the Public Sector Employers' Council Secretariat approved the compensation framework for PAs, which considered the Compensation Reference Plan, the BC Public Sector Guide to Accountable Compensation, and approved compensation frameworks for other healthcare providers.
- The mean salary for experienced PAs in Canada (including Canadian Armed Forces) ranges from $103,000 annually in Newfoundland and Labrador to $150,000 annually in Ontario. BC's top end range for PA salary is the third lowest out of eleven jurisdictions. The national average is $125,000 per year.[1]

LAST UPDATED

The content of this estimates note is current as of March 6, 2025, as confirmed by Ryan Murray.

APPROVALS

2025 03 10 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 07 – Finance and Corporate Services Division

[1] Compensation Report, Canadian Association of Physician Assistants: https://capa-acam.ca/_uploads/6762225987c29.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE
Postgraduate Medical Education

Topic: Postgraduate medical education (PGME or 'residency') and undergraduate medical education (UGME or 'medical school') programs are expanding across BC.

Key Messaging and Recommended Response:

- Training more doctors to deliver services for people living in B.C. is one of our top priorities.
- Our investments in recruitment, retention and resident training are making a difference as the number of physicians in B.C. continues to grow.
- To address the critical need for more physicians, UBC's Postgraduate Medical Education (PGME) programs will increase by over 160 positions between 2022 and 2028.
- At UBC, 40 new undergraduate medical education (UGME) seats have been added over two years: 18 in 2023 and 22 in 2024.
- In 2025, B.C. will have a total intake of up to 613 new PGME medical residents including 205 family medicine, 84 family medicine enhanced skills, 219 first-year specialty, 95 subspecialty, and 10 Re-entry into PGME intake positions. This is a 35% increase since 2017 when there were 453 intake positions.

CURRENT SITUATION

- The University of BC (UBC) has the single largest family medicine intake in Canada and has **filled all allocated family medicine positions** (100%) for the past eleven consecutive years (2014 to 2024).
- In 2024, HLTH introduced a new pilot '**competitive PGME stream' offering 20 entry-level positions** available to graduates from both Canadian and international medical schools.
  - Successful 2025 applicants to the competitive stream are required to make a **return of service commitment** to stay and practice in B.C. for three years upon completion of their training.
- As part of *BC's Health Human Resource Strategy,* medical education has expanded significantly since 2022.

UBC Undergraduate Medical Education (UGME) leading to an MD degree

- **40 new UGME seats** have been added over two years: 18 in 2023 and 22 in 2024.
- This brings UBC's distributed UGME program from **288 seats to 328**, a 14% increase:

	2022	2023		2024	
University - City	Total Intake #	Incremental Expansion #	Total Intake #	Incremental Expansion #	Total Intake #
University of BC - Vancouver	192	6	198	10	208
University of Northern BC - Prince George	32	4	36	4	40
University of Victoria - Victoria	32	4	36	4	40
University of BC Okanagan - Kelowna	32	4	36	4	40
TOTAL	**288**	**18**	**306**	**22**	**328**

UBC Postgraduate Medical Education (PGME) leading to full practice

- **162 PGME positions** will be added between 2022 and 2028:
  - **31 positions in family medicine** allocated in 2023 (12), 2024 (18) and 2025 (1):
    - Expansion sites: Coastal (Lions Gate/Sunshine Coast), St. Paul's, Surrey South, Vancouver Fraser, Victoria, Abbotsford-Mission, Chilliwack, Kamloops, Kelowna, Kootenay Boundary, Vancouver Island (Indigenous population focus), Vancouver (Indigenous population focus).
    - In 2024, new sites were established in Cowichan, Vernon, and rural northern communities.
  - **64 specialty positions** allocated across the province in 2023 (23), 2024 (21) and 2025 (20), including 'Re-entry in PGME' positions for licensed physicians seeking to retrain in high-priority specialties.
  - **19** total family medicine enhanced skills within key training areas between 2022 and 2025.
  - **48** additional positions beyond 2025: notionally planned as 24 family medicine and 24 specialties.

	Actual Filled*					Planned**							
	2022	2023		2024		2025		2026		2027		2028	
PGME Training Programs	Total Intake	Incremental Increase	Total Intake	Incremental Increase	Total Intake	Incremental Increase	Total Intake	Incremental Increase	Total Intake	Incremental Increase	Total Intake	Incremental Increase	Total Intake
Family Medicine (FM)	174	12	186	18	204	1	205	0	205	11	216	13	229
FM Enhanced Skills***	65	-1	64	-6	58	26	84	0	84	0	84	0	84
Specialty	260	17	277	20	297	17	314	0	314	11	325	13	338
Re-entry into PGME	0	6	6	1	7	3	10	0	10	0	10	0	10
TOTAL	**499**	**34**	**533**	**33**	**566**	**47**	**613**	**0**	**613**	**22**	**635**	**26**	**661**
Cumulative Increase		**34**		**67**		**114**		**114**		**136**		**162**	

* Positions filled by residents.
** Figures represent planned positions.
*** Due to insufficient applicant demand, some planned Enhanced Skills expansion positions were not filled in 2023 and 2024.

Second Medical School

- Ministry of Health (HLTH) continues to support the Ministry of Post-Secondary Education and Future Skills' (PSFS) mandate **to launch a new medical school in BC** at Simon Fraser University's (SFU) Surrey campus.
- SFU hired a Founding Dean, Dr. David J. Price and is working towards accreditation to welcome 48 medical school students by summer 2026 with potential growth to 120 seats by 2036.
- See SFU Estimates Note for more information.

FINANCIAL IMPLICATIONS

- HLTH funds PGME residency training, and PSFS funds UGME medical school education.
- $222.7 million has been allocated for PGME at UBC in 2024/25.
- Budget 2023/24 included increases through B.C.'s Health Human Resources Strategy.
- Please refer to Second Medical School Fact Sheet for School of Medicine at SFU funding.

KEY BACKGROUND

- UGME is four years in duration and is followed by either a family medicine residency requiring two additional years of PGME or a specialty residency requiring four to seven more years of PGME.
- UGME graduates must compete for PGME positions across Canada as part of a fair, transparent, and equitable national matching process through the Canadian Resident Matching Service (CaRMS).
- 92% of trainees completing both UGME and PGME at UBC choose to stay in BC to practice[1].
- In 2024, **58 International Medical Graduate (IMG)** first-year positions were allocated in BC:
  - 52 positions in family medicine and 6 in psychiatry, internal medicine, and pediatrics.
  - IMGs are distinguished on whether the applicant has graduated from a medical school accredited by a North American accreditation body, not on national origin. CaRMS does not differentiate between Canadians studying abroad and naturalized Canadian IMGs, as this would constitute a breach of the Canadian Charter of Rights and Freedoms in addition to human rights legislation.

LAST UPDATED

The content of this estimates note is current as of March 11, 2025 as confirmed by Jess Bossert obo ED Kevin Brown.

APPROVALS

2025 03 11– Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 22 – Finance and Corporate Services Division

[1] UBC. Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2023). Sankey. Data as of October 2023

LEGISLATIVE SESSION – ESTIMATES NOTE
Practice Ready Assessment-BC for Family Physicians

Topic: Practice Ready Assessment-BC (PRA-BC) program provides a pathway to licensure for internationally trained family physicians (FPs) in exchange for a practice commitment in a BC community.

Key Messaging and Recommended Response:

- Doctors who have completed their medical training outside of Canada contribute significantly to the Province's health workforce and play a vital role in achieving positive health outcomes for British Columbians.
- We've been working hard to make it easier for internationally trained doctors to receive faster credential recognition in the province. This includes expanding the Practice-Ready Assessment BC (PRA-BC) program in 2024 from 32 to 96 seats annually, which helps internationally trained family doctors get to work more quickly in B.C.
- By April 15, 2025, 318 PRA-BC IMGs will have been placed in 77 B.C. communities since the program was established in 2015.
- This is just one of the many ways in which we are making sure people in B.C. have access to the care they need, when and where they need it.

CURRENT SITUATION

- PRA-BC provides a pathway to licensure for internationally trained FPs in exchange for a three-year return of service (ROS) commitment within a community of need as identified by a health authority.
- As part of BC's Health Human Resources (HHR) Strategy (Action 41), PRA-BC program tripled in 2024 from 32 to 96 seats annually across two cohorts.
- Since the program was established in 2015, 318 FPs have been successfully assessed through PRA-BC and placed in 77 communities.[1]
- PRA-BC program is jointly funded by the Ministry and the Joint Standing Committee on Rural Issues (JSC), a joint collaborative committee between the Ministry and Doctors of BC.
- Of the 96 seats, 80 seats are funded by the Ministry and the ROS commitments may be fulfilled in urban, semi-urban or rural communities. The other 16 seats are funded by the Joint Standing Committee on Rural Issues and the ROS commitments must be fulfilled in a rural community
- The 2025 seat allocation is:

2025 PRA-BC Seat Allocation			
	JSC	MoH Direct	**Total**
Northern Health	6	16	**22**
Interior Health	4	16	**20**
Island Health	4	16	**20**
Vancouver Coastal	1	16	**17**
Fraser Health	1	16	**17**
Total	16	80	**96**

FINANCIAL IMPLICATIONS

- The 2024/25 budget was $8.3 million, in which $6.94 million was funded through HHR Strategy Action 41, and JSC funded $1.34 million.[2]
- The 2025/26 budget is $8.5 million, $7.131 million through the HHR Strategy.[2]
- PRA-BC has $7.327 million in ongoing funding through the HHR Strategy past FY25/26.

[1] PRA-BC Website, Practice Ready Assessment - BC (prabc.ca), January 28, 2025.
[2] 2025/26 PRA-BC Budget, provided by Health Employers Association of BC to JSC, January 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

PRA-BC Program

- FPs licensed in countries that are not recognized and approved by the College of Family Physicians of Canada (CFPC) can apply to the PRA-BC program. Approved jurisdictions are: US, UK, Ireland, and Australia.
- The program has a Spring and Fall intake with 48 seats respectively. Candidates participate in a 2-week orientation followed by a 12-week clinical field assessment under the supervision of a fully licensed FP.
- Following successful completion of the assessment the participant may be eligible for provisional licensure with the College of Physicians and Surgeons of BC (CPSBC) to practice medicine in BC.
- Successful participants are then required to complete a 3-year ROS practicing in a community family practice setting in a health authority-identified community of need.
- A number of PRA programs were recently established or expanded across Canada, with provinces actively competing for the same IMG candidates.
- PRA-BC is administered by Health Employers Association of BC, on behalf of the Ministry.

PRA Background

- PRA-BC follows a standardized format approved by the Medical Council of Canada's National Assessment Collaboration (NAC). The format meets medical regulatory authorities' provisional licensure requirements across Canada, aligned with the Agreement on Internal Trade which enables interprovincial labour mobility. Organizations participating in NAC include federal and provincial health ministries, faculties of medicine, medical regulatory authorities, and regional IMG assessment programs.
- Due to changes to the Agreement on Internal Trade in 2009, the CFPC began work on pathway 1: enabling licensure of FPs from the US, Australia, UK, and Ireland, and NAC began work on pathway 2: a practice assessment for FPs.
- In 2013, NAC finalized the PRA for internationally trained FPs. A pathway for internationally trained specialists has not yet been established.

LAST UPDATED

The content of this estimates note is current as of February 4, 2025 as confirmed by Kevin Brown.

APPROVALS

2025 03 10 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 07 – Health Sector Information, Analysis & Reporting Division
2025 02 27 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Provincial Rural Retention Incentives

Topic: Financial incentives to retain healthcare workers in rural and remote communities.

Key Messaging and Recommended Response:

- The Provincial Rural Retention Incentive (PRRI) is one program through which B.C.'s Health Human Resources (HHR) Strategy supports health service delivery in rural and remote communities.
- For Fiscal Year 2024/25, we expanded the prototype retention incentive to 80 rural communities across the province.
- Under this expanded program, eligible regular employees of a health authority or Health Employers Association of BC (HEABC) affiliate employer may receive up to $8,000 in 2024/25, pro-rated to their working hours.
- The PRRI-eligible communities were selected based on rurality and assessed health human resource risk.
- The decision to include each PRRI community also considered relative impact on surrounding communities, cost, and risk of staffing movement.
- Furthermore, workforce data provided by health authorities, such as vacancy rates, overtime hours, and agency utilization were analyzed in combination with qualitative data to support decision-making on eligible communities.
- The Ministry of Health is currently evaluating PRRI to assess its effectiveness as a retention initiative and to determine the scope of the program in 2025/26.

CURRENT SITUATION

- Eligible staff receive payments of up to $2,000 if they are retained at the end of a quarter.
  - Casual staff are not eligible.
  - Contractors are not eligible (e.g. contracted physicians and nurse practitioners).
  - Senior leaders are not eligible (i.e. Grid 11 and over).
  - Recipients must be employees of a health authority or HEABC affiliate employer.
- **The precise number of healthcare workers receiving PRRI is not known** as the eligibility of First Nations Health Authority (FNHA) and HEABC affiliate staff were only confirmed in December 2024 and some regional health authorities are still working to validate eligibility criteria.[1]
  - 26,802 PRRI payments have been made (it is likely many of these are to the same people in different quarters) since April 1, 2024.
  - At least 8,670 payments have been made to nurses and 4,402 to allied health staff.
- Preliminary evaluation results indicate:
  - It is difficult to separate PRRI's impact from other workforce supports, increased training, and general provincial trends.
  - From the PRRI prototypes in Northern Health Authority (NHA), it is unlikely that PRRI alone has stabilized regular employees, and outcomes are mixed depending on the community.

FINANCIAL IMPLICATIONS

- **In 2023/24, prototype incentives cost $11.641 million** against a budget of $32.120 million for Action 6 of the HHR Strategy. Surplus funding offset pressures elsewhere in the Strategy at 2023/24 year-end.
- **In 2024/25, HLTH is projected to fully spend its one-time budget of $68.408 million** for PRRI:
  - $32.120 million from Action 6 and $15.408 million re-allocated from Action 47 (Recruitment Incentives)

[1] Data provided to HSWBS through the Quarterly Reporting process. As of December 31, 2024.

  - $20.880 million from the Federal Working Together Agreement for nursing incentives in alignment with the minimum Nurse to Patient Ratios (mNPR) initiative.
- **In 2025/26, HLTH has a budget of $32.120 million for PRRI in one-time funding from Action 6** (less than half of the 2024/25 budget).

KEY BACKGROUND

- **Staff in 80 communities are eligible for PRRI**.
  - Communities were prioritized by health authorities.
  - Communities were validated through Memoranda of Agreement (MoAs) with the Nurses, Health Sciences Professionals, Communities, and Facilities Bargaining Associations.
  - Requests for community expansions were accommodated early in 2024/25 (Trail and South Okanagan including Osoyoos and Oliver were added) but have since been deferred for decision to 2025/26 pending program evaluation.

- **Eligible employers include**: all five regional health authorities, Provincial Health Services Authority, First Nations Health Authority, Providence Health Care, and HEABC affiliates (with unionized staff who receive significant public funding).
  - BC Emergency Health Services (BCEHS) staff are not eligible as there is no MoA with the Ambulance Paramedics and Ambulance Dispatchers Bargaining Association.
  - Private health sector staff (e.g. employees of Life Labs or private long-term care facilities) are not eligible as they are privately employed.
  - First Nations Community Nursing Station staff are not eligible as they are privately employed.

- **PRRI originated as a Northern prototype** and was piloted in tandem with the Northern Health Childcare Pilot (action 7), Clinical Management Resources (action 14), and Northern Health Housing Supports (action 42).
  - These rural, mostly non-financial, workforce supports provide communities and NHA with resources to help recruit, retain, and transition individuals into northern communities.

LAST UPDATED

The content of this estimates note is current as of March 25, 2025, as confirmed by Ryan Murray

APPROVALS

2025 03 25 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 26 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Psychological Health and Safety in the Health Care Workplace

Topic: The Ministry of Health (HLTH) is working with health authorities and Providence Health Care (HAs/PHC), health sector unions, Doctors of BC, WorkSafeBC, SWITCH BC, and other partners to reduce and prevent the risk of psychological injuries, fostering safe and healthy workplaces to retain the health workforce.

Key Messaging and Recommended Response:

- Poor mental health presents a significant barrier to health workforce retention, productivity, and staffing levels. Ensuring the psychological health and safety of the healthcare workforce is a priority for the province.
- The Provincial Psychological Health and Safety Directive (2017) is currently being refreshed in alignment with feedback from partners.
- The Ministry of Health is taking steps to further support psychologically safe workplaces for everyone in health care by engaging SWITCH BC to lead the Psychological Health and Safety Measurement and Evaluation Framework.
- The government is taking action to support employees and leaders by creating a provincial psychological health and safety resources team that will develop resources, training, and programs related to mental health and wellness. To date, 9 of 18 psychological health and safety positions allocated in FY 2024/25 have been hired.

CURRENT SITUATION

- In 2024, 4,513 psychological injury incidents were reported by HAs/PHC, representing 516 time-loss claims that resulted in 43,226 days lost (average 84 days per claim) and $10.196 million in claim costs (average $18,567 per claim).[1]
- HLTH is working with Health Employers Association of BC (HEABC), bargaining associations, and Doctors of BC to ensure alignment in the upcoming 2025 collective bargaining round.

Provincial Psychological Health and Safety Policy Directive

- In 2017, HLTH issued the *Implementation of the National Standard on Psychological Health and Safety in the Workplace* policy directive (PHS Directive), requiring HAs/PHC to implement the National Standard of Canada for Psychological Health and Safety in the Workplace (PHS Standard).[2]
- Implementation of the PHS Standard enables a systematic approach to psychological health and safety, which contributes to improved recruitment and retention, increased employee engagement, and a reduction of workplace risks including conflict, burnout, turnover, and time-loss claims.
- The PHS Directive is being refreshed with engagement from partners and stakeholders to reflect the current landscape of occupational and psychological health and safety.

BC's Health Human Resources Strategy – Actions 1 and 4

- Under the retention cornerstone of BC's Health Human Resources Strategy (HHR Strategy), Action 1 and Action 4 have been combined to expand supports for worker mental health and wellness through the recruitment of psychological health and safety positions in HAs/PHC, Provincial Workplace Health Services, OHS Solutions, and SafeCare BC to establish a provincial resources team.
- The new psychological health and safety positions will establish a provincial committee and dedicated governance structure that integrates into the existing, broader occupational health and safety context to ensure a coordinated approach to provincially standardized definitions, processes, and priorities.

[1] WHITE data from OHS Solutions, Feb 7, 2025

[2] Published in 2013, the PHS Standard is a voluntary, Canadian Standards Association standard (CAN/CSA-Z1003-13) that specifies requirements for a systematic approach to develop and sustain a psychologically healthy and safe workplace.

- Situated across HAs, PHC, SafeCare BC, and two existing, provincial occupational health and safety organizations (OHS Solutions and Provincial Workplace Health Services), the net new regional resources will advance each organization's progress towards implementing the PHS Standard and fulfilling their PHS regulatory obligations and collective agreement commitments, while the net new centralized resources will be available to facilitate coordination and alignment across organizations, alleviate administrative burden on individual organizations, and carry out the work directed by the provincial committee.
- In partnership with the Canadian Mental Health Association (BC Division) and SafeCare BC, free mental health resources and leadership development courses continue to expand through CareforCaregivers.ca, and confidential peer support is available via phone, text, and instant message through Care to Speak.

SWITCH BC – Psychological Health and Safety

- In collaboration with HLTH and health sector partners, including the provincial psychological health and safety resources team, SWITCH BC is supporting implementation of the PHS Standard by leading measurement and evaluation projects, establishing a Community of Practice, and developing supports for Joint Occupational Health and Safety Committees.

FINANCIAL IMPLICATIONS

- HLTH has committed $6.0 million between FY 2022/23 and FY 2024/25 through the Physician Master Agreement's Memorandum of Agreement on Physical and Psychological Health and Safety.
- Through a shared cost arrangement in FY 2024/25, HLTH has committed $5.0 million in operational funding and up to $3.0 million in project funding to support SWITCH BC-led initiatives, including the Psychological Health and Safety Measurement and Evaluation Framework.
- Through HHR Strategy Action 4, HLTH has committed $1.261 million in FY 2024/25 and $2.522 million in FY 2025/26 and ongoing annually for provincial psychological health and safety positions.
- HLTH has allocated an additional $1.727 million in FY 2025/26 for further expansion under Action 4.
- Through a shared cost arrangement in FY 2024/25 through FY 2025/26, HLTH has committed $298,205 to support SafeCare BC's psychological health and safety programs and services for the long-term care and continuing care sectors, in alignment with HHR Strategy Action 4.

KEY BACKGROUND

- The 2014-2019 Nurses Bargaining Association collective agreement committed HAs/PHC to adopt the PHS Standard. Similar commitments are in all six of the major provincial agreements negotiated by the Health Employers Association of BC (HEABC) and in the Physician Master Agreement.[3]
- The PHS Standard identifies thirteen widely accepted and measurable factors that are known to impact psychological health and safety. An additional two factors are unique to the health sector.[4]
    - Engagement with workers and leaders alike is key to implementation of the PHS Standard.
- Under the *Workers Compensation Act*, the *Mental Disorder Presumption Regulation* expedites access to care and compensation benefits for workers in eligible occupations who are exposed to traumatic events in their work and are diagnosed with a mental disorder.[5]
- WorkSafeBC's Mental Health Strategy 2023-2025 plans to develop new regulations for psychological health and safety, which may have regulatory implications for HAs/PHC once in place.

LAST UPDATED

The content of this estimates note is current as of March 12, 2025 as confirmed by Ryan Murray.

APPROVALS

2025 03 12 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 24 – Finance and Corporate Services Division

[3] Ambulance Paramedics and Ambulance Dispatchers Bargaining Association, Community Bargaining Association, Facilities Bargaining Association, Health Science Professionals Bargaining Association, Nurses Bargaining Association, and Resident Doctors of BC collective agreements
[4] Protection from moral distress and support for psychological self-care are the two healthcare-specific factors.
[5] Eligible health sector occupations include emergency medical assistants, emergency response dispatchers, health care assistants, nurses, community integration specialists, and respiratory therapists.

LEGISLATIVE SESSION – ESTIMATES NOTE

Recruitment Incentives

Topic: Provincial signing bonuses for select new health authority (HA) employees in fiscal year 2024/25.

Key Messaging and Recommended Response:

- Government launched a health human resource strategy that effectively revolutionized the province's approach to recruiting, retaining, training and redesigning service throughout the health care system.
- To support this work a range of incentives came into effect and varied in some cases on profession, occupation and circumstances – all intended to stabilize health system staffing as the sector faced current and future staffing challenges.
- One example was provincial signing bonuses with a two-year return of service.
- These were introduced for 2024/25 to support recruitment of net new health care workers for high needs communities and occupations where:
    - Up to $30,000 for northern communities
    - Up to $20,000 for rural communities outside of the north
    - Up to $15,000 for urban/metro communities
    - Up to $10,000 for GoHealth BC, our provincial rural travel resource pool
- Almost 1500 nurses and over 750 other healthcare workers have received signing bonuses to date.
- These incentives are being evaluated for impact and cost effectiveness for future years, however, the intent behind launching the health human resource strategy remains unwavering. Government is focused strengthening the health care system to ensure services are available for people when and where they need them.

CURRENT SITUATION

- Between April 1 and December 30, 2024, HAs have paid signing bonuses to:
    - 1,495 nurses[1] representing 1,330 FTEs:
        - 303 in Vancouver Coastal (VCHA), 211 in Fraser Health (FHA), 93 in Island Health (ISLH), 87 in Northern Health (NHA), 82 in Interior Health (IHA), 45 in Provincial Health Services Authority (PHSA), and 27 in Providence Health Care (PHC).
    - 765 other healthcare workers (HCWs) including allied health and community health workers:
        - 458 in VCHA, 337 in FHA, 189 in ISLH, 166 in NHA, 113 in PHSA, 61 in IHA, and 55 in PHC.
- The Urban/Metro incentive (up to $15,000) represents 74.9% of incentives paid to nurses and 76.9% of incentives paid to other HCWs.
- Combined, rural incentives (Northern, GoHealth, and Rural) represent just 25.7% of all signing bonuses to date.
    - 56 GoHealth BC Signing Bonuses, 197 Northern Signing Bonuses, and 255 Rural/Remote Signing Bonuses have been taken.
- Advice/Recommendations

FINANCIAL IMPLICATIONS

[1] registered nurses, registered psychiatric nurses, and licensed practical nurses

- HLTH allocated up to $71.319 million for signing bonuses in 2024/25:
  - $52.509 million for nursing incentives from the minimum Nurse to Patient Ratios (mNPR) budget
  - $18.810 million for other HCW incentives
- HAs have one budget for nurses and another for other healthcare workers, and are responsible for prioritizing roles, care settings, and communities within available funding.
- No funding has yet been allocated for 2025/26.

KEY BACKGROUND

- On March 1[2], and May 1, 2024[3], HLTH announced that Memoranda of Agreement had been signed with the Community, Facilities, Health Science Professionals, and Nurses Bargaining Associations for new signing bonuses to be offered in 2024/25 (April 1, 2024 to March 31, 2025). No agreement has been signed for 2025/26.
- For the nursing incentives, funds are allocated under section 6 of the Memorandum of Understanding (MOU): Process for Establishing, Reviewing/Amending Minimum Nursing/Staff Ratios
- The Ministry of Health set provincial criteria for determining the eligibility of vacancies for the recruitment incentive.
- Eligible health care workers are those who:
  - Are new to an eligible community (including those employed in an urban/metro centre, relocating to a rural/remote community, or new to B.C.'s public health sector), or
  - GoHealth BC nurses who accept an eligible permanent position.
- Health care workers currently employed in a rural/remote community relocating to another rural/remote community are *not* eligible.
- Health care workers who are employed by third party staffing agencies are eligible for the incentive if they meet the eligibility criteria above.
- To prevent destabilization, health care workers who were employed by a First Nation service provider or by the First Nations Health Authority or by a private/affiliate long-term care or assisted living employer in the community within the last 12 months prior to their date of hire are not eligible.

LAST UPDATED

The content of this estimates note is current as of March 13, 2025, as confirmed by Ryan Murray

APPROVALS

2025 03.13 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02.24 – Finance and Corporate Services Division

[2] HLTH (2024) Province announces minimum nurse-to-patient ratios, retention and recruitment investments https://news.gov.bc.ca/30389. Accessed Sep 18, 2024.
[3] HLTH (2023) Province supports allied health workforce, improves patient care. https://news.gov.bc.ca/30007 Accessed Sep. 18, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE
Relational Security Initiative

Topic: The status of the Relational Security Initiative (RSI) at 32 designated sites across B.C.

Key Messaging and Recommended Response:

- Workplace violence is a serious issue and is more common in healthcare than in other industries. Ensuring our health care facilities are free of violence is a priorty for the province.
- That is why this government took action to build safer workplaces for healthcare staff through the introduction of the new relational security model.
- We committed to creating 320 net-new relational security officer (RSO) positions. All those positions are now filled and we expanded the relational security model in Spring 2024 and Spring 2025 - there are now approximately 781 FTEs across 32 sites.
- This new relational security model ensures all security personnel have an acute awareness of patients and their surroundings, as well as how to anticipate, de-escalate and ultimately prevent aggression.
- It is based on trauma-informed practice, which integrates knowledge of how people are affected by trauma into procedures, practices and services.
- We are also working to create a culture of violence prevention, which means that we encourage staff to report incidents of violence in the workplace.

CURRENT SITUATION

- The RSI is operational at 32 sites across all health authorities and Providence Health Care (HAs/PHC).
- As of October 1, 2023, HAs/PHC hired, trained, and onboarded 14 Violence Prevention Leads and 320 net new Relational Security Officers (RSOs) at 26 sites across the province.
- The remaining contracted staff from the 26 sites were repatriated to RSOs in February of 2024, followed by four more sites in Northern Health in the spring of 2024 and two more sites in the spring of 2025 for Interior Health, bringing the total number of RSO Full time Equivalents (FTEs) to 781 provincially.
- The goal of this initiative is to support the retention of the health sector workforce through the reduction of workplace violence and psychological injury by integrating trauma informed protection services within a team-based care approach.
- All RSOs receive standardized training and onboarding, including additional customized Trauma Informed Practice (TIP) Training.
- TIP equips RSOs with the necessary skills, language, and knowledge to be able to apply an appropriate and trauma informed lens to interactions with patients, clients, and colleagues.
- The Ministry has worked in collaboration with the Provincial Health Services Authority (PHSA) to ensure the sustainability of TIP training for RSOs by establishing a TIP Facilitator Community of Practice and by offering more facilitator training sessions which support program growth and attrition. As of February 6, 2025, 47 individuals have been trained as TIP facilitators[1] and all RSOs (781 FTE) have completed TIP training.[2]
- To measure the effect of implementation of the relational security model, a year long evalution was completed and documented in a final report. Results have been communicated to senior executive and HAs/PHC.

[1] Email, K. George, Manager, Psychological Health and Safety, PHSA. January 30, 2025.
[2] WHITE.net, accessed January 31, 2025.

- The sites for the RSI were selected in consultation with BC Nurses' Union (BCNU) and HAs/PHC:

Fraser Health	Providence Health	Vancouver Coastal Health	Provincial Health Services Authority	Island Health	Interior Health	Northern Health
• Abbotsford Regional • Burnaby Hospital • Chilliwack General • Delta Hospital • Langley Memorial • Peace Arch • Royal Columbian • Surrey Memorial	• Mount Saint Joseph • St. Paul's Hospital	• Lion's Gate Hospital • Richmond Hospital • Vancouver General Hospital	• BC Women's and Children's Hospital	• Cowichan Lodge • Saanich Peninsula Hospital	• Cariboo Memorial • East Kootenay Regional • Kelowna General • Kootenay Boundary Regional • Penticton Regional • Royal Inland • Vernon Jubilee	• Mills Memorial • Prince Rupert Regional • University Hospital • Fort St. John General • Dawson Creek Hospital • GR Baker Memorial • Kitimat General

FINANCIAL IMPLICATIONS

- Through the BC Health Human Resources (HHR) Strategy, the Ministry has committed $40.000 million in 2023/2024 to support the RSI. For 2024/2025 and onwards, the commitment increased to $60 million annually. This funding covers all program area costs, including infrastructure, RSOs, Violence Prevention Leads (VPLs), corporate support, leadership expansion, and training.

KEY BACKGROUND

- Since 2002, most protection services positions in the health sector have been privately contracted – except in Island Health (ISLH) which has an in-house protection services officer (PSO) model, where PSOs are also integrated into team-based care planning.
-
- In 2021, BCNU reiterated workplace health and safety concerns and requested that 24/7 PSOs be added to sites deemed high-risk for violence.
- In response to the BCNU's requests, HLTH's Labour and Agreements Branch began work in 2021/22 on a provincial protection services/ relational security model.
- The RSI was announced as Action 3 of B.C.'s HHR Strategy with funding to hire 320 net new RSOs and 14 violence prevention leads across B.C.
- RSOs are HA/PHC employees and members of the Hospital Employees' Union (HEU)
    - All RSOs and PSOs are currently benchmarked at Grid 21 under the Facilities Bargaining Association (FBA) collective agreement.

LAST UPDATED

The content of this estimates note is current as of March 11, 2025 as confirmed by Ryan Murray.

APPROVALS

2025 03 11 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 24 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Requests for Expanded Scope of Practice

Topic: The Ministry receives requests to expand the scope of practice (SOP) of regulated health professions.

Key Messaging and Recommended Response:

- As part of the Province's Health Human Resources Strategy launched in 2022, government aims to optimize and innovate B.C.'s health system by reviewing scopes of practice for certain professions.
- When considering requests to expand the scope of practice of regulated health professions, the Ministry must consider a number of factors including education and training, impacts on service delivery, impacts on other health professionals (regulated and unregulated), consultation with regulatory colleges and health professions regulators, quality assurance mechanisms, and ultimately the impact on patients – their health, safety and the patient experience.
- Advice/Recommendations

CURRENT SITUATION

- The Ministry receives requests to expand the SOP of regulated health professions from a variety of sources (e.g., health professional associations, regulatory colleges, health authorities, government program areas, and other stakeholders).
- While advocating for broadening of SOP is within the role of a professional association, practitioner, or interest group, this advocacy is outside the mandate of the regulatory colleges under the Health Professions Act (HPA).
- Many requests to expand SOP received by the Ministry do not align with the Ministry's strategic direction or identified service delivery priorities.
- The requests are often related to professional 'self-interest,' as seeking a broadened SOP may expand the service delivery opportunities of an individual health practitioner and, in some instances, may be linked to perceived increases in health professional compensation/remuneration.
- The requests are often 'health profession-centric' and have not broadly considered the impact on other regulated health professionals and/or unregulated health occupations, impacts on existing service delivery and funding models, and patient experiences of care.
- Advice/Recommendations

KEY BACKGROUND

- SOP describes the services a regulated health professional is educated, trained, competent and authorized to provide.
- In BC, health professionals are regulated under the HPA through a "shared scope of practice and restricted activities" regulatory model. Profession-specific regulations establish SOP statements and a list of restricted activities the profession is authorized to perform.
    - **SOP statements** are concise descriptions, in broad, non-exclusive terms, of each regulated health profession's activities and areas of professional practice.
    - **Restricted activities** are a narrowly defined list of invasive, higher-risk activities that must not be performed by any person in the course of providing health services except: registrants of regulated health professions authorized to perform the restricted activity in their profession-specific regulation; and non-registrants who have been appropriately authorized to perform the restricted activity by an authorized regulated health professional (e.g., under a "delegation" or other regulatory authorizing mechanism).

- As health care service delivery is provincially regulated, there may be variances in the SOP of regulated health professions across Canada.
- A health profession's regulatory college is responsible for ensuring their registrants are educated, trained and competent to perform the services authorized in their SOP.
- In September 2024, the Ministry posted an Interpretive Bulletin on Scope of Practice, Restricted Activities and the Use of Delegation and Other Authorizing Mechanisms on its Professional Regulation website - which provides public guidance in relation to SOP and restricted activities under the HPA.
- A request to change SOP is any proposal that may result in an amendment to profession-specific regulation under the HPA/ Health Professions and Occupations Act (HPOA). These requests are typically made to expand the profession's SOP by adding restricted activities or by removing limitations on practice.
- The Ministry has many priorities and requests for SOP change are considered in relation to those (i.e., to ensure alignment with Ministry and government priorities and commitments).
- When considering changes to the SOP for regulated health professions, the Ministry will first consider "**what is the problem that we are trying to solve?**" When regulatory SOP changes are contemplated, substantial policy work is required to support any recommendation to the Minister for SOP expansion, including:
    - cross-jurisdictional scans of what is authorized SOP in other provinces/territories, including present issues and labour mobility considerations;
    - assessment of the education and training of health professionals;
    - assessment of regulatory college readiness to regulate;
    - extensive consultation with stakeholders, including the public and other health professions regulators;
    - assessment of what other health professions can already do;
    - assessment of the financial implications to the patient and government;
    - assessment of any quality assurance mechanisms that would have to be put into place to ensure certain practices are appropriate, and;
    - assessment against other Ministry regulatory priorities.
- Advice/Recommendations

LAST UPDATED

The content of this estimates note is current as of March 5, 2025, as confirmed by Christopher Bennett.

APPROVALS

2025 03 12 – Stephanie Power, Health Sector Workforce and Beneficiary Services

LEGISLATIVE SESSION – ESTIMATES NOTE
Rural Initiatives in B.C.'s Health Human Resources Strategy

Topic: Actions in BC's Health Human Resources Strategy to stabilize and enhance rural health service delivery.

Key Messaging and Recommended Response:

- As a rural resident myself, I understand how challenging it can be to access health-care services in rural and remote communities.
- That's why our government is dedicated to making sure people have access to the health care they need, especially in rural and remote areas of the province.
- To stabilize and enhance healthcare in rural communities, B.C.'s Health Human Resources (HHR) Strategy includes 70 actions that focus on the retention, redesign, recruitment and training initiatives for nurses, doctors, allied health workers and more.
    - Some highlights of these actions include: the expansion of GoHealth BC (the province's travel nursing program), targeted rural retention and recruitment incentives, and the expansion of the Practice Ready Assessment BC (PRA-BC) program that supports international medical graduates to practice across the province.
- In addition, the new Parliamentary Secretary for Rural Health (MLA Debra Toporowski) will be involved during the refresh of the HHR Strategy this year to ensure that rural perspectives help shape our province's health workforce priorities.

CURRENT SITUATION

- 17.8% of people in BC reside in a rural community but only 12% of nurses (and 13% of the HA workforce overall) work in a rural or remote local health area (LHA).
    - Of the 20 LHAs with the highest vacancy rates, 13 are rural or remote and 10 are in Northern BC.
- To support the rural health workforce, the B.C.'s HHR Strategy includes actions to:
    - Expand GoHealth BC which deploys **436** nurses and 5 allied health employees to **34 (29 active and 5 onboarding)** rural and remote communities with forecast need, reducing our reliance on private staffing agencies.
    - Expand PRA-BC, which provides a pathway to licensure for internationally educated family physicians for a return of service in a community of need, including rural or remote communities
    - Expand Northern Health's housing prototype, currently providing 460 units (+120 from 23/24) in 22 rural Northern communities:
        - Atlin, Burns Lake, Chetwynd, Daajing Giids, Dawson Creek, Dease Lake, Fort Nelson, Fort St James, Fort St John, Fraser Lake, New Hazelton, Kitimat, Mackenzie, Masset, McBride, Prince Rupert/Port Edward, Smithers, Stewart, Terrace, Tumbler Ridge, Valemount, and Vanderhoof.[1]
    - Expand Northern Health's childcare prototype, currently providing 120 (+7 spaces from 23/24) spaces in 10 Northern rural communities:
        - Chetwynd, Dawson Creek, Fort St. John, Hazelton, Hudon's Hope, Kitimat, Northern Haida Gwaii/Masset, Prince George, Prince Rupert, and Terrace.[2]
    - Fund retention incentives, up to $8,000 per year, for publicly-funded heath-sector employees serving in 80 rural communities across the province.
    - Fund signing bonuses, up to $30,000 for Northern communities, $20,000 for rural and remote communities outside of Northern Health, and $15,000 for GoHealth BC, for eligible nursing and allied health professions in 2024/25.

[1] Northern Health Authority Housing and Child Care Data for 24/25. Provided to HWPO on March 2025.
[2] Northern Health Authority Housing and Child Care Data for 24/25. Provided to HWPO on March 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- Actions 6 (rural retention incentives), 7 (childcare prototype), 34 (GoHealth), 41 (PRA-BC), and 42 (housing prototype) combined have $272.761 million 3-year funding commitment from BC's HHR Strategy being $66.258 million in FY2023/24, $121.300 million in FY2024/25 (including $20.880 million from the Federal Working Together Budget), and $85.203 million in FY2025/26 and $53.279 million ongoing.
- Action 47 (recruitment incentives) is funded for $133.754 million over 3 years: $24.726 million in FY2023/24, $80.592 million in FY2024/25 (including $18 million from Federal Working Together and $52.350 million from the Minimum Nurse-to-Patient Ratio Budget), and $28.436 in FY2025/26.

KEY BACKGROUND

- In September 2021, HLTH announced $6.38 million for prototype programs in Northern Health Authority (NHA),[3] which continued in 2022/23, and several of which were expanded through the Strategy.

LAST UPDATED

This estimates note is current as of March 12, 2025, as confirmed by Lynn Hancock.

APPROVALS

2025 03 28 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 27 – Finance and Corporate Services Division

[3] HLTH (Sep 14, 2021) Boosting support, hiring to enhance services in Northern Health. https://news.gov.bc.ca/25351 Accessed 2024-9-26

LEGISLATIVE SESSION – ESTIMATES NOTE
Second Medical School

Topic: Progress on the development of the School of Medicine at Simon Fraser University (SFU).

Key Messaging and Recommended Response:

- We are making investments to support the growing health-care needs in Surrey, and areas South of the Fraser.
- Those investments include the School of Medicine at Simon Fraser University, which will be the first new medical school in western Canada in 55 years and will mean more family doctors graduating each year to provide care for people.
- SFU is on track to meet the critical milestones in the planning and accreditation process and anticipates being able to welcome 48 medical school students by summer 2026 and grow to 120 seats by 2036.
- The first intake of Family Medicine residents is planned for 2027, with new family doctors graduating and entering practice by 2029.
- This new medical school is one of the key actions in B.C.'s Health Human Resources Strategy that works to optimize the health system by expanding training, further improving recruitment and retention of physicians in the province.

CURRENT SITUATION

- In May 2024, SFU's Senate and Board of Governors formally approved the establishment of a School of Medicine.
- On July 9, 2024, Premier David Eby formally announced the new School of Medicine at SFU, including the funding committed in *Budget 2024* and the hiring of the Founding Dean, Dr. David J. Price, who had previously been working with SFU as acting dean and special advisor.
- Cabinet Confidences; Government Financial Information

- *Budget 2024* also provided operational and capital funding to the Ministry of Post-Secondary Education and Future Skills (PSFS) to further support planning and start-up activities over the three-year fiscal plan.
- This includes funding to develop interim spaces near SFU's Surrey campus, and in leased space nearby. SFU will design, renovate, and equip these spaces to accommodate classrooms, labs, and faculty and staff office space.
- Cabinet Confidences; Government Financial Information

- SFU is developing a three-year medical school curriculum, which mirrors the content in traditional four-year programs but accelerates completion by minimizing breaks and focusing clinical rotations.
- SFU achieved candidate status with the Committee on the Accreditation of Canadian Medical Schools (CACMS), with the goal of preliminary accreditation by fall 2025.
- In addition to the undergraduate medical school program, SFU plans to establish a postgraduate medical education (PGME) residency program and is working towards a small initial intake of Family Medicine positions as early as 2027 (initial intake numbers are still in the planning stages and are not yet are yet confirmed).
- The residency program will continue to expand as the inaugural medical school cohort graduates in 2029 and enters residency training. The standard provincial ratio of undergraduate to postgraduate residency seats is 1:1.2. Applying this ratio would bring the residency intake to approximately 58 in 2029 subject to available funding.

FINANCIAL IMPLICATIONS

- As of March 31, 2024, SFU had received $14 million in operational funding to support planning and start-up activities, which included developing a business case, hiring key leadership positions, developing curriculum, and accreditation activities.
    - 2021/22 - $1.5 million awarded directly by HLTH to SFU
    - 2022/23 - $2.5 million transferred from HLTH to PSFS

  - 2023/24 - $10.0 million through the Health Human Resources Strategy as part of *Budget 2023*.
- *Budget 2024* committed base funding over the three-year fiscal plan for PSFS to further support development of the School of Medicine at SFU.
- Cabinet Confidences; Government Financial Information

KEY BACKGROUND

- The School of Medicine at SFU will complement UBC's Vancouver-Fraser, Island (Victoria), Northern (Prince George) and Southern (Kelowna) undergraduate medical education (UGME) program sites.
- The School of Medicine at SFU is in the process of accreditation with CACMS, which is a rigorous external peer review process to ensure the school meets critical standards so that graduates are sufficiently prepared to practice medicine in Canada.
- SFU is also in the process of planning for PGME program accreditation, which is set by the Canadian Residency Accreditation Consortium. Each PGME specialty will require accreditation in addition to the overall institutional PGME accreditation.
- SFU intends to integrate interprofessional education as part of the clinical training curriculum throughout both medical school and residency with a dedicated focus on immersing and training students and residents within team-based care practices.
- To facilitate interprofessional education, SFU plans to explore opportunities to develop collaborative relationships with institutions offering allied health professional training to provide clinical instruction in team-based settings.
- SFU has proposed a *community primary care clinic* in the Fraser Health region that would integrate different medical professions and provide SFU students with hands-on training and the opportunity to treat patients early in their education.
- Physicians graduating from the School of Medicine at SFU will have the skills and training to provide team-based community-level health care in various communities across BC.

LAST UPDATED

The content of this estimates note is current as of March 17, 2025, as confirmed by Kevin Brown.

APPROVALS

2025 03 17 – Stephanie Power obo Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 10 – Health Sector Information, Analysis & Reporting Division
2025 02 28 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Training Bursaries

Topic: Bursaries to increase access to post-secondary training for priority health careers.

Key Messaging and Recommended Response:

- Bursaries attract students to priority health education programs, reduce financial barriers to training, and ultimately fill key workforce gaps.
- In August 2022, we announced the Access to Practical Nursing Bursary with $3 million in funding to support Health Care Assistants (HCAs) to advance their careers and develop new skills by training to become Licensed Practical Nurses (LPNs).
    - Upon graduation, participants must return service with a publicly funded health employer for one to two years.
    - 221 students have received the bursary including 51 graduates that are now employed.
- Additional bursary programs have been launched through the Health Human Resources Strategy (HHR) Action 57 – Priority Program Bursaries:
    - A Student Recruitment and Retention Bursary (SRRB) of $2,000 per program year.
    - An Indigenous Student Recruitment Bursary (ISRB) of $5,000 per program year.
    - 2,174 students have received the SRRB and 187 students have received the ISRB.
- On March 1, 2024, the Ministry announced the expansion of provincial training bursaries for nursing students to support minimum Nurse to Patient Ratios:
    - Nursing students in bachelor of science in nursing (BSN), bachelor of psychiatric nursing (BPN), and practical nursing (PN) programs receive $2,000 per program year.
    - Indigenous students in BSN programs will receive an additional $5,000 per program year.
    - 23,526 seats in nursing programs are eligible for tuition credits over three years.
- These bursaries are already being deducted directly from tuition fees at eligible public post-secondary institutions – making health sector training more affordable.

CURRENT SITUATION

- On August 23, 2023, the Ministry launched **Access to Practical Nursing (APN) bursaries** worth up to $10,000 per student to offset tuition and other fees for HCAs enrolled in an APN program at a public post-secondary institution between September 1, 2022, and May 31, 2025.
    - The APN program is intended to reduce financial and other barriers for HCAs and improve the supply and geographic mix of new LPNs in BC with a special focus on rural communities.
    - The APN program is administered by the Health Employers Association of BC and paid for in equal installments to students each semester.
    - Bursary recipients must sign a Return of Service (ROS) agreement for employment with a publicly funded healthcare provider for one to two years, after completing their program.
    - As of January 2, 2025, 221 APN students have benefitted from the bursary, including 51 LPNs who have graduated and started their ROS with a qualifying employer[1].
- Action 57 of the HHR Strategy[2] supports the development of new **priority program bursaries (PPB)** that attract students to key health programs. Since the initial announcement, the previously planned Public Sector Recruitment Bursary (stream 3) has been repositioned, and the available funding instead utilized to continue to support students through the following streams:

[1] Ministry of Health PPB Report – Q3 FY24/25 report. As per data provided by HealthMatch BC on January 3, 2025 through *APN Period Report – P10_FY 2024-25 December 6 – January 2, 2025*.
[2] https://news.gov.bc.ca/files/BCHealthHumanResourcesStrategy-Sept2022.pdf

  - **Student Recruitment and Retention Bursary** ($2,000 per program year): Medical Lab Assistant, Medical Lab Tech, Medical Radiography Technician, Medical Resonance Imaging Technician – First Discipline, Nuclear Medicine, Respiratory Therapy, Environmental Health, and Radiation Therapy.
  - **Indigenous Student Recruitment Bursary** ($5,000/program year): Dietitian, Midwifery, Nurse Practitioner, Occupational Therapy, Physical Therapy, Practical Nursing, Psychiatric Nursing, and Speech Language Pathology.
  - PPB funding is available to students enrolled in eligible programs between September 1, 2023, to October 1, 2025.
- On May 1, 2024, the government announced the expansion of the Student Recruitment and Retention Bursary[3], and now includes Biomedical Engineering Technologist, Cardiovascular Perfusionist, Clinical Counsellors, Paramedic, and Rehabilitation Assistant.
- As of December 2024, 2,174 students have received funding through the Student Recruitment and Retention Bursary and 187 students through the Indigenous Student Recruitment Bursary[4].
- On March 1, 2024 – in support of Government's announcement of minimum Nurse to Patient Ratios, the Ministry announced nursing tuition bursaries (also referred to as tuition credits) for nursing students at eligible public post-secondary institutions[5].
  - Nursing students in bachelor of science in nursing (BSN), bachelor of psychiatric nursing (BPN) and practical nursing (PN) programs receive $2,000 per program year.
  - Indigenous students in BSN programs will receive an additional $5,000 per program year. This funding is already available to Indigenous students in the BPN and PN programs through the Indigenous Student Recruitment Bursary.
  - The nursing tuition grants are retroactively available to students enrolled in nursing programs in public post-secondary institutions from September 2023 to August 2026.
  - 23,526 seats over three years are eligible for tuition credits, but uptake data is not yet available.

FINANCIAL IMPLICATIONS

- In August 2022 the Ministry of Health announced one-time funding of $3 million for APN bursaries.[6]
- Action 57 has federal and provincial funding[7]: $57.71 million ($52.56 million from Federal Working Together and $5.15 million through the Strategy) in FY23/24, $15.15 million ($10.00 million from Federal Working Together and $5.15 million from the Strategy) in FY24/25, and $5.15 million from the Strategy in FY25/26 and ongoing.

KEY BACKGROUND

- The HHR Strategy highlights the importance of post-secondary training as a primary source of healthcare workers in BC.
- Tuition support is a key focus area within the Strategy, removing barriers to education and addressing the increased demand for health care workers in BC.[8]
- Most PPB and APN programs are offered only at select public post-secondary institutions.

LAST UPDATED

The content of this estimates note is current as of March 14, 2025, as confirmed by Meghann Brinoni.

APPROVALS

2025 03 14 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 24 – Finance and Corporate Services Division

[3] https://news.gov.bc.ca/releases/2024HLTH0054-000666
[4] Ministry of Health PPB Report – Q3 FY2425 report. Data provided by the Ministry of Post-Secondary Education and Future Skills by email, on December 19, 2024.
[5] https://news.gov.bc.ca/releases/2024HLTH0025-000272
[6] https://news.gov.bc.ca/releases/2022HLTH0053-001272
[7] https://news.gov.bc.ca/releases/2023HLTH0150-001930
[8] BCHealthHumanResourcesStrategy-Sept2022.pdf. Pg. 39.

LEGISLATIVE SESSION – ESTIMATES NOTE
Workplace Violence in Health Care

Topic: The Ministry of Health (HLTH) is working with health authorities and Providence Health Care (HAs/PHC), health sector unions, Doctors of BC, WorkSafeBC, SWITCH BC and other partners to reduce and prevent violence in health care.

Key Messaging and Recommended Response:

- Ensuring hospitals are safe for patients and staff is a top priority for our government.
- We committed to creating 320 net-new relational security officer (RSO) positions. All those positions are now filled and we expanded the relational security model in Spring 2024 - there are now approximately 781 FTEs across 32 sites.
- This new relational security model ensures all security personnel have an acute awareness of patients and their surroundings, as well as how to anticipate, de-escalate and ultimately prevent aggression.
- It is based on trauma-informed practice, which integrates knowledge of how people are affected by trauma into procedures, practices and services.
- We are also working to create a culture of violence prevention which means that we encourage staff to report incidents of violence in the workplace.
- We are exploring further expansions to continually improve healthcare worker safety.
- The Workforce Violence Prevention Policy Directive (2017) is currently being refreshed and HLTH is engaging SWITCH BC to lead a refresh of the Provincial Violence Prevention Curriculum (PVPC).

CURRENT SITUATION

- Over the last five years, workplace injuries due to violence have increased at an average of 15% year over year. In 2024, there were 6,406 reported incidents of violence in HAs/PHC, and 962 associated WorkSafe BC time loss claims. This represents an increase of 1089 incidents, or 17%, compared to 2023.[1]
- HLTH is taking several actions to address the increase in violent incidents, including:

Review of Protection Services in Health Care Settings

- On October 24, 2022[2], the Minister of Health announced the implementation of the Relational Security Initiative (RSI) across HAs/PHC (see RSI estimates note for more details)
    - The RSI established an in-house relational security model at 26 high risk sites identified in partnership with HAs/PHC and the Nurses Bargaining Association (NBA).
    - Northern Health added four more sites in the Spring of 2024, with two more being added by Interior Health in the Spring of 2025, bringing the total number of RSOs to 781 FTEs across 32 sites provincially.
- Since the *Health and Social Services Delivery Improvement Act (Bill 29)* was enacted in 2002, all HAs/PHC, except for Island Health, outsourced core physical security services. *Bill 47* (*Health Sector Statutes Repeal Act*), was brought into force through regulation on July 1, 2019, and repealed *Bill 29*.
    - HLTH and the *Bill 47* Project Board endorsed HAs/PHC to repatriate security services across 24 RSI sites to address challenges HAs/PHC had concurrently managing dual security models for similar scopes of work.
    - On February 2, 2024, the RSI further expanded, repatriating the remaining contracted security at 24 sites (2 of the original 26 sites are located in Island Health, which continues to have an in-house security model that the RSI was modelled after).

Provincial Framework and Policy Directive on Workplace Violence Prevention

[1] Data provided by OHS Solutions, Feb 3, 2025

[2] News Release: 320 protection services officers will support safer workplaces for health-care workers (https://news.gov.bc.ca/releases/2022HLTH0204-001579)

- In 2017, HLTH issued a Provincial Violence Prevention Policy Framework and a Policy Directive (WVP Directive) to improve injury reporting systems, provide more effective violence prevention training, and ensure greater accountability for policies and practices among all public and private employers.
- The WVP Directive is being refreshed in alignment with feedback from partners and stakeholders. It is anticipated that refresh should be completed by Fall 2025.

The Provincial Violence Prevention Curriculum (PVPC)

- As of February 3, 2025, 84% of HA staff who work in high-risk programs (including mental health and substance use, emergency, and residential care) have completed PVPC core training.[3]
- In 2019, the medical staff module of the PVPC curriculum was launched, consisting of 1.5 hours online and an additional 3.5 hours for classroom training.
- A 3-year project to refresh the content of the PVPC is currently underway, led by SWITCH BC.
    - The refreshed online modules and facilitator led training moduleincorporate a trauma-informed and cultural safety lens and are scheduled to be soft-launched in Spring 2025.
    - The medical staff module is undergoing a refresh in alignment with the PVPC refresh project.
- The Provincial Physician Health and Safety Working Group (PPHSWG) issued a recommendation in November 2024, for HLTH to work with HAs/PHC to help establish standards and expectations for a provincial physician violence prevention program. This includes online training (facility and community based), in-person training for physicians in high-risk environments, and team-based training for local health care teams.

BC Emergency Health Services (BCEHS) Paramedic Safety

- The dynamic and unpredictable work environment for Paramedics presents unique safety challenges compared to the broader healthcare system. Ensuring the safety of BCEHS staff is a top priority, with all efforts focused on maintaining a work environment free from physical and verbal violence.
- BCEHS dispatchers screen 911 calls for potential violence and may request police assistance, instructing paramedics to "WAIT" until the scene is deemed safe. Paramedics also have the authority to request police support, withdraw from escalating situations, or refuse to attend unsafe scenes until cleared by law enforcement. BCEHS staff are empowered to refuse unsafe work.
- In the event of an incident, BCEHS provides comprehensive support for staff recovery from both physical and psychological injuries.
- Paramedic Violence Prevention Training includes 10 hours of annual training, consisting of a two-to-three-hour online course followed by seven hours of in-person, hands-on training focused on violence prevention.

FINANCIAL IMPLICATIONS

- Through the BC Health Human Resources (HHR) Strategy, the Ministry committed $40.0 million in FY 2023/2024 to support the RSI. For FY 2024/2025 and onwards, the commitment increased to $53.8 million annually. This funding covers all program area costs, including infrastructure, RSOs, Violenc revntion Leads, corporate support, leadership expansion, and training.
- In 2015/16, the Ministry and the NBA each committed $1.0 million (total $2.0 million) to implement violence prevention measures at four high-priority sites.
- In 2016, the Ministry and the NBA each committed $2.0 million (total $4.0 million) to expand targeted violence prevention actions at six additional sites.

KEY BACKGROUND

- The BC Nurses Union (BCNU) called on the Ministry to have Island Health's protection service model be expanded to include 22 high-risk sites across the province in a briefing note to the Minister of Health on April 1, 2021.
- In 2016 HLTH signed a tripartite Memorandum of Understanding with the NBA and the Health Employers Association of BC to develop a provincial policy framework on violence prevention in the health sector.

Over the course of 2016/2017 the Provincial Violence Prevention Policy Framework and WVP Directive were developed.

- The PVPC was developed in 2010 to provide essential, comprehensive, and provincially recognized violence prevention education for publicly employed health care workers. Last refreshed in 2016, the PVPC was developed by the Violence Prevention Working Advisory Committee, under the direction of the Joint Provincial Occupational Health and Safety Violence Prevention Committee.

LAST UPDATED

The content of this estimates note is current as of March 18, 2025 as confirmed by Ryan Murray.

APPROVALS

2025 03 25 – Miranda Mason, Health Sector Workforce and Beneficiary Services
2025 02 24 – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Abortion Services Access

Topic: The Government of BC is committed to providing safe, effective and accessible abortion services to the residents of the province regardless of their income level.

Key Messaging and Recommended Response:

- The government of BC supports the rights of people who are pregnant to make decisions about their bodies.
- Abortion is a fundamental part of health care in the province.
- In 2018 we took action by making abortion medication free to ensure that people in BC can access this safe, legal and available option if they choose.
- Both medical abortions (i.e., use of medication, such as Mifegymiso) and surgical abortions (procedures provided in clinics or hospitals) are available in the province; various factors determine which is more suitable for a patient, including patient preference.
- In BC, people can access abortion services through abortion clinics and some general practitioners, nurse practitioners, gynecologists and hospitals.
- Mifegymiso® is available by prescription through primary care providers, community clinics (including public health clinics, walk-in clinics, urgent and primary care centres) and by telehealth and is dispensed by community pharmacies throughout the province. The Government of BC is committed to continuing to provide access to safe abortion services to all British Columbians who need them.
- Anyone who must travel for abortion services may be eligible for the Ministry of Health's Travel Assistance Program, which helps alleviate the costs of travelling for healthcare.

CURRENT SITUATION

- Abortion is an insured service when determined by a physician that it is medically required for a specific patient on a case-by-case basis. Abortion services are available at many facilities in BC.
- Both medical abortions (i.e., use of a medication, such as Mifegymiso) and surgical abortions (procedures provided in clinics or hospitals) are available in the province; various factors determine which is more suitable for a patient, including patient preference. Prior to the past few years, medical abortions made up a very small proportion of total abortions in BC, but since 2020/21 there have been more medical abortions than surgical abortions in the province.
- Regional health authorities are responsible for planning, managing and delivering publicly funded healthcare services in their jurisdictions and are expected to provide reasonable access to abortion services. Like any service, the provision of abortion services may be impacted by operational circumstances (e.g., limited availability of health human resources can create an access challenge).
- Government will continue to work with the health authorities to provide and expand, where appropriate, access to abortion services in BC while prioritizing the protection of people's privacy.

Impact of Mifegymiso on Access to Abortion Services

- Mifegymiso (combination of the drugs mifepristone and misoprostol) can be used to terminate pregnancies up to 9 weeks gestation. Since 2018 when Mifegymiso became available to all British Columbians at no cost, its uptake appears to indicate improved access and choice for patients.
- Between January 15, 2018, and March 31, 2024, 2,178 prescribers (excluding naturopaths) prescribed Mifegymiso and 934 pharmacies dispensed it to over 43,800 patients.[1] Table 1 shows the number of Mifegymiso dispenses and the number of surgical abortions since 2016/17.

[1] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting, February 14, 2025.

- Mifegymiso provides significant advantages over a surgical option as it can be provided through telemedicine, dispensed in community pharmacies, taken at home and is more cost effective.
- By avoiding unnecessary surgery, universal coverage of Mifegymiso has resulted in safer, more accessible abortion services. Removing the cost barrier helps ensure that individuals can access this safe and legal option if they choose. It is important, however, that patients are still able to access surgical abortion services as medical abortion is not always preferable or medically appropriate.

Table 1: Number of Mifegymiso Dispenses and Surgical Abortions in BC, by Fiscal Year[2,3]

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Mifegymiso Dispenses	91	1,844	4,922	6,327	8,205	8,440	9,960	11,610
Surgical Abortions	10,086	9,424	8,281	7,593	5,916	5,892	6,092	5,864
Total	10,177	11,268	13,203	13,920	14,121	14,332	16,052	17,474

Health Authority Access Issues:

- Service gaps in surgical abortion access in Kitimat and Quesnel have been brought to the attention of the Ministry of Health (HLTH). Northern Health Authority continues to work to fill any vacancies and anticipates that recruitment efforts will lead to improvements in access to reproductive healthcare. Surgical abortion access is available in some nearby communities, such as Terrace (Ksyen Regional Hospital) and Prince George (University Hospital of Northern BC). Medical abortion continues to be available.
- Fraser Health Authority is in the process of developing surgical abortion services within the region; patients can access abortion services at Vancouver clinics, if appropriate for their needs. Medical abortions are available in the Fraser Health Authority.

US Citizens - Access to Abortion Services in BC:

- Since 2022, access to abortion services has been restricted or banned in several US states.
- People from outside BC can access abortion services in the province but individuals not covered by the BC Medical Services Plan (MSP) or another federal/provincial/territorial MSP must pay for the healthcare services they receive in BC. New BC residents who are in the MSP wait period can receive coverage for Mifegymiso.

Protest Activities in BC:

- Currently, the main abortion-related protests in the province are held twice per year by an organization called "40 Days for Life" which promotes anti-abortion campaigns world-wide.
- The next protest period by the "40 Days for Life" group is scheduled for March 5 - April 13, 2025, with "vigils" in BC planned for Victoria (Victoria General Hospital), Vancouver (BC Women's Hospital) and Sechelt (Sechelt Hospital).

FINANCIAL IMPLICATIONS

- There are no known direct financial implications of abortion access zones for HLTH (see Key Background).

KEY BACKGROUND

Related Legislation and Regulations to Ensure Access and Safety

- Abortion is an insured service under the provincial *Medicare Protection Act* and the P*rovincial Hospital Insurance Act* Regulations.
- The *Access to Abortion Services Act* (the Act) states that all people who use the BC healthcare system and who provide services for it should be treated with courtesy and with respect for their

[2] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting, February 14, 2025.
[3] MSP. MSP Fee-For-Service Payment Analysis 2019/2020-2023/2024 fee items 4110, 4111, and 4114, https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_ffs_4_fee_item_detail.pdf., as of September 30, 2024.

dignity and privacy. The Act provides for the establishment of access zones around facilities, doctors' offices, and the homes of doctors and service providers to ensure the safety of staff and patients. Harassment (such as protest, interference and intimidation) is prohibited within access zones.

- In addition to those under the Act, access zones have been established by regulation at 5 facilities.

LAST UPDATED

The content of this estimates note is current as of February 10, 2025, as confirmed by Matt Erickson, Acting Executive Director.

APPROVALS

2025 02 28 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 06 – Ian Rongve, Pharmaceutical, Laboratory & Blood Services Division
2025 03 13 – Shana Ooms, Hospital & Surgical Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Alberta Health Care Services Access

Topic: British Columbia (BC) patients' access to health services in Alberta (AB)

Key Messaging and Recommended Response:

- The Ministry of Health continues to work collaboratively with the Alberta Ministry of Health to ensure people living on the eastern border of BC can access the critical care they need when they need it.
- The Ministries continue to work together to formalize the referral and transfer processes for time sensitive life, limb, and/or threatened organ (emergency patients in both BC and Alberta through a Memorandum of Understanding (MOU).
- While that agreement is being formalized, patients in the East Kootenay and Northeast Health Service Delivery Areas continue to be transported to Alberta hospitals if required.
- BC will continue to monitor access concerns and ensure collaboration between health-care systems in British Columbia and Alberta align with existing policy and legislation.
- Intergovernmental Communications

CURRENT SITUATION

- The Ministry of Health (HLTH) continues work begun prior to and delayed by COVID-19 with the Alberta Ministry of Health (AMoH) to address health care access along the eastern border of BC.
- Restrictions to Out-of-Province (OOP) non-urgent/elective surgeries have been in place since January 2021. In January 2023, Alberta Health Services (AHS) confirmed the continued restriction on provision of scheduled elective non urgent surgeries for OOP patients as AB continues to focus on reducing surgical wait times for Albertans.
- In February 2022, following discussions between HLTH, AMoH, and AHS representatives, AHS agreed to continue to provide health services for time-sensitive/life, limb, and/or threatened organ (LLTO) emergency patients along the BC and Alberta corridor and therefore replaced a previous directive with new guidance and criteria regarding OOP Intensive Care Unit (ICU) transfers.
- HLTH and AMoH resumed bimonthly meetings in April 2023 to formalize the referral and transfer of Red or LLTO emergency patients.
    - The draft MOU was reviewed by representatives of HLTH and AMoH again in October 2024.
    - The draft MOU incorporates feedback from all partner groups in both Alberta and BC and includes standardized language and simplified algorithms in the appendices.
    - Intergovernmental Communications
    - In February 2025, HLTH met with AmoH on the issue; AMoh committed to prioritizing the completing the MOU; but no specific timeline was committed to.
- Northern Health Authority, Interior Health Authority and BC Emergency Health Services have been engaged in the MOU development and are parties of the MOU.
- Consistent with the *Canada Health Act*, publicly insured individuals can receive publicly funded healthcare services in any Canadian jurisdiction.
- There is no obligation for a province to provide elective procedural care to patients from other provinces and it is widely accepted that provinces are to strive for self-sufficiency in their ability to meet the healthcare needs of their populations.
- HLTH continues to monitor access concerns and ensure collaboration between healthcare systems in Alberta and BC aligns with existing policy and legislation.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Prior to COVID-19, congestion in Calgary hospitals resulted in some BC patients being denied access to health care in Alberta hospitals.
- Between 2019/20 and 2023/24 there were 2,229 more acute care inpatient cases of Alberta patients treated in BC than cases of BC patients receiving care in Alberta. The annual average for this five-year period is 446.[1]

Table 1. Acute Inpatient Flow between BC and Alberta by Fiscal Year (excluding day surgeries)[2]

	2019/20	2020/21	2021/22	2022/23	2023/24
Acute care inpatient cases with BC HCN at AB Hospitals	2737	1651	1767	2065	2188
Acute care inpatient cases with AB HCN at BC Hospitals	2774	2487	2611	2483	2282
Percent more acute care inpatient cases with AB HCN served in BC	1%	51%	48%	20%	4%

Alberta Health Services Memorandum – OOP ICU Patients to Alberta

- This section is related to COVID-19 ICU memos sent from AHS during and following COVID-19
- In September 2021, AHS senior leadership issued a memorandum to zone officers and medical directors outlining a 4-stage approach in response to planning for a worst-case scenario where Alberta's health system reaches maximum capacity. AHS enacted Stage 1 and ceased ICU transfers from BC.
    - Stage 1 - From regions with their own ICU and specialty services, stop intake of ICU patients and those likely to utilize ICU/specialty ICU beds (CCU, Neuro ICU -stroke, neurotrauma and neurovascular, trauma).
- BC met with the AMoH and AHS representatives in February 2022, and came to an agreement on a revised directive that Alberta would continue to provide health services for time-sensitive/LLTO emergency patients.
- Patients requiring time dependent emergent interventions unable to be performed within the therapeutic window as listed below may be accepted:
    - Acute neuro interventional stroke;
    - Cardiac interventional procedures;
    - Critically ill trauma patients requiring time dependent referral to Level 1 or 2 Trauma Centres; and
    - High risk patients who require time dependent tertiary maternal fetal medicine care/neonatal ICU.
- In January 2023, AHS senior leadership issued a memorandum to zone officers and medical directors lifting the OOP ICU restrictions laid out in the February 2022 memorandum.
- Alberta physicians may again accept adult ICU patients in accordance with pre-pandemic/historical criteria and referral patterns with the condition that the sending site will repatriate the patient once the patient no longer requires ICU care and is safe for transport.
- Given current high occupancy in pediatric ICUs, pediatric transfers should be limited to those where AHS is western Canadian referral centre. Neonatal intensive care referral patterns remain unchanged.
- AHS will continue to monitor capacity pressures and may need to restrict OOP ICU transfers for adult patients in the future if capacity becomes further challenged.

[1] Data source: DAD, Health Sector Information, Analysis and Reporting (HSIAR) Division, Ministry of Health. PAS # 3000.1249 updated February 24, 2025, 2023: "Feb 2025 Factsheet update Alberta Health Care Services Access 2019-2023".

[2] Previously, this table included day surgeries and small counts of non-acute inpatient cases (psychiatric, rehab, extended care). Data for B.C. patients who received day surgery in Alberta is not available, and reporting standards for non-acute cases varies across provinces. This table is updated with only acute care inpatient cases to ensure comparisons are made for similar groups of services. Note this includes newborn cases. Stillbirth, cadaveric donor, and abortion cases are excluded.

LEGISLATIVE SESSION – ESTIMATES NOTE

Non-Urgent/Elective Surgeries

- In January 2021, AHS directed Alberta physicians to decline incoming non-urgent OOP patient referrals and that new non-urgent OOP patients would not be accepted on the AHS scheduled surgery waitlist.
- Alberta physicians were to assist waitlisted patients to find a provider to complete their non-urgent elective surgery within their home province.
- Due to East Kootenay's geographic location, patients often sought non-emergency specialized medical services at Alberta hospitals as travel to and convalescing locally is much easier and historical referral patterns existed.
- Previously, issues of access to ophthalmology surgery in Alberta for East Kootenay residents were raised. In March 2021, an escalation process to address critical ophthalmology cases involving intraocular gas and support access on a case-by-case basis was established with Alberta with at least

Personal Information East Kootenay residents receiving timely access to ophthalmology surgery.

LAST UPDATED

The content of this estimates note is current as of February 11, 2025, as confirmed by Matt Erickson, Acting Executive Director.

APPROVALS

2025 02 26 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 13 – Shana Ooms, Hospital & Surgical Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Alternate Level of Care

Topic: Active management of Alternate Level of Care rates plays an important role in ensuring patients receive health care services in the most appropriate setting and helps to reduce hospital congestion.

Key Messaging and Recommended Response:

- Active management of alternate level of care (ALC) patient days plays an important role in ensuring both ALC and new patients receive the care they need, in the most appropriate setting.
- We continue to work with health authorities to focus on strategies to reduce ALC rates in acute care hospitals and ensure all patients receive the care they need, in the most appropriate location.
- The Ministry of Health released the first phase of the Provincial Access and Flow Standards in October 2024, which included ALC standards, the new provincial ALC definition, and new provincial ALC reporting categories. These standards apply to all large and teaching hospitals under the *Hospital Act*.
- To reduce the risk of frail patients experiencing inappropriate extended lengths of stay in hospital, a new policy, *Management of Alternate Level of Care (ALC) Rates: Improving Access to Acute Care Services by Improving Patient Care Experiences and Outcomes*, has formalized some aspects of acute care screening, assessment and discharge planning.
- Work is also underway across the province to expand community-based transitional care programs so that patients - often elderly - have the opportunity to maintain or even improve their functional status in a supportive, non-hospital, health care environment immediately after an acute care hospital stay.

CURRENT SITUATION

- ALC is a clinical designation applied to a patient who is occupying a bed in a hospital and does not require the intensity of resources/services provided in the acute care setting.
- All HAs are working to lower ALC rates and ensure that patients receive the care they need, in the most appropriate care setting.
- In October 2024, HLTH released the first phase of the Provincial Access and Flow Standards, which includes a standard on ALC. The Provincial ALC standard covers the minimum requirements for how HAs are to designate and manage ALC as well as a common provincial ALC definition, categories and supporting guideline. This standard is expected to contribute to improvements in reporting, service accountability, and, most importantly, in planning for safe care transitions for patients leaving the hospital.
- In October 2024, HLTH released the new provincial policy, *Management of Alternate Level of Care (ALC) Rates: Improving Access to Acute Care Services by Improving Patient Care Experiences and Outcomes,* to help reduce ALC rates. The policy formalizes some aspects of acute care screening, assessment and discharge planning to reduce the risk of frail patients experiencing inappropriate extended lengths of stay in hospital and it establishes a provincial framework to deliver community-based transitional care services so that medically stable ALC patients receive services in an appropriate community care setting. In turn, this is expected to improve access to acute care hospitals for other patients and improve patient care experiences and outcomes.
- In preparation for Fall and Winter surge 2024/25, HAs implemented home and community care interim strategies to help reduce the number of ALC patients occupying acute care beds by providing additional patient/client supports that help meet care needs in community.
- Home Health Strategies: To support timely discharge home from acute care and mitigate risk of re-admission or emergency department visits, HAs used the following strategies:
    - Rapid response teams and enhanced supports (i.e., stabilization and activation after discharge from acute care, including overnight care, where required, for complex clients who can be supported at home).

- Expanded use of home support, adult day programs and respite to support higher needs clients and their caregivers.
- Expedited access to equipment to support acute care discharge.

Acute Care Strategies:

- Seven-day a week access and flow leadership structures in place at large hospitals to ensure timely escalation support with discharge planning.
- The provincial Access and Flow Committee developed and revised provincial capacity Management and surge response plan for all health authorities. This plan outlined standard ALC mitigation tactics that should be applied.

FINANCIAL IMPLICATIONS

- *Budget 2024* provides $354 million over 3 years to support seniors to age comfortably and safely in their own homes and maximize their quality of life, including:
  - $227 million over 3 years to improve the quality and responsiveness of home health services, including care management services delivered by community-based professionals (e.g., registered nurses, social workers, occupational and physical therapists) and home support services delivered by community health workers.
  - $127 million over 3 years to stabilize and expand community-based seniors' services that provide seniors with non-medical support, including assistance with day-to-day tasks, and deliver programs that help keep seniors physically active, socially engaged, and connected to their communities.
- Our government has invested over $3.5 billion since 2018/19 to improve care for seniors, including investments in primary care, community-based services, home health, long-term care, assisted living and respite services.
- This funding includes $175 million over the last 5 years to expand respite care and adult day services.
- BC has invested $2.58 billion in capital funding in LTC since 2017.

KEY BACKGROUND

- The new Provincial ALC definition, released October 25, 2024, states that ALC is the designation used to identify a patient who meets all three of the following conditions:
  - Occupies a bed in a hospital designated under the *Hospital Act*,
  - Has completed the acute care phase of their treatment, and
  - Is waiting to be transferred to a more appropriate care setting.
- There are eight new Provincial ALC Reporting Categories that HAs must use to quantify factors that can delay discharge of a patient from hospital and differentiate between waiting for a plan and an assessment or waiting for a service. Examples include:
  - Waiting for transition to another type of facility (LTC, convalescent care, etc.).
  - Waiting for clinical assessment to determine needs[1].
  - Waiting for arrangements with community service/helping agency (e.g., to set up equipment) or home modifications are being made (e.g., putting in a ramp).
  - Housing, economic, or social reasons (e.g., homelessness, financial resources).
- ALC patients may face increased risk of adverse events in hospital (falls, infection, functional decline, etc.). The services that these patients require may be offered more appropriately and cost-effectively via transitional care services (convalescent care, reactivation units, home health services), community-based programs or LTC.
- ALC rates vary between and within HAs, and are closely monitored by HAs and HLTH.
- While ALC rates are not expected to be zero since it can take time to arrange a service, alternative facility, or family member to provide care for the patient, hospitals should make every effort to minimize these rates.

[1] Clinical assessment of inpatients for appropriateness for admission to a LTC home should, whenever possible, take place after discharge from hospital and occur in a community setting.

Table 1: ALC Days as Percentage of Inpatient Days, by Fiscal Year, by Health Authority[2]							
Health Authority	**2017/18**	**2018/19**	**2019/20**	**2020/21**[3]	**2021/22**	**2022/23**	**2023/24**
Interior Health Authority	17.2%	18.1%	19.0%	15.1%	16.8%	19.7%	18.0%
Fraser Health Authority	14.1%	14.4%	16.0%	12.9%	12.2%	13.6%	13.4%
Vancouver Coastal Health Authority	6.9%	7.7%	8.0%	7.5%	7.4%	9.2%	10.7%
Vancouver Island Health Authority	14.1%	16.0%	15.9%	14.1%	13.7%	14.6%	16.9%
Northern Health Authority	19.3%	22.1%	29.2%	22.8%	23.5%	27.1%	27.8%
Provincial Health Services Authority	0.3%	0.3%	0.3%	0.3%	0.0%	0.0%	0.0%
British Columbia	**12.9%**	**13.9%**	**15.2%**	**12.6%**	**12.6%**	**14.4%**	**14.9%**

LAST UPDATED

The content of this estimates note is current as of March 26, 2025, as confirmed by Matt Erickson, Acting Executive Director.

[2] Ministry of Health.[3000_1991]. Inpatient Service Dashboard. Retrieved from: https://hspp.hlth.gov.bc.ca/Report/3/8/27. Last accessed on 3/7/2025 1:52:15 PM

[3] ALC rates in most health authorities were lower in 2020/21 than in the previous year due to significant decanting efforts as a result of the COVID-19 pandemic and reduced emergency department visits as a result of concerns regarding COVID-19.

LEGISLATIVE SESSION – ESTIMATES NOTE

Emergency Department Access

Topic: Nurse and physician staffing challenges have placed strains on emergency departments across BC causing temporary closures, particularly in rural and remote communities.

Key Messaging and Recommended Response:

- Healthcare worker shortages throughout BC, nationally and internationally, have resulted in unplanned emergency department closures.
- The decision to divert patients to a nearby hospital is never made lightly and is only done as a last resort.
- Health authorities look at all options prior to implementing diversions. This includes looking to move staff between sites as able/needed.
- Staffing pressures are often amplified at rural sites where staffing pools are typically smaller.
- When a hospital or department is under diversion, patients are sent to other available sites within the region.
- Patients who need care will be diverted to the closest hospital and have access to ambulance resources as required.
- Through the Province's Health Human Resources Strategy, launched in the fall of 2022, BC has made significant progress to better support the public health-care system by adding more doctors and other healthcare professionals, new education and training seats, and taking actions to improve healthcare worker retention, and optimize the health care system to ensure patients in BC get the care they need when they need it.
- Recruitment efforts, particularly in rural and remote communities, include incentives such as relocation assistance, rural retention grant and BC loan forgiveness.

CURRENT SITUATION

- Emergency departments (EDs) are faced with an increasing volume of patients, staffing shortages and staff burnout.
- Current ED wait times are impacted by increased ED visits, increased overall hospital occupancy rates, more hospital beds occupied by patients requiring an Alternate Level of Care (i.e., patients who do not require the intensity of services provided in that care setting) and staffing challenges across the entire acute care and community health sector.
- Staffing challenges and extraordinary climate events have meant some EDs have had to go on diversion to ensure safe care.

KEY BACKGROUND

Emergency Department Visit Volumes

- Between 2016/17 and 2019/20, the total number of ED visits increased by 3%[1].
- In 2020/21, total ED visits dropped significantly. Province-wide, the total number of ED visits decreased by 16.1% compared to 2019/20.[2]
- In 2023/24, total ED visits increased by 6.9% compared to 2018/19. For 2024/25 year to date (up to period 10), total ED visits increased by 0.8% compared to the same period in 2023/24.

[1] Ministry of Health. 3000.1585. British Columbia Emergency Departments. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/hospital-services/emergency-departments. Last accessed on 2025-03-03 9:15:54 PM

[2] Data Source: Ministry of Health. 3000.1585. British Columbia Emergency Departments. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/hospital-services/emergency-departments. Last accessed on 2025-03-03 9:15:54 PM

Table 1: Average Daily Emergency Department Visits by Fiscal Year[3]

HA	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	% Change 2023/24 from 2018/19	2024/25 (P1-P10)
IHA	1,364	1,377	1,172	1,325	1,429	1,486	8.9%	1,508
FHA	1,925	1,924	1,602	1,897	1,998	2,024	5.1%	2,173
VCHA	1,192	1,181	983	1,195	1,248	1,294	8.6%	1,346
VIHA	1,129	1,147	1,008	1,191	1,264	1,253	11.0%	1,265
NHA	747	746	591	670	738	738	-1.2%	692
PHSA	131	126	82	121	146	142	8.4%	118
BC	**6,487**	**6,502**	**5,439**	**6,399**	**6,823**	**6,937**	**6.9%**	**7,102**

Emergency Department (ED) Diversions

- Temporary diversions occur when there is a gap in service at one facility that can be filled using BC's extensive network of hospitals and health care services.
- While diversions are never ideal, they are sometimes necessary to ensure the best and safest care is provided to patients temporarily. Diversions can occur in many departments. When a hospital is under diversion, patients are sent to other available sites within the region. Every effort is made to divert a patient to the closest hospital.
- Health care worker shortages have contributed to staffing issues throughout BC and nationally. These pressures are often amplified at rural sites where staffing pools are typically smaller. These can be a result of:
    - Higher than normal sick call rates among existing staff, challenges with recruitment of full-time positions, challenges with retaining staff, and national nursing and physician shortages.
- At times, adverse weather events have impacted EDs (forest fires, flooding, freezing weather) which have also resulted in diversions.
- Health authorities look at all options prior to implementing diversions. This includes looking to move staff between sites as able/needed.
- Health authorities take steps to prepare for diversions, including advising BC Emergency Health Services as diversions may impact demand for ambulances in the area experiencing a diversion. Additionally, communities are advised via public service announcements which include information on how to safely access care.

Mitigation Strategies

- Together with the health authorities, the Ministry of Health (HLTH) continues to closely monitor EDs across the province and has implemented targeted strategies to mitigate diversions.
- Several ED sustainability actions have already been initiated to help address multiple challenges faced by patients and healthcare providers, including but not limited to:
- Establishment of Emergency Care BC (ECBC), a Health Improvement Network of provincial partners that drive improvement across the BC health care system and optimize health outcomes by:
    - Hosting reference groups of ED physicians and nurses who meet on a monthly basis. These groups have given input on the physician locum program, hybrid models of care, community partnerships with primary and community care, and ED clinical service planning which improve the quality and coordination of services.
    - Defining EDs clinical and workforce requirements such scope optimization of Licensed Practical Nurses (LPNs) will help broaden the ED workforce and support team-based care. ECBC is also participating in the physician assistant pilot in Island Health Authority (VIHA) and will gather learnings to implement provincially.
    - Identifying the necessary resources and/or clinical services required onsite to support hybrid models of care in EDs where virtual care could be delivered and help optimize physician capacity in that community.

[3] ibid

  - The Provincial Emergency Physician Locum Pool, which ran from September 2023 – September 2024, prevented 104 emergency department (ED) diversions. In October 2024, this program evolved into the Emergency Physician Resource team which has prevented an additional 47 ED diversions and continues to support many communities across the province in need of physician staffing.
- GoHealth BC staff are employed by Northern Health Authority (NHA) and provide planned travel health care services to rural and remote communities in NHA, Interior Health Authority (IHA), and VIHA.
  - Community GoHealth partnerships have been created across 34 rural and remote communities including 22 in NHA, 6 in IHA, 6 in VIHA.[4]
  - GoHealth currently employs 436 nurses, including registered nurses, registered psychiatric nurses and licensed practical nurses (Registered Nurses (RNs), Registered Practical Nurses (RPNs), and LPNs), alleviating workforce pressures and reducing health sector reliance on agency nursing.[5]
  - As of December 31, 2024, GoHealth nurses have collectively provided over 431,000 hours since January 2023. IHA has worked to create new rotations where feasible, to support weekend coverage and stronger recruitment (such as in Ashcroft and Clearwater). Local tables have also been set up in some communities, made up of a variety of key stakeholders, to look at ways to support the delivery of health services in these rural communities.
- To stabilize and support staffing on northern Vancouver Island, VIHA has enhanced staff recruitment and retention incentives for eligible staff with travel-wage increases, upgraded accommodations for travelling staff and increased protection-service officers to improve safety and site support.
- HLTH in partnership with VIHA, British Columbia College of Nurses & Midwives, College of Physicians and Surgeons of British Columbia and others have begun planning for introducing a pilot of Physician Assistants at Saanich Peninsula Hospital.
- Recently, to respond to the Minister's Mandate Letter commitment to address temporary emergency department closures, HLTH has established a provincial Emergency Department Sustainability Strategy Project which aims to:
  - Develop a multi-pronged strategy and recommendations to address sustained access to urgent and emergency care for communities across the province, particularly in smaller and rural and remote communities.
  - Initially this work will focus on reducing unplanned ED closures through a review of service delivery models along corridors of care where closures have been more prominent.
  - Medium and longer term focus will be on:
    - Patients waiting longer than expected in EDs, exceeding benchmark standards.
    - Overcrowding challenges and difficulties in discharging patients to appropriate care settings, leading to occupied ED stretchers and strain on surrounding emergency services.
    - Patients are struggling to navigate the healthcare system, using the ED for non-urgent conditions that may be better treated elsewhere.

LAST UPDATED

Content of this estimates note is current as of February 6, 2025, as confirmed by Matt Erickson, Acting Executive Director.

APPROVALS

2025 03 10 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 27 – Shana Ooms, Hospital & Surgical Health Services Division

[4] Go Health BC (2025). Communities. Retrieved Jan 30, 2025. Available at: https://gohealthbc.ca/communities?page=2.
[5] GoHealth Workforce Data –Jan 1, 2023, to Dec 31, 2024. Provided to WPRM & HWPO Jan 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Hospital Capacity

Topic: To ensure patients have timely access to emergency and acute care services maintaining hospital capacity is imperative, especially during periods of increased demand with seasonal variation season combined with shortages in health human resources.

Key Messaging and Recommended Response:

- Hospitals across BC and Canada are generally seeing higher volumes in the emergency departments and higher acuity patients.
- The Ministry works with the health authorities to address risks, barriers, as well as supports required to manage hospital surges, increased congestion, and escalate delays in accessing care through a daily provincial coordination call.
- In the event of increased demand, like the respiratory illness season for example, there are plans and processes in place at hospitals and within hospital networks to add beds and expediate patient flow as needed.
- To help ensure hospitals are ready for periods of increased inpatient demand, a standard provincial seasonal surge response plan has been developed based on the learnings of the past four seasons, in partnership with Health Emergency Management BC and the health authorities.
- In addition, the province continues to work with the health authorities to advance initiatives to manage hospital capacity, standardize best practices across the health care system, and increase inpatient capacity where possible.

CURRENT SITUATION

- On October 25, 2024, the Ministry of Health (HLTH) directed health authorities (HAs) to implement actions and policies to address the winter surge. Each HA designated 1 Vice President (VP) to be accountable, with VP representatives meeting weekly with HLTH to monitor key health system performance and ensure agile responses to challenges and increasing surge conditions. HAs were also asked to submit proposals to support the surge.
    - While seasonal increases in occupancy due to respiratory illnesses are expected, a growing alternate level of care (ALC) population in acute care beds has exacerbated the situation. The average daily inpatient census for fiscal year (FY) 2024/25 year to date (YTD) was 10,451, an increase of 1,484 patients compared to FY 2021/22 (8,967). The average ALC census for FY 2024/25 YTD was 1,596, an increase of 56% compared to FY 2021/22 (1,021).[1]
    - The average inpatient census for January 2024 was 10,212, an increase of 315 patients compared to November 2023. During that same period between November 2024 and January 2025 that increase was 161 patients.[1]
    - The actions supporting ALC patients to be discharged and cared for in a more appropriate setting for their care needs accounts for a significant portion of the improved trend. (ALC reduction strategies)
    - The average census of ALC patients between September 25 and October 25, 2024, was 1,674 (an increase of 218 patients over the same period in 2023).[1]
    - Through the combined efforts announced October 25, 2024, the average daily census of ALC patients between January 18 and February 18, 2025, was 1533, which is 154 patients less than October 2024 and 33 less than the previous year at the same period (2024)[1]

[1] Ministry of Health.[3000_2022]. Daily Monitoring of Hospital Capacity. Retrieved from: https://hspp.healthideas.gov.bc.ca/framework/service-delivery/hospital-services/daily-monitoring-dashboard-covid-19-sites-100-pm-daily Last accessed on 2/20/2025 4:36:03 PM. 2024/25 YTD data is up to March 13, 2025.

- Provincial Access and Flow Standards were released on October 25, 2024, and included a Capacity Management and Surge Response Standard. This standard involves:
    - Four-stage integrated capacity management and surge planning, including triggers and processes for activation/deactivation, service alterations like diversions and transfers, and a communication plan.
    - Appropriate, pre-determined staff deployment plans, including ensuring best possible skill mixes and nurse-to-patient ratios.
    - Pre-determined plan for using alternative patient spaces, including funded and unfunded beds.
    - Appropriate, pre-determined process for accessing additional resources, including leveraging technology whenever possible.
- Each HA has hospital surge plans in place to address the increasing demand seen in our winter surge months. Key mitigation strategies involve:
    - Standard access and flow leadership structures are in place or being developed for all HAs to enable provincial access and flow with identified regional leadership within large hospitals 7 days a week.
    - Critical Care BC and Emergency Care BC have been established to focus on supporting these priority services.
    - Daily Provincial Coordination calls are occurring daily with HAs, HLTH, and BC Emergency Health Services (BCEHS) to ensure timely movement of patients as well as provide any support to removing barriers as needed.
    - HAs continue to build out enhanced Urgent and Primary Care Centre capacity for urgent access.
    - HAs are implementing a variety of options to expand support to teams to connect patients with resources in the community (seniors and mental health).

FINANCIAL IMPLICATIONS

- HLTH continues to work with HAs to monitor their expenditures related to acute care and sustain service delivery.

KEY BACKGROUND

Provincial Access & Flow standards

- Developed in partnership with HAs through the Access & Flow Committee over the latter half of 2023 and most of 2024.
- Phase 1 release was October 25, 2024, and covered:
    - Access and Flow Leadership Standard
    - Capacity Management and Surge Response Standard
    - Flow Through Inpatient Beds Standard, Part B “Alternate Level of Care (ALC) Standard”
- Phase 2 will be released in the future, and will cover:
    - Flow Through Inpatient Beds Standard, Part A “Patient Care Planning”
    - Hospital Performance Monitoring Framework Standard

Acute Care Beds

- In anticipation of the fall/winter seasonal surge new bed definitions were developed in partnership with HAs which allowed a more complete inventory of base and overcapacity beds.
- HLTH invested in some of these additional acute care beds in November 2023. The provincial funded base acute care beds increased from 9,202 to 9,929 beds, an increase of 7.9% in the funded bed base.[1]
- The following were the beds added by each HA: Fraser Health Authority (FHA) 207; Interior Health Authority (IHA) 111; Northern Health Authority (NHA) 77; Provincial Health Services Authority

(PHSA) 14; Vancouver Coastal Health Authority/Providence Health Care (VCH/PHC) 225; Island Health Authority (VIHA) 93.[1]

Hospital Data

- The number of inpatient hospitalizations has been relatively stable (2% change) when comparing 2019/20 to 2023/24 with some HAs experiencing volume increases between 1 and 4 %. The largest decrease is in PHSA (-9%).

Inpatient cases	2019/20	2020/21	2021/22	2022/23	2023/24	% change in 2023/24 from 2019/20
IHA	84,855	80,987	83,909	85,024	86,972	2%
FHA	143,545	137,176	146,566	146,965	149,320	4%
VCHA	91,250	82,270	86,759	88,702	92,339	1%
VIHA	87,225	81,583	85,708	87,740	88,157	1%
NHA	29,377	27,228	28,325	28,209	28,759	-2%
PHSA	23,416	21,315	22,145	21,014	21,268	-9%
BC	**459,668**	**430,559**	**453,412**	**457,654**	**466,815**	**2%**

- Inpatient days have increased by 8% between 2019/20 and 2023/24. Smaller change in inpatient cases means the driver for the increase in inpatient days was length of stay. Patient complexity, an aging population, and staffing shortages have led to increased care planning needs for patients.

Inpatient days	2019/20	2020/21	2021/22	2022/23	2023/24	% change in 2023/24 from 2019/20
IHA	557,348	475,125	551,169	600,463	591,183	10%
FHA	1,076,459	960,315	1,086,504	1,139,057	1,186,305	6%
VCHA	756,864	671,007	763,565	801,074	847,497	12%
VIHA	690,250	603,768	675,043	710,599	722,945	5%
NHA	229,333	186,390	205,852	228,761	241,220	5%
PHSA	109,365	96,908	100,748	100,907	102,056	-7%
BC	**3,419,619**	**2,993,513**	**3,382,881**	**3,580,861**	**3,691,206**	**8%**

LAST UPDATED

The content of this estimates note is current as of February 13, 2025, as confirmed by Matt Erickson, Acting Executive Director.

APPROVALS

2025 03 18 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 25 – Shana Ooms, Hospital & Surgical Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Hospital at Home

Topic: Hospital at Home

Key Messaging and Recommended Response:

- The Hospital at Home (HaH) program provides patients with the choice to receive short-term acute care in the comfort of their own home.
- Eligible patients in hospital can receive care at home from a multidisciplinary team led by a most responsible practitioner with hospital admitting privileges, and they can be transferred back to the hospital if needed.
- Patients receive in-person care supplemented by virtual care and monitoring, with 24/7 access to care. It is a safe, respectful and effective alternative to traditional in-patient treatment.
- The program reduces pressure on inpatient hospital beds, decreases hospital congestion by optimizing patient flow, and improves overall system capacity.
- Over 8,200 patients have received care at home via HaH instead of in hospital since the program launch in 2020.
- The Ministry of Health is collaborating with partners and regional health authorities to expand the program into new patient populations and communities, however currently it is in place as a prototype in each health authority.

CURRENT SITUATION

- 8 HaH sites are in place in the province. Island Health Authority (VIHA) has 3 sites, and each of the other health authorities has 1 site.
- Combined, the sites offer 90 HaH acute care beds to patients who meet eligibility criteria.
- Currently HaH services are provided to 17-year-old or older surgical recovery patients, psychiatry patients, and medical patients. The Ministry of Health (HLTH), in collaboration with the health authorities, is pursuing options for expansion into new patient populations and new communities.

As of February 2, 2025, the current situation is as follows:

VIHA – 5,010 patients admitted into HaH since launch.

- Over 725 patients admitted to HaH in 2024.
- 27 HaH acute care beds.
- Victoria General Hospital - launched in November 2020 - has 10 beds.
- Royal Jubilee Hospital - launched in March 2021 - has 10 beds.
- Cowichan District Hospital (Duncan) – launched in April 2024 - has 7 beds
- In Victoria, most responsible provider (MRP) services are provided by Hospitalist physicians working exclusively on HaH for the duration of their shift. In Duncan, MRP is provided by community-based Family Physicians (FPs).
- In April 2022, VIHA's HaH program won a national award for *Excellence in Patient Experience* from the Canadian College of Health Leaders. The award honours organizations and individuals who have set in place innovations that improve the human experience in healthcare.

Northern Health Authority (NHA) – 1,996 patients admitted into HaH since launch.

- Over 385 patients were admitted to HaH in 2024.
- 9 HaH acute care beds at the University Hospital of Northern BC (UHNBC).
- Phase 1 (March 2021 to mid-May 2021) relied on community-based FPs with hospital-admitting privileges who provided HaH as part of their family practice; however, there were challenges with the physician compensation model for Prince George community-based family practitioners.
- Phase 2 (current) prototypes an approach focused on caring for patients after surgery, using surgeons as MRP.

Vancouver Coastal Health Authority (VCH) – 241 patients admitted in HaH since launch.

- Over 200 patients were admitted to HaH in 2024.
- 9 HaH acute care beds at Vancouver General Hospital – launched January 22, 2024
- MRP services are provided by hospital-based Internal Medicine physicians working exclusively on HaH for the duration of their shift.

Providence Health Care (PHC) - 240 patients admitted in HaH since launch.

- Over 200 patients were admitted to HaH in 2024.
- 9 HaH acute care beds at St. Paul's Hospital (prototype program launched December 18, 2023)
- MRP services are provided by hospital-based Internal Medicine physicians working exclusively on HaH for the duration of their shift.

Fraser Health Authority (FHA) Virtual Psychiatric Unit (VPU) – 805 patients admitted since launch.

- Over 285 patients admitted to HaH in 2024.
- 32 HaH acute psychiatric beds (prototype program launched September 20, 2022)
- MRP services are provided by a Fraser Health Psychiatrist with supported medical management. The Addiction Medicine Team provides specialized substance use services.
- The VPU is operated under a 'hub and spoke' model, where most health care providers are based out of a 'hub' in Central City, the FHA corporate office and additional nurses work out of 'spoke' locations based in Royal Columbian Hospital and complete home visits with HaH patients.
- In 2024/25, FHA expanded HaH to include a Virtual Medicine Unit (VMU) HaH out of Eagle Ridge Hospital which will launch in early 2025/26. HLTH worked with IHA to add a HaH program at Kelowna General Hospital which launched January 14, 2025, with 4 beds.

Interior Health Authority (IHA) – 15 patients admitted in HaH since launch.

- 4 HaH acute care beds at Kelowna General Hospital launched on January 14, 2025.
- MRP services are provided by Hospitalist physicians working exclusively on HaH for the duration of their shift.

FINANCIAL IMPLICATIONS

- Since 2020/21, HLTH has provided health authorities with over $22 million in funding to support HaH.
- Since its inception, HaH has not had an assigned budget and was previously funded through COVID-19 Contingencies.
- In 2024/25, HLTH allocated up to $55 million for HaH under the Canada-B.C. Agreement to Work Together to Improve Health Care for Canadians. Based on the health authorities' projections, HLTH will provide a total of $36.244 million in funding in 2024/25.

KEY BACKGROUND

- The government first committed to implementing a provincial HaH program in May 2020 as a COVID-19 response strategy to reduce pressure on hospital medical beds.
- 2 HaH prototype sites have been operational for nearly 3 years: 1 in VIHA and the other in NHA.
- FHA introduced a virtual psychiatric unit in 2022 that demonstrated the ability to provide HaH service to a new patient population safely.
- Budget 2022 referred to the need for HaH to become a permanent program.[1]

Program Description

- HaH allows a subset of acutely ill, clinically stable patients aged 17 years or older who require hospital care to choose an alternative to traditional in-patient treatment that is still safe, respectful and effective.
- Patients receive daily in-person care supplemented by virtual care and monitoring, with 24/7 access to care.
- Patients are admitted to hospital but receive care at home from an interdisciplinary team led by a MRP (either a physician, surgeon or Nurse Practitioner) with hospital admitting privileges.
    - The team consists of nurses, occupational therapists and/or physiotherapists, rehabilitation assistants, pharmacists, social workers, Indigenous liaison workers, peer support workers, and others.

[1] "Stronger Together: Budget and Fiscal Plan 2022/23 – 2024/25." p. 44 and p. 130. https://www.bcbudget.gov.bc.ca/2022/pdf/2022_Budget_and_Fiscal_Plan.pdf.

- HaH patients are considered hospital inpatients, therefore they can be transferred directly back to hospital, if needed, without going through the emergency department. Access to medically necessary general hospital services/resources (diagnostics, medications) is available in the same timely way as in a traditional hospital at no cost to the patient.
- Participation is entirely voluntary, and patients/caregivers can decline to participate or choose to return to hospital at any time.

BC HaH Patient Experience and Profile

- Patients and family caregivers report their experience of BC HaH care has been highly positive.[2]
- Common patient diagnoses have included: heart failure without coronary angiogram, lower urinary tract infection, cellulitis, viral/unspecified pneumonia, and chronic obstructive pulmonary disease.[3]
- The BC HaH patient population is primarily older, with the average age being 63.8 years.[4]
- The main admission type continues to support early discharge from hospital, but efforts continue to increase emergency department (ED) avoidance admissions (prevent visits to the ED altogether). Some patients in the surgical recovery HaH program at UHNBC do not spend any time on a hospital ward prior to being admitted, they are admitted directly to HaH from the recovery room.

Benefits of HaH for Patients

- Several Cochrane reviews, which represent the highest standard in meta-analysis, report that the HaH model has fewer complications compared to traditional hospitalization such as fewer instances of delirium, blood clots, infection and functional decline.[5,6]
- Other benefits may include lower readmission rates, high satisfaction among patients/caregivers, and potentially fewer admissions to long-term care.

LAST UPDATED

The content of this estimates note is current as of February 10, 2025, as confirmed by Matt Erickson, Acting Executive Director.

APPROVALS

2025 02 23 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 03 13 – Shana Ooms, Hospital and Surgical Health Services Division

[2] Island Health HaH patient experience data November 2020 to November 2021.
[3] Island Health HaH Patient Profile, October 2021.
[4] 2025 01 HaH ADM Report 1303183.docx
[5] Gonçalves-Bradley DC, Iliffe S, Doll HA, Broad J, Gladman J, Langhorne P, Richards SH, Shepperd S. Early discharge hospital at home. Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD000356. DOI: 10.1002/14651858.CD000356.pub4.
[6] Shepperd S, Iliffe S, Doll HA, Clarke MJ, Kalra L, Wilson AD, Gonçalves-Bradley D. Admission avoidance hospital at home. Cochrane Database of Systematic Reviews 2016, Issue 9. Art. No.: CD007491. DOI: 10.1002/14651858.CD007491.pub2

LEGISLATIVE SESSION – ESTIMATES NOTE

Medical Assistance in Dying - Access and Faith-Based Organizations

Topic: Faith-based organizations are exempt from the provincial requirement that medical assistance in dying (MAiD) be made reasonably available in settings where end-of-life services are normally offered; as a result, patients in facilities operated by faith-based organizations must be transferred to another facility for MAiD provision to take place.

Key Messaging and Recommended Response:

- Patients have the right to choose MAiD if they are eligible and that is their wish, and our medical system provides patients with access to that choice.
- Ministry of Health policy requires that each health authority has a MAiD Care Coordination Service in place to support individuals requesting MAiD to understand available services and to navigate access.
- Neither individuals nor organizations can abandon patients:
    - Under the federal legislation for MAiD, medical practitioners and nurse practitioners who conscientiously object to MAiD are not required to participate in MAiD assessment or provision but must ensure that any patient who requests MAiD is safely transferred to another practitioner willing to assist them, in accordance with their regulatory standards.
    - Provincial policy allows faith-based organizations the choice to opt out of the provision of MAiD at their facilities; however, they must ensure that patient-centered pathways are in place to support an effective connection with another health care provider or organization willing to explore a request for information, transfer of care, or physical transfer of the patient, as required.
- A new clinical space has been established next to St. Paul's Hospital staffed by Vancouver Coastal healthcare professionals and connected by a corridor to St. Paul's Hospital. Patients from St. Paul's Hospital accessing MAiD will be discharged by Providence Health Care and transferred to the care of Vancouver Coastal Health Authority in this new clinical space, which opened on January 6, 2025.

CURRENT SITUATION

- In 2024, there were 62 transfers for the provision of MAiD due to the originating facility's policy, which represents 2.1% of total MAiD provisions in BC during that year. All transfers in 2024 were facilitated by faith-based organizations.
- Of these transfers, 50 were within the geographic boundaries of the Vancouver Coastal Health Authority (VCH), representing 7.9% of the 634 cases that occurred within the health authority. St. Paul's Hospital was the originating facility Personal Informati of these transfers.
- Personal Information
- Since St. Paul's Hospital is operated by Providence Health Care (PHC), a Catholic health care organization, the provision of MAiD is not permitted on site. Personal Information Personal Information
- A new clinical space where MAiD can be provided, has been established adjacent to St. Paul's Hospital, staffed by VCH healthcare professionals, and connected by a corridor to St. Paul's Hospital. Patients from St. Paul's Hospital accessing MAiD will be discharged by PHC and transferred to the care of VCH in this new clinical space, which opened on January 6, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

MAiD Access and Care Coordination Policy

- Access to MAiD is prescribed by the Ministry of Health's (HLTH) *Medical Assistance in Dying: Access and Care Coordination* policy (the MAiD policy). The policy requires that MAiD be reasonably available where end-of-life services are normally offered, in all health authority owned/operated facilities and facilities run by contracted organizations that receive more than 50% of their bed funding from a health authority.
- Faith-based organizations are not required to allow access to MAiD in their facilities, regardless of the level of public funding they receive. The policy defines a faith-based organization as "an organization that is party to the 1995 Master Agreement with the Denominational Health Care Facilities Association (Master Agreement), or otherwise in its constitution declares itself as being an organization based on religion or spirituality."
- The MAiD policy's exemption for faith-based organizations respects the Master Agreement, which states that members of the Denominational Health Association (formerly called the Denominational Health Care Facilities Association) are "not required to provide those services which are inconsistent with [their] mission and values."
- The Master Agreement obligates faith-based facilities to plan and deliver health care services in collaboration with other health bodies, including health authorities. This relationship ensures the availability of an appropriate range of health services within each health region.
- The Denominational Health Association provides more than 7,800 beds and suites across BC, including over 5000 long-term care beds, over 1100 assisted living suites, and over 500 acute care beds.
- Advice/Recommendations

Personal Information

LAST UPDATED

The content of this estimates note is current as of February 14, 2025, as confirmed by Leesa Lyster, Acting Executive Director.

APPROVALS

2025 03 14 – Shana Ooms, Hospital & Surgical Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Medical Assistance in Dying (MAiD) – General

Topic: An overview of the provision of Medical Assistance in Dying (MAiD) in BC and its associated monitoring, reporting, and oversight structures.

Key Messaging and Recommended Response:

- MAiD is a legal end-of-life choice for eligible patients, and the Ministry of Health is committed to providing MAiD in a manner that is respectful and supportive of patients, families, and providers.
- To ensure MAiD is provided in a safe and appropriate manner, federal and provincial legislation, regulations, and standards of practice outline specific safeguards and eligibility criteria that doctors and nurse practitioners in BC must agree have been met, before approving a patient's request for medical assistance in dying.
- The MAiD Oversight Unit (the Unit) reviews every case of MAiD in BC.
- All required documentation, submitted by doctors and nurse practitioners who provide MAiD, is reviewed for compliance with the eligibility criteria, federal safeguards, federal regulations, provincial safeguards, and professional regulatory college practice standards for MAiD.
- As per the federal legislation, these forms are submitted following the provision of MAiD or a discontinuation in the planning for MAiD (i.e., natural death prior to MAiD, patient decides not to proceed with MAiD).
- The MAiD Oversight Unit does not conduct investigations and concerns identified during case reviews are not allegations of misconduct.
- Under the current federal and provincial frameworks, any potential investigation into a case where MAiD has been provided would be conducted by the appropriate professional regulatory college or law enforcement.
- The number of referrals to regulatory colleges and law enforcement represents less than 0.2% of the total number of cases reviewed by the MAiD Oversight Unit.

CURRENT SITUATION

- Between January 1 and December 31, 2024, there were 3,000 medically assisted deaths in BC. Of these, 97.8% (2,935) were individuals who were facing a reasonably foreseeable natural death (i.e., who had a terminal condition), whereas 2.2% (65) were not. In 2024, this represented 6.9% of deaths in BC.
- There were 62 transfers for the provision of MAiD due to the originating facility's policy on MAiD in 2024, representing 2.1% of MAiD provisions that year.
- MAiD provisions by health authority, sex, age, and underlying illness, disease, or disability, are now publicly posted to the Ministry of Health's (HLTH) MAiD website. This promotes transparency and allows faster access to a wider range of statistics for researchers, healthcare professionals, and the public.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The *Criminal Code* sets out the eligibility criteria and safeguards for MAiD:
    - To be eligible, the individual (1) must be eligible for health services funded by a government in Canada, (2) must be at least 18 years of age and capable of making decisions about their

health care, (3) must have a grievous and irremediable condition, (4) must be making a voluntary request for MAiD, and (5) must give informed consent for MAiD after having been informed of other means of alleviating their suffering.
    - Safeguards for MAiD include that (1) the request must be made in writing and signed before an independent witness, (2) at least 2 doctors or nurse practitioners must find the individual eligible, (3) the individual must be informed that they can withdraw their request at any time, and (4) they must give express consent immediately prior to receiving MAiD (unless a waiver of final consent is used).
    - On March 17, 2021, the *Criminal Code* was amended to expand eligibility for MAiD to patients whose natural death is not reasonably foreseeable. These cases are subject to additional safeguards.
- Patients whose sole underlying medical condition is mental disorder are currently not eligible for MAiD services. The *Criminal Code* includes a sunset clause that removes this exclusion on March 17, 2027.
- Advance requests for MAiD are not currently permitted under the *Criminal Code*. The federal government recently launched a national public consultation on advance requests and MAiD and is expected to share the results of this consultation in spring 2025.
- Oversight of MAiD in BC is provided by HLTH's MAiD Oversight Unit under HLTH's *MAiD Oversight Policy*:
    - Doctors and Nurse Practitioners who provide MAiD in BC must submit all required documentation to the MAiD Oversight Unit within 72 hours of a MAiD provision.
    - This includes documentation of the patient's request for MAiD, 2 independent assessments of the patient's eligibility, demonstrated compliance with safeguards, and a medication administration record.
    - All documentation is reviewed by the MAiD Oversight Unit for compliance with the eligibility criteria, federal safeguards, federal regulations, provincial safeguards and professional regulatory college practice standards for MAiD.
    - If concerns are identified, the MAiD Oversight Unit has the authority to gather more information, provide education, make a referral to the applicable professional college, and/or make a referral to law enforcement, as required.
- The MAiD Oversight Unit does not conduct investigations; concerns identified during case reviews are not allegations of misconduct. Under the current federal and provincial frameworks, any potential investigation into a case where MAiD has been provided would be conducted by law enforcement or the appropriate professional regulatory college.
- In BC, required reporting on MAiD is submitted to the federal government quarterly.
- The *MAiD: Access and Care Coordination* policy (the MAiD policy) outlines the HLTH's expectations of health authorities regarding the delivery of MAiD – that they are responsible for ensuring that MAiD is reasonably available in a manner like other end-of-life services. The policy provides 2 exemptions for facilities who can choose not to provide MAiD and transfer the patient to receive MAiD in another setting: 1) faith-based organizations; and 2) facilities who receive less than 50% of bed funding from the health authority.

LAST UPDATED

The content of this estimates note is current as of February 5, 2025, as confirmed by Leesa Lyster, Acting Executive Director.

APPROVALS

2025 03 14 – Shana Ooms, Hospital & Surgical Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Medical Assistance in Dying – Mental Disorder as the Sole Underlying Medical Condition

Topic: Individuals with a mental disorder as their sole underlying medical condition (MD-SUMC) are currently excluded from eligibility for medical assistance in dying (MAiD); however, this is currently legislated to change in 2027.

Key Messaging and Recommended Response:

- Parliament has passed legislation delaying the expansion of eligibility for MAiD to include people with mental illness as their sole underlying medical condition until March 2027.
- Intergovernmental Communications

- Additional safeguards are required to ensure the safe and appropriate delivery of MAiD for this population, and it is important that all jurisdictions, health authorities, regulators and MAiD practitioners have the required time to implement these safeguards.
- Our Government remains committed to continuing to support practitioners in meeting their legislative requirements and responsibilities, and to enact appropriate guidance and practices in accordance with the MAiD legislative framework.

CURRENT SITUATION

- The federal *Criminal Code of Canada*, which governs MAiD, currently excludes mental illness from eligibility for MAiD. This exclusion is set to expire on March 17, 2027, as the result of a sunset clause.
- On February 29, 2024, Parliament passed Bill C-62, *An Act to amend An Act to amend the Criminal Code (medical assistance in dying),* which extended the exclusion for mental illness from March 2024 until March 17, 2027.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The *Criminal Code of Canada* provisions for MAiD were amended on March 17, 2021, and eligibility for MAiD was extended to include persons whose natural deaths are not reasonably foreseeable (i.e. who do not have a terminal condition).
- However, individuals with MD-SUMC were temporarily excluded from eligibility for a period of 2 years, until March 2023. This exclusion was later extended to March 2024, and federal Bill C-62 has now extended the exclusion by an additional 3 years, to March 2027.
    - The federal government has stated that this extension would provide more time for provinces and territories to prepare their health care systems, including the development of policies, standards, guidance, and additional resources to assess and provide MAiD for MD-SUMC. It would also provide practitioners with more time to participate in training and become familiar with available supports, guidelines, and standards.
    - This delay in implementation aligns with the recommendations of the parliamentary Special Joint Committee on MAiD in its report *MAiD and Mental Disorders: The Road Ahead*, which was tabled on January 29, 2024.
    - Bill C-62 also requires that a joint parliamentary committee undertake a comprehensive review relating to the eligibility for MAiD of persons with MD-SUMC within 2 years after the bill receives royal assent (March 2026).

LEGISLATIVE SESSION – ESTIMATES NOTE

- In preparation for the proposed legislative change which would have allowed individuals with MD-SUMC to become eligible for MAiD, a provincial Subcommittee on MAiD and mental health was formed in August 2022 to advise on any new provincial safeguards required for this population, as well as resources and guidance required by MAiD assessors and providers in BC.
- The Subcommittee includes members with both clinical and operational expertise in mental health and MAiD, as well as representation from the Ministry of Health, Ministry of Mental Health and Addictions, and Ministry of Social Development and Poverty Reduction.
- Advice/Recommendations

- However, as the exclusion of eligibility for MD-SUMC will be extended by an additional 3 years, these provincial safeguards have not yet been implemented and the work for the Subcommittee is currently paused.
- Intergovernmental Communications

- Provincial safeguards for MAiD in BC are embedded within the practice standards of BC's regulatory colleges.

LAST UPDATED

The content of this estimates note is current as of February 3, 2025, as confirmed by Leesa Lyster, Acting Executive Director.

APPROVALS

2025 03 14 – Shana Ooms, Hospital & Surgical Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Private Surgical Centres

Topic: Health-care services in BC have long been provided through a mix of public, non-profit and private for-profit providers. Private for-profit providers include privately owned residential care facilities, community pharmacies, physician practices, and surgical clinics/centres.

Key Messaging and Recommended Response:

- In BC we use private facilities to expand capacity, and to leverage efficiencies already within our system. Contracting out some day care surgeries, for example, has assisted the province in maintaining service delivery levels and allowed hospitals to focus on more urgent and complex cases, such as cardiac surgeries.
- We do a small percentage of surgeries with private clinics every year. Under these arrangements, services are publicly funded, and clinics are prohibited from charging patients any additional fees for insured services – also known as "double billing" or "extra billing."
- We firmly support the Medical Services Commission as it fulfills its mandate to ensure compliance with the *Medicare Protection Act* (MPA) and *Canada Health Act*. For instance, we recently asked two companies – Telus Health and Harrison Healthcare – to come into compliance with the MPA. And for over a decade, the Province defended the public health care system in Canada through the Cambie Surgeries Centre litigation.
- Our focus remains on building and investing in the public system. We continue to work with health authorities, surgeons, anesthesiologists, and other essential surgical personnel to do more surgeries for patients in BC.

CURRENT SITUATION

In 2024/25, health authorities (HAs) have continued to contract out day procedures to expand surgical capacity in the province. In 2024/25, there are 7 private surgical centres (10 contracts) that HAs contracted with in compliance with the *Canada Health Act* to perform surgeries.

- Kamloops Surgical Centre - Interior Health Authority (IHA),
- Okanagan Health Surgical Centre - IHA,
- False Creek Healthcare Centre - Fraser Health Authority (FHA) and Vancouver Coastal Health Authority (VCH),
- New Westminster Surgical Centre - FHA and VCH,
- Valley Surgery Centre - FHA,
- LASIK MD Vancouver Hornby - VCH, and,
- Anesthesia For Dentistry (AFD) Clinic - Provincial Health Services Authority (PHSA).

- In 2022/23, the Island Health Authority (VIHA) purchased Seafield Surgical Centre (now Centre Island Surgical Centre) and View Royal Surgical Centre (now South Island Surgical Centre) for $11.5 million. In May 2023, Northern Health Authority (NHA) purchased Prince George Surgery Centre.
- Additional private surgical centres no longer contracted by HAs include Fraser Valley Cataract and Laser Centre (FHA) which ended in 2020/21 and Vancouver Ambulatory Surgical Centre (VCH) which ended in 2022/23.

FINANCIAL IMPLICATIONS

The total amount paid by HAs in 2022/23 to private surgical centres for acute care services was $23.8 million; 0.18% of the $13.6 billion HAs reported spending in acute care in the same time period (source: 2022/23 audited HA financial statements). The Ministry of Health (HLTH) provided funding of $18.9 million to the HAs to support contracts with private surgical centres in 2024/25.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Since 2002, HLTH policy[1] has allowed HAs to purchase outpatient clinical services from private diagnostic and medical/surgical facilities, in addition to providing these services directly, if quality, cost-effectiveness and accountability requirements are met. This change does not represent creation of a second tier of health care funded on a private pay basis. Health care services delivered through contracts with private clinics are fully funded by government, as required by the *Canada Health Act*[2]. The Medical Services Plan (MSP) pays the physician fees associated with such services, while the HAs fund facility costs for contracted services.
- Quality of care for purchased services is the responsibility of both the College of Physicians and Surgeons of BC (CPSBC) and the contracting HA. The Patient Service Delivery Policy[1] is being used by HAs to provide short-term relief for capacity pressures; and to re-direct less complex surgical procedures so that hospital operating rooms are available to deal with more complex, urgent procedures, such as cardiac surgeries.
- The types of surgeries contracted out to private surgical centres include cataracts, dentistry, ear, nose and throat procedures, neurosurgery, plastic surgery, ophthalmology procedures, orthopedic surgeries, and many others. These are all considered day care procedures, and the patient length of stay at the facility may be no more than 24 hours following a procedure.
    - 2016/17: 9,948 contracted surgical cases[3] (3.2%) out of 315,203 total surgical cases[4].
    - 2017/18: 9,355 contracted surgical cases[3] (2.9%) out of 319,143 total surgical cases[4].
    - 2018/19: 11,607 contracted surgical cases[3] (3.5%) out of 331,159 total surgical cases[4].
    - 2019/20: 12,336 contracted surgical cases[3] (3.7%) out of 330,405 total surgical cases[4].
    - 2020/21: 13,862 contracted surgical cases[3] (4.4%) out of 316,275 total surgical cases[4].
    - 2021/22: 16,777 contracted surgical cases[3] (5.0%) out of 337,560 total surgical cases[4].
    - 2022/23: 13,021 contracted surgical cases[3] (3.7%) out of 350,844 total surgical cases[5].
    - 2023/24: 11,454 contracted surgical cases[3] (3.2%) out of 361,959 total surgical cases[6].
    - 2024/25 YTD (P10): 9,166 contracted surgical cases[3] (3.3%) out of 279,464 total surgical cases[6].
- WorkSafe BC (WSBC) also procures surgical services from private for-profit providers across the province. Procedures include (but are not limited to) knee, ankle, foot, hand, shoulder, spine surgeries; hernia repair; hardware removal; etc.
- The *Health Professions Act* requires that the CPSBC establish, maintain, and enforce bylaws that regulate non-hospital medical and surgical facilities. The Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP), managed by the CPSBC, is responsible for all accreditation decisions. As per NHMSFAP, the patient length of stay at a non-hospital facility may be no more than 24 hours following a procedure. Only non-hospital facilities accredited as a general anesthesia facility may provide overnight stay services.
- Private facilities must also be approved by the Medical Services Commission (MSC) to bill the MSP for publicly funded surgeries.
- The *Medicare Protection Act* along with the *Canada Health Act* prevents physicians in private facilities from charging MSP-insurable patients (residents of BC) for MSP-billable services. It is illegal for private facilities to charge any additional fees for services that are insured benefits of MSP or hospital services under the *Hospital Insurance Act*. To allow such extra billing of patients is a violation of the legislation.
- In September 2020, the Province saw a successful outcome in the landmark Cambie Surgeries Corporation (Cambie) litigation. On April 6, 2023, the Supreme Court of Canada denied Cambie's application for leave to appeal, bringing this 14-year proceeding to a successful conclusion. This decision signals the end of movement towards a 2-tier healthcare system in BC, where private for-profit facilities could bill patients

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[1] Patient Service Delivery Policy - Communiqué 2002-37

[2] *Canada Health Act https://laws-lois.justice.gc.ca/eng/acts/C-6/ last amended on 2017-12-12*

[3] Contracted surgical cases: health authorities' submissions, Health Sector Information Analytics, and Reporting, Ministry of Health, Surgical Wait Times Database (RMS 9454)

[4] Total surgical cases: Health Sector Information Analytics, and Reporting, Surgical Wait Times Database (Site ID 285), Reporting exclusions are not applied.

[5] Total surgical cases: Health Sector Information Analytics, and Reporting, Surgical Wait Times Database (Site ID 399), Reporting exclusions are not applied.

[6] Total surgical cases: Health Sector Information Analytics, and Reporting, Surgical Wait Times Database (Site ID 453), Reporting exclusions are not applied.

for medically necessary and publicly insured procedures. The BC Supreme Court also ruled on January 27, 2025, that Cambie Surgeries Corporation should pay BC government's legal costs.

LAST UPDATED

The content of this estimates note is current as of February 10, 2025, as confirmed by Shana Hall, Executive Director.

APPROVALS

2025 03 11 – Brenda Rafter obo Rob Byers, Finance & Corporate Services Division
2025 03 14 – Patrick Day obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 25 – Shana Ooms, Hospital & Surgical Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Surgical Services Access (Surgical Renewal)

Topic: On May 7, 2020, the Minister of Health announced the Commitment to Surgical Renewal; a $250 million plan to increase surgical capacity to address postponed non-urgent scheduled surgeries due to the COVID-19 pandemic, meet growing demand for surgery, and change the way surgeries are delivered in BC[1].

Key Messaging and Recommended Response:

- Our Government is committed to strengthening the health-care system so people in British Columbia can get timely access to healthcare, where and when they need it.
- That's why we launched a surgical renewal program – catch up with wait lists, keep up with demand, and ensure surgeries postponed during the COVID-19 pandemic were rescheduled and completed.
- Although we need to keep up the work, we're already seeing results.
- We are doing more urgent surgeries than ever before and getting people off waitlists for urgent cases sooner:
    - In the last fiscal year (April 1, 2023, to March 31, 2024), we completed 361,959 surgeries[2]. This was the highest number of surgeries ever performed in a year in BC;
    - There are fewer patients waiting more than 4 weeks for urgent surgeries compared to the same period in 2019/20.
- And in addition, all 24,485 surgeries postponed throughout the COVID-19 pandemic were completed as of August 2023, and our work does not stop there.
- Since the last fiscal year (April 1, 2024, to January 31, 2025), we have increased operating room time by 12%, compared to the same timeframe in 2019-2020.
- As part of overall capacity expansion efforts, the health authorities are increasing operating room hours and surgical volumes to address surgical waitlists.
- The March 2024 Canadian Institute for Health Information (CIHI) report ranks BC first in Canada for the percent of patients meeting clinical benchmarks for cataract surgeries and second nationally for the percentage of patients meeting clinical benchmarks for hip and knee replacements in 2023.

CURRENT SITUATION

- As of September 2023, all 24,485 surgeries postponed throughout the COVID-19 pandemic were completed[3].
- Despite dealing with extreme weather events, and a shortage of health human resources (HHR), health authorities (HA) are expected to fully achieve the 11% targeted increase in capacity (operating room (OR) hours) planned for this fiscal year (FY). As of January 2, 2025 (P10), HAs are achieving a 12% increase over baseline and 101% (501,376 OR hours year to date (YTD)) of their targeted capacity plans YTD, collectively overachieving by 6,706 OR hours[4].
- Other surgical renewal achievements in FY 2024/25 include[2]:
    - Between April 1, 2024, to January 2, 2025 (P10 YTD):
        - Delivery of 279,464 scheduled and unscheduled surgeries – 19,544 surgeries or 7.5% more compared to the same timeframe in 2019/20.

[1] BC Gov News. (May 7, 2020). Province Launches Renewal Plan for Surgeries. Retrieved from: https://news.gov.bc.ca/releases/2020HLTH0026-000830
[2] Source: Health Sector Information Analysis and Reporting, For Spring Estimate Master Workbook, Site 453. Exclusions not applied; Data restated.
[3] Surgical Renewal Progress Report 21 (P6 FY 2023/24) retrieved January 2025.
[4] Source: AW Capacity Expansion Plan Monitoring by Fiscal Period – HLTH – 12b – FY2425 P10 – v01v.xlsx

        - Delivery of 25,853[5] urgent scheduled surgeries completed within 4 weeks – 5.0% more compared to the same timeframe in 2019/20.
        - Delivery of 22,563[7] non-urgent scheduled surgeries completed for patients waiting longer than 2 times their target wait – 11.7% more compared to the same timeframe in 2019/20.
        - Expansion of OR hours by 53,116, totalling 501,376 hours YTD – 12% more compared to the same timeframe as 2019[6].
        - Addition of 12 new initiatives in HAs to increase OR time and capacity.
    - As of P10 FY 2024/25[6]:
        - There are 3,258 urgent cases waiting over 4 weeks, which is 1,003 less cases compared to 4,261 cases in P10 FY 2019/20.
        - Completion of 2,285 urgent cases within 4 weeks, which was 505 more cases compared to 1,780 cases in P10 2019/20.
- Since April 1, 2020, to December 5, 2024[7]:
    - 1,802 nurses have completed surgical specialty training throughout BC, with 124 completions this FY to date.
    - BC has added additional (net) healthcare staff to surgical services across the province, including 191 surgeons, 175 anesthesiologists, 676 perioperative nurses, 11 general/family practitioner anesthetists, and 332 medical device reprocessing technicians.
- The Ministry of Health (HLTH) continues to work with HAs to find ways to increase HHR for surgery.

FINANCIAL IMPLICATIONS

- In addition to the initial $250 million investment, on September 9, 2020, the Government announced HLTH received approval to access operating funding of up to $1.6 billion and capital funding of $150 million in 2020/21 to respond to the health-care requirements related to the COVID-19 pandemic response[8]. Of this amount, approximately $187.5 million was allocated to support enhanced surgical capacity, including additional nursing staff and operating room costs.

KEY BACKGROUND

- On March 16, 2020, non-urgent scheduled surgeries were postponed because of COVID-19, and on May 18, 2020, non-urgent scheduled surgeries resumed.
- The Commitment to Surgical Renewal launched May 7, 2020, and outlines 5 steps: 1) increasing surgeries; 2) increasing essential personnel; 3) focusing on patients; 4) adding more resources; and 5) reporting on progress.
- The plan prioritizes urgent surgeries; patients who had their surgery postponed and have been waiting over twice their clinical benchmark; day surgeries; and maximizing surgeries that can be performed outside of ORs.
- During the initial COVID-19 response, surgeries were taking approximately 26% longer to complete due to a necessary increase in infection prevention controls. By the June 26 to July 23, 2020, reporting period, surgical efficiency returned to approximately pre-COVID-19 levels[9].
- HAs originally planned to add 16% more surgical capacity (OR hours) from June 15, 2020, to March 3, 2021, annualizing to a 24% gain in 2021/22[10]. Based on those plans, all HAs were projected to catch-up to postponed surgeries by the end of 2021. These plans were impacted by the subsequent waves of COVID-19.
- For FY 2020/21 (Year 1 of Surgical Renewal)[2]:

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[5] Health Sector Information Analysis and Reporting, Surgical Standard Report 2024/25 P10. RMS 2465. *Restated data, exclusions applied*

[6] Source: HSIAR: Surgical Wait Times (SWT) Standard Report (2024_25 P11 Surgical Standard Report Site 457).

[7] Source: FY24 Q3 – Surgical Workforce Paginated Report. Note: The number of active employees varies seasonally. For example, more people take vacation in the summer, so the number of active employees usually drops from Q1 to Q2. Examining the change from the same quarter last year accounts for seasonal variation and more accurately shows how the workforce has changed.

[8] BC Gov News. (September 9, 2020). Investment brings new support to those most vulnerable to COVID-19 and communities where they live. Retrieved from: https://news.gov.bc.ca/releases/2020PREM0050-001694

[9] BC Gov News. (September 1, 2020). B.C progresses on surgical renewal plan. Retrieved from: https://news.gov.bc.ca/releases/2020HLTH0049-001627 Progress Report 2 https://news.gov.bc.ca/files/2020_surgical-renewal-commitment-progress-report-June-July-2020.pdf

[10] BC Gov News. (January 6, 2021). Adding surgeries for patients: Catching up from COVID-19. Retrieved from: http://news.gov.bc.ca/releases/2021HLTH0003-000011 Progress Report #3 https://news.gov.bc.ca/files/SurgicalRenewalReport3.pdf

  - Total surgical volumes were 316,430, a decrease of 4.2% since 2019/20 and an increase of 0.4% since 2016/17 levels, despite significant impacts of the pandemic in 2020.
- For FY 2021/22 (Year 2 of Surgical Renewal)[2]:
  - Total surgical volumes were 338,169, an increase of 2.3% since 2019/20 and an increase of 7.3% since 2016/17 levels.
  - In August 2021, HAs met their goal of providing 400 additional surgical specialty nurse training seats.
  - HLTH and HAs also met their goal of training 100 medical device reprocessing technicians and continue to ramp up training.
- For FY 2022/23 (Year 3 of Surgical Renewal)[2,11:]
  - Total surgical volumes were 350,833, an increase in 6.2% since 2019/20 and an increase of 11.3% since 2016/17 levels.
- For FY 2023/24 (Year 4 of Surgical Renewal)[2]:
  - Total surgical volumes were 361,959, an increase in 9.5% since 2019/20 and an increase of 14.9% since 2016/17 levels.
- On July 13, 2021, and to be refreshed in 2025/26, HLTH issued an updated Waitlist Management Policy that all 6 HAs have implemented as of December 2022 (Q3/P09 2022/23). Policy implementation supports improved accuracy of reported wait times through enhanced sharing of patient unavailable time between HAs and surgeon offices, improved BC Diagnosis Code selection by surgeons, and routine waitlist audits by HAs and surgeons.

LAST UPDATED

The content of this estimates note is current as of February 3, 2025, as confirmed by Shana Hall, Executive Director.

APPROVALS

2025 02 27 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2025 03 03 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 03 21 – Shana Ooms, Hospital and Surgical Health Services Division

[11] Note – volume previously reported was 350,866. Data has since been restated as part of routine data integrity processes.

LEGISLATIVE SESSION – ESTIMATES NOTE

Access to Psychiatry Services

Topic: Access to Psychiatric Services in BC.

Key Messaging and Recommended Response:

- Our government has invested more than $1B to build up the mental health and substance use system of care for British Columbians.
- In June 2024, Dr. Daniel Vigo was appointed as the Chief Advisor for psychiatry, toxic drugs and concurrent disorder to provide advice and recommendation on how to improve care for individuals with severe, complex mental health and substance use disorders, including acquired brain injury.
- Based on Dr. Vigo's advice, government is moving forward to expand access to psychiatric care in our correctional facilities and tertiary care settings, including secure, longer term rehabilitative care centres.
- Recruitment of health human resources, including psychiatrist and psychiatric nurses continues to be a challenge, but our government is doing everything it can to attract and retain talent to fill vacancies so that we can provide the best care to British Columbians.
- We will continue to work with health authorities and the Ministry of Children and Family Development to expand psychiatric services throughout BC for people of all ages.

CURRENT SITUATION

- Access to psychiatrist remains inconsistent, with wait times varying from one day to over a year depending on location, program type, and patient acuity.
- Psychiatrists work in various settings, including private practice (MSP fee-for-service or private pay), hospitals, and publicly funded mental health and substance use (MHSU) programs operated by health authorities (e.g., Adult Community Support Services, Adult Short-Term Assessment and Treatment Services, Assertive Community Treatment, Early Psychosis Intervention, eating disorder programs and virtual/telepsychiatry services).
- In 2023/24, under MSP fee-for-service billing, psychiatrists provided 79,498 hospital services (up from 77,442 in 2022/23), 8,901 office visits (a slight decrease from 8,927), 1,645 home visits (up from 1,242), and 896 emergency visits (up from 803).[1]
- **Assertive Community Treatment (ACT)** teams provide community-based care for people with complex mental health or concurrent MHSU disorders. Recruitment and retention of psychiatrists in ACT teams remain challenging in some areas, with vacancies reported as of January 2025 in Vancouver Coastal (1.5 FTE), Interior Health (1.6 FTE), Island Health (3.0 FTE), and PHSA (0.5 FTE). In Northern Health, ACT psychiatry is provided through sessional contracts with no vacancies and Fraser Health has no vacancies.[2]
- **Fraser Health Authority (FHA)** has 95 adult psychiatrists and wait-times for various community-based psychiatry can vary from same day to approximately 9 months.[3]
- **Vancouver Coastal Health Authority (VCH)** and **Providence Health Care (PHC)** have 344 psychiatrists, many work part-time and some have leadership roles, resulting in an estimated 193 FTEs. Wait-times range from 3 weeks to 3 months, with urgent cases seen promptly via outreach, specialized teams (e.g., CAR program), or emergency department. Some programs remain understaffed due to recruitment challenges. [4]
- **Northern Health Authority (NHA)** has 20 full-time psychiatrists (fewest in BC) and no dedicated child/youth psychiatrists. They rely on telepsychiatry, BC Children's Hospital on-call services, and the Compass program. Wait-times range from 3-6 months with interprofessional support available while waiting for service.
- **Vancouver Island Health Authority (VIHA)** has a high provincial success rate for psychiatrist recruitment, adding

[1] BC Ministry of Health. (2024). *MSP Fee-for-Service Payment Analysis 2019/2020 to 2023/2024* (fee items 00605, 00607, 00608, and 00609). Retrieved from: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_ffs_payment_analysis_20192020_to_20232024.pdf

[2] Email, Devane, Courtney. Provincial ACT Advanced Practice. AP Response on ACT Team. January 20, 2025.

[3] Email. Caron, Laura. Executive Director, MHSU. Fraser Health Authority. March 11, 2025.

[4] Email, MacFarlane, Andrew. Executive Director, MHSU. Vancouver Coastal Health. March 10, 2025.

13 new psychiatrists in 2024/25, bringing the total to over 110 psychiatrists and representing over 80 FTEs. Wait times vary based on urgency and existing community support, ranging from less than a week to up to one year. Same day psychiatric care is available through PES or Emergency for crisis situations.[5]

- **Interior Health Authority (IHA)** has 67 psychiatrists providing over 56 FTE of services and active postings for 34 additional positions. Wait-times range from one week to one year with community support available while waiting for access to psychiatry at IHA.[6]
- **Ministry of Children and Family Development (MCFD)** provides mental health services for children and youth across community-based and inpatient/outpatient care settings. MCFD has contracted 67 psychiatrists and 11 pediatricians with sessional contracts.[7]
- **First Nations Health Authority (FNHA)** recorded 11,846 First Nations Virtual Doctor of the Day and 2,207 First Nations Virtual Substance Use and Psychiatry encounters in 2023/24. FNHA recruited three new Doctor of the Day physicians, a psychiatrist, and two substance use locums that year. [8] FNHA supported 984 virtual sessions with psychiatrists and addictions specialists between January and June 2024.[9]
- **BC Mental Health and Substance Use Services (BCMHSUS)**, under the Provincial Health Services Authority (PHSA), provides care across 650 beds provincially, including 398 provincial tertiary beds and 252 community-based MHSU beds. Services include specialized psychiatric care at Red Fish Healing Centre (105 beds), Provincial Assessment Centre (10 beds), and Adult Substance Use Treatment facilities (50 beds). BCMHSUS also provides primary and MHSU treatment across 10 provincial correctional health facilities and adult Forensic Psychiatric Services (190 beds), including hospital, community and court-mandated psychiatric assessments and treatment.[10]
- **Forensic Psychiatry Services (FPS)** currently have 30 forensic psychiatrists employed either part-time or full-time and no current vacancies.
- **BC Children's Hospital (BCCH)** provides inpatient, outpatient and community-based, psychiatric/substance use care, including, eating disorders treatment for children and youth across BC and Yukon. Urgent psychiatric support is available through the BCCH Emergency Department. Psychiatrists and interprofessional teams offer virtual consultations to support to Physicians and clinicians through the Compass Program.
    - As of March 1, 2025, the outpatient psychiatry wait time is 58 days (median from referral acceptance to first appointment), down from 74 days in 2023/24, with 0-day wait for inpatient and consult services.
    - BCCH has 35 Child and Adolescent Psychiatrists, providing a total of 25.8 full-time equivalent (FTE) psychiatrists and an additional 8.5 FTE positions are currently vacant. Psychiatrists use a blended billing model with MSP fee-for-service and sessional support. [11]

FINANCIAL IMPLICATIONS

- Psychiatrists billed $219.35 million in MSP fee-for-service payments in 2023/2024, an increase from $206.52 million in 2022/2023.[12]

KEY BACKGROUND

- As of 2024, BC has 14.8 psychiatrists per 100,000 people, exceeding the national average of 13.1 per 100,000.[13]
- The University of British Columbia (UBC) is the only Faculty of Medicine in BC, offering the province's psychiatry residency program (currently 136 residents). There were 31 residency positions available in 2024/25, with 12 in Vancouver, 11 in Fraser Health Greater Vancouver, 3 in Vancouver Island, 2 in Prince George and 3 in Interior.[14]
- Medical Education in BC and across Canada follows a two-step process:
    - Doctor of Medicine Degree (MD) is a four-year undergraduate medical program delivered across four university campuses and various hospitals, clinics, and community settings throughout BC.

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[5] Email. Nigro, Tracey. Director, MHSU Strategic Clinical Networks. Island Health. March 14, 2025
[6] Email. Morris, Debi. Director, Clinical Services, Mental Health & Substance Use Transformation. Interior Health Authority. March 21, 2025.
[7] Email. Czmielewski, Kelly. Director CYMH Policy. Ministry of Children and Family Development. March 11, 2025.
[8] First Nations Health Authority. (2024). *Annual report 2023/2024: Paddling together – Multi-year health plan progress update* (p.31). First Nations Health Authority. Retrieved from https://www.fnha.ca/Documents/FNHA-Annual-Report-2023-2024.pdf
[9] First Nations Health Authority. (2024). *First Nations and the Toxic Drug Poisoning Crisis in BC: Data Infographic (January–June 2024)*. Retrieved from https://www.fnha.ca/Documents/FNHA-First-Nations-and-the-Toxic-Drug-Poisoning-Crisis-in-BC-Jan-June-2024.pdf.
[10] Email, Madani, Aazadeh. Senior Director, Medical Administration & Project Management Office, BCMHSUS. March 14, 2025.
[11] Email. Burke, Sharlynne. Director, Child, Youth & Young Adult MHSU. BC Children's Hospital and Women's Center. March 6, 2025.
[12] BC Ministry of Health. (2024). *MSP Information Resource Manual 2023/2024. Retrieved from* https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_information_resource_manual_20232024.pdf.
[13] Canadian Mental Health Association. (2024). *Canadian Psychiatric Workforce Report, 2024*. Retrieved from https://cmha.ca
[14] UBC Department of Psychiatry. (2025) CaRMS 2025 Information Package. Retrieved from PowerPoint Presentation.

- Psychiatry Residency Program (UBC) is a five-year program accredited by the Royal College of Physicians and Surgeons of Canada.

- The UBC Department of Psychiatry offers sub-specialty training in Child and Adolescent, Forensic and Geriatric Psychiatry as well as fellowships in Concurrent Disorders, Addictions and Neuropsychiatry (1-2 years post-residency). The UBC Department of Psychiatry will receive annual funding for one Re-entry Residency Position in Psychiatry for FY 2025/26, requiring a three-year Return of Service (ROS) contract with the MoH, expected to be fulfilled within the Fraser Health Authority in BC.[15]

LAST UPDATED

The content of this estimates note is current as of March 14, 2025 as confirmed by Robyn White, ED, MHSU.

APPROVALS

2025 03 21 - Darryl Sturtevant, ADM & a/Associate Deputy Minister
2023 02 14 – Health Sector Information, Analysis & Reporting Division
2025 02 28 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

[15] Government of British Columbia. (2025). *Return of service programs: Physician compensation*. Retrieved February 10, 2025, from https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/physician-compensation/return-service-programs

LEGISLATIVE SESSION – ESTIMATES NOTE

Access To Withdrawal Management (Detox)

Topic: Access to withdrawal management (inpatient and outpatient services) in BC

Key Messaging and Recommended Response:

- For people seeking substance use care, appropriate and accessible withdrawal management (WDM) services are often an important step in the recovery journey.
- WDM may be necessary or recommended for numerous reasons. WDM can reduce the risk of experiencing severe withdrawal symptoms, help to prevent return to substance use, and support patient recovery goals.
- Improving access to WDM is a key part of Road to Recovery, a new model of care for addictions being implemented in each health region in BC.
- We are increasing access to WDM across the province of BC with new WDM beds, outpatient options for people looking for support at home or in community, and through expanded access to Opioid Agonist Therapy through new services like the Opioid Treatment Access Line.

CURRENT SITUATION

- There are currently 270 WDM beds across all regions of the province, with 57 of these added since 2017 (48 adult / 9 youth)[1].
- In addition to beds, all Health authorities provide outpatient WDM programs. Outpatient WDM is important for people who want to access care at home or in community, often because of existing home, work or childcare responsibilities. It takes different forms, for example, it can look like structured wellness checks at a client's home or having the client regularly present to a clinic for monitoring.
- Examples include:
    - **Vancouver:** Robert & Lily Lee Family Community Health Centre offers an intensive outpatient "daytox" program that is designed to be completed in 6-8 weeks.
    - **Interior:** Outpatient detox programs in Kamloops, Kelowna, Penticton and Vernon that support people to withdraw from alcohol or opioids and provides support in-person, virtually, or in their home. Between April 2023 and September 2024, the program served 471 unique clients[2].
    - **Rapid Access Addiction Clinic (RAACs):** Exist in many health regions, are low barrier clinics that provide assessment and treatment for people with substance use concerns, including medication management of substance use concerns. In Q2 of 2024/25, 3,352 unique clients were served at RAACs across the province[3].
- The Province is implementing new models of care that are improving access to treatment and recovery for British Columbians.
- This includes the Road to Recovery (R2R) model. As part of R2R, HLTH is actively planning to increase the capacity and accessibility of detox services in all regions, and work is progressing well.
- In Vancouver, where R2R has been operating since October 2023, R2R has been quickly connecting people with the treatment they need. From October 2023 to November 2024, more than 2,100 people were supported to access WDM services, with a median wait time of one day for those prioritized as urgent[4].
- Provincially wait times vary depending on client need and preference (e.g., readiness, need to take time off work or away from family), demand and availability.

FINANCIAL IMPLICATIONS

- Budget 2023 provided $55.86 million in operating funding over three years to support the Road to Recovery at St. Paul's Hospital in Vancouver.

[1] MHA Beds Sheet, January 2025.
[2] MHA Performance Data, provided by Health Authorities on quarterly basis
[3] MHA Performance Data, provided by Health Authorities on quarterly basis
[4] MHA Performance Data, provided by VCH

- Budget 2023 provided $153.76 million in operating funding over three years to support Road to Recovery expansion.
- Budget 2024 provided $117. 31 million over three years in operating funding for substance use beds.
- Cabinet Confidences; Government Financial Information

KEY BACKGROUND

- WDM, also known as detox, is an intervention aimed at reducing harm, such as withdrawal seizures, associated with substance use cessation.
- WDM is rarely accessed as a stand-alone service. People may also access medication-based treatments, bed-based recovery programs, and/or outpatient support.
- Not everyone needs or wants a bed. Substance use beds, including WDM, are typically most appropriate for people who require a higher intensity of services and support to address complex or acute mental health or addiction problems.
- Alcohol use disorder (AUD) and high-risk drinking are the most common substance use challenges in BC but often go unrecognized and untreated. Nearly 18% of people aged 15 years or older in Canada will meet the clinical criteria for an AUD in their lifetime[5].
- An estimated 78,325 people live with a diagnosed opioid use disorder (OUD) in BC. This estimate increases to 112,318 when accounting for people who may meet the criteria for OUD but are never diagnosed.[6]
- Unmanaged withdrawal from Alcohol and/or Benzodiazepines (which often contaminate the unregulated opioids) can be life threatening, and lead to seizures and delirium.[7]

Table 1: Publicly Funded Medical Withdrawal Management Beds (Detox) in BC by Health Authority[8]

Health Authority	Communities where Adult and/or Youth WDM beds are available[9]	Adult WDM Beds	Youth WDM Beds	Total
Fraser Health Authority	Surrey, Maple Ridge	24	10	34
Interior Health Authority	Cranbrook, Castlegar, Kelowna, Kamloops, Williams Lake	60	9	69
Northern Health Authority	Daajing Giids, Masset, Prince Rupert, Hazelton, Smithers, Kitimat, Terrace, Prince George, Fort Nelson	30	1	31
Vancouver Coastal Health Authority	Richmond, Vancouver, Powell River	85	0	85
Island Health Authority	Victoria, Nanaimo, Comox Valley, Port Hardy	43	8	51
Total		**242**	**28**	**270**

LAST UPDATED

The content of this estimates note is current as of February 13, 2025 as confirmed by Sarah Amyot as A/ED.

APPROVALS

2025 02 24 – Brenda Rafter OBO Rob Byers, ADM Finance and Corporate Services Division
2025 03 07 – Ally Butler, A/Associate DM, Mental Health and Addictions

[5] BC Centre for Substance use, Canadian Clinical Guidance, High Risk Drinking and Alcohol Disorder
[6] BC Ministry of Health. OERC Monthly Data Sheet – December 2024. Not publicly available.
[7] BC Centre for Substance Use, Co-occurring Substance use Principals of Care. Accessed: Feb. 11, 2025
[8] HLTH-MHA Substance Use Beds Data, monthly data sheet, January 28, 2025
[9] HLTH-MHA Substance Use Beds Data, monthly data sheet, January 28, 2025

LEGISLATIVE SESSION – ESTIMATES NOTE

Addressing Community Safety

Topic: Overview of Mental Health and Addictions initiatives that contribute to government priorities related to community safety

Key Messaging and Recommended Response:

- People in crisis are disproportionately stigmatized for the public nature of many community disturbances.
- When people are in crisis, they need quick compassionate support that meets them where they are at because the reality is the vast majority of people in crisis pose little to zero risk to community safety.
- To help prevent people in crisis from becoming a risk to themselves or others, government launched the Safer Communities Action Plan.
- Through this plan, peer assisted care teams, mobile crisis response teams, and others, work together to support people in crisis, deescalate situations and find people the care the need.
- By expanding crisis supports, we're making sure it's easier for everyone to get the help they need, when they need it, while also keeping communities safe.
- This is part of our Government's work to build a seamless system of mental health and addictions care that works for everyone.
- And, while we're making progress throughout the province, there is still much more work to do.
- These are complex issues, and each community faces these challenges a little differently.
- That's why we're committed to working with community leaders, partners and experts to ensure we're continually renewing our efforts while maintaining priorities focused on ensuring community safety throughout BC.

CURRENT SITUATION

- Improving mental health and substance use supports is a focus of government's Safer Communities Action Plan (SCAP).
- SCAP included the following initiatives led by or closely involving the Ministry of Health (HLTH):
  - Expansion of Peer Assisted Care Teams (PACTs)
  - Expansion of Mobile Integrated Crisis Response (MICR) Teams
  - Implementation of Road to Recovery
  - Investments in the Brain Injury Alliance
  - Implementation of Community Transition Teams
- The following initiatives are led by other ministries, with involvement from HLTH:
  - Implementation of Situation Tables
  - Implementation of HealthIM
- Additionally, the work of the Chief Scientific Advisor for Psychiatry, Toxic Drugs and Concurrent Disorders will be an important part of government's approach to addressing community safety.

FINANCIAL IMPLICATIONS

- Budget information is available in topic-specific Estimates notes on the programs listed above.

KEY BACKGROUND

- SCAP, announced by Premier Eby in November 2022, committed to immediate measures to promote safety for all British Columbians.
- SCAP is focused on strengthening enforcement for individuals with repeat criminal justice encounters and

strengthening services for individuals with mental health and substance use (MHSU) challenges.

- Strategic drivers behind the MHSU initiatives in the plan include key recommendations from 3 reports released in 2022 (the Special Committee on Reforming the Police Act, the Rapid Investigation into Repeat Offender and Random Stranger Violence in BC, and the Select Standing Committee on Health) to fund a continuum of MHSU care from crisis response to stabilization, to ongoing treatment and support.

LAST UPDATED

The content of this estimates note is current as of February 18, 2025, as confirmed by Tricia Poilievre, Executive Director, Complex Care Housing & Community Initiatives.

APPROVALS

2025 03 05 – Francesca Wheler, ADM, Child, Youth, Indigenous Partnerships & Community Initiatives
2025 03 06 – Ally Butler, A/Associate DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Clinical Guidance & Evidence-based Care / BC Centre on Substance Use

Topic: Clinical guidance and evidence-based care supports led by the BC Centre on Substance Use

Key Messaging and Recommended Response:

- The Ministry works with a wide range of partners, including clinical experts, physicians, research scientists, academics and people with lived experience to ensure that best evidence guides care.
- The BC Centre on Substance Use (BCCSU) is a provincial centre of leadership and expertise in addiction medicine education and training, clinical care guidance, and research.
- BCCSU supports evidence-based addiction medicine care by delivering education and training initiatives and developing clinical guidance and practice resources for health care providers.

CURRENT SITUATION

- BCCSU is a research and clinical organization that supports evidence-based addiction medicine care in BC by developing and overseeing substance use training, education, clinical guidance, and practice resources for substance use care providers, including physicians, nurses, pharmacists, and other health professionals.

FINANCIAL IMPLICATIONS

- The Province provided BCCSU with $4.64 million in 2024/25 funding to support activities aligned with provincial priorities.

KEY BACKGROUND

BCCSU's three core pillars of work include research, education and training, and clinical care guidance:

Education and Training:

- BCCSU is an academic training centre affiliated with Providence Health Care and the University of British Columbia Faculty of Medicine.
- BCCSU leads several key addiction medicine education activities across disciplines, academic institutions, and health authorities, including the Provincial Opioid Addiction Treatment Support Program for Physicians/Nurse Practitioners and Registered Nurses/Registered Psychiatric Nurses, and the Interdisciplinary Addiction Medicine Fellowship Program.

Clinical Care Guidance:

- BCCSU develops and helps implement evidence-based clinical practice guidelines, treatment pathways and other practice support documents on the treatment of substance use disorders, opioid use disorder, alcohol use disorder, stimulant use disorder, and substance use in acute care settings.
- In addition to provincial guidance on treatment of substance use disorders, BCCSU also develops protocols and practices resources related to emerging substance use topics such as prescribed alternatives and benzodiazepine use.
- BCCSU also leads initiatives to support substance use care, including the ECHO Community of Practice and 24/7 Addiction Medicine Consultation Line.

Research:

- BCCSU is an academic research centre affiliated with Providence Research and Vancouver Coastal Health Research Institute and is part of the national Canadian Research Initiative in Substance Matters network.
- BCCSU leads a multidisciplinary program of research, monitoring, evaluation, and quality improvement activities to guide health system improvements in the area of substance use. BCCSU researchers have led several

prominent epidemiological studies (e.g., Vancouver Injection Drug Users Study), clinical studies (e.g., Optimizing Patient Centered-care: a pragmatic randomized control trial comparing models of care in the management of prescription opioid misuse) and program evaluations (e.g., Road to Recovery Evaluation).

Core Clinical Guidance Documents and Practice Updates

Opioid Use Disorder

- A Guideline for the Clinical Management of Opioid Use Disorder (2023)
  - Clinical guidance aligned with the best available evidence on interventions across the continuum of opioid use disorder care. Includes information on oral and injectable opioid agonist treatment, antagonist pharmacotherapies, withdrawal management strategies, psychosocial interventions including bed-based treatment programs, harm reduction services and programs, and peer-based support.

Alcohol Use Disorder

- Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder (2019)
  - Guideline for the optimal screening, diagnosis, treatment, and care of individuals drinking above low-risk limits. 13 recommendations that are supported by current, and rigorously reviewed evidence. The guideline bridges the significant research-to-practice gap, which will improve access to evidence-based treatment for patients and families, and reduce the significant harms associated with alcohol use in BC

Stimulant Use Disorder

- Stimulant Use Disorder Practice Update (2022)
  - Practice update to provide an overview of evidence-based treatment options and introduce new evidence and approaches relevant for those providing care for individuals who use illicit stimulants.

Prescribed Alternatives

- Prescribed Safer Supply Clinical Protocols
  - These protocols contain detailed clinical guidance on prescribing specific medications included under the provincial prescribed alternatives policy.
- Opioid Use Disorder Practice Update Part 2 (2022)
  - Includes guidance for clinicians considering prescribed alternatives for individuals assessed as being at high risk of toxic drug poisoning.
- Stimulant Use Disorder Practice Update (2022)
  - Includes guidance for clinicians considering prescribed alternatives for individuals assessed as being at high risk of toxic drug poisoning.

Substance Use in Acute Care Resources (2024)

- Developed to support the Substance Use and Addictions Management in Hospitals Policy
  - Providing Care in Acute Care Settings
  - Acute Care and Opioid Use Disorder
  - Managing Acute Opioid Withdrawal
  - OAT Initiation
  - OAT Maintenance
  - Managing Acute Stimulant Intoxication and Withdrawal
  - Co-occurring Substance Use Principles of Care

LAST UPDATED

The content of this estimates note is current as of February 12, 2025 as confirmed by Evan Howatson, Executive Director, Overdose Response.

APPROVALS

2025 03 09 – Darryl Sturtevant, ADM, Substance Use Policy Division
2025 02 24 – Brenda Rafter OBO Rob Byers, ADM Finance and Corporate Services Division
2025 03 10 – Ally Butler, A/Assoc Deputy Minister, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Complex Care Housing

Topic: Services and supports for people with complex mental health, addictions or concurrent needs who are not adequately served by supportive housing in BC.

Key Messaging and Recommended Response:

- Everyone needs a safe, reliable place to call home – somewhere they can live with dignity.
- Yet many people living with serious mental health and addictions challenges are living with the threat of eviction, relying on shelters, and landing in emergency rooms or jail cells.
- We're expanding access to Complex Care Housing so more people can get the help they need in their own home.
- Since 2022, Government has invested $261 million to provide health and other services in complex care housing.
- More than 540 people across BC now have access to support through Complex Care Housing.

CURRENT SITUATION

- Complex Care Housing (CCH) serves BC's most vulnerable individuals, who are facing or at risk of homelessness, and who have complex mental health, addictions, or concurrent issues and other health challenges.
- As of January 1, 2025, 543 people across BC now have access to housing, health, social and cultural supports through CCH.[1]
- CCH is currently delivered in a variety of housing settings through a mix of service delivery models.
- In 2023, the Province announced it was expanding CCH by building 240 new, purpose-built units across BC. These units are in the planning and design stages.
- Indigenous-led CCH is a key commitment within the program. This includes operational partnerships with First Nations and Indigenous organizations, as well as 40 of the new purpose-built units dedicated to this purpose.

FINANCIAL IMPLICATIONS

Budget / Expenditures:

- Budget 2022 provided $164 million to create services for more than 500 people.
- Budget 2023 provided $266 million to expand these services and create new CCH units.
  - $97 million in operating funding to the Ministry of Health.
  - $169 million in capital funding through the Ministry of Housing and Municipal Affairs and BC Housing.

KEY BACKGROUND

- CCH has been a government mandate priority since 2020.
- CCH is part of the BC's homelessness action plan, Belonging in BC, and its housing plan, Homes for People, both led by the Ministry of Housing and Municipal Affairs.
- The first phase of CCH saw new health services layered onto existing housing services. The next phase will include purpose-built homes developed in partnership with BC Housing and regional health authorities.

LAST UPDATED

The content of this estimates note is current as of February 13, 2025 as confirmed by Tricia Poilievre.

APPROVALS

2025 03 06 – Francesca Wheler, ADM, Child, Youth, Indigenous Partnerships & Community Initiatives
2025 02 18 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 07 – Ally Butler, A/Assoc DM, Mental Health and Addictions

[1] Complex Care Housing & Community Initiatives Branch. Reporting from health authorities and Indigenous service leads, January 1, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Complex Concurrent Disorders / Involuntary Care (Chief Scientific Advisor)

Topic: Provincial response to the growing population of persons with complex mental health and substance use challenges, including acquired brain injury.

Key Messaging and Recommended Response:

- As the toxic drug crisis has changed, we're grappling with a small but growing group of people with extremely complex needs - people with severe mental health and substance use issues, coupled with brain injuries from repeated overdoses.
- A small number of these people are a risk to themselves or others and can't make decisions about their own care.
- In June 2024, Premier Eby appointed Dr. Daniel Vigo as BC's first Chief Scientific Adviser (CSA) for Psychiatry, Toxic Drugs and Concurrent Disorders. Dr. Vigo is working with partners to find better ways to support this growing population.
- Government is moving forward to implement Dr. Vigo's recommendations for new involuntary care services for people with complex need.
- Alouette Homes in Maple Ridge, the first 20-bed secure, longer term rehabilitation centre for people with mental health and addiction and who also have high-risk behaviours will open in Spring 2025
- The first 10-bed designated mental health unit opened in March 2025 in Surrey Pretrial Correctional centre. It is serving inmates with acute mental health and substance use needs.
- In March 2025, Dr. Vigo released a guidance document for clinicians that clarifies how the Mental Health Act may be applied to people with overlapping mental health and substance use challenges if they are unable to seek care themselves.
- This is just one part of our work – including a focus on expanding voluntary services - to build a seamless system of mental health and substance use care that works for everyone while keeping our communities safe.

CURRENT SITUATION

- Based on Dr. Vigo's 2023 cohort study of 257.741 unique patients, he estimates that approximately 2500 people in BC have mental health, addiction and brain injury. A smaller subset of people exhibits dangerous or violent high-risk behaviours.
- The government has taken immediate action on the following Dr. Vigo recommendations:
    - **Centralized access, analysis, and interpretation of provincial data**
        - CSA is working with the Ministry to establish an authoritative provincial database to support ongoing analysis and evaluation. Access to other ministry data sets is underway.
    - **Implement secure, longer term rehabilitation centres "Approved Homes"**
        - The first of these centres, Alouette Homes (20-beds) in Maple Ridge will open in Spring 2025. Alouette Homes will serve people with severe, complex mental health and substance use disorder, with acquire brain injury who also have high-risk behaviours.
    - **Designated Mental Health Units in Corrections**
        - The first designated mental health unit in a correctional centre will be launched in March 2025. The 10-bed unit at the Surrey Pretrial Correctional Center will serve individuals in corrections requiring urgent, crisis mental health voluntary and involuntary care while in custody.
    - **Clarify the application of the *Mental Health Act* for substance use treatment of concurrent disorders**
        - On March 12, 2025, Dr. Vigo released guidance to clinicians that clarifies the use of the MHA as it pertains to the involuntary treatment of adults in British Columbia with severe mental disorders and substance use disorders, where their substance use is contributing to the mental

disorder.

- In addition, Dr. Vigo's other recommendations actively under consideration are:
  - **Streamlining access to Life-Saving Pharmacotherapies:**
    - Access to Clozapine/point of care blood monitoring devices
    - Access to pharmacotherapies (i.e., OAT, depo Naltrexone)
  - **Addressing Physician Compensation to Incentivize Complex Patient Population**
  - **Expanding of Assertive Community Treatment (ACT) /Specialized ACT teams**
  - **Expanding Tertiary Psychiatric Rehabilitation Centre (i.e., site of the former Prince George Youth Correctional Centre)**
  - **Expansion of "approved homes" (aka Alouette model) to other health authority regions** (i.e. potential site of former Prince George Youth Correctional Centre), and
  - **Expansion of designated mental health units in other correctional facilities**.

KEY BACKGROUND

- In June 2024, the Premier appointed Dr. Daniel Vigo, CSA for Psychiatry, Toxic Drugs, and Concurrent Disorders. His mandate is to work with psychiatrists, addiction medicine physicians, health authorities, public health as well as experts in the mental health and substance use to provide advice and recommendations on the care and treatment, including involuntary treatment.
- The CSA's recommendations are focused on the creation and expansion of key community and inpatient services for complex patients to help ensure that this small but growing patient population receives adequate mental health treatment in secure settings when required.
- The MHA sets out the authority, criteria, and procedures for involuntary admission and psychiatric treatment while safeguarding individuals' rights. A patient can only be involuntarily admitted under the MHA if all four of the following criteria are met:
  a) suffers from a mental disorder that seriously impairs their ability to react appropriately to their environment, or to associate with others;
  b) requires psychiatric treatment in or through a designated facility;
  c) requires care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration, or for their own protection or the protection of others; and
  d) are not suitable as a voluntary patient.

FINANCIAL IMPLICATIONS

***Office of the Chief Scientific Advisor*:**

- A secondment agreement for $.30 million has been established with UBC to support Dr. Vigo's appointment as CSA. The agreement is for the period July 1, 2024, and June 30, 2025.
- On July 1, 2024, a shared cost arrangement in the amount of $1.0 million with Providence Health Care, Centre for Advancing Health Outcomes was established to support the work of the CSA.

Alouette Homes, Maple Ridge "Approved Home" Centre:

- In 2024/2025 Vancouver Coastal Health (VCH) was allocated $2.2 million and $0.09 million in one-time only start-up cost for the Unique Complexity Residential Tertiary project. Budget is supported by Federal Early Actions with notional allocations of $.2 million through to 2026/2027.
  - VCH funding proposal for the new Approved Home facility in Maple Ridge has repurposed the Unique Complexity Residential Tertiary allocation for 2024/2025.
- VCH requires an annual operating budget for 2025/26 of $5.7 million and $7.5 million for 2026/27 ongoing for Alouette Homes, Maple Ridge.
- VCH capital request includes $2.1M in 2025/2026 and $0.9M in 2026/2027[1].

Designated Mental Health Unit, Surrey Pretrial Correctional Center:

- PHSA's projected operational budget for the designated mental health facility within the Surrey Pre-Trial Correctional Centre is $2.6million for 2024/2025 and $9.9 million 2025/2026 ongoing. One-time capital of

[1] September 6, 2024, Email Communication, Bob Chapman, Vice President VCH

$0.5M is also requested for 2024/2025[2].

Other CSA Recommendations:

- The financial implications of addressing and/or scaling up all recommendations are currently being assessed.

LAST UPDATED

The content of this estimates note is current as of February 14, 2025, as confirmed by Robyn White.

APPROVALS

2025 02 27 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 07 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 24 – Darryl Sturtevant, ADM and a/Associate Deputy Minister

[2] September 13, 2024, Email Communication, Susan Wannamaker, Executive Vice President, PHSA

LEGISLATIVE SESSION – ESTIMATES NOTE
CORRECTIONAL SERVICES (INCLUDING COMMUNITY TRANSITION TEAMS)

Topic: Treatment and Recovery Services in Correctional Services, including Community Transition Teams

Key Messaging and Recommended Response:

- The treatment and supports people get in the weeks following release from a correctional centre are key for a safe transition back into community.
- Following release from prison, people, especially those with mental health and substance use challenges, are at increased risk of toxic drug poisoning.
- Community Transition Teams (CTTs) connect people to lifesaving mental health and substance use supports following their release from a correctional centre, and help people with a safe and successful transition back into the community during a very vulnerable period in their life.
- These teams, which are a responsibility of the Provincial Health Services Authority (PHSA), fill a critical gap to reduce the risk of toxic drug poisoning, and are an important part of our government's work to build a system of mental health and addictions care that works for everyone.
- Through new investments, each of BC's 10 provincial correctional centres now has a dedicated CTT to assist clients with safely transitioning into their communities.

CURRENT SITUATION

- PHSA is responsible for delivering health services in provincial correctional centres and offer primary, acute and trauma care, as well as mental health and addiction support.
- In the first three quarters of FY24/25, 41% of clients in BC Corrections were receiving OAT[1].
- As of October 2023, all 10 CTTs have been fully implemented.
- For Q1 and 2 of 2024/25[2] CTTs reported 877 unique clients served with a median wait time (from client referral and service initiation) of 5.5 days.
- In Q1, 49.16% and in Q2, 64.65% of clients were retained in service at 90 days.
- In Q1, 72.19% of and in Q2, 54.53% of clients were connected to health and/or community services and supports upon transition from service.

FINANCIAL IMPLICATIONS

The Ministry of Health provides $44.054 million in annual funding to PHSA to support the BC Correctional Health Services, including funding for Opioid Agonist Treatment.

KEY BACKGROUND

- People who are incarcerated are often in poorer health than the general population, and more likely to live with chronic conditions, including mental health and substance use disorders.
- In 2017, PHSA assumed responsibility for health services provided in BC correctional centres to ensure people receive the same quality of care as they would in the community.
- Correctional Health Services (CHS) offers access to OAT. This treatment uses medications to help people manage addiction and withdrawal symptoms. These medications might include Suboxone and methadone.
- If someone is already on OAT when they are admitted to a correctional centre, CHS ensures they can stay on their medication.
- CTTs provide comprehensive care coordination and peer support to clients with Opioid Use Disorder (OUD) to facilitate safe outcomes for those transitioning from correctional centres to the community. The goal is to provide seamless support and care for individuals at high risk of substance use harms or fatal overdose.
    - When an individual is about to be discharged, CHS via CTTs will help them transition safely to the community. CTTs will provide a prescription for the individual's OAT and connect them to a community physician so they can continue their treatment.

[1] Personal communication, February 14, 2025. Kam Parmar, PHSA.
[2] Performance Data, provided by PHSA on a quarterly basis.

- In 2018, PHSA established five CTTs (in Surrey, Prince George, Kamloops, Nanaimo and Maple Ridge) to support clients with an elevated risk of harms from the toxic drug supply when transitioning from correctional facilities.
- Through Budget 2021, the Province expanded this initiative to a total of 10 CTTs, serving people transitioning from all BC correctional centres (provincial correctional centres) and Tier 5 Mental Health and Substance Use facilities. This expansion also improved CTT services by:
    - Increasing the length of service offered from 30 days post release to 90 days.
    - Providing 7 days a week access and virtual support options.
    - Adding Indigenous patient navigator positions to better support Indigenous clients.
    - Standardizing care coordination through enhanced clinical and operational oversight and infrastructure.
    - Providing virtual specialized resources to teams working in communities.
- CTTs are comprised of social workers, nurses, peer support workers and Indigenous patient navigators who connect people with short-term substance use and mental health treatment, medication-assisted treatment, life-skills training, as well as psychiatric, clinical and social support.
- This is a voluntary service, and clients are not mandated by the courts or corrections to participate. Clients are triaged based on factors such as risk level and expected discharge from correctional services.

LAST UPDATED

The content of this estimates note is current as of February 13, 2025, as confirmed by Sarah Amyot, A/ED

APPROVALS

2025 02 25 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division
2025 03 11 – Ally Butler, A/Associate DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Crisis Response, Community-Led (CRCL) formerly Peer Assisted Crisis Teams (PACTs)

Topic: Civilian-led mobile mental health and substance use crisis response teams

Key Messaging and Recommended Response:

- When people are in crisis, they need quick compassionate support that meets them where they are at.
- That's why Government is expanding Crisis Response, Community-Led (CRCL) across the province.
- (CRCLs) are mobile mental health crisis response teams that provide an alternative to police-only crisis response for calls that do not involve violence or criminality. These teams help free up police resources to focus on crime.
- The team connects people to ongoing community services and supports.
- Currently, five CRCLs are supporting individuals in crisis, connecting them to services, while diverting calls away from police. In 2024, these teams responded to 5,882 calls and only 1.3% needed to be escalated to police.
- CRCLs are part of the Province's Safer Communities Action Plan.

CURRENT SITUATION

- Five CRCLs are currently operating in: North and West Vancouver, New Westminster, Victoria, Prince George and the Comox Valley. A sixth CRCL in Kamloops is planned to launch before the end of fiscal 2024/2025.
- The CRCLs are responding to calls with little need to involve police:
  - In 2024, the 5 operating CRCLs responded to a total of 5,882 calls.[1,2]
  - Of these, only 77 calls (1.3%) were escalated to police.[2]
- CRCLs receive positive feedback, including from police partners.
  - In January 2025, Prince George RCMP Superintendent Darin Rappel told local city council that the partnership between Prince George CRCL and RCMP was "very successful" and that in some instances it provided a "better service" to clients than what RCMP would typically be able to provide. He indicated that the CRCL's launch coincided with a decrease in mental health calls to the RCMP. [3]
- The Safer Communities Action Plan (November 2022) committed support to expand to a total of 12 CRCLs, including two Indigenous-led models.
- 3 of the 6 CRCLs are operated with local Indigenous partners: K'ómoks (pronounced: "co-mox") First Nation, Prince George Native Friendship Centre, and Kamloops Aboriginal Friendship Society (not yet launched).
- The Canadian Mental Health Association – BC Division (CMHA-BC) has renamed the PACT program to CRCL (pronounced "circle" – standing for Crisis Response, Community Led) on March 18, 2025.

FINANCIAL IMPLICATIONS

- Budget 2024 invested $30.3 million over 3 years to support CRCLs.

KEY BACKGROUND

- CRCLs are a civilian-led mobile crisis response model that respond over the phone and in person to people experiencing a mental health or substance use challenge or crisis.
- Teams consist of a trained peer (someone with lived and/or living experience of mental health or substance use challenges) and a mental health professional.
- CMHA-BC leads the implementation of CRCL in partnership with local non-profit operators:

[1] Note that this number includes in-person responses, and responses via text and phone.
[2] Quarterly reporting received from Canadian Mental Health Association, BC Division. January 28, 2025.
[3] City of Prince George. (January 13, 2025). *January 13, 2025, Council.* [Video] https://princegeorgebc.new.swagit.com/videos/325666. January 31, 2025.

- North Shore – CMHA North and West Vancouver (launched 2021)
- Victoria – AVI Health and Community Services (launched 2023)
- New Westminster – Lower Mainland Purpose Society (launched 2023)
- Prince George – Prince George Native Friendship Centre (launched 2024)
- Comox Valley – AVI Health and Community Services in relation with K'omoks First Nation (launched 2024)
- Kamloops – Kamloops Aboriginal Friendship Society and Ask Wellness (launching by end of 2024/25)

LAST UPDATED

The content of this estimates note is current as of February 7, 2025, as confirmed by Tricia Poilievre, Executive Director, Complex Care Housing and Community Initiatives.

APPROVALS

2025 03 05 – Francesca Wheler, ADM, Child, Youth, Indigenous Partnerships & Community Initiatives
2025 02 18 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 12 – Ally Butler, A/Associate DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Decriminalization

Topic: Decriminalization is one tool to support British Columbians in accessing life-saving health and social services.

Key Messaging and Recommended Response:

- Our communities are facing big challenges – people are dying from deadly street drugs, and we see the issues with public use and disorder on our streets.
- British Columbians want the same thing – for people and communities to be safe and secure, and for treatment to be available for those who need it.
- Our goal has always been to make it easier for people struggling with addiction to get the help they need, when and where they need it.
- Because addiction is a health matter, not a criminal justice one.
- Last May, our government reached an agreement with Health Canada to change the decriminalization rules to ban open drug use in nearly all public places.
- With these changes now in place, the Restricting Public Consumption of Illegal Substances Act is no longer needed, so it has now been repealed.
- Decriminalization still applies in specific places including private residences, designated health clinics (including overdose prevention sites and drug checking sites), and where people who are unhoused are legally sheltering. It is important that people feel comfortable to test their drugs and access lifesaving healthcare services without fear of arrest.
- We are going to keep doing everything we can to save lives, and build strong, livable communities where everyone is safe.

If asked if decriminalization is over:

- No, we have worked with Health Canada to change the rules to make it illegal to possess and use drugs in nearly all public spaces.
- Decriminalization was never about being able to use in public spaces – but it is critical that people feel able to come forward for help.
- We are maintaining decriminalization in specific spaces – while making it clear that public spaces are not places to use drugs - that we can continue to support people to come forward and ask for help.

CURRENT SITUATION

- On January 31, 2025, BC's S.56(1) exemption to remove criminal penalties for possession of small amounts of illegal drugs for personal use entered the final year of a three-year pilot project.
- The current version of the exemption, which came into effect on May 7, 2024, restricts possession and use in most public settings. The updates to the exemption were made in response to concerns raised by police, local governments, and some community members about public drug use. Under the new exemption, police have the tools they need to address these concerns.
- The Province continues to fulfill its obligations under Health Canada's Letter of Requirements. This includes:
    - Engagement with key stakeholders, including law enforcement, local governments, health authorities and Indigenous partners;
    - Monitoring and evaluation, including monthly narrative and quarterly data reports submitted to Health Canada, implementation evaluation and BC Centre for Disease Control-led (BCCDC) research with people who use drugs (PWUD);
    - Development of police training to support law enforcement in operationalizing the new exemption;
    - The *Building Relationships in Collaboration* (BRIC) grant program for Indigenous communities to support

building relationships with police.

FINANCIAL IMPLICATIONS

- Budget 2023 committed $15.6 million over three years to the Ministry of Health, of which
    - $1.9 million over three years is allocated for staffing, stakeholder engagement, public communications and education, and a third-party implementation evaluation.
    - $13.7 million over three years is allocated to the regional HAs and the First nations Health Authority to support resource card distribution and decriminalization FTEs. This also includes funding for harm reduction supplies for police (i.e. Naloxone), a drug checking pilot, and to support additional evaluation activities.
- PSSG received $3.26 million over three years for law enforcement readiness, including the development and implementation of police training and $1M over two years for BRIC grants.

KEYBACKGROUND

- In 2022, BC submitted a request to Health Canada for an exemption to the *Federal Controlled Drugs and Substances Act* (CDSA) to decriminalize personal possession of small amounts of illegal substances.
- Health Canada granted an exemption. On January 31, 2023, decriminalization came into effect in BC, allowing adults aged 18 and over to possess up to 2.5 grams of certain illegal substances with certain exceptions.
- Due to feedback from law enforcement and local governments about problematic public drug use and public disorder, on May 7, 2024, at the request of the Province, Health Canada issued a revised exemption.
- Under the new exemption, decriminalization remains in effect in the following settings:
    - Private residences;
    - Indoor and outdoor locations where unhoused individuals are legally sheltering;
    - Overdose prevention, drug checking and supervised consumption sites; and
    - Places that provide out-patient addiction services.
- Health Canada released an updated Letter of Requirements accompanying the new exemption. It details required activities related to health system and law enforcement implementation, engagement with the public, Indigenous partners and other stakeholders, monitoring and evaluation, and governance.
- Decriminalization and efforts to address public substance use have been the subject of multiple legal challenges, including an injunction preventing public substance use legislation from coming into effect and a federal judicial review of the federal government's decision to issue a new exemption.

LAST UPDATED

The content of this estimates note is current as of 2025-02-13 as confirmed by Chris Van Veen, Executive Director, Decriminalization and Strategic Initiatives.

APPROVALS

2025 02 26 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division
2025 03 21 – Ally Butler, a/Associate Deputy Minister

LEGISLATIVE SESSION – ESTIMATES NOTE

Diversion of Prescribed Alternatives

Topic: Diversion of Prescribed Alternatives

Key Messaging and Recommended Response:

- The toxic drug supply remains one of the most serious threats to public health, and prescribed alternatives are part of how our government is helping to keep people at risk of overdose alive – so they can connect to treatment and care.
- We know from some investigations that some prescription medications are being diverted into the illegal market.
- Our government is taking the diversion of prescription medication – including prescribed alternative medications – very seriously.
- That's why our government is strengthening safeguards to prevent the diversion of prescribed opioids and hold bad actors accountable for putting people and communities at risk.
- In February 2025, we modified the Prescribed Alternatives Program to require that the consumption of all PA medications must be witnessed by health professionals to ensure they are consumed by their intended recipient.
- This is being implemented immediately for new patients, and we are working with clinicians to transition existing patients to witnessed consumption as soon as possible.
- We are also investigating bad actor pharmacies and holding them accountable, pursuing criminal charges if needed, and we are fixing the fee structure for pharmacies to stop the misuse of the daily dispensing and witnessing fees.
- Our government continues to take action to expand access to treatment and connect people to the right supports. This includes launching the new Opioid Treatment Access Line and expanding the made-in-B.C. Road to Recovery model of care.
- Prescribed alternatives is only one part of this work to address the toxic drug crisis, and evidence shows it helps to keep people at the highest risk of overdose alive so they can stabilize their lives and connect to treatment and care.
- Our government's goal is to save lives, keep communities safe, and get people the care and treatment they need.

CURRENT SITUATION

- Some diversion of Prescribed Alternatives and opioid medications prescribed for other reasons is happening, and we are working to better understand its extent and impact.
    - Diversion can happen at points of the distribution chain and can involve individual patients, pharmacies, prescribers, and organized crime.
- On February 19, 2025, the Minister of Health announced that the Province will now require that the consumption of all prescribed alternatives medications be witnessed by health professionals to ensure medications are consumed by their intended recipient.
- BC Centre for Substance Use is developing clinical guidance to support transitioning existing patients to witnessed consumption. New patients will be required to have their consumption witnessed immediately.
- The Province has been monitoring and mitigating the risk of diversion since the inception of the PA program.
    - Clinicians are equipped with tools to monitor and address diversion, such as urine drug screens and witnessed dosing.
    - The Province supports the BC Centre on Substance Use to develop and maintain protocols for PA medications. These protocols include comprehensive direction for clinicians to address diversion.
    - Regulatory Colleges in BC, under the Health Professions Act, have the authority to audit and sanction practitioners that prescribe/dispense controlled substances to ensure safe, legal and ethical prescribing

practices.
    - In April 2024, the Province announced additional efforts to mitigate diversion, such as extending the Provincial Evaluation of the Implementation of PA, monitoring new incidences of opioid use disorder and fatal overdose, and establishing the Diverted Prescribed Alternatives Working Group.
- Analysis of the data we have so far indicates that there has been no increase in opioid use disorder since the PA program was introduced in 2020.

FINANCIAL IMPLICATIONS

- The Province annually allocates $8.87 million to support PA programs and PA prescribing.

KEY BACKGROUND

- Concerns about whether PA medications are being diverted, shared, or stolen and sold illegally have been raised in the media since the program was created.
- PA is a critical component of the continuum of substance use care, supporting clients at risk of harms or death to separate from the toxic illicit drug supply by prescribing pharmaceutical-grade alternatives.
- PA is delivered through a medical model. Medications can only be prescribed by a physician or nurse practitioner after a clinical assessment is completed to ensure the person is right for the program.
- PA was initiated in 2020 with the *Risk Mitigation Guidance* (RMG), released by the BCCSU in partnership with the Province. In 2021, the Province released *Access to Prescribed Safer Supply in British Columbia: Policy Direction*, which builds upon the RMG. Both of these documents have now been retired.
- Evidence shows that PA is helping keep people at the highest risk of drug poisoning alive, so they can stabilize their lives and connect with care and treatment. A peer-reviewed study[1] in the British Medical Journal published in January 2024 found that opioid PA dispensations were associated with a 61 percent reduction in death, and a dispensation for four or more days was associated with a 91 percent reduction in death in the subsequent week.[2]
- People may divert medications to obtain a substance that better meets their needs; to share with others who do not have access to reduce their risk or alleviate their withdrawal symptoms; and to obtain basic needs like food and shelter. Some diversion occurs involuntarily due to coercion or theft.
- In the month of December 2024, 3,892 people were dispensed any PA (opioids, stimulants, benzodiazepines). The number of clinicians prescribing any PA in December 2024 was 699.[3]
- Co-prescribing opioid PA and opioid agonist treatment (OAT) is common practice in BC and helps patients adjust to OAT more quickly and maintain engagement with OAT.
    - In December 2024, 3,055 people received a dispensation of OAT and opioid PA in the same month.[4]
    - This represents 83.4 percent of people that received an opioid PA in December 2024.[5]

LAST UPDATED

The content of this estimates note is current as of February 21, 2025, as confirmed by Evan Howatson, Executive Director, Overdose Emergency Response.

APPROVALS

2025 03 03 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 07 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 21 – Darryl Sturtevant, ADM & a/Associate Deputy Minister

[1] Slaunwhite A, Min J E, Palis H, Urbanoski K, Pauly B, Barker B et al. Effect of Risk Mitigation Guidance for opioid and stimulant dispensations on mortality and acute care visits during dual public health emergencies: retrospective cohort study *BMJ* 2024; 384 :e076336 doi:10.1136/bmj-2023-076336

[2] Slaunwhite A, Min J E, Palis H, Urbanoski K, Pauly B, Barker B et al. Effect of Risk Mitigation Guidance for opioid and stimulant dispensations on mortality and acute care visits during dual public health emergencies: retrospective cohort study *BMJ* 2024; 384 :e076336 doi:10.1136/bmj-2023-076336

[3] BCCDC Unregulated Drug Poisoning Emergency Dashboard. http://www.bccdc.ca/health-professionals/data-reports/substance-use-harm-reduction-dashboard

[4] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting, February 27, 2025

[5] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting, February 27, 2025

LEGISLATIVE SESSION – ESTIMATES NOTE

Drug Checking

Topic: Overview of drug checking services in BC.

Key Messaging and Recommended Response:

- The toxic drug crisis continues to devastate families and communities.
- Over the past few years, this public health emergency has worsened dramatically and become more complex due to the unpredictability and increased toxicity of the unregulated drug market.
- That's why the province has invested in critical lifesaving services such as drug checking throughout BC.
- Drug checking lets people know what is in their illicit substances they have purchased so they can make informed decisions about whether to take it or not and how much of the substance to take.
- Drug checking also helps to connect people to other community support and health services.
- There are over 100 drug checking sites in BC where people can drop off drug samples.

CURRENT SITUATION

- As of December 31, 2024, there are 113 sites where people can drop off drug samples, 48 of which offer point-of-care testing with an Fourier Transform Infrared Spectrometry (FTIR) spectrometer at least one day per week.
- In 2024, these sites analyzed more than 49,000 drug samples.
- Most drug checking in BC is done with FTIR technology. All drug checking services also incorporate fentanyl test strips.
- Fentanyl test strips are available through harm reduction services/sites across BC, including for take-home use.
- Budget 2024 included funding to sustain health authority-led regional drug checking operations, ensuring the long-term durability of these life-saving services, and supporting initiatives to improve access and reporting.
- Budget 2024 also provided funds to support new First Nations Health Authority drug checking programs.
- University of Victoria-Substance and Vancouver Island University have partnered to provide drug checking using a Paper Spray Mass Spectrometer (PS-MS). This provides higher-level testing for point-of-care clients in Victoria, as well as confirmatory testing for samples submitted from across BC.
- This technology detects substances at lower concentrations, helping to identify novel adulterants and identify risks associated with high-potency drugs.
- The Province has engaged key partners to deliver BC's drug checking program i.e., UVic-Substance (PS-MS testing, client results portal), the BC Centre for Substance Use (training, quality assurance) and the BC Centre for Disease Control (BCCDC) (reporting and surveillance).
- The Province has funded UVic-Substance to develop a provincial client results portal, making it easier for clients across BC to view their drug checking results and connect with complementary health services.
- The Province has funded BCCDC to develop a provincial surveillance dashboard, making it easier for health system planners to identify emerging trends in the illicit drug supply, issue timely alerts and adjust services. This provincial dashboard is anticipated to come online in late 2025.

FINANCIAL IMPLICATIONS

- Budget 2024 provided $15.7 million over three years to sustain drug checking services.
- Budget 2024 built on the Budget 2017 investment of $3.0 million over three years.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

Section 56 UPHNS Exemption

- In April 2020, a Section 56 class exemption under federal *Controlled Drugs and Substances Act*, enabling "Urgent Public Health Need Sites" (UPHNS) was issued to BC. In June 2021, Health Canada amended the UPHNS class exemption to allow service providers to collect, store, and transport illicit drug samples for drug checking.
- Regional Medical Health Officers approve all UPHNS exemptions, following provincial guidelines.
- The UPHNS exemption expires on September 30, 2025,

Intergovernmental Communications

Drug Checking Statistics and Trends

- In 2024, 49,204 drug samples were checked using analytical instruments in BC, compared to 47,574 in 2023.
- In December 2024, BCCSU drug checking found the median fentanyl concentration of all opioid samples was 17.6%, compared to 16.7% in December 2023.
- Also in December 2024, 48.7% of opioids tested positive for benzodiazepines, compared to 54.6% in December 2023. These results fluctuate month to month.

LAST UPDATED

The content of this estimates note is current as of February 19, 2025, as confirmed by Evan Howatson.

APPROVALS

2025 03 13 – Darryl Sturtevant, ADM, Mental Health and Substance Use Policy
2025 02 26 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division
2025 03 14 – Ally Butler, A/Associate DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Drug User Liberation Front (DULF)

Topic: Co-founders facing federal charges for the operation of an illicit compassion club in Vancouver Downtown Eastside (DTES).

Key Messaging and Recommended Response:

- Ensuring the voices of people with lived/living experience is important and is incorporated into government's work to address the toxic drug crisis.
- Our expectation is that peer organizations follow the law. Procuring and distributing illicit drugs is illegal.
- Upon learning of the Drug User Liberation Front's (DULF) activities, the Province took swift and decisive action to end all contracts with drug-user groups engaging in compassion clubs, in May 2024.
- Government continues to engage with people with lived/living experience and drug user groups to ensure front-line toxic drug services are working for the people they intend to serve.

CURRENT SITUATION

- On May 31, 2024, Jeremy Kalicum and Eris Nyx, co-founders of the DULF, were each charged with **three counts of possession for the purpose of trafficking** under the *Controlled Drugs and Substances Act*.
- DULF's legal team (Pivot Legal Society) have filed a **constitutional challenge** arguing that criminalizing their safe supply program violates **Section 7** of the *Charter of Rights and Freedoms* by forcing people to rely on the toxic drug supply.
- DULF has received some public support, crowdfunding and endorsements, and through their constitutional challenge aim to set legal precedent for non-medical models of safe supply.
- Kalicum, Nyx and Dr. Thomas Kerr (UBC) continue to publish research on the impacts of their compassion club in reducing risk of overdose and death in BC.

Advice/Recommendations; Government Financial Information

KEY BACKGROUND

LEGISLATIVE SESSION – ESTIMATES NOTE

- In **February 2019,** the BC Centre for Substance Use (BCCSU) published a white paper detailing how a compassion club model could help reduce opioid overdose deaths[1].
- DULF was established in **2020** as a drug user group aimed at reducing harms associated with the toxic illicit drug supply.
- In **2021**, DULF submitted a request to Health Canada for a Section 56 exemption to purchase pharmaceutical-grade substances for supervised sales, with support from BCCSU, Vancouver Coastal Health (VCH), the University of British Columbia, and the City of Vancouver, among others. That request was denied in 2022.
- In **2022,** DULF partnered with the Vancouver Area Network of Drug Users (VANDU) to establish a compassion club. They purchased illicit drugs off the internet, sent them for testing to confirm their contents, and distributed them to its approximately 50 members at below-market cost.
- DULF worked with BCCSU to design an evaluation framework for the compassion club and in **September 2023** released findings from the first year of operation, which found participation in the club was associated with decreased instances of overdose, hospitalization, and negative police interactions. This evaluation was funded through a Canadian Institutes for Health Research (CIHR) grant, which did not pay for the operations of DULF, only the scientific evaluation.
- On **October 25, 2023,** the Vancouver Police Department Vancouver police arrested DULF co-founders after executing search warrants on the DULF office and their homes.
- On **October 31, 2023,** due to DULF's admitted transactions on the illicit market, contracts held with VCH (drug-checking, overdose prevention training & other harm reduction services) and the Province (Provincial Peer Network funding) were terminated. Funding for Kootenay Independent Safe Supply Society (KISSS) was also revoked upon discovery of operating a model similar to DULF.
- In **December 2023**, DULF's legal team at Pivot Legal Society filed a Charter challenge related to the federal *Controlled Drugs and Substances Act* and Health Canada's decision not to grant an exemption to the compassion club.
- In **February 2024,** published scientific evaluation findings of the DULF compassion club model reported reductions in non-fatal overdoses, suggesting that enrollment in DULF's intervention likely decreased overdose rates.
- On **May 31, 2024**, the Public Prosecution Service of Canada formally charged both individuals with three counts each of possession for the purpose of trafficking.
- **In January 2025**, DULF released new findings from their ongoing evaluation indicating a 49% decrease in non-fatal drug poisonings and nearly 60% reduction in incidents requiring naloxone administration among participants of the unsanctioned compassion club.

LAST UPDATED

The content of this estimates note is current as of February 21, 2025, as confirmed by Evan Howatson.

APPROVALS

2025 03 07 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 21 - Darryl Sturtevant, ADM & a/Associate Deputy Minister

[1] Heroin Compassion Clubs. (2019). *BC Centre on Substance Use*. Available at: https://www.bccsu.ca/wp-content/uploads/2019/02/Report-Heroin-Compassion-Clubs.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

First Nation Treatment Centres

Topic: Under a Tripartite Memorandum of Understanding, BC, Canada, and the First Nations Health Council, through the First Nations Health Authority (FNHA), have provided funding to replace six existing First Nation-run treatment centres and build two new ones throughout BC.

Key Messaging and Recommended Response:

- The toxic drug crisis continues to have a disproportionate impact on Indigenous Peoples in BC.
- To address this, our government has made unprecedented investments to support Indigenous-led mental health and wellness programs that provide culturally safe care.
- This includes renovating six and building two new First Nations-run treatment centres that incorporate traditional healing practices.
- The treatment centres are progressing, with the Tsow-Tun-Le-Lum Society Helping House Centre open in Duncan and both the NAMGIS Treatment Centre in Alert Bay and Seven Nations Soaring Eagle Treatment Centre in Creston scheduled to be completed this year. Of the remaining five centres, two are in the construction phase, two are in the design phase and one is in the feasibility phase.
- The Province remains committed to supporting the implementation of these projects, and to expanding access to treatment and recovery services for Indigenous Peoples throughout BC.

CURRENT SITUATION

- FNHA manages the contribution agreements with each of these First Nations-led projects.
- Treatment Centre projects are in various phases of capital construction. Ministry staff participate in several working groups alongside project partners including First Nations, Indigenous-led organizations, regional health authorities and other interested parties to guide the development of each project.
- The most recent status update from the FNHA (February 2025) on the Treatment Centres is as follows:
  - Seven Nations Soaring Eagle Treatment Centre (Creston) is currently in the construction phase. Construction commenced in September 2024 and target completion is December 31, 2025. It is estimated to yield 16 beds.
  - Carrier Sekani Family Services Treatment Centre (Tachick Lake) currently has seasonal bed-based treatment available May to October (land-based setting), while outreach occurs the rest of the year. It is currently in the construction phase and the target completion is Advice/Recommendations with a possibility of being completed Advice/Recommendations Through various sources of funding and partnership, it is estimated there will be 36 treatment and supportive recovery beds, and 10 withdrawal management beds for a total of 46 beds.
  - Katzie First Nation Treatment Centre (Maple Ridge) is a new build in the design phase. Construction is scheduled to start Advice/Recommendations and target completion is Advice/Recommendations . It is estimated to yield 20 beds. Intergovernmental Communications

    Intergovernmental Communications
  - Namgis Treatment Centre (Alert Bay) is currently in the construction phase, and the target completion is Advice/Recommendations It is estimated to yield 16 beds.
  - North Wind Treatment Centre (Pouce Coupe) is currently in the construction phase, and target completion is Advice/Recommendations Through various sources of funding and partnership, it is estimated there will be 10 withdrawal management beds: 10 treatment beds; 40 housing units; and a Recovery Community Centre for outpatient services.
  - Intergovernmental Communications

- Intergovernmental Communications

  - Tsow-Tun-Le-Lum Society - Helping House Centre (Duncan) is complete and has 20 FNHA and MOU funded beds. Since intake began in January 2024, 71 participants have completed the Stabilization program, 201 have completed the 6-week intensive Thuy Na Mut substance use program, and 86 have completed the five-week Kwunatsustul second stage (trauma) program.
- BC is directly supporting some other First Nations Treatment Centre projects through its Indigenous Treatment, Recovery and Aftercare Services Program (See Indigenous Fund estimate note for more information).

FINANCIAL IMPLICATIONS

- As per the commitments in the MOU, each Tripartite partner committed $20 million in funding to replace six existing First Nations treatment facilities and to build two new facilities. Of the $60 million in total, the Province committed $20 million in funding to complete these projects.
- The Province provided one-time funding of $35 million in 2023/24 to FNHA to address the capital costs overrun for community based Indigenous treatment funds.[1]

KEY BACKGROUND

- In 2018, the First Nations Health Council (FNHC), the Government of Canada and the Province signed the *Memorandum of Understanding: Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* ('the MOU'). The MOU is to establish a new and more flexible funding approach that enables First Nations to plan, design, and deliver a continuum of mental health and wellness services.
- As per commitments in the MOU, the FNHA developed the First Nations Treatment Centre Investment Plan, which outlined an approach and an estimated capital investment need of $60 million to replace six existing National Native Alcohol and Drug Abuse Program treatment facilities and build two new facilities. This investment was intended to fully cover capital construction costs for the projects. Each partner committed $20 million in funding to complete these projects.
- Construction costs have risen steeply over the course of the pandemic beyond anticipated contingency funds (39% increase). Additionally, FNHA has identified that new building code requirements resulting from COVID-19 Infection Control Measures have had a significant impact on project costs (5% increase in project cost for infection prevention and 16% increase in cost for additional site servicing requirements attributable), including reduced occupancy loads (number of occupants in bedrooms), increased HVAC requirements, increased space to meet WorksafeBC standards – change rooms, lockers and showers for staff, etc. The estimated overall shortfall for all eight projects is $35 million.

LAST UPDATED

The content of this estimates note is current as of March 11, 2025 as confirmed by Kelly McConnan, Executive Director of Child & Youth Mental Health Substance Use Policy.

APPROVALS

2025 03 11 – Francesca Wheler, ADM, Child, Youth, Indigenous Partnerships & Community Initiatives
2025 03 12 – Ally Butler, A/Associate DM, Mental Health and Addictions

[1] Ministry of Mental Health and Additions. (2024, July 16). *Province helps more people access Indigenous-led addictions treatment. BC Gov News*. https://news.gov.bc.ca/releases/2024MMHA0036-001116.

LEGISLATIVE SESSION – ESTIMATES NOTE

Foundry

Topic: Expansion of Foundry Integrated Youth Services

Key Messaging and Recommended Response:

- Foundry is undergoing its largest expansion of in-person and virtual services to date with nearly $75 million committed in Budget 2023 to expand access to Foundry youth centres throughout the province.
- Foundry centres provide a welcoming and judgement-free place for young people aged 12-24 and their families to connect to free and confidential health, mental health, addiction care and social supports in one convenient location.
- There are 17 Foundry centres open across the province, with an additional 18 centres in development. In addition, people can access virtual services using an app anywhere in BC.

CURRENT SITUATION

- Foundry is undergoing its largest expansion of in-person and virtual services to date, through Budget 2023 investments of $74.900 million over three years.
- Currently, there are 17 Foundry centres open throughout the province in Vancouver-Granville, North Shore (North Vancouver), Campbell River, Abbotsford, Ridge Meadows, Kelowna, Prince George, Victoria, Penticton, Terrace, Comox Valley, Langley, Richmond, Cariboo-Chilcotin (Williams Lake), Sea to Sky (Squamish), Port Hardy and East Kootenay (Cranbrook).
- In addition, 18 new Foundry centres are in development in Burns Lake, Surrey, Fort St. John, Tri-Cities, Kamloops, Sunshine Coast, Vernon, qathet (Powell River), Burnaby, Chilliwack, Snuneymuxw (Nanaimo), Port Alberni, Quesnel, Vancouver, Kootenay Boundary, Vanderhoof, Sooke-West Shore, and South Surrey.
    - Foundry Surrey is anticipating a summer 2025 opening and Foundry Burns Lake is expected to open in fall 2025.
    - Foundry Kamloops and Foundry Tri Cities are expected to open in 2026.
    - The remaining centres will open in a phased approach, with all centres expected to open by the end of 2027.
    - On average, it can take 18 months to three years to open a Foundry centre, though this can vary depending on such factors as site identification, construction labour availability, etc.
- Through Budget 2023, the Foundry virtual platform is being integrated with each Foundry centre to improve service accessibility by enabling both in-person and virtual services to be scheduled via the app. This will also improve data collection across the Foundry network, to ensure services are supporting positive outcomes for young people.
    - To date, the virtual platform has been integrated with the Richmond, Cariboo-Chilcotin, Port Hardy, East Kootenay, and Sea to Sky Foundry centres.

FINANCIAL IMPLICATIONS

- Through Budget 2023, the Ministry of Health (HLTH) is providing $74.900 million over three years to enhance Foundry services. This includes the addition of 12 new Foundry centres (current Phase 5 expansion), increased operating support to deliver services at existing centres, and enhancements to the Foundry BC app.
- Funding is provided to Foundry Central Office (FCO) through Vancouver Coastal Health Authority and Providence Health Care (PHC), which includes:
    - One-time funding for the establishment of each new centre – funding varies by phase of development, with Phase 5 centres receiving $1.5 million towards the establishment of each new centre, and
    - $1 million per centre per year, which supports operations once a centre is open.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Foundry, a program of PHC, was created in 2015 with funding from the Province and philanthropic organizations.
- Foundry is a provincial network of in-person centres and virtual supports, offering young people ages 12-24 and their families integrated primary care, mental health supports, substance use services, youth and family peer support, and social services in one convenient location.
- The first Foundry centre opened in 2015 in Vancouver. Expansion followed in 2016-2018 with 10 more centres (Phase 1 and Phase 2 expansion), 2019/20 with eight new centres (Phase 3 expansion/Budget 2019), and in 2021 with four more centres (Phase 4 expansion). Phase 5 expansion is currently underway, through Budget 2023 investments.
- Communities are selected to host a Foundry centre through an open application process which is followed by reviews by youth and families, focusing on organizational and community alignment with the Foundry service model, as well as readiness with respect to organizational and partnership capacity.
- 16,047 young people accessed Foundry services in fiscal year 2023/24.
    - 14,317 young people accessed services in-person at Foundry centres
    - 1,876 young people accessed Foundry Virtual BC
- Each Foundry centre is operated by a lead agency that works with local partners to support service integration including health authorities, Ministry of Children and Family Development and Ministry of Social Development and Poverty Reduction partners, local divisions of family practice, Indigenous organizations, school districts, and local youth-serving nonprofit organizations.
- HLTH is the provincial lead on Foundry, working with FCO (the backbone organization for Foundry), PHC, and cross-ministry partners to ensure Foundry aligns with the Province's strategic direction as its primary funder.

LAST UPDATED

The content of this estimates note is current as of February 12 as confirmed by Kelly McConnan.

APPROVALS

2025 03 11 – Francesca Wheler, ADM, Child, Youth, Indigenous Partnerships and Community Initiatives
2025 03 12 – Ally Butler, A/Associate DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Indigenous Fund

Topic: Budget 2023 investment for Indigenous-led treatment, recovery, aftercare services, and supports.

Key Messaging and Recommended Response:

- Indigenous communities in British Columbia continue to be disproportionately impacted by the toxic drug crisis. The impact on Indigenous peoples has been exacerbated by both historical and recent trauma including the global pandemic, climate emergencies, and the discovery of unmarked graves at the sites of former residential schools.
- In response, the Province established an Indigenous Fund through Budget 2023 from which unprecedented investments were dedicated to support the mental health and wellness of Indigenous peoples, including focused efforts to resource Indigenous-led treatment, recovery, and aftercare services and supports.
- Through the Indigenous Fund, the Ministry continues to work with BC First Nations, regional Health Authorities and First Nations Health Authority, Métis Nation BC, and community service providers to advance strategic, Indigenous-led mental health and wellness initiatives in areas of critical need across the province.

CURRENT SITUATION

- The Indigenous Fund is a strategic program aimed at empowering Indigenous communities to design, plan, and deliver self-determined models of mental health and wellness care. While helping to address the alarming increase in toxic drug deaths among Indigenous peoples, the program also seeks to enhance cultural and land-based healing modalities, along with Indigenous-led substance use treatment, recovery, and aftercare facilities and services.

Indigenous Fund – Announced Major Projects

- In June 2024, Orca Lelum Youth Wellness Centre in Lantzville began offering culturally appropriate, Indigenous-led bed-based treatment services to cohorts of up to 10 Indigenous youth aged 12-18 years. Orca Lelum is a first-of-its-kind wellness centre for Indigenous youth on Vancouver Island, and once fully operational, is anticipated to open an additional 10 beds, dedicated to youth detox and treatment.
- In July 2024, the We Wai Kai Nation, began converting its former Tsakwa'lutan resort on Quadra Island into a new healing centre dedicated to helping people struggling with addiction. Facility renovations are currently nearing completion and once fully operational, staff at the centre will offer medical, cultural and healing services for as many as 40 people at a time. The centre is expected to operate 20 adult treatment beds initially, which will prioritize service for Indigenous adults.
- To address critically needed, culturally safe treatment and addictions supports in the Northwest region of BC, the Province is supporting the Northwest working group , to develop and implement new services and supports for Indigenous people. The working group, comprised of members from the Northern First Nations Alliance, Northern Health Authority, First Nations Health Authority (FNHA), and the HTLH, is developing solutions for phased implementation of new treatment and recovery services in the Northwest.
- In FY 2023/24, the Province provided $675,000 via the Indigenous Fund to support Lheidli T'enneh First Nation's regional engagement and coordination efforts for a northern Centre of Excellence for Children in Youth, anticipated near Prince George, BC. HLTH has subsequently committed an additional $500,000 to support the development of a more detailed feasibility plan included service design.

Indigenous Fund – Allocated Support for Unannounced Initiatives

- Intergovernmental Communications

LEGISLATIVE SESSION – ESTIMATES NOTE

Intergovernmental Communications

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Indigenous Fund – Grant Program Partnership with Community Action Initiative (CAI)

- The Ministry, along with the CAI and the First Nations Health Authority, is supporting 11 First Nations, Métis, Inuit and urban Indigenous-led organizations providing bed-based treatment and recovery services with one-time funding of $25,000 each.
- The grants help organizations expand and improve their treatment and recovery services by supporting investments in programming supplies, equipment, technology, enhanced staffing, staff training, resident resources and other initiatives that support long-term service improvements.
- In the summer of 2025, First Nations, Métis, Inuit and urban Indigenous-led organizations providing bed-based treatment and recovery services will have a second opportunity to apply for one-time funding of $25,000.

FINANCIAL IMPLICATIONS

- Intergovernmental Communications

KEY BACKGROUND

- The Indigenous Fund is intended to result in new culture-based treatment, and mental health and wellness services delivered through First Nations communities; Métis Nation BC; and Indigenous-serving organizations. The program approach aligns with the flexible funding intentions outlined in *A Pathway to Hope* and supports Indigenous self-determination by resourcing Indigenous-designed and Indigenous-delivered models of care.
- Design of the Indigenous Fund was informed by numerous engagements undertaken by the Province to-date, including (but not limited to): A Pathway to Hope (2019); In Plain Sight (2020); Adult Substance Use System of Care Framework (2022); Declaration on the Rights of Indigenous Peoples Act Action Plan (2022); and direct engagement with communities through BC Cabinet-First Nations Leadership Gathering events (2017-ongoing). As well, the Ministry continues to engage regularly with key service delivery partners, and Indigenous-led organizations such as the First Nations Health Authority and Métis Nation BC.
- In keeping with *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care*, the Ministry, through the Indigenous Fund, is working to support cross government and health authority action on recommendation 17 to increase access to culturally safe mental health, wellness, and substance use services, including harm reduction.

LAST UPDATED

The content of this estimates note is current as of February 13, 2025 as confirmed by Kelly McConnan.

APPROVALS

2025 03 11 – Francesca Wheler, ADM, MHA: Child, Youth, Indigenous Partnerships, and Community Initiatives
2025 02 26 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division
2025 03 12 – Ally Butler, A/Associate DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Indigenous Peoples – Toxic Drug Crisis and FNHA Response

Topic: The Ministry collaborates with the First Nations Health Authority to help ensure provincially funded responses support First Nations, who are disproportionately impacted by the toxic drug crisis.

Key Messaging and Recommended Response:

- First Nations people continue to be disproportionately represented in drug poisoning events and toxic drug deaths. This is particularly true for First Nations women.
- The Ministry remains committed to working with First Nations Health Authority (FNHA) to support initiatives addressing the key action areas within FNHA's Toxic Drug Emergency Response Framework:
    - Prevent people who experience drug poisoning from dying
    - Keep people safer when using substances
    - Create an accessible range of treatment options
    - Support people on their healing journeys
- The Ministry continues to build a seamless system of care and expand support for Indigenous-led mental health and addictions care, including early intervention and prevention services, harm reduction supports, treatment and recovery services and more.

CURRENT SITUATION

The Ministry has supported FNHA to address key actions identified within FNHA's Toxic Drug Emergency Response Framework[1] through implementation of new and ongoing programs and initiatives, including:

- Implementation of certified practice for opioid use disorder (CP-OUD), enabling certified registered nurses and registered psychiatric nurses to provide OUD care, including prescribing opioid agonist treatment (OAT).
- From December 1, 2023, to November 30, 2024, 18 harm reduction education sessions through Not Just Naloxone training were held and 354 health care workers, youth, Elders, and community champions were trained.[2]
- Between January and June 2024, 2,415 nasal naloxone kits were distributed to 51 First Nations Communities.
- Renovation of six First Nations-run treatment centres throughout British Columbia, and two new builds.
- Support for Land Based Healing initiatives across 81 sites, supporting 147 communities in FY2023/24.
- The FNHA is working with partners to establish First Nations-focused overdose prevention sites (OPS) and mobile harm reduction services[3]:
    - In the Fraser Salish region, the FNHA partners with Cheam First Nation and Fraser Health to implement the first of its kind OPS in the Cheam First Nation community;
    - FNHA has funded Nuu-Chah-Nulth Tribal Council for a harm reduction mobile van to provide outreach with expanded service hours; services will include drug testing; accessing harm reduction supplies; assisting with detox/treatment application; and cultural support uplifted with additional elders and peers; and,
    - The FNHA has coordinated with the Western Aboriginal Harm Reduction Society to open an episodic OPS in the Downtown Eastside and is working on identifying other sites in BC for these projects, to be known as Raven's Eye Sage Sites.
- Development and maintenance of a harm reduction hub – a centralized service for community workers and healthcare providers with easy access to harm reduction services and supplies.

[1] *A Framework for Action: Responding to the Toxic Drug Crisis for First Nations.* Retrieved February 2, 2025, from: https://www.fnha.ca/Documents/FNHA-Overdose-Action-Plan-Framework.pdf

[2] Toxic Drug Crisis Events and Deaths: FNHA Response. *Community Situation Report December 2024*. Retrieved February 27, 2025 from: https://www.fnha.ca/Documents/FNHA-Toxic-Drug-Poisonings-Community-Situation-Report-December-2024.pdf.

[3] Toxic Drug Crisis Events and Deaths: FNHA Response. *Community Situation Report December 2024*. Retrieved February 27, 2025 from: https://www.fnha.ca/Documents/FNHA-Toxic-Drug-Poisonings-Community-Situation-Report-December-2024.pdf

- Investment in new and expanded youth substance use services within FNHA, through Budget 2023.
- The Ministry is working with FNHA on an Indigenous Treatment, Recovery and Aftercare Services Program (see Indigenous Fund estimates note for further information).

FINANCIAL IMPLICATIONS

- Budget 2024 provides an investment of $15.670 million over three years to sustain Drug Checking services, bringing government's total base budget for Drug Checking to $18.670 million over three years. This investment includes $660,000 over three years for First Nations Health Authority to establish capacity building and innovation seed funding for drug checking services to reach more First Nations communities.
- Through Budget 2023, the Ministry provided $3.584 million over two years to FNHA for new and expanded youth substance use services.
- In 2019, the Province provided $20 million (matched by FNHA totaling $40 million) to build and revitalize First Nations-run treatment centres across the Province. Federal budget 2021 provided an additional $20 million from the Government of Canada to support this initiative, for a combined total allocation of $60 million.[4] The Province committed one-time top-up funds of $35 million in 2023/24 to address capital costs overrun.
- In 2018, the Province, the Government of Canada and the FNHA committed $10 million each, for a total of $30 million, to support the implementation of the Tripartite Mental Health and Wellness MOU. An additional one-time allocation of $5 million was provided by the Province in March 2023.
- In FY 2024/25 the Ministry provided FNHA with $10.75 million to support Land Based Healing
- In FY 2024/25 Ministry provided $0.69 million to support implementation of nurse OAT prescribing.
- In FY 2024/25, Ministry provided $4.54 million toward Mental Health and Addictions Care to support FNHA's toxic drug emergency response.

KEY BACKGROUND

- Between January and June 2024, First Nations people died from toxic drug poisoning at 6.7 times the rate of other BC residents during the same time period. This number has grown from 6.0 during the same period in 2023.[5]
- While First Nations people represented 3.4% of the population in BC between January 1, 2022, and December 31, 2024, 21.1% of all paramedic-attended drug poisoning events during that time were supporting First Nations people, and First Nations people represented 17.9% of toxic drug deaths in that period.[6]

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Kelly McConnan.

APPROVALS

2025 03 02 – Darryl Sturtevant, Assistant Deputy Minister, Mental Health and Substance Use Policy
2025 03 24 – Francesca Wheler, Assistant Deputy Minister, CYIPCI
2025 02 26 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

[4] Indigenous Services Canada. (2021, August 14). *Government of Canada highlights funding for Indigenous communities to support critical infrastructure*. Retrieved February 2, 2025 from: https://www.canada.ca/en/indigenous-services-canada/news/2021/08/government-of-canada-highlights-funding-for-indigenous-communities-to-support-critical-infrastructure.html

[5] First Nations Health Authority Semi-Annual Data Report. *First Nations and the Toxic Drug Poisoning Crisis in BC.* January – June 2024. Retrieved February 2, 2025 from: https://www.fnha.ca/Documents/FNHA-First-Nations-and-the-Toxic-Drug-Poisoning-Crisis-in-BC-Jan-June-2024.pdf . *Note: Surveillance data includes only status First Nations people and their status-eligible descendants. Additionally, data is limited to biological sex at birth, which may misidentify two-spirit, transgender, non-binary, intersex and gender diverse people.

[6] Toxic Drug Crisis Events and Deaths: FNHA Response. *Community Situation Report December 2024*. Retrieved February 27, 2025 from: https://www.fnha.ca/Documents/FNHA-Toxic-Drug-Poisonings-Community-Situation-Report-December-2024.pdf.*Note: FNHA utilizes the term "drug poisoning" rather than "overdoses" to emphasize the contamination and inherent danger within the unregulated drug supply, acknowledging the risk to users who may unknowingly consume toxic substances.

LEGISLATIVE SESSION – ESTIMATES NOTE

Integrated Child and Youth Teams

Topic: Implementation of Integrated Child and Youth Teams

Key Messaging and Recommended Response:

- The toxic drug crisis continues to have a devastating impact on individuals and families, including youth, across the country and throughout BC.
- Our focus continues to be on wellness promotion, prevention, and early intervention, so we can stop small problems from becoming bigger down the road.
- That's why the Province is expanding Integrated Child and Youth Teams (ICY) to school district communities across the province, making it easier for young people to connect to the care they need.
- These teams deliver wraparound mental health and substance use services and supports for children and youth ages 0-19 years – with flexibility to continue care up to 21 years old.
- ICY Teams are unique in that members coordinate with each other and take on the responsibility of system and service navigation so that children/youth and families/caregivers can access appropriate services earlier, minimizing repeated storytelling.
- ICY Teams provide services in flexible community settings (e.g. park, coffee shop, etc.), work closely with schools, early years services, and primary care, and connect children and youth to specialized and higher intensity services when needed.
- There are currently 39 ICY teams operating or being implemented in 20 school districts across British Columbia.

CURRENT SITUATION

- ICY Teams are a multidisciplinary wraparound approach to child and youth mental health and substance use services. There are currently 39 ICY teams operating or being implemented across 20 school district communities (Phases 1, 2, and 3). Each community has between 1 and 6 teams.
- ICY Teams are implemented through a partnership between the ministries of Health, Children and Family Development, and Education and Child Care. The Ministry of Health (HLTH) is the lead partner and supports ICY Teams through the Provincial Support Office. Leadership and oversight are provided across ministries. HLTH works with partners to support the three key employer organizations to oversee core team members:
    - MCFD (CYMH clinicians and FamilySmart under contract for family peer support workers)
    - School Districts (Ministry of Education and Child Care) (School-based Clinical Counsellors and peer support workers), and
    - Health Authorities (Ministry of Health) (Youth Substance Use or Concurrent Disorder Clinicians, ICY program leaders, and administrative support).
- All of Phase 1 and Phase 2 communities (12 total) are currently operational, providing services to children, youth, and families. Phase 3 communities are in early stages of implementation.
- ICY Teams provided services to an average of 1,447 children/youth per month across the Phase 1 (first 5) communities. More recent data on the number of youth being served by Phase 1 and 2 communities is currently being collected. Phase 3 communities will begin collecting indicator information once they are operational.
- Key access points for ICY Teams include Child and Youth Mental Health (CYMH) Intake Clinics as well as schools.
- In addition to supporting core ICY Team Members, ICY Teams collaborate with other service providers such as Foundry, and local community service organizations.

FINANCIAL IMPLICATIONS

- The Province has committed $101 million over three years to implement ICY teams in 20 school districts to be operational by 2025.

KEY BACKGROUND

- ICY Teams were announced as part of *A Pathway to Hope* – the provincial strategy for improved mental health

and substance use care in British Columbia. The development of ICY Teams was informed by extensive cross-jurisdictional and literature reviews and over 94 consultation meetings that occurred in the development of *A Pathway to Hope* regarding mental health and substance use services for children, youth and young adults (including those with lived experience).

- The implementation of ICY Teams has followed a phased approach, beginning in 2019.
    - **Phase 1:** 5 communities announced in 2019 and 2020 - SD42 Maple Ridge-Pitt Meadows; SD38 Richmond; SD71 Comox Valley; SD82 Coast Mountains (Terrace-Hazelton); and SD53 Okanagan-Similkameen (Oliver-Osoyoos); and,
    - **Phase 2:** 7 communities announced in February 2023 - SD78 Fraser-Cascade (Hope); SD20 Kootenay-Columbia (Trail); SD75 Mission; SD68 Nanaimo-Ladysmith; SD83 Ḵwsaltktnéws (KWA-SEELT-K-NAUS) ne Secwepemcúl'ecw (NAY SUH-KWEP-MUK-OO-LOO) (Formerly North Okanagan-Shuswap; Salmon Arm); SD70 Pacific Rim (Port Alberni); and SD47 Powell River (qathet).
    - **Phase 3:** 8 communities announced in Spring 2024 (to be operational in 2025) - SD49 Central Coast (Bella Coola - Bella Bella); SD79 Cowichan Valley; SD37 Delta ; SD74 Gold Trail (Lytton, Cache Creek, Lilooet); SD58 Nicola-Similkameen (Princeton, Merritt), SD59 Peace River South (Dawson Creek, Chetwynd); SD69 Qualicum; and SD36 Surrey (Phased approach: Cloverdale and Fleetwood neighborhoods).
- Community selection process included quantitative and qualitative analysis of several data sources to understand community need and readiness and aligned with concurrent process for selection of Phase 5 (Budget 2023) Foundry Centres.

LAST UPDATED

The content of this estimates note is current as of Feb 13 as confirmed by Kelly McConnan.

APPROVALS

2025 03 06 – Francesca Wheler, ADM, Child, Youth, Indigenous Partnerships and Community Initiatives
2025 03 07 – Ally Butler, A/Assoc DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Mental Health Act

Topic: Overview of *Mental Health Act* (MHA).

Key Messaging and Recommended Response:

- The Province has made significant investments to build up voluntary mental health and substance use services across the full continuum of care.
- While we have made significant progress, I recognize there is more work to do to fully meet the needs of British Columbians.
- I also recognize that there are some British Columbians who may be in acute crisis and who may not be capable of making treatment decisions and who may also be at high risk of causing harms to either themselves or others and may require involuntary care.
- The Mental Health Act (the MHA) outlines the legislative requirements i.e., criteria, procedures for admission and treatment for involuntary care, including the safeguards for ensuring that individual's rights are protected.
- The Government's Chief Scientific Advisor for Psychiatry, Toxic Drugs and Concurrent Disorder recently release guidance to clinicians to clarify the application of the Act for people with concurrent mental health and substance use disorders so that people who are in crisis and need care, get the care they need.

CURRENT SITUATION

- In June 2024, Dr. Daniel Vigo was appointed Chief Scientific Advisor (CSA) for Psychiatry, Toxic Drugs and Concurrent Disorders to provide advice and recommendations for services, including involuntary treatment to meet the needs of individuals with severe, complex mental health and substance use disorders, including acquired brain injury.
- September 2024, Premier Eby and the CSA announced steps to ensure severely mentally ill people get the compassionate care they need to keep them safe, while also keeping communities safe.
- The province is supporting the implementation of key actions including providing clarity on the interpretation of the MHA and increasing available facilities in communities that provide access to treatment and services for this complex population.
    - On March 12, 2024, the CSA released clinical guidance to help physicians and providers determine when involuntary admission and concurrent substance use treatment may be appropriate for individuals with severe persistent mental disorders.
    - The first 20-bed secure, long term rehabilitative centre in BC will open in Spring 2025. Alouette Homes in Maple Ridge will serve individuals with severe, complex mental health, substance use and acquired brain injury who have persistent illness and high-risk behaviours.
    - The first 10-bed mental health care unit within Correctional Centers in BC will also be launched in March 2025 at Surrey Pretrial Services Centre.
- The Independent Rights Advice Service (IRAS) is currently available in all 75 facilities designated under the MHA Beginning March 1, 2025, IRAS will expand its services to people on Extended Leave in the community.
    - The Independent Rights Advice Service provides information to people who are detained and experiencing involuntary treatment under the MHA in BC. This information helps people understand what their legal rights are and how they can act on those rights.
    - As of January 2025, there had been 516 requests for Rights Advice. Rights Advisors provide assistance in a number of areas including assisting clients with a Review Panel Hearing Application.
- Hospitalizations with a MHA Condition:
    - In 2023/24 there were 25,058 detentions and/or involuntary hospitalizations under MHA in acute hospitals, down from 26,626 in 2022/23. In the few provincial psychiatric facilities reporting, there

were an additional 343 cases in 2023/24, up from 335 in 2022/23.[1]
    - In 2023/24 there were 18,137 unique patients detained and/or involuntarily hospitalized under the MHA at acute hospitals, down from last year (2022/23 - 18,905).
- Current legal challenges regarding the MHA:
    - *Council of Canadians with Disabilities v. AGBC* (British Columbia Supreme Court) - The plaintiff Council of Canadians with Disabilities is challenging provisions of the MHA, the *Health Care (Consent) and Care Facility (Admission) Act*, and the *Representation Agreement Act* that concern the ability of involuntarily detained patients to consent to treatment. Trial is currently scheduled for May 26, 2025.
    - *L.M., A.S., & C.F., v. HMQ, Health Auth. et al* (British Columbia Supreme Court) - This is a class action constitutional challenge to section 31 of the MHA which is being held in abeyance pending the outcome of the *Council of Canadians with Disabilities* case.
    - *Renae Real and Leland Richards (by Renae Real) v. Northern Health Authority and Ministry of Health* (BC Human Rights Tribunal) - this case is proceeding but does not have a scheduled hearing date.

FINANCIAL IMPLICATIONS

- The financial implications of addressing and/or scaling up all CSA's recommendations have not been assessed.
- Cabinet Confidences

- The implementation of the IRAS is anticipated to have implications on the system pressures of health authorities and the Mental Health Review Board. Analysis if forthcoming as part of the evaluation of the service.
- IRAS is funded through the Ministry of the Attorney General. The BC Canadian Mental Health Association contract amount with is $1,737,244 to provide the service.

KEY BACKGROUND

- The MHA sets out the authority, criteria, and procedures for involuntary admission and psychiatric treatment while safeguarding individuals' rights. The MHA has not been substantially revised since 2005, with minor adjustments made in 2022 (IRAS) and in 2023 (Authorizing Nurse Practitioners to complete assessment for involuntary admission under the MHA).
- A patient can only be involuntarily admitted under the MHA if all four of the following criteria are met:
    a) suffers from a mental disorder that seriously impairs their ability to react appropriately to their environment, or to associate with others;
    b) requires psychiatric treatment in or through a designated facility;
    c) requires care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration, or for their own protection or the protection of others; and
    d) are not suitable as a voluntary patient.
- As of February 2025, there are 75 facilities designated under the MHA including: 25 provincial mental health facilities, 37 psychiatric units in acute care hospitals, and 13 rural hospital observation units.[2]
- The Office of Ombudsperson's (OoO) 2019 report: *Committed to Change: Protecting the Rights of Involuntary Patients Under the MHA*, made 24 recommendations to improve the MHA.
    - The MHA form audit is one of the recommendations. The Ministry has conducted 19 quarterly audits of MHA form compliance since 2019. The most recent audit (as of February 3, 2025) covered January-March 2024, assessing the presence, completeness, and quality of MHA Forms 4.1, 4.2, 5, 13/14, 15, and 16.
    - The OoO released a follow-up to their 2019 report in the Spring of 2022. The report indicated that further improvement was necessary.

[1] Not all Provincial Psychiatric Centres report to the Discharge Abstract Database. Data is accurate for acute hospitals. It is not meaningful to provide a total of the two since it is incomplete and does not represent all involuntary stays in the province.
[2] Riverview Hospital is included in this number but has been closed since 2012.

- 5 recommendations remain outstanding for the Ministry of Health; they are currently in progress:
  1. R7: Develop an appropriate method for identifying, in a timely way, those patients who are clients of the Public Guardian and Trustee of BC or who have private committees,
  2. R10: Establish a regulation under section 3(1) of the Health Authorities Act to codify standards to support 100% compliance with involuntary admission procedures,
  3. R11: To publicly report the results of form audits, including compliance rates for each health authority for the fiscal year,
  4. R12: Revise all training materials and policies and procedures to address deficiencies identified including appropriate completion of forms,
  5. R13: Develop and implement mandatory training plan for all directors, physicians, and other staff exercising authority under the MHA.

LAST UPDATED

The content of this estimates note is current as of February 14, 2025 as confirmed by Robyn White.

APPROVALS

2025 03 21 - Darryl Sturtevant, ADM & a/Associate Deputy Minister
2025 03 14 – Rhiannon Pretty obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 19 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Mobile Integrated Crisis Response Teams

Topic: Police/health mobile mental health crisis response teams

Key Messaging and Recommended Response:

- When people are in distress, we need to take the right steps to make sure they are safe and connected to the care they need.
- Through the Safer Communities Action Plan, government has invested in expansion of Mobile Integrated Crisis Response Teams. 18 Mobile Integrated Crisis Response (MICR) teams are operating in communities across BC.
- These teams are staffed with police officers and mental health professionals specifically available to support people experiencing mental health and substance use crisis in the community, and connect them with appropriate health care services.
- They support individuals through de-escalation, clinical assessment, and/or connections to appropriate services.

CURRENT SITUATION

- 18 Mobile Integrated Crisis Response (MICR) teams are operating in communities across BC.
- This includes 8 of the 9 teams funded as part of the Safer Communities Action Plan (SCAP)[1], operating in Abbotsford, Burnaby, Chilliwack, Coquitlam/Port Coquitlam, Vernon, Penticton, Squamish, and the Westshore.
    - The ninth team in Prince Rupert has not yet launched.
- The remaining 10 teams are in: Vancouver, North Vancouver, Richmond, Surrey, Victoria, Nanaimo, Kamloops, Kelowna, Prince George, and Fort St. John.
- These teams are known locally by various names, including Car Programs, Co-Response Teams, and Integrated Crisis Response Teams.

FINANCIAL IMPLICATIONS

- Budget 2024 provided $9 million over 3 years to support the 9 MICR teams.
- This built on the one-time funding allocation of $3 million provided in Budget 2023.
- Targeted provincial funding for the 9 new MICR teams is for the health component of the teams only.

KEY BACKGROUND

- In many communities in BC, police are the default first responders to mental health crises. Funding teams where a mental health professional responds alongside a police officer ensures that people in a mental health crisis are met with a health-based response and connected to the supports they need.
- MICRs are run by regional health authorities in partnership with local police departments.
- The mental health professionals on MICR teams can include psychiatric nurses, social workers, or registered counsellors.

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Tricia Poilievre, Executive Director, Complex Care Housing and Community Initiatives.

APPROVALS

2025 03 11 – Francesca Wheler, ADM, Child, Youth, Indigenous Partnerships & Community Initiatives
2025 02 18 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 12 – Ally Butler, A/Associate Deputy Minister, Mental Health and Addictions

[1] News release: "Supports expanding for people in mental-health, substance-use crisis", July 17,2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

Naloxone (including Nasal Naloxone)

Topic: Overview of naloxone services in BC, including nasal naloxone provision.

Key Messaging and Recommended Response:

- Naloxone is a life-saving medicine that can quickly reverse the effects of drug poisoning or overdose from opioids.
- Naloxone is available in two forms: intramuscular (IM) and intranasal. Both formulations have similar efficacy.
- Currently, IM naloxone is available free-of-charge to anyone in B.C. at risk of experiencing or witnessing an overdose via the BCCDC's Take Home Naloxone (THN) Program.
- As of December 2024, THN kits are available at more than 2,360 locations, including 896 community pharmacies.
- We understand that nasal naloxone may be more appropriate for people who face barriers to using IM naloxone, including people with dexterity limits, people in cold climates, youth unfamiliar with administering needles, and Indigenous Peoples.
- This is why, in May 2024, the government initiated a series of pilot programs to explore expanding access to nasal naloxone.
- Nasal naloxone is available for specific high-needs groups in priority locations, while also ensuring that everyone has access to IM naloxone and the necessary training to use them.

CURRENT SITUATION

- Naloxone is available in two forms: intramuscular and intranasal. Both formulations have similar efficacy.
- Current evidence-based guidance suggests that nasal naloxone may be more appropriate for people who face barriers to using IM naloxone, including people with dexterity limits, people in cold climates, youth unfamiliar with administering needles, and Indigenous Peoples.[1]
- IM naloxone is available free-of-charge to anyone in BC at risk of experiencing or witnessing an overdose via the BC Centre of Disease Control's (BCCDC) Take Home Naloxone (THN) Program. **THN has 2,362 participating distribution sites, including 896 community pharmacies. 501,000 kits were distributed by THN in 2024[2].**
- In May 2024, the Province initiated a pilot project to distribute nasal naloxone kits in various settings.
    - **Ministry of Post-Secondary Education & Future Skills –** 1,600 kits distributed to 25 post-secondary institutions and 25 First Nations Mandated Institutions in August 2024.
    - **THN** - 50,000 kits are being distributed via THN to 150 community sites and up to 700 pharmacies. Sites are prioritizing people with dexterity limits, those in cold climates, youth and Indigenous peoples.
    - **Public Institutions** - 8,400 kits are being distributed via the Ministry of Citizens Service Product Distribution Centre to eligible public agencies (e.g. libraries, secondary schools, firehalls).[3]
- Initial pilot evaluation results will be available in Spring 2025 and will inform future planning.
- Demand for naloxone increases on average 20% each yearGovernment Financial Information

Government Financial Information

FINANCIAL IMPLICATIONS

- The Ministry of Health has allocated in one time funding $7.4M for the nasal naloxone pilot in 2024/25
- From 2019/20 to 2022/23, the base annual THN budget allocation was $11.06 M. This includes $4M of pre-existing core funding for provincial harm reduction supplies. THN Budget was increased to $12.06M in 2024/25 through the addition of $1.00M in annual funding from Budget 2024 to support the THN program.

[1] Canadian Research Initiative in Substance Matters. (2023). *Canadian Take-Home Naloxone Program Guidance.*

[2] Take Home Naloxone Infographic. (2025). https://towardtheheart.com/thn-in-bc-infograph

[3] Nasal Naloxone DBN. (2025). Cliff #1301829

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Naloxone is a medication that quickly reverses the effects of drug poisoning or overdose from opioids. It is not effective in reversing the effects of stimulants, benzodiazepines or other non-opioid drugs and adulterants.
- It is estimated that up to 43% of naloxone kits distributed through THN have been used to reverse an overdose.[4]
- BCCDC estimates that 31,430 deaths in BC were prevented by THN from January 2019 to October 2024[5].
- In 2024, 47.7% of unregulated drug deaths occurred in private residences, 3.3% occurred in public buildings or washrooms, and 0.4% occured on industrial/construction/manufacturing/natural resource sites.[6]
- THN is not the only public source of naloxone in BC. Indigenous clients can access free IM and nasal naloxone through First Nations Health Authority (FNHA), and Indigenous people eligible for Non-Insured Health Benefits can access nasal at pharmacies. Public institutions can purchase IM kits from the PDC and some community organizations can access free IM naloxone through the BCCDC Facility Overdose Response Box (FORB) program.

LAST UPDATED

The content of this estimates note is current as of February 18, 2025, as confirmed by Evan Howatson, Executive Director, Overdose Response.

APPROVALS

2025 02 27 - Lenore Ogilvy obo ADM Martin Wright – Health Sector Information, Analysis & Reporting Division
2025 03 07 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 XX – Darryl Sturtevant, ADM & a/Associate Deputy Minister

[4] International Journal on Drug Policy. (2024). Estimating the total utilization of take home naloxone during an unregulated drug toxicity crisis: A Bayesian modeling approach.
[5] Harm Reduction Infographic. (2025). http://www.bccdc.ca/Health-Professionals-Site/Documents/Harm-Reduction-Reports/Drug_poisoning_death_events_prevented-2019-2024.pdf
[6] Unregulated Drug Deaths – Place of Injury. (2024). *Unregulated Drug Deaths Summary.*

LEGISLATIVE SESSION – ESTIMATES NOTE

Nurse Prescribing

Topic: BC is the first jurisdiction in Canada to establish a permanent, certified nursing practice for Opioid Use Disorder, enabling certified nurses to provide comprehensive care for people with OUD including prescribing of life-saving opioid agonist treatment.

Key Messaging and Recommended Response:

- Opioid agonist treatment (OAT) is recognized as a first-line, evidence-based treatment for opioid use disorder.
- As part of our government's efforts to expand access to OAT, BC is the first jurisdiction in Canada to enable registered nurses (RNs) and registered psychiatrics nurses (RPNs) to diagnose opioid use disorder and prescribe lifesaving opioid agonist treatment.
- The transition to a permanent, certified practice reflects government's sustained commitment to expanding access to OAT in BC.
- In addition, we have also launched the Opioid Treatment Access Line, which allows people anywhere in the province to call and get same day care and a prescription for opioid agonist medications.
- This work aligns with provincial goals of increasing the available workforce for substance use care; increasing initiation and retention in treatment; and separating people from the toxic drug supply.
- Nurse OAT prescribing has helped transform the substance use system of care for people with opioid use disorder by providing low-barrier access to evidence-based lifesaving treatment across the province, including in underserved, equity-deserving populations including people in First Nations communities.

CURRENT SITUATION

- Since 2020, nurse prescribing has been implemented in all five regional health authorities, the Provincial Health Services Authority (PHSA) and First Nations Health Authority (FNHA). Implementation is taking a phased approach and remains ongoing.
- RNs and RPNs with certified practice in opioid use disorder (CP-OUD nurses) diagnose and treat opioid use disorder, including prescribing OAT, in a variety of settings such as mental health and substance use programs, outreach, virtual care, and acute care.
- CP-OUD nurses are able to prescribe the four most commonly prescribed OAT medications in BC: Methadone (e.g. Methadose® and Metadol-D®), buprenorphine/naloxone (e.g. Suboxone®), slow-release oral morphine (Kadian®), and extended-release buprenorphine (e.g. Sublocade®).
- Health system partners have reported that implementation to date has produced positive results, including increased flexibility of service offerings, improved ability to connect with clients who may be difficult to reach, and enhanced access to OAT, particularly in rural and remote communities.
- In December 2024, 718 patients received dispenses for buprenorphine, buprenorphine/naloxone, methadone, or slow-release oral morphine at community pharmacies within BC written by 70 RN or RPN prescribers.[1]
- As of January 15, 2025, 15 RNs and 41 RPNs hold a CP-OUD designation from the BC College of Nurses and Midwives.[2]

FINANCIAL IMPLICATIONS

- Budget 2023 provided $14.48 million in ongoing funding over three years to support nurse prescribing implementation.
- Government contracted Changemark Research + Evaluation Services to evaluate the effectiveness of the provincial implementation of the nurse OAT prescribing initiative under the PHO order to inform ongoing

[1] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting Division, February 20, 2025.
[2] BCCNM Communication. January 15, 2025.

prescribing practices, service delivery adjustments, and policy refinements. The contract for $170,000 over three years was completed in 2024.

KEY BACKGROUND

- OAT is recognized by the medical community as a first-line evidence-based treatment for opioid use disorder and is associated with substantial reductions in the risk for all cause and overdose mortality in people dependent on opioids.
- In 2020, under an Order of the Provincial Health Officer (PHO), RNs and RPNs who completed additional training were temporarily allowed to prescribe OAT.
- In November 2023, this temporary practice transitioned to a permanent, certified practice through the BCCNM's new designation of certified practice for opioid use disorder for RNs and RPNs. This was preceded by amendments made to the nursing regulations under the *Health Professions Act* that were approved by the Minister of Health in April 2023.
- On Dec 17, 2024, the Provincial Health Officer rescinded the PHO Order as BCCNM had implemented the certified practice for opioid use disorder and the order no longer needed.
- Eligible RNs and RPNs are required to complete training provided by the BC Centre on Substance Use (BCCSU) to obtain a certified practice for opioid use disorder designation.
- The certified training aligns with the BCCSU's *Guideline for the Clinical Management of Opioid Use Disorder* and includes an online course, related course work, and an in-person preceptorship, supporting nurses to build the skills required to effectively provide opioid use disorder care.

LAST UPDATED

The content of this estimates note is current as of February 18, 2025, as confirmed by Evan Howatson, Executive Director, Overdose Response.

APPROVALS

2025 02 25 – Christine Voggenreiter obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 02 28 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division
2025 03 24 – Darryl Sturtevant, ADM & a/Associate Deputy Minister

LEGISLATIVE SESSION – ESTIMATES NOTE

Opioid Agonist Treatment (includes full OAT spectrum: OAT, iOAT, TiOAT)

Topic: Overview of the full spectrum of opioid agonist treatment available in BC, including injectable OAT and tablet injectable OAT.

Key Messaging and Recommended Response:

- People who use opioids in BC are at elevated risk of harm due to exposure to the toxic illicit drug supply, which increases an individual's risk of experiencing a toxic drug poisoning.
- That's why our government is taking action to increase access and enhance the services people need to stay alive and get connected to care.
- Increasing the number of people with opioid use disorder who are engaged and retained in treatment is a key priority in the provincial response to the toxic drug crisis.
- OAT is a first-line evidence-based treatment for opioid use disorder and is associated with substantial reductions in the risk for all cause and overdose mortality in people dependent on opioids.
- Our government continues to work with health system partners to expand access to opioid agonist treatment (OAT), including through the implementation of nurse OAT prescribing and the launch of the Opioid Treatment Access Line, which people anywhere in BC can call to get same-day access to life-saving medications.
- OAT is only one part of this work to address the toxic drug crisis. Our government is determined to save lives, keep communities safe, and get people the care and treatment they need.

CURRENT SITUATION

- An estimated 78,311 people live with diagnosed Opioid Use Disorder (OUD) in BC. This estimate increases to 112,318 when accounting for people who may meet the criteria for OUD but are never diagnosed.[1]
- People who use opioids in BC, including those with OUD, are at elevated risk due to exposure to the toxic illicit drug supply, which increases an individual's risk of experiencing toxic drug poisoning.
- OAT is recognized by the medical community as a first-line, evidence-based treatment for OUD.[2]
  - In December 2024, 23,414 clients received OAT prescribed by 2,029 OAT providers across BC.[3]
- iOAT is an injectable treatment option intended to meet the needs of people with OUD who have not experienced benefits from and/or have declined traditional OAT options.
  - In December 2024, 101 clients received diacetylmorphine injection OAT prescribed by 24 clinicians across BC and 21 clients received hydromorphone injection OAT prescribed by 15 clinicians across BC.[2]
- The Ministry continues to work with partners to expand access to treatment and address service gaps. This includes efforts to better understand and address barriers to accessing and being retained on treatment.

FINANCIAL IMPLICATIONS

- Intergovernmental Communications

KEY BACKGROUND

Opioid Agonist Treatment:

- The 4 most commonly prescribed OAT medications in BC are methadone (e.g. Methadose® and Metadol-D®),

[1] BC Ministry of Health. OERC Monthly Data Sheet – December 2024. Not publicly available.
[2] BCCSU. 2023. A Guideline for the Clinical Management of Opioid Use Disorder. Available at: https://www.bccsu.ca/wp-content/uploads/2023/12/BC-OUD-Treatment-Guideline_2023-Update.pdf
[3] BCCDC. 2025. Unregulated Drug Poisoning Emergency Dashboard. Available at: www.bccdc.ca/health-professionals/data-reports/substance-use-harm-reduction-dashboard

buprenorphine/naloxone (e.g. Suboxone®), slow-release oral morphine (Kadian®), and extended-release buprenorphine (e.g. Sublocade®).

- As of June 6, 2023, OAT medications are covered through Plan Z, which provides full medication cost coverage for BC residents with an active Medical Services Plan.
- OAT medications are more effective for treating opioid dependence compared to other forms of treatment, such as psychological treatment and/or withdrawal management alone.[4]
- OAT also has a protective effect with mortality rates and risk of death being significantly lower among recipients compared to non-recipients.[5]
- Despite the benefits of OAT for people who use opioids, retention rates have decreased over time. In 2023/24, the percentage of people on OAT who have been retained for 12 months was 44.4% (a slight decrease from 2022/23 where it was 44.9%).[6]
- Barriers to OAT access and retention are multifactorial and span across the health system. Low OAT engagement and retention is due to barriers to treatment access (e.g., mobility challenges, lack of prescribers or pharmacies nearby, medication availability); fragmented care systems (e.g., lapse in access to/from correctional institutions and the community); stigma and aspects of OAT provision that limit people's ability or willingness to continue engagement in treatment (e.g., witnessing, frequent visits, unsuitable medications).
- In November 2023, the BC Centre on Substance Use (BCCSU) released updated provincial guidance on the clinical management of OUD.[2] The guidelines provide recommendations to clinicians, nurses, pharmacists and allied healthcare professionals on supporting patients with OUD, including detailed information and recommendations on providing OAT through flexible, patient-centered care.[2]

Injectable Opioid Agonist Treatment:

- The two iOAT medications available in BC are hydromorphone and diacetylmorphine.
- iOAT programs are currently operating in Fraser Health, Interior Health and Vancouver Coastal Health.
- In October 2017, the BCCSU released provincial guidance for the use of iOAT as an evidence-based specialized, intensive treatment option for clients who have not benefited from traditional OAT.[7]

Tablet Injectable Opioid Agonist Treatment:

- Tablet Injectable Opioid Agonist Treatment (TiOAT) is an alternative form of OAT featuring supervised consumption of hydromorphone (HDM) tablets via oral intake and/or injection.
- TiOAT programs are currently operating in Interior Health and Vancouver Coastal Health.
- In recent years, many TiOAT clients have transitioned to other opioid medication options (i.e., fentanyl patch) that better meet their needs.

Increasing Access to OAT

Certified Practice for Opioid Use Disorder:

- In November 2023, a new Certified Practice for Opioid Use Disorder (CP-OUD) was created, enabling certified Registered Nurses (RN) and Registered Psychiatrics Nurses (RPN) to diagnose and treat OUD, including prescribing OAT medications.
- To obtain the CP-OUD designation, eligible RNs and RPNs are required to complete training relating to OUD and OAT prescribing.
- In December 2024, 719 patients filled prescriptions for buprenorphine, buprenorphine/naloxone, methadone, or slow-release oral morphine at community pharmacies within BC written by 70 RN or RPN prescribers.[8]
- As of January 15, 2025, 115 RNs and 41 RPNs hold a CP-OUD designation from the BC College of Nurses and Midwives.[9]

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[4] Nielsen S, Larance B, Lintzeris N. 2017. Opioid agonist treatment for patients with dependence on prescription opioids. JAMA. Available at: https://doi.org/10.1002/14651858.cd011117.pub3

[5] Nielsen, S., Larance, B., Degenhardt, L., Gowing, L., Kehler, C., & Lintzeris, N. 2016. Opioid agonist treatment for pharmaceutical opioid dependent people. Cochrane Database of Systematic Reviews. Available at: https://doi.org/10.1002/14651858.CD011117.pub2

[6] BC Ministry of Health. 2025. HSIAR. Provided via email by Pharmaceutical Analytics for MHA Data snapshot and Annual Service Plan Report.

[7] BCCSU. 2017. Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder. Available at: https://www.bccsu.ca/wp-content/uploads/2021/07/BC_iOAT_Guideline.pdf

[8] BC Ministry of Health. January 28, 2025. HSIAR. Monthly RN/RPN OAT Utilization Report. RMS #3425

[9] BCCNM Communication. January 15, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Opioid Treatment Access (OTA) Line:

- A toll-free line (1-833-804-8111) is open daily from 9am to 4pm available to people across BC.
- Callers can speak with a clinician who can prescribe an OAT medication over the phone.
- The OTA Line can provide medication starts, restarts, and bridging prescriptions for buprenorphine/naloxone, methadone, or slow-release oral morphine.
- Prescriptions are faxed to a local pharmacy for the patient to pick up. People who call the OTA Line are also connected to a regional nurse liaison who helps them access care in their local health authority.
- The OTA Line launched in August 2024 and has provided prescriptions to clients in all HAs.

LAST UPDATED

The content of this estimates note is current as of February 18, 2025, as confirmed by Evan Howatson, Executive Director, Overdose Response.

APPROVALS

2025 02 28 – Ian Rongve, ADM, Pharmaceutical, Laboratory and Blood Services Division
2025 03 07 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 10 - Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 24 – Darryl Sturtevant, ADM & a/Associate Deputy Minister

LEGISLATIVE SESSION – ESTIMATES NOTE

Overdose Prevention Services

Topic: Overview of overdose prevention services (OPS) and supervised consumption services (SCS) in BC

Key Messaging and Recommended Response:

- The toxic drug crisis continues to devastate families and communities in BC, Canada and around the world.
- While we have seen decrease in toxic drug deaths over the last year, the illicit drug supply remains a serious threat to public health that affects communities across the province and people from all walks of life.
- Lifesaving supports like overdose prevention services, nasal and intramuscular naloxone kits, and drug checking services are a critical component of our overall response to address this public health emergency.
- These services are often the first point of access to the health care system where people can be referred to treatment and other health care supports such as primary care.
- The Province is enhancing oversight of the overdose prevention sector by developing Minimum Service Standards for publicly-funded fixed and mobile overdose prevention services in BC.
- We are committed to building and expanding a seamless system of mental health and addiction care because keeping people alive is the first step in connecting them with the support and care they need.

CURRENT SITUATION

- OPS allow people to consume illicit substances under the observation of personnel trained in drug poisoning response, who can intervene in case of adverse events (e.g., toxic drug poisoning).
- OPS are a key entry point into the substance use continuum of care by connecting people to health care and the other supports they need.
- OPS provide people with an alternative to public substance use, supporting individuals and communities as they navigate the toxic drug crisis.
- In hospital settings, OPS help to retain patients in treatment and to prevent harms to other patients, staff and visitors through secondary exposures to illicit substances.
- OPS are available across all health authority regions in BC. As of March 4, 2025, there were 59 known fixed, mobile, and episodic-OPS/SCS operating in BC. Of these, 33 sites provide observed inhalation.
- From January 2017 until the end of January 2025, there have been approximately 5.6 million visits to OPS/SCS in BC, 30,742 overdoses responded to and survived, and two deaths at OPS (in 2022 and 2024). Note that not all OPS/SCS report to the BC Centre for Disease Control (BCCDC).
- BCCDC estimates from January 2019 to October 2024, there were 12,430 death events prevented by OPS/SCS.[1]
- The Ministry of Health is currently developing Minimum Service Standards (MSS) for publicly funded fixed and mobile OPS in BC.
    - These standards will enhance Provincial oversight of the OPS sector while promoting access to high quality, person-centred services.
    - The development of the MSS aligns with the Office of the Auditor General's recommendations regarding OPS, particularly recommendation 1 (B.C.'s Toxic Drug Crisis: Implementation of Harm Reduction Programs, OAG, 2024).

FINANCIAL IMPLICATIONS

- Budget 2024 provides $48.7 million to support existing harm reduction initiatives at OPS throughout the province, drug checking, and naloxone kit distribution.
    - This includes $10 million annually over three years to support OPS services.
- This funding expands on existing investments in OPS/SCS in BC.

[1] http://www.bccdc.ca/Health-Professionals-Site/Documents/Harm-Reduction-Reports/Drug_poisoning_death_events_prevented-2019-2024.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- In April 2016, BC's Provincial Health Officer declared a public health emergency due to an increase in toxic drug-related deaths. This emergency persists today.
- In BC, OPS operate under provincial Ministerial Order 488/2016, which mandates regional health boards and BC Emergency Health Services to establish OPS wherever there is a need during the toxic drug public health emergency.
- SCS operate under Health Canada exemptions to the *Controlled Drugs and Substances Act.*
- OPS are considered "designated healthcare clinics" under BC's current decriminalization exemption.
- OPS services are key components of the continuum of substance use care, which aims to reduce harms and promote wellness among all BC residents.

LAST UPDATED

The content of this estimates note is current as of March 17, 2025, as confirmed by Rebecca Salpeter, a/Executive Director, Overdose Response.

APPROVALS

2025 03 19 – Darryl Sturtevant, ADM, MHSU
2025 02 26 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 03 19 – Ally Butler, a/Associate Deputy Minister

LEGISLATIVE SESSION – ESTIMATES NOTE

Oversight Of Substance Use Beds

Topic: Oversight of Adult Substance Use Bed-Based Treatment and Recovery Services

Key Messaging and Recommended Response:

- People living with addiction need a safe place to receive services and supports – especially at such a vulnerable time in their lives.
- Bed-based substance use treatment and recovery services provide a safe, structured, communal environment for individuals with substance use disorders to focus on their recovery.
- Significant actions have already increased oversight and care quality including new regulations and standards for supportive recovery homes as well as adding more investigators.
- Government is actively exploring additional options to enhance service quality and strengthen sector oversight, guided by opportunities identified through intensive engagement.

CURRENT SITUATION

- In 2022, building on previous work to strengthen oversight of the sector, Government launched the *Adult Bed-based Substance Use Treatment and Recovery Oversight and Accountability (BOA)* Project.
- BOA is developing strategies and policy options that support equitable access to services, improve sector oversight and accountability, and enhance service quality and consistency.
- In 2024 the Ministry expanded the Assisted Living Registry (ALR) team by adding 2 senior investigators and 6 investigators to support oversight of supportive recovery and other registered residences.
- To date, the expanded team has launched Proactive Compliance Inspections in registered supportive recovery residences in
    - Fraser Health Regions (68 of 74 completed). Launched: Spring-Summer 2024
    - Northern Health (2 of 3 completed). Launched: Fall 2024
- BOA also expanded training resources to support operators in implementing the Provincial Standards for Registered Assisted Living Supportive Recovery Services (2021). This is in addition to direction provided to Health Authorities and the Canadian Mental Health Association to incorporate Standards into funding agreements for publicly funded beds.
- Key resources include an updated Operator Handbook, educational fact sheets, enhancements to the ALR website, and a self-paced online learning course. Since 2023, 680 learners have registered with financial support from the government's training bursary.[1]
- Advice/Recommendations

- In addition, all Health Authorities report quarterly to the Ministry on available data such as the number of clients served and wait times for publicly funded bed-based treatment and recovery services.

FINANCIAL IMPLICATIONS

- Budget 2023 invested $4.04 million over three years to increase accountability for supportive recovery residences and explore options to further enhance oversight.

KEY BACKGROUND

[1] Source: OpenSchool BC data report February 2025

- Bed-based substance use treatment and recovery services provide a safe, structured, communal environment for individuals with substance use disorders to focus on their recovery.
- The majority of these services are delivered in licensed treatment facilities or registered supportive recovery residences, regulated under the *Community Care and Assisted Living Act* (CCALA), Residential Care Regulation (Licensed Services), and Assisted Living Regulation (Registered Services).
    - The Assisted Living Registry (ALR) is responsible for the oversight of registered residences, which typically offer a lower intensity of support and programming.
    - Health authorities are responsible for the oversight of licensed facilities, which typically offer a higher intensity of support and programming.
- In 2019, the government strengthened oversight with the introduction of the Assisted Living Regulation and amendments to the CCALA. These include the requirement for substantiated complaints and unregistered services to be listed on the ALR website. These changes responded to recommendations from advocates and significantly enhanced regulatory oversight for supportive recovery homes.
- In 2021, provincial Standards were introduced. The Standards expand on minimum regulatory health and safety requirements and set service expectations including evidence-based care.
- Indigenous-led services offering culture-based programs with federal funding are generally governed by the First Nations Health Authority in partnership with First Nations, with some exceptions.

LAST UPDATED

The content of this estimates note is current as of February 13, 2025, as confirmed by Sarah Amyot, Acting ED.

APPROVALS

2025 02 24 – Brenda Rafter OBO Rob Byers, Finance and Corporate Services Division
2025 03 05 – Ally Butler, A/Assoc DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Red Fish Healing Centre

Topic: Red Fish Healing Centre

Key Messaging and Recommended Response:

- We need to use every tool possible to fight the toxic drug crisis and support people struggling with addiction.
- Red Fish Healing Centre is a 105-bed purpose-built facility that provides treatment to people with the most complex and concurrent mental health and addiction challenges.
- The centre treats mental health and substance use together and research shows that this can result in better outcomes for people because each affects the other.
- The Province is working with Provincial Health Services Authority to expand Red Fish services.
- There is funding from previous budgets to support that work, and we are actively searching for appropriate locations.
- In addition, government is working to create new beds dedicated for involuntary care throughout the province.
- We are working closely with the Chief Scientific Advisor as locations are identified and watching for opportunities to co-locate these sites with future expansions to the Red Fish model.
- The expansion to Red Fish is an important step in continuing to build a seamless system of mental health and substance-use care in BC.

CURRENT SITUATION

- Since opening in 2021, Red Fish Healing Centre (RFHC) has been operating at 95%[1] capacity and has experienced increased demand.
- In 2023/24, work began to plan the expansion of RFHC model of care, led by the Provincial Health Services Authority (PHSA) in partnership with the Ministry of Health (HLTH). Once built, the new service will be operated by PHSA.
- In the current market, there are significant challenges in finding a suitable site that can accommodate the proposed 105-bed facility. These include the potential to recruit and retain staff and physicians, finding a large enough area for the facility, and the balance between proximity to services, community acceptance and municipal zoning.
- Given these challenges PHSA has identified options to increase the range of acceptable locations, including a "hub and spoke" model, with the existing Red Fish serving as the central, highest acuity service, and other sites throughout the province serving the same client population, but lower acuity.
- PHSA is working with Regional Health Authority and other community partners to explore options and identify potential locations for a new RFHC site(s).

FINANCIAL IMPLICATIONS

- Budget 2023 included $1.1M over three fiscal years to evaluate RFHC and to support the development of a clinical care model for expansion.
- Budget 2024 included notional funding of up to $725M (capital) for expansion for RFHC.

KEY BACKGROUND

- RFHC is a 105 bed, purpose-built facility that opened in October 2021 on səmiq̓ʷəʔelə (Pronounced Suh-mEE-kwuh EL-uh) in Coquitlam, (formerly known as the Riverview lands). The facility provides the highest tier of service intensity for concurrent mental health and substance use services.

[1] Personal communication, January 13, 2025, Kathryn Embacher, Provincial Health Services Authority

- RFHC is a live-in treatment site staffed 24/7 with medical professionals and offers highly structured programming including psychiatric care. RFHC clients may be admitted voluntarily, or involuntarily under BC's *Mental Health Act*.
- In BC, concurrent disorder treatment beds, such as RFHC, provide specialized care to meet the needs of individuals with serious and persistent mental health or concurrent substance use concerns who have not been successfully treated by other programs. These Tertiary beds primarily fall under the *Hospital Act*, the *Community Care and Assisted Living Act*, and the *Mental Health Act*.
- There are 1,277 tertiary mental health and substance use beds across the province. Of these, 135 are PHSA substance use /concurrent beds[2]:

Heartwood Centre for Women	30
RFHC	105

- Since opening in 2021, data indicates a sustained, high demand for this service (see table below)[3]:

RFHC - Annual Data	**FY2021/22***	**FY2022/23**	**FY2023/24**	**FY2024/25 – YTD***
Number of clients admitted	104	213	202	148
Average wait time to admission (days)	39 days	106 days	70 days	81 days
Occupancy Rate	77%	95%	96%	95%

*RFHC opened in October 2021
**As of December 2024

- Since work began on the RFHC expansion, a clinical service model and functional plan have been developed. The service model includes a Secure Enhanced Care Unit that will serve individuals who suffer from a serious mental illness and co-occurring aggression/significant behavioural challenges.
- As of December 2024, 86.84% of RFHC clients reported improved mental health between admission and discharge in FY 2024/25.[4]

LAST UPDATED

The content of this estimates note is current as of Feb 19, 2025, as confirmed by Bethany Estiverne.

APPROVALS

2025 02 26 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 02 28 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division
2025 03 21 – Ally Butler, a/Associate DM, Mental Health and Addictions

[2] HSIAR Division, Ministry of Health (2024). Sep 30, 2024. MHSU Bed Survey. RMS 10367 MHSU Bed Information 2024-09-30.xlsx
[3] Personal communication, January 13, 2025, Kathryn Embacher, Provincial Health Services Authority
[4] Personal communication, January 28, 2025, Kathryn Embacher, Provincial Health Services Authority

LEGISLATIVE SESSION – ESTIMATES NOTE

ROAD TO RECOVERY

Topic: Road to Recovery and Province-wide Expansion

Key Messaging and Recommended Response:

- When people living with addiction reach out for help, we need services ready to meet them, regardless of where they live.
- Road to Recovery (R2R) has been operating in Vancouver since October 2023.
- This new model of care is changing the way people access addictions services, making it easier for people to access the right care for their needs.
- In Vancouver, 60 of 95 new substance use beds have been implemented and more than 2,137 people have been supported to access a withdrawal management bed between October 2023 and November 2024.
- Government has committed to expanding the Road to Recovery model to every health region.
- The expansion will include the implementation of a same day access to clinical assessment through Access Central in every health region, up to 100 new substance use beds over three years, and new or expanded outpatient services. Access Central is expected to open in each region through Spring and Summer 2025.

CURRENT SITUATION

- R2R Vancouver is substantially implemented with 60 new substance use beds implemented to date, and a new single access phone line called Access Central offering same day clinical assessments and service matching.
- Between October 2023 to November 2024, R2R Vancouver received 22,619 calls through Access Central, and supported 2,137 people into a withdrawal management (detox) bed with a median wait time of one day for those clients prioritized as urgent[1].
- As announced in July 2024 active implementation is underway in every other region, with an immediate focus on implementing Access Central to ensure same day access to clinical assessment and service matching by Spring/Summer 2025, while planning continues for new substance use beds and new or expanded outpatient services.
- Through R2R, long-term recovery supports are also being expanded in every health region through new aftercare clinicians and Recovery Community Centres. To date three Recovery Community Centres are operational in Vancouver Coastal Health and 40 aftercare clinicians are serving clients throughout the province.
- The R2R model continues to be implemented in close partnership with addictions medicine clinical and operational leadership from each Health Authority through the Provincial Addictions Recovery and Treatment Supports (Prov-ARTS) Network.
- Prov-ARTS is meeting regularly to support collaborative system planning, focusing on adult substance use system of care and to ensure alignment across Health Authorities.

FINANCIAL IMPLICATIONS

- Budget 2023 provided $55.864M in operating funding over three years to support the Road to Recovery at St. Paul's Hospital in Vancouver.
- Budget 2023 provided $153.757M in operating funding over three years to support Road to Recovery expansion.
- Cabinet Confidences; Government Financial Information

KEY BACKGROUND

- The original R2R model was developed in partnership between Providence Health Care, led by Dr. Seonaid Nolan and the BC Centre on Substance Use.

[1] MHA Performance Monitoring Data, provided by VCH.

- R2R was developed in response to identified challenges in the system by creating a single front door in each region, making access to clinical assessment easier and faster, and using consistent clinicals assessments to ensure clients are matched to the right service for their needs.
- Prior to this, clients may have experienced multiple programs with different entry points making it difficult to know where to access care, may not have been clinically assessed for their needs, and as a result may have been put on multiple wait lists resulting in longer wait times.

Table 1: Gaps Addressed by Road to Recovery

Previous State	R2R Model
Multiple programs with different entry points making it difficult to know where to access care	Single "front door" in each region: Access Central
Limited access to clinical assessment resulting in clients being directed to the wrong service for their needs	Same-day clinical assessment by an addiction specialist available through Access Central
Access to service based on "first come, first serve" rather than need and/or risk	Individuals matched to services based on their unique needs identified through clinical assessment and medical triage
Clients put on multiple wait lists for services resulting in longer wait times and making it confusing for clients	One wait list for bed-based withdrawal management and stabilization managed by the Access Central care team
Fragmented care journey that can result in gaps in care and create risk for clients	Health Authority teams ensure consistent and proactive connection across the continuum of care
Insufficient dedicated long-term support	New aftercare and recovery support across the province

- R2R Vancouver was initiated at St. Paul's Hospital with support from the Diamond Family Foundation, alongside the Province.
- Expansion of R2R is underway in every health region.
    - Northern Health is implementing services in the Northwest Region in partnership with the Northern First Nations Alliance.
    - Fraser, Interior and Island Health are implementing regional R2R models.
- The BC Centre on Substance Use is leading an evaluation of R2R Vancouver. In addition, a common reporting framework has been developed to support consistent monitoring and evaluation across all health regions.
- Learnings from the R2R Vancouver model are being used for continuous quality improvement and to inform, improve and adapt the R2R expansion to other regions.

LAST UPDATED

The content of this estimates note is current as of February 7, 2025 as confirmed by Bethany Estiverne.

APPROVALS

2025 02 24 – Brenda Rafter obo Rob Byers Finance and Corporate Services Division
2025 03 06 – Treatment and Recovery Division
2025 03 07 – Ally Butler, A/Associate DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

SUBSTANCE USE BEDS

Topic: Substance Use Beds Data, including investments, clients served, wait-times & utilization

Key Messaging and Recommended Response:

- Every person's path to treatment and recovery is different, and the journey is not always linear. From harm reduction to treatment and recovery, an integrated, patient-centred approach to care is needed to support people throughout their journey.
- When people make the brave decision to seek help for their mental health and wellbeing, they need to be met with appropriate care. That's why we're working urgently to build a seamless system of mental health and addictions care that works for everyone.
- In 2023-24, publicly funded treatment and recovery beds served 5,238 adult clients – an increase of more than 1,100 from the previous year.
- Since 2017, we have added more than 750 new publicly-funded adult and youth substance use treatment beds, including withdrawal management (detox), sobering and assessment, transition, treatment and supportive recovery beds across BC.
- Health authorities report quarterly to the Ministry of Health on available data about the number of clients served and wait times for bed-based treatment and recovery services.
- From this data, BC is the first Canadian jurisdiction to publicly report wait times for bed-based services; this is included in the Ministry's annual service plan.
- Wait times are complex data to collect and interpret accurately as they can be defined differently across regions and service types and they can be impacted by a range of factors, including a client's personal readiness to start treatment, travel time to services, and family, childcare and work commitments
- In 2023/24, the average wait time for health authority funded substance use treatment and recovery beds (31 days) in BC surpassed the target (32 days).
- Our government will continue to work closely with health authorities and other partners to monitor and improve access; strengthen data to support system planning; and ensure the health and safety of people receiving mental health and addiction care.

CURRENT SITUATION

- Substance use bed types include, but are not limited to, withdrawal management (detox), supportive recovery, treatment, and transitional beds. Beds are a small portion of the service continuum and support people with complex substance use issues.
- As of March 2025, there are 3,778[1] publicly-funded substance use beds in BC including:
  - 3,435 adult beds
  - 208 youth beds
- Budget 2023[2] committed to adding 375 new substance use beds over the next three years to the system of care. This includes:
  - 95 beds as part of the initial Road to Recovery site in Vancouver
  - Up to 100 additional new beds over three years through the expansion of Road to Recovery to every health region.
  - 180 beds through provincial funding to the CMHA, exceeding the initial target of 100 beds committed through Budget 2023.
- A total of 202 of these beds have been implemented since then, with the rest in active planning and development.
- Since 2017, a total of 758 publicly funded substance use beds have been opened.
- In 2023/24, publicly funded treatment and recovery beds served 5,238 clients (adults only), more than 1,100 more clients than the previous year.
- In the first two quarters of FY 2024/25, Health Authority funded treatment and recovery beds served 2, 085 clients

[1] MMHA Substance Use Beds Data, monthly data sheet, March 25, 2024.

[2] Province of BC. BUDGET AND FISCAL PLAN - 2023/24 to 2025/26/7

(adult only) with a median wait-time of 28.2 days and bed utilization rate of Government %[3].

- In 2023/24, B.C. surpassed the forecast for the year, as well as the 2024/25 wait time target of 32 days for Health Authority funded treatment and recovery beds with an actual wait time of 31 days[4].

KEY BACKGROUND

- Data used for monitoring and evaluating publicly funded bed-based substance use beds services in BC comes from several sources including the Ministry's quarterly Beds Survey and quarterly performance measures data; and CMHA BC's monitoring and evaluation of grant funded beds.
- Historically, little data was collected from bed-based treatment and recovery services in BC beyond publicly funded bed counts.
- Since 2021, the Ministry has worked with health authorities to develop a performance measurement framework to monitor access and service utilization for HA funded adult bed-based SU treatment and recovery services.
- The Ministry continues to work with health authorities to strengthen data to support system planning.

Table 1: Client Counts, Utilization and Wait times for HA funded treatment and recovery beds, over time (does not include CMHA grant funded bed data)

Government Financial Information

Wait Time Benchmarks

- In 2024, Government introduced wait time benchmarks for HA funded treatment and recovery beds.
- In 2023/24, B.C. surpassed the forecast for the year, as well as the 2024/25 wait time target of 32 days for Health Authority funded treatment and recovery beds with an actual wait time of 31 days[5].
- Targets beyond 2026/27 and are under development and will be informed by the impact of recent investments in the system and the implementation of new models of care, like Road to Recovery.
- Wait times are complex data to collect and interpret, and there are numerous factors that contribute to wait times beyond bed availability. For example, wait times can be impacted by a client's personal readiness to start treatment, travel time to services, as well as family, childcare and work commitments

Table 2. Wait Times Benchmarks for HA funded Adult Treatment and Recovery beds[6]

Service Plan Cycle	Publicly Reported Benchmark in Annual Service Plan
Year 1: 2024/25	31 days (revised down from 32 days)
Year 2: 2025/26	30.5 days (revised down from 31 days)
Year 3: 2026/27	30 days

LAST UPDATED

The content of this estimates note is current as of Feb 7, 2025, as confirmed by Bethany Estiverne.

APPROVALS

2025 03 07 – Christine Voggenreiter obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 21 – Ally Butler, a/Associate Deputy Minister

[3] Data for Health Authority funded, adult treatment and supportive recovery beds only; excludes CMHA beds and youth beds.
[4] MHA Performance Data, provided by Health Authorities on quarterly basis.
[5] MHA Performance Data, provided by Health Authorities on quarterly basis.
[6] Ministry of Mental Health and Addictions. 2024/25-2026/27 Service Plan. https://www.bcbudget.gov.bc.ca/2024/sp/pdf/ministry/mha.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

Substance Use in Hospitals

Topic: Current policy and issues surrounding illicit substance use in hospital settings.

Key Messaging and Recommended Response:

- Illicit drug use at hospitals is prohibited outside of designated overdose prevention service (OPS) locations
- The safety of staff, patients, and visitors is of the utmost importance.
- That's why our government established a provincial policy, which supersedes local health authority policies, to clarify that drug use in hospitals is not allowed outside of designated OPS.
- Illicit drugs have become increasingly unpredictable and toxic. In this context, OPS are critical for saving lives and connecting people to care and treatment.
- We are working to finalize new minimum service standards for publicly funded fixed and mobile OPS, which will support consistency, quality, service accessibility, and cultural safety at these services.
- Minimum service standards development aligns with a recent recommendation from the Office of the Auditor General.
- Once the standards are finalized, we will work with health authorities and service providers on their implementation.
- This work is ongoing, and we will provide an update as soon as we can.
- In the meantime, we are going to keep building and expanding mental health and addictions services so people can get the care they need, where and when they need it. This includes detox, treatment, and aftercare services.

CURRENT SITUATION

- The *Substance Use and Addictions Management in Hospitals* policy (SUAM policy) lays out a coordinated provincial approach to substance use in hospitals, focusing on safety, patient care, and staff training.
- The SUAM policy prohibits the self-management of illicit substances in hospitals in BC, outside of a designated overdose prevention service (OPS) site.
    - OPS exist at some hospitals in BC.
    - Hospital-based OPS help keep patients, staff, and visitors safer by reducing harms associated with substance consumption, enhancing patient retention, and mitigating the risk of second-hand exposures to illicit drugs.
- The Ministry is working closely with health authorities to operationalize the SUAM policy, including posting signage in hospitals regarding the prohibition of illegal substances and substance use outside of designated OPS.
- In August 2024, the Province launched the Opioid Treatment Access (OTA) Line providing toll-free access to Opioid Agonist Treatment and connection to community resources for anyone in the province.
- Advice/Recommendations

FINANCIAL IMPLICATIONS

- Budget 2024 provides $48. 79 million over three years to support existing harm reduction initiatives at overdose prevention sites throughout the province, drug checking, and naloxone kit distribution.
    - This includes $10 million annually over three years to support OPS/supervised consumption services.

- Investments since Budget 2021 have enabled the implementation of on-site addictions care at most larger hospitals and virtual care supporting smaller hospitals.

KEY BACKGROUND

- In Spring 2024, the Ministry of Health released the SUAM policy, which lays out a coordinated provincial approach to substance use in hospitals. The policy comprises seven directives:
  - *The self-management (injection, inhalation/smoking or other means) of illicit drugs in hospitals or hospital sites is prohibited outside of a designated overdose prevention service site*
  - *All patients with substance use disorders will be supported in managing their addiction while in hospital and provided more effective support as needed towards stabilization, withdrawal management, treatment and recovery services both while in hospital and post-discharge into the community.*
  - *Addiction specialist care will be provided by on site clinicians or teams and/or through virtual clinical consultation.*
  - *All health authorities will continue to work to provide culturally safe care, free of racism.*
  - *Noncompliance to the policy will not be tolerated and will be effectively addressed.*
  - *Evidence based approaches to staff safety will be implemented with increased staff education.*
  - *Ensure Overdose Prevention Sites are working for people.*
- OPS save lives, reduce harms, and promote connections to care by allowing for the observed consumption of illicit substances and providing rapid response to adverse events.
- OPS can exist in community and hospital settings.
- In BC, OPS operate under provincial Ministerial Order 488/2016, which mandates BC Emergency Health Services and regional health boards to establish OPS wherever there is a need.

LAST UPDATED

The content of this estimates note is current as of February 19, 2025, as confirmed by Evan Howatson

APPROVALS

2025 02 26 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division
2025 03 24 – Darryl Sturtevant, ADM & a/Associate Deputy Minister

LEGISLATIVE SESSION – ESTIMATES NOTE
Treatment and Recovery System of Care Progress

Topic: Transforming Substance Use (SU) Care in BC.

Key Messaging and Recommended Response:

- Treatment and recovery services offer support and hope to people and families struggling with addiction challenges. Work is underway to continue to build up these services in every region.
- Every person's path to recovery is different, and the journey is not always linear.
- An integrated, patient-centred approach to care is needed to support people throughout their journey.
- To help people access the services they need, when they need them, we are implementing new models of care that are improving access to treatment and recovery for British Columbians.
- This includes expanding Road to Recovery, creating a new provincial Opioid Treatment Access Line, so people can access medication to treat opioid-use disorder and connect them to care; and adding more than 750 new publicly-funded adult and youth SU beds throughout the province.

CURRENT SITUATION

- The treatment and recovery system of care includes inpatient (bed-based) and outpatient services, and in-person and virtual services, available to both adults and youth.
- Treatment and recovery services include initial access, assessment and referral; withdrawal management (detox) and stabilization; transitional support; treatment, and long-term aftercare support.

Access, Assessment and Referral:

- As part of Road to Recovery, all Health Authorities (HAs) are establishing new **Access Central** service in 2025/26, that will provide a single phone line offering access to same-day clinical assessment for addictions and service matching.
- In Vancouver, where Access Central is already operating, between October 2023 to November 2024 more than 2,100[1] people were clinically assessed and supported to access withdrawal management services, with a median wait time of one day for those prioritized as urgent.
- **Rapid Access Addictions Clinics (RAACs)** throughout BC provide low barrier, same-day, assessment and treatment for people with SU concerns. In Q2 of 2024/25, 3,352 unique clients were served at RAACs across the province[2].

Withdrawal Management (Detox and Stabilization)

- Inpatient (bed-based) withdrawal management services exist in all health regions. There are currently 270 withdrawal management beds in BC, with 57 new beds since 2017 (48 adult and 9 youth)[3].
- There are also outpatient options available that support people in their homes and communities.

Transitional Supports

- Transitional support makes sure people do not get disconnected from care. For example, Community Transition Teams (CTTs) support individuals with Opioid Use Disorder to transition safely from provincial correctional facilities to community services. Budget 2021 supported the expansion by adding 5 new CTTs, and as of October 2023, there is a CTT team at each of the 10 provincial correctional centres in BC serving clients across the province. For Q1 and Q2 of 2024/25, CTTs reported 877 unique clients served with a median wait time (from client referral and service initiation) of 5.5 days[4].

Treatment

- In 2023/24, publicly funded treatment and recovery beds served 5,238 clients (adults only), more than 1,100 more clients than the previous year[5].
- One initiative that is expanding access to treatment services is provincial funding to the Canadian Mental Health

[1] MHA Performance Data, provided by VCH
[2] MHA Performance Data, provided by Health Authorities on quarterly basis
[3] MHA Bed Sheet, January 2025
[4] MHA Performance Data, provided by Health Authorities on quarterly basis
[5] MHA Performance Data, provided by Health Authorities on quarterly basis

Association (**CMHA)** to deliver new treatment and supportive recovery beds. Currently 248 CMHA funded beds are open, with 45 expected to open this year, for a total of 293 beds being implemented by Summer 2025[6].

- The **Road to Recovery (R2R) expansion** will also add up to 100 new SU beds over three years, and an additional 35 new treatment beds in the Vancouver region.
- The Opioid Treatment Access (OTA) Line launched in August 2024 and provides 7-day a week same-day access to opioid agonist treatment. The Access Line has provided prescriptions to clients in all HAs.
- Work is also underway to expand access to culturally safe treatment services through an **Indigenous Treatment, Recovery and Aftercare Services Program** (XREF: Indigenous Fund EN) and Tripartite work to replace six existing First Nations-run treatment centres and build two new ones (XREF: First Nations Treatment Centres EN).
- In addition, outpatient treatment services play an important role in supporting clients. For example, the **Day, Evening, Weekend (DEW) Treatment Program** in Fraser Health offers group outpatient support online or in person. Government invested in this program through Budget 2021 and is continuing to support the enhancement of this program as part of Road to Recovery.

Aftercare Supports

- Long term supports are being expanded in every health region new aftercare clinicians (ACCs) and Recovery Community Centres (RCCs).
- RCCs provide low-barrier, community-based supports beyond the clinical setting. Services include: 1:1 support, support groups, education and learning, and health and wellness activities. To date, there are 3 RCCs operating in the Vancouver Coastal region in Vancouver, the North Shore, and Sunshine Coast, with four more in planning stages, one in each HA.
- In addition, 40 aftercare clinicians funded through Budget 2023 have been hired and are serving clients.

Service Quality and Oversight

- In addition to actions to improve access, government has been working on strategies to improve safety and quality across the bed-based sector since 2018.
- Budget 2023 funded the Adult Bed-based SU Treatment and Recovery Oversight and Accountability (BOA) Project. Key progress includes the establishment of a new team of dedicated investigators and initiated proactive annual inspections in 2024 at registered sites (starting in the Fraser Health region; 68 of 74 completed).

FINANCIAL IMPLICATIONS

- Budget 2023 provided $55.86 million in operating funding over three years to Road to Recovery in Vancouver.
- Budget 2023 provided $153.76 million in operating funding over three years to support Road to Recovery expansion.
- Budget 2024 provided $117.31 million over three years in operating funding for substance use beds.
- Cabinet Confidences; Government Financial Information

BACKGROUND

- Since 2017, the province has been working to increase treatment and recovery services across the province of BC for people with SU challenges.
- In Budget 2023, the province made a historic investment to expand mental health and addiction care and strengthen the continuum of care including through new approaches, like R2R.
- Since 2021, the Ministry has worked with HAs to develop a performance measurement framework to monitor access (with a focus on wait times) and service utilization for HA funded adult bed-based SU treatment and recovery services in BC. Prior to this little information was available.
- The Ministry continues to work with HAs and partners to strengthen data for system planning.

LAST UPDATED

The content of this estimates note is current as of February 7, 2025, as confirmed by Bethany Estiverne.

APPROVALS

2025 02 26 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division
2025 03 12 – Ally Butler, A/Associate DM, Mental Health and Addictions

[6] CMHA reporting to MHA

LEGISLATIVE SESSION – ESTIMATES NOTE

Youth Substance Use Services (including beds and data)

Topic: Implementation of new and expanded youth substance use (YSU) beds and services.

Key Messaging and Recommended Response:

- Young people in British Columbia need access to age-appropriate mental health and addiction services that meet their unique needs.
- That's why our Government is taking action to improve mental health and addictions services and increase access to specialized treatment and recovery so young people can live full and healthy lives.
- This includes expanding youth addiction services across the whole spectrum of care in every health authority and creating new youth substance-use beds to increase access to treatment.
- As of January 2025, there are 208 community-based YSU beds in British Columbia.[1]
- 110 YSU beds have opened since 2017, including 38 new beds since March 2024.
- The ministry is also working with health authorities to expand non-bed-based substance use services for young people, including crisis supports, culturally safe wraparound services, improved emergency room hospital-based care, and enhanced discharge planning and transition between acute care and community-based services. This builds on investments made in new and expanded YSU services in Budget 2021.

CURRENT SITUATION

- The system of YSU care includes a broad range of bed-based and non-bed-based services, spanning prevention and wellness promotion, early identification and intervention, assessment and care planning, treatment, ongoing healing and transition support, and crisis response.
- Services are intended to meet each individual's unique needs and include case management, outreach programs, community counselling, day treatment, home and community-based withdrawal management (detox), bed-based treatment (generally 30-90 day program duration), bed-based supportive recovery (generally 60-120 days), bed-based transitional services (generally up to 30 days), harm reduction services and supports, crisis intervention services, and medication-assisted treatment.
- Progress continues to be made in opening new youth substance use beds, including in Indigenous-led spaces.
- There are currently 208 publicly-funded YSU beds across the province. This includes 110 that have been opened since 2017:
  - 90 new beds have opened since government committed to opening 123 new beds in 2020, and
  - of those 90 new beds, 32 have opened since March 2024.
- Challenges to opening new YSU beds include facility availability, cost pressures relative to the model of care for youth often requiring a more intensive clinical response than adults (e.g., 24/7 monitoring), and health human resource recruitment challenges (particularly in rural and remote areas).
- Provincially, as of September 2024, the unweighted average utilization rate is Gov ern men t% for youth withdrawal management beds and Go ver % for treatment, supportive recovery, and transitional beds.[2]
- Wait times for YSU beds do not necessarily indicate a shortage of bed-based services. At any given time, there may be both wait times and underutilization of beds across the system of care, depending on referral volumes, geographic location, specific client needs, type of bed-based care, and demands in the given region. For example, wait times can be impacted by personal readiness to start treatment, including release from custody or the need to arrange child care. Similarly, a bed may be held for a young person in preparation for them to begin treatment soon,

[1] Child and Youth Mental Health and Substance Use Policy Branch, Mental Health and Addictions Division, Ministry of Health. (2025). January 2025 Bed Sheet. Data as of January 28, 2025.

[2] The utilization rate is the unweighted average percentage of funded beds occupied during the most recent three complete fiscal periods, before the survey date, for which data are available. Integrated Analytics: Community and Cross Sector Branch; Health Sector Information Analysis and Reporting Division, Ministry of Health. (2024). RMS 10367 MHSU Bed Information 2024-09-30. Data as of November 28, 2024.

but the bed would only be counted as utilized from the start of service.

- An increasing number of youth are presenting with complex care needs (e.g., anoxic brain injury, eating disorder, concurrent mental health and substance use disorders), making it more difficult to match youth with appropriate supports. HLTH continues to work with health authorities to address these challenges.
- Regional health authorities, the Provincial Health Services Authority (PHSA), and First Nations Health Authority are implementing new and expanded non-bed-based YSU services funded through Budget 2023.
- The Ministry of Health (HLTH) and PHSA have co-led the creation of a draft provincial framework, together with partners, to help guide system planning towards an optimal system of YSU care. The draft framework and corresponding analysis will be presented to the Minister in spring 2025.

FINANCIAL IMPLICATIONS

- In 2017/18, HLTH provided one-time funding of $3.7 million to the Fraser Health Authority to implement 20 youth live-in treatment beds and intensive outpatient treatment services at Traverse (Chilliwack).
- Budget 2021 provided $50.55 million over three years to support 123 new YSU beds and enhance provincially accessible specialized beds.
- Budget 2023 provided $161.52 million in funding over three years to increase services for young people, including YSU crisis supports, culturally safe wraparound services, enhanced transition services, and improved emergency room hospital-based care and discharge planning.

KEY BACKGROUND

- Through Budget 2021, government made a historic investment in 33 new and expanded non-bed-based substance use services for youth across the continuum of care in all regions of the province. 12,848 young people accessed these new and expanded services in fiscal year 2023/24.
- Budget 2023 built on previous investments to further expand non-bed-based substance use services for young people across the province, including crisis supports, culturally safe wraparound services, improved emergency room hospital-based care, and enhanced discharge planning and transition between acute care and community-based services. HLTH continues to work with health authorities to support implementation of the new and expanded services funded through Budget 2023.
- Investments made in non-bed-based YSU services complement investments made in youth bed-based care.

LAST UPDATED

The content of this estimates note is current as of February 12 as confirmed by Kelly McConnan.

APPROVALS

2025 03 11 – Francesca Wheler, Child, Youth, Indigenous Partnerships and Community Initiatives
2025 03 12 – Ally Butler, A/Associate DM, Mental Health and Addictions

LEGISLATIVE SESSION – ESTIMATES NOTE

Access to New Drugs in BC Compared to Other Jurisdictions

Topic: Access to New Drugs in BC Compared to Other Jurisdictions

Key Messaging and Recommended Response:

- The Provincial Government is committed to ensuring that people in BC have access to the medications they need to manage their health conditions.
- In 2023, BC became the first province to provide 100% coverage of prescription contraceptives and 100% coverage of opioid agonist treatment for all residents.
- BC has income-based Fair PharmaCare, which provides universal coverage for residents.
- BC's PharmaCare Program is one of the most generous drug coverage programs in Canada with many plans providing 100% coverage.
- In 2018, the Government invested $105 million to eliminate or reduce Fair PharmaCare deductibles for working families with the lowest incomes in the province. These were the first changes to deductibles since 2003.

If asked about the drug review process

- To ensure health services are sustainable, fair and effective, the Ministry of Health requires all drugs to undergo a rigorous, scientific review process at both the national and provincial level.
- The Ministry makes PharmaCare coverage decisions by considering existing PharmaCare policies, programs, priorities and resources, and the evidence-informed recommendations of an independent advisory body called the Drug Benefit Council, as well as recommendations by Canada's Drug Agency.

If asked about drug coverage in BC compared to other provinces/territories:

- Although Canada has established national processes to review drugs and negotiate drug prices, each province and territory makes funding decisions based on their individual health system needs.
- Similarly, each province has a drug plan that is unique to their local needs.
- While there are cases in which other provinces cover a drug not included in BC's PharmaCare's benefit list, there are also cases in which PharmaCare covers a drug that other provinces do not.
- In cases where a particular drug is not covered by the province, PharmaCare may cover a clinically equivalent alternative drug within the same drug class.

CURRENT SITUATION

- Innovative Medicines Canada (IMC) is a lobby group that represents Canada's innovative pharmaceutical industry. They, along with their network of patient groups such as the Gastrointestinal Society, assert the following:[1]
  - BC covers the fewest drugs of all provinces, e.g., between 2018 and 2023, BC refused to cover 31 newly recommended medications when Ontario declined coverage for only 2 and Alberta for 3.
  - BC underfunds its drug program and spends only $257 per person on medications compared to the Canadian average of $442.
  - While these low spending figures might be touted by government as good fiscal management, what it really means is that patients can't get the medications they need.

FINANCIAL IMPLICATIONS

- A drug that has not demonstrated value for money when reviewed by PharmaCare's rigorous and transparent process is not added to the PharmaCare formulary.
- A formal budget impact analysis has not been completed for all 39 drugs identified by the IMC. Advice/Recommendations

Advice/Recommendations

[1] BC Medication Coverage Report https://badgut.org/wp-content/uploads/BC-Medication-Coverage-Report-2024-FINAL.pdf. P2

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- IMC represents 47 of the largest pharmaceutical companies in the world including Eli Lilly, Novo Nordisk, Johnson & Johnson, Merck, Roche, AstraZeneca, AbbVie and Pfizer.
- IMC therefore has a direct financial interest in advocating for increased drug expenditure in BC.
- In summer 2023, IMC presented BC PharmaCare with its latest analysis that there are drugs used to treat 39 indications that, since 2015, BC has not covered even though there is a positive recommendation from Canada's Drug Agency – L'Agence des médicaments du Canada (CDA-AMC), as well as a pan-Canadian Pharmaceutical Alliance (pCPA) negotiated price.
- BC completed 467 drug reviews between January 1, 2015, and October 1, 2023. The 39 coverage decisions about which IMC and MedAccessBC have inquired are a fraction of the total decisions made.[2]
- The drugs on the IMC list have either therapeutic alternatives already listed on the PharmaCare formulary that provide better value for money or the confidential negotiated price by the pCPA did not reach the cost -effective price determined by the CDA-AMC and, therefore, would not be an efficient allocation of resources.
- Overall, among the provinces, there is a relatively high degree of consistency in terms of which drugs are covered. In cases where a particular drug is not covered by a province, the province may in fact cover a clinically equivalent alternative drug within the same drug class. In terms of the extent of coverage, BC provides one of the most generous drug coverage programs in Canada with many plans providing 100% coverage and Fair PharmaCare, providing universal income-based coverage.
- The pharmaceutical industry has used similar arguments to lobby for increased drug expenditure in BC for over a decade.
- BC has the lowest debt-to-GDP ratio in the country. This puts BC in a stronger position to continue to invest in people, not in drugs without proven cost-effectiveness.
- BC, Saskatchewan and Manitoba are the only provinces that offer income-based universal drug coverage programs.

LAST UPDATED

The content of this estimates note is current as of March 19, 2025, as confirmed by Tijana Fazlagic, Executive Director.

APPROVALS

2025 03 20 – Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025 02 24 – Health Sector Information, Analysis & Reporting Division, Lenore Ogilvy OBO. Martin Wright
2025 03 07 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division

[2] Data taken from PharmaCare Formulary Management Database by Drug Review Process Manager, Kyle Stirling.

LEGISLATIVE SESSION – ESTIMATES NOTE

Cabenuva Drug Coverage for HIV

Topic: Coverage of Cabenuva, an injectable antiretroviral therapy for people living with HIV.

Key Messaging and Recommended Response:

- BC provides drug treatments for HIV-AIDS through the BC Centre for Excellence in HIV/AIDS (BC-CfE).
- The BC Centre for Excellence is the largest HIV/AIDS research and treatment facility in Canada.
- The BC Centre for Excellence is responsible for reviewing drugs for treatment of HIV/AIDS, establishing treatment guidelines, and providing coverage for eligible drugs.
- Cabenuva is an extended-release injectable therapy to treat HIV-1 infection in people 12 years and older. It is a relatively new injectable treatment for HIV patients that is administered monthly or bi-monthly and can be used by some patients as an alternative to daily oral medications.
- Cabenuva has been reviewed by the BC-CfE and is currently available to people in BC through the BC-CfE.
- Patients must meet certain criteria to be eligible for provincial funding of Cabenuva. Because of the particulars of the drug, Cabenuva is recommended in very specific clinical circumstances, consistent with the product's regulatory approval.
- Healthcare providers experienced in the management of HIV can request Cabenuva for eligible patients by making an application to the BC-CfE, which reviews such applications on a case-by-case basis.

CURRENT SITUATION

- In British Columbia, the BC Centre for Excellence in HIV/AIDS (BC-CfE) leads HIV/AIDS research and treatment. In that role, BC-CfE develops the guidance and patient eligibility requirements for drugs used to treat HIV/AIDS, including Cabenuva.
- As with all drugs considered for coverage in BC, the decision about whether and how to fund this drug is based on expert input and clinical evidence.
- The Ministry of Health (the Ministry) and the First Nations Health Authority support the BC-CfE's development of policies and programs, which includes decisions about the drug treatments it oversees.
- In order for BC patients to receive funding for Cabenuva, they must meet certain clinical criteria, which are consistent with the drug's regulatory approval, and be able to satisfy all logistical considerations. This is to ensure patient safety.
- Cabenuva has exacting requirements for its prescribing, handling, storage, scheduling, and administration. The BC-CfE reviews and adjusts criteria as necessary as evidence evolves and health care challenges evolve.
- The BC-CfE leads HIV/AIDS research and treatment in the province and develops guidance and patient eligibility criteria for the drugs used to treat HIV/AIDS.
- As is the case for all drugs funded by the Ministry , the funding criteria for HIV/AIDS treatments were developed based on expert input and clinical evidence.
- The Ministry supports the BC-CfE's decisions about the drug treatments it oversees.
- Certain criteria must be met for patients to receive funding for Cabenuva therapy; one of the requirements is that they are unable to take oral drug alternatives.
- Patients who have a prescription for HIV/AIDS drugs can opt to fill their prescription at any pharmacy, if they don't qualify for or choose not to receive them through the BC-CfE.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- For fiscal year 2023-24, the Ministry committed to provide up to $110M in funding to the BC-CfE.
- Based on transparent pricing, the cost of one year of Cabenuva treatment is approximately $14,500 per patient. The cost of comparable oral treatments ranges from $9,907 to $19,769 annually based on transparent pricing.
- HIV/AIDS treatments provided by the BC-CfE are 100% covered for qualifying patients.

KEY BACKGROUND

- Cabenuva is a combination therapy made up of cabotegravir (200mg/mL, 2mL vial) and rilpivirine (300mg/mL, 2mL vial) injections. It is an extended-release injectable treatment used to treat HIV infection in people who are 12 and older.
- In contrast to currently available oral HIV therapies, there are a range of additional clinical, logistical, and administrative considerations in determining whether this treatment is right for the patient.
- The key difference between Cabenuva and conventional oral therapies is that Cabenuva must be injected by a healthcare professional every month (or, in some cases, every two months), while oral therapies (one to three pills) are taken at home every day.
- The potential failure to ensure clinical appropriateness for this 2-drug therapy, or the inability to support on-time injections, include possible treatment failure and acquired drug resistance to key HIV drug classes.
- The possibility of acquiring drug resistance has potential serious implications in limiting future treatment options for an individual and warrants thoughtful consideration for eligibility.
- As of September 2024, 32[i] patients are receiving Cabenuva through the BC-CfE's Drug Treatment Program.

LAST UPDATED

The content of this estimates note is current as of January 28, 2025, as confirmed by Tijana Fazlagic.

APPROVALS

2025-02-28– Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025 02 24 – Brenda Rafer obo Rob Byers, ADM, Finance and Corporate Services Division

[i] BC-CfE Drug Treatment Program monthly report, p36 table 2.9, retrieved on February 6, 2025. https://bccfe.ca/wp-content/uploads/2024/12/cfe-status-report-sept2024.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

Canada's Drug Agency Appropriate Use Strategies

Topic: Overview of current programs in BC that support appropriate use of medications and Canadian Drug Agency's upcoming pan-Canadian Appropriate Use Strategy as mandated by Bill C-64*, An Act respecting pharmacare* (Pharmacare Act)

Key Messaging and Recommended Response:

- Appropriate use can be defined as taking medications in a manner best suited for a person's needs to provide the greatest possible benefit and avoid unnecessary harm.
- As required by the *Pharmacare Act*, Canada's Drug Agency (CDA) is developing a pan-Canadian Appropriate Use strategy to address appropriate use of prescription medications in Canada.
- For many years, BC has implemented several evidence-informed appropriate use programs and is well-positioned to support and participate in CDA's new Appropriate Use Strategy.
- The Ministry will continue to collaborate with provincial and federal partners to facilitate and advance appropriate use of medications in BC.

CURRENT SITUATION

- As mandated by the *Pharmacare Act*, Canada's Drug Agency (CDA) is developing a pan-Canadian Appropriate Use Strategy with the goal of coordinating and supporting existing appropriate use organizations and initiatives across the country while developing a national program to address appropriate use of prescription medications in Canada.
- The CDA is currently conducting townhall meetings with partners to identify jurisdictional needs. Intergovernmental Communications
- For many years, the Ministry has funded several provincial programs to support the appropriate use of medications, including:
    1) **BC Provincial Academic Detailing (PAD) service**[1]: A collaborative initiative with the regional health authorities that provides evidence-based and practical drug information to primary care clinicians with the goal of supporting clinical decision-making. PAD's team of 12 pharmacists provide 1-on-1 or small group educational sessions on selected drug therapy topics. Internal program evaluation reports indicate that the service reaches over 2500 health care professionals for each topic in over 100 communities. Academic detailing has been demonstrated to be an effective method for educating health care professionals and promoting better patient health.[2,3]
    2) **Community Antimicrobial Stewardship (CAS) Program**[4]: Based at the BC Centre for Disease Control (BCCDC), the program addresses the problem of antibiotics resistance and supports the appropriate use of antimicrobials through public education, professional outreach and education, and surveillance and research. A cost benefit analysis on the first 9 years of the CAS program (2005-2014), formerly known as 'Do Bugs Needs Drugs,' demonstrated that for every dollar spent on the program, there was a conservative savings of $76.20.[5]
    3) **Prescribing Portraits**[6]: Developed by UBC's Therapeutics Initiative, Prescribing Portraits is an audit and feedback program that provides BC clinicians with timely evidence, personalized prescribing data, and recommendations to support better prescribing and better health for patients. Generally, 2 Portraits are implemented each year on select topics where inappropriate medication use has been identified. Past topics have included opioids in treatment naïve patients, antibiotics for dental

[1] BC Provincial Academic Detailing (PAD) service - Province of British Columbia. https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pad-service

[2] Sketris I, Ingram EL, Lummis H. Optimal Prescribing and Medication Use In Canada: Challenges And Opportunities. Toronto ON: Health Council of Canada; 2007.

[3] Health Council of Canada. Safe and Sound: Optimizing Prescribing Behaviours - Summary of Main Themes and Insights (Report on a Policy Symposium). Toronto, ON: Health Council; 2007.

[4] Community Antimicrobial Stewardship. http://www.bccdc.ca/our-services/programs/community-antimicrobial-stewardship

[5] Mamun A, Zhao B, McCabe M, et al. Cost-benefit analysis of a population-based education program on the wise use of antibiotics - PMC Aug 2019.

[6] Therapeutics Initiative | Prescribing Portraits https://www.ti.ubc.ca/portrait/

infections. In general, audit and feedback programs are effective at encouraging professionals to change their clinical practice.[7] Formal evaluation of TI's Prescribing Portrait program is underway.

4) **Prescription Monitoring Program (PMP)**: In partnership with the Health Information, Analysis and Reporting Division and regulatory colleges, the PMP was established to promote public safety and enhance health outcomes through identifying trends in prescribing and/or dispensing of opioids, sedatives, stimulants, benzodiazepines or other psychoactive compounds as well as providing individual prescribing statistics for clinicians.

- The Ministry also regularly collaborates with researchers and partner organizations (such as Health Quality BC) to identify areas of inappropriate use and facilitate and advance appropriate use initiatives.

FINANCIAL IMPLICATIONS

For fiscal year 2024/25, funding in the amount of $2,438,902 is committed for the BC PAD Service; $998,000 for the CAS Program (BCCDC); and $1,915,000 for UBC's Therapeutics Initiative, which includes funding for the Prescribing Portraits program.

KEY BACKGROUND

- Over half of Canadian adults aged 18 to 79 have used at least 1 prescription medication in a month[8] and according to data from the Canadian Institute for Health Information, 1 in 4 Canadian seniors were prescribed 10 or more drug classes in 2021.[9]
- Inappropriate use of medications can cause more harm than benefit even when taken as prescribed. It can also lead to significant negative health safety, social and financial impacts (e.g. antimicrobial resistance, falls, hospitalizations) and disproportionately impacts vulnerable populations (e.g. seniors, racialized communities, people living with mental illness). It also has significant final costs to the health system and for individual patients.
- On October 10, 2024, Bill C-64, *An Act respecting Pharmacare (Pharmacare Act),* received Royal Assent. In addition to setting out the principles for working toward the implementation of national universal pharmacare, the Act also requires the CDA to develop a pan-Canadian strategy on the appropriate use of prescription medications.
- The CDA states "appropriate use of prescription medications means people are taking medications best suited for their needs in order to provide the greatest possible benefit and avoid potential harm. Medication appropriateness prioritizes patient safety and creates better health outcomes, which will help health systems become more sustainable."[10]
- The CDA's Appropriate Use Strategy will have four priorities:
    1) Connect – Link partners, enhance connections and provide comprehensive information about appropriate use;
    2) Partnerships and program development – Create opportunities to develop, adapt and implement appropriate use initiatives;
    3) Strategy and policy – Develop evidence-informed advice and recommendation for policy makers on the adoption and implementation of appropriate use policies and strategic initiatives; and
    4) Evaluation and reporting – Evaluate projects and clearly communicate their effectiveness.

LAST UPDATED

The content of this estimates note is current as of March 7, 2025, as confirmed by Susan Bouma.

APPROVALS

2025 03 25 – Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025 03 11 – Patrick Day obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 14 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

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[7] Ivers, N Jamtvedt G, Flottorp S, et al. Audit and feedback: effects on professional practice and patient outcomes | Cochrane Jun 2012.
[8] Statistics Canada. (2021, June 28). Retrieved from Prescription medication use among Canadian adults, 2016 to 2019: https://www150.statcan.gc.ca/n1/en/daily-quotidien/210628/dq210628e-eng.pdf?st=C5O2xztn
[9] Drug use among seniors in Canada | CIHI https://www.cihi.ca/en/drug-use-among-seniors-in-canada
[10] A Path to Improving Medication Appropriateness in Canada: Canadian Drug Agency Transition Office: https://www.canada.ca/en/health-canada/corporate/about-health-canada/activities-responsibilities/canadian-drug-agency-transition-office/path-improving-medication-appropriateness-canada.html#a3

LEGISLATIVE SESSION – ESTIMATES NOTE

Canadian Blood Services Plasma Collection Contract

Topic: Canadian Blood Services (CBS) has a contract with Grifols, a global healthcare company, to increase Canada's domestic self-sufficiency of lifesaving plasma derived products. Under the contract, Grifols is establishing and operating collection centres that financially remunerate donors for their plasma.

Key Messaging and Recommended Response:

- In 2018 British Columbia passed the Voluntary Blood Donations Act (The Act) that prohibits organizations from paying donors for blood and plasma donations.
- The Act was brought into force to: protect the public blood system from encroachment by the private sector; ensure that plasma collected from British Columbians was used to treat patients in Canada; and, to prevent private entities from exploiting an essential resource and the individuals who generously donate blood.
- The Act provides exemptions for select organizations and prescribed classes in the event that renumeration of donors was necessary. It was not intended to allow a private entity to establish collection sites in BC with a donor renumeration model.
- In September 2022, Canadian Blood Services (CBS) announced an agreement with Grifols to ensure patients in Canada continue to have long-term access to immunoglobulins following the global shortage of plasma to make into immunoglobulin products during the COVID-19 pandemic. The goal is to make Canada less dependent on the global market by producing 50-60% of products domestically.
- Of note, Grifols isn't planning to open any payment for donation centres in BC.
- On behalf of the provinces and territories, CBS is responsible for ensuring Canadian patients who rely on immunoglobulin have a secure supply. All provinces and territories contribute to the national operational funding of voluntary non-renumerated CBS plasma collection sites in Canada.
- CBS is increasing their own plasma collection through the establishment and operation of 11 CBS plasma donor centres, funded by federal, provincial, and territorial governments.
- There are two CBS plasma collection centres open in BC: one in Kelowna and one in Abbottsford.
- Currently, in BC, the CBS model for blood and plasma collection does not pay donors for blood, plasma or any other kind of donation. Our voluntary blood donation system is an integral resource that patients rely on. We are thankful to people who graciously donate their blood to save lives every day.
- Plasma self-sufficiency is an important topic for BC. BC has and will continue to support Canadian Blood Service's efforts to increase plasma collections and ensure domestic security of immunoglobulins for Canadian patients.
- At the same time, BC also remains committed to protecting and enhancing the voluntary donations system, through enforcement of the Voluntary Blood Donation Act.

CURRENT SITUATION

Plasma and Ig

- Ig is a life-saving treatment for over 50% of the patients who rely on this product.[1]
- Currently, only 25% of the Ig that is used to treat Canadian patients is made from plasma collected in Canada.[2] The rest comes from paid donors in the United States.

[1] Plasma and Immunoglobulin Security of Supply: Risk-Based Decision-Making Analysis (June 2022) p 11.
[2] Canadian Blood Services Performance Report to Members (Q1 2024-25), September 27, 2024, p 12.

- In recent years, the global supply of plasma has been disrupted and constrained due to factors such as the COVID-19 pandemic and inflation, highlighting the importance of a domestic supply of plasma.
- To increase domestic plasma self-sufficiency for making Ig, CBS, with the backing of PT governments, has nine dedicated plasma collection centres and plans for two more. Two centres are open in BC: one in Kelowna (opened June 2021), and the other in Abbotsford (opened April 2023).

Grifols Contract

- CBS is targeting 50% plasma self-sufficiency, based on a 2022 Risk Based Decision Making framework created by the Association of Blood Operators, an evidence based-based review that recommended a self-sufficiency target range of 50-60% and to leverage the expertise of the commercial plasma collection industry.
- CBS has a 15-year contract with Grifols (publicly announced September 7, 2022) under which Grifols will open plasma collection centres in Canada, with the plasma collected used to make Ig exclusively for Canadian patients.
- CBS' collections, once fully established, are expected to provide 25% domestic plasma sufficiency and Grifols is expected to provide the additional capacity to reach the 50% target.
- CBS currently collects 18% and Grifols currently collects 7% of the plasma used to make Ig for Canadian patients, together bringing Canada's sufficiency halfway towards the 50% target.[2]
- Grifols pays donors for their plasma, which contrasts with CBS' voluntary donation model.
- As the national blood operator for Canada, CBS is entrusted with the operational authority to establish and implement this contractual agreement.

Other Jurisdictions

- Ontario and Quebec are the only other jurisdictions with legislation prohibiting remuneration for blood and plasma donation. Ontario will allow Grifols to operate as an agent of CBS under their legislation.
- Grifols has centres in Alberta, Saskatchewan, Manitoba, New Brunswick, and Nova Scotia plans to open five more in Ontario, in locations approved by CBS.

FINANCIAL IMPLICATIONS

- For 2023/24, CBS' total national expenditures were $1.49 billion with BC's portion of this at $251 million. Of the total expenditures, the amount for plasma operations totaled $35 million nationally, and $6 million for BC.[3]

KEY BACKGROUND

- CBS is a national not-for-profit organization established in 1998, by a Federal/PT Memorandum of Understanding to supply blood, blood products and their alternatives to PT health systems (except Québec, which has its own blood system). CBS operates at arm's-length from governments.
- PT Ministers of Health do not direct operational decisions of the CBS Board of Directors or its staff. As Corporate Members of CBS, PT Ministers of Health have a role similar to shareholders and are responsible for funding CBS.

LAST UPDATED

The content of this estimates note is current as of February 4, 2025, as confirmed by Mariana Diacu, Executive Director of the Laboratory and Blood Services Branch.

APPROVALS

2025-03-03– Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025 02 24 – Brenda Rafter obo, Rob Byers, Finance and Corporate Services Division

[3] Canadian Blood Services 2023-24 Non-Consolidated Financial Statements, Schedule 3

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Antiviral Treatments

Topic: Update on access to antiviral drugs nirmatrelvir/ritonavir (Paxlovid) and remdesivir (Veklury) for the treatment of mild to moderate COVID-19

Key Messaging and Recommended Response:

- Two antivirals, an oral treatment, nirmatrelvir/ritonavir (Paxlovid™), and an IV treatment, remdesivir (Veklury™), are approved for treatment of mild to moderate COVID-19 in patients at high risk for progression to severe disease.
- Paxlovid was approved by Health Canada in January 2022 and initially provided to BC residents through a federal supply. In 2024, after the federal stock expired, the BC Ministry of Health decided to continue offering Paxlovid under PharmaCare Plan Z making it accessible at no cost for eligible patients.
- In BC, Paxlovid is recommended for use in clinically extremely vulnerable groups, such as immunocompromised individuals or patients with serious chronic conditions as these patients are most likely to benefit from treatment. Paxlovid must be initiated within 5 days of symptom onset for COVID-19.
- BC patients may get a prescription for Paxlovid through their primary care provider or through a centralized intake system by contacting Service BC. All community pharmacies in BC can order and dispense Paxlovid.
- A real-world effectiveness study in BC has shown that Paxlovid moderately reduces the risk of hospitalization or death (an absolute risk reduction of 2.5%, 95% CI, -4.8% to -0.2%) amongst those who are severely and moderately immunosuppressed. Given the high vaccination rate and most patients having experienced at least 1 COVID-19 infection, the overall risk of hospitalization or death in severely immunosuppressed patients is now low (approximately 3%), even without treatment with Paxlovid.
- In October and November 2024 there was a temporary shortage of Paxlovid.
- The COVID-19 Therapeutics Committee (CTC) and the COVID-19 Treatment Review and Advisory Group (CTRAWG) recommend Veklury can be used as the first-line alternative IV treatment if Paxlovid cannot be prescribed.
- Patients who require Veklury are receiving treatment through hospital clinics.

CURRENT SITUATION

- Paxlovid is an oral antiviral medication indicated for individuals with mild to moderate COVID-19 who are at high risk of developing serious illness. Paxlovid is available through community pharmacies.
- Veklury is an antiviral administered intravenously (IV) with a similar indication as Paxlovid and is generally used when an individual cannot take Paxlovid due to drug-drug interaction or contraindications. Veklury is also approved for hospitalized COVID-19 patients requiring supplemental oxygen. Veklury is available through hospital clinics.
- Other specific treatments available for hospitalized COVID-19 patients are dexamethasone, tocilizumab, baricitinib, anticoagulation and longer courses of remdesivir (Veklury).
- From January 31, 2022, the Public Health Agency of Canada procured and allocated Paxlovid and Veklury to provinces and territories. Federally procured Paxlovid was provided to patients through PharmaCare Plan Z. From January 31, 2022, to December 31, 2024, over 45,300 Paxlovid treatment packs were dispensed to more than 40,800 patients in BC.[1]
- The federal supply ended on March 31, 2024, and Paxlovid supply expired by May 31, 2024.

[1] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting Division, March 5, 2025

- A real-world evaluation by the Therapeutics Initiative (TI) using BC data showed that clinically extremely vulnerable 1 (CEV1) patients who received Paxlovid were associated with a 2.5% absolute risk reduction in hospitalization and mortality compared to similar patients without Paxlovid. There was a 1.7% risk reduction in CEV2 patients, and no benefit was observed in the CEV3 and non-CEV patients.[2]
- The TI study informed the Canada's Drug Agency (CDA-AMC) recommendations for reimbursement conditions of Paxlovid, which includes treatment of patients who are moderately or severely immunosuppressed.
- Effective May 28, 2024, after the federal stock expired, the Ministry of Health decided to continue offering Paxlovid under PharmaCare Plan Z, making it accessible at no cost for eligible patients.
- The CDA-AMC completed its reimbursement reviews for Veklury (for both hospitalized and non-hospitalized patients) on August 16, 2024. The CDA-AMC recommended participating drug plans should reimburse Veklury as a benefit with specific clinical criteria and with a significant price reduction.
- BC participated in the pan-Canadian Pharmaceutical Alliance negotiations with the manufacturer and remdesivir is provided to patients through health authorities.

FINANCIAL IMPLICATIONS

- The coverage of Paxlovid was estimated at $24 million per year based on transparent pricing and utilization.[2]

KEY BACKGROUND

- The COVID-19 Therapeutics Committee (CTC) and the COVID-19 Treatment Review and Advisory Group (CTRAWG) reviewed clinical evidence for drugs proposed for treatment of COVID-19 and provided recommendations and decisions on their use in BC.
- A real-world evaluation by the TI using BC data showed that clinically extremely vulnerable 1 (CEV1) patients who received Paxlovid were associated with a 2.5% absolute risk reduction in hospitalization and mortality compared to similar patients without Paxlovid. There was a 1.7% absolute risk reduction in CEV2 patients and no statistically significant benefit was observed in the CEV3 and non-CEV patients.[3]
- The TI study informed CDA's draft recommendations for reimbursement conditions of Paxlovid which include treatment of patients who are moderately or severely immunosuppressed.
- Paxlovid is associated with significant drug-drug interactions and contraindications. Pharmacists are involved in patient medication reviews prior to the prescription being provided by a prescriber or at the time of dispensing.
- CTC and CTRAWG recommend Veklury be used as the first-line alternative IV treatment if Paxlovid cannot be prescribed. Veklury was also studied in severely ill COVID-19 patients and was authorized by Health Canada in July 2020 for the treatment of hospitalized patients with pneumonia requiring supplemental oxygen. However, due to a lack of clinical benefit in survival, disease progression of length of hospital stays, the CTC did not recommend routine use of Veklury in severely ill patients.

LAST UPDATED

The content of this estimates note is current as of March 4, 2025, as confirmed by Tijana Fazlagic.

APPROVALS

2025 03 25 – Ian Rongve, ADM Pharmaceutical, Laboratory and Blood Services Division
2025 03 12 – Patrick Day obo Martin Wright, Health Sector Information, Analysis & Reporting Division

[2] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting Division, March 12, 2025.
[3] Dormuth CR, Kim JD, Fisher A, et al. Nirmatrelvir-Ritonavir and COVID-19 mortality and hospitalization among patients with vulnerability to COVID-19 complications *JAMA Network Open.* 2023;6(10):e2336678. doi:10.1001/jamanetworkopen.2023.36678.

LEGISLATIVE SESSION – ESTIMATES NOTE
Diacetylmorphine Expenditures

Topic: Diacetylmorphine drug expenditures for injectable opioid agonist treatment programs

Key Messaging and Recommended Response:

- Treatment and recovery services in BC offer support and hope to people and families struggling with mental health and addiction challenges. Work is underway to continue to build up these services in every region.
- Every person's path to treatment and recovery is different, and the journey is not always linear. From harm reduction to treatment and recovery, an integrated, patient-centred approach to care is needed to support people throughout their journey.
- To help people access the services they need, when they need them, we are implementing new models of care that are improving access to treatment and recovery for British Columbians.
- The Ministry of Health has a contract with Pharmascience, a Canadian pharmaceutical manufacturer, to domestically supply diacetylmorphine. It ensures a protected supply of drug to support evidence-based, supervised injectable opioid agonist treatment (iOAT) programs in BC that assist individuals who have not benefitted from oral opioid agonist treatment.
- Diacetylmorphine is a medical intervention when used as part of an iOAT program, shown to reduce illicit heroin use, criminal activity and improve overall health and social functioning comparable to methadone.

CURRENT SITUATION

- The Ministry has an agreement with Pharmascience, a drug manufacturer, to manufacture and provide diacetylmorphine (DAM) to British Columbia's injectable opioid agonist treatment (iOAT) programs. This agreement provides access to iOAT DAM as an evidence-based treatment option in BC.
- Pharmascience's DAM product may only be used as part of a supervised iOAT program for adult patients with severe opioid use disorder who use injectable opioids and have failed previous attempts at opioid agonist therapy including methadone maintenance therapy.[1]
- DAM is purchased from Pharmascience by the Province and is supplied to iOAT programs in Surrey, Kelowna and Vancouver.
- In November 2024, there were 103 unique clients receiving DAM as iOAT.[2]

FINANCIAL IMPLICATIONS

- Government is investing $12.49M over three years, 2023/24 to 2025/26, to support drug costs for iOAT DAM.

Operating Costs ($M)	2023/24 Actual *	2024/25 Planned
Drug Costs	$0.814M	$1.392M
Average monthly clients	130	105

* Beginning November 2023

KEY BACKGROUND

- DAM is an evidence-based medical intervention when used as part of an iOAT program, shown to reduce illicit heroin use, criminal activity and improve overall health and social functioning comparable to methadone.[3]

[1] Health Canada Drug and Health Product Portal https://dhpp.hpfb-dgpsa.ca/review-documents/resource/RDS00920 accessed January 29, 2025
[2] BCCDC Unregulated Drug Poisoning Emergency Dashboard http://www.bccdc.ca/health-professionals/data-reports/substance-use-harm-reduction-dashboard accessed January 29, 2025
[3] Strang J, Groshkova T, Uchtenhagen A, et al. Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction. The British Journal of Psychiatry. 2015;207(1):5-14

- The BC Centre on Substance Use published clinical guidance for DAM iOAT which includes clinical practice recommendations, and an extensive evidence review.[4]
- Health Canada approved Pharmascience's DAM product in February 2022 and an initial Supply Agreement between Provincial Health Services Authority and Pharmascience was signed August 2022. Following this, a new Supply Agreement between the Ministry of Health and Pharmascience was signed November 2023 and is still in place.
- To receive market authorization for DAM, a risk mitigation plan and controlled distribution program was submitted by Pharmascience to Health Canada, which includes measures to prevent, monitor and address diversion, minimize risk and provide additional oversight on criteria to access DAM for iOAT.
- Previously, iOAT DAM was accessed in BC in the form of the Swiss marketed product Diaphin® from DiaMo Narcotics imported under Health Canada's List of Drugs for an Urgent Public Health Need pathway.[5] Manufacturer reported shortages of Diaphin in 2021 led to efforts to encourage Pharmascience, a Canadian pharmaceutical manufacturer, to develop a domestic supply of injectable DAM.[6]

LAST UPDATED

The content of this estimates note is current as of February 7, 2025, as confirmed by Susan Bouma, Executive Director, Clinical Services

APPROVALS

2025-02-11 – Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025-02-13 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025-03-07 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division

[4] BC Centre on Substance Use Guidance for Injectable Opioid Agonist Treatment https://www.bccsu.ca/wp-content/uploads/2021/07/BC_iOAT_Guideline.pdf accessed January 29, 2025
[5] Health Canada List of Drugs for an Urgent Public Health Need https://www.canada.ca/content/dam/hc-sc/documents/services/drugs-health-products/access-drugs-exceptional-circumstances/list-drugs-urgent-public-health-need-07-20.pdf accessed January 29, 2025
[6] Schmitt-Koopmann C, Baud CA, Junod V, Simon O. Switzerland's Dependence on a Diamorphine Monopoly. Front Psychiatry. 2022 May 9;13:882299 https://pmc.ncbi.nlm.nih.gov/articles/PMC9125182/ accessed January 29, 2025

LEGISLATIVE SESSION – ESTIMATES NOTE

Drug Shortages

Topic: The Ministry works with its provincial and territorial counterparts, Health Canada and other key partners to monitor, mitigate and resolve drug shortages.

Key Messaging and Recommended Response:

- As of January 29, 2025, there were 1,953 reported drug shortages in Canada[1]. Of these, 23 are considered critical, having a Health Canada 'Tier 3' designation[2], and 713 are BC PharmaCare benefits[3].
- BC plays an instrumental role in coordinating stakeholder strategies and responses to shortages, including by chairing multi-collaborator drug-shortages committees, and hosting and staffing the Provincial-Territorial Drug Shortages Unit established in fall 2024.

CURRENT SITUATION

- The Provincial-Territorial Drug Shortages Unit (PTDSU) was created in October 2024 and has been working with all Canadian provinces and territories to help coordinate responses to and management of drug shortages.
- In its first 6 months of operation, the PTDSU engaged directly with the other provinces and territories to:
  - solicit provincial/territorial feedback on proposed amendments to federal drug shortage legislation and share that feedback with Health Canada;
  - streamline the process by which the provincial and territorial drug plans consider covering foreign drugs imported during a shortage; and
  - formally define the PTDSU's work to best serve all provinces and territories through development of a memorandum of understanding (in progress).
- BC also participates in, and chairs multi-collaborator committees dedicated to preventing and managing shortages.
- Some of the ongoing drug shortages of interest to BC:

Drug	Shortage onset	Reason	Mitigation	Indication
salbutamol 100 mcg metered-dose inhalers and salbutamol nebules	January 2025	manufacturing disruptions	200 mcg inhaler temporarily added as a PharmaCare benefit. Escalated to tier 3 to allow sourcing of foreign products	asthma
doxepin 10 mg capsules	December 2024	manufacturing disruptions	different brand and strength of doxepin temporarily added as a PharmaCare benefit	anxiety, depression, and insomnia
methotrexate injectable solution	November 2024	increased demand	different format (pre-filled syringe) covered under same criteria	certain cancers
oxybutynin syrup	November 2024	production delays	compounded product temporarily added as a PharmaCare benefit	overactive bladder

[1] Drug Shortages Canada – Summary report
[2] Health Canada – Tier 3 drug shortages
[3] Province of BC – Drug shortages

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- A drug shortage happens when a drug manufacturer or distributor cannot supply enough product to meet demand.
- Drug manufacturers are required to publicly report anticipated and actual drug shortages and discontinuations to Drug Shortages Canada.

Provincial Work

- The Ministry maintains a drug shortages webpage with up-to-date information about PharmaCare-covered drugs that are in short supply at BC pharmacies, which includes information about any temporary replacement or alternate products that are covered during a shortage. The list does not include shortages of drugs PharmaCare does not cover nor hospital drugs.
- BC participates in drug shortages committees that work to identify and manage drug shortages. These include:
  - The federal/provincial/territorial assistant deputy Minister-level and director-level drug shortages tables created in 2020 to address drug supply issues during the COVID-19 pandemic.
  - The Multi-Stakeholder Steering Committee on Drug Shortages, which provides a forum for federal/provincial/territorial governments, industry associations, health professional associations and patient advocacy groups to discuss policy issues and shortage mitigation and prevention measures.
  - The PT Drug Shortages Task Team which helps identify, prevent, alleviate and resolve drug shortages that could have a significant impact on public health.

Federal Work

- Health Canada is responsible for ensuring drug shortages are properly reported and for regulating the import of foreign drugs into Canada during a critical shortage.
- Health Canada is accepting feedback until early March 2025 on proposed changes to the Food and Drug Regulations that will help address and mitigate harm to public health caused by drug-product shortages.
- Health Canada collaborates with drug supply-chain interest-holders, including BC and the other provinces and territories, to determine the details of a shortage, share information and develop mitigation strategies.
- Health Canada's shortage mitigation tools include:
  - working with manufacturers to review alternate suppliers or expedite the review of alternative drugs;
  - allowing manufacturing-practice flexibilities, such as expiry-date extensions;
  - allowing exceptional importation of foreign drugs;
  - prohibiting the export of drugs if it would cause or worsen a shortage; and
  - providing early access to new drugs via the Special Access Program.

LAST UPDATED

The content of this estimates note is current as of February 13, 2025, as confirmed by Susan Bouma

APPROVALS

2025-03-03– Ian Rongve, ADM, Pharmaceutical Laboratory and Blood Services Division, Ministry of Health

LEGISLATIVE SESSION – ESTIMATES NOTE

Drugs for Rare Diseases

Topic: Overview of PharmaCare's Expensive Drugs for Rare Diseases (EDRD) process, and British Columbia's involvement in implementing a national strategy aimed at addressing the accessibility, evidentiary and sustainability challenges associated with these therapies.

Key Messaging and Recommended Response:

- Expensive Drugs for Rare Diseases (EDRDs) are drugs that cost more than $100,000 per patient per year to treat diseases that have an incidence of less than 1.65 people per 100,000 population.
- Government recognizes the importance of accessing these rare drugs as they often improve quality of life, reduce suffering and lead to better health outcomes for people struggling from rare diseases.
- There are currently more than 600 people benefiting from coverage for these expensive drugs and estimates these expenditures for 2024/25 to be approximately $198 million.
- In 2023, the federal government announced the National Strategy for Drugs for Rare Diseases to help provinces and territories improve access to emerging drugs for rare diseases and support early diagnosis and screening for rare diseases.
- Through a $1.5 billion investment over three years, BC was the first province to sign a bilateral agreement with the federal government in July 2024.
- Although the costs for this program are significant, so are the benefits for the people suffering from rare diseases.
- Government will continue funding EDRD coverage where possible, find ways to manage costs while partnering with the federal government to supporting funding to ensure people needed access to this important drug coverage continues to have it.

CURRENT SITUATION

- The Ministry's EDRD process has over 600 active beneficiaries, each receiving funding between $100,000 and $2.9 million annually[1]. At list price, EDRD expenditures in 2024/25 are projected to be approximately $165 million[1].
- Notable cost drivers include:
    - More EDRDs being considered for funding under the process (35 drugs are currently covered[2], an increase from 32 drugs the year prior[3])
    - Growing uptake of high patient-volume EDRDs
        - Elexacaftor/tezacaftor/ivacaftor and ivacaftor (Trikafta®): as of February 21, 2025, 260 people with cystic fibrosis receive Ministry coverage for Trikafta; Trikafta costs approximately $300,000 per patient per year[4]
        - Tafamidis (Vyndaqel™, Vyndamax™): as of February 11, 2025, 178 patients with cardiac amyloidosis are funded for Vyndaqel or Vyndamax at a cost of approximately $195,000 per patient per year[4]
    - Routine provincewide newborn screening for spinal muscular atrophy (SMA), introduced in fall 2022[5], result in earlier SMA diagnoses and eligibility for the one-time $2.9-million gene therapy, Zolgensma[6].
- A bilateral agreement between the federal government and the province of BC was signed in July 2024 to further support drugs for rare diseases[7]. This agreement involves a $194 million contribution from the federal government to support the province in implementing the NSDRD[7].

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[1] Financial Analysis and Decision support March projection.
[2] Excel Spreadsheet. *EDRD Funding Criteria Database – Updated 2025-03-10.* Specialty Medicines Team, BC Ministry of Health. Accessed March 14, 2025.
[3] *2024 Fact Sheet, Drug for Rare Diseases.* Specialty Medicines Team, BC Ministry of Health. Accessed March 10, 2025.
[4] Access Database. *EDRD Database.* Specialty Medicines Team, BC Ministry of Health. Accessed February 21, 2025.
[5] Perinatal Services BC. *B.C. newborn screening expands; early detection improves quality of life.* http://www.perinatalservicesbc.ca/about/news-stories/stories/bc-newborn-screening-expands. Last updated October 12, 2022. Accessed March 7, 2025.
[6] BC Ministry of Health. *Exceptional funding of EDRDs.* https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/exceptional-funding-edrd. Last updated January 7, 2025. Accessed March 7, 2025.
[7] Government of Canada. *Government of Canada signs two bilateral agreements with BC.* https://www.canada.ca/en/health-canada/news/2024/07/government-of-canada-signs-two-bilateral-agreements-with-british-columbia.html. Last updated July 23, 2024. Accessed March 7, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- In fiscal year 2025/26, it is expected that the Ministry will spend approximately $226 million on EDRDs[8].
- EDRD expenditures were $152.2 million in 2023/24[9] and are on track to be $165 million in 2024/25[1].
- Expenditures in the previous fiscal year (2022/23) was $100M[10].
- These costs do not reflect any confidential pricing agreements between the Ministry and drug manufacturers, which can result in lower costs for certain drugs.

KEY BACKGROUND

EDRD

- EDRDs are drugs that cost more than $100,000 per patient per year to treat diseases that have an incidence of less than 1.65 people per 100,000 population.
- The EDRD process and the decisions it makes have ethical, clinical, and financial implications, particularly considering disease rarity (a relatively small number of BC residents directly benefit from funding), often-limited clinical evidence in support of available therapies, and high per-patient costs.
- The list of Ministry-funded EDRDs continues to grow, and four drugs were added in 2024/25: lumasiran (Oxlumo®) for the treatment of primary hyperoxaluria type 1[2], berotralstat (Orladeyo®) for the treatment of hereditary angioedema[2], vutrisiran (Amvuttra®) for the treatment of hereditary transthyretin-mediated amyloidosis[2] and selumetinib (Koselugo™) for Neurofibromatosis type 1, and this drug is administered through Special Authority[11]. Five drugs were also added in fiscal year 2023/24: tafamidis (Vyndamax™)[2], givosiran (Givlaari®)[2], triheptanoin (Dojolvi™)[2], sebelipase alfa (Kanuma®)[2] and mecasermin (Increlex®)[2]. In addition, criteria for Trikafta were expanded to include children 2 years of age and older, and to include patients with rare mutations that have evidence of clinical or in vitro response to Trikafta[12].
- In 2024, the Ministry delisted inotersen (Tegsedi™) for the treatment of stage 1 or stage 2 polyneuropathy in adult patients with hereditary transthyretin amyloidosis[13], as well as sodium phenylbutyrate and ursodoxicoltaurine (Albrioza) for the treatment of patients with amyotrophic lateral sclerosis[14]. Both drugs were delisted due to manufacturer withdrawal from the market.
- In making EDRD funding decisions, the Ministry considers advice from the arm's-length EDRD advisory committee and its eight clinical subcommittees:
    - The advisory committee is composed of expert clinicians and professionals in health economics and ethics
    - The clinical subcommittees are composed of practicing clinicians with expertise in managing rare diseases and the EDRDs used to treat those conditions
    - The clinical subcommittees and/or advisory committee evaluate funding requests and make funding recommendations to the Ministry
    - Criteria for the funding of EDRDs is mainly based on recommendations from the Canadian Drug Expert Committee from Canada's Drug Agency – L'Agence des medicaments du Canada
    - The committees' evaluation considers factors such as: natural disease history, drug efficacy and safety, alternative treatment options, clinical practice guidelines, patient history and disease details, coverage criteria, expected treatment outcome, consequences of withdrawing or not providing funding, and ethics
- Since April 2016, the Ministry has partnered with the PHSA to administer the EDRD process.

National Strategy for Drugs for Rare Diseases

- In March 2023, the federal government announced the National Strategy for Drugs for Rare Disease (NSDRD) and committed to investing up to $1.5 billion over 3 years to improve screening, early diagnosis, and access to drugs for rare diseases across the country[7].
- This funding will help provinces and territories improve access to emerging drugs for Canadians with rare diseases, as well as support early diagnosis and screening for rare diseases[7].

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[8] Excel Spreadsheet. *2025-26 Forecast (Projection FY2025-26).* Specialty Medicines Team, BC Ministry of Health. Accessed March 7, 2025.
[9] General Leger balance, Corporate Accounting System.
[10] Excel Spreadsheet. *EDRD Expenditures – MoH FY22-23_Final (MoH Cost Breakdown).* Specialty Medicines Team, BC Ministry of Health. Accessed March 7, 2025.
[11] Government of British Columbia. *Limited coverage drugs – selumetinib.* https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/programs/limited-coverage-drug-program/limited-coverage-drugs-page-selumetinib. Last updated February 12, 2025. Accessed March 7, 2025.
[12] *Elexacaftor/tezacaftor/ivacaftor (Trikafta) Drug Decision Summary*. Specialty Medicines Team, BC Ministry of Health. November 2024. Accessed March 7, 2025.
[13] *Inotersen (Tegsedi) Drug Decision Summary*. Specialty Medicines Team, BC Ministry of Health. September 2024. Accessed March 7, 2025.
[14] *PB-TURSO (Albrioza) Drug Decision Summary.* Specialty Medicines Team, BC Ministry of Health. July 2024. Accessed March 7, 2025.

- In addition, the federal government is also investing $68 million for various initiatives to support collaborative governance, data infrastructure, and research for drugs for rare diseases[15].
- On July 23, 2024, the federal government signed a bilateral agreement with BC to support drugs for rare diseases[7]. Through this agreement, the Government of Canada will contribute $194 million to improve access to drugs for rare diseases, early diagnosis, and screening, starting with funding to support the province in providing access to drugs under the NSDRD[7].
- The common set of drugs for the NSDRD has been in development over the last year. The names of the drugs on the common set are published online on a drug-by-drug basis as the pan-Canadian Pharmaceutical Alliance concludes its price negotiations and at least one participating jurisdiction has elected the drug.
- Drugs from the common set that BC has elected include mogamulizumab (Poteligeo®) for the treatment of mycosis fungoides or Sézary syndrome, lumasiran (Oxlumo®) for the treatment of primary hyperoxaluria type 1, epcoritamab-bysp (Epkinly®) for relapsed or refractory diffuse large B-cell lymphoma, belzutifan (Welireg®) for Von Hippel-Lindau disease, axicabtagene ciloleucel (Yescarta®) for follicular lymphoma and 2nd line treatment of diffuse large B-cell lymphoma or high-grade large B-cell lymphoma, and selumetinib (Koselugo™) for the treatment of neurofibromatosis type 1[16].
- BC supports the NSDRD and its aim of achieving Canada-wide consistency in access to drugs for rare diseases.

LAST UPDATED

The content of this estimates note is current as of February 26, 2025, as confirmed by Tijana Fazlagic.

APPROVALS

2025 03 28 – Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025 03 20 – Lenore Ogilvy obo Martin Wright - Health Sector Information, Analysis & Reporting Division
2025 03 27 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[15] Government of Canada. *Government of Canada signs two bilateral agreements with BC.* https://www.canada.ca/en/health-canada/news/2023/03/government-of-canada-improves-access-to-affordable-and-effective-drugs-for-rare-diseases.html. Last updated March 22, 2023. Accessed March 7, 2025.
[16] Government of Canada. *Drugs for rare diseases: Common list of drugs.* https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/drugs-for-rare-diseases-bilateral-agreements/common-list-drugs.html. Last updated March 22, 2023. Accessed March 7, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Free Prescription Contraception Coverage

Topic: In recognition of the right of British Columbia residents to make and implement informed choices about their sexual health, effective April 1, 2023, contraception is free to all BC residents with active MSP coverage.

Key Messaging and Recommended Response:

- As of April 1, 2023, BC became the first jurisdiction in Canada to offer free prescription contraception to its residents with active MSP coverage.
- This makes it easier for people to access prescription contraceptives and is a milestone for gender equity in BC as costs are no longer a barrier for people to make choices about their reproductive and sexual health.
- Over 60 commonly used contraceptive methods are covered by BC PharmaCare, including oral contraceptives, copper and hormonal intrauterine devices (IUDs), hormonal injections and the morning-after pill.
- Since the start of the program, more than 306,000 people have benefitted from the free contraceptive policy (this includes people receiving emergency contraceptives).
- The Government of Canada and the Government of BC have also recently signed a bilateral agreement pursuant to the federal *Pharmacare Act*.
    - This agreement enables the federal government to provide funding to BC to support access to certain medications and related products.
- Since BC already provides free contraception, both governments have agreed that the funds intended for free prescription contraceptives under national pharmacare may be used for hormonal replacement therapy for the treatment of menopausal symptoms.

CURRENT SITUATION

- Since April 1, 2023, contraception is free for all BC residents with active MSP coverage.
- As of June 1, 2023, pharmacists in BC can prescribe contraceptives.
- The Ministry transitioned all current prescription contraceptive products listed on PharmaCare formularies, including oral contraceptives, hormonal IUDs, an injection, an implant, and emergency oral contraceptives ('morning after pill') to Plan Z (Assurance), which provides 100% coverage to BC residents. At the same time, PharmaCare added copper IUDs as a new benefit under Plan Z.
- If a patient is taking a brand name contraceptive and PharmaCare covers the generic alternative, then PharmaCare will cover 100% of the cost of the generic alternative and the patient will be responsible for the difference.
- The Ministry is working with clinics that provide sexual health testing, such as Options for Sexual Health and Foundry, to support their clients in accessing free contraceptives. In the meantime, the public can access free contraceptives through a community pharmacy.
- The federal *Pharmacare Act*, which received Royal Assent on October 10, 2024, proposes the federal government work with provinces and territories to provide universal, single-payer coverage for a number of contraception medications. The current proposed national formulary replicates the current provincial contraception formulary under Plan Z.
- As the Province of BC has already implemented free prescription contraception, the Province and Government of Canada have agreed in a memorandum of understanding that the funds intended for free prescription contraceptives under national pharmacare may be used for hormonal replacement therapy for the treatment of menopausal symptoms.[1]

[1] Government of Canada and the Government of British Columbia Memorandum of Understanding - Canada.ca

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- In 2022/23, the year prior to the introduction of universal coverage, PharmaCare paid $3.36 million in drug cost and dispensing fees for contraceptives (including $2.04 million on short acting hormonal contraceptives[2] and $1.14 million on IUDs).[3] In 2023/24, PharmaCare paid $35.8 million in drug cost and dispensing fees for contraceptives (including $16.2 million on short acting hormonal contraceptives and $15.9 million on IUDs).[4]
- The net cost impact to transition current PharmaCare benefit products and copper IUDs to Plan Z was estimated at $39.4 million, $46.1 million, and $33.4 million in years 1, 2 and 3, respectively.[5]
- Budget 2023 dedicated $119 million over three years to making contraceptives free.[6]

KEY BACKGROUND

- Offering free prescription contraception to all BC residents supports a range of population health benefits.
- Cost has been identified as the main barrier to accessing prescription contraception in BC.
- Effective April 1, 2023, the Ministry transitioned all current prescription contraceptive products listed on PharmaCare formularies to Plan Z, which provides 100% coverage to BC residents.
- Any product available through PharmaCare is reviewed for safety and efficacy; review of an expanded range of contraceptive products may take longer than other implementation activities.
- In December 2021, the Nexplanon contraceptive implant was added as a regular benefit under PharmaCare.
- On August 3, 2023, Haloette, a vaginal ring, was added to the Plan Z formulary.
- Planning is underway within the Ministry to strengthen equitable access to contraception-related health services; to align the provision of free prescription contraception with the Minister's Mandate Letter on addressing systemic racism in the health care system; and to align with the principles of anti-racism set out in the Ministry of Health's 2022/23 to 2024/25 and 2023/24 to 2025/26 Service Plans.

LAST UPDATED

- The content of this estimates note is current as of March 5, 2025, as confirmed by John Capelli.

APPROVALS

2025 03 25 – Ian Rongve, Pharmaceutical, Laboratory and Bloods Services Division
2025 03 07 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 12 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[2] PharmaNet database. Health Sector Information, Analysis and Reporting, March 6, 2025
[3] PharmaNet database. Health Sector Information, Analysis and Reporting, March 6, 2025
[4] PharmaNet database. Health Sector Information, Analysis and Reporting, March 6, 2025
[5] PharmaNet database. Health Sector Information, Analysis and Reporting, March 6, 2025
[6] Budget 2023 takes action on issues that matter most | BC Gov News

LEGISLATIVE SESSION – ESTIMATES NOTE

Minor Ailments

Topic: Updates on pharmacists assessing and prescribing minor ailments and contraception.

Key Messaging and Recommended Response:

- BC residents continue to benefit from pharmacists' expanded scope of practice, gaining free access to treatment for 21 minor ailments and contraception through the Minor Ailments and Contraception Service (MACS) launched in June 2023.
- Between June 1, 2023, and December 31, 2024, more than 477,000 people in BC have used the service.
- Enabling pharmacists to prescribe for minor ailments and contraception is expected to reduce patient volumes at emergency departments and primary care clinics, as these patients can now get the care, they need faster and easier by visiting their local pharmacy.
- The top 5 reasons people are seeing a pharmacist are for contraception, uncomplicated urinary tract infections, pink eye (conjunctivitis), allergic rhinitis and cold sores (herpes labialis).
- As of December 31, 2024, 93.2% of community pharmacies and 77.5% of active pharmacists in BC are providing the service.

CURRENT SITUATION

- Rapid and positive uptake of Pharmacists Prescribing for Minor Ailments and Contraception (PPMAC) was seen with more than 477,000 patients accessing the service between June 1, 2023, and December 31, 2024. 93.2% of community pharmacies and 77.5% of active BC pharmacists have participated in providing the service.[1]
- The top 5 conditions for PPMAC have remained consistent since its launch and between June 1, 2023, and December 31, 2024, the most common conditions were 1) contraception, 2) uncomplicated urinary tract infections, 3) conjunctivitis, 4) allergic rhinitis, and 5) herpes labialis (cold sores).[2]
- Between June 29, 2023, and December 31, 2024, about 42,600 appointments have been made on the provincial booking system.[3]
- Descriptive analysis based on first year of data (June 1, 2023, to May 31, 2024)[4] shows:
    - Median age of individuals accessing MACS) is 40 with 73% being female, 56% taking 0 to 1 medication and 53% with unknown income status based on Fair PharmaCare registration data.
    - Similar uptake of the MACS by individuals attached or not attached to family physicians with approximately 4.4% and 4.6% of attached and unattached BC residents, respectively, having accessed the service.
    - Preliminary analysis suggests consistent uptake of MACS by BC residents across all local health areas when factoring in population size, age, low-income family, rurality and primary care capacity (i.e. number of pharmacies, prescribers and pharmacists).
- Program evaluation activities are underway to assess the impact of PPMAC/MACS and ensure quality of care by pharmacists. This includes:
    - A patient survey through BC Stats was launched between May 7, 2024, and October 15, 2024, to better understand patients' experiences in accessing pharmacists for minor ailments and contraception. The final report is expected in Q1 2025/26.

[1] PharmaNet, Healthideas, Health Sector Information, Analysis, and Reporting Division, March 11, 2025.
[2] PharmaNet, Healthideas, Health Sector Information, Analysis, and Reporting Division, March 11, 2025.
[3] PharmaNet, Healthideas, Health Sector Information, Analysis, and Reporting Division, March 11, 2025.

  - 4 qualitative research studies funded through the Ministry of Health's Seed Grant Program to understand pharmacists' experience, including barriers and facilitators in contraceptive prescribing, impact on youth's access
  - to contraceptive care and to identify areas for quality improvement is currently underway. Final results will become available in Q2 2025/26.
  - Research by the BC Centre for Disease Control to describe antimicrobial prescribing following the scope of practice change for pharmacists and develop stewardship strategies.
  - Internal evaluation to describe the impact of PPMAC/MACS on primary care resources.
- Sharing of clinical documentation between pharmacists, physicians, other healthcare professionals and PharmaCare remains a challenge; feasibility of options such as CareConnect is being explored.
- On September 14, 2024, the College of Pharmacists of BC (CPBC) published a report on its anonymous survey from spring 2024 that assessed the impact of business metrics on public safety and working conditions of pharmacists. The report noted that registrants in corporate and franchised settings were twice as likely to feel pressured to conduct and complete a specific number of assessments within strict time frames compared to their counterparts in different pharmacy settings.

FINANCIAL IMPLICATIONS

- PharmaCare paid $5.1 million in 2023/24 for eligible MACS.[4]
- The Ministry contracted the BC Pharmacy Association and the University of BC's (UBC) Continuing Pharmacy Professional Development to provide supporting educational resources at no cost to pharmacists.
- The 4-year contract commitment (2022/23 to 2025/26) with BCPhA is $765,000.
- The 5-year contract commitment with UBC over 5 years is $763,500.
- Cost for evaluation to date include an estimated $169,200 in funding to BC Stats over 2 years (2023/24 to 2024/25) to implement a patient survey. Other evaluation activities led by UBC researchers are funded through the Ministry's Seed Grant Research Program.

KEY BACKGROUND

- In June 2023, the Ministry worked with the CPBC to enable pharmacists to prescribe for 21 minor ailments and contraception. Amendments to the Pharmacists Regulation outline the expanded scope and specify the drug categories pharmacists are authorized to prescribe for each listed ailment. CPBC sets the standards, limits and conditions for making a diagnosis and prescribing under the bylaws of *Health Professions Act*.
- The 21 minor ailments included are acne, allergic rhinitis, conjunctivitis, dermatitis, dysmenorrhea, dyspepsia, fungal infections, gastroesophageal reflux disease, headache, hemorrhoids, herpes labialis, impetigo, musculoskeletal pain, nicotine dependence, oral ulcers, oropharyngeal candidiasis, shingles, threadworms or pinworms, uncomplicated urinary tract infection, urticaria, and vaginal candidiasis.
- The implementation team held broad partner engagement sessions with pharmacy operators, independent pharmacy owners, patients, patient advocacy groups, the First Nations Health Authority, regulatory bodies of health professionals, professional associations, and others.
- PharmaCare pays pharmacies $20 for each MACS provided to eligible patients. The MACS fee is included in the $78 PharmaCare maximum daily limit. PharmaCare does not reimburse pharmacies for dispensing fees when they prescribe medications for daily and/or frequent dispensing.

LAST UPDATED

The content of this estimates note is current as of March 6, 2025, as confirmed by Susan Bouma, Executive Director of the Clinical Services & Evaluation Branch.

APPROVALS

2025 03 27 – Ian Rongve, ADM, Pharmaceutical Laboratory and Blood Services Division
2025 03 13 – Patrick Day obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 17 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[4] PharmaNet & Provincial Attachment System, Healthideas, Health Sector Information, Analysis, and Reporting Division, March 11, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

National Pharmacare

Topic: On March 6, 2025, BC and the federal government signed a bilateral agreement for the implementation of national universal pharmacare in the province starting March 1, 2026.

Key Messaging and Recommended Response:

- Our top priority is to make essential health care more accessible and affordable by ensuring people in BC get the necessary medications they need, regardless of income,.
- That's why we signed the historic bilateral agreement with the federal government to invest more than $670 million over four years to implement national pharmacare.
- Set to begin March 1, 2026, national pharmacare will offer universal, first-dollar coverage for diabetes medications, insulin and contraceptives.
- This will support the reproductive freedom of more than 1.3 million British Columbians and ensure that nearly 550,000 people with diabetes can access essential medications – reducing their risk of serious health complications and improving their quality of life.
- Since BC already provides free contraceptives, our portion of the funding will cover free hormone replacement therapy for menopausal symptoms, in addition to enhancing coverage for diabetes devices and supplies.
- This additional coverage is a significant step toward improving health care for women and gender diverse people throughout their lifetimes.
- Through this historic agreement, our government will improve the health and well-being of BC residents.
- This is an important step towards strengthening BC's universal, public health-care system in the long-term – one where everyone can get the essential medications they need without having to pull out their credit card.

CURRENT SITUATION

- On March 6, 2025, BC and the federal government signed a bilateral agreement for national pharmacare coverage to commence on March 1, 2026, for BC residents. The agreement invests $670 million over a four-year period for universal, single-payer, first-dollar coverage of diabetes drugs, insulins, and HRT for the treatment of menopausal symptoms.[1]
- The funding from this agreement will also improve access to diabetes devices and supplies.

FINANCIAL IMPLICATIONS

- The bilateral agreement signed between BC and the federal government invests $670 million over a four-year period starting in FY 2025/26 and ending in FY 2028/29.[2]
- The proposed funds allocated in the federal budget for national pharmacare are expected to cover diabetes drugs, insulins, and HRT for menopausal symptoms.

KEY BACKGROUND

- On October 10, 2024, Bill C-64, *An Act respecting pharmacare* ("Pharmacare Act") received royal assent. The federal Pharmacare Act sets out the principles for the implementation of national universal pharmacare, which contemplates full coverage for contraceptives which includes birth control pills, intrauterine devices (IUDs) and emergency contraception; insulins; as well as additional diabetes drugs.
- On September 12, 2024, BC and the federal government signed a Memorandum of Understanding (MOU) committing both governments to enter into formal negotiations to implement universal, single-payer, first-dollar

[1] Government of Canada signs pharmacare agreement with British Columbia to improve universal access to free medications - Canada.ca
[2] Government of Canada signs pharmacare agreement with British Columbia to improve universal access to free medications - Canada.ca

coverage for diabetes drugs and contraception.[3]

- Because BC already provides free contraception, the MOU recognized that the province intended to extend universal, single-payer, first-dollar access, consistent with Bill C-64, HRT to help support the health of Canadians throughout their lifetime. Free HRT was possible because funding for contraceptives, which BC already covers and pays for, could be reallocated.
- PharmaCare currently covers two semaglutide (Ozempic) products, the 0.68 mg/mL (2 mg/pen) and 1.34 mg/mL (4 mg/pen), as Limited Coverage benefits for treatment of Type 2 diabetes mellitus. Semaglutide is not included in the national pharmacare list and will not be eligible for universal, single-payer, first-dollar access in March 2026.

LAST UPDATED

The content of this estimates note is current as of March 27, 2025, as confirmed by John Capelli.

APPROVALS

2025 03 27 – Ian Rongve, ADM, Pharmaceutical, Laboratory & Blood Division
2025 03 17 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 25 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[3] Government of Canada and the Government of British Columbia Memorandum of Understanding - Canada.ca

LEGISLATIVE SESSION – ESTIMATES NOTE

Out-of-Country Sale of Drugs

Topic: The Patented Medicines Price Review Board protects Canadians by ensuring that prices of patented medicines sold in Canada are not excessive. The United States (US) does not have the same measures to regulate drug prices and US residents are turning to Canada for access to cheaper drugs.

Key Messaging and Recommended Response:

- For many years, people living in the US have turned to Canada for access to cheaper drugs as they do not have measures to regulate affordable drug prices in their country.
- Health Canada actively monitors the Canadian drug supply to ensure Canadians have access to the drugs they need and works with jurisdictions like BC to prevent drug inventories from depleting due to US demand.
- BC has taken additional measures to impose conditions on out-of-country sales.
- For example, through the enactment of the new Drug Schedules (Limits on Sale) Regulation under the *Pharmacy Operations and Drug Scheduling Act*, semaglutide (known as Ozempic) is restricted so that only Canadian citizens and permanent residents are able to purchase the drug online, ensuring BC patients who need this medication can access it in BC.
- Through this new regulation, BC residents and other Canadian citizens and permanent residents can buy Ozempic through BC pharmacies, in-person and online. Others can only purchase the drug in-person at a pharmacy.
- Currently, the new regulation only includes semaglutide drugs, but other drugs can be added if there are supply issues.

CURRENT SITUATION

- On January 5, 2024, the US Food and Drug Administration (FDA) announced its approval of Florida's Agency for Health Care Administration's drug importation program, a pathway facilitating Florida's importation of certain prescription drugs from Canada.
- Canada's Food and Drug Regulations prohibit Drug Establishment Licence holders (i.e., drug manufacturers, wholesalers and distributors) from distributing Canadian drugs for consumption or use outside Canada if there are reasonable grounds to believe that doing so could cause or worsen a drug shortage.
- Following the FDA announcement, Health Canada issued a reminder to Drug Establishment Licence holders of their obligations under the Food and Drug Regulations. Health Canada is actively monitoring the Canadian drug supply and continues to ensure that Canadians have access to the drugs that they need.[1]
- Ozempic® is an injectable prescription drug designed to treat type 2 diabetes mellitus. In BC, from January 1 to April 18, 2023, 15% of Ozempic dispenses were sold to people with addresses in the US whereas the percent of dispenses of other drugs sold to people with addresses in the US is 0.4%.[2]
- On April 19, 2023, the new Drug Schedules (Limits on Sale) Regulation under the *Pharmacy Operations and Drug Scheduling Act* was enacted to impose conditions on the sale of semaglutide by pharmacies in BC. Through this new regulation, BC residents and other Canadian citizens and permanent residents can buy Ozempic through BC pharmacies, in-person and online. Others can only purchase the drug in-person at a pharmacy.
- Currently, the new regulation only includes semaglutide drugs (i.e., Ozempic, Rybelsus, and Wegovy), but other drugs can be added if there are supply issues.
- The Ministry of Health is considering including tirzepatide (Mounjaro®) and dulaglutide (Trulicity®) in the Regulation as its manufacturer, Lilly, has raised concerns that it may experience supply issues if customers in the US continue to purchase the drug from Canadian online pharmacies.
- On January 22, 2025, Drug Shortages Canada listed a shortage of Mounjaro in the 15mg solution with additional anticipated shortages of the 12.5mg, 10mg, and 7.5mg solutions.[3]

[1] Statement from Health Canada on FDA decision on Florida bulk drug importation plan - Canada.ca
[2] PharmaNet, Health Sector Information, Analysis and Reporting Division, September 23, 2024
[3] Drug Shortages Canada, Reports for Tirzepatide

- Prior to the new regulation coming into force, the monthly number of semaglutide (Ozempic) dispenses to people with US addresses increased from 378 in January 2021 to 12,753 in March 2023; since the regulation was enacted, the monthly average has been 21, constituting a reduction of 99.8% from March 2023.[4]

FINANCIAL IMPLICATIONS

- N/A

KEY BACKGROUND

- Semaglutide is a prescription drug designed to treat type 2 diabetes mellitus. Under the brand name Ozempic, semaglutide has been approved by Health Canada for the treatment of type 2 diabetes mellitus in adults.
- Semaglutide under the brand name Wegovy® has been approved by Health Canada for chronic weight management in adult patients.
- Rybelsus®, an oral tablet version of semaglutide, has been approved by Health Canada and is available by prescription only.
- PharmaCare currently provides Limited Coverage for Ozempic for the treatment of type 2 diabetes mellitus through Special Authority.
- One of the side effects of Ozempic is weight loss; it has gained popularity as a weight loss medication due to extensive social media coverage. As a result of the social media coverage and heavy marketing, demand for Ozempic has driven shortages of the drug in the US.[5]
- Tirzepatide and dulaglutide are now also gaining popularity as alternative medications to Ozempic, sparking Lilly's concerns about Canadian supply.[6] [7]
- Under existing provincial and federal legislation, BC pharmacies are legally permitted to fill prescriptions for patients written by US doctors if they are co-signed or re-written by a Canadian practitioner.

LAST UPDATED

The content of this estimates note is current as of March 5, 2025, as confirmed by John Capelli.

APPROVALS

2025-03-21 – Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025-03-07 – Christine Voggenreiter obo ADM Martin Wright - Health Sector Information, Analysis & Reporting Division -

[4] PharmaNet, Health Sector Information, Analysis and Reporting Division, September 23, 2024
[5] Ozempic shortage: Diabetes drug is being used for weight loss | CTV News
[6] Drug used in diabetes treatment Mounjaro helped dieters shed 27 kg, study finds
[7] Trulicity vs Ozempic for Weight Loss: Which GLP-1 Is Better? | Woman's World

LEGISLATIVE SESSION – ESTIMATES NOTE

PharmaCare's Response to the Toxic Drug Crisis

Topic: High number of unintended overdose deaths due to the toxic and unregulated street drug supply

Key Messaging and Recommended Response:

- Any person who uses drugs faces the risk of a toxic drug poisoning or death, and one of the best ways to save lives is to separate them from the unpredictable and potentially fatal illicit drugs.
- Our government is committed to keeping people alive and connecting them to the support and care they need by building and expanding a seamless system of mental health and addiction care – from harm reduction to treatment and recovery services.
- The Ministry continues to work with health system partners to expand access to opioid agonist treatment (OAT), which is the first-line, evidence-based medical treatment for opioid use disorder, and significantly reduces the risk of overdose death.
- To support this, our government expanded PharmaCare's Plan Z coverage for OAT drugs making them free for all BC residents.

CURRENT SITUATION

- PharmaCare covers OAT medications including methadone, buprenorphine/naloxone, extended-release injectable buprenorphine and slow-release oral morphine by including them in Plan Z (Assurance) for all BC residents.
- Plan Z is a no deductible, 100% coverage plan and improves access to opioid use disorder (OUD) treatment as it reduces the cost of treatment for individuals not already part of a 100% coverage plan.
- PharmaCare provides limited coverage of fentanyl patches and fentanyl buccal tablets (Fentora®) when used as a pharmaceutical alternative.
- The BC Centre on Substance Use (BCCSU) has published protocols for using these products as pharmaceutical alternatives.
- In addition to previous existing plan coverage across the other PharmaCare plans, PharmaCare added regular benefit coverage for sufentanil and hydromorphone 8mg tablets under Plan G (Psychiatric Medications).
- Pharmaceutical, Laboratory and Blood Service Division (PLBSD) pharmacists work closely with the Mental Health and Addictions Division to proactively respond to emerging needs of those at risk of harm from the street supply, including support for the Take Home Naloxone program (intramuscular naloxone) and nasal naloxone initiatives and prescribed alternative program adjustments.
- PLBSD pharmacists also support BC's Chief Scientific Advisor for Psychiatry, Toxic Drugs and Concurrent Disorders' recommendations related to medication access.
- PLBSD maintains the contract for the Opioid Agonist Treatment Compliance and Management Program for Pharmacy (OAT-CAMPP), a mandatory course that must be completed by pharmacists and pharmacy technicians working at a community pharmacy that provides OAT pharmacy services.
- OAT-CAMPP is an accredited course that provides training on best practices in the clinical management of OUD by applying provincial guidelines, reviews regulatory and PharmaCare requirements when dispensing OAT prescriptions and discusses how to provide patient-centred, non-stigmatizing care to improve patient engagement in healthcare.

FINANCIAL IMPLICATIONS[1]

- PharmaCare spend on OAT products for opioids in 2023/24 was $103.4M for nearly 32,600 beneficiaries.
- PharmaCare spend on prescribed alternatives products, including opioids, stimulants and benzodiazepines in 2023/24 was $17.5M for over 7,200 beneficiaries.

[1] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting Division, February 21, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

PharmaCare Expenditure in 2023/24 for OAT Drugs, selected drugs				
	Methadone	Buprenorphine/ naloxone	Slow-release oral morphine	Extended-release buprenorphine
Dispensing Fees	$21.5M	$3.7M	$8.1M	$0.2M
Witnessing Fees	$17.2M	-	-	-
Drug Cost	$5.9M	$9.8M	$24.3M	$12.5M
Subtotal	$44.6M	$13.5M	$32.4M	$12.7M
PharmaCare Clients (Beneficiaries)	18,106	12,260	7,029	4,054
PC Expenditure per client	$2,461	$1,095	$4,604	$3,126

PharmaCare Expenditure in 2023/24 for PA Drugs			
	Opioids	Benzodiazepines	Stimulants
Dispensing Fees	$7.7M	$0.1M	$0.8M
Drug Cost	$8.5M	$0.004M	$0.4M
Subtotal	$16.2M	$0.1M	$1.2M
PharmaCare Clients (Beneficiaries)	6,867	173	729
PC Expenditure per client	$2,361	$652	$1,652

KEY BACKGROUND

- According to BC Coroners Service, the number of unregulated drug deaths in 2024 was 2,271. This represents a 12% decrease from the number of deaths in 2023 (2,581).[2]
- Fentanyl, or fentanyl analogues such as carfentanil, was detected in 83% of unregulated drug deaths in 2024.[2] The BC Coroners Service reports on average 4.7 people dying daily in December 2024, mainly because of the illicit supply of opioids containing extremely potent opioid fentanyl and analogues.
- The BCCSU updated OUD treatment guidance in 2023, which included the addition of extended-release injectable buprenorphine and iOAT as options for OUD management, removal of first-line treatment classifications for methadone, buprenorphine/naloxone and slow-release oral morphine, increased OAT starting and titration doses in the context of the fentanyl era and adjusted missed dose protocols. .[3]
- PharmaCare considers exceptional coverage of non-benefit OAT medications on a case-by-case basis with a Special Authority application under 100% coverage plans Plan C, Plan G, Plan W (First Nations Health Benefits) and Plan Z.
- PharmaCare provides exceptional coverage for hydromorphone as part of an injectable opioid agonist treatment (iOAT) program when the prescriber has completed additional iOAT training offered by the BCCSU.

LAST UPDATED

The content of this estimates note is current as of March 26, 2025, as confirmed by Susan Bouma.

APPROVALS

2025 03 28– Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025 03 27 – Darryl Sturtevant, Substance Use Policy
2025 02 24 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 07 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division

[2] Unregulated Drug Deaths in BC. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/bccsjan2025pdfdashboard.pdf f accessed March 26, 2025

LEGISLATIVE SESSION – ESTIMATES NOTE

Provincial Retinal Diseases Treatment Program

Topic: The Provincial Retinal Diseases Treatment Program (PRDTP) operates in collaboration with the Provincial Health Services Authority (PHSA) and registered BC retinal specialists.

Key Messaging and Recommended Response:

- The Ministry of Health and the Provincial Health Services Authority (PHSA) remain committed to supporting excellent patient access, safety and quality for retinal care within BC, and ensuring continued full coverage of retinal drugs at no cost to the patient.[1]
- The Provincial Retinal Diseases Treatment Program (PRDTP) offers BC residents 100% coverage for bevacizumab (Avastin®), ranibizumab (Lucentis®) and aflibercept (Eylea®) to treat 3 retinal diseases: neovascular (wet) age-related macular degeneration (nAMD), diabetic macular edema and retinal vein occlusion.
- The PHSA administers the PRDTP on behalf of the Ministry.
- The program's retinal specialists are required to track the safety and effectiveness of the treatments they administer. The PHSA uses this data to adjust the program as needed.
- The Ministry and the PHSA continue to monitor the safety and effectiveness of therapy provided through the program.
- On January 2, 2025, the retinal specialists and PHSA signed a new PRDTP contract after the retinal specialists terminated their participation in the program effective March 31, 2024.
- In fiscal year 2025/26, it is projected that the PRDTP will serve 27,153 patients.

CURRENT SITUATION

- In December 2023, Doctors of BC's Tariff Committee completed a review of a Medical Services Plan (MSP) Tariff Fee change proposal from the Ophthalmology Section. The application package was set to be presented to the Doctors of BC's Board on March 8, 2024.
- On January 15, 2024, PRDTP retinal specialists issued the Ministry and PHSA notice of termination of their participation in the PRDTP, effective March 31, 2024.
- The retinal specialists terminated the contract because they were dissatisfied with the proposed new MSP fees and expected their program management fee (PMF) to be increased to match the proposed reduction to their MSP fees.
- The Ministry and PHSA developed an interim solution to ensure uninterrupted coverage and care for PRDTP patients since March 31, 2024.
- Contract negotiations were successfully completed between PHSA and the retinal specialists, and a new contract came into effect on January 2, 2025, continuing until March 31, 2029.
- The new contract pays the retinal specialists both a PMF and a clinical services fee. The clinical services fee is based on fee-for-services codes that the retinal specialists are no longer billing through MSP (excluded codes), however, the retinal specialists are required to shadow bill for the excluded codes for auditing purposes.
- The PMF compensates retinal specialists for performing administrative activities including database submissions, program quality initiatives, drug safety and effectiveness monitoring, clinical practice guideline development (including drug utilization ratio guidance), and drug budget co-management.
- It is projected that the PRDTP will serve 27,153 patients in fiscal year 2025/26.[2]

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[1] From March 15 2024 media response: https://hub.gcpe.gov.bc.ca/MediaRequests/request/7d11c0f6-2d8c-481f-bdce-6a59a4e3dd65

[2] PHSA Funding Advisory 2025/2026.

- PRDTP retinal specialists are predominantly located in urban centers. The PHSA monitors geographical accessibility and patient demand, and adds new retinal specialists to the program where it is possible to help meet demand. A retinal specialist with experience in rural and remote issues will also be enlisted as part of the Program Oversight Committee, a forum for discussion amongst the Ministry, PHSA and the retinal specialists to oversee the performance of the program.
- An estimated 91% of patients with the retinal diseases treated under the program can receive funded treatment through the PRDTP.[3] The remainder pay out of pocket or use third-party insurance to cover the treatment.

FINANCIAL IMPLICATIONS

- In 2024/25, PRDTP is projected to treat 25,979 patients with estimated program operational expenses of $30.958 million ($19.88 million for cost of drugs and syringes, program administrative costs of $8.808 million, PHSA employee compensation of 1.67 million, and $2.714 million for PMFs). PHSA pays a representative on behalf of all retinal specialists, in full payment and reimbursement for providing the services and the funding amounts. Compensation is paid in equal bi-weekly installments to the retinal specialists via the representative.
- Based on the new contract with the addition of payment for clinical services, the projected clinical services fee for 2024/25 is Government Financial million.
- The projected costs for 2025/26, based on treating 27,153 patients, include Governm ent million for drug and syringe costs, Government Financial million for PMFs, and Governmen t million for clinical services fees, for a total of Governmen t million.

KEY BACKGROUND

- Established in 2009, the PRDTP provides residents of BC 100% coverage for bevacizumab (Avastin®), ranibizumab (Lucentis®), and aflibercept (Eylea®) to treat 3 retinal diseases: neovascular (wet) age-related macular degeneration (nAMD), diabetic macular edema, and retinal vein occlusion. The program also covers verteporfin (Visudyne®) with photodynamic therapy for nAMD.
- Coverage is provided only when the drugs are prescribed and administered by retinal specialists who have signed an agreement with the PHSA to participate in the PRDTP.
- The program's retinal specialists are required to track the safety and effectiveness of the treatments they administer. The PHSA uses this data to adjust the program as needed.
- The Ministry and PHSA continue to monitor the safety and effectiveness of therapy provided through the program. More information is available at: http://www.phsa.ca/our-services/programs-services/provincial-retinal-disease-treatment#Quality--Improvement

LAST UPDATED

The content of this estimates note is current as of February 26, 2025, as confirmed by Tijana Fazlagic.

APPROVALS

2025 03 25 – Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025 03 03 - Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 11 – Brenda Rafter, OBO ADM Rob Byers, Finance and Corporate Services Division

[3] PHSA database and PRDTP-queried MSP data – October 2024

LEGISLATIVE SESSION – ESTIMATES NOTE

Sale of Nicotine Replacement Therapies including Buccal Pouches (Zonnic)

Topic: Zonnic is a buccal nicotine pouch authorized for sale in Canada as a nicotine replacement therapy (NRT). To ensure NRTs are used for their intended purpose of helping people quit smoking, and not for recreational purposes, the Drug Schedules Regulation was amended February 7, 2024, to schedule buccal nicotine pouches as Schedule 2 drugs, to be sold only behind the pharmacy counter.

Key Messaging and Recommended Response:

- Buccal nicotine pouches can be used as a nicotine-replacement therapy (NRT) product to help people reduce nicotine dependency. However, public health experts have identified the concerning trend of youth using nicotine-cessation products recreationally.
- That's why through an amendment to the Drug Schedules Regulation (the Regulation) in February 2024, government moved to have buccal nicotine pouches, sprays and inhalers as regulated Schedule 2 drugs, meaning they can only be sold by pharmacies from behind the counter.
- In August 2024, the federal Minister of Health followed suit and introduced an Order (the Order) that requires that NRTs that are administered orally be sold by pharmacies behind-the-counter. The Order includes buccal pouches but excludes other forms of oral nicotine products (e.g., gum, lozenges, inhalers, and sprays under 4mg/dos).
- Advice/Recommendations
-

CURRENT SITUATION

- Zonnic, produced by Imperial Tobacco Canada, is the first buccal nicotine pouch approved for sale in Canada.
- The provincial Drug Schedules Regulation (the Regulation) regulates how and where drugs can be sold. Each drug is classified as Schedule I (prescription), II (behind-the-counter), III (over the counter), or unscheduled.
- Nicotine itself is classified as a Schedule I drug, but most nicotine products (e.g., NRTs) were unscheduled under the Regulation.
- On February 7, 2024, the Regulation was amended via Ministerial Order M32 (M32) to address concerns that youth were using buccal nicotine pouch NRTs such as Zonnic for recreational purposes.[1] This amendment classifies all NRT's administered into the oral cavity for buccal absorption by means of a non-active device as Schedule II drugs (i.e., sold in pharmacies behind the counter).
- On August 15, 2024, the federal Minister of Health introduced a Ministerial Order (the Order) that targets the labelling of new and emerging NRTs that are administered orally. Under the Order, buccal nicotine pouches can only be sold from behind the counter. The Order came into effect on August 28, 2024.[2]
- Advice/Recommendations

- Manufacturers of nicotine products have expressed concerns over M32 and the Regulation restricting access to other nicotine products (i.e., sprays and inhalers) that are not associated with misuse.
- With the introduction of the Order and its requirement that new NRT products require consultation with a practitioner (e.g., a pharmacist) prior to sale, M32 is no longer necessary to restrict access to buccal pouch products. Advice/Recommendations

[1] Ministerial Order M32, Province of British Columbia, February 5, 2024.

[2] Supplementary Rules Respecting Nicotine Replacement Therapies Order: SOR/2024-169.

- Advice/Recommendations; Legal Information

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Nicotine is highly addictive, and children and youth are more likely to develop nicotine dependence. Nicotine affects memory and concentration, can alter brain development, reduce impulse control, and cause cognitive and behavioral issues in children and youth.
- Buccal nicotine pouches are taken orally and contain up to 4 milligrams of nicotine, which is equivalent to the amount of nicotine absorbed from 3 to 4 cigarettes.[3]
- As part of providing the Minor Ailments and Contraception Service, BC pharmacists can assess and prescribe for nicotine dependance.
- The BC Smoking Cessation Program helps BC residents of any age to stop using tobacco by assisting them with the cost of quit ads such as certain prescription drugs or NRTs.
- Under the *Pharmacy Operations and Drug Scheduling Act* the board of the College of Pharmacists is responsible for bylaws respecting the requirements for the dispensing, sale, storage and disposal of a drug or device listed in the drug schedules.

LAST UPDATED

The content of this estimates note is current as of March 6, 2025, as confirmed by John Capelli.

APPROVALS

2025 03 27 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 03 28 – Ian Rongve, Pharmaceutical, Laboratory and Blood Services Division
2025 03 13 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division

[3] Province takes action to prevent sale of nicotine products to youth, BC Gov News, February 7, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

Semaglutide for Diabetes and Weight Loss

- **Topic:** PharmaCare coverage of Semaglutide (Ozempic) for diabetes and semaglutide (Wegovy) for weight loss

Key Messaging and Recommended Response:

- PharmaCare currently covers 2 semaglutide (Ozempic) products, the 0.68 mg/mL (2 mg/pen) and 1.34 mg/mL (4 mg/pen), as Limited Coverage benefits for treatment of type 2 diabetes.
- Ozempic is not approved by Health Canada for weight loss.
- Semaglutide (Wegovy) is approved by Health Canada for chronic weight management in adult patients and pediatric patients aged 12 to less than 18 years, and to reduce the risk of non-fatal myocardial infarction in adults with established cardiovascular disease.
- PharmaCare does not currently cover semaglutide (Wegovy); however, a PharmaCare review is currently pending for Wegovy for chronic weight management and to reduce the risk of non-fatal myocardial infarction in adults with cardiovascular disease and BMI ≥27.
- Government recognizes the need some people have for access to publicly funded Semaglutide for diabetes and potentially chronic weight management, which is why it took steps to ensure US-based demand for the off-label use of these medications was restricted in BC.

CURRENT SITUATION

- Semaglutide (Ozempic) is approved by Health Canada for the treatment of type 2 diabetes mellitus (T2DM) in adult patients. Ozempic is not approved by Health Canada for weight loss.
- Semaglutide (Wegovy) is approved by Health Canada for chronic weight management in adult patients and pediatric patients aged 12 to less than 18 years, and to reduce the risk of non-fatal myocardial infarction in adults with established cardiovascular disease.
- PharmaCare currently covers 2 semaglutide (Ozempic) products, the 0.68 mg/mL (2 mg/pen) and 1.34 mg/mL (4 mg/pen), as Limited Coverage benefits for treatment of T2DM.
- Another Ozempic product, the 2.68 mg/mL (8 mg/pen), is approved by Health Canada for T2DM but is not currently a PharmaCare benefit.
- PharmaCare does not cover oral semaglutide (Rybelsus) for T2DM since it has not demonstrated a reduction in cardiovascular disease (CVD) events unlike the injectable version Ozempic.
- PharmaCare does not currently cover semaglutide (Wegovy); however, a PharmaCare review is currently pending for Wegovy for chronic weight management and to reduce the risk of non-fatal myocardial infarction in adults with cardiovascular disease and BMI ≥ 27.
- Out-of-country sales of Ozempic within BC were reduced to low/normal levels once the Drug Schedules (Limits on Sale) Regulation under the *Pharmacy Operations and Drug Scheduling Act* was enacted to limit the sale of semaglutide by pharmacies in BC.
- Tirzepatide and dulaglutide have similar effects to semaglutide in lowering blood sugar levels. PharmaCare is considering whether these drugs should be added to the Drug Schedules Regulation to limit out-of-country sales, at the request of the manufacturer.

FINANCIAL IMPLICATIONS

- In fiscal year 2023/24, more than $243M of Ozempic was sold in BC with a total PharmaCare expenditure of more than $41M.[1] Of note:
    - Shortages in late 2023 reduced overall Ozempic sales.

KEY BACKGROUND

- As of April 19, 2023, the new Drug Schedules (Limits on Sale) Regulation under the *Pharmacy Operations and Drug Scheduling Act* imposed conditions on the sale of semaglutide by pharmacies in BC. Through this new

[1] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting Division, March 6, 2025.

regulation, BC residents and other Canadian citizens and permanent residents can buy Ozempic through BC pharmacies in-person and online. Others can only purchase the drug in-person at a pharmacy.

- In 2022, Canada's Drug Agency/L'Agence des médicaments du Canada (CDA-AMC) recommended that participating drug plans should not provide coverage for Wegovy because, although the drug demonstrated effectiveness in weight loss in combination with a reduced calorie diet and increased physical activity, it was not clear from the clinical trials that Wegovy treatment resulted in a reduction in weight-related comorbidities such as major adverse cardiovascular events (MACE), osteoarthritis, and obstructive sleep apnea, or improvement in health-related quality of life.
- As a result, PharmaCare decided not to list Wegovy due to the lack of clinical evidence. However, the SELECT[2] study, which was published on December 14, 2023, demonstrated a 20% reduction in MACE compared to placebo. Coverage of Wegovy is now being reevaluated at the CDA-AMC and is pending review at the Ministry of Health.
- The manufacturer, Novo Nordisk, has significant future plans for semaglutide, including combining it with insulin or Amylin, obtaining an indication for the treatment of metabolic dysfunction-associated steatohepatitis and Alzheimer's disease, and launching extended-release versions (weekly oral product and monthly injectable product).
- Ozempic's closest competitor is tirzepatide (Mounjaro) has not yet been reviewed by the CDA-AMC despite obtaining a Notice of Compliance for the treatment of T2DM in November 2022. Tirzepatide is currently undergoing phase 3 trials for heart failure, obstructive sleep apnea, morbidity and mortality in obesity, and cardiovascular outcomes in T2DM.

LAST UPDATED

The content of this estimates note is current as of March 3, 2025, as confirmed by Tijana Fazlagic.

APPROVALS

2025 03 25 – Ian Rongve, Pharmaceutical Laboratory & Blood Services Division
2025 03 07 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division

[2] https://pubmed.ncbi.nlm.nih.gov/37952131/

LEGISLATIVE SESSION – ESTIMATES NOTE

Special Authority

Topic: The PharmaCare Special Authority (SA) program grants full benefit status to drugs, medical supplies or medical devices that otherwise would not be covered or would be only partially covered.

Key Messaging and Recommended Response:

- Our government is committed to ensuring patients have access to the medical treatment they need, including providing coverage for essential treatments through PharmaCare's SA program.
- The program prioritizes cost-effective, safe, and effective therapies with coverage granted based on published criteria. Exceptions are made in medically justified cases, such as when a patient can't tolerate covered options.
- The BC Government is working to reduce the administrative burden for prescribers, making it easier to submit requests and reduce the processing time.
- As of January 2024, the wait time for regular-status medication coverage requests has been reduced to approximately 6 weeks, down from 11 weeks in 2021. Urgent requests continue to be processed within 1 to 2 business days.
- As one of the most generous drug coverage programs in Canada, BC's PharmaCare program continues to help remove the barriers to health care for people in BC.

CURRENT SITUATION

- The SA program currently receives approximately 1,500 requests a day by eForm, fax and phone submissions.[1]
- As of December 31, 2024, 60% of submissions are faxed, 37% are received digitally via eForms and 3% are received by phone/voicemail. Target turnaround times for urgent requests is 24 hours (1 business day) and 2 weeks for regular priority requests. The average wait time for the urgent SA phone line is 30 seconds.[2]
- In 2024, PharmaCare received 376,102 cases, which is a 0.2% increase from 2023; 358,866 cases were processed, which is a 3% decrease from 2023.
- The approval rate of SA requests is 67%, whereas 8% are "Not Approved", 9% of requests require more information and for 13% of requests the patient already has coverage in place for the requested medication. The activity of entering the coverage into the PharmaNet system by SA staff is 95%+ accurate.[3]
- The total number of SA requests in the queue and the time waiting for adjudication is growing:
    - at the beginning of 2024, there were 18,677 requests in the queue; wait time of 5.9 weeks.
    - at the end of 2024, there were 21,828; with a wait time of 10.6 weeks.
    - urgent requests continue to be completed within 1 to 2 business days.[4]
- SA has increased wait times due to the increased volume of requests, decreased staffing levels, project delays and slow implementation of physician office electronic integrations (eMR), requiring more manual work.

Special Authority Transformation Project: eForms Platform and SalesForce Case Management System

- In March 2020, the Special Authority Transformation (SAT) project began to improve service delivery through end-to-end digitization of the SA process.
- In collaboration with the Provincial Health Services Authority, SA eForms were introduced on the Provincial eForms Solution platform in 2021. eForms are far more efficient than fax and phone submissions as some fields are automatically filled, inputs are always legible and there is less room for input errors.

[1] Pharmaceutical, Laboratory & Blood Services Division (PLBSD), Special Authority Summary of 2024 Calendar Year. Word doc.
[2] PLBSD, Cases by Origin and Open Status, Jan 2025. https://bchealth.lightning.force.com/lightning/r/Report/00O4W000006bJhBUAU/view
[3] PLBSD, All Cases Processed - All Time, Jan 2025. https://bchealth.lightning.force.com/lightning/r/Report/00OOG000001vt8r2AA/view
[4] Pharmaceutical, Laboratory & Blood Services Division (PLBSD), Special Authority Summary of 2024 Calendar Year. Word doc..

- All eligible SA medications/devices are available for request through the eForms submission system and can be adjudicated in the SalesForce case management system. Certain drugs (currently 29 medications) are automatically adjudicated, resulting in shorter wait times for patient coverage.[5]
- Only 3.2% of eForm requests must go back to the submitter for more information.[6] Provider feedback has been positive around ease of use and improved turnaround rates.
- As of December 31, 2024, PharmaCare has received over 275,000 eForm submissions from prescribers and pharmacists in both the community and health authority settings. PharmaCare has also processed over 1,200,000 SA drug coverage requests through the new SalesForce Case Management system. **Note:** This total includes phone, fax and eForm submissions.[7]
- Phase 4 of the SAT project is awaiting funding to continue development and further improve this system.
- SA requests that were processed through SalesForce since May 2021 are now records that patients can access through the Health Gateway portal rather than contacting their prescriber or pharmacist.
- The Ministry of Health, Doctors of BC and Health Quality BC are committed to working together to review current requirements to support accessible, high-quality care. One of the identified areas of focus is eMR integration with the eForm platform.
- As part of this commitment and of the 2022 Physician Master Agreement, the Administrative Burdens Working Group was formed with the goal of creating recommendations to reduce time spent on administrative tasks. SA form burden was the group's top priority as requested by practicing physicians.

FINANCIAL IMPLICATIONS[8]

- Limited Coverage drug expenditures for 2023/24 were $729.6 million of the total PharmaCare drug (ingredients) spend of $1.1 billion.
- 64% of PharmaCare drug expenditures for 2023/24 were attributed to SA submissions.
- HSIAR estimates an approximate cost savings to the system of $500 million for fiscal year 2023/2024 for the SA Limited Coverage drug program.
- In fiscal year 2023/24, some more commonly prescribed medications with PharmaCare accepted claims for at least 10,000 patients (e.g., gliclazide, zopiclone and rabeprazole) ranged in price from $30 to $50 per patient excluding dispensing fees.
- In fiscal year 2023/24, the top 3 most costly medications, excluding dispensing fees, with accepted claims for at least 10 patients were glycerol phenylbutyrate, treprostinil and carbidopa/levodopa. The annual cost per patient of glycerol phenylbutyrate, treprostinil and carbidopa/levodopa was $135,000, $103,000 and $84,000, respectively.

KEY BACKGROUND

- There are currently 317 Limited Coverage drugs on the PharmaCare formulary.[9]
- In 2024, 25 out of 33 new listings to the PharmaCare formulary were listed as Limited Coverage drugs (75.76%). Since 2013, there have been 253 Limited Coverage drug listings (74.41%) out of 340 total listings, which include Limited Coverage and Regular benefit drugs.[10]
- The task of completing an SA request is considered part of a prescriber office visit. Prescribers should not be charging patients for completing SA forms, based on the Medical Services Commission as stated in the *Medicare Protection Act* (Section 7 - General limits on direct or extra billing), which is current as of March 29, 2023.

LAST UPDATED

The content of this estimates note is current as of March 7, 2025, as confirmed by Susan Bouma, Executive Director.

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[5] Special Authority drug list - Province of British Columbia. https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/programs/special-authority/sa-drug-list.

[6] PLBSD, MIR Cases - All Time, Jan. 2025. https://bchealth.lightning.force.com/lightning/r/Report/00O5W000000XkuGUAS/view

[7] PLBSD, All Cases Processed - All Time, Jan. 2025. https://bchealth.lightning.force.com/lightning/r/Report/00OOG000001vt8r2AA/view

[8] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting Division, March 14, 2025.

[9] Special Authority drug list - Province of British Columbia: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/programs/special-authority/sa-drug-list

[10] FMDB 2024 Listings Report. Excel doc.

LEGISLATIVE SESSION – ESTIMATES NOTE

APPROVALS

2025 03 27 – Ian Rongve, Pharmaceutical, Laboratory, and Blood Services Division
2025 03 17 – Patrick Day obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 25 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Avian Influenza (H5N1)

Topic: The global epidemic of animal-based, highly pathogenic avian influenza (avian influenza).

Key Messaging and Recommended Response:

- Avian influenza (H5N1) is spreading at an unprecedented rate among wild birds and domestic poultry flocks in Europe, North America and South America.
- H5N1 does not spread easily from animals to people or from person to person.
- BC is actively monitoring the global, national and provincial situation regarding H5N1. The current risk to the public in BC remains low.
- Between January 1, 2022, and January 20, 2025, there have been 100 officially reported cases of human infection with H5N1 around the world, including one human case identified in BC in November 2024. An extensive public health investigation of the BC case found no evidence of human-to-human transmission.
- BC's hospitals are fully equipped to safely manage and treat patients with acute viral respiratory illnesses, including H5N1.
- As of February 19, 2025, the Public Health Agency of Canada has proactively purchased a supply of 500,000 H5N1 vaccine doses, giving us another important tool to protect against H5N1, if needed.

If asked about H5N1 vaccine eligibility in BC.:

- Canada's National Advisory Committee on Immunizations (NACI) does not currently recommend the broad use of H5N1 vaccine for the general public.
- As with all other provinces and territories, BC's public health experts will be considering the potential use of H5N1 vaccine in the context of local epidemiology and risks.

CURRENT SITUATION

- The current circulating strain of avian influenza (H5N1) is causing extensive, ongoing wild bird and poultry epidemics in Europe (starting in 2020), North America (starting in late 2021), and South America (starting in late 2022).[1,2]
- H5N1 does not spread easily from animals to people or from person-to-person. Transmission can occur through close contact with infected animals, exposure to highly contaminated environments (e.g., animal farms or live animal markets), and exposure to backyard/small flocks with infected animals.[3,4]
- Between January 1, 2022, and January 20, 2025, there have been 100 officially reported cases of human H5N1 infection globally, including one human case identified in BC in November 2024.[5,6] The fatality rate among

[1] Skowronski DM, Montoya S, Kaweski S, et al. Risk assessment: human health implications of the clade 2.3.4.4b highly pathogenic avian influenza (HPAI) H5Nx epizootic, 2021-2022 (British Columbia: BC Centre for Disease Control, 2022). Accessed February 05, 2025 at www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Statistics and Reports/Epid/Influenza and Respiratory/ERV/HPAI_H5N1_Risk_Assessment_19_May_2022.pdf.

[2] FAO/WHO/WOAH. Updated joint FAO/WHO/WOAH assessment of recent influenza a (H5N1) virus events in animals and people. August 14, 2024. Accessed February 05, 2025 at https://www.who.int/publications/m/item/updated-joint-fao-who-woah-assessment-of-recent-influenza-a(h5n1)-virus-events-in-animals-and-people.

[3] Government of Canada. Avian influenza A(H5N1): Prevention and risks. Last updated January 10, 2025. Accessed February 05, 2025 at https://www.canada.ca/en/public-health/services/diseases/avian-influenza-h5n1/prevention-risks.html

[4] Government of Canada. Rapid risk assessment update: Avian influenza A(H5N1) clade 2.3.4.4b, public health implications for Canada. Last updated December 06, 2024. Accessed February 05, 2025 at https://www.canada.ca/en/public-health/services/emergency-preparedness-response/rapid-risk-assessments-public-health-professionals/avian-influenza-a-h5n1-clade-2-3-4-4b-update.html.

[5] World Health Organization. Cumulative number of confirmed human cases for avian influenza A(H5N1) reported to WHO, 2003-2025, 20 January 2025. Updated January 20, 2025. Accessed February 05, 2025 at https://www.who.int/publications/m/item/cumulative-number-of-confirmed-human-cases-for-avian-influenza-a(h5n1)-reported-to-who--2003-2025--20-january-2025.

[6] Government of Canada. Statement from the Public Health Agency of Canada: Update on Avian Influenza and Risk to Canadians. November 13, 2024. Accessed March 7, 2025 at https://www.canada.ca/en/public-health/news/2024/11/update-on-avian-influenza-and-risk-to-canadians.html.

reported human cases globally since 2003 is 48%.[7]

- The Public Health Agency of Canada's (PHAC) Avian Influenza A (H5N1) pandemic risk assessment from November 2024 identifies the overall risk of the H5N1 virus to the general human population as low.[8]

BC's Human Case of H5N1

- In November 2024, BC reported Canada's first locally-acquired human avian influenza case, a critically ill BC resident in the Fraser Valley diagnosed with an H5N1 influenza strain linked to wild birds.[9]
- An extensive public health investigation found no evidence of human-to-human transmission relating to this case.[10]

Safely Managing H5N1 Cases

- The BC Centre for Disease Control (BCCDC) publishes guidelines supporting public health officials and clinicians in managing H5N1 influenza as part of its Communicable Disease Control Manual.[11]
- BC's hospitals are equipped to manage cases of viral respiratory illness, including caring for those with acute illness. If a symptomatic patient with a potential exposure to an infected animal accesses health care in BC, provincial infection prevention and control guidelines are in place to safely manage and care for the patient.[12] Several antiviral medications for influenza viruses, including H5N1, are available for use in cases of acute illness.[13]

H5N1 Vaccination

- On February 19, 2025, PHAC announced the approval and proactive purchase of 500,000 H5N1 vaccine doses. PHAC will be providing the vaccine doses to provinces and territories based on an equitable, risk-based approach. 60% of the vaccine doses will be going to provinces and territories and 40% will be kept in the federal stockpile for national preparedness.[14]
- Coinciding with PHAC's announcement, Canada's National Advisory Committee on Immunization (NACI) released initial guidance on the use of H5N1 vaccine in a non-pandemic context. Of note, NACI is not recommending the broad deployment of H5N1 vaccine but has identified considerations for when the vaccine could be used for higher risk populations (e.g., poultry and dairy workers).[15]
- BC looks to its public health experts to provide recommendations on the use of all new vaccine products. As with other provinces and territories, BC's public health experts will be considering the potential use and administration of the H5N1 vaccine in the context of local risk conditions.

FINANCIAL IMPLICATIONS

- Procurement costs for H5N1 vaccine are covered by the Government of Canada.

KEY BACKGROUND

[7] World Health Organization. Cumulative number of confirmed human cases for avian influenza A(H5N1) reported to WHO, 2003-2025, 20 January 2025. Updated January 20, 2025. Accessed February 05, 2025 at https://www.who.int/publications/m/item/cumulative-number-of-confirmed-human-cases-for-avian-influenza-a(h5n1)-reported-to-who--2003-2025--20-january-2025.

[8] Government of Canada. Rapid risk assessment update: Avian influenza A(H5N1) clade 2.3.4.4b, public health implications for Canada. Last updated December 06, 2024. Accessed February 05, 2025 at https://www.canada.ca/en/public-health/services/emergency-preparedness-response/rapid-risk-assessments-public-health-professionals/avian-influenza-a-h5n1-clade-2-3-4-4b-update.html.

[9] Government of BC. BC Gov News: First presumptive positive case of H5 avian influenza detected in BC November 09, 2024. Accessed February 05, 2025 at https://news.gov.bc.ca/releases/2024HLTH0152-001583.

[10] Government of BC. BC Gov News: Final update on human avian influenza case in BC November 26, 2024. Accessed February 05, 2025 at https://news.gov.bc.ca/releases/2024HLTH0155-001601.

[11] BCCDC. Communicable Disease Control, Chapter I Interim H5N1 Avian Influenza Outbreak August 2024. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/Avian-Influenza-Interim-Guidelines-H5N1-Outbreak.pdf

[12] Provincial Infection Control Network of British Columbia. Subject: Highly Pathogenic Avian Influenza – Interim Infection Prevention and Control Recommendations for Health Care Settings, June 27, 2023. Accessed February 05, 2024 at https://picnet.ca/wp-content/uploads/PICNet-Memo-Pathogenic-Avian-Influenza-June-27-2023_approved_final.pdf.

[13] BCCDC. Communicable Disease Control, Chapter I Interim H5N1 Avian Influenza Outbreak August 2024. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/Avian-Influenza-Interim-Guidelines-H5N1-Outbreak.pdf

[14] Government of Canada. Government of Canada purchases avian influenza vaccine to protect individuals most at risk. Retrieved February 19, 2025 from https://www.canada.ca/en/public-health/news/2025/02/government-of-canada-purchases-avian-influenza-vaccine-to-protect-individuals-most-at-risk.html.

[15] Government of Canada. Rapid response: Preliminary guidance on human vaccination against avian influenza in a non-pandemic context as of December 2024. Retrieved February 24, 2025 from https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-statement-rapid-response-preliminary-guidance-human-vaccination-avian-influenza-non-pandemic-december-2024.html#a9

- Avian influenza is a disease of birds caused by Type A influenza viruses that can affect domestic poultry (e.g., chickens, turkeys) and wild birds, primarily migratory waterfowl (e.g., ducks, geese).
- Avian influenza subtypes H5 and H7 are reportable diseases under Canada's national *Health of Animals Act*.[16] All suspected cases must be reported to the Canadian Food Inspection Agency for immediate investigation. The Canadian Food Inspection Agency leads the response with public health to assess and manage human health risks.[17]
- Under BC's *Public Health Act*, avian influenza is also reportable through the BCCDC to the Provincial Health Officer.[18]

LAST UPDATED

The content of this estimates note is current as of March 24, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control.

APPROVALS

2025 03 24 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 03 24 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 03 05 – Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 03 11 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis and Reporting Division

[16] Government of BC. Avian influenza. Last updated January 09, 2025. Accessed February 05, 2025 at https://www2.gov.bc.ca/gov/content/industry/agriculture-seafood/animals-and-crops/animal-health/reportable-notifiable-diseases/avian-influenza-ai.
[17] Government of Canada. Canadian Food Inspection Agency. Facts about Avian Influenza. Last modified November 21, 2024. Accessed February 05, 2025 at https://inspection.canada.ca/en/animal-health/terrestrial-animals/diseases/reportable/avian-influenza/facts-about-avian-influenza.
[18] Government of BC. BC Reg. 167/2018: Reporting Information Affecting Public Health Regulation. Amended June 19, 2023. Accessed February 05, 2025 at https://www.bclaws.gov.bc.ca/civix/document/id/lc/statreg/167_2018.

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Long COVID (Post COVID-19 Conditions)

Topic: Symptoms, risk factors, prevalence, and health system supports for people experiencing Post COVID-19 conditions (aka “Long COVID").

Key Messaging and Recommended Response:

- We know COVID-19 can leave people with symptoms long after they’ve recovered.
- Government is supporting and caring for every person who gets COVID-19, including people experiencing longer-term symptoms.
- B.C. was the first jurisdiction in Canada to recognize the need to support people living with post-COVID symptoms.
- In July 2020, BC established the Post-COVID-19 Interdisciplinary Clinical Care Network offering clinical care, education and research supporting patients with post-COVID conditions and their health care providers.
- This was the first network of its kind in Canada to standardize post-COVID-19 care across health authorities and integrate real-time research into clinical care through standardized care pathways and online tools.
- In its first two years, the Network had 6,439 referrals, of which 4,014 (62 %) were accepted.
- The number of patients referred to the Network continues to decrease over time. Operations at PC-ICCN’s fully virtual clinic can scale up or down easily as demand changes (if referrals increase or decrease in the future).
- The Network has permanent funding from the Ministry of Health and will continue to evolve their services in response to current demands, patient needs and feedback.

CURRENT SITUATION

- Most people with acute COVID-19 fully recover within a few days to a few weeks after infection.[1] Post-COVID-19 Condition, also known as “Long COVID”, refers to the persistence of COVID-19 symptoms or the onset of new symptoms for more than 12 weeks after a COVID-19 infection.[2]
- Post-COVID Conditions can manifest in over one hundred different symptoms of varying severity, including fatigue, trouble sleeping, shortness of breath, general pain and discomfort, cognitive problems (e.g., difficulty concentrating), and mental health symptoms (e.g., depression) in adults.[3]
- In a study of BC’s Post-COVID Recovery Clinics, 892 patients presented three months after their COVID-19 infection with the following symptoms: shortness of breath (85.9%), fatigue (75.7%), weakness (56.1%), memory problems (47.3%), and muscle pain (45.6%), with a variability in severity and burden of symptoms.[4]
- In July 2020, BC established the Post-COVID-19 Interdisciplinary Clinical Care Network (the Network) to provide clinical care, education, and research for patients with Post-COVID Condition and their health care providers.[5]
    - The Network offers a province-wide virtual Post-COVID Recovery Clinic, operated by Provincial Health Services Authority (PHSA) and based at Providence Health Care, for eligible patients across BC.[6]

[1] Government of Canada. Post-COVID-19 Condition in Canada: What we know, what we don’t know, and a framework for action. Last updated October 10, 2024. Accessed January 31, 2025 at https://science.gc.ca/site/science/en/office-chief-science-advisor/initiatives-covid-19/post-covid-19-condition-canada-what-we-know-what-we-dont-know-and-framework-action.

[2] Government of Canada. Post COVID-19 condition (long COVID). Last updated October 22, 2024. Accessed January 31, 2025 at https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/symptoms/post-covid-19-condition.html.

[3] Government of Canada. Post COVID-19 condition (long COVID). October 22, 2024. Accessed January 31, 2025 at https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/symptoms/post-covid-19-condition.html.

[4] Tran, K. C., Wong, A., Schwartz, Z., Greiner, J., Birks, P., Kahlon, S., Carlsten, C., Ryerson, C. J., Shao, S., Er, L., Russell, J. A., & Levin, A. (2023). Post-COVID-19 condition characterizing the burden of symptoms using standardized assessment: A prospective observational cohort British Columbia, Canada. Canadian Journal of General Internal Medicine, 18(2), 18-30. Accessed at January 31, 2025 at https://utppublishing.com/doi/full/10.22374/cjgim.v18i2.682.

[5] Provincial Health Services Authority. Post-COVID-19 Interdisciplinary Clinical Care Network. Accessed January 29, 2025, at http://www.phsa.ca/our-services/programs-services/post-covid-19-care-network.

[6] Provincial Health Services Authority. Post-COVID-19 Interdisciplinary Clinical Care Network. Post-COVID Recovery Care. Accessed January 31, 2025 at http://www.phsa.ca/health-professionals/clinical-resources/post-covid-19-care.

- Eligible patients can be referred by their primary care provider if they experience symptoms limiting their daily activities for at least three months after presumed or confirmed COVID-19 illness. Once accepted, a specialist nurse assesses the patient to determine the necessary level of support, providing access to self-management supports and group learning opportunities. Referrals to specialists are made if needed.[7]
- The Network also offers MyGuide Long COVID, an online tool to help people living with post-COVID symptoms to self-manage with customized care plans and resources, accessible anytime from any device.[8]

- In the first two years, the Network had 6,439 referrals, of which 4,014 (62.3%) were accepted. A 2023 evaluation of the Network found that 40% of patients referred between July 2020 and June 2022 showed improvements in their health-related quality of life and 36% had stability.[9]
- PHSA continues to maintain public websites with information and resources for BC residents living with Post-COVID Condition symptoms,[10] as well as information for health care providers.[11]

FINANCIAL IMPLICATIONS

$5 million annually to support the Post-COVID-19 Interdisciplinary Clinical Care Network central infrastructure and consolidated provincial clinic.

KEY BACKGROUND

- The biological cause of the complex symptoms and conditions seen in Post-COVID Condition remain unknown. It is hypothesized that some populations may have an increased susceptibility due to underlying chronic conditions, lack of COVID-19 vaccination, or severe COVID-19 illness requiring hospitalization or critical care.]
- There are currently no specific diagnostic tests or treatments available for Post-COVID Condition.

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2025 02 12 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 03 10 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 02 13 – Eugene Johnson, Executive Director, Provincial Services Branch
2025 02 14 – Kelly Uyeno, Assistant Deputy Minister, Provincial Health Services Division
2025 02 18 – Lenore Ogilvy, obo Martin Wright, Assistant Deputy Minister, Health Sector Information, Analysis & Reporting Division
2025 02 24 – Brenda Rafter obo Rob Byers, Assistant Deputy Minister, Finance and Corporate Services Division

[7] Provincial Health Services Authority. Post-COVID-19 Interdisciplinary Clinical Care Network. Long COVID Patient Care Pathway. Accessed January 31, 2025 at http://www.phsa.ca/our-services-site/Documents/Possible%20PC-ICCN%20Care%20Pathways.pdf
[8] Provincial Health Services Authority. Post-COVID-19 Interdisciplinary Clinical Care Network. MyGuide Long COVID. Accessed January 31, 2025 at https://www.longcovidbc.ca/.
[9] A Learning Health System for Long COVID Care and Research in British Columbia, New England Journal of Medicine, August 2023. Accessed January 31, 2025 at https://catalyst.nejm.org/doi/full/10.1056/CAT.23.0120
[10] Provincial Health Services Authority. Post-COVID-19 Interdisciplinary Clinical Care Network. Living with Post-COVID Symptoms. Accessed January 31, 2025 at http://www.phsa.ca/health-info/post-covid-19-care-recovery.
[11] Provincial Health Services Authority. Post-COVID-19 Interdisciplinary Clinical Care Network. Post-COVID Recovery Care. Accessed January 31, 2025 at http://www.phsa.ca/health-professionals/clinical-resources/post-covid-19-care.

LEGISLATIVE SESSION – ESTIMATES NOTE

Immunization - COVID-19 Vaccination Program

Topic: BC's provincial COVID-19 immunization program.

Key Messaging and Recommended Response:

- Vaccination is a key measure for protecting ourselves, our loved ones, and our communities against COVID-19.
- This fall, Canada's National Advisory Committee on Immunization (NACI) strongly recommended people aged 65 years and older, residents of long-term care homes and congregate living settings, Indigenous people, pregnant people, and people with underlying medical conditions receive a dose of the most up to date COVID-19 vaccine this viral respiratory illness season.
- Beginning October 15, 2024, free COVID-19 vaccines became available for anyone 6 months of age and older in BC, if it was 6 months after their last dose.
- As of January 26, 2025, 1,080,133 doses of COVID-19 vaccine have been administered during the 2024/25 (most recent) viral respiratory illness season.
- For spring 2025, NACI recommends those people who are most at risk of severe illness from COVID-19 **should** get an additional vaccine dose per year. This includes adults aged 80 years and older, residents of long-term care and other congregate living settings, and people 6 months and older who are severely immunocompromised due to an underlying condition or treatment.
- For spring 2025, NACI also recommends that adults aged 65 to 79 years **may** receive a second dose of COVID-19 vaccine per year. This is a change from past years when spring COVID-19 vaccinations were recommended for a much larger segment of the population.

CURRENT SITUATION

- BC's 2024/25 fall/winter COVID-19 immunization program for the general public started on October 15, 2024. Immunization of long-term care (LTC) and assisted living (AL) residents began on October 8, 2024, when shipments of COVID-19 vaccine began arriving in the province.[1]
- All BC residents 6 months of age or older are eligible to receive the updated formulation of COVID-19 vaccine targeting the KP.2 strain of SARS-CoV-2.[2]
- BC's priority populations for COVID-19 vaccination during the 2024/25 fall/winter immunization program are people 65 years of age or older, residents of long-term care homes and other congregate living settings, Indigenous people, pregnant people, people with underlying medical health conditions at increased risk, members of racialized or other equity-deserving communities, and people who provide essential community services.[3]
- BC has been allocated 2,235,250 doses of COVID-19 vaccine by the Government of Canada for the 2024/25 fall/winter immunization program.[4] A third of the doses are Moderna's KP.2 formulation. The remaining two thirds of the doses are Pfizer's KP.2 formulation.
- As of January 26, 2025, uptake of COVID-19 vaccine for the 2024/25 fall/winter immunization program has been as follows:[5]
    - 1,080,133 doses of COVID-19 vaccine were administered in total.
    - 457,771 doses of COVID-19 vaccine were administered to people 65 years of age or older.
    - 88,420 doses of COVID-19 vaccine were administered to people who are clinically extremely vulnerable.
    - 70,405 doses of COVID-19 vaccine were administered to health care workers.

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[1] BC Gov News. Updated vaccines for influenza, COVID-19 available throughout B.C. October 22, 2024. https://news.gov.bc.ca/releases/2024HLTH0150-001562

[2] Government of BC. COVID-19 Immunization. Accessed March 3, 2025, from https://www2.gov.bc.ca/gov/content/covid-19/vaccine/register.

[3] Government of Canada. Guidance on the use of COVID-19 vaccines in the fall of 2024. Accessed March 3, 2025, from https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-guidance-covid-19-vaccines-fall-2024.html.

[4] BC Vaccine Operations Centre. Start Date of Fall Vaccination Program Decision Briefing Note. July 31, 2024.

[5] BC Vaccine Operations Centre. BCVOC Weekly Status Update. January 28, 2025.

- Since the advent of COVID-19 vaccines in 2020, the total number of COVID-19 vaccinations administered in BC are, as of January 31, 2025:

Calendar Year	COVID-19 Vaccinations Administered (All Vaccine Products; as per Daily Provincial Immunization Registry (PIR) report as January 31, 2025)[6]
2020 (Dec 14 – Dec 31)	20,437
2021	9,220,481
2022	4,549,452
2023	2,048,533
2024	1,058,531
2025 (Jan 1 - Jan 31)	86,767
Total Administered to Date	**16,984,201**

FINANCIAL IMPLICATIONS

- The cost of COVID-19 vaccines was paid by the Government of Canada until December 31, 2024. Starting with the 2025/26 fall/winter COVID-19 vaccination program, vaccine purchase will transition from a federally paid program to provincial and territorial paid programs.[7]
- Government Financial Information

KEY BACKGROUND

- Beginning October 8, 2024, for the 2024/25 COVID-19 immunization program, the provincial Get Vaccinated system is being used to send invitations for people to book appointments for COVID-19 and influenza vaccinations, including 'co-administration' at the same appointment.[8]
- For the 2024/25 fall/winter immunization program in BC, approximately 1,300 pharmacies are participating in the influenza and COVID-19 vaccination programs.[9]
- Evidence on vaccine safety is available from COVID-19 clinical trials and ongoing national and international COVID-19 vaccine safety monitoring. No new adverse events have been identified for the updated COVID-19 vaccines.[10]
- COVID-19 vaccines may be given on the same day or at any time before or after non-COVID-19 vaccines. This includes children who can get their COVID-19 and influenza vaccinations at the same time as their routine childhood vaccines.[11]

LAST UPDATED

The content of this estimates note is current as of March 4, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Planning, Population and Public Health Division.

[6] Personal communication with Lori Smart, BCCDC, February 13, 2025.
[7] Government of Canada. Summary of NACI Statement of January 10, 2025: Guidance on the use of COVID-19 vaccines for 2025 to summer 2026. January 10, 2025. https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-guidance-covid-19-vaccines-2025-summer-2026.html
[8] BC Gov News. Updated vaccines for influenza, COVID-19 available throughout B.C. Oct. 22, 2024. https://news.gov.bc.ca/releases/2024HLTH0150-001562.
[9] BC Gov News. Updated vaccines for influenza, COVID-19 available throughout B.C. Oct. 22, 2024. https://news.gov.bc.ca/releases/2024HLTH0150-001562.
[10] Government of Canada. Guidance on the use of COVID-19 vaccines for 2025 to summer 2026. January 10, 2025. https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-statement-guidance-covid-19-vaccines-2025-summer-2026.html#a5
[11] Government of Canada. COVID-19 vaccines: Canadian Immunization Guide. Accessed February 5, 2025, from https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/page-26-covid-19-vaccine.html

LEGISLATIVE SESSION – ESTIMATES NOTE

APPROVALS

2025 03 04 – Brian Sagar, Executive Director, Communicable Disease Prevention and Planning Branch
2025 03 24 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 03 05 – Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 03 07 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 13 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Immunization – Health Care Worker Immune Status Policy

Topic: BC's Immune Status Reporting Policy requiring health care workers employed or contracted by health authorities to have their immune status records on file with their employer.

- Everyone is encouraged to keep their immunizations up to date.
- By doing our part to avoid vaccine preventable illnesses, we help stop and slow the spread of disease to more vulnerable people whose health outcomes could be dire or fatal.
- At the height of the pandemic emergency, COVID-19 immunization mandates were in effect. Those have since been rescinded.
- Instead, all clinical and non-clinical health-care workers employed, contracted by, and appointed to health authorities are required to have a current immune status record on file.
- Immunization records are not mandates. Vaccination is not a condition of employment.
- Anonymized data from Immunization records help health officials plan the response to exposures and outbreaks faster and more effectively and helps the overall health system prepare for future pandemics.
- If a health care worker does not have their immune status on file, they are considered "not immune" for that pathogen and may be required to follow appropriate infection control measures and protocols in the event of an exposure or outbreak (e.g., wearing additional personal protective equipment or being temporarily excluded from a worksite in active outbreak).
- Even though the COVID-19 public health emergency has ended, immunization is still highly recommended for health care workers.
- Considering their proximity to vulnerable patients, we encourage all health care workers get vaccinated for COVID-19, influenza, and to stay up to date on all their routine vaccinations (e.g., measles, mumps, rubella, pertussis, hepatitis B and varicella) to protect themselves, their patients, colleagues, families and visitors against illness.

CURRENT SITUATION

- On July 29, 2024, the Ministry of Heath issued Policy Communique 2024-10 "Reporting of Health Care Worker Immune Status" (the Policy) requiring all clinical and non-clinical health care workers employed, contracted by, and appointed to health authorities to have a current and complete immune status record on file with their employer. The Policy includes medical staff, volunteers, and students.[1]
- While the requirement for employers to collect immune status for health care workers is not new, the Policy builds on existing requirements and provides a provincially coordinated and consistent approach to implementation.
- The Policy includes priority pathogens relevant to occupational health and safety and infection prevention and control, as outlined in the BC Centre for Disease Control Immunization Manual. This includes COVID-19, influenza, measles, mumps, rubella, pertussis, hepatitis B and varicella.[2]
- The Policy does not require a health care worker to be vaccinated as a condition of employment.
- If a health care worker does not have their immune status on file, they are considered "not immune" for that pathogen and may be required to follow appropriate infection control measures and protocols in the event of an exposure or outbreak (e.g., wearing additional Personal Protective Equipment or being temporarily excluded from work).

Implementation

- Retroactive to July 26, 2024, all new hires are being asked to provide their immune status records.
- Health authorities are reviewing their records for existing employees and reaching out for any missing records.

[1] BC Gov News. July 26, 2024. "COVID-19 public-health emergency ends, new vaccine registry will keep people safe". https://news.gov.bc.ca/releases/2024HLTH0115-001204.

[2] BCCDC. Immunization Manual – Health Care Workers. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/Part2/HealthCareWorkers.pdf

- Health care workers who are not up to date with their immunizations, missing immunization records or otherwise deemed 'not immune' to any of the antigens covered by the policy are being provided opportunities to get any missing vaccinations through public health units and community pharmacies.
- Health authorities are expected to complete their review, outreach and collection of records to build the most complete data set possible by September 2, 2025.

KEY BACKGROUND

- The following is the percentage of health care workers (excluding physicians) employed in a health authority who are immune and/or fully vaccinated, according to current records, as of February 3, 2025[3]:
  - 39% have received an updated influenza vaccine;
  - approximately 58% are immune/fully vaccinated for measles;
  - approximately 53% are immune/fully vaccinated for mumps;
  - approximately 68% are immune/fully vaccinated for rubella;
  - approximately 39% are immune/fully vaccinated for hepatitis B;
  - approximately 59% are immune/fully vaccinated for varicella (chicken pox); and,
  - approximately 26% are immune/fully vaccinated for pertussis.
- The Policy is enforceable under the *Health Authorities Act* and the *Ministry of Health Act.*[4,5]
- Employers of private facilities under the *Residential Care Regulation* and *Assisted Living Regulation* (e.g., long-term care and assisted living) are required to collect information about their employees' compliance with the BCCDC Immunization Manual as a licensing requirement.[6,7]

LAST UPDATED

The content of this estimates note is current as of February 26, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control.

APPROVALS

2025 02 26 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 03 26 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 02 20 – Dr. Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 03 11 – Miranda Mason, Assistant Deputy Minister, Health Sector Workforce and Beneficiary Services Division
2025 02 27 – Lenore Ogilvy obo Martin Wright, Assistant Deputy Minister, Health Sector Information, Analysis & Reporting Division

[3] Personal communication with Kiran Dhillon, Workplace Health Call Centre. February 3, 2025.
[4] Health Authorities Act. Current to January 28, 2025. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96180_01
[5] Ministry of Health Act. Current to January 28, 2025. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96301_01
[6] Residential Care Regulation. Amended October 24, 2022. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96_2009
[7] Assisted Living Regulation. Amended September 27, 2022. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/189_2019

LEGISLATIVE SESSION – ESTIMATES NOTE

Immunization – Human Papillomavirus (HPV)

Topic: Human Papillomavirus (HPV) vaccinations to prevent cervical and other cancers, and genital warts.

Key Messaging and Recommended Response:

- BC has been a world leader in preventing cervical cancer and is continuing its efforts by increasing opportunities for Human Papillomavirus (or HPV) vaccination through BC's 10-year Cancer Action Plan.
- The most effective way to help prevent cervical cancer is being vaccinated against HPV.
- HPV vaccine is offered for free starting with any students in grade 6 through school-based immunization clinics.
- In addition, HPV vaccine is offered in schools to students in Grade 7, Grade 8, and Grade 9, who may have missed their Grade 6 immunization, providing an additional opportunity to get vaccinated.
- In Fall 2023, to further broaden protection from HPV and the cancers it can cause, government further expanded eligibility to include males born in 2005.
- This meant, beyond school-based immunization programs, BC has now moved to publicly fund HPV immunization for anyone aged 9 to 18, and for special populations aged 19-26 such as people who are HIV positive or living with HIV, Two-Spirit, transgender and non-binary, and cisgender men who have sex with men (MSM) or who are street-involved.
- Anyone who missed their HPV vaccine at school should contact their health unit, community health centre, or pharmacy to make an appointment to get vaccinated while they're still eligible.

CURRENT SITUATION

HPV Vaccination – Background

- The publicly funded HPV9 vaccine protects against nine types of HPV, including two types that cause 70% of cervical cancers and 80% of anal cancers. The HPV9 vaccine also protects against five additional types of HPV that cause 15% of cervical cancers, 11% of anal cancers in females and 4% in males[1] and that can also cause cancers of the mouth and throat, penis, vagina, vulva, and genital warts.[2]
- HPV9 vaccine is routinely offered for free to all students in grade 6 in BC through school-based immunization clinics. The vaccine is also offered routinely in schools to students in Grade 9, who may have missed the HPV vaccine in grade 6.
- The HPV vaccine is currently offered in BC as a 2-dose series if initiated before age 15, or a 3-dose series if initiated at age 15 and older and for immunocompromised individuals.
- Children who missed getting the HPV vaccine at school can contact their local health unit, community health centre, or pharmacy to make an appointment to get vaccinated.

HPV Vaccination – BC Cancer Action Plan

- As announced on February 24, 2023, BC's 10-year Cancer Action Plan commits to achieving the national target of 90% HPV vaccination coverage among adolescents by 17 years of age in support of the World Health Organization (WHO) goal of eliminating cervical cancer.[3]
- As of March 31, 2024, 71% of 12-year-old females and 68% of 12-year-old males had received one dose of HPV vaccine and 76% of 17-year-old females and 73% of 17-year-old males had received two doses of HPV vaccine.[4]

[1] BCCDC. Vaccines in BC – Human Papillomavirus (HPV) Vaccine. Retrieved February 12, 2025, from http://www.bccdc.ca/health-professionals/clinical-resources/vaccines-in-bc.
[2] ImmunizeBC. HPV Vaccine. Retrieved February 12, 2025, from https://immunizebc.ca/vaccines-by-disease/hpv.
[3] Government of BC. 10-Year Cancer Action Plan. Retrieved February 12, 2025, from https://news.gov.bc.ca/files/CancerPlan2023.pdf.
[4] BC's Cancer Action Plan Year-1 Progress report. June 2024. Retrieved February 12, 2025, from https://news.gov.bc.ca/files/CAP1YearReport.pdf.

- Health authorities are working to increase HPV vaccine uptake in their school-based immunization program by providing at least one additional school-based clinic per school in order to give additional opportunities to get vaccinated.
- In February 2024, the province delivered a successful advertising campaign for school age youth promoting the importance of protecting "Future You" through HPV vaccination.
- Health authorities are also working to provide additional outreach to populations experiencing barriers to accessing the HPV vaccine, supporting provincial education and awareness-raising campaigns about HPV vaccination.

HPV Vaccination – Proposed Changes to HPV Vaccination Schedule

- On July 24, 2024, Canada's National Advisory Committee on Immunization (NACI) published updated recommendations to adopt a one-dose HPV vaccine schedule for individuals aged 9 to 20.[5]
- The Ministry is currently reviewing these recommendations.

FINANCIAL IMPLICATIONS

- BC has allocated Government Financial in 2025/26 to support the HPV9 vaccine program, including a purchase of 135,000 incremental doses.[6]

KEY BACKGROUND

- HPV is a common sexually transmitted infection that most adults have in their lifetime. The body usually clears HPV without treatment; however, the abnormal cells caused by HPV can remain in the body. Over time, these abnormal cells can evolve into cervical, oral, penile, anal, and other cancers.[7]
- In BC as of 2021, 1 in 170 unvaccinated females is expected to develop cervical cancer during their lifetime and 1 in 530 females are expected to die of cervical cancer.[8]
- The most effective way to help prevent cervical cancer is to get vaccinated against HPV.
- In BC, HPV9 is publicly funded for all individuals aged 9 to 18, and for special populations aged 19-26 who are HIV positive or living with HIV, Two-Spirit, transgender and non-binary, and cisgender men who have sex with men (MSM) or who are street-involved. The HPV9 vaccine was first publicly funded in 2009 for females in grade 6 and 9. By 2017, the program expanded to include males in grades 6 and 9. In Fall 2023, the program expanded eligibility further to include males born in 2005.

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2025 02 12 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 03 10 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 02 20 – Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 02 23 – Lenore Ogilvy obo, Martin Wright, Assistant Deputy Minster, Health Sector Information, Analysis & Reporting
2025 02 28 – Brenda Rafter obo Rob Byers, Assistant Deputy Minister, Finance and Corporate Services Division

[5] Summary of NACI statement of July 24, 2024: Updated recommendations on human papillomavirus vaccines. Retrieved February 12, 2025, from https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-updated-recommendations-hpv-vaccines.html.
[6] Personal communication with Zaahira Lalani, BCCDC and Brian Sagar, CDPC. September 26, 2024.
[7] BC Cancer Agency. Cervical Cancer. Retrieved February 12, 2025, from http://www.bccancer.bc.ca/health-info/types-of-cancer/pelvic-area/cervix.
[8] BC Cancer Agency. Statistics by Cancer Type - Cervix. Retrieved February 12, 2025, from http://www.bccancer.bc.ca/statistics-and-reports-site/Documents/Cancer_Type_Cervix_2018_20210305.pdf.

LEGISLATIVE SESSION – ESTIMATES NOTE

Immunization – Influenza Vaccination Program

Topic: BC's publicly funded seasonal influenza immunization program, including enhanced influenza vaccines for all BC seniors (65+).

Key Messaging and Recommended Response:

- Immunization is one of the best ways to protect against influenza. When you get immunized, you are also helping protect others by reducing the spread of the influenza virus.
- Everyone in BC aged 6 months and older is eligible to receive publicly funded influenza vaccine each fall.
- In addition to universal eligibility, all BC seniors (65+) are offered 'enhanced' influenza vaccines that are formulated to provide better protection against influenza-related illness in older adults.
- All eligible people in BC can receive their influenza and COVID-19 vaccine doses at the same appointment.
- As of January 31, 2025, over 1.36 million doses of influenza vaccine have been administered in BC so far during the 2024/25 respiratory illness season.

CURRENT SITUATION

- In BC, influenza vaccines are publicly funded for everyone in BC aged 6 months or older.
- In addition to universal eligibility, all BC seniors (65+) are offered an 'enhanced' influenza vaccine that provides better protection to seniors against influenza-related illness.
- For the current 2024/25 season, BC purchased a total of 2.32 million doses of influenza vaccine, including 691,630 doses of enhanced influenza vaccine for seniors (65+).[1, 2]
- All eligible people in BC can receive their influenza and COVID-19 vaccine doses at the same appointment (i.e., "co-administration").
- For the current 2024/25 season, immunizers in BC have administered over 1.36 million doses of influenza vaccine as of January 31, 2025. Of these, 84% were administered in pharmacies and between 10% and 16% were administered in health authority clinics. In addition, approximately 210,000 doses of influenza vaccine were distributed to primary care.[3]
- For the current 2024/25 season, over 515,000 doses of influenza vaccine have been administered to seniors (65+) as of the end of January 2025.
- As of January 31, 2025, the 65+ age group had the highest percentage of co-administration of influenza with COVID-19 at 30%.[4]

FINANCIAL IMPLICATIONS

- For the 2024/25 viral respiratory illness season, the province invested $26.111 million to purchase influenza vaccine.[5] Of this amount, $8.832 million was for purchasing enhanced influenza vaccine for seniors.[6]

KEY BACKGROUND

- Influenza is an acute respiratory illness caused by an influenza virus.[7]

[1] BC Vaccine Operations Centre. Start Date of Fall Vaccination Program Decision Briefing Note. July 31, 2024
[2] Personal communication with Lori Smart, BCCDC. August 27, 2024.
[3] Personal communication with Lori Smart, BCCDC. February 13, 2025.
[4] Personal communication with Lori Smart, BCCDC. February 13, 2025.
[5] Personal communication with Lori Smart, BCCDC. August 27, 2024.
[6] Personal communication with Lori Smart, BCCDC. August 27, 2024.
[7] HealthLink BC. "Facts about influenza". https://www.healthlinkbc.ca/healthlinkbc-files/facts-about-influenza-flu. Accessed March 3, 2025.

- Those at the greatest risk of severe disease and influenza-related complications include residents in long-term care facilities, infants and children, pregnant individuals, Indigenous peoples, and adults 65 years of age and older.[8]
- As of October 19, 2021, the Province adopted universal eligibility criteria for publicly funded influenza vaccines. This includes all BC residents aged 6 months or older. [9]

Enhanced Influenza Vaccine Program

- Fluad is an 'enhanced' influenza vaccine for adults aged 65 years and older. Fluad has been offered to all seniors (65+) in BC for the 2024/25 viral respiratory illness season.
- Enhanced influenza vaccines have been formulated to create a stronger immune response to compensate for the natural weakening of the immune system that occurs with age. Evidence shows that enhanced influenza vaccines are effective at protecting seniors against influenza-related illness, complications, and hospitalization, and have increased benefit compared to standard dose influenza vaccines, with no difference in safety.[10]
- Canada's National Advisory Committee on Immunization (NACI) strongly recommends that all adults aged 65 years and older should be offered enhanced influenza vaccines.[11] However, if no enhanced influenza vaccine for adults 65 years and older is available, NACI recommends that a 'standard' dose of influenza vaccine should be used.[12]
- BC's enhanced influenza vaccine program for Indigenous elders and seniors in LTC/AL started with the 2020/21 influenza season. The enhanced influenza vaccine program was expanded to include all other seniors (65+) in community settings as of the 2022/23 influenza season.

LAST UPDATED

The content of this estimates note is current as of March 4, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch, Population and Public Health Division.

APPROVALS

2025 03 04 – Brian Sagar, Executive Director, Communicable Disease Prevention and Planning Branch
2025 03 24 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 03 05 – Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 03 06 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 13 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[8] Government of Canada. Influenza vaccines: Canadian Immunization Guide. Retrieved March 3, 2025 from https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/page-10-influenza-vaccine.html
[9] BC Government News. Roll up your sleeves, B.C.: Influenza immunization prevents serious illness, deaths. October 19, 2021. https://news.gov.bc.ca/releases/2021HLTH0062-001997
[10] Government of Canada. Supplemental guidance on influenza vaccination in adults 65 years of age and older. July 25, 2024 https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-supplemental-guidance-influenza-vaccination-adults-65-years-older.html
[11] Government of Canada. Supplemental guidance on influenza vaccination in adults 65 years of age and older. July 25, 2024 https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-supplemental-guidance-influenza-vaccination-adults-65-years-older.html
[12] Government of Canada. Statement on seasonal influenza vaccine for 2024–2025. July 25, 2024. https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-statement-seasonal-influenza-vaccine-2024-2025.html

LEGISLATIVE SESSION – ESTIMATES NOTE
Immunization – Respiratory Syncytial Virus (RSV) Vaccine

Topic: Respiratory Syncytial Virus (RSV) vaccines approved for use in Canada for older adults and pregnant people.

Key Messaging and Recommended Response:

- Our government believes in vaccine science and listens to experts when it comes to saving people's lives – especially from vaccine preventable illnesses.
- When considering new population health initiatives, such as expanding RSV vaccine coverage beyond high-risk infants, we look to the National Advisory Committee on Immunization (NACI), Canada's Drug Agency (CDA) and provincial immunization and child health experts to recommend, assess, and advise on program changes.
- Right now, in B.C. RSV prevention for high-risk infants is available through a program managed by the Provincial Health Services Authority and run by BC Children's Hospital.
- Their experts determine eligibility for publicly funded RSV vaccines based on evidence-based criteria, centered in clinical rationale.
- Similarly for seniors, Canada's National Advisory Committee on Immunization (NACI) recommends immunization with a single dose of RSV vaccine for adults over 75 years of age, and adults over 60 years of age who are residents of care facilities.
- Advice/Recommendations
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CURRENT SITUATION

RSV Vaccine for Older Adults

- Three RSV vaccines (Arexvy, Abrysvo and mRESVIA) are authorized for use in Canada in adults aged 60 and older to reduce the impact of severe disease caused by respiratory syncytial virus.
- RSV vaccines for older adults are not publicly funded in BC at this time.
- In BC, publicly funded vaccine programs are reviewed, approved, and funded in the context of guidance from Canada's National Advisory Committee on Immunization (NACI), and recommendations from our provincial immunization and public health experts.
- On July 12, 2024, NACI released a statement on the prevention of RSV disease in older adults. The statement included a 'strong' recommendation for immunization with a single dose of RSV vaccine for adults aged 75 years and older, particularly for those who are at increased risk of severe illness due to RSV, and for adults 60 years of age and older who are residents of nursing homes and other chronic care facilities.[1]
- Advice/Recommendations

RSV Vaccine for Pregnant Individuals

[1] A summary of NACI statement of July 12, 2024: Statement on the prevention of respiratory syncytial virus disease in older adults. Retrieved January 31, 2025, from https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-statement-prevention-rsv-disease-older-adults.html.

- Of the three RSV vaccines authorized for use in older adults in Canada, Abrysvo is also authorized for use in pregnant individuals during weeks 32 to 36 of pregnancy to reduce severe lower respiratory tract disease caused by RSV in infants for up to 6 months after birth.
- NACI has not recommended a publicly funded RSV vaccination program for pregnant individuals at this time.[2]
- In December 2024, the First Nations Health Authority announced that it will provide reimbursement for vaccine that is privately purchased by eligible pregnant people, retroactive to August 25, 2024.[3]
- RSV vaccine is currently available for purchase in select pharmacies and travel clinics in BC.[4]

FINANCIAL IMPLICATIONS

- The purchase cost of publicly funded RSV vaccine for the province is estimated at approximately $130/dose.[5] Vaccine pricing is determined through a federal collective purchasing agreement managed by Public Service and Procurement Canada (PSPC).
- The cost of buying RSV vaccine doses does not include vaccine distribution, immunizer fee-for-service costs, and other related program costs.

KEY BACKGROUND

RSV Illness

- RSV is a common respiratory virus that typically causes a mild illness with cold-like symptoms. RSV has a greater likelihood of developing into more severe illness, including bronchiolitis and lower respiratory tract infections, in very young children and older adults.[6]
- In Canada, the RSV season typically lasts from fall to early spring.[7]
- At the peak of BC's 2024/25 viral respiratory illness season, the BCCDC recorded a significant 12% test positivity rate for RSV, which is approximately 584 positive cases out of 4,797 total tested samples.[8]

RSV Vaccines

- On August 4, 2023, Health Canada approved GlaxoSmithKline's "Arexvy" vaccine for use in adults 60 years of age and older.[9] On December 21, 2023, Health Canada subsequently approved Pfizer's "Abrysvo" vaccine for use in adults 60 years of age and older and for pregnant individuals.[10] On November 6, 2024, Moderna's mRNA "mRESVIA" vaccine was authorized for use in Canada for adults 60 years of age and older.[11]
- Arexvy, Abrysvo and mRESVIA are single dose vaccines.

RSV Vaccination Programs - Canada

- Since Fall 2023, Ontario has offered publicly funded RSV vaccine to high-risk adults aged 60 years and older, including residents of long-term care (LTC), Elder Care Lodges, or retirement homes, patients in hospital receiving alternate level of care, patients receiving hemodialysis or peritoneal dialysis, recipients of solid organ or hematopoietic stem cell transplants, people experiencing homelessness, and people who identify as First Nations, Inuit, or Métis.

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[2] A Summary of NACI statement of May 17, 2024: Statement on the prevention of respiratory syncytial virus disease in infants. Retrieved February 12, 2025 from https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-statement-prevention-respiratory-syncytial-virus-disease-infants.html

[3] FNHA now covering RSV vaccine for pregnant people. Retrieved February 12, 2024. https://www.fnha.ca/about/news-and-events/news/fnha-now-covering-rsv-vaccine-for-pregnant-people#:~:text=The%20First%20Nations%20Health%20Authority,pregnant%20individuals%20and%20their%20babies.

[4] BC Pharmacy Association. Respiratory Syncytial Virus (RSV) Vaccines in Pharmacies. Retrieved January 31, 2025, from https://www.bcpharmacy.ca/rsv-vaccines

[5] Personal communications with BCVOC. August 27, 2024.

[6] Government of Canada. "Respiratory Syncytial Virus (RSV): Symptoms and Treatment". Retrieved January 31, 2025, from https://www.canada.ca/en/public-health/services/diseases/respiratory-syncytial-virus-rsv.html.

[7] Government of Canada. "Respiratory Syncytial Virus (RSV): Symptoms and Treatment". Retrieved January 31, 2025 from https://www.canada.ca/en/public-health/services/diseases/respiratory-syncytial-virus-rsv.html.

[8] Respiratory Surveillance, Viral Pathogen Characterization, BCCDC. Number of samples and percent positivity of RSV in BC: All ages, Epi week 2024-12-22 to 2024-12-28. Retrieved January 31, 2025, from https://bccdc.shinyapps.io/respiratory_pathogen_characterization/

[9] CBC News. "Health Canada approves 1st RSV vaccine for people 60 and older". Retrieved January 31, 2025, from https://www.cbc.ca/news/health/rsv-health-canada-vaccine-1.6928175.

10 Pfizer Canada. "Product Monograph Including Patient Medication Information – ABRYSVO". December 21, 2023. https://pdf.hres.ca/dpd_pm/00073900.PDF

[11] Moderna Biopharma Canada Corporation. "Product Monograph Including Patient Medication Information – mRESVIA". November 6, 2024. https://static.modernatx.com/pm/6cef78f8-8dad-4fc9-83d5-d2fbb7cff867/d5e74c61-2c8d-486b-a8ef-fbf72d0f71c1/d5e74c61-2c8d-486b-a8ef-fbf72d0f71c1_viewable_rendition__v.pdf

- Ontario also offers RSV vaccine (Abrysvo) to pregnant individuals between 32 to 36 weeks gestational age who delivered near the start of or will deliver during the 2024/25 viral respiratory illness season.[12]
- In 2024/25, Alberta, Manitoba, Quebec, Prince Edward Island, New Brunswick and Nova Scotia are providing publicly funded RSV vaccine programs to adults 60 years and older living in LTC/AL facilities and other senior supportive living accommodations.[13, 14, 15, 16, 17]
- Alberta is also offering publicly funded RSV vaccine to individuals 75 years and older living in community settings who are at high risk of RSV infection. [18]
- In all other provinces and territories, RSV vaccine is available for private purchase in community pharmacies.

LAST UPDATED

The content of this estimates note is current as of February 24, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2025 02 24 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 02 28 – Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 03 03 – Lenore Ogilvy obo Martin Wright, Assistant Deputy Minister, Health Sector Information, Analysis & Reporting Division
2025 03 04 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division

[12] Respiratory Syncytial Virus. Government of Ontario. Retrieved February 3, 2025, from https://www.ontario.ca/page/respiratory-syncytial-virus
[13] Government of Manitoba. Manitoba's Immunization Program: Vaccines Offered Free-of-Charge. Retrieved February 3, 2025, from https://manitoba.ca/health/publichealth/cdc/vaccineeligibility.html#RSV
[14] Government of Quebec. Immunization against respiratory syncytial virus (RSV) infections. Retrieved February 3, 2025 from https://www.quebec.ca/en/health/advice-and-prevention/vaccination/immunization-against-respiratory-syncytial-rsv-infections#c287963
[15] PEI Dept. of Health and Wellness. Guidelines for Viral Respiratory Infections and Outbreak Management in Long-Term Care and Community Care Facilities. Section 5.2.3. Retrieved February 3, 2025 from https://www.princeedwardisland.ca/sites/default/files/publications/viral_respiratory_guidelines_and_outbreak_management_for_ltc_and_ccfs_sept2024.pdf
[16] Government of New Brunswick. RSV Vaccine. Retrieved February 3, 2025 from https://www2.gnb.ca/content/gnb/en/departments/health/DrugPlans/TheNewBrunswickPrescriptionDrugProgram/publichealthplan/rsv-vaccine.html
[17] Province of Nova Scotia. Publicly Funded Respiratory Virus Immunizations…2024/25. p. 12. Retrieved February 3, 2025, from https://novascotia.ca/dhw/cdpc/documents/Publicly-Funded-Seasonal-Inactivated-Influenza-Vaccine-Information.pdf
[18] Government of Alberta. Respiratory syncytial virus (RSV) vaccine. Retrieved February 3, 2025, from https://myhealth.alberta.ca/Topic/Immunization/pages/rsv-vaccine.aspx

LEGISLATIVE SESSION – ESTIMATES NOTE

Immunization – Respiratory Syncytial Virus (RSV) Monoclonal Antibodies (Nirsevimab)

Topic: Monoclonal antibodies for preventing Respiratory Syncytial Virus (RSV) in infants and children.

Key Messaging and Recommended Response:

- RSV is a common respiratory virus that typically causes a mild illness with cold-like symptoms.
- Babies and children who are at higher risk of severe illness from RSV may be eligible to receive injections of monoclonal antibodies, such as Palivizumab and Nirsevimab.
- Antibodies are not vaccines. They do not activate the immune system as would occur with an infection or vaccination. Rather, the antibodies themselves protect against disease.
- In BC, RSV prevention for high-risk infants is managed by the BC Infant RSV Immunoprophylaxis Program (the RSV Program), run by BC Children's Hospital.
- BC Children's Hospital determines eligibility for funded RSV immunoprophylaxis and administers doses to approximately 425 high-risk BC children under two years of age each year.
- This year, the RSV Program was able to procure a small number of doses of Nirsevimab and expanded eligibility to include children with specific chronic conditions up to 2 years of age, as well as all infants heading into their first RSV season in isolated and remote communities in BC.
- The RSV Program's eligibility criteria are evidence-based, centered in clinical rationale, and reviewed annually.
- A decision on program eligibility for the 2025/2026 RSV season will be made prior to the next RSV season in fall 2025.

CURRENT SITUATION

Respiratory Syncytial Virus (RSV) Illness and Prevention

- RSV is a main cause of respiratory infections in young children, occurring seasonally between October and April. An average of 600 children in BC require hospitalization for RSV annually, with 55% occurring in those under 6 months of age[1].
- There are two monoclonal antibody products, Palivizumab and Nirsevimab, available for the prevention of severe RSV illness in children. Clinical data indicates that Nirsevimab and Palivizumab are effective at reducing the rate of medically attended RSV infections in infants at higher risk for severe RSV due to prematurity, congenital heart disease, and chronic lung disease, in their first and second RSV seasons[2].
- Antibodies are not vaccines. They do not activate the immune system as would occur with infection or vaccination. Rather, the antibodies themselves protect against disease (passive immunization). Monoclonal antibodies (such as Nirsevimab) are currently managed like a therapeutic (i.e., a drug) and not like a vaccine. Monoclonal antibodies are not part of BC's publicly funded immunization program.

BC Infant RSV Immunoprophylaxis Program

- The BC Infant RSV Immunoprophylaxis Program is a program of PHSA, run by BC Children's Hospital. In that role, BC Children's Hospital determines eligibility for funded RSV immunoprophylaxis and administers doses to approximately 425 high-risk BC children under two years of age each year[3]. The RSV Program's eligibility criteria are evidence-based, centered in clinical rationale, and reviewed annually.[4]

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[1] BC Infant RSV Immunoprophylaxis Program presentation: BCIC Meeting Oct 30 - RSV

[2] BCCDC. BC Infant Respiratory Syncytial Virus (RSV) Immunoprophylaxis Program Questions and Answers for Immunization Providers November 2024. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Immunization/Vaccine%20Info/RSV_Nirsevimab_HCP_QA.pdf Retrieved March 4, 2025.

[3] BC Infant RSV Immunoprophylaxis Program presentation: RSV Program Expansion May 14, 2024

[4] BCCDC. BC Infant Respiratory Syncytial Virus (RSV) Immunoprophylaxis Program Questions and Answers for Immunization Providers November 2024. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Immunization/Vaccine%20Info/RSV_Nirsevimab_HCP_QA.pdf . Retrieved March 4, 2025

- In October 2024, the RSV Program secured 900 doses of Nirsevimab to augment the doses of Palivizumab historically used by the program[5]. With the addition of Nirsevimab, the RSV Program expanded eligibility to include children with specific chronic conditions up to 2 years of age, and to include all infants heading into their first RSV season in isolated and remote BC communities who would have complex transportation needs for severe RSV disease treatment, as well as who would experience barriers in receiving additional doses of palivizumab to maintain protection[6].

FINANCIAL IMPLICATIONS

- Government Financial Information

Government Financial Information For the 2024/25 RSV season, both Nirsevimab and Palivizumab were purchased due to Palivizumab contractual commitments.

- Nirsevimab and Palivizumab are unavailable for private purchase. Availability in the private market depends on the product manufacturer making it available for purchase.

KEY BACKGROUND

RSV Illness and Prevention

- RSV is a common respiratory virus that typically causes a mild illness with cold-like symptoms. RSV is more likely to develop into severe illnesses, including bronchiolitis and lower respiratory tract infections, in very young children and older adults.[8]

RSV Immunoprophylaxis Product Choice and Future Programming

- In May 2024, Canada's National Advisory Committee on Immunization (NACI) preferentially recommended Nirsevimab as the product of choice over Palivizumab due to its longer duration of protection and requiring only one dose compared to the required monthly dosing of Palivizumab, or RSV prevention in infants and recommended that provinces and territories work towards building a universal RSV prevention program, prioritizing infants at the highest risk of RSV illness, with Nirsevimab where the product is available, and cost-effective.[9]
- Currently Ontario, Quebec, and Nunavut have incorporated Nirsevimab, and have broadly expanded eligibility, as part of their publicly funded RSV immunoprophylaxis programs. Eligibility differs between jurisdictions:
    - Ontario: At-risk children up to 24 months of age[10]
    - Quebec: Infants below 6 months of age[11]
    - Nunavut: Infants up to 24 months of age[12]
- BC is actively discussing the scope of future RSV immunoprophylaxis programming, as informed by the May 2024 NACI guidance.

LAST UPDATED

The content of this estimates note is current as of March 5, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control, Population and Public Health Division.

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[5] BC Infant RSV Immunoprophylaxis Program presentation: BCIC Meeting Oct 30 - RSV

[6] BCCDC. BC Infant Respiratory Syncytial Virus (RSV) Immunoprophylaxis Program Questions and Answers for Immunization Providers November 2024. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Immunization/Vaccine%20Info/RSV_Nirsevimab_HCP_QA.pdf . Retrieved March 4, 2025

[7] ELT Briefing Note RSV Immunoprophylaxis Program July 12, 2014

[8] Government of Canada. Respiratory Syncytial Virus (RSV): Symptoms and Treatment.https://www.canada.ca/en/public-health/services/diseases/respiratory-syncytial-virus-rsv.html Retrieved January 31, 2025

[9] Government of Canada. An Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI): statement on the prevention of respiratory syncytial virus (RSV) disease in infants Retrieved February 10, 2024

[10] Government of Ontario. Respiratory Syncytial Virus (RSV) prevention programs. https://www.ontario.ca/page/respiratory-syncytial-virus-rsv-prevention-programs Retrieved October 9, 2024

[11]Government of Quebec. Immunization against respiratory syncytial virus (RSV) infections. https://www.quebec.ca/en/health/advice-and-prevention/vaccination/immunization-against-respiratory-syncytial-rsv-infections Retrieved October 9, 2024

[12] CBC News. After years of advocacy by a pediatrician, all Nunavut babies to get RSV immunization. https://www.cbc.ca/news/canada/north/all-nunavut-babies-to-get-rsv-vaccine-1.7329567 Retrieved October 9, 2024

LEGISLATIVE SESSION – ESTIMATES NOTE

APPROVALS

2025 03 05 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 03 25 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 03 11 – Ian Rongve, Assistant Deputy Minister, Pharmaceutical Laboratory and Blood Services Division
2025 03 10 – Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 03 13 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 13 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Infection Control - Infection Prevention and Control Guidance in Health Care

Topic: Provincial guidance for the prevention and control of viral respiratory illnesses, including COVID-19, influenza, and respiratory syncytial virus (RSV) in health care settings.

Key Messaging and Recommended Response:

- The Ministry of Health, along with partner agencies, monitors viral respiratory illness trends throughout the year.
- These trends inform necessary changes to infection prevention and control guidelines in healthcare facilities and resources to reduce the spread of infectious disease in healthcare settings.
- Updates are made in accordance with emerging scientific data, the evolving epidemiology of viral respiratory illnesses – including COVID-19, influenza, RSV, and common cold infections, and recommendations from international, national, and provincial experts.
- In January 2025, the Ministry updated infection prevention and control guidance directing health authority facilities, programs, and services to implement enhanced infection control measures during the 2025/26 respiratory illness season. These measures include:
- Medical masking by all health care workers, volunteers, contractors, and visitors in waiting rooms and in patient care areas where patients, clients and residents are actively receiving care;
- Continued emphasis on rigorous hand hygiene; and,
- Continued enhanced cleaning and disinfection procedures in patient rooms, treatment rooms, and at high-touch points across all facilities.
- Implementing these measures when necessary and where they will have the greatest benefits (i.e. in patient care areas) is a balanced approach that protects patients, families and healthcare workers, and reduces the spread of illness, while not being overly cumbersome.

CURRENT SITUATION

- In collaboration with the Office of the Provincial Health Officer, the Ministry of Health continually updates and maintains over 40 evidence-based infection prevention and control guidelines and resources to reduce the spread of infectious disease in health care settings.
- Updates are made in accordance with emerging scientific data, the evolving epidemiology of viral respiratory illnesses (VRIs) – including COVID-19, influenza, RSV, and common cold infections, and recommendations from international, national, and provincial experts. These updates are made in partnership with health authorities, the Office of the Provincial Health Officer, the Provincial Infection Control Network of BC (PICNet), the BC Centre for Disease Control (BCCDC), the First Nations Health Authority, and other health system partners.
- Ongoing surveillance of viral respiratory illness trends and variants of concern informs necessary changes to infection control measures.[1]
- In January 2025, the Ministry released *Policy Communiqué 2025-01,* directing health authority facilities, programs, and services – including emergency health services, outpatient clinics, and ambulatory care settings, to implement enhanced infection control measures. These measures include universal medical masking by all health care workers, volunteers, contractors, and visitors in waiting rooms and in patient care areas where patients, clients and residents are actively receiving care; continued emphasis on rigorous hand hygiene; and continued enhanced cleaning and disinfection procedures in patient rooms, treatment rooms, and at high-touch points across all facilities. For more information, please refer to the "Infection Control – Mask Policy" estimates note.

[1] BC Centre for Disease Control. Respiratory Virus data. January 30, 2025. Accessed February 05, 2025 at http://www.bccdc.ca/health-professionals/data-reports/respiratory-virus-data.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- The Ministry's three-year plan includes base funding for ongoing initiatives resulting from the COVID-19 pandemic. As of 2024/25, the Ministry no longer has access to COVID-19 Contingencies.

KEY BACKGROUND

- BC's strategy for preventing and controlling the transmission of infectious diseases in health care settings is based on a comprehensive hierarchy of infection prevention and exposure measures. These include elimination measures (e.g., hand hygiene, staying home when sick, keeping immunizations up-to-date); environmental measures (e.g., appropriate ventilation, enhanced cleaning and disinfection); administrative measures (e.g., symptom screening, signage, sick leave policies, training); and personal protective equipment (use of medical masks, eye protection, gloves, and respirators based on point-of-care risk assessments or when indicated).[2]
- On March 20, 2020, the Ministry of Health and the Office of the Provincial Health Officer issued *Policy Communiqué 2020-01: Infection Prevention and Control for COVID-19* to health authorities, which included requirements to implement infection prevention and control guidance in acute care, long-term care and seniors' assisted living settings. The Policy Communique was subsequently updated on May 19, 2020, and September 1, 2021[3] with additional, revised content.
- Following the announcement by Dr. Henry and Minister Dix on April 6, 2023,[4] PICNet and the Ministry of Health developed comprehensive viral respiratory illness resources. This effort was led by the Provincial COVID-19 Infection Prevention and Control/Workplace Health and Safety working group, in partnership with health authority representatives, the Office of the Public Provincial? Health Officer, and other health system partners.
- The updated provincial viral respiratory illness guidelines and resources can be found on PICNet's Respiratory Infections webpage.[5]

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Brian Sagar, Executive Director,
Communicable Disease Prevention and Control Branch.

APPROVALS

2025 02 12 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 03 03 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 02 14 – Dr. Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 02 24 – Brenda Rafter obo Rob Byers, Assistant Deputy Minister, Finance and Corporate Services Division

[2] Provincial Infection Control Network of BC. Hierarchy of Controls for Infection Prevention and Exposure Measures for Communicable Diseases. November 22, 2024. Accessed February 05, 2025 at https://picnet.ca/wp-content/uploads/2024_11_22_Hierarchy-of-Controls_IPC_Final.pdf.
[3] Both the May 19, 2020, and the September 1, 2021 versions of Policy Communique #2020-01 can be accessed through the Infection Prevention and Control Team at the Ministry of Health.
[4] BC Ministry of Health. BC Gov News: Provincial health officer's, minister's statement on end of respiratory season, spring COVID-19 boosters. April 06, 2023. Accessed February 05, 2025 at https://news.gov.bc.ca/releases/2023HLTH0039-000473.
[5] Provincial Infection Control Network of BC. Respiratory Infections. Accessed February 05, 2025 at https://picnet.ca/guidelines/gastrointestinal-respiratory-illness/respiratory-infections/.

LEGISLATIVE SESSION – ESTIMATES NOTE

Infection Control – Mask Policy

Topic: The Ministry of Health's policy requiring the use of medical masks and other enhanced infection control measures during viral respiratory illness season.

Key Messaging and Recommended Response:

- In January 2025, the Ministry directed health authority facilities, programs, and services to implement enhanced infection prevention and control measures during the 2025/26 respiratory illness season.
- This includes, but is not limited to:
  - Medical masking by all health care workers, volunteers, contractors, and visitors in waiting rooms and in patient care areas where patients, clients and residents are actively receiving care;
  - Continued emphasis on rigorous hand hygiene; and,
  - Continued enhanced cleaning and disinfection in patient rooms, treatment rooms, and at high-touch points across all facilities.
- Implementing these measures when necessary and where they will have the greatest benefits (i.e., in patient care areas) is a balanced approach that protects patients, families and health care workers, and reduces the spread of illness, while not being overly cumbersome.
- Enhanced infection prevention and control measures may be reinstated in health care facilities again in future if the risk of spread of respiratory illness is high.
- The Ministry will continue to evaluate these additional measures to ensure the steps we are taking to protect patients, residents, health care workers, and others remain appropriate and effective.

CURRENT SITUATION

- On January 6, 2025, the Ministry of Health issued *Policy Communiqué 2025-01* ("Infection Prevention and Control Measures for Preventing Viral Respiratory Illness") directing health authorities to implement a range of infection control measures for health care workers, visitors, and patients, regardless of their immunization status[1]:
  - Health care workers must wear a mask while working in all patient care areas where patients, residents or clients are actively receiving care. This includes waiting rooms, home and community care locations (including a client's home), and any location where emergency health services are being provided. This does not include administrative areas or private offices that are not generally accessed by patients, residents, or clients, or areas where care is not being provided, such as foyers, hallways, cafeterias, chapels and family rooms.
  - Patients and those accompanying them must wear a medical mask in emergency departments and in waiting rooms, when instructed by a health care worker, and based on personal choice.[2]
  - Visitors should wear a medical mask in all patient/resident care areas in health care facilities where patients are actively receiving care, and when participating in indoor group events, celebrations, gatherings and activities in Long-Term Care and Seniors' Assisted Living residences, except when eating and/or drinking.
  - Visitors are not required to wear a medical mask when visiting a single resident in a patient care area or in communal areas.
- Masking and the other enhanced infection prevention and control measures apply to all health authority facilities, programs, and services, including hospitals, emergency health services, outpatient clinics,

[1] BC Government. "COVID-19 guidance in B.C.". January 9, 2025. https://www2.gov.bc.ca/gov/content/covid-19/vaccine/proof.

[2] BC Ministry of Health. Policy Communiqué 2023-04 "Infection Prevention and Control Measures for Viral Respiratory Illness Season". October 13, 2023. Retrieved September 10, 2024 from https://picnet.ca/wp-content/uploads/1280797-Policy-Communique-2024-02-FINAL.pdf.

ambulatory care settings, long-term care homes, seniors' assisted living settings, private hospitals, stand-alone extended care hospitals designated under the Hospital Act, and provincial mental health facilities. The measures also apply to services contracted by health authorities.

- Masking requirements and other infection control measures for regulated health professionals operating in community settings (e.g., nurses, midwives, physicians, nurse practitioners, pharmacists, oral health professionals in private practice) are determined by their applicable regulatory college.
- The Ministry of Health's approach to reducing the spread of viral respiratory illnesses and protecting patients, residents, clients, and health care workers focuses on implementing the entire hierarchy of controls for viral respiratory illnesses. Other measures in the hierarchy of controls include appropriate hand washing, appropriate ventilation, enhanced cleaning of high touch areas twice a day, keeping immunizations up to date, not visiting when sick, and respecting personal space.

KEY BACKGROUND

- BC's viral respiratory illness season takes place each year, starting in the fall and ending in early spring. It is the time of year when higher than average levels of viral respiratory illnesses, including influenza, RSV and COVID-19, are observed in our communities.
- The start and end of the viral respiratory illness season in BC are determined by the Provincial Health Officer, based on current international, national, and provincial data, health system trends, and other considerations.
- Since February 2020, BC has required additional infection prevention and control measures (e.g., wearing of medical masks) in health care settings during viral respiratory illness season in order to protect patients and health care workers.
- Viral respiratory illnesses, such as influenza, COVID-19, and respiratory syncytial virus (RSV), are mainly spread by liquid droplets that come out of the mouth and nose when a person infected with the virus breathes, coughs, sneezdes, talks, or sings.[3, 4]
- Droplets come in a wide range of sizes that behave differently depending on their size: Larger droplets are heavier and usually fall quickly to the ground; and smaller droplets (i.e., aerosols) are lighter and can float in the air for longer periods. Smaller droplets can collect in enclosed spaces, especially those without fresh air circulation.[5]
- Viruses naturally mutate over time, leading to new versions or 'variants' that affect their ability to transmit and how they respond to vaccination.[6] Some emerging COVID-19 variants transmit differently than previous wild type variants: they preferentially infect the upper airway; have an increased ability to overcome neutralizing antibodies; evade immunity from prior infection; have an enhanced capacity to bind to the receptive surfaces of human cells; have a shorter incubation period and faster onset of illness; and have an increased ability to spread to others even if they have been vaccinated.[7]

LAST UPDATED

The content of this estimates note is current as of March 10, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2025 03 10 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 02 20 – Dr. Bonnie Henry, Provincial Health Officer, Office of the Provincial Health Officer
2025 02 20 – Lenore Ogilvy obo Martin Wright, Assistant Deputy Minister, Health Sector Information Analysis and Reporting
2025 03 03 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division

[3] Government of Canada. "Evidence of the risk of COVID-19 transmission in flight: update 3". November 2021. Retrieved January 30, 2025 from https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/canadas-reponse/summaries-recent-evidence/evidence-risk-covid-19-transmission-flight-update-3.html.
[4] Provincial Infection Control Network of British Columbia (PICNet). "COVID-19: Risk of SARS-CoV-2 Aerosol Transmission in Health-Care Settings". September 27, 2023. Retrieved January 30, 2025 from https://picnet.ca/wp-content/uploads/Archived-Aerosol-Transmission-HC-Settings-SARSCoV2_27Sep2023.pdf.
[5] BC Centre for Disease Control. "COVID-19: Risk of SARS-CoV-2 Aerosol Transmission in Health-Care Settings." August 29, 2022. Retrieved January 30, 2025 from https://medicalstaff.islandhealth.ca/sites/default/files/covid-19/latest-communications/bccdc/aerosol-transmission.pdf.
[6] Government of Canada. "COVID-19 epidemiology update: Testing and variants". September 3, 2024. Retrieved January 30, 2025 from https://health-infobase.canada.ca/covid-19/testing-variants.html#a2.

LEGISLATIVE SESSION – ESTIMATES NOTE

Infection Control – Outbreak Management

Topic: Outbreak management in acute care, long-term care and seniors' assisted living settings for viral respiratory illnesses, including COVID-19, influenza, and respiratory syncytial virus (RSV).

Key Messaging and Recommended Response:

- The official declaration of an outbreak in a health care facility is made by a Medical Health Officer (MHO) or their official designate.
- Declaring an outbreak coincides with the implementation of additional infection prevention and control measures, over and above those that would be routinely implemented. These measures may include closing the affected unit to new admissions or transfers and/or temporarily restricting non-essential visits.
- Weekly reporting of new respiratory illness outbreaks in long-term care and assisted living facilities is publicly available on the BC Centre for Disease Control's website.
- From February 2-8, 2025, there were 11 influenza outbreaks reported in long-term care facilities and one outbreak reported in an acute care facility. During this same time period, there were no COVID-19 outbreaks reported in long-term care facilities and acute care facilities.
- The thresholds for declaring an influenza outbreak in acute care and long-term care facilities are set low to enable early implementation of outbreak control measures, preventing transmission and reducing severe outcomes.
- Health authorities put measures in place in long-term care facilities well ahead of respiratory season to help prevent and prepare for outbreaks, such as:
  - Offering influenza and COVID-19 immunizations to residents, asking staff to report their immunizations, and encouraging visitors to get immunized.
  - Practicing and encouraging excellent hand hygiene and respiratory etiquette.
  - Ensuring infection prevention and control measures are in place and practiced, including measures to limit the spread of illness when infections occur.
  - Asking staff and visitors to stay home if they feel unwell.
  - In January, masking requirements were also introduced for the remainder of respiratory season.

CURRENT SITUATION

- The official declaration of an outbreak in a health care facility is made by a Medical Health Officer (MHO) or their official designate. Declaring an outbreak coincides with the implementation of additional infection prevention and control measures, over and above those that would be routinely implemented. These measures may include closing the affected unit to new admissions or transfers and/or temporarily restricting non-essential visits.
- The BC Centre for Disease Control's (BCCDC) facility outbreaks dashboard provides weekly reports on viral respiratory illness outbreaks in LTC and acute care facilities.[1] From February 02-08, 2025, there were 11 influenza outbreaks reported in LTC facilities, and one outbreak in acute care facilities. During this same period, there were no COVID-19 outbreaks reported in LTC and acute care facilities.

KEY BACKGROUND

- On March 4, 2021, BC issued a standardized provincial outbreak management protocol (the Outbreak Protocol) to provide guidance and best practices to prepare for, detect, and respond to COVID-19 outbreaks in LTC/seniors' AL and acute care settings.
- In January 2025, BC's COVID-19 outbreak management protocols for LTC/seniors' AL and acute care settings were updated to include measures for managing outbreaks of all viral respiratory illnesses, including COVID-19, influenza,

[1] BC Centre for Disease Control. Respiratory Surveillance – Facility Outbreaks. Report updated on February 13, 2025. Accessed February 14, 2025 at https://bccdc.shinyapps.io/respiratory_aggregate_outbreaks/.

and RSV. The updated outbreak documents were publicly posted on January 14, 2025.[2,3]

- Enhanced monitoring and implementation of additional IPC measures occurs in circumstances where the cases of viral respiratory illness in a health care unit or facility do not meet the threshold for an outbreak but still require increased attention to prevent transmission. This can include increased active symptom screening and precautionary initiation of droplet and contact precautions for some patients, clients, or residents. Enhanced IPC measures are applied and adjusted as necessary based on assessed risks and in consultation between the MHO (or designate), the facility, and the IPC team.

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2025 02 12 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 02 14 – Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 02 20 – Lenore Ogilvy obo, Martin Wright, Assistant Deputy Minister Health Sector Information, Analysis & Reporting Division
2025 03 04 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division

[2] Provincial Infection Control Network of British Columbia. Provincial Outbreak Guidance for Viral Respiratory Illness in Long-Term Care Settings in British Columbia. January 14, 2025. Accessed January 31, 2025 at https://picnet.ca/wp-content/uploads/APPROVED-Provincial-Outbreak-Guidelines-for-VRI-in-Long-Term-Care-Jan-14-2025-1.pdf.

[3] Provincial Infection Control Network of British Columbia. Provincial Outbreak Guidance for Viral Respiratory Illness in Acute Care Settings in British Columbia. January 14, 2025. Accessed January 31, 2025 at https://picnet.ca/wp-content/uploads/APPROVED-Provincial-Outbreak-Guidelines-for-VRI-in-Acute-Care-Jan-14-2025.pdf.

LEGISLATIVE SESSION – ESTIMATES NOTE

Nicotine and Health

Topic: BC's response to tobacco, vaping and nicotine harms

Key Messaging and Recommended Response:

- BC is a leader in preventing youth addiction to nicotine.
- In February 2024, BC took action to protect youth from nicotine use and potential dependency by restricting the sale of nicotine pouches behind the counter at pharmacies.
- Following this, Health Canada introduced new measures to help prevent harms to youth from improper use of nicotine replacement therapies (NRTs) across the country.
- In November 2019, the 10-Point Action Plan to Prevent Youth Vaping was launched to address the rise in youth vaping in BC and focused on regulatory, financial, and education and awareness measures to protect youth from the harms of vaping.[1] All 10 of the actions from the Plan are now considered complete.[2]
- While nicotine use is harmful, especially for young people, NRTs are an important tool for individuals looking to quit or reduce smoking or vaping.
- In BC, eligible NRT products are provided at no cost to all eligible individuals.

CURRENT SITUATION

- Nicotine is an addictive substance found in tobacco, nicotine-containing vapour products, and nicotine replacement therapies (NRT).
- Nicotine affects memory and concentration, can alter brain development, reduce impulse control, and cause cognitive and behavioural issues in youth. Nicotine dependence can result in withdrawal and cause symptoms such as headaches, shakes, dizziness and feelings of anxiety and depression.
- Tobacco and nicotine-containing vapour products are regulated under the *Tobacco and Vapour Products Control Act*, the Tobacco and Vapour Products Control Regulation, and the E-Substances Regulation (ESR).
- Tobacco and vapour enforcement officers employed by the regional health authorities are responsible for the compliance and enforcement of tobacco and vaping related legislation.
- In November 2019, the 10-Point Action Plan to Prevent Youth Vaping (the Action Plan) was launched to address the rise in youth vaping in BC and focused on regulatory, financial, and education and awareness measures to protect youth from the harms of vaping.[3] All 10 of the actions from the Plan are now considered complete.[4]
- Therapeutic nicotine products such as NRTs are regulated under the *Pharmacy Operations and Drug Scheduling Act*'s Drug Schedules Regulation (DSR).
- On February 7, 2024, the Premier announced an amendment to the DSR to restrict the sale of buccal nicotine pouch products to behind the counter at pharmacies.[5] This action is to ensure that NRTs are used for their intended purpose and to prevent misuse, especially among youth and non-smokers.
- In August 2024, the federal government enacted new regulations which set out additional requirements for NRTs, including restricting the sale of buccal nicotine pouches to behind pharmacy counters.

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[1] BC Gov News, *Vaping restrictions to protection you*, https://news.gov.bc.ca/releases/2019HLTH0118-002192 (accessed January 29, 2025)

[2] BC Gov News, *Province implements vaping action plan*, https://news.gov.bc.ca/releases/2020HLTH0038-001324 (accessed January 29, 2025)

[3] BC Gov News, *Vaping restrictions to protection you*, https://news.gov.bc.ca/releases/2019HLTH0118-002192 (accessed January 29, 2025)

[4] BC Gov News, *Province implements vaping action plan*, https://news.gov.bc.ca/releases/2020HLTH0038-001324 (accessed January 29, 2025)

[5] BC Gov News, *Province takes action to prevent sale of nicotine products to youth*, https://news.gov.bc.ca/releases/2024HLTH0004-000159 (accessed January 29, 2025)

- BC's Smoking Cessation Program through BC PharmaCare helps eligible residents stop smoking or using other tobacco products by assisting them with the cost of quit aids such as prescription drugs or NRT.
- QuitNow provides free, 24-hour online, phone and text support for British Columbians who wish to quit or reduce smoking or vaping. QuitNow has a dedicated page to help youth quit vaping. QuitNow is operated by the BC Lung Foundation on behalf of the Ministry of Health.
- Talk Tobacco is a free program through the Canadian Cancer Society, available to Indigenous peoples in BC. It offers culturally appropriate support and information about quitting smoking, vaping and commercial tobacco.
- In 2020, the province launched the anti-vaping social media campaign 'Evapourate'. In February 2023, a second social media campaign called the 'A-Z of Vaping' was launched and is currently in its third flight. Both campaigns aim to highlight the harms of vaping for young people. To date, the A-Z of Vaping campaign has garnered 84.9 million impressions with 26 million users across different social media platforms.
- The provincial and territorial governments and class action plaintiffs of Imperial Tobacco Canada, Rothmans Benson and Hedges, and JTI-Macdonald Corp have voted to accept a court-appointed mediator plan.[6] This will close a two-decade long litigation with tobacco companies over the harms brought to Canadians by commercial tobacco use.
- Funding from the settlement will be invested in health promotion/prevention, smoking cessation, cancer treatment, primary care, and research into treatment.

FINANCIAL IMPLICATIONS

- The Ministry of Health (the Ministry) provides $2.35 million in annual funding to the regional health authorities to support tobacco and vaping enforcement, as follows:
  - Fraser Health Authority: $0.586 million
  - Interior Health Authority: $0.508 million
  - Northern Health Authority: $0.246 million
  - Vancouver Coastal Health Authority: $0.586 million
  - Vancouver Island Health Authority: $0.414 million
- In 2022/23, the Ministry invested $142,000 for user and design enhancements to the BC E-Substances Reporting (BCER) database. The Ministry previously invested:
  - $413,471 in 2020/2021 to design and develop the BCER.
  - $424,190 in 2021/2022 to add reporting functionality and user and design enhancements.
- The Ministry provides $1.8 million in annual funding to the BC Lung Foundation to deliver QuitNow.
- The Ministry spends approximately $9,590,000 yearly on the BC Smoking Cessation Program.
- If the tobacco litigation settlement is approved, BC is set to receive approximately $3.5 billion over 25 years.
- The Ministry spent $187,000 in 2019/20 and $362,356 in 2020/21 on developing and implementing the social marketing campaign known as 'Evapourate.'
- The Ministry spent $511,608 in 2022/23, $ 518,456 in 2023/24, and $152,939 in 2024/25 on developing and implementing the social marketing campaign known as 'the A-Z of Vaping.'
- The Ministry provides the McCreary Society Centre $94,000 per year to convene the youth advisory council (YAC)

KEY BACKGROUND

- In 2023, 9.5% of BC residents were daily or occasional smokers, which is one of the lowest rates in Canada. In the same year, 6% of British Columbians over age 12 had vaped in the past 30 days.[7] 15% of BC youth aged 12-17 vape daily.[8]

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[6] BC Gov News, *BC creditors approve plan to resolve long-standing tobacco litigation*, https://news.gov.bc.ca/releases/2024AG0049-001654 (accessed January 29, 2025)

[7] Statistics Canada, *Canadian Community Health Survey 2024*, https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1310090501 (accessed January 30, 2025)

[8] McCreary Centre Society, *The Big Picture: An Overview of the 2023 BC Adolescent Health Survey Provincial Results*: https://mcs.bc.ca/pdf/2023_bcahs_the_big_picture.pdf (accessed January 29, 2025

- In Canada, smoking rates are higher among Indigenous peoples (2 to 5 times higher), LGBTQ+ persons (estimates are 24-45% across groups), and young adult males (22%) .[9]
- In many First Nations communities, traditional tobacco plays a sacred and ceremonial role.
- On January 1, 2020, a 20% provincial sales tax increase on all nicotine-containing vapour products and accessories was brought into force and is administered by the Ministry of Finance.
- The ESR was enacted on July 20, 2020, as part of the Action Plan. Fulfilling actions 1, 2, and 3, the ESR placed limits on e-substance volume and nicotine concentration, restricted the sale of flavoured e-substances, and required report from retailers and manufacturers in BC.
- In 2021, the provincial YAC was launched. The YAC is conducted in partnership with the McCreary Society Centre and has helped inform the development of many youth vaping prevention resources and initiatives.

LAST UPDATED

The content of this estimates note is current as of February 4, 2025, as confirmed by Geneen Russo, Executive Director, Health Protection Branch.

APPROVALS

2025 02 04 – Geneen Russo, Executive Director, Health Protection Branch, Population and Public Health Division
2025 02 23 – Lenore Ogilvy OBO Martin Wright, Assistant Deputy Minister, Health Sector Information, Analysis and Reporting
2025 02 26 – Brenda Rafter OBO Rob Byers, Assistant Deputy Minister, Finance and Corporate Services Division
2025 03 10 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division

[9] Government of Canada, *Overview of Canada's Tobacco Strategy* https://www.canada.ca/en/health-canada/services/publications/healthy-living/canada-tobacco-strategy/overview-canada-tobacco-strategy.html (accessed January 31, 2025

LEGISLATIVE SESSION – ESTIMATES NOTE

Pandemic Readiness Planning

Topic: Preparing BC's health care system for a future pandemic.

Key Messaging and Recommended Response:

- The Ministry of Health and the Provincial Health Officer continue to work together to ensure that coordinated provincial pandemic response and readiness plans are in place to effectively prepare the health system for a future pandemic.
- B.C.'s *Response Plan* describes how B.C.'s health care system will respond to a pandemic by setting out a comprehensive province-wide approach for health sector preparedness and response planning in critical areas such as public health measures, disease surveillance, and human resources. The *Response Plan* was used to guide and inform B.C.'s response to the COVID-19 pandemic.
- The *Coordination Plan* supports an all-of-government response to a pandemic by outlining the province's strategy for cross-ministry coordination, internal and external communications, and provincial government business continuity.
- Central to this work is the development of a draft 'Pandemic Preparedness Playbook' that will serve as a living document to build on COVID-19 pandemic learnings, support ongoing health system resilience, and guide the management and response to future pandemics.

CURRENT SITUATION

- BC has a pathogen-specific *Pandemic Influenza Response Plan* (the *Response Plan*, 2012)[1] and a non-pathogen specific *Pandemic Provincial Coordination Plan* (the *Coordination Plan*, 2020).[2] In 2020, the Response Plan provided the basis for the health sector's COVID-19 Response Plan.[3]
- BC's *Response Plan* describes how BC's health care system will respond to a pandemic by setting out a comprehensive province-wide approach for health sector preparedness and response planning in critical areas such as public health measures, disease surveillance, and human resources. The *Response Plan* is intended to be reviewed and revised every three years and would be tailored to an emerging pathogen and newly declared pandemic. The *Response Plan* was used to guide and inform BC's response to the COVID-19 pandemic.
- Most recently updated in February 2020, the *Coordination Plan* supports an all-of-government response to a pandemic by outlining the province's strategy for cross-ministry coordination, internal and external communications, and provincial government business continuity.
- The Ministry of Health and the Provincial Health Officer have continued their work to ensure that coordinated provincial pandemic response and readiness plans are in place to effectively prepare the health system for a future pandemic. Central to this work is the development of a draft 'Pandemic Preparedness Playbook' that will serve as a living document to build on COVID-19 pandemic learnings, support ongoing health system resilience, and guide the management and response to future pandemics.

KEY BACKGROUND

- At the provincial level, on November 8, 2023, the *Emergency and Disaster Management Act* (*the Act*) replaced the former *Emergency Program Act* in BC.[4]
- On July 6, 2024, BC's *Emergency and Disaster Management Regulation* (*the Regulation*) was introduced under

[1] Province of British Columbia, *BC Pandemic Influenza Response Plan,* https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/bc-pandemic-influenza-plan-2012.pdf (accessed January 31, 2025).

[2] Province of British Columbia, *BC Pandemic Provincial Coordination Plan,* https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/pandemic-provincial-coordination-plan.pdf (accessed January 31, 2025).

[3] Correspondence from Dr. Bonnie Henry, Provincial Health Officer. February 16, 2024.

[4] BC Ministry of Emergency Management and Climate Readiness, *When does BC's new emergency management legislation come into effect?* https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/emergency-preparedness-response-recovery/embc/legislation/edma_coming_into_force_primer.pdf (accessed January 31, 2025).

the *Act* to identify the government ministries that must prepare hazard-specific risk assessments and emergency management plans.[5] The *Regulation* identifies the Minister of Health as the minister responsible for preparing and maintaining government's emergency management plan relating to threats caused by human diseases.[6]

- At the national level, BC is participating in the Federal/Provincial/Territorial process to develop a comprehensive Pandemic Preparedness Plan as part of the Pandemic Preparedness Task Group.
- At the global level, the WHO has two initiatives for pandemic preparedness and response which inform BC's planning:
  - An international, legally binding agreement on pandemic preparedness and response for member states which is under development; and,
  - A technical platform that follows an integrated mode of transmission response.
- In the first phase of its initiative, the WHO is supporting countries to develop pandemic plans for respiratory pathogens, focusing on emergency coordination; access to countermeasures; clinical care; surveillance; and community protection.[7]

LAST UPDATED

The content of this estimates note is current as of February 13, 2025, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2025 02 13 – Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch
2025 02 20 – Dr. Elizabeth Brodkin, Deputy Provincial Health Officer, Office of the Provincial Health Officer
2025 02 20 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2025 03 03 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division

[5] Province of British Columbia, *Order of the Lieutenant Governor in Council No. 435* https://www.bclaws.gov.bc.ca/civix/document/id/oic/oic_cur/0435_2024 (accessed January 31, 2025).
[6] Ibid. Pg. 7.
[7] World Health Organization, *Preparedness and Resilience for Emerging Threats Module 1: Planning for respiratory pathogen pandemics* https://www.who.int/publications/i/item/9789240084674 (accessed January 31, 2025).

LEGISLATIVE SESSION – ESTIMATES NOTE
British Columbia's Population and Public Health (PPH) Framework

Topic: In 2024, the Ministry of Health and Provincial Health Officer released a new provincial strategy for population and public health in British Columbia (BC).

Key Messaging and Recommended Response:

- Population and public health programs and services focus on the protection and promotion of health, the prevention of disease, and improving the social determinants of health, which helps reduce demands on the health system and improve people's health and well-being.
- B.C. is a leading jurisdiction for population and public health advancement, as demonstrated by the new provincial strategy, *British Columbia's Population and Public Health Framework: Strengthening Public Health*, which was released in September 2024.
- The framework is grounded by the foundational principles of Truth, Rights and Reconciliation, Health Equity and Anti-Racism, and System Capacity, and establishes a set of long-term priorities and core functions for the sector.
- The COVID-19 pandemic demonstrated the importance of a well-planned, coordinated population and public health system with the expertise, resources and infrastructure necessary to protect the health of the public, promote well-being and prevent disease and injury.

CURRENT SITUATION

- The Strengthening Public Health Initiative (SPHI) is a collaborative, ongoing effort to drive the renewed provincial vision and strategic direction for population and public health in B.C.
- A new provincial strategy, called *British Columbia's Population and Public Health Framework: Strengthening Public Health* (the framework), was released in September 2024[1].
- The framework is grounded by the foundational principles of Truth, Rights and Reconciliation, Health Equity and Anti-Racism, and System Capacity.
- The framework also establishes a set of long-term priorities and core functions for the sector.
- Advice/Recommendations

- The COVID-19 pandemic demonstrated the importance of a well-planned, coordinated population and public health system with the expertise, resources and infrastructure necessary to protect the health of the public, promote well-being and prevent disease and injury.
- The COVID-19 pandemic has also highlighted opportunities for the population and public health sector, such as action on the roots of wellness and determinants of health.

FINANCIAL IMPLICATIONS

- Out of a total $500,000 shared cost agreement with PHABC for Fiscal Year (FY) 2024/25, $400,000 is allocated toward SPHI implementation and action planning (Contract # 2025-246).
- A $74,999 2024/25 general service agreement also exists between Be the Change Consulting Group and the Ministry of Health (Contract # 2025-012) for SPHI planning, engagement, facilitation and graphic design services.

KEY BACKGROUND

- The framework was developed by the Population and Public Health Division beginning in 2019. Despite capacity constraints during the COVID-19 pandemic, over 1,100 people and partners were engaged in the development

[1] https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/health-priorities/pph-framework

process. This includes health authority leadership, population and public health workforce, epidemiologists and technical experts, community-based organizations, and Indigenous partners and equity-deserving groups.

- The framework establishes six new population and public health priorities: Best Start in Life, Health Impacts of Climate Change, Communicable Disease Prevention and Response, Prevention and Reduction of Substance-related Harms, Non-communicable Disease and Injury Prevention, and Population Mental Health and Wellness.
- The framework establishes an updated set of core public health and enabling functions which together represent the key activities and capacities needed within the health system to support population health.
- Key indicators for monitoring public health system readiness are being developed and aligned with national work led by the Canadian Institute for Health Information and the Public Health Agency of Canada.
- Further resources to enable shared measurement and evaluation, such as *Closing the Gap: A Measurement Primer to Reduce Population Health Inequities in British Columbia* (available on the main B.C. Government *Population and Public Health Framewor*k webpage[1]), have been collaboratively developed with and for broader public health sector partners.

LAST UPDATED

The content of this estimates note (previously a Fact Sheet) is current as of February 5, 2025, as confirmed by Meaghan Thumath, Executive Director, Strategy, Planning and Evaluation Branch.

APPROVALS

2025 02 05 – Meaghan Thumath, Executive Director, Strategy, Planning and Evaluation Branch
2025 03 04 – Maryna Korchagina, Assistant Deputy Minister, Population and Public Health Division
2025 02 13 – Brenda Rafters, obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Access to Psychologists/Counselling Services

Topic: Government investments and commitments supporting access to psychologists and counselling.

Key Messaging and Recommended Response:

- When people make the brave decision to reach out for help, we need services to meet them.
- Psychologists and counselling services are an important part of our Government's work to build a seamless system of mental health and addictions care that works for everyone.
- In July 2023, the Ministry's Primary Care Division (PCD) invested in a feasibility and sustainability assessment led by the British Columbia Psychological Association (BCPA) to explore a potential proof-of-concept trial placing psychologists in team-based primary care settings.
- In December 2024, an Agreement in Principle was reached between the BC Greens and BC NDP. This included a $50 million commitment to work with the BCPA to expand access to publicly funded psychologists.

CURRENT SITUATION

- Under the Agreement in Principle with the BC Green Caucus (BCGC), the Province has committed to work with the British Columbia Psychological Association (BCPA) and BCGC to expand public coverage of psychologists with an investment of $50 million. Work on next steps to fulfill this commitment is underway.
- Since 2019, government has funded counselling services through the Community Counselling Grant (CCG) program, which is administered by Community Action Initiative (CAI). Services through this program are typically delivered by clinical counsellors or supervised post-secondary student interns, not psychologists.
- As of February 2025, 47 counselling services organizations receive annual grants. Originally, grants were provided to 49 organizations; however, in 2024 CAI terminated contracts with two organizations due to non-compliance with contract requirements.
- As of December 31, 2024, 328,096 counselling sessions have been delivered since the CCG program began.[1]
- In the 2024 calendar year, CCG funded organizations supported over 18,000 individuals and families through more than 46,000 counselling sessions.[2]
- Funding for the CCG program is set to end on March 31, 2025.

FINANCIAL IMPLICATIONS

- Details of the $50 million commitment to expand psychologist services have not yet been determined.
- The Primary Care Division (PCD) invested $135k in July 2023 to fund a Feasibility and Sustainability Assessment led by the BCPA to explore a primary care psychologist (PCPsych) pilot.[3]
- Since 2019, the province has provided a total of $35 million to support the CCG program, primarily through year-end grants:
    - 2018/19 - $11.0 million to support 29 counselling service providers
    - 2020/21 - $4.8 million to expand supports to an additional 20 providers
    - 2021/22 - $4.2 million to continue grant funding through March 2023 for all providers
    - 2022/23 - $15 million to continue funding to the end of March 2025

KEY BACKGROUND

- Discussions between the BCPA and the Ministry of Health (the Ministry) regarding the role of psychologists in BC's health care system have been ongoing since 2022.
- In July 2023, PCD invested $135k to fund a Feasibility and Sustainability Assessment led by the BCPA to explore a primary care psychologist (PCPsych) model (i.e., psychologists positioned in team-based primary care settings).[3]

[1] Complex Care Housing & Community Initiatives Branch. Quarterly reporting received from CAI, February 7, 2025.
[2] Complex Care Housing & Community Initiatives Branch. Quarterly reporting received from CAI, February 7, 2025.
[3] General Services Agreement (GSA) between Ministry of Health PCD and BCPA. July 2023.

The purpose of this Assessment was to facilitate a potential proof-of-concept trial placing 10 full-time equivalent (FTE) psychologists in team-based primary care settings for 12+ months (with the potential for subsequent province-wide scale-up).[4] While the Assessment was completed in February 2024, the initiative was paused in September 2024 due to challenges reaching agreement on the compensation model .

- Since this time, and following the Agreement in Principle, the Ministry has received a revised proposal from BCPA. Discussions are underway to determine next steps.

LAST UPDATED

The content of this estimates note is current as of February 19, 2025 as confirmed by Tricia Poilievre, Executive Director, Complex Care Housing and Community Initiatives and Kelly McQuillen, Executive Director, Primary Care Planning and Implementation Oversight.

APPROVALS

2025 02 18 – Kelly McQuillen obo Ted Patterson, Primary Care Division
2025 02 27 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

[4] BCPA Feasibility and Sustainability Assessment. February 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE
Accomplishments: Primary Care Strategy

Topic: With the launch of the Primary Care Strategy in May 2018, the Ministry continues to collaborate with health partners to expand team-based care, improve access to primary care and increase attachment of people living in BC to primary care providers.

Key Messaging and Recommended Response:

- Our mandate is clear: we must strengthen primary care by expanding access and attachment to more family doctors and nurse practitioners.
- That's why the Ministry invested more than $579M in FY2024/25 to support Primary Care Strategy implementation and has committed over $627M in FY2025/26.
- Since introducing the Primary Care Strategy in 2018, the Ministry has:
  - Launched the Provincial Attachment System, including the Health Connect Registry. For the first time, we know who is seeking primary care and where, and where provider capacity to take on new patients exists.
  - Connected more than 695,000 people with a primary care provider in their community, averaging 680 attachments per day in 2024, with almost 250,000 people attached to a primary care provider in 2024 alone – the highest since the Ministry started tracking attachment rates.
  - Established 92 Primary Care Networks, which coordinate care and services throughout 94% of the province's population, including by funding:
    - 42 Urgent and Primary Care Centres (UPCCs), with more on the way.
    - 15 Community Health Centres, with more being considered.
    - 14 First Nations-led Primary Care Centres, and
    - three Nurse Practitioner-led Primary Care Centres.[1]
  - Delivered more than three million patient visits through UPCCs alone.[2]
  - Recruited more family doctors. BC has the second-most family doctors per capita of all provinces, with 5,364 family doctors hired since 2018.[3]
  - Nearly tripled the number of nurse practitioners in BC since 2018 to more than 1,200, including 178 new nurse practitioners registered in 2024.[4]
  - Introduced and expanded the Longitudinal Family Physician Payment Model, which enables patients to discuss multiple health concerns in a single visit and ensures fair compensation to doctors for their time. Currently, 4,474 family physicians are actively working under the model.[5]
  - Invested in the New-to-Practice Incentive Program for early career or 'new to BC' physicians, attracting 365 new doctors to primary care.[6]
  - Expanded pharmacists' scope of practice for 21 minor ailments, relieving pressure on clinics and hospitals and increasing access for 500,000 people.[7]
  - Despite the challenges of a global health care crisis including recruitment and retention issues, population growth, and an ageing population with increased health complexity, significant investments to improve access and attachment to primary care are working.

[1] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 PCN Status Report, Data as of January 2, 2025.
[2] Health Sector Information, Analytics & Reporting, Integrated Analytics: Primary Care. PAS Reporting. Data as of January 16, 2025.
[3] HealthLinkBC, Provincial Patient Attachment & Access, and HealthLinkBC Service Strategy. Data as of February 6, 2025.
[4] BCCNM Registration Statistics Report January 2025.
[5] HSIAR Longitudinal Family Physician Payment Model Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[6] Results Management Office, Primary Care Division, Ministry of Health, NTP Incentives Program Update, December 31, 2024
[7] HSIAR Pharmacy Clinical Services Dashboard – Health System Performance Portal – data to Jan 31, 2025. Accessed February 27, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- The Ministry of Health (the Ministry) is in Year 8 of the Primary Care Strategy (the Strategy), focused on increasing access to primary care, connecting people to primary care providers, expanding team-based care and improving the coordination of health care services through local Primary Care Networks (PCNs).
- The Strategy's targets of 103 PCNs and 50 Urgent and Primary Care Centres (UPCCs) are on track to be delivered in 2025/26.[8]
- Through the Strategy, funding was committed for approximately 3,420 new full-time equivalent (FTE) health care workers to support team-based care through various initiatives. As of January 2025, 2,283 FTEs are recruited (including Family Physicians, Nurse Practitioners, Registered Nurses, allied health professionals, pharmacists, and Indigenous providers).[9]
- Launched in 2023, the Provincial Attachment System (PAS), which includes the Health Connect Registry, continues to help connect more people to primary care providers:
    - On average, in 2024, 680 people were matched with a primary care provider every day, up from 510 per day in 2023 – a 33% increase.[10]
    - As of January 2025, 94.2% of primary care providers have uploaded their patient panels to the PAS and have identified their capacity to attach to new patients.[11]
    - Approximately 70 Attachment Coordinators throughout the province continue to connect people to primary care providers in their community.[12]
    - As of January 31, 2025, there are 404,000 British Columbians registered and waiting for attachment on the Health Connect Registry – more than 33,000 of those are pending attachment.[13]
- Other initiatives in various phases supporting the Strategy include:
    - Launched in 2023, the Longitudinal Family Physician (LFP) payment model better compensates family doctors for time spent with patients. As of January 31, 2025, 4,474 family doctors are working under the LFP model.[14]
    - 365 newly trained family doctors have signed up to the New-to-Practice Incentives program, which is attracting more doctors to practice longitudinal primary care.[15]
    - More internationally trained doctors have joined the workforce through Practice Ready Assessment BC, which expanded from 32 to 96 seats in 2024. To date, 318 internationally trained family doctors have been placed in 77 communities in need.[16]
    - The new Nurse in Practice Program places Registered Nurses and Licensed Practical Nurses into primary care clinics. In 2024/25, 89 primary care clinics are approved to recruit up to 109.5 nurse FTEs across clinics to support team-based care delivery. [17]

FINANCIAL IMPLICATIONS

The Ministry's budget includes $579.09M in 2024/25 to support the continued implementation of Primary Care Strategy's Initiatives (including PCNs, UPCCs, Community Health Centres, and Family Physician- and Nurse Practitioner- led clinics), and $627.82M for 2025/26.

[8] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 PCN Status Report, Data as of January 2, 2025.
[9] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 PCN Workforce Report, Data as of January 2, 2025.
[10] HSIAR Provincial Attachment System Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[11] HSIAR Provincial Attachment System Executive Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[12] HealthLinkBC, Provincial Patient Attachment & Access, and HealthLinkBC Service Strategy. Data as of February 6, 2025.
[13] HSIAR Health Connect Registry Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[14] HSIAR Longitudinal Family Physician Payment Model Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[15] Divisional Services Branch, Primary Care Division, Ministry of Health. New-to-Practice P10 Report, Data as of January 2, 2025
[16] Health Sector Workforce and Beneficiary Services, Physician Services, Programs & Policy. Data as of February 3, 2025.
[17] Divisional Services Branch, Primary Care Division, Ministry of Health. Nurse in Practice Program update. Data as of January 1, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- The After-Hours Care Program continues to help people who have a family doctor access care outside of regular office hours, in: Greater Victoria, Langley, Thompson Region, Shuswap North Okanagan and South Okanagan Similkameen.
- Expanding the scope of community pharmacists increases access to primary care services for people, including treatment for minor ailments, contraception, prescription renewals and immunizations.
- The Strategy also focuses on digital health solutions that bring virtual and telehealth care to people where and when they need it, particularly those in rural and remote areas, including:
    - HealthLink BC 24/7 telehealth services through 8-1-1 for patients.
    - HealthLink BC access to services through the newly launched Primary Care Online – an online directory for people to search for local health services, with a strong focus on access to primary care, both in-person and virtual/telehealth.
    - Real-Time Virtual Supports (RTVS) offer access to virtual care for patients and providers in rural, remote, and First Nations communities in BC, including through:
        - HealthLink BC Emergency iDoctor-in-assistance (HEiDi) (provides 8-1-1 access to physicians),
        - Rural Urgent Doctors in-aid (RUDi) (emergency medicine support for rural and remote providers),
        - Child Health Advice in Real-Time Electronically (CHARLiE) (pediatric medicine support for rural and remote providers), and
        - Maternity and Babies Advice Line (MaBAL) (maternity and newborn care support for rural and remote providers).
    - First Nations Virtual Doctor and First Nations Virtual Substance Use and Psychiatry Service for First Nations people to make virtual appointments with doctors.
    - Northern Health Authority also offers a Virtual Primary and Community Care Clinic to deliver primary care services for unattached patients.

LAST UPDATED

The content of this estimates note is current as of February 11, 2025, as confirmed by Kirsten Youngs.

APPROVALS

2025 02 11 – Ted Patterson, ADM, Primary Care Division
2025 02 28 – Rhiannon Pretty obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 02 28 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Attachment Progress

Topic: Provide an overview of the status of patient attachment to primary care providers (either a family doctor or nurse practitioner) and progress to date in BC.

Key Messaging and Recommended Response:

- Attachment to a primary care provider is shown to have numerous health and wellbeing benefits for people, including living healthier, longer lives and feeling supported to make informed health decisions.
- Having access to a family doctor or nurse practitioner also reduces emergency department visits and hospitalizations for issues that could be managed in a family practice clinic or office.
- BC continues to make substantial progress on connecting people to a family doctor or a nurse practitioner[1]:
    - Year over year, we are attaching more and more people to a primary care provider in their community - more than 695,000 people have been attached to a family doctor or nurse practitioner in BC since the launch of the Primary Care Strategy in 2018.
    - In the 2024 calendar year, 248,000 people were attached to a primary care provider in BC – compared to 186,000 attached in the 2023 calendar year, and 130,000 attached in the 2022 calendar year.
    - On average in 2024, 680 people were attached to a primary care provider or nurse practitioner each day – a 33% increase in attachment rate from 2023.
- The Ministry, Doctors of BC and Nurses and Nurse Practitioners of BC continue to work collaboratively to further increase attachment rates and provider capacity to attach, including by:
    - continuing to reduce administrative burdens for providers so they have more time for direct patient care,
    - improving the Provincial Attachment System and Health Connect Registry user experience for both patients and providers,
    - increasing the role of Attachment Coordinators and non-licensed clinical staff in supporting attachment processes, and
    - continuing to streamline and centralize the provincial attachment process.
- We remain committed to maintaining this momentum alongside our primary care partners, as we work together to achieve our attachment goals of an additional 250,000 attachments each fiscal year in our Service Plan.

CURRENT SITUATION

- Increased attachment in BC is supported by a broad range of actions enabled through BC's Primary Care Strategy, including:
    - the implementation of the Provincial Attachment System (PAS) and ongoing improvements,
    - hiring 70 attachment coordinators in communities throughout BC,
    - the continued implementation of Primary Care Networks, Community Health Centres and Urgent and Primary Care Centres, that include family doctor and nurse practitioner resources who may also be able to attach patients,
    - the launch of the Nurse in Practice program so family doctors and nurse practitioners have capacity to attach more people,
    - the implementation of the Longitudinal Family Physician (LFP) Payment Model and New-to-Practice Incentives program that encourage health care professionals to remain in

[1] HSIAR Provincial Attachment System Attachment Dashboard – Health System Performance Portal, accessed February 27, 2025.

longitudinal family practices and maintain current, responsive patient panels to community need,
    - the focus on New to Practice and Nurse Practitioner contracts to attract and retain new primary care providers, and
    - a host of other service improvements that help to lift administrative burden off providers and ensure they can focus on their patients.
- As of January 2025, more than 4,300 family physicians (FPs) and almost 600 nurse practitioners (NPs) have uploaded their panel data into the PAS – approximately 94% of FPs and NPs providing longitudinal care. Of these providers, 1,129 have indicated they can accept new patients for a collective maximum total of approximately 291,000 new patients.[2]
- In terms of attachments reported, with growing adoption of the PAS among thousands of FPs, NPs, and clinic staff, we are seeing a substantial increase in the number of patients attached through their registration on the Health Connect Registry (HCR) and expect attachment progress through this centralized mechanism to continue to grow.
- As of January 31, 2025, there are 404,000 people in British Columbia registered on the HCR, with 33,000 of those pending attachment.[3]
- New registrants and those transferred from community lists will receive an email confirmation they are on the HCR. Registrants will retain their original registration date date on the HCR or from their community waitlist.
- PAS is actively working with all communities throughout BC to close and transition all local waitlist to the HCR.

Patients seeking attachment, by health authority, January 31, 2025

Health Authority	Registrant Status			Total attached and pending
	Active	Attached	Pending	
FHA	102,503	47,187	15,108	62,295
IHA	74,864	38,678	4,125	42,803
NHA	18,667	6,848	768	7,616
VCHA	53,847	21,708	6,359	28,067
ISLH	120,249	58,280	7,089	65,369
Total	**370,130**	**172,701**	**33,449**	**206,150**

- Median time to attachment by health authority (province-wide: 302 days):[4]
    - Fraser: 259 days
    - Interior: 462 days
    - Northern: 212 days
    - Coastal: 182 days
    - Island: 402 days

FINANCIAL IMPLICATIONS

- In 2018/19, $264,000 in capital funding went into the initial development of the HCR proof of concept.
- In 2019/20 - 2022/23, maintenance of the HCR was funded through the Primary Care Division's HealthLink BC annual operational web maintenance budget.

[2] HSIAR Provincial Attachment System Executive Dashboard – Health System Performance Portal, accessed February 27, 2025.
[3] HSIAR Health Connect Registry Dashboard – Health System Performance Portal, accessed February 27, 2025.
[4] Ibid.

- For operating funding, the Province has invested $37.63M in 2023/24 and $55.20M in 2024/25 to support the Primary Care Digital Enablers.
- The Province has invested $26.60M in 2023/24 and $5.61M in 2024/25 for capital funding (including capital allocated to Provincial Health Services Authority).

KEY BACKGROUND

- Work is underway to work with providers and patients to resolve panel conflicts (i.e., cases where patients appear on more than one provider panel). This will help increase capacity for more people without a primary care provider to become attached to one.

LAST UPDATED

The content of this estimates note is current as of February 13, 2025, as confirmed by Brande Strachan.

APPROVALS

2025 02 14 – Ted Patterson, ADM, Primary Care Division
2025 03 03 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 02 28 – Rhiannon Pretty obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE ESTIMATES NOTE

Community Health Centres

Topic: As part of the Primary Care Strategy, Community Health Centres provide comprehensive, person-family-and community centered, culturally safe, quality primary health care to a community population.

Key Messaging and Recommended Response:

- Community Health Centres (CHCs) are one of a number of clinic models that the Ministry funds to support team-based care through the Primary Care Strategy.
- Designed by the community, for the community - every CHC offers unique services based on the needs of people living in the areas they serve.
- CHCs connect underserved people of the community who do not have a primary care provider with a family doctor or nurse practitioner in a community-centered, culturally safe environment.
- They also provide access to preventative and health services to patients who:
    - Experience barriers to care
    - May have unmet medical and social needs
    - May have mental health and substance use challenges
    - May require help getting connected to other community services
- As of January 2025, the Province has committed over $35M in annual funding to support the 15 CHCs funded through the Primary Care Strategy – 11 of those are currently delivering services with four in planning.
- As of January 2025, CHCs funded through the Primary Care Strategy have hired more than 120 health care and wellness providers to increase access to care and attachment to primary care providers to communities.
- Together with partners such as the BC Association of Community Health Centres, the Ministry also supports other CHCs providing primary care services, outside of those funded through the Primary Care Strategy, through grant funding.
- Discussions with the BC Green Party on the future potential of CHCs are ongoing and we look forward to delivering care to communities through this unique model, together.

CURRENT SITUATION

- As of January 2025, there are 15 Primary Care Strategy-funded Community Health Centres (CHCs) delivering care or in planning phases in communities throughout BC:[1]
    - Fraser Health (3):
        1. Umbrella Multicultural Health Co-op CHC,
        2. Roots CHC, and
        3. Elizabeth Fry Health Centre CHC
    - Vancouver Coastal Health (3):
        1. Bowen Island CHC,
        2. RISE CHC, and
        3. RésoSanté
    - Island Health (5):
        1. Island Sexual Health CHC,
        2. Laichwiltach Family Life Society CHC,
        3. Luther Court CHC,

[1] Divisional Services Branch, Primary Care Division, Ministry of Health, Results Management Office Period 10 Workforce Report Dec 6, 2024 to Jan 2, 2025 from Primary Care DataCite

4. Port Alberni Urban Indigenous CHC, and
5. Westshore Pacific Centre CHC

- Interior Health (3):
  1. Lower Columbia CHC,
  2. Rutland CHC, and
  3. STEPS CHC
- Northern Health Authority (1):
  1. Central Interior Native Health Society CHC

- Eleven of the above CHCs are fully operational while four are approved but not yet seeing patients.
- In 2024, the Ministry opened two new CHCs: RésoSanté and Bowen Island, both in Vancouver Coastal Health Authority region.
- As of January 2025, CHCs funded through the Primary Care Strategy have hired 120.86 full-time equivalents (FTEs) to deliver care to communities.[2]
- Since 2018, the Ministry has provided grant funding ($15.34M) to the British Columbia Association of Community Health Centres (BCACHC) to distribute to other CHCs in the province providing primary care services, outside of those funded through the Primary Care Strategy.
- The Ministry partners with the BCACHC, a not-for-profit advocacy body, who acts as a key intermediary between the Ministry and the broader CHC sector.
- As of January 2025, there are 46 active BCACHC members (including Strategy-funded CHCs as well as several non-Strategy-funded CHCs).[3] Thirty-two of these members offer primary care, while 10 represent "emerging CHCs" (community not-for-profits working towards becoming a CHC).
- The Ministry has provided emergency sustainment funding (in the form of grants and, more recently, Shared Cost Arrangements) to support the continued delivery of critical primary care services for BCACHC CHC members.
- 14 BCACHC CHCs (non-Strategy funded) received grant funding in FY 24/25.[4]
- An inventory completed in January 2024 identified an estimated 134 "other" community health centres in the province (not Strategy-funded, and not BCACHC members, some are health authority owned) providing a range of health and non-clinical services, some including primary care.[5]
- On December 12, 2024, an Agreement in Principle was reached between the BC Green Party Caucus and the BC NDP Caucus, with a focus on primary care and CHCs:[6]
  - Commitment 1a speaks to establishing targets for the opening of CHCs in 2025 and 2026, to be funded by government.
  - Commitment 1b speaks to performance analysis of the primary care system, with CHCs as one of the focus areas.
  - Commitment 1c speaks to assessing and addressing the barriers that exist for health professionals and communities who want to establish a CHC and allocating $15M to assist in the creation of new, or support for existing, CHCs.

FINANCIAL IMPLICATIONS

- As of January 2025, the Ministry has committed to fund $48.81M in annual operating costs for the 15 Strategy-funded CHCs currently in implementation, $23.46M in one-time start-up costs and $1.34M in Change Management Costs.
- The Ministry has also invested a total of $15.34M in emergency sustainment funding to non-Strategy-funded CHCs since 2018 ($2.13M in 2017/18; $1M in 2019/20; $2.13M in 2020/21; $3.78M in 2021/22; $3.50M in 2023/24; $3.05M in 2024/25).

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[2] Divisional Services Branch, Primary Care Division, Ministry of Health, Results Management Office Period 10 Workforce Report Dec 6, 2024 to Jan 2, 2025 from Primary Care DataCite

[3] Retrieved from BCACHC 2025 2 pager (PDF from BCACHC January 2025)

[4] Ministry of Health Shared Cost Arrangement signed April 15, 2024 (between BCACHC and the Ministry of Health)

[5] CHC inventory drafted by CHC Provincial Team (note that data in this inventory is verified for Primary Care Strategy-funded CHCs as well as for BCACHC member CHCs; however, the list of "other" CHCs remains a draft that is unconfirmed/unvalidated at this time)

[6] BC Greens – BC NDP Agreement in Principle: https://bcgreens2024.ca/wp-content/uploads/2024/12/Agreement-in-Principle.pdf (December 12, 2024)

LEGISLATIVE ESTIMATES NOTE

- The Ministry's budget includes $579.09M in 2024/25 to support the continued implementation of Primary Care Strategy's Initiatives (including Primary Care Networks, Urgent and Primary Care Centres, CHCs, and Family Physician-and Nurse Practitioner- led clinics), and $627.82M for 2025/26.

KEY BACKGROUND

- CHCs are geographically defined and can serve multiple Community Health Service Areas.
- With a focus on providing direct and indirect access to social determinants of health-related services, CHCs are community-governed with primary care services (longitudinal and episodic) tailored to meet the health needs of the community.
- The Ministry established a CHC Provincial Reference Group in January 2024, with membership including the Ministry, Health Authorities, BCACHC, and all primary care strategy-funded CHCs.
- Key accomplishments of this group include the initiation of formal metric reporting (i.e., attachment, visits, and encounters), support for Provincial Attachment System onboarding, introduction of Primary Care Network attributes and metrics, and engagement supporting the draft Roles and Responsibilities Framework along with the draft CHC Provincial Strategy.

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Kelly McQuillen.

APPROVALS

2025 02 14 – Ted Patterson, Primary Care Division
2025 0227 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 02 18 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Episodic Primary Care

Topic: Within the overarching primary care strategy in BC, an episodic primary care system is required to provide both unattached patients access to urgent and non-urgent primary care, and to provide attached patients access to urgent primary care that cannot be accommodated by their primary care provider.

Key Messaging and Recommended Response:

- The BC Primary Care Strategy is focused on increasing access to team-based, culturally safe primary care for people, where and when they need it, whether that be through family practice clinics, virtual care or through episodic primary care services.
- Episodic primary care services lift the burden off hospitals and emergency rooms as episodic care can be accessed by those who may otherwise seek care in emergency departments unnecessarily.
- Episodic care can be delivered through walk-in clinics and other clinic models, urgent and primary care centres, community health centres, virtual care and other initiatives aimed at increasing people's access to care – whether they are attached to a family doctor or nurse practitioner, or not.
- The strategy for Episodic Primary Care aims to provide people with access to a clear set of urgent and non-urgent primary care service options when they are unattached or are attached but need urgent access to primary care, which will be achieved by:
    - Increasing access for attached patients to their longitudinal providers to reduce the demand on episodic primary care.
    - Increasing and stabilizing episodic primary care service options.
    - Better coordinating patient access to the most appropriate care.
- As government works to expand access to primary care providers, it will continue to support access to episodic care throughout BC.

CURRENT SITUATION

- The goal of attaching all people in BC to longitudinal primary care takes time; there will always be a need for patients to access episodic primary care services (i.e., approximately 10% of all primary care visits).
- To increase **access for attached patients to their longitudinal providers** and reduce demand for episodic primary care, the following actions are being taken:
    - **After-Hours Care** - A pilot program was established in September 2023 through HealthLink BC that provides virtual access to after-hours care for patients attached to participating clinics outside of regular business hours. The service is currently available in 16 Primary Care Network (PCN) communities and HealthLink BC is exploring the potential to expand the service provincewide.
    - Advice/Recommendations

- To increase and stabilize **episodic primary care service options** for people in BC, the following actions are taken:
    - **UPCCs -** 50 Urgent and Primary Care Centres (UPCCs) will be operational by January 2026 and health authorities will be provided performance reporting to further drive quality improvement to ensure UPCCs provide 700K episodic patient visits in 2024/25 and visit volumes grow in subsequent years.
        - At P10, UPCCs provided 552K patient visits of which 64% (351K) were for unattached patients, and 36% (200K) for patients attached but not to the clinic.[1]
    - **Walk-in and Mixed-model Clinics** – Since 2023/24, the Ministry of Health (the Ministry) has provided $20.25M in walk-in stabilization funding to 13 clinics. In 2024/25, the Ministry budgeted $10.86M to support 12 walk-in clinics. Work is underway to identify compensation and funding model options for walk-in and mixed-model clinics offering episodic primary care services and to continue work to identify walk-in and mixed-model clinics through the Clinic and Provider Registry.
        - At P10, walk-in and mixed model clinics had provided 262,171 episodic primary care patient

[1] Divisional Services Branch, Primary Care Division, Ministry of Health. Patient Service Report, PCDC, P10. Data as of January 2, 2025.

visits at UPCCs and Community Health Centres (CHCs) within FY2024/25 i.e. from April 2024 to January 2025.

- **Virtual Episodic Primary Care Services –** Several government-funded virtual episodic primary care services have been established in BC, including HealthLink BC 8-1-1, Northern Health Virtual Care services, and the First Nations Doctor of the Day. Additionally, a provincial virtual episodic primary care service pathway is in development with the aim of connecting the highest priority patients on the Health Connect Registry to care while waiting to be attached to longitudinal primary care.
    - The HealthLink BC 8-1-1 virtual health team includes patient navigators, nurses, dietitians, exercise professionals, pharmacists, and physicians. 8-1-1 is available 24 hours a day, 7 days a week. At approximately 1,551 calls per day, the virtual health team supports 567,551 calls per year.
    - For UPCCs, in FY 24/25, the cumulative virtual patient encounters as of P10 was 91,148 (32% of total patient encounters).
- **Community Pharmacy Services** – The Pharmacy, Laboratory, and Blood Services Division (PLBSD) has worked closely with the College of Pharmacists of BC to expand the scope of practice for community pharmacists to independently renew/adapt prescriptions and to provide treatment for minor ailments and contraception.
    - Between 2024/25 P1 and P10, community pharmacists provided 378,365 episodic primary care patient visits, of which 82,942 (22%) were with unattached patients.

- To better **coordinate patient access to the most appropriate care** for people in BC, the following actions are being taken:
    - Processes have been established with the BC Emergency Health Services (BCEHS) Clinical Hub to transition patients to UPCCs and other health services when patients do not require transfer to an emergency department.
        - In 2024, 518 patients were transferred to UPCCs by BCEHS who would otherwise have been transported to the emergency department.[2]
    - Processes are in development with HealthLink BC and health authorities to transition patients in need of in-person primary care from the HealthLink BC virtual physician services (HEiDi) to UPCCs.
    - In UPCCs, health authorities are standardizing how patients access care in UPCCs, and implementing a Schmidtt-Thompson based triage tool that registered nurses will use for all patients accessing care in UPCCs to prioritize and help connect patients to the most appropriate services to meet their care needs.
    - HealthLinkBC is implementing a Schmidtt-Thompson based triage and assessment tool for HealthLink BC nurses to inform priority of need and support transition of care to the most appropriate service.
    - Initial planning underway to pilot the use of a "patient summary record", to be developed by HSMIT, to support transitions of care for patients and shared care between providers.

FINANCIAL IMPLICATIONS

- The Ministry has committed to fund $169.41M in annual operating costs for 42 UPCCs which have received a funding letter and are currently in implementation (funding is based on full staffing), $185.89M in capital and $15.57M in one-time start-up costs.
- As of January 2025, the Ministry has committed to fund $21.25M in one time funding to support 12 walk-in clinics over the next 2 fiscal years.
- As of January 2025, the Ministry has approved $100.21M of funding for the suite of Real Time Virtual Support services, from 2020-2025.
- As of January 2025, the Ministry has committed $6.99M to First Nations Health Authority ($3.19M) and Northern Health Authority ($3.80M) to support FNvDOD and FNvSUPs.
- As of January 2025, the Ministry has committed $13.50M towards an Episodic Virtual Care Services contract.

KEY BACKGROUND

- Episodic primary care is defined as "a single encounter with a patient focused on a presenting concern(s) or referred consultation, where neither the regulated practitioner nor patient expect an ongoing care relationship."

[2] BCEHS Clinical Hub Provincial UPCC Dashboard 2024, PDF received from BC Emergency Health Services. Last accessed January 13, 2025.

- Interim data suggest that episodic care needs in BC are much higher than the aspirational target of approximately 10% of all primary care visits.
    - At P10, UPCCs provided 552K patient visits of which 64% (351K) were for unattached patients, and 36% (200K) for patients attached but not to the clinic.[3]
    - Of patients who accessed minor ailments and contraception services in community pharmacies between 2024/25 P1 and 2024/25 P10, 21% (61,564) were unattached and 79% (225,376) were attached.
    - Walk-in clinics have been a long-standing option for British Columbians to access primary care which have been negatively impacted by the longitudinal family practice compensation model.

LAST UPDATED

The content of this estimates note is current as of February 17, 2025 as confirmed by Kelly McQuillen

APPROVALS

2025 02 18 – Kelly McQuillen obo Ted Patterson, Primary Care Division
2025 03 27 – Rhiannon Pretty obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
[date approved, e.g., 2023 01 27] – Finance and Corporate Services Division

[3] Divisional Services Branch, Primary Care Division, Ministry of Health. Patient Service Report, PCDC, P10. Data as of January 2, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Family Practice Services Committee

Topic: Dedicated to strengthening longitudinal family practice as the foundation of an integrated primary and community care system, the Family Practice Services Committee is a collaborative table co-chaired by the Ministry and Doctors of BC.

Key Messaging and Recommended Response:

- The Family Practice Services Committee – a partnership between the Ministry and Doctors of BC established through the Physician Master Agreement (PMA) – has worked collaboratively since 2002 to improve the quality, sustainability and accessibility of primary care services in BC.
- In 2024/25, FPSC's work focused on:
  - Improving patient attachment to a family physician, including physician payments based on panel size and complexity, supporting the Provincial Attachment System and funding local attachment.
  - Improving access to long-term care, maternity care, and inpatient care, focusing on supporting family physicians to work together to provide services and meet community needs.
  - Improving access with pilot projects focused on access to after-hours primary care and continuity of care through the locum pilot project, supporting new-to-practice physicians into family practice.
  - Enabling partner collaboration to integrate services throughout BC, including the development and operations of Divisions of Family Practice and supporting new policies and initiatives that support Primary Care Networks' planning and implementation.
  - Supporting practice improvements, including clinical workflow efficiencies and advanced access, preparing physician panel data for upload to the Provincial Attachment System, helping physicians integrate new health technologies into their clinics, addressing administrative burdens, and providing coaching support for quality improvement projects.
- What began as a trial collaboration has resulted in positive trends:
  - Recruitment of family physicians in BC being the highest among Canadian provinces.
  - Strong uptake of the Longitudinal Family Physician Payment Model.
  - Feedback from family physicians who are seeing a difference in family practice and hearing their voices reflected in the Committee's work.

CURRENT SITUATION

The Family Practice Services Committee (FPSC) supports the actions to improve primary care:

- **Longitudinal Family Physician (LFP) Payment Model:** (see Primary Care Recruitment estimates note)
  - Including physician billing support, resources and education to ensure clarity and compliance, and improvement of the LFP Payment Schedule. FPSC also administers the LFP Panel Payment to eligible Family Physicians (FPs).
- **Community Longitudinal Family Physician (CLFP) Payments:**
  - Funds and administers the CLFP payment (reflecting panel size and complexity) to community-based, longitudinal FPs not enrolled in the LFP Payment Model
- **Nurse in Practice Program (NinP):** (see the Nurses in Primary Care estimates note).
  - NinP enables FPs to recruit registered nurses and licensed practical nurses into their clinical team.
- **Team-Based Care (TBC) Grant:**
  - Grant provides up to $15,000 to eligible family practices to address the costs of recruiting and onboarding team-based professionals into practice. In 2024/25 Q1-Q3, 11 FPs in 14

family practices received the grant, for a total of 28 interprofessional team members (totaling $77,500 and ranging between 0.2-1.0 full-time equivalent [FTE]).[1]

- **Maternity**: (see Maternity Care estimates note)
  - The FPSC Maternity Care Network Grant provided $5,000 to FPs who participated in the FPSC Maternity Care Network Initiative. The grant supported FPs to maintain maternity care services in-hospital until they could bill for pregnancy and newborn care through the LFP Payment Model. In 2024/25 Q1, 317 FPs received the Maternity Care Network Grant, totaling $1.582M. This was the last quarter the grant was available.
  - The 14010 Maternity Care Network Fee provides $2,100 per quarter to eligible FPs, supporting collaboration in providing full-scope maternity care within communities. The 2024/25 annual projection is $3M.[2]
- **Long-term Care (LTC)**:
  - The FPSC Long-term Care Grant provided $5,000 to FPs who provided LTC services, to maintain services until they could bill for LTC through the LFP Payment Model. In 2024/25 Q1, 830 FPs received the Long-term Care Grant totaling $4.163M.[3] This was the last quarter the grant was available.
  - Since 2015, FPSC has provided $12.1M in annual funding for the Long-term Care Initiative (LTCI), to increase the implementation of five Best Practice Expectations and to help ensure patients living in LTC facilities have access to a Most Responsible Provider (MRP).[4] In June 2024, FPs began billing for LTC through the LFP Payment Model. To adapt to the new model, LTCI funding was reallocated to the following payments, budgeting $13.1M in funding for 2024/25 [5]:
    - On-Call/Availability Funding for LTC: Each division receives an annual amount of $130,000, plus $80 per LTCI bed.
    - Quality Improvement (QI)/Administration Funding for LTCI: For local LTC QI activities.
    - LTCI MRP Payment: FPs who provide ongoing longitudinal care to patients in LTC facilities and are participating in the LTCI but are not eligible for the LFP payment model. This payment became available in July 2024. In 2024/25 Q2 -Q3, the FPSC has provided $1.18M to support 212 FPs providing LTC services.
- **Inpatient Care:**
  - The FPSC Assigned Inpatient Network fee (14086) pays $2,100 per quarter to FPs who enroll in the LFP for Inpatient Care and FPs compensated by fee-for-service and Alternate Payment (AP) models. In 2024/25 Q1-Q3, 761 FPs billed this fee (14086) for a total of $4.269M.
  - The FPSC Unassigned Inpatient Care Network fee (14088) pays $150 per hospital admission to FPs who accept MRP status for the unassigned inpatient hospital stay. This payment is made to FPs not enrolled on the LFP Payment Model. In 2024/25 Q1-Q3, 575 FPs billed this fee (14088) for a total of $1.626M.
  - In 2024/25 Q1-Q3, $18.69M in FPSC Transition Funding for Inpatient Care supported 46 hospital locations maintain inpatient care services until they could bill for LTC through the LFP Payment Model.[6]
- **Quality Improvement (QI):**
  - $8.8M is budgeted annually to compensate physicians for participating in QI projects, e.g., using data to inform improvement and streamline processes using health technology tools.
  - In 2024/25 Q1-Q3, Practice Support Program (PSP) coaches supported 1,776 FPs (including 330 on New to Practice contracts and 1,040 on the LFP payment model) and completed

[1] Based on FPSC payment expenditure information.
[2] Based on FPSC payment expenditure information
[3] Based on FPSC payment expenditure information
[4] FPSC Work Plan and Budgets
[5] FPSC Work Plan and Budgets
[6] Based on FPSC payment expenditure information

7,789 practice visits. 953 FPs completed at least one QI Cycle, with 540 FPs with at least one QI Cycle in progress.[7]
    - The PSP and Doctors Technology Office (DTO) supported 139 FPs related to Provincial Attachment System participation.[8]
    - In 2024/25 Q1-Q3, DTO provided 579 health technology advisory and escalation support services, the majority related to clinic network security (35%), electronic medical records (18%), and Practice Tools such as AI (16%).[9]
- **Divisions of Family Practice (DoFP)**:
    - In 2024/25, FPSC budgeted $44.7M to fund 36 DoFP working with community and health care partners to improve patient care. Funding supports[10]:
        - $26.9M Infrastructure (core function) Funding, e.g. governance and operations;
        - $9.4M Physician engagement in system transformation, including developing Primary Care Networks;
        - $500,000 in Health Emergency Management and response to health-related emergencies, e.g., floods and wildfires;
        - $5.1M for DoFPs to hire Health Connect Registry Attachment Coordinators;
        - $2.8M for recruitment, retention and FP career lifecycle to retirement.
- **Urban Locum Program (ULP):**
    - Since October 2022, the ULP has supported FPs access practice locum coverage for up to 10 days per year, ensuring continuity of care during leaves. The ULP is currently available in the Victoria and South Island DoFPs and since its inception, 66 locums and 161 host physicians have participated in the program, with a total shift coverage of 45.6%.[11]
- **After-Hours Care Program (AHCP)**: (see HealthLink BC estimates note)
    - Developed in collaboration with the FPSC and HealthLink BC, the AHCP provides care to patients when family practices are closed evenings, nights, weekends and holidays.
- **Primary Care Networks (PCNs):** (see PCN estimates note)
    - PCNs are led and primarily funded by the Ministry, with support from the FPSC.
    - In 2024/25 Q1-Q3, the FPSC was a key partner in the development of a shared PCN Steering Committee Terms of Reference, aimed to strengthen engagement with Indigenous, community and patient partners.

FINANCIAL IMPLICATIONS

- The FPSC's approved budget for 2024/25 is $226.2M.[12]

KEY BACKGROUND

- The **Family Practice Services Committee (FPSC)** meets weekly and is co-chaired by Primary Care Division's Assistant Deputy Minister, Ted Patterson, and Doctors of BC's Dr Sari Cooper.
- FPSC Core meets regularly to workshop challenges and opportunities, and discuss and receive feedback from primary care representatives.

LAST UPDATED

The content of this transition factsheet is current as of February 14, 2025, as confirmed by Kirsten Youngs.

APPROVALS

2025 02 14 – Ted Patterson, Primary Care Division
2025 03 13 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[7] COMET data base
[8] COMET data base
[9] Salesforce data base
[10] FPSC Work Plan and Budget 2024/25
[11] ULP Quarterly reports
[12] FPSC Work Plan and Budget 2024-25.

LEGISLATIVE SESSION – ESTIMATES NOTE

HealthLink BC Services

Topic: HealthLink BC (HLBC) delivers multidisciplinary virtual and digital health services to people living in British Columbia to manage their symptoms, answer health-related questions, identify when and where to access health services, and support their attachment to a longitudinal primary care provider.

Key Messaging and Recommended Response:

- HealthLink BC provides trusted, virtual and digital health information and advice to people living in BC, any time of the day or night.
- Nurses, dietitians, pharmacists, exercise professionals and physicians are available to people in BC at 8-1-1.
- HealthLink BC helps reduce burden on hospitals, walk-in clinics and primary care providers. For example:
    - Through virtual nurse encounters, HealthLink BC diverted nearly 30% of 8-1-1 callers from local emergency departments and clinics by providing self-management support and health education.
    - Through virtual physician consultations, that percentage goes up to 48% of diverted patients by providing self-management support and education.
- HealthLink BC helps patients understand the health services available in their community and, through the Health Connect Registry, supports the registration for and attachment to a primary care provider.
- HealthLink BC 8-1-1 provides virtual health supports to an average of 1,550 callers a day and healthlinkbc.ca digital health info to more than 33,750 web visitors a day.

CURRENT SITUATION

- HLBC digital health services at healthlinkbc.ca provide access to trusted health information and interactive tools on over 5,000 health topics and a searchable database of over 6,500 health and health-related services throughout BC.
- The HLBC website provides the provincial digital solution to health-related campaigns such as trending health topics, seasonal events, back to school, vaccination, and the Health Connect Registry.
- The HLBC health content and health-service information is utilized by health sector partners on their digital platforms, such as the mental health and addictions focused Health Starts Here resources, as well as the Health Gateway, Lifeguard App and more. The HLBC website receives up to 33,780 visits/day.[1]
- HLBC 8-1-1 virtual health services support people to manage their symptoms, answer health related questions, identify when and where to access health services, and support their attachment to a longitudinal primary care provider through the Health Connect Registry (hosted by HealthLink BC).
- The virtual health team includes patient navigators, nurses, dietitians, exercise professionals, pharmacists, and physicians. 8-1-1 is available 24 hours a day, 7 days a week. At approximately 1,551 calls per day, the virtual health team supports 567,551 calls per year.
- In addition, the virtual health team provides these specific virtual health services:
    - Provincial COVID-19 Treatment Program:

[1] Symmetrics NVISION Data Mart, *BIU23_ NAV_ Org*, 2023, HealthLink BC

- Offers clinically vulnerable patients experiencing mild to moderate symptoms of COVID-19 an opportunity to access antiviral treatments though 8-1-1 physicians and pharmacists.
- Since launch on February 19, 2022, to December 31, 2024, the service has received 16,267 patient referrals. Of the patients seen, 8,538 (53%) were provided with treatment options (8,074 Paxlovid prescription and 464 IV therapy referral).

- Provincial Prescription Renewal Support Service:
  - 8-1-1 physicians and pharmacists are available for the patients of pharmacists throughout BC to support successful implementation of the expanded scope of community pharmacists.
  - Since launching on January 24, 2023, to December 31, 2024, the service has received 1,541 patient referrals.
  - Of patients seen, 975 (65%) received a prescription renewal, 336 (22%) required laboratory testing, and 166 (11%) required referral to in-person care for physical assessment.[2]
- After-Hours Care (AHC) program:
  - The AHC pilot program provides attached patients of family physicians and nurse practitioners participating in the program with access to after-hours, virtual medical care and advice from 5:00 p.m. to 9:00 a.m. during the week and 24 hours on weekends and holidays.
  - The AHC pilot is currently available in six regions: Victoria, South Island, Langley, Thompson, South Okanagan Similkameen, and Shuswap North Okanagan. The program is a partnership with the Family Practice Services Committee (FPSC) leveraging HLBC staff and its operational infrastructure.
  - Between September 29, 2023, and December 31, 2024, 7,605 calls were answered directly by the AHC program. 42% (3,161) of those calls were resolved by non-clinical navigators and did not require a clinical encounter, while 58% (4,444) of those calls required a clinical encounter with an AHC physician.
  - An additional 3,967 calls to 8-1-1 from attached patients in the participating AHC communities were transferred from 8-1-1 to AHC physicians.
  - Approximately 70% of physicians and nurse practitioners in communities participating in the AHC program have signed up to use the service with their patients, serving an estimated combined panel of 500,000 attached patients.

FINANCIAL IMPLICATIONS

- HLBC's expenditures were $29.3M in 2019/20, $35.9M in 2020/21, $36.3M in 2021/22, $39.1M in 2022/23 and $43.2M in 2023/24. For 2024/25 HLBC budget is $45.5M and expenditures are projected at $44M.
- HLBC Budget in 2025/26 is estimated at $45.5M.

KEY BACKGROUND

- HLBC has seen an increase in demand for all services since 2016/17:
  - 8-1-1 service demand averaged 1,250 calls/day in early 2020 compared to 6,700 calls/day during the peak of the pandemic response.
  - Healthlinkbc.ca experienced a 400% increase in demand with up to 60,000 or more visits/day in 2021.[3]
- HealthLink BC 8-1-1 virtual health service calls received/encounters with patients:

[2] KDR Data Mart, *HEiDi_Summary_2023*, 2023, HealthLink BC
[3] Symmetrics NVISION Data Mart, *BIU23_ NAV_ Org*, 2023, HealthLink BC; KDR Data Mart, *Project BIU23_NS_Org, Project BIU23_DS_Org, Project BIU23_PAS_Org, Project BIU23_PS_Org, HEiDi_Summary_2023*, 2023, HealthLink BC

	2022[4]		2023[5]		2024[6]	
	Annual	Daily Average	Annual	Daily Average	Annual	Daily Average
Navigators	689,610	1,889	543,518	1,489	543,045	1,484
Nurses	304,242	834	319,291	875	294,308	804
Dietitians	9,474	36	9,603	38	9,470	38
Exercise	1,221	5	1,694	7	1,342	5
Pharmacists	23,337	64	22,741	62	24,450	67
Physicians	43,937	120	50,825	139	46,516	127

- Of the nurse encounters:
  - 9% of clients were recommended to call 9-1-1,
  - 32% recommended to visit the emergency department or health care provider within hour,
  - 25% recommended to visit their physician or clinic within 12 hours,
  - 5% recommended to make an appointment with their primary care provider within 1-2 weeks, and
  - 29% provided self-management support and health education.
- Of the physician consultations:
  - 18% of patients recommended to visit the emergency department,
  - 8% recommended to seek care with a primary care provider,
  - 26% recommended to schedule an appointment with physician within 1–2 weeks, and
  - 48% provided self-management support and health education.
  - Physicians have diverted 61% of calls where an HLBC nurse had initially referred the patient to an emergency department or Urgent and Primary Care Centre.
- Virtual Physician Services: Since launch on April 6, 2020, to December 31, 2024, physicians have provided 206,870 patient consults. For continuity of care, the medical consult is shared with community providers via CareConnect.[6]

LAST UPDATED

Content is current as of February 7, 2025, as confirmed by Sandra Sundhu.

APPROVALS

2025 02 11 – Ted Patterson, ADM, Primary Care Division
2025 02 26 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[4] Symmetrics NVISION Data Mart, *BIU23_ NAV_ Org*, 2023, HealthLink BC; KDR Data Mart, *Project BIU23_NS_Org, Project BIU23_DS_Org, Project BIU23_PAS_Org, Project BIU23_PS_Org, HEiDi_Summary_2023*, 2023, HealthLink BC
[5] Symmetrics NVISION Data Mart, *BIU23_ NAV_ Org*, 2023, HealthLink BC; KDR Data Mart, *Project BIU23_NS_Org, Project BIU23_DS_Org, Project BIU23_PAS_Org, Project BIU23_PS_Org, HEiDi_Summary_2023*, 2023, HealthLink BC
[6] KDR_Genesys_PHR Data Mart, *HEiDi_Summary_2023*, 2023, HealthLink BC

LEGISLATIVE SESSION – ESTIMATES NOTE

Indigenous Primary Care Initiatives

Topic: Enhancing access to culturally safe primary care for Indigenous people is a key focus of the Ministry of Health's Primary Care Strategy, in alignment with the United Nations Declaration on the Rights of Indigenous Peoples.

Key Messaging and Recommended Response:

- In order to meet the health and wellness needs of First Nations people, it is important that primary care is culturally safe and trauma-informed, and Indigenous ways of knowing and being are woven into health care services.
- The Ministry's Primary Care Strategy enables access to culturally safe care through various models of care including Primary Care Networks, Community Health Centres, Urgent and Primary Care Centres, and First Nations-led Primary Care Centres, as well as virtual care options.
- Through partnership with the First Nations Health Authority and local partners, we have opened three First Nations-led Primary Care Centres in rural and urban locations throughout BC, and staffed with primary care providers:
    - Lu'ma Medical Centre opened in October 2019 in Vancouver.
    - All Nations Healing House opened in October 2022 in Williams Lake.
    - Northern Nations Wellness Centre opened in August 2024 in Chetwynd.
- Eleven more First Nations-led Primary Care Centres have opened their doors and are in early hiring stages for team-based care positions such as Elders, nurses or mental health and wellness providers.
- These centres provide access to culturally safe, quality primary health care services primarily for First Nations people and their families, where they feel safe, welcomed, valued, respected and heard when they access care.
- First Nations-led Primary Care Centres meet the health needs of Indigenous people blending both western and traditional approaches to health and look to the knowledge of Elders within the care team.
- More than 60 health care professionals, Elders and traditional wellness workers have been recruited to deliver culturally safe care through these centres to date.

CURRENT SITUATION

- As of January 2025, three First Nation-led Primary Care Centres (FNPCCs) are open and delivering primary care through a family doctor or nurse practitioner.
- Eleven FNPCCs are approved with funding and are in early hiring stages for team-based care roles, but not yet providing primary care services through a family doctor or nurse practitioner (Éyameth' Health Centre, Nuu-chah-nulth, Dadzi Wellness Centre, Gitxsan & Wet'suwet'en, Fraser West, Kwakwaka'wakw, es zúmin, Coast Salish, Nlaka'pamux, northern St'át'imc, and Nuxalk & Ulkatcho).[1]
- 60.20 full-time equivalents (FTEs) have been recruited for the three FNPCCs which are open and delivering primary care services, as well as early hiring efforts for the eleven FNPCCs that are open but not yet providing primary care through a family doctor or nurse practitioner.[2]

Primary Care Networks (PCNs)

- Local community PCNs engage with First Nations and Indigenous health organizations during service plan development and implementation. Representatives from each are members of PCN Planning and Steering Committees, active in PCN governance, and some are serving as PCN co-chairs.

[1] First Nations Health Benefits & Services; First Nations Health Authority. (2024). FNPCI Timeline Tracker. Data as of December 31, 2024.
[2] Divisional Services Branch, Primary Care Division, Ministry of Health. Workforce Report P10. Data as of January 2, 2025.

- Through the Primary and Community Care Governance Refresh, the Family Practice Services Committee (FPSC) introduced changes to improve patient access to quality primary care. The refresh includes enhancing authentic engagement with First Nations, Indigenous, and Métis partners, empowering physician leadership and community connections, and other improvements.[3]

First Nations-led Primary Care Centres (FNPCCs)

- As of January 2025, there are three FNPCCs with most responsible providers (e.g. physicians, nurse practitioners, and/or nursing staff) that are open and serving the public. There are eleven FNPCCs that have had their service plans approved and are not yet open.[4] Fraser South Wellness Centre FNPCC (Langley/Abbotsford/Chilliwack) is awaiting service plan approval.[5]

Provincial Partnerships

- Established in 2013, the Joint Project/Priorities Board (JPB) is a First Nations Health Authority (FNHA) and Ministry partnership supporting 27 primary and community care projects.[6]
- In Plain Sight (IPS) recommendations are actioned in part through the co-chaired Ministry and FNHA Indigenous Cultural Safety and Humility (ICSH) in Primary and Community Care Provincial Working Group. Established in 2021, the group includes Ministry and FNHA representatives with Métis Nation BC, health authorities, Doctors of BC, Colleges, and health system partners.
- The ICSH Working Group's focus is to design an ICSH Engagement and Learning Pathway for community-based physicians and primary care teams leveraging existing ICSH materials and and partnerships to improve relational and culturally safe practice(s) with Indigenous Peoples.

Culturally Safe Virtual Health Services

- In March 2020, primary care practitioners began providing virtual patient care to limit COVID-19 exposure. As part of the Rural, Remote, First Nations, and Indigenous COVID-19 Response Framework and by working in partnership with the FNHA, the Ministry leveraged virtual technologies to reduce inequities in accessing services for rural, remote, and Indigenous communities.
- FNHA's First Nations Virtual Doctor of the Day (FNvDOD) and First Nations Virtual Substance Use and Psychiatry Service (FNvSUPs) provide Indigenous clients and families with access to virtual family physicians, psychiatrists, and addictions specialists, all specialized in culturally safe care.
- Since implementation (April 1, 2020 for FNvDOD and August 17, 2020 for FNvSUPS) to December 31, 2024, there were 50,529 FNvDOD encounters and 7,984 FNvSUPS encounters. From April 1, 2024, to December 31, 2024, there were 8,546 FNvDOD encounters and 1,209 FNvSUPS encounters.[7]

Cultural Safety and Humility Standards

- The Ministry has provided FNHA funding of $1,634,647 between June 1, 2023 and March 31, 2026 to support the development and implementation of an Indigenous Cultural Safety and Humility (ICSH) Engagement and Learning Pathway for Community-Based Physicians and Primary Care Teams. This includes $1.42 million for 4.0 new FTE positions and $210,000 to support additional one-time and ongoing costs.[8]

FINANCIAL IMPLICATIONS

The Ministry provided the following funding in fiscal year 2024/2025 to support Indigenous Primary Care Initiatives throughout BC:

- Government Financial Information; Intergovernmental Communications

[3] Family Practice Services Committee. (2023). Refreshed approach to Primary Care Networks. fpsc-pdc_strategy-20230915-web.pdf, Last accessed January 25, 2025.
[4] First Nations Health Benefits & Services; First Nations Health Authority. (2024). FNPCI Timeline Tracker. Data as of December 31, 2024.
[5] First Nations Health Benefits & Services; First Nations Health Authority. (2024). FNPCI Timeline Tracker. Data as of December 31, 2024.
[6] Indigenous Health and Reconciliation, Ministry of Health. (2021). Joint Project Board: Year in Review 2020/21. Data as of June 14, 2021.
[7] Planning, Implementation and Oversight Branch; Primary Care Division, Ministry of Health. (2025). Real Time Virtual Supports Updated Statistics 01.23.25. Data as of January 23, 2025.
[8] Planning, Implementation and Oversight Branch; Primary Care Division, Ministry of Health. (2023). FNHA Funding Letter for ICSH Provincial Working Group. Data as of January 23, 2025
[9] Data retrieved from PCD FNHA 24-25 budget

- Government Financial Information; Intergovernmental Communications
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KEY BACKGROUND

- The Ministry is committed to enhancing the health and wellbeing of Indigenous peoples, as identified through the United Nations Declaration on the Rights of Indigenous Peoples, the Truth and Reconciliation Commission, and the IPS recommendations that are being actioned through First Nations health plans and agreements, as is mental health and wellness and substance use, Indigenous recruitment, anti-racism, cultural humility, and trauma-informed training.

LAST UPDATED

The content of this factsheet is current as of February 12, 2025 as confirmed by Kelly McQuillen

APPROVALS

2025 02 14 – Ted Patterson, Primary Care Division
2025 02 24 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division
2025 02 18 – Lenore Ogilvy obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division

[10] Planning, Implementation and Oversight Branch; Primary Care Division, Ministry of Health. (2024). FNHA Funding Letter 24-25. Data as of March 6, 2024.
[11] Planning, Implementation and Oversight Branch; Primary Care Division, Ministry of Health. (2024). NHA Funding Letter 24-25. Data as of March 6, 2024.
[12] Data retrieved from Ministry of Health 24-25 Funding Letters for Primary Care Networks.
[13] Indigenous Health and Reconciliation, Ministry of Health. (2021). Joint Project Board: Year in Review 2020/21. Data as of June 14, 2021.

LEGISLATIVE SESSION – ESTIMATES NOTE

Maternity/Newborn Services in Primary Care

Topic: Government response to addressing primary care maternity and newborn services in BC.

Key Messaging and Recommended Response:

- The Ministry's 2025/26 mandate letter states our commitment to improving the delivery of maternity and reproductive care for people throughout the province. In primary care, this includes:
    - The Longitudinal Family Physician (LFP) payment model, which expanded in June 2024 to include family doctors who provide maternity and newborn care in facilities (e.g., hospitals), fairly compensating them to provide maternity care where and when patients need it.
    - Supporting family doctors providing facility-based maternity services with on-call payments through the Medical On-Call Availability Program.
    - The 2022-2025 Midwifery Main Agreement, which creates a new contract option for midwives and commits to development of an alternative funding model similar to the LFP for midwives.
    - Making team-based care resources available through Primary Care Networks and the Nurse in Practice program to increase capacity of primary care maternity services throughout the province.
    - Funding several maternity programs, including a Maternity Network, Maternity Care Risk Assessment, Maternity Care for BC and a Maternity Care Grant, through the Family Practice Services Committee – a partnership between Doctors of BC and the Ministry of Health.
    - Supporting the Maternity and Baby Advice Line (MaBAL), which offers rural, remote, and Indigenous primary care providers with 24/7 virtual access to family doctors with expertise in maternal/newborn care.
- Primary Care Networks are improving service planning and development for maternity and newborn services throughout BC, with the goal to increase access to maternity and newborn services across the primary care system.

CURRENT SITUATION

- The Ministry mandate includes a commitment to improving the delivery of maternity and reproductive care for people across the province through targeted initiatives.[1]
- The Primary Care Division is collaborating with the Nursing Policy Secretariat (NPS), Hospital Services Division, Health Sector Workforce and Beneficiary Services, and the Provincial Health Services Authority (PHSA) on a province-wide maternity care strategy.
- There are three types of providers whose scope of practice includes intrapartum (i.e., labour and delivery) care: family physicians (FPs), registered midwives, and Obstetric/Gynecology specialists (OBGYNs). These providers are further supported by pediatricians and nurses. Providers can also work closely with nurses and nurse practitioners (NPs) whose scope of practice includes antenatal and postnatal care.
- Addressing compensation is a key strategy for improving recruitment and retention of FPs to provide maternity care services.
    - In June 2024, an amendment to the Longitudinal Family Physician (LFP) payment model expanded eligible billing to include pregnancy and newborn care provided in facilities. Previously FPs on the LFP payment model could only bill for maternity care provided in their own family practice clinics. As of Q3 2024/25 (June-December 2024), FPs billed for 158,282 service units related to Pregnancy and Newborn Services, amounting to a total of $9.867M

[1] BC Ministry of Health, Minister Mandate Letter: mandate_letter_josie_osborne.pdf. January 16, 2025.

  - Similarly, as of December 1, 2023, FPs providing maternity call coverage (inclusive of labour and birth care in hospital) became eligible to receive on-call availability payments through the Medical On-Call Availability Program (MOCAP).
- Family Practice Services Committee (FPSC) maternity programs include a Maternity Network, Maternity Care Risk Assessment, Maternity Care for BC (MC4BC), and a Maternity Care Grant (stabilization).
  - As of Q1 2024/25 (April – June 2024), 317 FPs providing maternity care in hospitals received the Maternity Care Network Grant, totaling $1.582M.
  - As of Feb 28, 2025, the 14010 Maternity Care Network fee was billed by 435 FPs for a total of $2.41M.[2]
- Alternative Payment Program (APP) service contracts have been put in place in the past year to stabilize facility-based FP maternity services provided by family physicians for patients in Kamloops, Kelowna, and Victoria. APP is anticipating the implementation of similar APP contracts in at least three additional communities in the province – all are in early discussions.
- Service contracts put in place to support the continued delivery of midwifery maternity services in Hazelton, Haida Gwaii, Invermere, Salt Spring Island, Port Hardy and Powell River have been increased from 2 to 3 full-time equivalents (FTEs) in each community to ensure adequate cross coverage, prevent burnout and account for leave time (e.g., vacation, sick time).
- Under the new Midwifery Main Agreement, the Ministry commits to developing both a service contract compensation model and a new payment model for midwives, similar to the LFP payment model for FPs. Collaborative work on these models is underway.
- Primary Care Networks (PCNs) are mapping maternity services and capacity in each of their communities to support planning and policy development.

FINANCIAL IMPLICATIONS

- The Ministry's budget includes $579.09M in 2024/25 to support the continued implementation of Primary Care Strategy Initiatives (including PCNs, Urgent and Primary Care Centres, Community Health Centres, and Family Physician-and Nurse Practitioner- led clinics).

KEY BACKGROUND

- The number of births in BC has steadied over the last four years with 44,082 births reported in 2021, 41,934 births in 2022, 41,406 births in 2023, and 43, 887 in 2024.[3]
- Low-risk maternity care is part of the comprehensive basket of services PCNs are expected to provide to their local populations. This includes sexual health promotion, preconception counselling, and health promotion services through all stages of the perinatal period, as well as access to contraception, abortion services and post-abortion care.
- Recruitment and retention of primary care maternity service providers is a significant challenge:
  - Since 2010, the number of FPs providing birth delivery (intrapartum) services dropped 39.6% (874 in 2010/11 vs 528 in 2023/24).[4]
  - Of the 642 midwives registered to practice in the province, 446 are actively practicing.[5]
- Since 2020, the Ministry has provided funding support to the Maternity and Baby Advice Line (MaBAL), which offers rural, remote, and Indigenous primary care providers with 24/7 virtual access to FPs with expertise in maternal/newborn care. From August 2020 to December 2024, MaBAL received 5,028 calls and 2,180 encounters.[6]

LAST UPDATE

The content of this estimates note is current as of February 11, 2025, as confirmed by Jeremy McLay.

APPROVALS

2025 02 11 – Ted Patterson, Primary Care Division
2025 03 07 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 02 28 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division

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[2] Extracted February 28, 2024, from MSP using fee item 14010 by HSIAR. Data as of February 2025.
[3] HSIAR Vital Events: birth events data extracted February 13, 2025. Data for 2024 subject to change as some births may not be registered.
[4] Extracted February 28, 2024, from MSP using claim specialty codes 00, 50, 76 and fee items for induction of labour, labour management and delivery by HSIAR. Data as of February 2025.
[5] BC College of Nurses and Midwives registration statistics report for NPS, as of January 5, 2025.
[6] Planning and Implementation Oversight Branch; Primary Care Division, Ministry of Health. (2025). Real Time Virtual Supports Updated Statistics 01.23.25. Data as of January 23, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Mental Health and Substance Use in Primary Care

Topic: Access to quality, culturally safe, person and family-centred mental health and substance use primary care services.

Key Messaging and Recommended Response:

- A key focus of the Ministry's Primary Care Strategy, and expectations of Primary Care Networks, is that we provide *comprehensive, team-based* primary care, including appropriate and timely care for people when they are struggling.
- This expectation includes mental health and substance use services delivered through screening, assessment and management of mild to moderate conditions, and ensuring effective transitions of care to the nearest specialized community services program as needed.
- More than 90% of BC's Primary Care Networks are recruiting to deliver these health services across primary care settings, including through family physicians, nurse practitioners, Indigenous health providers, mental health clinicians, clinical counsellors and social workers.
- More than 355 care providers have been hired to specifically support the mental health and wellness of patients in BC communities – this is on top of the family doctors, nurse practitioners and other staff supporting people every day.
- The Ministry also offers First Nations Virtual Substance Use and Psychiatry Services, delivered by the First Nations Health Authority, which supports First Nations people's access to virtual appointments with doctors.
- And as part of government's agreement with the BC Green party, discussions on how we can work with the British Columbia Psychological Association to expand access to psychologists, potentially within primary care settings, are ongoing.

CURRENT SITUATION

- The majority of Primary Care Networks (PCNs) (approximately 77%) offer some level of focused primary care mental health and substance use (MHSU) services.[1]
- Specific examples of MHSU-specific primary care include:
    - **Province-wide** longitudinal primary care services are available in Foundry Centres: approximately 20 full-time equivalents (FTEs) of Family Physicians (FPs) providing primary care services at ~20 Foundry Centres currently open or under development, including Foundry Virtual.
    - **Vancouver Coastal Health** is prioritizing MHSU use resources, including PCN clinical counselling.
    - **Fraser Health**: All PCNs communities in implementation have focused MHSU primary care resources through community partnerships. For example, the Burnaby PCN supported the Indigenous-led Burnaby Dudes club, providing advocacy of MHSU care. The Fraser Northwest PCN is supporting Rapid Access Mental Health Program.
    - **Interior Health:** Cranbrook, Kelowna, Williams Lake and Penticton PCNs have Foundry Centres.
    - **Island Health:** The Island Sexual Health Community Health Centre (CHC) in Victoria provides MHSU services; Foundry is partnering with Campbell River and District, Comox Valley, North Vancouver Island and Victoria PCNs; and the Nanaimo Urgent and Primary Care Centre (UPCC) and Laichwiltach CHC provide Opioid Agonist Therapy (OAT) services.

[1] Divisional Services Branch, Primary Care Division, Ministry of Health, PC DataCite HR Records Report. Data as of January 30, 2025.

  - **Northern Health:** All PCN communities apart from the Nisga'a PCN region have focused MHSU primary care resources. For example, the Carrier Sekani Family Services Foundry is partnering in the Northern Interior Rural PCN.
- As of January 2025, 77% of the 92 PCNs in implementation have successfully recruited MHSU care providers who deliver primary MHSU care services.[2]
- Of the 2,283.55 FTEs recruited under the broader primary care strategy, 355.24 FTEs are delivering dedicated MHSU care services (see Table 1), with more to come as the number of PCNs and associated clinics grows.[3]
- Commitment 2 in the *BC Greens – BC NDP Agreement in Principle* states that the Government will work with the British Columbia Psychological Association (BCPA) to expand public coverage for psychologists with an investment of $50M. Discussions are ongoing to determine details, with the potential for some psychologist resources to be placed in primary care settings.

Table 1: Primary care – total (355.24) clinical MHSU care providers recruited as of January 2025[4]

Resource	CHC	FNPCC	NPPCC	PCN	UPCC
Counsellor	2.93	-	3.00	47.00	4.93
Community Health Worker	18.35	-	-	3.00	-
Life Skills Worker	-	-	-	6.00	-
Mental Health Clinician	3.00	1.00	-	43.86	10.42
Mental Health Professional (Indigenous)	-	2.00	-	1.00	-
Psychologist	-	-	-	2.10	-
Social Worker & Disciplines Allied to Social Work	12.83	2.80	2.60	144.02	40.40
Social Worker/Navigator (Indigenous)	-	3.00	-	1.00	-
Totals	**37.11**	**8.80**	**5.60**	**247.98**	**55.75**

FINANCIAL IMPLICATIONS

- The Ministry has committed $48.82M towards MHSU recruited resources throughout the Primary Care Strategy Initiatives as outlined in Table 1.
- The Ministry's budget includes $579.09M in 2024/25 to support the continued implementation of Primary Care Strategy's Initiatives (including PCNs, UPCCs, CHCs, and Family Physician-and Nurse Practitioner- led clinics), and $627.82M for 2025/26.

KEY BACKGROUND

- The Ministry's PCN policy requires that PCNs provide comprehensive primary care services, including MHSU services such as screening, counselling, pharmacological treatment, medication monitoring, crisis intervention services, harm reduction resources, and OAT services.
- Primary care practitioners and PCNs also enable effective transitions of care to and from health authority specialized community services programs when more specialized care is needed.
- In August 2024, the Province launched the Opioid Treatment Access Line, a resource for patients to make it faster and easier to access life-saving OAT and get connected to same-day care. This is also a positive resource for primary care providers with patients with substance use needs that they are not comfortable or professionally equipped to provide.
- The Guidelines and Protocols Advisory Committee has produced five clinical practice guidelines and a learning document to support primary care practitioners in the effective treatment of several MHSU conditions.

[2] Divisional Services Branch, Primary Care Division, Ministry of Health, Primary Care DataCite HR Records data extracted Jan 30, 2025; FY2024/25 P10 Financial report direct submissions from Health Authorities (CHCs and FNPCCs), January 2025
[3] Divisional Services Branch, Primary Care Division, Ministry of Health, FY2024/25 P10 Workforce Report. Data from Dec 6, 2024, to Jan 2, 2025
[4] Divisional Services Branch, Primary Care Division, Ministry of Health, Primary Care DataCite HR Records data extracted Jan 30, 2025; FY2024/25 P10 Financial report direct submissions from Health Authorities (CHCs and FNPCCs), January 2025

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this factsheet is current as of February 12, 2025, as confirmed by Jeremy McLay.

APPROVALS

2025 02 14 – Ted Patterson, Primary Care Division
2025 02 19 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 27 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Nursing in Primary Care

Topic: Integration of Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses into team-based, longitudinal primary care.

Key Messaging and Recommended Response:

- Nurse practitioners (NPs), registered nurses (RNs) and licensed practical nurses (LPNs) play vital roles in primary care, including optimizing team-based care, enhancing the patient experience of care and improving population health.
- NPs are an integral part of the government's Primary Care Strategy, providing comprehensive services in longitudinal care, urgent care, episodic care and priority population settings.
- Across all Primary Care Initiatives since 2018 including Primary Care Networks, Urgent and Primary Care Centres, and Nurse Practitioner-led Primary Care Centres, 432 primary care NPs have been recruited, representing 382.21 full-time equivalents (FTEs) since 2018.[1]
- NPs have also attached more than 152,000 patients in BC since 2018, providing a longitudinal primary care relationship to people who previously lacked access to a consistent primary care provider.
- 662.87 FTE nurses (RNs and LPNs) have been hired to date across all longitudinal and episodic primary care initiatives funded through the primary care strategy.[2]
- In February 2024, the Ministry implemented the provincial Nurse in Practice program, which provides eligible longitudinal and focused primary care practices funding to hire RNs and LPNs.
    - In 2024/25, 89 primary care clinics were approved to recruit up to 109.5 nurse FTEs to support team-based care delivery.

CURRENT SITUATION

- As of January 2, 2025, across all primary care initiatives underway under this government's primary care strategy, 432 nurse practitioners (NPs) or 382.21 full-time equivalents (FTE) (65.9%) of the approved 580.12 FTE NPs, have been recruited:[3]
    - 274.56 FTE in Primary Care Networks (PCNs),
    - 9.53 FTE in Community Health Centres (CHCs),
    - 1.95 FTE in First Nations-led Primary Care Centres (FNPCCs),
    - 19.70 FTE in Nurse Practitioner-led Primary Care Centres (NPPCCs), and
    - 76.47 FTE in Urgent and Primary Care Centres (UPCCs).
- NPs have attached more than 152,000 patients since April 2018.
- An estimated 85% of total hired NPs are self-employed on a PCN NP service contract and 15% are health authority or CHC employed.[4]
- Of the approximately 1150 NPs practicing in BC, 550 work in primary care settings.[5]
- As of Feb 2024, approximately 50% of the NP positions for longitudinal primary care are funded through the Primary Care Strategy and the remaining are positions that pre-date the Primary Care Strategy funded by previous Ministry of Health (Ministry) programs such as Nurse Practitioners for British Columbia (NP4BC), or through Health Authority global operating funds.[6]

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[1] Divisional Services Branch, Primary Care Division, Ministry of Health. Workforce Report P10. Data as of January 2, 2025.
[2] Ibid.
[3] Ibid.
[4] Health Sector Workforce and Beneficiary Services, Nursing Policy Secretariat, Ministry of Health. NP workforce data analysis. Data as of February 2024.
[5] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 Workforce Report, FY2024/25. Data as of January 2, 2025.
[6] Health Sector Workforce and Beneficiary Services, Nursing Policy Secretariat, Ministry of Health. NP workforce data analysis. Data as of February 2024.

- As of January 2025, 592 NPs have uploaded their panels to the Provincial Attachment System (PAS) and 442 NPs have indicated they have capacity to attach new patients.[7] PAS can be used to facilitate new attachment to NPs to support them in building their panels and help them in meeting panel size requirements.
- There are three Ministry-funded NP Primary Care Centres in operation in Nanaimo, Surrey and Victoria with a total hired staffing of 27.23 FTEs of 31.0 approved FTE[8], and 15,375 patients attached. Of these 27.23 FTEs, there are 19.7 NPs, 5.6 nurses and 1.93 Allied Health Practitioners
    - A unique service model under the primary care strategy, NPPCCs are developed by NPs who work within a collaborative, team-based environment and as part of local PCNs. The Ministry works collaboratively with local Divisions of Family Practice and health authorities to support integration of the NPPCCs in PCN planning at the community level.
- Registered nurses (RNs) and licensed practical nurses (LPNs) work collaboratively in an integrated, coordinated manner with a complement of interdisciplinary providers and the persons/populations they serve, to support the health and well-being of individuals, families, groups, communities, populations, and systems.
- Recruitment of RNs and LPNs in the primary care strategy to date (episodic – including UPCCs – and longitudinal) include 662.87 FTEs hired of the 944.33 FTEs approved .[9,10]
- Distinct from the above numbers, the Ministry also provides funding directly to family practice clinics to support recruitment of RNs and LPNS through the Nurse in Practice (NinP) Program:
    - Launched in February 2024, the NinP program provides funding to longitudinal family practices and focused primary care practices serving priority populations to recruit and hire RNs and LPNs to work as part of their core clinical practice team.
    - As of January 2025, 108.5 NinP Nurse FTEs have been approved for funding with 43 contracts executed with primary care clinics. An additional 55 funding applications are under review.[11]
    - The provincial Nurse in Practice Program builds on a pilot program launched in Kelowna in 2017 that provided funding to integrate RNs and LPNs into physician family practices.
    - While the Ministry leads the program's delivery and implementation, the Family Practice Services Committee supports the planning and implementation, and Nurses and Nurse Practitioners of BC, along with the Ministry's Nursing Policy Secretariat, support nurses in approved contracts as they integrate into clinics and practice within them.

FINANCIAL IMPLICATIONS

- As of January 2025, the Ministry has committed:
    - $6.27M in annual operating costs (including NP, RN, Allied Health Provider salaries and overhead) for three NPPCCs currently in implementation, $1.70M in one-time start-up costs and $0.54M in change management costs.
    - $148.80M towards NPs in Primary Care (including the salaries of NPs working in NPPCCs), through all of BC's team-based care models currently in implementation.
    - $129.34M towards Nursing resources in implemented PCNs.
    - $3.66M in 2021/22, $4.34M in 2022/23, $5.34M in 2023/24, $8.2M in 2024/25, $9.1M in 2025/26 and $10M in 2026/27 to support the Provincial Initiatives Program delivered by NNPBC.
- Funding for the Nurse in Practice program for FY2024/25 is projected to be up to $4.12M, $20.08M in 2025/26, $36.58M in 2026/27 and $49.88M in 2027/28, with the full annual ongoing funding forecasted to be ~$66.50M at full implementation.

[7] Health Sector Information, Analysis & Reporting. Provincial Attachment System. Data as of January 31, 2025. Access on February 27, 2025.
[8] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 Workforce Report, FY2024/25. Data as of January 2, 2025.
[9] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 Workforce Report, FY2024/25. Data as of January 2, 2025.
[10] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 Workforce Report, FY2024/25. Data as of January 2, 2025.
[11] Divisional Services Branch, Primary Care Division, Ministry of Health. NinP_App_Data_Tracker_MASTER. Data as of January 2, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- NPs are autonomous practitioners with a broad scope of practice, providing primary care such as: assessing patients; ordering and interpreting diagnostic tests; diagnosing and managing acute and chronic illnesses, medical conditions and injuries; conducting screening health assessments; prescribing medication and other interventions; and referring patients to specialists and other care providers as needed.
- Within primary care settings, RNs or LPNs may undertake key functions, including triaging concerns, conducting assessments, facilitating care by the FP/NP, and fulfilling key clinical functions including health promotion and disease/injury prevention, and care coordination.

LAST UPDATED

The content of this estimates note is current as of February 7, 2025, as confirmed by Jeremy McLay.

APPROVALS

2025 02 11 – Ted Patterson, Primary Care Division

2025 03 03 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

2025 02 28 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Primary Care Networks

Topic: Primary Care Networks (PCNs) are geographically based, locally planned, and coordinated systems of care where family practices, Urgent and Primary Care Centres, Community Health Centres, First Nations-led Primary Care Centres, Foundry Clinics, and Nurse Practitioner Primary Care Centres deliver longitudinal and episodic primary care services.

Key Messaging and Recommended Response:

- Primary Care Networks (PCNs) are a key element of the Primary Care Strategy, launched in 2018 to increase patient attachment and access to quality, comprehensive, culturally safe, and person-centered primary care.
- Patients are supported through a team of health care providers, including family doctors, nurse practitioners, registered nurses, pharmacists, social workers, mental health professionals, and Indigenous and community providers.
- PCNs work with the community to develop local health care solutions to meet the unique needs of their communities.
- Providers in PCNs understand a person's health history and seamlessly connect them with the right service, at the right time. As part of the network, patients can maintain an ongoing relationship with primary care providers.
- Working together, primary care providers:
    - Enhance patient care using a team-based approach to care.
    - Support each other and work to their unique strengths and skillsets.
    - Ensure patients are linked to other parts of the system, including specialized community services programs for high risk and vulnerable population groups.
    - Collectively work to increase access and attachment to primary care.
- The development of PCNs is led by the Ministry of Health in partnership with Doctors of BC, Nurses and Nurse Practitioners of BC, Health Authorities, Divisions of Family Practice, Indigenous partners, patient and community representatives, and other partners.
- As of January 2025, $440 million in annual funding is committed to support the implementation of 92 PCNs, which will service 94% of BC's population
- As of January 2025, 2,284 full-time equivalents (FTEs) have been hired across the 92 PCNs across all models of care to support team-based primary care
- Putting patients at the center of health care delivery, BC is implementing team-based primary care through various models of care under the PCN umbrella.

CURRENT SITUATION

- The total Community Health Service Areas (CHSAs) covered by PCNs in implementation is 91% of all CHSAs, equating to 94% of the provincial population.[1]
- PCN CHSA coverage by Health Authority (from highest to lowest population coverage)[2]:
    - Vancouver Coastal: 99% of their population and 93% of CHSAs in their region.
    - Northern Health: 98% of their population and 95% of CHSAs in their region.
    - Vancouver Island: 98% of their population and 92% of CHSAs in their region.
    - Interior Health: 96% of their population and 88% of CHSAs in their region.
    - Fraser Health: 89% of their population and 89% of CHSAs in their region

[1] Divisional Services Branch, Primary Care Division, Ministry of Health. RMO CHSA PCI Mapping Tracker FY24/25 P10, utilizing 2021 Census data
[2] Divisional Services Branch, Primary Care Division, Ministry of Health. RMO CHSA PCI Mapping Tracker FY24/25 P10, utilizing 2021 Census data

- As of January 2025, 2,283.55 full-time equivalents (FTEs) have been hired into the 92 PCNs across all models of care.[3] 1,445.77 FTEs have been hired for the PCNs[4]:
    - 1,081.09 FTEs have been hired across 41 steady state[5] PCNs (20 communities);
    - 134.42 FTEs have been hired across 14 PCNs in Year 4 (4 communities);
    - 107.80 FTEs have been hired across 9 PCNs in Year 3 (3 communities);
    - 92.38 FTEs have been hired across 16 PCNs in Year 2 (9 communities); and
    - 30.08 FTE have been hired across 12 PCNs in Year 1 (8 communities).

FINANCIAL IMPLICATIONS

- The Ministry's budget includes $579.09M in 2024/25 to support the continued implementation of Primary Care Strategy's Initiatives (including PCNs, Urgent and Primary Care Centres, Community Health Centres, and Family Physician- and Nurse Practitioner- led clinics), and $627.82M for 2025/26.
- As of January 2025, the Ministry has committed to fund $440M in annual operating costs for the 92 PCNs currently in implementation once fully implemented, $52.57M in capital, $14.28M in one-time start-up costs and $48.30M in change management costs. (See: PCN Supplemental Financial Breakdown)

KEY BACKGROUND

- PCNs are supported by local PCN Steering Committees that reflect and prioritize community primary care needs. They create and adjust service plans, outline current primary care gaps, and identify resources required to fill the gaps through access to interdisciplinary team-based care.
- PCN Steering Committees focus on the PCN in the community while newly refreshed Collaborative Steering Committees focus on the interface between primary care and specialized community service programs operated by the regional health authorities.
- In a PCN, patients get access to timely, comprehensive and coordinated team-based care, guided by ten core attributes (originally eight):
    1. *Longitudinal Care*: Delivery of longitudinal primary care to everyone within a PCN via attachment to a primary care provider or enrollment to a clinic (where applicable).
    2. *Coordinated Care*: Coordination of primary care across all parts of the health system, including, for example, community service programs, specialist care, diagnostic services, emergency services, hospital care, facility-based care.
    3. *Timely Access*: Access to episodic or longitudinal primary care within 24 hours for urgent, non-life-threatening conditions, and within 7 days for non-urgent appointments.
    4. *Extended Hours*: Availability of extended clinic service hours for in-person primary care services during weekdays (5 pm to 8 pm), weekends (9 am to 5 pm) and statutory holidays (9 am to 5 pm); and access to virtual services after-hours.
    5. *Comprehensive Care*: Access to a full-range of comprehensive primary care services including clinical screening, diagnostic testing and treatment provided through different clinical settings (e.g., community-based clinics, virtual care services, mobile outreach, long-term care facilities, in-patient care facilities).
    6. *Team-Based Care*: Intentional commitment to health care practitioners from different professional backgrounds (e.g., physicians, nurse practitioners, nurses, allied health providers, traditional wellness providers and administrative staff) working together as integrated primary care teams within clinics and across the network.
    7. *Population Health Promotion*: Commitment to improving population health outcomes at a community level through collaboration in primary care and with other sectors. **NEW**

[3] Divisional Services Branch, Primary Care Division, Ministry of Health. RMO FY 2024/25 Period 10 Workforce Report, Dec 6, 2024 to Jan 2, 2025
[4] Divisional Services Branch, Primary Care Division, Ministry of Health. RMO FY 2024/25 Period 10 Workforce Report, Dec 6, 2024 to Jan 2, 2025
[5] Steady state is defined as in year 5 or more of implementation, as per Service Plan template and Funding Letter renewals, schedule 2.

8. *Digital Enablement*: Support innovation and improvements in care, and in particular, information continuity across care settings and team members, through the adoption of provincially/regionally endorsed digital technology solutions.
9. *Culturally Safe Care*: Commitment to truth, reconciliation, and humility, ensuring provision of care that is culturally safe, addresses and eliminates racism and discrimination, and respects the dignity, well-being, and unique health care needs of Indigenous Peoples.
10. *Equitable Access*: Removal of systemic barriers to ensure everyone is supported in achieving good health and wellbeing, regardless of age, ability, socio-economic status, ethnicity, gender, sexuality, or geographic location. **NEW**

- PCNs are funded to include nurses and allied health providers that are most often employed by the regional health authority, located in hubs, and can be accessed by referrals from a family physician. Alternatively, these may be employed in primary care clinics who hire directly.
- Most often, direct-hiring occurs in non-profit models of care (e.g. Community Health Centres, Indigenous-focused or Nation-based clinics).
- PCNs identify what type of nurse and/or allied health provider will be hired based on the needs of the community. Although there is no universal definition of allied health providers, typically PCNs seek chronic disease nurses, pharmacists, dietitians, social workers and occupational and/or physical therapists.
- PCNs may also include a traditional wellness worker (TWW) to their Allied Health Provider team or provide funding for a TWW for Indigenous-focused clinics in the catchment area.

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Kelly McQuillen.

APPROVALS

2025 02 14 – Ted Patterson, Primary Care Division
2025 02 20 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 02 26 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Primary Care Strategy Recruitment

Topic: Status of recruitment across all initiatives funded through the Ministry of Health's Primary Care Strategy, launched in May 2018.

Key Messaging and Recommended Response:

- The Ministry's mandate is clear: we must tackle the training, recruitment, retention, and system redesign needed to make sure our health human resources keep pace with the growing needs of people in BC and deliver better, faster care.
- Through the Primary Care Strategy, the Ministry is focused on recruiting more family doctors, nurse practitioners and other health care professionals, and ensuring family practice is an attractive field for new graduates, by:
    - Increasing the number of family physicians providing primary care. Between 2022/23 and 2023/24, the net number of family doctors working in longitudinal primary care increased to 5,364.
    - Since 2018, the number of nurse practitioners has almost tripled in BC to more than 1,200, including 178 new nurse practitioners registered in 2024.
    - Investing in team-based care by funding 3,420 new, full-time equivalent (FTE) resources under the Primary Care Strategy, including registered nurses, pharmacists, social workers, dietitians, physiotherapists, as well as Elders and traditional healers. To date, 2,283 FTEs have been recruited.
    - Introducing and expanding the new Longitudinal Family Physician Payment Model, which ensures fair compensation to doctors for their time. Now, 4,474 physicians are working under the model – a clear signal that the new compensation model is helping to recruit and retain them.
    - Implementing the provincial Nurse in Practice program, which provides eligible longitudinal and focused primary care practices funding to hire registered nurses and licensed practical nurses. In 2024/25, 89 primary care clinics were approved to recruit up to 109.5 nurse FTEs.
    - Making it easier to get international credentials recognized. Since January 2023, 1,355 internationally educated doctors and 1,319 internationally educated nurses have received full or provisional registration.
    - Investing in the New-to-Practice Incentive Program for newly graduated physicians, attracting more than 300 new doctors to primary care in BC.
- And it's working - BC has the second-most family doctors per capita of all provinces (*138 family doctors per 100,000 residents in BC compared to 141 per 100,000 in NB).*
- With partners like Doctors of BC and Nurses and Nurse Practitioners of BC, the Ministry is committed to supporting family doctors and nurse practitioners to stay in their profession, be inspired by their work and grow their expertise.
- To meet growing demand for health care services driven by BC's aging and growing population, as well as a global shortage of care providers, we are investing in a multi-front approach that supports the people who need care and the health care providers who offer it.

CURRENT SITUATION

- As of 2023/24, there were 5,364 Family Physicians (FPs) working in longitudinal primary care; an increase of 403 from 2022/23.[1]
- In addition, there were 1,205 Nurse Practitioners (NPs) working in the province, an increase of more than triple from 2017's 418.[2]
- Launched in 2023, the Longitudinal Family Physician (LFP) payment model better compensates family doctors for time spent with patients. As of January 31, 2025, 4,474 family doctors are actively working under the LFP model, with 62 in transition, and 1,069 working as locums under LFP.[3]
- As of January 2025, 2,283.55 approved full-time equivalent (FTE) resources have been recruited to support team-based care under the Primary Care Strategy. This includes FPs; NPs; registered nurses; pharmacists; social workers and other mental health workers; dietitians, physiotherapists and other allied health workers; Elders, traditional healers and cultural support workers:
    - 1,081.09 FTEs hired across 41 steady-state[4] Primary Care Networks (PCNs) (covering 20 communities)
    - 134.42 FTEs hired across 14 PCNs in Year 4 of implementation (covering 4 communities)
    - 107.80 FTEs hired across 9 PCNs in Year 3 of implementation (covering 3 communities)
    - 92.38 FTE hired across 16 PCNs in Year 2 of implementation (covering 9 communities)
    - 30.08 FTEs hired across 12 PCNs in Year 1 of implementation (covering 8 communities)
    - 629.49 FTEs hired in 42 Urgent and Primary Care Centres (UPCCs)
    - 27.23 FTEs hired in 3 Nurse Practitioner Primary Care Centres
    - 120.86 FTEs hired in 15 Community Health Centres (CHCs)
    - 60.20 FTEs hired in 14 First Nations-led Primary Care Centres[5]
- By profession, recruitment to date (episodic and longitudinal) includes:
    - 447.64 FTEs of FPs (of 588.01 FTEs approved)
    - 382.21 FTEs of NPs (of 580.12 FTEs approved)
    - 662.87 FTEs of Nursing Resources (of 944.33 FTEs approved)
    - 501.72 FTEs of Allied Health Professionals (of 861.34 FTEs approved)
    - 57.20 FTEs of Clinical Pharmacists (of 79.07 FTEs approved)
    - 160.29 FTEs of Administrative Staff including PCN managers (of 192.24 FTEs approved)
    - 71.62 FTEs of Indigenous Health Resources, including Elders, Traditional Healers, and Health Coordinators (of 175.55 FTEs approved)[6]
- Increasing the number of family physicians providing longitudinal primary care. Between 2022/23 - 2023/24, the net number of FPs working in longitudinal primary care increased by 403 from 4,961 to 5,364.[6] Breakdown by Health Authority:
    - Fraser – 1,513 (+114 from 2022/23)
    - Interior – 946 (+28)
    - Vancouver Coastal – 1,506 (+141)
    - Vancouver Island – 1,055 (+90)
    - Northern – 344 (+30)
- In February 2024, the Ministry implemented the provincial Nurse in Practice program, which provides eligible longitudinal and focused primary care practices funding to hire registered nurses and licensed practical nurses.
    - In 2024/25, 89 primary care clinics were approved to recruit up to 109.5 nurse FTEs to support team-based care delivery.[7]

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[1] Health Sector Information, Analytics & Reporting, Integrated Analytics: Primary Care. Data as of February 27, 2025.
[2] BCCNM Registration Statistics Report January 2025
[3] HSIAR Longitudinal Family Physician Payment Model Dashboard. Accessed February 27, 2025.
[4] Steady state is defined as in year five or more of implementation/operation
[5] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 Workforce Report. Data as of January 2, 2025. [Coast Salish, Dadzi Wellness Centre, es zúmin', Fraser West, Nlaka'pamux, and Nuxalk FNPCCs are approved and in implementation, not yet operational.]
[6] Divisional Services Branch, Primary Care Division, Ministry of Health. P10 Workforce Report. Data as of January 2, 2025.
[7] Divisional Services Branch, Primary Care Division, Ministry of Health. NinP_App_Data_Tracker_MASTER. Data as of January 2, 2025

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

The Ministry's budget includes $579.09M in 2024/25 to support the continued implementation of Primary Care Strategy's Initiatives (including PCNs, UPCCs, CHCs, and Family Physician-and Nurse Practitioner- led clinics), and $627.82M for 2025/26.

KEY BACKGROUND

- Since launching the New-to-Practice Incentives Program for FPs in summer 2022, as of January 2025, 365 new FPs committed to providing longitudinal primary care under the program[8], and more than 382 FTEs of NPs are working in longitudinal primary care under service contracts.
- The Ministry tripled the number of seats in the Practice Ready Assessment BC (PRA-BC) program, from 32 seats to 96 by March 2024.
    - Since 2015, 318 internationally trained family doctors have been placed in 77 communities in need.[9]
    - PRA-BC supports increased access to family physicians by requiring successful applicants to provide a three-year Return of Service in a health authority-determined community of need, and half of all graduates will practice in priority population PCNs after receiving licensure.
    - PRA-BC is funded by the Ministry and the Joint Standing Committee on Rural Issues – a partnership between the Ministry and Doctors of BC.
- The Health Human Resources Strategy. announced in September 2022. helps ensure people get the health services they need and are cared for by a healthy workforce. The strategy focuses on 70 actions to recruit, train and retain health care workers, while redesigning the health care system to foster workplace satisfaction and innovation.
- Working with the College of Physicians and Surgeons of BC to prepare bylaw changes to allow doctors trained in the US for three years to practice medicine in community settings, such as UPCCs, community clinics, and family practices.

LAST UPDATED

The content of this estimates note is current as of March 14, 2025, as confirmed by Kirsten Youngs.

APPROVALS

2025 02 11 – Ted Patterson, ADM, Primary Care Division
2025 03 06 – Rhiannon Pretty obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
2025 03 14 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[8] Results Management Office, Primary Care Division, Ministry of Health, NTP Incentives Program Update, December 31, 2024
[9] Health Sector Workforce and Beneficiary Services, Physician Services, Programs & Policy. Data as of February 3, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Provincial Attachment System

Topic: The Ministry of Health created the Provincial Attachment System to better connect people to primary care providers who have the capacity to take on new patients, to better measure and manage attachment effectively, and to better understand the availability of episodic and longitudinal primary care in the province.

Key Messaging and Recommended Response:

- Our mandate is clear: we must strengthen primary care by expanding access and attachment to more family doctors and nurse practitioners.
- That's why the Ministry of Health is working with partners like Doctors of BC and Nurses and Nurse Practitioners of BC to implement programs and services that improve and expand access to care, including the Provincial Attachment System.
- BC's Provincial Attachment System, launched in July 2023, streamlines the process for connecting patients who do not have a primary care provider (family doctor or nurse practitioner) with one with capacity to take on new patients.
- This system is the first of its kind in BC and supports a coordinated approach to connecting people and primary care providers, by:
    - Connecting more people to the family doctor or nurse practitioners they need in their communities, through a centralized provincial system.
    - Creating a streamlined, digitally enabled process for measuring and managing attachment (connecting people to providers) throughout BC.
    - Supporting clinics, nurse practitioners and family doctors through community-based attachment coordinators who are assisting with the attachment process.
    - Helping the Ministry of Health and its partners better understand primary care capacity – which is an important part of continuously improving BC's provincial health care system.
- Since the Provincial Attachment System launched in July 2023:
    - BC has attached more than 370,000 people to the primary care they need, including more than 130,000 people connected to primary care through the Health Connect Registry (date range – July 2023 to January 2025).[1,2]
    - BC had a record-breaking year – in 2024, BC attached almost 250,000 patients to a family doctor or nurse practitioner – the highest since BC starting tracking attachment.[3]
    - More than 94% of providers have uploaded their panels to the Provincial Attachment System, and 1,129 have told us they have capacity to take on new patients.[4]
- Through the Provincial Attachment System, including the Health Connect Registry, BC is moving closer to finding a primary care provider for everyone in BC who wants one.

CURRENT SITUATION

- As part of the Provincial Attachment System (PAS) and in partnership with the Doctors of BC (DoBC) and Nurses and Nurse Practitioners of BC (NNPBC), the Ministry of Health (the Ministry):
    - expanded activities to increase the number of attachment coordination resources across BC that, through PAS, match Health Connect Registry registrants to accepting primary care providers;

[1] HSIAR Health Connect Registry Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[2] HSIAR Provincial Attachment System Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[3] Ibid.
[4] HSIAR Provincial Attachment System Executive Dashboard – Health System Performance Portal. Accessed February 27, 2025.

  - added additional capacity to HealthLink BC (HLBC) to facilitate the attachment process and support patients with registration and services in the interim of attachment.
- The Ministry, DoBC and NNPBC are working to improve registries aiming to streamline the patient experience for attachment and reduce administration barriers for providers.
- As a new, provincial approach to attachment management and panel management in BC, the program is actively working with primary care providers, clinics, attachment coordinator and other key stakeholders to ensure the full adoption of PAS.
- The PAS consists of three elements: the Health Connect Registry (HCR) for patients; and the Patient Panel Registry (PPR) and Clinic and Provider Registry (CPR) for primary care providers and clinics.
- The HCR is available province-wide for anyone with a Personal Health Number (PHN) to register their interest in attachment to a primary care provider and receive information on where to access care in the interim.
- Since announcing the expansion of the HCR in July 2023, the Province has been working with DoBC and NNPBC on building out the PPR and CPR, which launched in September 2023.
- The PPR supports family physicians and nurse practitioners to upload their panel data and identify when they are accepting patients. As of January 31, 2025, the PPR has 4,936 providers who have submitted panels and the CPR has 1,129 providers who have indicated capacity to take new patients.[5]
- The CPR collects clinic and staff information for all types of primary care clinics throughout the province. As of January 31, 2025, there are 1,653 clinics in the CPR.[6]
- Together, these three elements of PAS will enable us to improve connections between patients and longitudinal providers, measuring and managing current attachment and the capacity for future attachment, and assessing the availability of all primary care services and infrastructure in communities throughout BC.
- In April 2024, the HCR introduced assignment of health complexity in the PAS, which will further support attachment by priority for attachment and inform primary care providers and clinics who have focused attachment criteria. HLBC uses this information to determine which primary care supports may be helpful to people while they wait for attachment.
- As of January 31, 2025, there are approximately 404,000 people actively registered on the HCR, including over 33,000 pending attachment to a provider.[7]
- As of April 2024, registrants on the HCR receive regular communications about health services they can access in their community while they wait for attachment.

FINANCIAL IMPLICATIONS

- For operating funding, the Province has invested $37.63M in 2023/24 and $55.20M in 2024/25 to support the Primary Care Digital Enablers.
- The Province has invested $26.60M in 2023/24 and $5.61M in 2024/25 for capital funding (including capital allocated to Provincial Health Services Authority).

KEY BACKGROUND

Patient-Facing Solution (Health Connect Registry):

- HCR proof of concept was launched in 2019 with 30 early adopter communities by HLBC.
- Expanded in 2023, anyone in BC with a PHN can register themselves, their family or a person in their care for a primary care provider online at healthlinkbc.ca/hcr.

[5] HSIAR Provincial Attachment System Executive Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[6] HSIAR Clinic Provider Registry Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[7] HSIAR Health Connect Registry Dashboard – Health System Performance Portal. Accessed February 27, 2025.

- Those unable to register online can do so by calling 8-1-1. Registration support is available in over 130 languages, by 7-1-1 for the deaf and hard of hearing, and Video Relay Service (VRS) for sign language interpretation.
- HLBC is actively working with all communities across BC to close and transition all local waitlists to the HCR. New registrants and those transferred from community lists will receive an email confirmation they are on the HCR retaining their original registration date.

Provider Focused Registry (Patient Panel Registry):

- 94% of longitudinal primary care providers in BC have uploaded panels to the PPR and 1,129 have indicated open capacity for new attachments.[8]
- As of January 31, 2025, 256,000 people have been included on multiple providers' panels in the PPR.[9] The Ministry is currently working with partners and providers to clarify each person's most responsible provider.
- Since Fall 2023, the Ministry, DoBC and NNPBC have provided ongoing informational webinars and training sessions for providers so they can learn about PAS and upload and maintain panels.
- All longitudinal providers regardless of payment model are required to maintain panels and identify capacity on PAS.

Clinic Focused Registry (Clinic and Provider Registry):

- Medical and Clinic Directors in all primary care clinics are to provide data to the CPR on service delivery location, provider capacity, and infrastructure for primary care in BC communities.
- The data collected in the CPR enables the Ministry to better understand where services are needed and to provide oversight of the primary care system.
- 1,653 primary care clinics exist in the CPR.[10]

LAST UPDATED

The content of this estimates note is current as of February 13, 2025, as confirmed by Brande Strachan and Tristan Smith.

APPROVALS

2025 02 14 – Ted Patterson, Primary Care Division
2025 03 03 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 02 28 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division

[8] HSIAR Provincial Attachment System Executive Dashboard – Health System Performance Portal. Accessed February 27, 2025.
[9] Ibid.
[10] HSIAR Clinic Provider Registry Dashboard – Health System Performance Portal. Accessed February 27, 2025.

LEGISLATIVE SESSION – ESTIMATES NOTE

Rural Primary Care Services & Delivery

Topic: Expanding access to longitudinal team-based primary care to communities throughout the province, including rural/remote communities, is a key focus of the Ministry of Health's Primary Care Strategy.

Key Messaging and Recommended Response:

- Everyone in BC needs access to primary care to support their health and overall wellness, no matter where they live.
- That is why in 2018, BC launched a transformational Primary Care Strategy focusing on the implementation of team-based care through Primary Care Networks, which reflect the unique needs of the communities they serve.
- Nearly 50 Primary Care Networks serve rural and remote communities, with more in planning, which will provide primary care access to approximately 770,000 people living in rural and remote communities throughout BC.[1]
- More than 750 family doctors, nurse practitioners and other team-based care support workers have been recruited to deliver this crucial access to primary care in rural and remote communities.[2]
- We know more needs to be done and the Ministry remains committed to working with its primary care partners to implementing the primary care services people need – where they need them.

CURRENT SITUATION

- As of January 2025, the Ministry of Health (the Ministry) has launched 36 Primary Care Networks (PCNs) that service completely rural/remote community health service areas (CHSAs) with committed resources to recruit 143.81 full-time equivalent (FTE) net new most responsible provider (MRP), and 304.27 FTE of interprofessional team-based care supports. These include primary care nursing, allied health professionals, primary care clinical pharmacists, midwifes, and Indigenous traditional wellness providers.
    - 96.35 FTE out of 143.81 FTE MRP and 163.86 FTE out of 304.27 FTE team-based care supports have been recruited to rural PCNs.[3] A total of 260.21 FTE out of 448.08 FTE has been recruited for the 36 rural PCNs
    - These 36 rural/remote PCNs serve 676,750 rural/remote BC residents.
- As of January 2025, the Ministry has also launched another 25 PCNs that service both urban and rural/remote CHSAs, with committed resources to recruit 230.34 FTE net new most responsible provider (MRP), and 440.98 FTE of interprofessional team-based care supports.[4]
    - 173.28 FTE out of 230.34 FTE MRP and 242.44 FTE out of 440.98 team-based care supports have been recruited to PCNs serving urban and rural/remote areas. A total of 415.72 FTE out of 671.32 FTEs have been recruited for the 25 PCNs serving both urban and rural/remote areas.
    - These 25 PCNs serve 311,678 rural/remote BC residents.
- As of January 2025, urgent and episodic primary care services in rural/remote communities are supported by 6 Urgent and Primary Care Centres (UPCCs) operated by regional health authorities.[5]
    - 9.66 FTE out of an approved 34.23 FTE MRP and 33.66 FTE of an approved 67.40 FTE team-based care supports have been recruited to rural UPCCs.[6]
    - As of January 2025, there have been 30,936 patient visits at rural/remote UPCCs in fiscal year 2024/25, and 140,414 cumulative patient visits since these 6 UPCCs first opened.[7]
    - A seventh rural UPCC is currently in planning for Elkford, BC.
- Episodic primary care services in rural/remote communities are further enhanced by Real-Time Virtual Support

[1] CHSA Urban-Rural Classification, https://meta.healthideas.gov.bc.ca/concepts/chsa-urban-rural-classification AND Primary Care Network (PCN) rurality was determined by the rurality of the Community Health Service Area that it services. A PCN can be rural only, urban only, or rural and urban depending on the CHSAs.
[2] Ibid.
[3] Ibid.
[4] Divisional Services Branch, Primary Care Division, Ministry of Health. PCN, UPCC, CHC and FNPCC Funding Letters approved as of FY2024/25.
[5] Divisional Services Branch, Primary Care Division, Ministry of Health. PCN, UPCC, CHC and FNPCC Funding Letters approved as of FY2024/25.
[6] Divisional Services Branch, Primary Care Division, Ministry of Health. Workforce Report P10. Data as of January 2, 2025.
[7] Divisional Services Branch, Primary Care Division, Ministry of Health Extracted data from Primary Care Patient Services in the Primary Care DataCite (PCDC).

(RTVS) services, providing accessible and culturally safe virtual health care that reduces inequities in accessing services for rural, remote, and Indigenous communities.[8]

- As part of the Ministry and the First Nations Health Authority's partnership under the First Nations-led Primary Care Initiative, 13 First Nations-led Primary Care Centres (FNPCCs) are slated to serve rural/remote communities by fiscal year 2025/26. Currently, 4 rural FNPCCs are open and providing services, while 8 are recruiting staff in preparation for opening this year, and 1 is awaiting final approval.[9,10]
    - 2.20 out of an approved 29.16 FTE MRP and 28.10 out of an approved 160.36 FTE team-based care supports have been recruited to serve rural/remote FNPCCs.[11]

FINANCIAL IMPLICATIONS

- The Ministry's budget includes $301.20M in FY2024/25 to support the continued implementation of rural/remote community-serving Primary Care Strategy initiatives.[12]
    - 36 Rural/remote PCNs: $99.91M committed in FY2024/25 for ongoing clinical staffing costs
    - 25 Rural/remote and Urban serving PCNs: $146.76M committed in FY2024/25 for ongoing clinical staffing costs
    - 6 Rural/remote UPCCs: $20.47M committed in FY2024/25 for ongoing clinical staffing costs
    - 3 Rural/remote CHCs: $7.78M committed in FY2024/25 for ongoing clinical staffing costs
    - 12 approved rural/remote FNPCCs: $26.28M committed in FY2024/25 for ongoing clinical staffing costs
- As of January 10, 2025, PCD has approved $100.21M of funding for the suite of RTVS services.[13]

KEY BACKGROUND

- Rural communities rely on family physicians practicing full scope primary care, whereby physicians support both longitudinal primary health care services to the community in a patient medical home setting and also support local acute care services such as anesthesia, obstetrics, general surgery and emergency room services.[14]
- Primary Care services in small rural/remote areas are typically delivered in clinics that are owned/operated by regional health authorities and often co-located within the local acute care facility, as opposed to private physician-run clinics to deliver primary care.
- Recruitment and retention in rural/remote communities remains a longstanding challenge. There is a suite of rural programs that offer benefits to support the recruitment and retention of rural physicians available to them through the Rural Practice Subsidiary Agreement and are under the responsibility of the Joint Standing Committee on Rural Issues.[15]
- During service planning for rural primary care initiatives, the Ministry adjusts its primary care funding parameters for rural communities to make available more direct care FTE per capita than in urban and metro areas.[16]
- Primary care attachment targets for rural MRPs are decreased from urban targets, recognizing that rural full scope providers may spend on average 60% of their contract hours on primary care and 40% on acute care.[17]
- As part of the Rural, Remote First Nations, and Indigenous COVID-19 Response Framework (April 2020), the Ministry funded the Rural Coordination Centre for BC to implement RTVS services include:
    - Patient-facing Pathways: (1) FNHA's First Nations Virtual Doctor of the Day (FNvDOD), (2) First Nations Virtual Substance Use and Psychiatry Service (FNvSUPs); and (3) NHA's Virtual Primary and Community Care Clinic (VPCCC)
    - Peer-to-Peer Pathways: (1) Rural Urgent Doctor-in-aid (RUDi) for support from emergency physicians; (2) the Child Health Advice in Real-Time Electronically (CHARLiE) for support from pediatric specialists; (3) the Maternity and Baby Advice Line (MaBAL) (4) Virtual Emergency Room Rural assistance (VERRa); and (5) the Rural Outreach in Critical Care and Internal Medicine (ROCCi).[18]

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[8] 2025 Primary Care Division Estimates Note EN11: Virtual Primary Care.
[9] 2025 Primary Care Division Estimates Note EN10: Indigenous Primary Care.
[10] Coast Salish FNPCC is a hub and spoke model where some of the hubs are based on south island rural /remote or urban communities.
[11] Divisional Services Branch, Primary Care Division, Ministry of Health. Workforce Report P10. Data as of January 2, 2025.
[12] Divisional Services Branch, Primary Care Division, Ministry of Health. PCN, UPCC, CHC and FNPCC Funding Letters approved as of FY2024/25.
[13] 2025 Primary Care Division Estimates Note EN11: Virtual Primary Care.
[14] Physician Master Agreement – Alternative Payment Subsidiary Agreement Consensus Decision.
[15] Rural Practice Programs - Province of British Columbia.
[16] Primary Care Strategy Funding Parameters.
[17] Northern Health Authority Medical Affairs. Note: a 60-40% time breakdown between primary and acute care service delivery is an average and may fluctuate in different rural contexts depending on service demand and physician supply levels across different rural health operations.
[18] 2025 Primary Care Division Estimates Note EN11: Virtual Primary Care.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this estimates note is current as of February 20, 2025, as confirmed by Kelly McQuillen.

APPROVALS

2025 02 20 – Kelly McQuillen obo Ted Patterson, Primary Care Division
2025 03 27 – Rhiannon Pretty, Health Sector Information, Analysis & Reporting Division
[date approved, e.g., 2023 01 27] – Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Urgent and Primary Care Centres

Topic: Urgent and Primary Care Centres provide access to same-day, urgent, non-emergency primary care; increase existing primary care capacity; enable new patient attachment; and reduce pressures on emergency departments.

Key Messaging and Recommended Response:

- Providing urgent and primary care when and where people need it is a priority, and we have directed key funding through the Primary Care Strategy to meet those needs.
- BC is well on its way to establishing 50 Urgent and Primary Care Centres (UPCCs) throughout BC, the target we set when we launched BC's Primary Care Strategy in 2018.
- We have opened 40 UPCCs throughout BC, providing access to same-day, urgent, non-emergency health care for people who need it – with more on the way.
- UPCCs are often open evenings, at weekends and on statutory holidays, providing people and families with increased access to care outside of regular business hours.
- UPCCs provide a primary and urgent care option for people and families who may have otherwise gone to a hospital's emergency department for issues that don't necessarily require emergency care – alleviating some of the pressure on our hospitals.
- Some UPCCs also attach people to primary care providers and a long-term health relationship that we know improves overall health and wellness.
- This innovative model is producing results for people:
    - Delivering more than three million patient visits since the first UPCC opened in 2018.
    - Providing 648,964 patient visits in the first three quarters of 2024/25 alone (to January 2025).
    - Attaching 27,261 people to longitudinal care so far in 2024/25 – an increase of 1,811 patients in 2024/25.
- Together with Primary Care Networks, Community Health Centres, First Nations-led Primary Care Centres and Nurse Practitioner-led Primary Care Centres, UPCCs improve access and increase attachment to comprehensive, quality primary care for people and families throughout BC.

CURRENT SITUATION

- As of January 2025, and since launched as an initiative in 2018 through the Primary Care Strategy:
    - 40 Urgent and Primary Care Centres (UPCCs) are providing services in either temporary or permanent sites, with two more with approved funding letters, which will expand to 50 by early 2026.
    - UPCCs have hired 629.49 full-time equivalents (FTEs), including 121.64 FTE Family Physicians (FPs), 76.47 FTE Nurse Practitioners (NPs), 322.78 FTE Nursing, 91.54 FTE allied health professionals (AHPs), 1.56 FTE Indigenous Health Resources, and 7.20 FTE Clinical Pharmacists.[1]
    - UPCCs have collectively provided total cumulative patient visits since opening: 3,188,957 and have attached 27,261 patients.
- As of January 2025, UPCCs have provided 648,964 patient visits in FY 2024/25. [2]
    - Of these visits, approximately 15% were provided to patients attached to the UPCC, 54% were provided to unattached patients; and 31% were provided to patients attached outside of the UPCC.[3]

[1] Divisional Services Branch, Primary Care Division, Ministry of Health, Primary Care Workforce Report FY2024/25 P10 as of January 02, 2025.
[2] Divisional Services Branch, Primary Care Division, Ministry of Health, FY2024/25 P10 UPCC Patient Services Report and PCDC data. As of January 02, 2025.
[3] Ibid.

- As a team-based model of care, patients accessing care in UPCCs had 1,066,629 encounters with providers to meet their care needs. Of these encounters, 29% (315K) were with FPs; 10% (110K) were with NPs; 55% (590K) were with nurses; and 5% (52K) were with AHPs or Indigenous health workers.[4]
- UPCCs are to provide extended hours of access for patients. Of the total encounters patients had with care teams, 37% were provided outside regular business hours.[5]
- UPCCs are expected to focus on providing in-person care aiming to keep virtual encounters under 20% of total encounters. As of January 2025, on average, 15% of encounters occurred virtually across all UPCCs.[6]
- All UPCCs include some mental health and substance use (MHSU) access and/or services and can coordinate rapid access to MHSU crisis intervention services. Some UPCCs emphasize care for underserved populations and have more extensive MHSU services (e.g., Vernon UPCC focuses on providing specialized services and support to those experiencing MHSU challenges and Nanaimo Medical Arts provides timely access for patients looking for Opioid Agonist Therapy).

FINANCIAL IMPLICATIONS

- The Ministry has committed to fund $169.41M in annual operating costs for 42 UPCCs which have received a funding letter and are currently in implementation (funding is based on full staffing), $185.89M in capital and $15.57M in one-time start-up costs.[7]
- The Ministry's budget includes $579.09M in 2024/25 to support the continued implementation of Primary Care Strategy's Initiatives (including Primary Care Networks, UPCCs, Community Health Centres, and Family Physician-and Nurse Practitioner- led clinics), and $627.82M for 2025/26.

KEY BACKGROUND

- UPCCs provide access to same-day, urgent, non-emergency health care. UPCCs are often open evenings, weekends and statutory holidays (actual hours vary by clinic). UPCCs are an alternative to visiting the hospital for issues that do not require emergency care.
- Patients who require medical attention within 12 to 24 hours can receive care at UPCCs for conditions such as:
  - High fevers
  - Sprains and strains caused by minor accidents and falls
  - Minor bleeding or cuts that require stitches
  - Minor burns that may require care
  - Mild to moderate breathing difficulty or asthma attacks
  - Sinus, oral or lung infections
  - Nausea, vomiting, diarrhea or constipation
  - Skin conditions such as rashes or infections
  - Minor allergic reactions
  - Pain or burning when urinating
  - Non-severe new or worsening pain
  - New or worsening mental health concerns

LAST UPDATED

The content of this factsheet is current as of February 11, 2025, as confirmed by Kelly McQuillen.

APPROVALS

2025 02 14 – Ted Patterson, Primary Care Division
2025 03 07 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 02 28 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division

[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Includes 36 UPCCs with final funding letters and 3 UPCCs which have early draw funding.

LEGISLATIVE SESSION – ESTIMATES NOTE

Virtual Primary Care Services

Topic: Virtual Primary Care Health Services offered by the Ministry of Health as part of BC's Primary Care Strategy.

Key Messaging and Recommended Response:

- Virtual Primary Care services are key to the Ministry's Primary Care Strategy, delivering needed care to people in rural, remote and Indigenous communities, as well as for those who don't have a family doctor or nurse practitioner, or who can't get in to see their provider in a timely manner.
- Virtual Primary Care services available include:
    - HealthLink BC provides telehealth services 24/7 through 8-1-1. When you call 8-1-1, a Health Service Navigator can connect you to a registered nurse, registered dietician, physician, qualified exercise professional, and/or pharmacist depending on your health needs and questions.
    - Real-Time Virtual Supports (RTVS) offer access to virtual care for patients and providers in rural, remote, and First Nations communities in BC. There are multiple pathways available through RTVS, including:
        - HEiDi (provides 8-1-1 access to physicians),
- RUDi (emergency medicine support for rural and remote providers),
        - CHARLiE (pediatric medicine support for rural and remote providers), and
        - MaBAL (maternity and newborn care support for rural and remote providers).
    - The Ministry also offers First Nations Virtual Doctor and First Nations Virtual Substance Use and Psychiatry Service to enable First Nations people to make virtual appointments with doctors.
    - Northern Health Authority offers Virtual Primary and Community Care Clinic to deliver primary care services for unattached patients.
- The Ministry's virtual primary care services provide accessible and culturally safe virtual health care and reduce inequities in accessing services for rural, remote, and Indigenous communities.

CURRENT SITUATION

- Virtual Primary and Community Care Clinic (VPCCC): Since implementation in April 2020 to January 2025, there have been 224,877 calls and 158,109 patient encounters (73,674 seen primary care appointments; 84,435 nursing encounters) in 104 Northern communities.[1]
- Peer Support Pathways: Since implementation in August 2020 to December 2024, the lines have received 72,537 calls from primary care providers in 186 rural, remote, and Indigenous communities and supported 26,647 patient encounters.[2]
    - Maternity and Baby Advice Line (MaBAL) – Calls: 5,028; Encounters: 2,180
    - Rural Urgent Doctor-in-aid (RUDi) – Calls: 58,009; Encounters: 20,155
    - Child Health Advice in Real-Time Electronically (CHARLiE) – Calls: 9,500; Encounters: 4,312
- First Nations Health Authority's (FNHA) First Nations Virtual Doctor of the Day (FNvDOD) and First Nations Virtual Substance Use and Psychiatry Service (FNvSUPs): Since implementation (April 1, 2020 for FNvDOD and August 17, 2020 for FNvSUPS) to December 31, 2024, there were 50,529

[1] Planning and Implementation Oversight Branch; Primary Care Division, Ministry of Health. (2025). Real Time Virtual Supports Updated Statistics 01.23.25. Data as of January 23, 2025.
[2] Planning and Implementation Oversight Branch; Primary Care Division, Ministry of Health. (2025). Real Time Virtual Supports Updated Statistics 01.23.25. Data as of January 23, 2025.

FNvDOD encounters and 7,984 FNvSUPS encounters. From April 1, 2024, to December 31, 2024, there were 8,546 FNvDOD encounters and 1,209 FNvSUPS encounters[3].

- Clients' satisfaction rates for FNvDOD and FNvSUPs:
  - From patient satisfaction surveys from November 10, 2022 to December 31, 2024, over 95% of users accessing the FNvDOD service report satisfaction with their appointment and over 96% of users indicate they would recommend the service to their family and friends.
  - From patient satisfaction surveys from April 1, 2024, to December 31, 2024, over 94% of users accessing the FNvDOD service report satisfaction with their appointment and over 96% of users indicate they would recommend the service to their family and friends.
  - From patient satisfaction surveys from March 15, 2023 to December 31, 2024, over 90% of users accessing the FNvSUPS service report satisfaction with their appointment and over 93% of users indicate they would recommend the service to their family and friends.
  - From patient satisfaction surveys from April 1, 2024, to December 31, 2024, over 88% of users accessing the FNvSUPS service report satisfaction with their appointment and over 92% of users indicate they would recommend the service to their family and friends.[4]

- On August 26, 2024, the Ministry of Health (the Ministry) determined an interim strategy to fund and operate the suite of Real Time Virtual Supports (RTVS) services until 2025/26. Primary Care Division (PCD), Hospital & Surgical Health Services and Provincial Health Services (HSHS/PHS), Health Sector Workforce and Beneficiary Services (HSWBS), and Finance and Corporate Services (FCS) will conduct further policy work on coordinated virtual services and establish a long-term governance structure for RTVS services before seeking base funding for 2026/27 and ongoing.
- On September 4, 2024, PCD, HSWBS and HSHS/PHS confirmed funding to Northern Health Authority (NHA) and Rural Coordination Centre of BC (RCCbc) to pilot the Virtual Emergency Room Rural Assistance (VERRa) and Rural Outreach in Critical Care and Internal Medicine (ROCCi) lines until 2025/26. VERRa (formally known as RUDi MRP) will support rural and remote communities with dedicated virtual physician support and help to maintain overnight emergency department services. ROCCi will provide internal medicine and critical care support that is tailored specifically for rural health care providers. Programs are co-managed by PCD and HSHS/PHS.
  - Since implementation (August 2024) to December 2024, VERRa has covered 281 emergency shifts and experienced 396 patient encounters.
  - Since implementation under RUDi MRP (May 2021) to July 2024, the line has supported 16 distinct hospitals, covered 611 ED shifts, and prevented 7,015 hours of potential Emergency Department closures.
  - Since implementation (October 2024) to December 2024, ROCCi has received 856 calls and experienced 135 patient encounters[5].

FINANCIAL IMPLICATIONS

- As of January 2025, PCD has approved $100.21M of funding for the suite of RTVS services.
  - Budget 2020/21: $12.79M
  - Budget 2021/22: $20.42M
  - Budget 2022/23: $20.81M
  - Budget 2023/24 $20.94M

[3] Planning and Implementation Oversight Branch; Primary Care Division, Ministry of Health. (2025). Real Time Virtual Supports Updated Statistics 01.23.25. Data as of January 23, 2025.
[4] Planning and Implementation Oversight Branch; Primary Care Division, Ministry of Health. (2025). Real Time Virtual Supports Updated Statistics 01.23.25. Data as of January 23, 2025.
[5] Planning and Implementation Oversight Branch; Primary Care Division, Ministry of Health. (2025). Real Time Virtual Supports Updated Statistics 01.23.25. Data as of January 23, 2025.

- Budget 2024/25: $25.25M

- PCD projects that Budget 2025/26 will cost an estimated $26.13M (estimate does not include salary increases aligned to the Physician Master Agreement and other labour market-lifts).

KEY BACKGROUND

- In March 2020, primary care practitioners began providing virtual patient care to limit COVID-19 exposure. Additionally, working in partnership with RCCbc, NHA, and FNHA, the Ministry leveraged virtual technologies to reduce inequities in accessing services for rural, remote, and Indigenous communities. Labelled Real Time Virtual Supports (RTVS), this initiative provides a suite of virtual clinical services for both patients and providers living and working in rural, remote, and Indigenous communities. As part of the Rural, Remote First Nations, and Indigenous COVID-19 Response Framework (April 2020), the Ministry funded and implemented RTVS services which include:
    - FNHA's First Nations Virtual Doctor of the Day (FNvDOD) and First Nations Virtual Substance Use and Psychiatry Service (FNvSUPs): provide Indigenous clients and families with access to virtual family physicians, psychiatrists, and addictions specialists, all specialized in culturally safe care.
    - NHA's Virtual Primary and Community Care Clinic (VPCCC): delivers services for unattached patients and patients with limited primary care access in the rural North. It serves an approximate population of 300,000 people.
    - RTVS has three Peer Support Pathways: (1) Rural Urgent Doctor-in-aid (RUDi) for support from emergency physicians; (2) the Child Health Advice in Real-Time Electronically (CHARLiE) for support from pediatric specialists; and (3) the Maternity and Baby Advice Line (MaBAL) for support in maternal and newborn care. RCCbc also provides the Consultation to Conversation (C2C) program which enhances rural patients' continuity of care and access to specialist care. Virtual care coordinators facilitate three-way calls between patients, their primary care providers, and specialists. This is further supported by QuickWay pathways for dermatology, neurology, rheumatology, hematology, thrombosis, and myofascial pain. Additionally, RCCbc is piloting the Virtual Emergency Room Rural assistance (VERRa) to provide overnight virtual emergency department support; and the Rural Outreach in Critical Care and Internal Medicine (ROCCi) to provide specialized internal medicine support services.

LAST UPDATED

The content of this factsheet is current as of February 13, 2025 as confirmed by Brande Strachan.

APPROVALS

2025 02 14 – Ted Patterson, Primary Care Division
2025 02 24 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
BC Emergency Health Services – General

Topic: BC Emergency Health Services (BCEHS) is part of the Provincial Health Services Authority (PHSA) and coordinates emergency health services to more than 5 million[1] British Columbians across the province and governs emergency health services provided by first responders to British Columbians.

Key Messaging and Recommended Response:

- Government recognizes how important it is for people to have timely and reliable access to emergency health services, when and where they're needed.
- Since 2017, BC Emergency Health Services' annual spending on emergency health services has increased by more than $475 million, reaching close to $1 billion per year.
- This has helped increase BCEHS staffing, training, and mental-health supports, as well as investments to improve equitable access to ambulance services to support communities across BC.
- Since 2017, BCEHS has added approximately 1,900 new full time and part time permanent paramedic Emergency Medical Responder (EMR) positions, with 700 of these paramedics working in rural and remote communities throughout the province.
- Since 2020, BCEHS has added 77 ground ambulances and 5 air ambulances. 55 new ground ambulances and 5 air ambulances were added as part of the Rural, Remote, First Nations and Indigenous COVID-19 Response Framework.
- In November 2023, government announced that the "scheduled on call" (SOC) staffing model in 60 rural and remote communities across the province would be converted to another model by March 31, 2024, to improve overall coverage in rural communities.
- Now, 22 new communities have converted to 24/7 emergency response service where staff are in station and on duty 24/7. As of April 1, 2024, as part of the SOC phase-out, an additional 55 FTE stand-alone Community Paramedics (CP) were added to provide dedicated community-based care and community outreach.
- We still have work to do but we're making progress. In 2024, BCEHS paramedics responded to a new record of over 600,000 medical emergency 9-1-1 events and transferred more than 74,000 patients between facilities.

CURRENT SITUATION

- BCEHS paramedics respond to more than half a million medical emergency 9-1-1 events a year and transfer more than 74,000 patients a year between facilities (usually hospitals).
    - In 2023, calendar year (January- December), BCEHS responded to 586,625 medical emergencies (9-1-1 events).
    - In 2024, BCEHS responded to 607,716 medical emergencies (9-1-1 events).
        - This represents an increase of 21,091 events from 2023 to 2024.
    - In 2023, BCEHS completed 69,591 inter-facility patient transfer events.
    - In 2024, BCEHS completed 74,709 inter-facility patient transfer events.
        - This represents an increase of 5118 transfer events from 2023 to 2024.
- From 2017 to the end of 2024, close to 1,900 new paramedics, dispatch and emergency responder positions have been added, with more than 900 of these paramedics working in rural and remote communities throughout the province.
- Out of 3,044 total permanent regular part-time and full-time paramedic positions, 2,460 of these positions were filled (81%) on February 3, 2025.

[1] B.C. government population estimates 2022.

- BCEHS added 18 temporary ground ambulances and 1 temporary air ambulance to support emergency department closures and diversions. These added resources have been in place since June 1, 2024, and are scheduled to end March 31, 2025.
- A 3-year agreement (April 1, 2022, to March 31, 2025) between the Ambulance Paramedics and Ambulance Dispatchers Bargaining Association, and the Health Employers Association of BC was reached on January 6, 2023, with ratification announced on February 15, 2023.
- The ratified agreement includes general wage increases:
    - Year 1 - a flat increase of $0.25 per hour, which provides a greater percentage increase for lower-paid employees, plus a wage increase of 3.24%
    - Year 2 - 5.5% plus a potential cost-of-living adjustment to a maximum of 6.75%
    - Year 3 - 2% plus a potential cost-of-living adjustment to a maximum of 3%
    - The next round of bargaining is forecasted to commence approximately April 2025.

System Performance/Impacts

- BCEHS responds to the most critically ill and injured patients first, based on a Medical Priority Dispatch System (MPDS) used around the world. Patients reported to have life-threatening symptoms such as: cardiac arrest, chest pain, breathing difficulties, and severe bleeding or unconsciousness – which are prioritized.
- BCEHS meets its provincial median target of under 9 minutes to respond to the most life-threatening category of calls (Purple calls) in metro and urban communities.
- In 2024, BCEHS responded to an average of 1,660 9-1-1 events per day. Of these, 33.4% were lower acuity, (e.g., require care for cuts, wounds, sprains, muscle strains, mild illness, or skin conditions). Some of these patients do not require a trip to an emergency department, but they require some form of connection to care.
- Secondary triage primary care paramedics were added in early 2022, to manage less urgent calls to help reserve ambulances for emergencies. The secondary triage desk is supported by paramedic specialists, senior dispatchers and a patient navigator for patients who may not need transport to hospital.
- In 2021, BCEHS introduced alternate transport methods that provides “Link and Referral Units” (LARU) to transport patients with non-urgent conditions to health care centres. The program was launched with 11 units in 2021 and, as of 2024, was expanded to 15 units, along with 3 additional supernumerary units that can be upstaffed from Station 287 (Clinical Hub) as staffing availability allows. The units are distributed as follows: 6 in Fraser Health Authority, 3 in Interior Health Authority, 2 in Island Health Authority, 2 in Northern Health Authority, and 5 in Vancouver Coastal Health Authority, with 3 of these being supernumerary.

Rural Staffing

- In November 2023, the Minister of Health announced that the Scheduled On Call (SOC) staffing model currently in 60 rural and remote communities across the province would be phased out to another model by March 31, 2024.
    - The 3 new staffing models are the “Alpha” model, which has staff in station and on duty 24/7, the “Mix-Shift” model which has staff on duty in station for 16 hours and on call (pager) 8 hours at night and the “Kilo” model which has a full-time permanent unit chief and staff on call (pager).
    - BCEHS is experiencing recruitment and staffing challenges in select rural and remote areas of the province.
- With these new models in place and the addition of 278 full-time paramedic positions, these communities will benefit from improved 9-1-1 responsiveness. In addition, 55.2 full-time equivalent Community Paramedic positions added as part of the SOC phase out will provide dedicated community-based care and community outreach. A portion of this deployment model remains unfunded.

Mental Health

- In 2024, currently, accepted stress-related injuries account for 42.6% of all BCEHS time-loss claims (584 claims[2]). Claims from 2024 have not been finalized and last quarter injury claims are still pending WorkSafeBC (WSBC) review and acceptance.
- In 2024, currently, there is a total of 249 accepted claims[2] related to psychological injury[3]
- On July 14, 2021, an announcement by the Minister of Health called for immediate actions to support the wellness of BC’s front-line staff.

[2] The 2024 claim count, claim costs, and coding will not be complete until the end of March 2025.

- As part of the immediate actions, BCEHS expanded the network of trauma informed, occupationally competent clinical counsellors, therapists and psychologists supporting all BCEHS staff bringing the total to approximately 357 professionals (September 30, 2024). These new resources have increased the availability of important mental health support for frontline staff and their families.

FINANCIAL IMPLICATIONS

- Since 2017, BCEHS' annual spending has increased from $424.254 million to $955.240 million in 2023/24 – a nearly 125.16% increase.

LAST UPDATED

The content of this estimates note is current as of March 7, 2025, as confirmed by Eugene Johnson, Executive Director.

APPROVALS

2025 03 14 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 03 26 – Kelly Uyeno, Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
BC's 10-Year Cancer Action Plan

Topic: Achievements and progress on BC's 10-Year Cancer Action Plan (CAP)

Key Messaging and Recommended Response:

- In 2023 the Province launched a transformational 10-Year Cancer Action Plan and invested nearly a half-a-billion dollars ($440 million) to support immediate steps to better prevent, detect and treat cancers.
- This supported immediate efforts to better recruit and retain cancer care physicians and staff to urgently reduce waits for cancer care.
- Through Budget 2024, government announced an additional $270 million over the next three years to support the 10-Year Cancer Action Plan with $150 million of the funding earmarked to support the BC Cancer Foundation advance research, recruit additional cancer talent and enhance patient access to treatments.
- This supported a range of important initiatives such as detecting cancer earlier by launching a first in Canada HPV take home test to help detect cervical cancer.
- Government's commitment to this 10-year plan means more cancer centers are opening throughout the province, more efforts are underway to detect and treat rare cancers faster, and waitlists are being more effectively managed despite growing demand as the prevalence of cancer increases in society.
- To ensure people living in rural and remote communities can access the cancer care they need, a further $20 million was provided to the Canadian Cancer Society (CCS) and Hope Air to expand travel programs that support cancer patients.
- Overall, these investments and focus on continual improvement are helping improve BC's cancer care system, and after years of neglect set a better course for the province to ensure people are getting access to the cancer care they need.

CURRENT SITUATION

Cervical Cancer Prevention (Human papillomavirus (HPV) Immunization)

- Additional school-based HPV immunization clinics were offered in Fall 2024, with more planned throughout 2024/25 school year. Out-of-school vaccination opportunities are also expanding through pharmacies.
- A Winter 2025 public awareness campaign will build on the Fall 2024 HPV vaccination awareness campaign, targeting youth and parents while enhancing outreach for those facing access barriers.

Cervical Cancer Screening

- HPV testing, including province-wide self-screening for cervical cancer, was launched January 29, 2024, with 115,512 kits being distributed as of December 31, 2024.[1]
- Self-collection reduces barriers for those without a primary care provider or facing cultural/logistical challenges.

Specialized Cancer Treatments – Delivering Chimeric Antigen Receptor T-Cell (CAR-T) in BC

- CAR-T therapy, an advanced immunotherapy, became available in March 2024, at Vancouver General Hospital and BC Children's Hospital (BCCH), initially to treat refractory or relapsed large B-cell lymphoma (adult) and acute lymphocytic leukemia (pediatric/young adult). Since then, 2 indications were added, with an additional 6 being approved by the FDA and 1 by Health Canada.
- The program is expected to provide treatment for up to 50 patients per year (45 adults and 5 pediatric/youth).
- Between January 22 and December 5, 2024, 37 adult patients were treated (20 in province (IP) and 17 out of province/country (OOP/C)) and Personal Informati patients were treated via clinical trial. BCCH referred, approved, and treated Per son al Info standard-of-care pediatric Personal Information during this time. No pediatric patients were treated via clinical trials

[1] BC Cancer. *BC Cancer Cervix Screening Program FY2024/25 Q3 Report*. January 21, 2025. Last accessed February 20, 2025.

or sent OOP/C.[2]

New Cancer Centres and Technologies

- Progress is being made on BC's 4 new cancer centres in Surrey (expected completion 2030), Burnaby (expected completion 2030), Kamloops (expected completion 2028), and Nanaimo (expected completion 2028).
- A new cyclotron and radiopharmacy laboratory is under construction in Vancouver to support Positron Emission Tomography-Computed Tomography (PET/CT) scanning in Kelowna and Victoria, operations expected in 2026.

Team-Based Care and Investments in Cancer Workforce

- As of January 2, 2025, 13.3% of oncologist follow-up appointments were supported by a team-based care nurse, up from 10.8% the previous year, improving care quality and reducing physician workload.[3]
- Since April 1, 2023, targeted recruitment has added 214.4 full-time equivalents (FTE) to regional cancer centres staffing in nursing, pharmacy, supportive care, molecular imaging, radiation therapy, clerical, and data roles.[4]
- Pay structures were revised, effective April 1, 2023, to attract and retain in-demand cancer care professionals, including increased compensation for oncologists and radiation therapists. As of January 10, 2025, these changes have supported the hiring of 51 new physician FTEs (14.9% increase). By headcount, that equates to 140 new physicians, including 93 oncologists, and 61 FTE radiation therapists.[5, 6]
- Eight Indigenous patient navigators at Abbotsford, Prince George, Surrey, Victoria, Kelowna (2), Vancouver (2), are now in place to support culturally safe care.

Increased Treatment Capacity[7]

- The volume of patients receiving treatment or consults from January 5, 2024, to January 2, 2025, was consistently higher than the previous year. New patient consults increased by 3.7% (Medical Oncology) and 3.6% (Radiation Oncology), while follow-up visits increased 11.7% and 7.2%, respectively. Extended hours are currently operational in Vancouver and Victoria with further RT optimization planned for other sites.
- Additional PET/CT capacity was added in Victoria and Kelowna through expanded operating hours. From January 5, 2024, to January 2, 2025, 19,571 exams were completed, a 15.7% increase from the previous year.
- Launched in May 2023, the temporary 2-year Across Borders Radiation Treatment Commitment offers radiation treatment in Bellingham, WA (for up to 50 eligible patients each week). As of January 2, 2025, 4,887 patients have been referred to receive radiation treatment, and 1,059 have completed treatment.

Travel Supports for Cancer Patients

- From April to December 2024, 2,281 cancer patients received travel support funding through CCS, representing a 63% increase from the previous year. In addition, 20,349 lodge nights were provided at no cost (previously $55 per night) and 5,343 one-way trips were made by volunteer drivers.[8, 9]
- Hope Air provided a total of 9,428 travel arrangements, a 60.7% increase over the previous year, supporting 1,066 patients and 471 escorts, an 83.0% increase.[10, 11]

Investing in Research and Recruitment[12]

- From April 1, 2023, to January 2, 2025, BC Cancer has hired 59.5 new FTEs to support clinical trials, there are 158 actively enrolling interventional clinical trials, 37 radiation oncology clinical trials funded, 7 population health and five multidisciplinary research projects.
- BC Cancer has awarded 18 clinical researcher start up grants, including research on topics such as equity-oriented cancer care, survivorship, and AI models, 26 Rising Star (MSc/PhD) scholarships, 10 Rising Stars post-doctoral

[2] BC Cancer. *BC Cancer Update Fiscal Period 09 (Nov 8 – Dec 5, 2024) – Performance Report*. January 30, 2025. Last accessed February 20, 2025.
[3] BC Cancer. *BC Cancer Update Fiscal Period 10 (Dec 6, 2024 – Jan 2, 2025) – Performance Report*. January 20, 2025. Last accessed February 20, 2025.
[4] Ibid.
[5] Headcount exceeds FTEs as it includes part-timers and those with signed contracts yet to start. Oncologist recruitment takes 8-12 months on average.
[6] BC Cancer. *BC Cancer Update Fiscal Period 10 (Dec 6, 2024 – Jan 2, 2025) – Performance Report*. January 20, 2025. Last accessed February 20, 2025.
[7] Ibid.
[8] Canadian Cancer Society. *Canadian Cancer Society Travel and Accommodation Service 2025 Q3 Report*. January 30, 2025. Last accessed February 21, 2025.
[9] Canadian Cancer Society. *Canadian Cancer Society Impact Report October 2023 to March 2024*. May 16, 2024. Last accessed February 21, 2025.
[10] Hope Air. *Hope Air Program Report April - December 2024*. February 14, 2025. Last accessed February 21, 2025.
[11] Hope Air. *Hope Air and BC Ministry of Health 2023/24 Annual Report*. June 5, 2024. Last accessed February 21, 2025.
[12] Email, Levchuk, Deanna. Project Manager, Strategy, Planning, and Implementation – BC Cancer, PHSA. February 19, 2025.

scholarships, one Canadian College of Medical Geneticists Fellowship, and two medical oncology scholarships.[13]
- As of January 2, 2025, there were 158 active clinical trials.

FINANCIAL IMPLICATIONS

- BC Cancer annual expenditures have risen from $812.4 (2018/19) to $1,262.0 million (2023/24). In addition, the BC Cancer drug expenditures (net of rebates) rose from $310.1 (2018/19) to $467.7 million (2023/24).
- In February 2023, the Province invested $440 million and launched the CAP which is to provide:
  - $270 million over 3 years to BC Cancer's budget.
  - $150 million to the BC Cancer Foundation to support cancer research and attract the skilled cancer-care providers needed to provide specialized treatments.
  - $10 million to the CCS to support cancer patients in rural and remote areas to travel.
  - $10 million to Hope Air to enable expansion of existing travel and accommodation services.
- In February 2024, the Province announced an additional $270 million in the next three years to support the CAP.
- An additional $10 million per year has been committed to the CCS for both 2024/25 and 2025/26.

KEY BACKGROUND

- Cancer diagnoses in BC are expected to rise from approximately 30,000 (2021) to 45,000 (2035), a 50% increase.
- The CAP, launched in spring 2023, aims to address this increase through increased prevention, early detection, and improved treatment capacity.
- Funding has expanded cancer care teams, service hours, pay structures, therapy access, research, Indigenous patient support, and travel assistance for rural patients. The additional funding in 2024 is supporting prevention (HPV vaccination), screening (cervical and hereditary cancer), workforce capacity, and specialized treatments like malignant hematology, immunotherapy, theranostics, and pediatric oncology.

LAST UPDATED

The content of this estimates note is current as of February 21, 2025, as confirmed by Lindsay Arscott.

APPROVALS

2025 02 28 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 03 28 – Kelly Uyeno, Provincial Health Services Division

[13] Two additional Rising Star (MSc/PhD) scholarships accepted in name only because of other funding.

LEGISLATIVE SESSION – ESTIMATES NOTE

Diagnostic Imaging Access

Topic: Update on the diagnostic imaging strategy focused on access and wait times for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) exams.

Key Messaging and Recommended Response:

- Recognizing the growing demand on medical imaging services, our government launched a diagnostic imaging strategy to help catch up, and keep up with demand. We still have work to do but we're making progress and ensuring more people have access to the diagnostic imaging services they need.
- Since 2016/17, the Province has increased the total number of MRI units to 44 from 25, and total number of CT units to 74 from 63.[1]
- Eleven net-new CT units and 19 net-new MRI units have been added across BC to both increase capacity and improve geographic access to diagnostic imaging services.[2]
- Additionally, since 2016/17, health authorities have significantly increased exams, and in 2024/25 are expected to provide:
  - 342,115 MRI exams, 95% or 166,408 more compared to 2016/17.
  - 1,010,625 CT exams, 45% or 315,377 more compared to 2016/17.[3]
- In 2023, BC ranked 2nd out of 7 reporting provinces for MRI exam wait time; nine out of ten people in B.C. waited 159 days or less for their MRI exam, compared to the national average of 167 days,[4] according to last year's Canadian Institute for Health Information (CIHI) report.
- We have made tremendous progress on improving our capacity for services, and we recognize we couldn't achieve such success without everyone involved in delivering medical imaging services.
- We launched a direct-entry MRI technologist training program at BC Institute of Technology (BCIT) in 2023 to bolster the workforce. This direct-entry program allows high school graduates to apply instead of requiring an existing medical imaging certification.

CURRENT SITUATION

Enhanced access to MRI and CT exams is supported by 4 key strategies: 1) building further capacity; 2) increasing essential personnel; 3) optimizing business processes; and 4) improving waitlist management and reporting.

1) The Province, through Provincial Health Services Authority (PHSA), has invested $5.3 million in 2 mobile units (1 CT & 1 MRI). Hospitals across BC can book these units to maintain imaging capacity during renovations and replacements. When not supporting hospital sites, the MRI unit is stationed in Sechelt and the CT unit is stationed in Chilliwack, where they provide services to local patients.
2) To build and grow the MRI and CT workforce across BC, the Ministry of Health (HLTH) has implemented several initiatives aligned with the BC Health Human Resource (HHR) Strategy, 10-year Cancer Action Plan, Allied Health Strategic Plan, and broader ministry priorities.
   - MRI and CT technologists are eligible for financial incentives of up to $30,000 for high-needs vacancies in Northern Health Authority, $20,000 in rural areas, and $15,000 for difficult-to-fill urban/metro positions, effective April 1, 2024, with a two-year return of service. They may also receive up to $8,000 per year through the Provincial Rural Retention Incentive.
   - Launch of the Student Recruitment and Retention Bursary in Fall 2023. Providing students in medical imaging training programs at public post-secondary institutions in BC with tuition credits of up to $2,000

[1] Capital Services, Finance and Corporate Services (FCS) Division
[2] Capital Services, Finance and Corporate Services (FCS) Division
[3] Health Sector Information, Analysis and Reporting (HSIAR) Division..
[4] Canadian institute for Health Information Report: *Wait Times for Priority Procedures in Canada, 2023*

per program year. Since the program was offered 224 Medical Radiation Technologists (MRT) and 38 first discipline MRI tech students have benefited from this initiative to help them cover tuition costs.[5]

- A new direct-entry diploma program for MRI technologists commenced at the BCIT in January 2023. The first cohort enrolled 12 students, and BCIT will increase annual seats to 16 students starting in January 2025. This expansion was funded through Budget 2024 as part of the 10-year Cancer Action Plan.
- In March 2022, HLTH provided $2.5 million in one-time funding to Post-Secondary Education and Future Skills (PSFS) for BCIT to administer an MRI Technologist bursary. This bursary supports health authority (HA) employees in the MRI Technologist 2nd Discipline program by covering expenses and providing a monthly stipend, enabling full-time course and clinical completion to accelerate graduation. The bursary was available until December 2024. Since the bursary program was first offered, 75 students have taken advantage of the bursary funding. Throughout the 9 terms since the bursary became available, those students have received funding to complete 162 individual courses, including 94 theory courses and 68 clinical placements.[6]

3) Starting in March 2024, diagnostic imaging reports from HA facilities dated September 1, 2023, or later became available through the provincial Health Gateway portal with a 7-day publishing hold. Patients can access reports for X-ray, CT, MRI, fluoroscopy, ultrasound, mammography, cardiology exams, nuclear medicine, bone density, positron emission tomography (PET), interventional radiology and vascular exams.
4) To improve waitlist management, HLTH is actively focusing on formalizing updated waitlist audit practices and advancing the implementation of an electronic workflow. These efforts aim to enhance the efficiency and effectiveness of the waitlist process across the province by increasing access and improving communication.

FINANCIAL IMPLICATIONS

- In both 2021/22 and 2022/23, HLTH allocated $42.16 million to address medical imaging wait times in the HAs.
- In 2023/24, HLTH allocated $46.9 million.
- In 2024/25, HLTH allocated $61.4 million.

KEY BACKGROUND

NOTE: All 2024/25 data is based on Period 11 submissions and are subject to change post-audit. Year-end projections have been provided by the HAs.

Magnetic Resonance Imaging (MRI)

Volumes[7]:

- In 2024/25, HAs are expecting to exceed their MRI target of 321,455 by 20,660, a 95% increase in exams provided over 2016/17 fiscal year.

MRI	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22	2022/23	2023/24	2024/25** *P10 YTD	2024/25*** Projections
Vol.	175,707	189,520	233,368	252,527	247,106	296,408	299,061	322,043	260,459	342,115

** For the first 6 weeks of 2020/21, non-urgent MRI exams were postponed due to the COVID-19 pandemic.*
***2024/25 Period 10 Medical Imaging report*
****Based on P11 Year End Estimations/Projections. Final numbers may differ.*

Equipment Inventory:

- Since 2017, the number of MRI scanners in BC has increased from 25 to 44, an increase of 19 MRI scanners or an increase of 72%.[8]

[5] Post Secondary Programs, Ministry of Post Secondary and Future Skill (PSFS)
[6] Allied Health Policy Secretariat HSWBS Division
[7] Health Sector Information, Analysis and Reporting (HSIAR) Division..
[8] Capital Services, Finance and Corporate Services (FCS) Division

- This equates to 7.7 MRI units per 1,000,000 population,[9] compared to the national rate of 10.0.[10]

Computed Tomography (CT)

Volumes[11]:

- In 2024/25, HAs are expecting to exceed their CT target of 974,120 by 36,505 exams, a 45% increase in exams over 2016/17 fiscal year.

CT	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22	2022/23	2023/24	2024/25 P10 YTD**	2024/25*** Projections
Vol.	695,248	733,787	788,439	805,584	812,212	901,296	923,989	994,073	765,691	1,010,625

**For the first 6 weeks of 2020/21, non-urgent MRI exams were postponed due to the COVID-19 pandemic.*
***2024/25 Period 10 Medical Imaging report*
****Based on P11 Year End Estimations/Projections. Final numbers may differ.*

Equipment Inventory:

- Since 2017, the number of CT scanners in BC has increased from 63 to 74, an increase of 11 CT scanners or an increase of 17%.[12]
- This equates to 13.1 CT units per 1,000,000 population,[13] compared to the national rate of 14.5.[14]

LAST UPDATED

The content of this estimates note is current as of February 10, 2025, as confirmed by Richele Shorter, Acting Executive Director.

APPROVALS

2025 03 17 – Brenda Rafter obo Rob Byers, Finance & Corporate Services Division
2025 03 26 – Kelly Uyeno, Provincial Health Services Division
2025 03 27 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division

[9] Based on 2024 BC Stats population estimate
[10] CADTH Health Technology Review – The Canadian Medical Imaging Inventory: 2022-2023
[11] Health Sector Information, Analysis and Reporting (HSIAR) Division. HAMIS data.
[12] Capital Services, Finance and Corporate Services (FCS) Division
[13] Based on 2024 BC Stats population estimate
[14] CADTH Health Technology Review – The Canadian Medical Imaging Inventory: 2022-2023

LEGISLATIVE SESSION – ESTIMATES NOTE
Medically Complex Children & Youth in BC – Nursing Support Services

Topic: Nursing Support Services (NSS), a provincial program operated by the Provincial Health Services Authority (PHSA) through the BC Children's Hospital (BCCH), provides support to children and youth (0-19) with chronic, complex health conditions for whom aspects of their community care needs require the knowledge, judgement, and skill of a licensed nurse in the absence of parents/guardians.

Key Messaging and Recommended Response:

- Children with health complexity, and their families, face unique and significant challenges. The Ministry of Health is committed to ensuring they receive the support they need, when and where they need it.
- Nursing Support Services (NSS), a program of the BC Children's Hospital, provides support to children and youth whose medical care needs in community settings require additional assistance in the absence of their parents/guardians.
- NSS provides care for hundreds of families across BC, offering respite and clinical support to enable them and their children to live the highest quality of life possible from their home communities.
- In recent years, due to a variety of social, health and economic factors, the needs of children with chronic health conditions, and their families, have significantly increased. We recognize the current system of supporting medically complex children and youth has a number of challenges for families using the services and for the care providers delivering services.
- The Ministry of Health is engaged in ongoing collaboration with NSS and other partners, including the Ministries of Education and Child Care, and Children and Family Development, to explore options for enhancements to programming that better meet the needs of children and youth with health complexity, and their families.
- In addition to the evolution of the NSS program, BC Children's Hospital will also open a first-of-its-kind dedicated facility in Vancouver for children and families with health complexity, in 2028.

CURRENT SITUATION

- Currently, NSS delivers services through 2 distinct streams of care: Delegated Nursing Care/Seizure Rescue Intervention Training and In-Home Nursing Respite Care.
- Delegated Nursing Care/Seizure Rescue Intervention Training is currently only available in the K-12 school system. Childcare settings are out of scope for the program at this time.
- NSS does not have a wait list and accepts children as they are eligible.
- Currently, 1,208 children across the province receive care through Delegated Nursing Care/Seizure Rescue Intervention Training and 216 children are eligible for NSS In-Home Nursing Respite Care [1].
- NSS is also responsible for providing functional assessments of children with medical complexity, neurodevelopment complexity, intellectual differences, and mental health conditions for the Ministry of Children and Family Development's (MCFD) At Home Program.
- In 2024, NSS completed 1,070 At Home Program assessments, a 27% increase from the prior year[2].
- In May 2023, BCCH undertook a comprehensive engagement strategy with families and partner organizations to inform and support a reimagining of the NSS program. The focus was on the overall service delivery model, including clarifying and identifying accountability for service delivery components. Work is underway to move forward on implementing program enhancements aligned with engagement session findings.
- A working group with membership from the Ministry of Health (HLTH), NSS, and the Ministry of Education and Child Care are engaged in ongoing work to develop short and long-term solutions for challenges

[1] GCPE-HLTH Issues Note, *BCCH/PHSA Nursing Support Services*, February 7, 2025
[2] GCPE-HLTH Issues Note, *BCCH/PHSA Nursing Support Services*, February 7, 2025

associated with NSS school-based care and the delivery of care for medically complex children in the school setting more broadly.

- As part of an overall strategy to align services, optimize clinical expertise, and advance best practices to improve care and experience for children living with health complexity and their families, NSS will form part of the suite of services being offered through the new BCCH Centre for Children and Youth Living with Health Complexity, scheduled to open in Vancouver in 2028.

FINANCIAL IMPLICATIONS

- The budget for NSS in 2024/25 is $33.010 million.
- 2023/24 actual expenditures were $28.246 million.

KEY BACKGROUND

- Several thousand children across BC require specialized health care supports due to health complexity. Children with health complexity have complex, chronic health conditions, functional limitations, substantial health care needs, and frequently interact with health care and social support systems. Their care requires family members and caregivers to have specialized knowledge and skills.
- The NSS program was initiated in 1997, with governance and oversight provided by the PHSA since April 2015 when the program transitioned from MCFD to HLTH.
- NSS In-Home Nursing Respite Care provides parents/guardians with scheduled, intermittent periods of respite. Families eligible for In-Home Nursing Respite Care may also receive In School Support hours to enable eligible children to attend in-person, classroom instruction at school. Since the NSS program's inception, the needs of children and youth with health complexity, and their families, have significantly evolved.
- As a medical service, the NSS program must comply with the *Health Professions Act* regarding care standards and professional practice. NSS nurses are also required to comply with the BC College of Nurses and Midwives (BCCNM) practice standards.
- NSS provides most school-based support through Delegated Nursing Care which includes teaching and supervising school staff to care for children with diabetes, tube feeding, and catheterization needs.
- In late Spring 2022, it was determined that delegating the administration of seizure rescue medication to non-medical school staff falls outside the scope of care a registered nurse is allowed to delegate per BCCNM practice standards. A working group was established to examine the issue and recommended the transition to a training model which was implemented in September 2022.
- NSS seizure rescue training ensures children who may require the administration of seizure rescue intervention (including medication) while at school can receive it. Training provides general information and skills education to school staff about aspects of care.

LAST UPDATED

The content of this estimates note is current as of February 13, 2025, as confirmed by Eugene Johnson, Executive Director.

APPROVALS

2025 02 26 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 03 13 – Kelly Uyeno, Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Out of Country Radiation Treatment

Topic: Status update on the out of country (OOC) radiation treatment program

Key Messaging and Recommended Response:

- The province is taking action to ensure BC patients can continue their active treatment and to provide a temporary option to access timely treatment, if needed.
- In consideration of the current status of our relationship with the U.S., we are assessing our options to determine the need to extend our Bellingham contracts for BC patients to access timely treatment. Planning with BC Cancer is in progress.
- Additional treatment capacity in BC is actively in progress to treat patients closer to home. Over the coming years, new linear accelerators are being replaced and more will become available starting in 2028 as part of four new cancer centers in Nanaimo, Kamloops, Burnaby and Surrey.
- This is part of the government's commitment to better detect, treat and prevent cancer for people living throughout BC.
- That's why government launched a 10-year Cancer Care Action Plan with an initial investment of $440 million to support immediate steps to better prevent, detect and treat cancers, deliver improved care for people while preparing for the growing needs of the future.
- Budget 2024 announced a further $270 million to support the implementation of the cancer plan.
- This work includes reducing waits for cancer care people need and to ensure immediate action was being taken while recruitments and equipment procurements could take place, BC Cancer launched a temporary out of country radiation treatment program to get cancer patients the treatment they need, sooner.
- This program is just one tool in our toolbox to improve cancer care in the province, which is outlined in the 10-year strategy while also helping free-up space and capacity for more patients to get their treatment in BC right away.
- Between May 29, 2023, and January 2, 2025, 4,887 breast and prostate cancer patients have been referred to receive radiation therapy at 1 of 2 facilities in Bellingham, Washington. 1,059 of these patients have completed their treatment in the U.S.
- As a result of successful recruitment efforts, including radiation oncologists and radiation therapists, along with projects to improve provincial capacity to deliver radiation therapy, we have steadily improved access to radiation therapy within our province.
- Currently, 89.5% of all patients start radiation therapy treatment within 4 weeks. This is an 11.3% improvement over the same period last year.

CURRENT SITUATION

- As of January 2, 2025, 4,887 patients have been referred to receive radiation treatment, and 1,059 have completed radiation therapy in the U.S.[1]
- As of January 2, 2025, an average of 53 radiation therapy patients per week were referred to the OOC program, with an average of 14 unique patients per week participated in OOC radiation therapy treatment.[2]
- BC Cancer continues to emphasize the importance of OOC for overall provincial capacity. Particular emphasis is currently placed on BC Cancer- Victoria due to comparatively longer wait times for treatment, and to provide additional capacity required when linear accelerators are replaced and/or maintained.
- The majority of patients who have completed treatment in the U.S. were referred from the BC Cancer- Surrey, BC Cancer-Abbotsford, and BC Cancer- Victoria.

[1] BC Cancer. BC Cancer Update Fiscal Period 10 (Dec 6, 2024 – Jan 2, 2025) – Performance Report. January 20, 2025. Last accessed February 20, 2025.
[2] Ibid

Patient referrals and completed treatment by BC Cancer Centre (as of January 2, 2025)[3]

BC Cancer Centre	Referrals	Patients completed treatment
Victoria	1,208	270
Abbotsford	569	276
Vancouver	1,651	51
Surrey	1,292	413
Prince George	142	38
Kelowna	25	11
TOTAL	4,887	1,059

FINANCIAL IMPLICATIONS

- Total expenditures for 2023/24 were $16.8 million, or approximately $26,000 per patient[4].
- For fiscal year (FY) 2024/25, the costs were originally estimated to be $35 million, including $30 million in U.S. facilities contracts, $3.7 million in patient travel, and $1.4 million for the implementation of BC Cancer's Across Borders Cancer Radiation Treatment commitment patient travel program to support patients travelling to receive care in Washington State. Please note, the actual costs for in-province radiation treatment per patient are complex and subject to a number of variables. One of the variables is the number of radiation treatment fractions a patient requires, which is dependent on their patient-specific medical treatment plan.
- As of January 2, 2025, year-to-date expenditures are $13.96 million[5].

Breakdown of OOC Radiation Treatment Spending 2024/25 P10 YTD[6]

Category	Amount	Number of Patients	Average per Patient
Amount spent on patient travel and supports	$3,173,649	428	$7,415
Amount provided to each of the two Bellingham clinics to pay for treatment	$9,478,138	428	$22,145
Program administration	$1,306,445		
TOTAL	**$13,958,232**	**428**	**$29,560**
Centre Breakdown of $9.48 million			
North Cascades	*$5,231,691*	*300*	*$17,439*
Peace Health	*$4,246,447*	*128*	*$33,175*

Notes:

- This is based on 460 patients that have completed treatment from April 1, 2024, to January 2, 2025 (P10 24/25). Due to a lag in reconciling expenses, BCC has processed 428 patients to date.
- The average travel is based on total cost/number of patients. There is a range of 5-28 days for the most common treatments, but in some cases, patients stay for longer (up to 8 weeks).
- Majority of patients in FY 2024/25 are from Vancouver Island, resulting in higher travel costs (hotels, ferries, flights, and car rentals) compared to FY 2023/24, when most patients were from the Fraser Valley.
- Currency fluctuations have also increased treatment costs in FY 2024/25.
- PeaceHealth more frequently sees cases with a higher number of treatments so the average cost per patient shown below is higher.
- Program administration is BC Cancer staff providing concierge service for travel.

KEY BACKGROUND

- On May 29, 2023, BC Cancer began offering eligible breast and prostate cancer patients the opportunity to receive radiation treatment at 1 of 2 clinics in Bellingham, Washington, supporting up to 50 patients each week.
- The goal of the OOC Radiation Treatment commitment is to help address immediate challenges with wait times while BC Cancer expands its capacity to deliver radiation therapy services by recruiting additional oncologists and radiation therapists, continues to implement team-based care at all 6 cancer centres, and

[3] Ibid
[4] Email, Levchuk, Deanna. Project Manager, Strategy, Planning and Implementation – BC Cancer, PHSA. February 21, 2025.
[5] Email, Levchuk, Deanna. Project Manager, Strategy, Planning and Implementation – BC Cancer, PHSA. February 19, 2025.
[6] Ibid

expands hours of operation.

- BC Cancer is committed to minimizing any need for patients to have to access care outside their home health region and is actively working to optimize its provincial radiotherapy capacity.
- The option to receive treatment in Washington State is provided at no cost to patients and each patient has comprehensive access to a BC Cancer support team to arrange appointments, coordinate and facilitate travel plans, and support them upon their return to care at BC Cancer.
- This solution was previously used in the 1990s, when BC Cancer patients were sent to Bellingham for radiation therapy.

APPROVALS

2025 03 03 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 03 26 – Kelly Uyeno, Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Emergency Medical Assistants Scope of Practice

Topic: The Province has expanded the care Emergency Medical Assistants (EMAs) can provide to British Columbians in emergency situations.

Key Messaging and Recommended Response:

- Emergency Medical Responders, known EMAs, are usually medical first responders, paramedics, and fire fighters – people in the community responding to others in medical distress.
- In 2022, the Province expanded the EMA scope of practice allowing them to better help patients at the scene of an incident, including more life-saving interventions, like administering epinephrine for life-threatening allergic reactions.
- This means future EMA licenced personnel can work to a more fulsome scope, and pre-existing personnel would require scope expansion training to ensure they have the skills required to work at the new, expanded level.
- BC Emergency Health Services (BCEHS) is currently working to train their staff members in this expanded scope of practice including approximately:
    - 993 Emergency Medical Responders
    - 3,482 Primary Care Paramedics
    - 117 Critical Care Paramedics, and
    - 375 Advanced Care Paramedics, beginning later this spring.
- All levels of paramedics are expected to complete their training by Summer 2025.
- Progress is well underway, BCEHS partnered with a variety of training organizations and scope expansion courses are rolling out in every corner of the province.

CURRENT SITUATION

- As of December 31, 2024, BCEHS is currently working to provide advanced training to their approximately 993 Emergency Medical Responders, 3,482 Primary Care Paramedics (PCPs) and 117 Critical Care Paramedics (CCPs).
- Training for the 372 BCEHS Advanced Care Paramedics (ACPs) will begin April 2025. Training for all levels of paramedics is expected to be complete by Summer 2025.
- As these changes are implemented, paramedics and first responders will increasingly be able to better help patients on scene. For paramedics, this means the ability to provide more life-saving interventions, which at various licensing levels can include:
    - improved access to a range of analgesic (pain medications) options, including opiates
    - enhanced airway management approaches
    - providing life supporting or sustaining medications during transport
- These changes are further supported by increases to the care that EMA first responders (many of whom are firefighters, non-BCEHS employees who do not transport patients) can provide including:
    - additional diagnostic testing including blood pressure and blood glucose that can better inform paramedics about the next steps in patient care
    - administering epinephrine for a life-threatening allergic reaction
    - supporting the preparation or packaging of patients for transport by paramedics
- The scope of practice implementation is affected by the frequency of training cohorts, which in turn are affected by ongoing cost-saving measures within Provincial Health Services Authority (PHSA).

Training Statistics:

Table 1: EMA Upskilling Achievements (Source: BCEHS).[1]

[1] Provincial Services Branch, Provincial Services Division, Ministry of Health (2025) BCEHS SoP Expansion Project: Bi-Weekly Status Report, December 16, 2024-January 3, 2025.

BCEHS EMAs			
License Level	Total Employees	BCEHS Graduates from upskilling	Updated Licensees (Total employees who have had Emergency Medical Assistants Licensing Board licenses updated)
Emergency Medical Responder (EMR)	993	919 = 93%	851 = 86%
Primary Care Paramedic (PCP)	3,482	1,318 = 38%	1,259 = 36%
Advanced Care Paramedic (ACP)	372	0	0
Critical Care Paramedic (CCP)	117	103 = 88%	103 = 88%
Infant Transport Team (ITT)	19	16 = 84%	16 = 84%

- *Numbers are based on license that EMA is currently holding. For example, some PCP licensed employees choose to work EMR transfer fleet.*

Table 2: EMA Restriction Removal Licensing Data by Schedule* (Source: EMALB – data as of January 20, 2025). Note: *The EMA Regulation defines 6 categories of licenses of EMAs in BC*[2].

EMA Licensing Stats – December 6, 2024			
License Category	**Total Licensees**	**Total Schedule 1 Restrictions Removed**	**Percent Removed**
EMA FR	7,295	2,563	35.13%
EMR	4,082	2,281	55.88%
PCP	4,711	1,212	25.73%
ACP	837	35	4.18%
CCP	136	105	77.21%
ITT	19	0	0.00%
Total	**17,080**	**6,196**	**36.28%**

*The table represents all license holders, including non-BCEHS employed.

FINANCIAL IMPLICATIONS

- In 2023/24, the Ministry of Health (HLTH) provided $10 million in ongoing base funding to BCEHS to continue the scope of practice changes.
- Due to ongoing budget pressures, BCEHS alongside PHSA will be, and have been, working towards continued savings mitigation initiatives in 2025/26 to support health authority targets.
- This cost saving affects the frequency of training cohorts, which creates a level of risk for meeting implementation timelines.

KEY BACKGROUND

- To improve patient care and overall patient safety, amendments were made to the Emergency Medical Assistants (EMA) Regulations which came into effect September 23, 2022, by way of Ministerial Order No. M292.
- On July 22, 2024, the revised EMA Regulations were amended by way of Ministerial Order No. 244, and the transition timeline was extended to September 2025. In addition, minor changes to the regulations were made to reflect the EMAs current need or practice.
- The changes to the regulations stem from recommendations made by the Emergency Medical Assistants Licensing Board (EMALB) to provide better outcomes for patients needing emergency health services. The recommendations were made following the EMALB's consultation with partners, including BCEHS, Ambulance Paramedics of BC (CUPE 873), BC Professional Fire Fighters Association, Fire Chiefs Association of BC, EMA recognized training program representatives, and paramedics in industry.
- The Justice Institute of BC were responsible for developing the PCP and ACP upskilling curriculum, in addition to developing and delivering EMR upskilling education for BCEHS employees. In February 2024, after identifying a misalignment with Justice Institute of BC's curriculum and BCEHS' educational needs, BCEHS' brought the development and delivery of the PCP and ACP curriculum in-house.

[2] Email, Vowles, Wendy. Director, Emergency Medical Assistants Licensing, Health Sector Workforce and Beneficiary Services Division. December 9, 2024.

- It is anticipated that the use of internal educators, instructors, and resources will prevent further strains on BCEHS clinical operations staffing, increase equitable access to education for all employees, minimize total implementation costs and ensure training is complete by the revised transition date.
- The BCEHS Scope of Practice Expansion Project operationalizes full Schedule 1 and select Schedule 2 skills from the updated EMA Regulations for BCEHS. In the future BCEHS may elect to operationalize additional Schedule 2 skills which are not currently being implemented at the PCP and ACP levels.

LAST UPDATED

The content of this estimates note is current as of February 24, 2025, as confirmed by Eugene Johnson, Provincial Services Branch, and Wendy Vowles, Emergency Medical Assistants Licensing Branch, HSWBS.

APPROVALS

2025 03 05 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 03 24 – Kelly Uyeno, Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE
Access and Admission to Long-Term Care

Topic: Long-Term Care (LTC) access and admissions policy, legislation and HLTH access monitoring.

Key Messaging and Recommended Response :

- We are working to ensure that B.C.'s growing and aging population has the support they need, when and where they need it.
- In response to requests from seniors and recommendations from the Ombudsperson and the Seniors Advocate, the policy on access to long-term care was updated in 2019 to provide greater choice for those in need of care.
- Seniors (65+) represent 20% of B.C.'s population in 2024 and is projected to reach 23% in 2034.
- To address the increasing demand, our government has established a capital funding envelope for long-term care renewal and expansion. Since 2017, there have been 37 projects approved, providing 2,152 replacement LTC beds, 3,436 net new LTC beds, and 154 private LTC beds, for a total of 5,588 LTC beds.
- In addition, innovations in services to support seniors to remain at home include The LTC@Home program, which equips seniors' homes with technology for virtual care that is customizable to an individual's needs and monitored by a care team. The program also includes respite care, offering up to a 1-week period of respite every 4 to 6 weeks to help alleviate family caregiver burnout, extending their ability to care for a loved one in the home.
- In addition to expanding infrastructure, we are also taking steps to strengthen the long-term care workforce. We have put in place a standardized approach to wages for workers in LTC and have moved forward with funding temporary wage increases while work is underway on a standardized LTC Funding Model. These same standardized wages support our home health and assisted living sectors.

CURRENT SITUATION

- The Ministry is monitoring the impact of the revised LTC Access Policy over time through the collection of data and information from health authorities.
- The most recent data from 2024/25 Q2[2] shows:

  Admissions from the community:
  - 55% (1,240 of 2,268) of LTC admissions were from the community.
  - This rate has varied from a low of 44% in 2022/23 Q4 to a high of 55% in both 2022/23 Q4 and 2024/25 Q2.

  Wait times for admission:
  - The average wait time for LTC admission was 138 days (4.5 months). Wait times have steadily increased since 2019/20 Q3 when they were 63 days.
    - Clients admitted directly from acute care waited 48 days on average. Wait times have been increasing from a low of 26 days in 2021/22 Q2.
    - Clients admitted from the community waited 182 days (6 months) on average. Wait times have steadily increased since 2019/20 Q3 when they were 80 days.

  Preferred care home (PCH) admission:
  - 36% of all LTC clients were admitted directly to a PCH.
  - 29% of acute care admissions and 42% of community community were to a PCH.
  - Admissions directly to a PCH have declined since the policy was implemented, starting at 43% in 2019/20 Q3, increasing to a high of 53% in 2020/21 Q4 and decreasing to a low of 33% in 2023/24 Q2.

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[1] Ministry of Health. Report ID: 4112. Population Statistics. Retrieved from: Population StatisticsHealth System Performance Portal. Last accessed on: 2025-02-14 9:09:13 PM

[2] Ministry of Health. Report ID: 3886. Long-Term Care Access Monitoring. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/long-term-care-access-monitoring. Last accessed on 2/14/2025 9:15:04 PM

Interim care home transfer:

- Clients admitted to an Interim Care Home (ICH) before transferring to a PCH waited an average of 345 days for transfer. Over the last four fiscal years, the wait time has trended upward from a low of 131 days (2019/20 Q4) to a high of 350 days (2024/25 Q1).

LTC waitlist:

- 6,714 clients were waitlisted, with an average wait time of 246 days (8 months).
- 6,102 were from community, waiting for an average of 259 days (8.5 months)
- 612 were from acute care, waiting for an average of 117 days (4 months).
- Waitlist size and wait times have been grown significantly over the last four fiscal years. The total number of clients waitlisted and their average wait time have increased from 3,091 clients waiting 196 days (6.5 months) in 2021/22 Q1 to the current high of 6,714 clients waiting 246 days (8 months).

- Alternative level of care (ALC) patients waiting for LTC
  - 1,071 ALC patients were waiting for LTC in 2024/25 Q1, with an average wait time of 47 days.
  - While the number of ALC patients waiting for LTC has remained relatively steady, wait times have risen since 2021/22 Q1. As a result, the total bed-days in ALC for patients waiting for LTC in 2024/25 Q1 is a historical high. It is 25% higher than the same period last year (2023/24 Q1) and 75% higher than in 2021/22 Q1.

KEY BACKGROUND

LTC Access Policy

- On July 15, 2019, the policy regarding access to long-term care (LTC) in the Home and Community Care (HCC) Policy Manual was revised to provide greater choice for individuals and their families through a more client-centered, consistent, transparent, and clear LTC access process. Chapter 2.D, Client Access, Assessments, and Chapter 6, LTC Services, provide the regional health authorities with direction for planning and delivering publicly subsidized LTC services.
- The LTC Access Policy complies with Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* (HCCCFAA), removing any elements in the previous admission criteria that could be construed as coercive, such as the requirement that a client accept the first appropriate bed to be eligible for LTC. This came into force November 4, 2019.
- Both the policy and the legislation address recommendations made in the Ombudsperson's 2012 seniors' care report and promote a more client-centered approach to how seniors enter LTC homes.

Part 3 of HCCCFAA

- Part 3 of the HCCCFAA legally requires consent to be obtained for an adult's admission into a care facility, including LTC homes and licensed mental health and substance use facilities.
- This consent is given by the adult to be admitted, unless they have been determined to be incapable of giving or refusing consent to care facility admission, through an assessment conducted according to the requirements of the HCCCFAA and Health Care Consent Regulation.
- An incapability assessment can be conducted by a registered nurse, registered psychiatric nurse, nurse practitioner, psychologist, occupational therapist, social worker, or medical practitioner.
- If the adult is determined to be incapable of giving or refusing consent, consent must be obtained from a substitute, according to the ranked list set out in legislation. In the event there is no appropriate substitute available, the Public Guardian and Trustee can make the care facility decision on behalf of an incapable adult.
- If a person is found incapable of giving or refusing consent, they have the right to a second assessment. Second assessments must be conducted by a medical practitioner or nurse practitioner if the first assessment was not done by one of these professions.

LAST UPDATED

The content of this estimates note is current as of February 21, 2025, as confirmed by Danielle Prpich.

APPROVALS

2025 03 28 – Ross Hayward, ADM, Seniors Services Division
2025 03 04 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 07 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division

LEGISLATIVE SESSION - ESTIMATES NOTE

Office of the Seniors Advocate Report: Affordability for Seniors

TOPIC

BC's Office of the Seniors Advocate (OSA) has raised affordability issues facing BC Seniors in the report titled *BC Seniors: Falling Further Behind, published 2022.*

Key Messaging and Recommended Response:

- Nothing is more important than ensuring seniors and elders have the care and support they need to live a healthy and happy life.
- We are committed to improving care to steward public investments made in seniors' care, given the growing population of seniors in our province.
- To support our work, government appreciates efforts from the Seniors Advocate whose shared priorities bring important recommendations on where to direct funding and programs to support.
- Over $3.5 billion has been invested since 2018/19 to expand and improve care for seniors across BC including investments in primary care and home and community care (home health, long-term care and assisted living).
- For example, recent budgets have provided $354 million over three years to support seniors to age comfortably and safely in their own homes and maximize their quality of life, including:
  - $127 million over three years to stabilize and expand community-based seniors' services that provide seniors with non-medical support, and
  - $227 million to improve the quality and responsiveness of home health services.
- Our government is committed to supporting seniors and making up for years of funding neglect and we're committed to continuing this work through ongoing budget and program investments.

CURRENT SITUATION

- The OSA report *BC Seniors: Falling Further Behind*[1] released on September 22, 2022, offered a systemic review of affordability issues for seniors across BC. The report's ten recommendations span initiatives and projects across multiple BC Ministries, including Housing and Municipal Affairs, Social Development and Poverty Reduction, and Health.
- Since then, the new Seniors Advocate identifies affordability issues in *Ageing matters: Listening to B.C.'s seniors,* released on June 5, 2024[2], a report in which affordability is identified as a priority issue impacting seniors' ability to age well, calling attention to Recommendations 1, 2, and 3 below.

The table below outlines recommendations from the *BC Seniors: Falling Further Behind* report and government initiatives / planned actions related to the recommendations:

Recommendation and Government Response
#1: Index the BC Seniors Supplement to inflation consistent with other income supports (e.g., GIS/OAS, CPP). **Government Response:** Direct to Ministry of Social Development and Poverty Reduction
#2: Redesign the Shelter Aid for Elderly Renters (SAFER) program; **Government Response:** Direct to Ministry of Housing and Municipal Affairs
#3: Increase the number of Seniors Subsidized Housing Units with a focus on rural B.C. **Government Response:** Direct to Ministry of Housing and Municipal Affairs

[1] Office of the Seniors Advocate British Columbia. (2022). BC Seniors: Falling Further Behind. Retrieved from: BC Seniors: Falling Further Behind - Seniors Advocate

[2] Office of the Seniors Advocate British Columbia. (2024). Ageing matters: Listening to B.C.'s seniors. Retrieved from: https://www.seniorsadvocatebc.ca/osa-reports/ageing-matters-listening-to-b-c-seniors/

#4: Increase awareness of the Property Tax Deferral Program; examine expansion of the program for low- and modest-income seniors to defer other costs (e.g., strata fees, hydro costs, other municipal charges).
Government Response: Direct to Ministry of Finance

#5: Develop a program to assist low- and modest-income seniors with major home repairs.
Government Response: Direct to Ministry of Housing and Municipal Affairs (BC Rebate for Accessible Home Adaptations, operated by BC Housing)

#6: Eliminate the daily rate for publicly funded home support services.
Government Response:

- In 2025, 67% of long-term HS clients (~16,100 clients) were assessed a $0 rate (i.e., no client charge), 9% (~2,200 clients) had their fee capped at $300 per month, and 24% (~6,100 clients) paid an income-tested fee.
- If a client or their family will experience serious financial hardship by paying the assessed client fee, the client may apply for a waiver of all, or a portion, of the client fee for up to one year.

#7: Provide an extended health benefit for seniors (e.g., for eyeglasses, hearing aids, mobility aids and necessary medical equipment). Cost of the plan could be covered by premiums based on income.
Government Response:

- Eligibility for the Medical Services Plan (MSP) Supplementary Benefits Program (SBP) is based on a person's adjusted net income, which must be less than $42,000, from the preceding tax year (combined with that of their spouse, if applicable); not dependent on age.
- The SBP includes a contribution of $23 per visit, regardless of provider, up to a total combined limit of 10 visits per year summed across 6 provider types: acupuncture, chiropractic, massage therapy, naturopathic, non-surgical podiatry, and/or physiotherapy.
- In addition to the SBP, the Province via MSP also provides funding towards supplementary health care services like optometry, surgical podiatry, dental, and midwifery services.
- The SBP does not fund devices (e.g., eyeglasses or mobility aids); devices generally not covered by MSP.

#8: Work with the federal government to ensure dental coverage for seniors with co-payments and deductibles based on income or include in an overall extended benefit plan.
Government Response: Direct to Ministry of Social Development and Poverty Reduction

#9: Provide an annual province-wide bus pass for all seniors that includes handyDART (e.g., on a sliding scale)
Government Response: Direct to Ministry of Social Development and Poverty Reduction

#10: Develop a comprehensive plan to build the capacity of seniors' centres across BC to better support social engagement and support older peoples' access to the supports and services needed to live independently.
Government Response:

- Budget 2024 provided $127M to expand community-based seniors services (CBSS) provided through non-profit organizations, with funding managed by the United Way British Columbia.
- Please see CBSS Estimates Note for information about work well underway to modernize strategy and service delivery in this sector, placing social connection at the core of all service delivery (providing non-medical support and health promotion services), at low or no cost to participants. Low to modest income seniors are a prioritized group for service delivery.

FINANCIAL IMPLICATIONS

- *Budget 2024* provides $354 million over three years to support seniors to age comfortably and safely in their own homes and maximize their quality of life, including:
  - $127 million over three years to stabilize and expand community-based seniors' services that provide seniors with non-medical support.
  - $227 million to improve the quality and responsiveness of home health services.
- OSA recommendations to eliminate the client co-payment for HS would reduce health authority (HA) revenues. In 2023/24, HAs reported ~$35 million in HS client co-payment revenue.
-
- In 2024/25, HLTH entered into a 5-year (April 1, 2025 to March 31, 2030) agreement with UWBC (**not announced**) to support the delivery of existing and new publicly subsidized CBSS, as well as the development and maintenance of provincial resources to support the sector and build its capacity.

- In 2022/23, HLTH provided United Way BC (UWBC) $70 million to deliver CBSS programs over two (2) years and implement changes to the CBSS service delivery model.

KEY BACKGROUND

- The stated intention of the *BC Seniors: Falling Further Behind* report was to understand the impact of rising costs on seniors. A range of government supports, services and subsidies were reviewed to determine their effectiveness, using data from a 2022 survey of low-income seniors and consultation with 82 community agencies.
- Recommendations touch many areas of government, signaling ongoing need for affordable and appropriate services to meet rising demand from a growing seniors' population.

LAST UPDATED

The content of this fact sheet is current as of February 13, 2025 as confirmed by Alix Adams, Executive Director, Seniors' Services Division.

APPROVALS

2025 03 28 – Ross Hayward, ADM, Seniors Services Division
2025 03 13 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Age Forward Strategy

Topic: Age Forward: British Columbia's 50+ Health Strategy and 3-Year Action Plan

Key Messaging and Recommended Response:

- B.C.'s population is growing and changing at an unprecedented rate.
- To meet the increasing demand from our growing senior population, Age Forward: B.C.'s 50+ Health Strategy and 3- Year Action Plan (The Strategy) is a proactive, evidence-based strategy and action plan designed to enhance the health and wellbeing of older adults in B.C.
- The plan focuses primarily on fall prevention and addressing related healthcare challenges through evidence-based approaches, focused on preventing & reducing falls, and associated health care challenges among older adults in B.C.
- The Strategy prioritizes prevention and supports to empower older adults to maintain their independence and dignity while optimizing their health outcomes.
- Goals include extending health span, supporting aging in place, and reducing preventable healthcare utilization through enhanced programs and services.

CURRENT SITUATION

The Ministry of Health (HLTH) launched *Age Forward: British Columbia's 50+ Health Strategy and 3-Year Action Plan* in September 2024. This initiative aims to prevent and reduce frailty, falls, and fall-related injuries through a 3-year action plan consisting of 35 actions across five focus areas. The Strategy presents HLTH's plan for supporting, expanding, and developing policies, services, programs and resources to promote and protect the health of older adults as they age.

The goals of Age Forward are to:

- Promote an increase in health span, extending the years older adults live in good health;
- Provide necessary services to support adults to age in their homes; and to
- Reduce preventable emergency care, hospitalizations, and admissions to long-term care through the enhancement of home-based and community supports and improving the responsiveness of health services to meet the diverse needs of the aging population.

The Strategy presents five focus areas:

- **Prevention and Health Promotion**: empower older adults to lead active, healthy lives by promoting physical activity, nutrition, social engagement, and preventative care.
- **Screening, Early Identification, and Risk Reduction**: to build a strong system for early frailty detection and management, enabling timely, tailored interventions to reduce incidences and impact.
- **Supporting Health at Home**: to help older adults live safely and independently in their preferred environment by enhancing services, community resources, and home adaptations to meet their changing needs.
- **Restoring & Preserving Health**: to ensure seamless access to integrated care – spanning preventative, acute, and community – to manage health.
- **Collaboration, Accountability, and Continuous Improvement**: to create governance structures and a monitoring framework that drive continuous improvement and ensure The Strategy stays effective, relevant, and responsive to the needs of BC's older adults.

The 3-Year Action Plan addresses these five focus areas by enhancing existing Ministry programs, services and actions, including:

- Community-based physical activity and fall prevention programs, health information resources, and food and nutrition supports.

- Preventative health assessments, clinical screenings, and frailty management programs.
- Fall prevention, home safety supports, and home & community-based health services.
- Culturally safe and integrated healthcare services, along with specialized acute care practices.
- Cross-sector collaboration and community engagement initiatives.

The Ministry is leading the Strategy's implementation by coordinating with internal partners and regularly measuring progress to track achievements on the action plan's goals.

FINANCIAL IMPLICATIONS

- To inform development of Age Forward, in 2023/24: $145,000 was allocated for facilitation and strategic advisory services from external agencies and $20,000 to the BC Injury Research and Prevention Unit for staff capacity. Graphic design funding for Age Forward totaled $15,000 in 2024/25.
- The Strategy consolidates and optimizes existing funded initiatives supporting older adults living in BC and provides a strategic framework to align ongoing resources with the needs of older adults and plan for future investments.
- Any new funding required to commit to the actions within the 3-Year Action Plan was sourced as needed by the accountable division within the Ministry of Health.
- Population and Public Health was allocated $720,075 to deliver on Prevention and Health Promotion actions in 2024/25, including:
    - Exploring opportunities to develop a provincial approach to accessible, community-based physical activity programming and resources for fall prevention ($110,000)
    - Exploring the feasibility of developing a provincial navigation tool/repository of community-based physical activity programs and services for older adults ($110,000)
    - Exploring opportunities to expand the Indigenous Elders Activity Program ($50,000)
    - Expanding food access support through the Farmers Market Nutrition Coupon Program ($250,000)
    - Developing distinction-based, food-related wellness tools for Indigenous communities ($75,000)

KEY BACKGROUND

- Frailty is a condition of reduced function and health among older individuals, influenced by factors like poor nutrition, falling, medication effects, and social isolation. Frailty can be managed and prevented.
- It is estimated that 1 in 4 older adults, and 1 in 2 First Nations older adults, are medically frail, with more females affected compared to males.[1]
- The Strategy was informed by evidence reviews, jurisdictional scans, analysis of population health data, an inventory of current Ministry actions, external engagement with partners, experts, and Indigenous Elders.
- The Strategy has been endorsed by the Seniors' Advocate and was reviewed by the Office of the Provincial Health Officer in advance of finalization and release.
- The Age Forward Strategy was publicly released in September 2024 and is available on the BC Government website.

LAST UPDATED

The content of this estimates note is current as of February 12 2025, as confirmed by Karen Neilson, Executive Director, Specialized Services, Seniors' Services Division

APPROVALS

2025 03 25 – Ross Hayward, Seniors' Services Division
2025 03 07 – Brenda Rafter obo Rob Byers, ADM, Finance & Corporate Services Division

[1] Canadian Frailty Network. 2024. What is Frailty? Available from: https://www.cfn-nce.ca/frailty-matters/what-is-frailty/

LEGISLATIVE SESSION – ESTIMATES NOTE

Antipsychotic Use in Long-Term Care

Topic: Antipsychotic medications are commonly prescribed to manage behavioral and psychological symptoms of dementia (BPSD) and are associated with an increased risk of serious side effects.

Key Messaging and Recommended Response:

- Our government is committed to delivering the best quality of care to patients , and a part of that is ensuring people receive appropriate care.
- At a national level, the potentially inappropriate use of antipsychotic medication in long-term care increased in 2020/21 to 2022/23 during the pandemic, including in B.C.
- Prior to the pandemic, the performance measure was holding steady in B.C. (25.4% in 2017/18, 24.7% in 2018/19 and 24.7% in 2019/20).
- Adverse effects to antipsychotic medications can include sedation, and increased risk of falls, stroke and death.
- That is why the ministry has increased funding for dementia education programs to support staff to provide person-centred cared. This includes initiatives like the PIECES Learning and Development program to support health-care providers to assess and manage behavioural and psychological symptoms of dementia with interpersonal strategies.
- In addition, the Ministry implemented a policy in September 2024, that strengthens the oversight requiring providers to fully explore all non-pharmacological interventions before prescribing antipsychotics and complete more frequent reviews of existing prescriptions.

CURRENT SITUATION

- The Canadian Institute for Health Information (CIHI) indicator *Potentially Inappropriate Use of Antipsychotics in Long-Term Care* (PIALTC) is identified as a system performance measure in the 2025/26 – 2027/28 Ministry of Health Service Plan[1]. Baseline and targets are:

2017/18 Baseline	2024/25 Forecast[1]	2025/26 Target	2026/27 Target	2027/28 Target
25.4%	**29.0%**	**28.0%**	**27.0%**	**26.0%**

Data source: Continuing Care Reporting System, data represents risk-adjusted rates.
[1] Forecast based on historical data from 2016/17 to Q1 2024/25, generated as of January 2025.

Potentially inappropriate use of antipsychotics by health authority[2]									
	2017/18 (Baseline) [3]	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	
								Q1	**Q2**
IHA	25.8%	26.0%	24.9%	26.3%	25.7%	29.1%	30.5%	30.5%	30.7%
FHA	22.8%	21.4%	21.4%	23.6%	26.4%	26.8%	27.7%	27.9%	28.2%
VCHA	26.9%	26.6%	26.4%	27.8%	31.0%	32.3%	33.1%	33.2%	32.9%
VIHA	26.5%	25.7%	25.6%	27.7%	27.4%	27.3%	26.0%	25.7%	25.4%
NHA	32.2%	32.3%	36.3%	39.8%	35.3%	35.7%	29.2%	29.1%	30.1%
BC	**25.4%**	**24.7%**	**24.7%**	**26.5%**	**27.9%**	**29.0%**	**29.3%**	**29.4%**	**29.4%**
Canada		20.7%	20.2%	21.1%	23.9%	24.5%	24.5%		

Canada rates include participation from approximately 70% of LTC facilities across the country.[4]

- The national average for PIALTC was 24.5% in 2023/24, representing no change since 2022/23.
- BC's average was 29.3% (4.8% higher than the national average.)

[1] Ministry of Health Service Plan 2025/26 - 2027/28 TBD
[2] CIHI, eReporting Extracted 2025-01-08 for 2020/21 to present.
[3] CIHI, eReporting Extracted 2022-07-20

- BC's average has increased 4.6 percentage points since 2018/19 (24.7%)
- Of the seven jurisdictions in Canada that reported on the measure in 2023/24, BC's rate is the 5th highest, below Yukon (35.3%), Saskatchewan (34.8%), New Brunswick (33.7%), and Newfoundland and Labrador (31.8%).[4]

The Ministry has strengthened the monitoring and oversight of the use of antipsychotics in LTC by implementing policy that creates a standard provincial expectation for the use of medications to manage or modify behaviours, including antipsychotics, in publicly-funded LTC settings.

- The policy 'Medications to Manage or Modify Behaviours' was added to the LTC Chapter of the Home and Community Care Policy Manual in September 2024.
- In April 2024 the Long-Term Care Quality Framework Policy Directive was released in April 2024, which established requirements for health authorities to assess long-term care service quality including the use of antipsychotics.

The Ministry has invested in dementia care education programs for health care providers in LTC to enable all members of the care team to have a common knowledge base, language and approach to care:

- PIECES Learning and Development Program™ is an evidence-based approach for the care of people with dementia that health care providers apply in LTC settings. This program has been funded in BC since 2013 and funding is planned to be extended until 2028.
- U-First! ® Dementia Education Training helps non-regulated health care providers understand the person with dementia and associated behaviour changes and work together as a team to develop individualized support strategies:
- B.C. provided a $7.54 million grant to the Alzheimer Society of B.C. to roll out U-First!® education program for LTC staff.

FINANCIAL IMPLICATIONS

- The PIECES Learning and Development Program™ has received $0.625M in Ministry funding since 2013, with an additional $0.400M allocated through March 2028.
- In 2024/25, the Ministry provided $7.54 million to the Alzheimer Research Foundation of BC to work with Alzheimer Society of B.C. to make U-First!® training available to staff working in long-term care settings.

KEY BACKGROUND

- Antipsychotics may be prescribed when dementia-related behavioral symptoms pose safety risks or significantly impede care
- However, these medications can increase seniors' risk of falls, stroke, and death
- The Canadian Institute for Health Information tracks potentially inappropriate antipsychotic use in long-term care as a quality indicator
- In 2024, the Office of the Seniors Advocate reported this indicator reached a five-year high, likely due to pandemic-related factors such as limited in-person visits, Increased stress on residents and staff and additional workload from COVID-19 [5]

LAST UPDATED

The content of this fact sheet is current as of Feb 12, 2025, as confirmed by Karen Neilson, ED, SSD.

APPROVALS

[2025 03 11] – Ross Hayward, Seniors' Services Division
[2025 02 26] – Heather Richards obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 02 27– Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[4] CIHI Your Health System in Depth

[5] OSA, Monitoring Seniors Services (2024). https://www.seniorsadvocatebc.ca/monitoring-seniors-services

LEGISLATIVE SESSION – ESTIMATES NOTE

Assisted Living - Seniors

Topic: The *Community Care and Assisted Living Act* (CCALA) and the Assisted Living Regulation (Regulation), provide authority for the Assisted Living Registry (Registry) to register assisted living residences, conduct site inspections, and respond to complaints.

Key Messaging and Recommended Response:

- Improving oversight and accountability of supportive recovery residences is a priority for government. We will continue to employ all means available to ensure the health and safety of assisted living residents in registered facilities throughout the province.
- The Assisted Living Registry is responsible for the monitoring and inspection of registered assisted living residences
- If a residence is found to be in contravention of the Community Care and Assisted Living Act (CCALA) and/or the Assisted Living Regulation, the Registry first works with the operator to provide education and resources, as many contraventions can be resolved in that way.
- If the operator is unable or unwilling to remedy the deficiencies, and the health or safety of a resident is at risk the Registrar may also take action, including attaching terms or conditions, suspending admissions, suspending a registration, or cancelling a registration.
- Anyone can make a complaint to the Assisted Living Registry if they are concerned that the operator is not protecting the health or safety of a resident.
- The Registry has staff that are specifically assigned to monitor seniors assisted living residences. A dedicated supportive recovery team in the Assisted Living Registry is in place to investigate safety concerns, hold operators accountable for regulatory requirements, and conduct proactive inspections.

CURRENT SITUATION

- Over the last few years, the Registry has experienced ongoing staffing and database challenges and has been struggling to respond to and address registration applications and public complaints in a timely manner.
- The Registry was previously unable to implement proactive ongoing regulatory education and operator compliance inspections due to staffing vacancies and workload.
- The Registry has since reorganized the staffing structure to create two population focused portfolios which include one for seniors and persons with disabilities and another for supportive recovery and mental health assisted living residences.
- Registry staffing has also been enhanced within the portfolios, with the creation of two director positions, two practice leads, four senior investigators and additional front-line investigator positions.
- Both practice lead positions and three of the four senior investigator positions have been filled and recruitment to achieve a full complement of front-line investigative staff continues.
- With the new structure and staffing increase, the Registry is better positioned to carry out its legislative duties under the CCALA.
- On April 19,2024, the Registry launched its new data system. Staff attended a two-day training event to familiarize themselves with the data system functionality and enhanced features.
- The new system includes enhanced reporting and workload management.
- Each residence must re-register and pay an annual renewal fee on March 31 of each year.
- The renewal process includes a review of each residence to confirm or update the number of registered units, update any changes to business operations and staffing, as well as confirmation of the services being offered to residents.

- For new applicants, an initial registration process typically takes between 3 – 6 months for each new applicant to complete. This includes time for the applicant to complete all the required components (such as municipal approvals and business licensing) as well as for the applicant to submit the required policies to the Registry. The Registry then reviews all the documents and policies to ensure that they meet regulatory requirements. Once this process is successfully completed and a registration fee is paid, a registration to operate can be issued.

Ongoing work conducted by the Registry includes:

New registrations, applications, and renewals April 1, 2024, to December 31, 2024

- Five applications to open Senior's residences were received:
  - 3 are currently under review
  - 2 have been approved
- Three sites were deregistered:
  - 2 stopped operating
  - 1 changed the services they offer to independent living
- 201 Seniors' registration residences were renewed.

Incident Reports April 1, 2024, to December 31, 2024

- 4742 incident reports were received, reviewed and closed.
- The Regulation requires incident reports to be submitted by the operator within 24 hours of an incident occurrence. Operators must report on specific incident types as required by the Regulation such as missing/wandering residents, falls and disease outbreak.
- Registry staff review and follow up with the operator on incidents they report. Some incident reports require multiple follow ups and further assessment for compliance with the legislation and to ensure the operator is protecting the health and safety of their residents.

Site Inspections April 1, 2024, to December 31, 2024

- 46 Seniors residence site inspections were conducted by the Registry.
- Site inspections included complaint follow-up, new registrations, compliance monitoring and education.

KEY BACKGROUND

- Assisted Living (AL) is congregate housing that provides 1 or more AL services (i.e., assistance with activities of daily living, assistance with medication management, assistance with safekeeping money and personal property, assistance with managing therapeutic diets, assistance with behaviour management, and psychosocial supports) and 5 hospitality services (meals, housekeeping, laundry, recreation, emergency response system).
- AL residences for seniors support adults who require support but can make decisions on their own behalf that are necessary to live safely in a semi-independent environment.
- The Registry registers AL residences and responds to complaints or other information that indicates residences are being operated in a way that does not ensure the health and safety of the residents, or that an unregistered AL residence is being operated. Anyone with a concern can make a complaint to the Registry. Registry staff conduct investigations that are remedial in nature.
- Residences which meet the definition of AL and provide services to three or more persons are required to be registered with the provincial Registry, regardless of whether they are publicly subsidized or private pay.

LAST UPDATED

The content of this fact sheet is current as of December 31, 2024, as confirmed by Dawn Williams.
Data sourced from the Assisted Living Registry data system.

APPROVALS

2025 03 02 Ross Hayward, ADM, Seniors Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Caregiver Support

Topic: Caregiver support provides relief from the emotional and physical demands of caregiving and in BC includes in-facility (overnight) respite, adult day services, and in-home respite visits.

Key Messaging and Recommended Response:

- Caregivers are integral to BC's health care system.
- Family and friend caregivers are key supports enabling the growing seniors' population to remain living at home, which we know is where most seniors want to be.
- To support caregivers, the Province has invested $175 million over the last 5 years to expand respite care and adult day services.
- Our government has increased the number of dedicated respite beds available to 266 across the province, a capacity increase of 18% since 2018/19.
- Another example of this investment is the 162 space expansion to the Progressive Intercultural Society's (PICS) adult day program April 2024, a program that is tailored to South Asian seniors.
- Budget 2024 provided $145.563M in 2025/26 and $163.034M in 2026/27 and ongoing to improve the quality and responsiveness of home health services and to stabilize and expand community-based seniors services, investments that will also benefit caregivers.

CURRENT SITUATION

Adult Day Services (ADS)[1]

- Health authorities (HAs) are working to return ADS to pre-pandemic service levels, however, attendance is impacted by changing client preference for 1:1 care in their home vs. a group setting.
- For 2023/24, ADS days returned to 89% of pre-pandemic volumes, serving 95% of pre-pandemic clients, while utilization of available ADS spaces dropped from 70% to 63%, indicating lower uptake.
- As of December 2024 (P09), ~6,200 unique clients attended ~198,000 program days in ~32,000 available spaces.[2] Complete 2024/25 volumes are projected to be similar to 2023/24.
- HAs are investing in innovative ADS to better meet the needs of BC's diverse population, including programs tailored to specific cultures (e.g., South Asian clients) and mobile and virtual programs.

In-Facility Respite[3]

- There are currently 266 dedicated respite beds in BC, a capacity increase of 18% since 2018/19.
- HAs report challenges returning in-facility respite service to pre-pandemic levels due to workforce shortages, long-term care (LTC) admissions, and bed prioritization for alternate level of care/acute patients.
- By the end of 2023/24, ~77,600 service days were delivered to ~3,200 unique clients.
- Service days and client counts are projected to be lower for the 2024/25 year, as YTD, HAs are 3% behind in service days and 4% behind in clients served compared to the same period in 2023/24.

In-Home Respite

- Budget 2024 investments enable delivery of enhanced in-home respite services, where eligible clients receive a wellness visit from an unregulated care provider. The focus of the service is to provide companionship for clients while engaging them in social/recreational activities and cognitive stimulation that enriches their day, in addition to providing assistance with basic household tasks.

[1] HSIAR, Home and Community Care Progress Report, 2024/25 Period 09, last accessed February 3, 2025.
[2] ADS spaces are reported as the average number of spaces reported by HAs by reporting period; YTD is averaged over 9 periods and annual values are averaged over 13 periods.
[3] Report on Home and Community Care Bed Inventory, November 2024.

- Enhanced in-home respite services will be prioritized for highest needs clients, as caregivers of these clients are at the greatest risk of experiencing distress.

LTC@Home

- LTC@Home is an innovative seniors care program leveraging virtual care and monitoring technology that emulates some of the essential support of a LTC facility, but in one's own home.
- The program also offers in-facility respite for 1 week per month to seniors with more complex needs, relieving caregiver pressures and providing a health check-in while the senior is in the facility.

FINANCIAL IMPLICATIONS

- Over 3 years, Budget 2024 provides $227M to improve home health services and $127M to stabilize and expand community-based seniors services, which will benefit caregivers.
- In 2023/24 BC and Canada entered into the Aging with Dignity bilateral agreement, which includes funding of up to $47 million over 4 years to support caregivers through the LTC@Home program.

KEY BACKGROUND

- Caregiver support services provide relief from the emotional and physical demands of caregiving.
- Caregivers are integral to BC's health care system. The Office of the Seniors Advocate (OSA) reports that LTC and acute care would be overwhelmed if the network of family caregivers collapsed.[4]
- As of 2022/23, 95% of long-term home health clients have a caregiver, for whom average informal care hours and rates of distress have risen, impacting their ability to continue to provide care.[5]
- Budget 2024 investments support caregivers via enhanced care planning and in-home respite visits.
- Both ADS and in-facility respite are recovering from pandemic service suspensions, seeing higher capacity and utilization, but investments and innovation are needed to support those inadequately assisted through core programs and to meet higher service needs associated with population growth.

Adult Day Services

- ADS are programs provided in a community setting. Clients receive personal care, health care, and therapeutic social/recreational activities and caregivers receive a break from caregiving duties.
- HAs may charge a daily rate to clients for ADS to assist with the cost of supplies, transportation (if provided), and meals, to a maximum of $10 per day.

In-Facility Respite

- In-facility respite provides short-term care for clients in a licensed LTC home, supporting caregivers by enabling time away from caregiving while clients receive safe, professional care.
- The daily client rate for short-stay services, including in-facility respite, is pro-rated based on the minimum monthly rate for LTC services. As of January 1, 2025, the fixed daily client rate is $48.20.

Seniors' Guide

- The BC Seniors' Guide (12th Ed., 2020) is an invaluable resource for seniors and caregivers, providing information about services and support, available through the OSA and Ministry in 10 languages.

Family Caregivers of BC

- Family Caregivers of BC is a non-profit supporting informal and unpaid caregivers via health system navigation, education and information, emotional support groups, and a toll-free support line.

LAST UPDATED

The content of this fact sheet is current as of February 12 2025, as confirmed by Alix Adams, SSD.

APPROVALS

2025 03 18 -Ross Hayward, ADM, Seniors Services Division
2025 03 03 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2025 03 10 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[4] Office of the Seniors' Advocate (2023). We Must Do Better, Page 48.
[5] Canadian Institute for Health Information, Profile of Home Care Clients 2022-23.

LEGISLATIVE SESSION – ESTIMATES NOTE

Community-Based Seniors' Services

Topic: The Ministry of Health's (HLTH) investment in the community-based seniors' services (CBSS) sector focuses on healthy aging and supporting seniors to live independently at home in the community for as long as possible. United Way British Columbia (UWBC) manages CBSS programing funded by HLTH and delivered by local non-profit agencies (e.g., seniors' centres, neighborhood houses, community centres) throughout the province.

Key Messaging and Recommended Response:

- Community-based seniors' services (CBSS) are integral to the Province's plan to support seniors aging in place.
- These services provide seniors with a broad range of non-medical home support, health promotion programs and services that aim to address the social determinants of health.
- Community-based services demonstrated their value through rapid roll out of the *Safe Seniors, Strong Communities* program during the COVID-19 pandemic; its support during climate emergencies.
- A modernized CBSS service delivery model is being implemented in phases in 2024/25 and 2025/26 to enhance access, coordination, and support for seniors, prioritizing those who are most in need.
- Better at Home is the flagship program providing non-medical support services to seniors. There are 97 BH programs in B.C.
- The new model includes the creation of ~90 Community Collaboratives, which are local senior-serving agencies that coordinate program delivery . Forty-five (45) Community Collaboratives were established in 2024/25.
- A Community Connector (CC) position supports each Collaborative to support at-risk seniors, coordinate care with health authorities, and strengthen partnerships in community to improve referrals and address service gaps.
- Budget 2024 provided $127 million over 3 years to modernize CBSS, expand and improve services, and stabilize the workforce.

CURRENT SITUATION

Transition to a modernized CBSS service delivery model started April 1, 2024, to increase the sector's capacity to provide more robust care to more seniors. Changes include the following:

1. Community Collaboratives are being formed province-wide, each around a Better at Home (BH) program (see Key Background) and made up of local senior-serving agencies that agree to coordinate their program delivery based on each agency's strengths, capacities, and experiences. Forty-five (45) were established in 2024/25; full implementation of ~90 is planned for 2025/26.
2. Collaboratives will each be supported by one or more Community Connector (CC) positions that: 1) work one-to-one with seniors who are frail or at risk for frailty to develop health and wellness plans and connect seniors to programming that meets their needs; 2) establish communication & referral pathways with health authorities to coordinate care; and 3) strengthen relationships between the CBSS sector, other local senior-serving organizations (e.g., food banks), and local governments to improve referrals and fill local service gaps. In 2024/25, 58.4 CC positions were funded. Full implementation of ~90 CCs is planned by the end of 2025/26.
3. Seniors who will benefit most from programming are being prioritized, including seniors with low to modest income, low to moderate frailty, social isolation, and members of underserved populations.

4. As of April 1, 2024, the BH basket of services has expanded, putting social connection at the heart of service delivery. New services include information & referral, peer support, expanded group activities, and transportation to non-medical appointments.
5. Demonstration projects (see Key Background) are evolving and expanding based on their learnings: the Social Prescribing program will increase from 19 to ~90 programs through full implementation of CC positions by the end of 2025/26; Therapeutic Activation Program for Seniors (TAPS) and Family & Friend Caregiver Support program will each increase from 16 programs by ~6-7 programs per year, starting in 2025/26; and Navigation & Peer Support program will end as an independent program on March 31, 2025, with information and referral being fully integrated as a core BH service.
6. Food insecurity has been identified as a risk to many seniors. Supplementary funding is available to offer food in a social setting (e.g., a group meal or sharing a meal with a home-bound senior).
7. Transportation is consistently recognized as a gap in services to support seniors to age in place. Supplementary funding is now available for agencies to enhance an existing transportation service, provide a new service, or explore innovative transportation practices in their region.
8. Volunteers play a vital role in CBSS service delivery. The new service delivery model supports provincial and local initiatives related to volunteer recruitment, training, and retention.
9. The CBSS sector supports seniors' through climate-related events (heat dome, wildfires, floods) by providing wellness checks, supplies, transportation, and other related activities. HLTH funding to UWBC supports continued coordination with municipal, regional, and provincial emergency services.

FINANCIAL IMPLICATIONS

- Since 2017/18, HLTH has provided over $169 M to UWBC to deliver CBSS ($210 M since 2011/12).
- Budget 2024 provides $127 million over three years to expand and evolve programming, modernize the service delivery model, and stabilize the workforce to help meet the increasing demand for services.

KEY BACKGROUND

- The CBSS sector provides seniors with a broad range of non-medical home supports and health promotion programs and services that aim to address the social determinants of health.
- HLTH's investment in CBSS began in 2011/12 with the BH program, to help seniors with non-medical tasks such as light housekeeping, transportation to medical appointments, and grocery shopping. There are 97 BH programs in B.C.: VCH – 17, FH – 15, IH – 28, VIHA – 19, and NH – 18. In 2023/24, BH provided 336,415 services to 15,859 seniors, and almost 27% of low-income eligible seniors accessed BH programs free of cost.
- In 2019/20, 3 demonstration projects were added, targeting "higher needs" seniors: 1) Social Prescribing pairs seniors at risk of frailty with a Community Connector who helps them access services such as exercise, nutrition, and social programs; 2) the Therapeutic Activation Program for Seniors (TAPS) provides regular check-ins, transportation, meals, and recreational activities to enhance well-being; and 3) the Family & Friend Caregiver Support program offers coaching, peer support, and education for caregivers of older adults with complex needs.
- In 2021/22, and fourth demonstration project was added: Navigation & Peer Support, which assists vulnerable seniors in accessing financial and healthcare benefits to support independent living.
- The CBSS sector has demonstrated its value in supporting seniors through rapid roll out of the *Safe Seniors, Strong Communities* program during the COVID-19 pandemic; its support during climate emergencies; as well as multiple program evaluations, regional consultations, provincial summits, and ongoing informal communications with front-line staff, volunteers, seniors, and their families.
- In addition to providing program management, UWBC provides key sector supports, including Healthy Aging CORE (https://bc.healthyagingcore.ca/), which is an online knowledge hub, and bc211, which is a free information & referral service to community, government, & social services.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this Estimates Note is current as of February 12, 2025 as confirmed by Alix Adams, ED, SSD.

APPROVALS

2025 02 12 – Alix Adams, Executive Director, Seniors Services Division
2025 03 25- Ross Hayward, ADM, Seniors Services Division
2025 03 14 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Dementia Care

Topic: The Ministry of Health (HLTH) supports a person and family-centred approach to care, where people living with dementia are empowered and supported to make informed decisions about their care and daily living, from diagnosis through to end of life.

Key Messaging and Recommended Response:

- The impact of dementia on families and the health care system will increase as BC's population continues to grow and age.
- That's why we are actively investing in dementia care across the continuum of care, including:
  - funding for Alzheimer Society BC to deliver the First Link program,
  - the PIECES Learning and Development program, which equips health care staff with knowledge and skills to apply non-pharmacological interventions when an LTC resident with dementia is expressing distressed behaviours.
- Since 2017, we have approved 37 projects providing upgrades or new-builds of long-term care facilities with dementia-friendly design features, ensuring modern infrastructure that supports dignity, independence, and high-quality dementia care.
- Government recognizes the important of this work, and sustained commitments to programs and initiatives that support seniors, and especially people with dementia.

CURRENT SITUATION

- In 2022/23, there were 70,106 British Columbians aged 40 or older living with Alzheimer's disease or other dementia, an increase from 67,738 people in 2021/22 due to the growing aging population.[1]
- The impact of Alzheimer's disease and other forms of dementia on the health care system and families will increase as the size of the senior's population grows.
- In 2023/24, 62% of long-term care (LTC) residents in B.C. had a diagnosis of dementia, and in 2022/23, 34% of adults receiving home care services had a diagnosis of dementia.[2,3]
- The impact of Alzheimer's disease and other forms of dementia on the health care system and families will increase as the size of the seniors population grows.

Provincial Strategies:

- HLTH released Age Forward: British Columbia's 50+ Health Strategy and 3-Year Action Plan in September 2024. Age Forward includes specific actions that address shared risk factors between frailty and dementia, which can further delay or prevent the onset of some dementia cases.
- HLTH is developing a dementia strategy that builds on BC's 2016 *Provincial Guide to Dementia Care* and provides better alignment of actions with the 2019 National Dementia Strategy. The provincial strategy aims to improve the lives of people with dementia, their caregivers and families while decreasing the impact of dementia on communities and the health care system.

Dementia Research:

- The province funds provincial organizations and BC researchers through Michael Smith Health Research BC and Genome BC. Funding is also provided to non-profit organizations that engage in dementia-related research and support services such as ASBC, Brain Canada Foundation, Djavad Mowafaghian Centre for Brain Health and the Canadians for Leading Edge Alzheimer Research Foundation.

Government priorities and investments in dementia care in the community and LTC:

- HLTH funds and works closely with the Alzheimer Society of BC (ASBC), United Way British Columbia (UWBC), and Active Aging Society to provide a suite of community programs and services to help

[1] BC Centre for Disease Control, Chronic Disease Dashboard. www.bccdc.ca/health-professionals/data-reports/chronic-disease-dashboard

[2] CIHI, Profile of Residents in Residential and Hospital-Based Continuing Care, 2023-2024. Retrieved from: www.cihi.ca/en/quick-stats

[3] CIHI, Profile of Clients in Home Care, 2022-2023. Retrieved from: www.cihi.ca/en/quick-stats

seniors stay active, socially and mentally engaged, and find resources and supports at any stage in the disease.
- HLTH provides adult day programs and in-facility respite that supports seniors and caregivers, including people with dementia.

The Ministry has invested in dementia care education programs for health care providers in LTC to enable all members of the care team to have a common knowledge base, language and approach to care:
- PIECES Learning and Development Program™ is an evidence-based approach for the care of people with dementia that health care providers apply in LTC settings. This program has been funded in BC since 2013 and funding is planned to be extended until 2028.
- U-First! ® Dementia Education Training helps non-regulated health care providers understand the person with dementia and associated behaviour changes and work together as a team to develop individualized support strategies; B.C. provided a $7.54 million grant to the Alzheimer Society of B.C. to roll out U-First!® education program for LTC staff.
- Recent capital investments include 32 projects in long-term care homes, incorporating design features to meet the needs of those with cognitive changes (e.g., dementia) providing upgrades (1,764 replacement beds) or new builds (3,434 new beds).

FINANCIAL IMPLICATIONS

- HLTH and the Provincial Health Services Authority have provided approximately $32.7 million to Alzheimer Society BC for First Link® and related programs, including $490,000 in2023/24 to support equity deserving communities.
- HLTH has funded the PIECES Learning and Development Program™ since 2013 for total of $0.625 million, with an additional $0.400 million allocated through March 2028.
- In 2024/25, HLTH also provided $7.54 million to the Alzheimer Research Foundation of BC to work with the Alzheimer Society of B.C. to provide U-First!® training to long-term care staff.
- Budget 2021 provided $68 million over the 3 years of the fiscal plan ($22.67 million annually) to increase support for home care services, including increasing care aides and community providers.
- HLTH has invested $175 million over the last 5 years to expand respite care and adult day services.
- HLTH provided $7 million (2022/23) to the Centre for Technology Adoption for Aging in BC to support seniors living at home.

KEY BACKGROUND

The national framework "A Dementia Strategy for Canada: Together We Aspire" (2019) guides BC's actions through the Federal Provincial Territorial Coordinating Committee on Dementia.
Within BC, three main documents shape dementia care delivery:
- The "Provincial Guide to Dementia Care" (2016) outlines priorities for improving care quality and life quality for people with dementia
- The "Cognitive Impairment Recognition, Diagnosis and Management" guidelines (2014) help primary care providers identify and treat cognitive impairment, particularly Alzheimer's disease
- The "Best Practice Guideline for Behavioral and Psychological Symptoms" (2012) provides guidance for residential care facilities on non-pharmacological interventions and appropriate antipsychotic use, supported by a dedicated behavioral symptoms algorithm

LAST UPDATED

The content of this estimates note is current as of Feb 12, 2025as confirmed by Karen Neilson, SSD

APPROVALS

2025 03 27 – Ross Hayward, ADM, Seniors Services
2025 03 03 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 10 Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Home and Community Care (HCC) Seniors Funding

Topic: The Ministry of Health invests significant funding in programs and services to support seniors and individuals with complex medical conditions and/or frailty.

Key Messaging and Recommended Response:

- Many seniors prefer to age in their communities, close to friends and families.
- That's why government continues to invest in home and community care services, including publicly subsidized community-based seniors' services, home health, assisted living, and long-term care to support older adults to receive the care they need within their communities.
- Partnering with communities and local agencies is critical to supporting this work. It ensures the unique services and supports seniors need are tailored to the community.
- Therefore, the Ministry provides grants to non-profit organizations to deliver various non-medical and health promotion programs/services to support seniors.
- The United Way BC is a particularly crucial partner in this work providing flow-through funding to approximately 120 non-profit organizations to deliver community based seniors services.
- Examples include: seniors day programs, visitation and socialization programs, home visits and grocery delivery services, community shuttle busses for seniors, and much more.
- Through this work, Health authority community and long-term care investments have increased 78.9% since 2018/19.
- In addition, the Province has expanded training for health-care assistants in LTC, assisted living and home care program through targeted funding to address staffing shortages.
- Budget 2024 provided $354 million over 3 years to expand home health services provided by health authorities and strengthen the home health workforce ($227M) and community-based seniors' services ($127M) provided by non-profit organizations.
- In 2023/24, B.C. and Canada entered into the Aging with Dignity bilateral agreement which provides B.C. with $733 million over 5 years to help meet the health needs of older adults.

CURRENT SITUATION

Health Authority Home and Community Care (HCC) Expenditures

- Health authorities (HA) reported expenditures on services that primarily support the seniors population increased almost 80% between 2018/19 and 2023/24 (Table 1).
- Year over year increases are attributed to population growth, negotiated wage increases, the COVID-19 pandemic response, and targeted funding to improve HCC quality and support increased demand.

Table 1 - Community[1] and Long-Term Care Expenditures (2016/17 to 2023/24)

	Health Authority Expenditures ($M)								2018/19 - 2023/24	
	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	$ Change	% Change
Community Care	1,157	1,228	1,316	1,490	1,729	1,940	2,163	2,590		
Long-Term Care	1,905	1,985	2,074	2,230	2,643	2,871	3,078	3,475		
Total	**3,062**	**3,213**	**3,390**	**3,719**	**4,372**	**4,811**	**5,240**	**6,065**	**2,675**	**78.9%**
% increase year-over-year	**N/A**	**4.9%**	**5.5%**	**9.7%**	**17.5%**	**10.0%**	**8.9%**	**15.7%**		

HCC Targeted Budgets – Included in HA Expenditures

[1] Includes primary care – community, assisted living, home health, other community services programs

- HCC HA expenditures are supported through HCC base budget funding and partly through targeted Provincial budget increases, including $227 million over 3 years for home support and community-based professional services in Budget 2024 and Government of Canada agreements/contributions (below).

Government of Canada Agreements/Contributions - Targeted HCC Budget Included in HA Expenditures

- In 2018, BC entered into an agreement with the Government of Canada that provided $394M over 5 years to increase support for home and community care, as well as palliative and end-of-life care.
- In 2021/22, the bilateral agreement was amended committing $134.9M in funding for BC for the Safe Long-Term Care Fund to support infection prevention and control in Long-Term Care (LTC) facilities.
- In 2023/24, BC and Canada entered into the Aging with Dignity bilateral agreement which provides BC with $733 million over 5 years to help meet the health needs of older adults in BC by improving access to high-quality, safe, dignified HCC, palliative and end-of-life care, and LTC services.

Community-Based Seniors' Services (CBSS) – Funding to Non-Profit Organizations

The Ministry provides grants to non-profit organizations to deliver various non-medical and health promotion programs/services to support seniors. United Way BC (UWBC) is the Ministry's primary partner, providing flow through funding to approximately 120 non-profit organizations to deliver CBSS. The Ministry also provides grants directly to some non-profit organizations. Table 2 shows the evolution of grant funding in the CBSS sector (to UWBC and directly to non-profit agencies).

Table 2 – Seniors' Grant Funding (2016/17 to 2024/25)

	Grant Funding ($M)								
	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Total	26.76	19.6	15.801	74.981	9.266	26.776	100.515	13.11	6.593

- In 2024/25, the Ministry entered a 5-year (April 1, 2025, to March 31, 2030) agreement with UWBC (Not Yet Announced) to support the delivery of existing and new publicly subsidized CBSS, as well as the development and maintenance of provincial resources to support the sector and build capacity.

Notable Funding Provided to Non-Profit Organisations for HCC – Included in Grant Funding Table 2.

- Government Financial Information

- In 2019/20, $10M was provided to the BC Care Providers Association (BCCPA) to support and expand EquipCare BC, which helped public and private LTC and AL operators' COVID-19 pandemic response.
- Government Financial Information

Capital Funding

In addition to operating funding, BC has invested $2.58B in capital funding in LTC since 2017.

Health Career Access Program (HCAP)

Budget 2021 provided $585 million over 3 years to HCAP, supporting HCC workforce training and recruitment.

Office of the Seniors Advocate

Ministry funds the Office of the Seniors Advocate (OSA), an independent office of the BC government. In 202/2, the OSA was provided $3.3 million to monitor and analyze senior services and issues in BC and make recommendations to address systemic issues.

FINANCIAL IMPLICATIONS

- Over $3.5 billion has been invested since 2018/19 to expand and improve care for seniors in BC, including investments in primary care, community-based services, home health, long-term care, assisted living and respite services.

KEY BACKGROUND

- Ministry provides funding to HAs to deliver HCC services, including home support, community professional services (e.g., nursing), respite (e.g., adult day services), AL, LTC and palliative care.

- The Ministry also funds non-profit CBSS organizations to provide seniors with non-medical supports and health promotion programming they need to age well in the community.

LAST UPDATED

The content of this estimates note is current as of February 11, 2025, as confirmed by Alix Adams, SSD.

APPROVALS

2025 03 26- -Ross Hayward, ADM Seniors Services Division
2025 03 19 – Brenda Rafter OBO Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Home Health

Topic: BC has a comprehensive range of home health (HH) services that support seniors and their caregivers, as well as people experiencing short or long-term disability, to manage their health care needs and remain living well at home and in their community.

Key Messaging and Recommended Response:

- Seniors' care is a top priority for our government as our province's population continues to grow, and age.
- Home health services are integral to seniors' care as we know many seniors value their independence and wish to age at home, for as long as possible, close to their loved ones and in their communities.
- Investing in home health services has positive impacts on the broader health system – such as reducing avoidable emergency department visits, delaying or preventing long-term care admission, and preventing/reducing caregiver burn out.
- Budget 2024 provided $354 million over 3 years to expand services for older adults living at home, including $227 million to improve home health services delivered by health authorities.
- Our investments will improve responsiveness and coordination of services, including extending care hours for clients and improve client-to-healthcare provider ratios, which means more one-on-one care.
- Our government continues to invest in the healthcare workforce to support seniors through the Health Career Access Program (HCAP), a work integrated learning program designed to increase the supply of Health Care Assistants. As of Dec 31, 2024, there have been 1,990 HCAP hires into home health.

CURRENT SITUATION

- Minister Osborne's Mandate Letter calls to: *"improve the delivery of care for seniors and steward public investments made in seniors' care to improve efficiency and effectiveness given the growing population of seniors in our province".*
- Budget 2024 commits $227 million over 3 years to improve the quality, responsiveness, and effectiveness of HH services provided by health authorities to:
    1. Provide more robust care management and coordination of care so clients have more contact and support with the person and team accountable for their care plan.
    2. Expand hours of service availability, to provide more comprehensive, equitable, and timely service coverage in all regions of BC (urban and rural).
    3. Increase the flexibility and coverage of home support (HS) services, enabling an enhanced level of support to meet the daily living needs of seniors, especially those of highest need.
    4. Expand the community-based professional workforce (e.g., registered nurses, physical and occupational therapists, social workers; approx. 400 net new FTEs) and home support workforce (community health workers [CHWs]; approx. 500 net new FTEs).
- Focus on these priority areas enables services to be more timely, reliable, and effective, so HH can serve as a viable and cost-effective alternative to higher levels of care.
- On February 15, 2024, the Office of the Seniors' Advocate (OSA) released a report highlighting the challenges for BC's rural seniors. Findings noted the higher proportion and faster growing rural seniors' population and inequities in access and provision of HS services compared to urban regions.[1]
- On February 23, 2023, the OSA released a report on HS services and recommended government eliminate the HS client fee to remove the financial barrier to access HS services, increase respite care,

[1] For more information see Seniors, Rural Estimates Note

standardize and set targets for all aspects of service delivery, modernize care plans, and measure, monitor, and report on performance.
- The OSA's recent findings and recommendations align with work underway to improve HH services and Budget 2024 investment makes strategic improvements to care for seniors in all regions of BC.

FINANCIAL IMPLICATIONS

- Budget 2024 provides $227 million over 3 years to improve the quality, responsiveness, and effectiveness of HH services through optimization of services and workforce expansion.
- In 2023/24, HAs reported spending more than $2.5 billion on community care services, including home support, professional services (nursing, rehabilitation, care management), respite care, adult day services, and assisted living services.
- In 2023/24 BC and Canada entered into the Aging with Dignity bilateral agreement, which includes funding of up to $47 million over 4 years for the LTC@Home program.

KEY BACKGROUND

- Seniors and older adults are among the most frequent and highest-cost users of health services.[2]
- Demand for seniors' care is rapidly growing and expanding HH services is a key opportunity to provide care in the most cost-effective setting.
- Improvements to HH services positively impact the broader health system, reducing avoidable emergency department visits, expediting acute care discharge, and delaying or preventing long-term care (LTC) admission, while preventing or reducing caregiver burden and distress.

Home Support (HS) Services

- HS services are provided by unregulated care providers (community health workers) to clients who require assistance with activities of daily living (e.g., personal care, mobilization), delegated nursing and rehabilitation tasks as required, and in-home respite.
- The Health Career Access Program (HCAP) is a work integrated learning program designed to increase the supply of Health Care Assistants (HCAs)[3], and provide opportunities for individuals to access health sector careers. As of Dec 31, 2024, there have been 1,990 HCAP hires into HH.
- Some eligible HS clients receive support through the Choice in Supports for Independent Living (CSIL) program[4], a self-directed option for clients with high-intensity care needs.
- Table 1 provides client counts and service volumes for HS by fiscal year (FY) from 2019/20 – 2024/25.[5]

Table 1. Home Support Client Counts and Service Hours by Fiscal Year and Year-to-Date[6]

	Fiscal Year	2019/20	2020/21	2021/22	2022/23	2023/24	YTD 2024/25 P9*
Client Counts	Clients	52,300	50,900	53,900	54,700	57,300	49,800
	Year over Year % Change	-	-3%	6%	1%	5%	4%
	Cumulative % Change	-	-3%	3%	5%	10%	
Service Hours	Service Hours	11.29M	11.13M	11.54M	11.33M	12.26M	9.05M
	Year over Year % Change	-	-1%	4%	-2%	8%	9%
	Cumulative % Change	-	-1%	2%	0%	9%	

*Compared to Period 9 2023/24

[2] Canadian Institute for Health Information (N.D.) Seniors (65 and Older). Rationale.
[3] Health Care Assistant training is required to become a community health worker in home support.
[4] For further information see Choice in Supports for Independent Living (CSIL) Program Estimates Note
[5] Ministry of Health. Report ID: RMS 2391. Home and Community Care Services Report. Retrieved from: https://hspp.hlth.gov.bc.ca. Accessed on February 21, 2025.
[6] Home support data reported by MoH differs from that of the Office of the Seniors Advocate. Both include short-term and long-term home support, but MoH also includes home support provided in assisted living, whereas OSA includes CSIL. NHA could not provide annual client counts for 2022/23, therefore NHA data is excluded from the year-over-year 2023/24 growth rate calculation (cumulative % change). YTD 2024/25 % changes are in comparison to YTD 2023/24 data.

Community Based Professional (CBP) Services

- CBP services provide clients with professional nursing, rehabilitation social work, and care management.
- CBP services embody a care management approach, and include assessment, care planning, provision of care, and care coordination. Emphasis is on early intervention, preventing unnecessary acute care admission, supporting timely discharge and preventing readmission through linkages with primary care, community-based seniors services, and specialized services.
- Table 2 provides client counts and service for CBP services by FY from 2019/20 – 2024/25.[7]

Table 2. Community Based Professional Services Client Counts and Visits by Fiscal Year and Year-to-Date[8]

	Fiscal Year	2019/20	2020/21	2021/22	2022/23	2023/24	YTD 2024/25 P9*
Client Counts	Clients	130,000	133,500	140,000	141,700	142,600	117,500
	Year over Year % Change	-	3%	5%	1%	1%	2%
	Cumulative % Change	-	3%	8%	9%	10%	
Visits	Number of Visits	1.61M	1.73M	1.71M	1.71M	1.72M	1.20M
	Year over Year % Change	-	7%	-1%	0%	1%	1%
	Cumulative % Change	-	7%	6%	6%	7%	

*Compared to Period 9 2023/24

Caregiver Support (CS) Services[9]

- CS services provide relief from the emotional and physical demands of caregiving. Services are designed to provide caregivers with a break while supporting clients to receive safe professional care.
- CS includes in-facility (overnight) respite (short-term care for clients in a licensed long-term care facility); adult day services (group programs provided in a community setting that involve therapeutic social/recreational activities amongst other activities); and in-home respite visits.
- The February 2023 OSA report, We Must Do Better, recommended increasing overall respite care and the Ministry is exploring options to provide enhanced support and respite for caregivers.

LAST UPDATED

The content of this estimates note is current as of February 12, 2025, as confirmed by Alix Adams, SSD.

APPROVALS

2025 03 25 – Ross Hayward, ADM, Seniors' Services Division
2025 02 28 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis, and Reporting Division
2025 03 10 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[7] Ministry of Health. Report ID: RMS 2391. HCC Services Report. Retrieved from: https://hspp.hlth.gov.bc.ca. Accessed on February 21, 2025.
[8] Community Based Professional Services include community nursing, community rehabilitation, clinical social work, care management and care coordination. NHA could not provide total client counts for 2022/23, therefore NHA data is excluded from the year-over-year 2023/24 growth rate calculation. YTD 2024/25 % changes are in comparison to YTD 2023/24 data. Cumulative YTD 2024/25 %change are intentionally left blank because it requires comparing P09 2018/19 data.
[9] For further information see Caregiver Supports Estimates Note

LEGISLATIVE SESSION – ESTIMATES NOTE

Licensed Community Care Facilities – Residential Care (All Categories)

Topic: Community care facilities are regulated under the *Community Care and Assisted Living Act* (CCALA) and are licensed through the regional health authorities (HAs).

Key Messaging and Recommended Response:

- Our health-care system includes a robust network of private and subsidized community care facilities that are regulated under the *Community Care and Assisted Living Act* and licensed through the regional health authorities.
- There are several types of care licensed under *the Community Care and Assisted Living Act*, including long term care, child and youth residential care, hospice, supportive recovery residence for subsentence use, and care for specialized populations including those with acquired brain injury and mental health issues. Currently, there are 1,133 facilities throughout B.C. that provide licensed care services.
- The Assisted Living Registry (ALR) is responsible for the oversight of licensed facilities, including regular inspection. This is to ensure a consistent model of care throughout the province and the protection of residents' health and safety. The government is working on improving and expanding support for caregivers, recognizing the importance of their health and well-being, so they can continue their vital role in helping people receive care in their communities.

CURRENT SITUATION

- HAs provide quarterly data to the Community Care Facility Licensing branch of the Ministry of Health. The data consists of the number of facilities under each service type, as described in the CCALA's Residential Care Regulation.
- Licensed community care facilities include both publicly subsidized and private pay models.

[1]December 31, 2024	FHA[2]	IHA	Island[3]	NHA	VCHA	BC
Facility Service Type						
Acquired Injury	11	6	1	1	10	**29**
Child and Youth Residential	16	8	17	17	19	**77**
Community Living	160	96	121	29	88	**494**
Hospice	5	4	1	1	5	**16**
Long Term Care	70	69	67	15	56	**277**
Mental Health	33	3	13	3	47	**99**
Substance Use	20	9	9	1	20	**59**
Hospital Act	24	16	17	10	15	**82**
[4]	0	0	0	0	0	**0**
Total	***339***	***211***	***246***	***77***	***260***	***1133***

[1] Source: HCC Long-Term Care & Assisted Living Summary Report, data as of December 31, 2024 (for Acquired Injury, Hospice, and Long-Term Care), and HA Community Care Facility Licensing programs (for the remaining 5 service types)
[2] Vancouver Coastal Health reports each service type separately, therefore the sum of facilities by service types is more than the number of individual facilities.
[3] Island Health reports by primary service type. Some facilities will have more than one service type at a premise, but only the dominant service type is counted.
[4] Category Mental Health and Substance Use is now reported out separately by HAs.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

There are several types of licensed care under the CCALA, including long term care, child day care, child and youth residential care, and care for specialized populations including Acquired Brain Injury, Community Living, Hospice, Long Term Care, Mental Health, and Substance Use. The tables below provide facility counts by type and HAs.

[5]December 31, 2023	FHA[6]	IHA	Island[7]	NHA	VCHA	BC
Facility Service Type						
Acquired Injury	12	6	1	1	11	**31**
Child and Youth Residential	17	7	15	17	19	**75**
Community Living	152	95	118	27	87	**479**
Hospice	5	4	1	1	6	**17**
Long Term Care	68	68	67	15	52	**270**
Mental Health	33	10	13	3	46	**105**
Substance Use	19	11	8	1	19	**58**
Hospital Act	24	16	17	10	18	**85**
[8]	0	0	0	0	0	**0**
Total	***330***	***217***	***240***	***75***	***258***	***1120***

LAST UPDATED

The content of this fact sheet is current as of December 31,2024 , as confirmed by Sue Bedford, ALRCCL, Seniors Services Division

APPROVALS

PENDING Mar 30 - Ross Hayward, Seniors' Services Division
2024 03 13 Patrick Day obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 17 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division

[5] Source: HCC Long-Term Care & Assisted Living Summary Report, data as of December 31, 2024 (for Acquired Injury, Hospice, and Long-Term Care), and HA Community Care Facility Licensing programs (for the remaining 5 service types)
[6] Vancouver Coastal Health reports each service type separately, therefore the sum of facilities by service types is more than the number of individual facilities.
[7] Island Health reports by primary service type. Some facilities will have more than one service type at a premise, but only the dominant service type is counted.
[4] Category Mental Health and Substance Use is now reported out separately by HAs.

LEGISLATIVE SESSION – ESTIMATES NOTE

Long-Term Care Staffing (3.36 HPRD)

Topic: Summary of measures increasing the average hours per resident day (HPRD) in publicly-funded Long-Term Care (LTC) facilities.

Key Messaging and Recommended Response:

- Seniors, especially those living in long-term care, deserve dignified and compassionate care that meets their complex social and medical needs during late stages of life.
- Unfortunately, following years of funding neglect, publicly funded long-term care homes were not providing adequate "per hour" to residents.
- In fact, the 2017 *Residential Care Staffing Review Report* found that each health authority, on average, should maintain a minimum of 3.36 Hours per Resident Day (HPRD) of care at LTC facilities to ensure safe, quality care.
- Sadly, in 2016/17, only 15% of facilities were funded to meet or exceed the 3.36 HPRD (44 of 293).
- That's why budget 2018 allocated $240 million over three years to increase direct care hours in LTC facilities to reach the target of 3.36 HPRD, on average, across all facilities by 2021.
- That has been achieved and continues to be implemented and monitored. Additional investments in April 2022 ensured that all publicly funded LTC facilities met the minimum 3.36 HPRD requirement, in addition to achieving the average across the health authority.
- In 2024/25, the provincial average funded HPRD was 3.44, an increase of 0.33 HPRD from the 2016/17 baseline provincial average HPRD of 3.11.
- As of Q2 in 2024/25, all 5 HAs met or exceeded the HPRD target based on resident days (i.e., actual bed occupancy) resulting in a forecasted average HPRD of 3.61 in BC.
- The government will continue to work with health authorities and take action across B.C. to support seniors, and that includes strengthening their healthcare.

CURRENT SITUATION

- In fiscal 2020/21, all 5 regional health authorities were funded to meet or exceed the target of 3.36 HPRD, on average, across all facilities; and this was achieved.
- At April 1, 2022 all 295 publicly funded LTC facilities were funded to meet, at a minimum, the standard of 3.36 HPRD, raising funding to 59 facilities to achieve this goal.
- In 2024/25, the provincial average funded HPRD is 3.44, an increase of 0.33 HPRD from the 2016/17 baseline provincial average HPRD of 3.11. Further, in 2016/17, 15% of facilities met or exceeded 3.36 HPRD (44 of 293), and in 2024/25 100% of facilities were funded to meet or exceed 3.36 HPRD.

FINANCIAL IMPLICATIONS

In 2024/25, the total annual incremental HPRD investment is $113.6 million, and all 296 facilities continue to be funded to meet a minimum of 3.36 HPRD.

KEY BACKGROUND

- The Residential Care Staffing Review Report (2017) concluded that a minimum of 3.36 HPRD, on average, across each health authority was required for safe, quality care. The target of 3.36 comprises 3.0 hours of direct nursing care (including health care assistants) and 0.36 hours of direct allied health care (physiotherapy, occupational therapy, social work, and recreation).[1]

[1] Ministry of Health. Residential Care Staffing Review Report. (March 2017). https://www.health.gov.bc.ca/library/publications/year/2017/residential-care-staffing-review.pdf

- HPRD is measured in two ways: funded HPRD and actual HPRD. Funded HPRD refers to the funding calculation that determines funding for LTC operators for direct care staffing to achieve HPRD targets. The funding calculation is based on 100% bed occupancy (i.e., bed days), which ensures sufficient direct care funding for a LTC operator to achieve the HPRD target can be met when the facility is fully occupied. This is the funded HPRD.
- Actual HPRD, however, calculates the amount of direct care provided, based on the beds that are occupied (i.e., resident days). When occupancy levels fall below 100%, residents receive a higher number of direct care hours, as staff care for fewer residents when some beds are empty. HPRD based on resident days (rather than 100% occupancy) is a more accurate reflection of the amount of care residents are receiving.
- As of Q2 in 2024/25 all health authorities met or exceeded the 3.36 HPRD target, on average, in 2024/25 based on resident days (i.e., actual bed occupancy) for the fourth year in a row, with a forecast provincial average HPRD of 3.61.
- Since April 1, 2022, all facilities have been funded to meet, as a minimum, the 3.36 HPRD target. As of Q2 in 2024/25, 246 facilities or 83% are forecasted to meet the 3.36 minimum target, with 50 facilities forecasting to not achieve the target.

Increasing benchmarks:

- In January 2023 the Health Standards Organization released Federal Long-term Care Standards. The HSO standards reference 4.1 Hours Per Resident Day (HPRD) as a recommendation from researchers. The Ministry of Health has reviewed this recommendation, and to date no decision has been made to adjust 3.36 HPRD as the standard in BC.
- In 2020, the Royal Society Report *Restoring Trust: Covid-19 and the Future of Long-Term Care"* made a recommendation for provinces to adopt 4.1 HPRD as the standard in LTC.
- In January 2024, the Royal Society Report *Repair and Recovery in Long-Term Care: Restoring Trust in the Aftermath of Covid-19 (2020 – 2023)* made recommendation for provinces to adopt 4.5 HPRD as the standard in LTC.
- Across Canada funding commitments toward increasing HPRD have been made by:
  - Nova Scotia to move to 4.10 HPRD.[2]
  - Ontario continues to progress on reaching 4.00 average direct care per resident per day (actual HPRD) by March 31, 2025.[3]
  - In 2023, Manitoba has funded homes to increase to 3.80 HPRD and they plan to increase to 4.1 but there are staffing challenges that will require a human resource strategy.[4]
  - In Alberta, continuing care homes are funded to provide 3.62 HPRD but there are challenges with staffing shortages.[5]

LAST UPDATED

The content of this estimates note is current as of February 28, 2025, as confirmed by Danielle Prpich, ED Long Term Care & Assisted Living Strategy & Policy (LASP), SSD.

APPROVALS

2025 03 26 – Ross Hayward, Seniors Services Division (SSD)
2025 03 12 – Patrick Day obo Martin Wright, Health Sector Information, Analysis & Reporting Division (HSIAR)
2025 03 19 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division (FCS)

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[2] Province of Nova Scotia, (July 2024). Accountability Report 2023–2024. Seniors and Long-Term Care. Retrieved from: https://novascotia.ca/government/accountability/2023-2024/accountability-report-2023-24-department-seniors-and-long-term-care-en.pdf

[3] Ontario Ministry of Long-Term Care. (April 2024). Long-Term Care Homes Funding Policy. Policy: 2024-25 Long-Term Care Staffing Increase Funding Policy. https://www.trontario.org/wp-content/uploads/2024/05/2024-25-Long-Term-Care-Staffing-Increase-Funding-Policy.pdf

[4] Global News. (Aug. 2023). Daisy Woelk. Manitoba's home and long-term care straining to see end of staffing struggles. https://globalnews.ca/news/9915552/manitobas-home-and-long-term-care-straining-to-see-end-of-staffing-struggles/

[5] Red Deer Advocate. (March 2024). Susan Zielinski. Care standards at continuing care facilities to be eliminated, say nurses and NDP. New Continuing Care Act Regulations coming into effect April 1. https://www.reddeeradvocate.com/news/care-standards-at-continuing-care-facilities-to-be-eliminated-say-nurses-and-ndp-7333768

LEGISLATIVE SESSION – ESTIMATES NOTE

Long-Term Care Quality Framework

Topic: Implementation of the BC LTC Quality Framework

Key Messaging and Recommended Response:

- As part of BC's strategy to improve care for seniors, the Ministry has developed an evidence-based Quality Framework (the Framework) and Policy Directive for long term care (LTC) that enables and formalizes comprehensive provincial-level reporting, monitoring and evaluation that supports continuous quality improvement within the LTC sector.
- The Policy Directive came into effect April 1st, 2024, and requires Health Authorities (HA) to:
  - report on, monitor and evaluate the quality of LTC services in their region using 16 indicators identified in the Framework,
  - establish regional quality improvement initiatives that are consistent with the Framework; and,
  - establish regional quality improvement leadership structures that monitor quality and collaboratively participate in continuous quality improvement with their LTC providers.
- The baseline LTC quality report from Ministry of Health in 2024 shows the outcomes of quality indicators for the 2023/24 fiscal year, quality improvement initiatives, and investments made both within the Ministry and across HAs to support quality improvement and improve person-centred outcomes for people in LTC. Annual updates to the indicators will involve ongoing collaboration with health authorities, sector partners, and residents and their family members.
- The Framework is expected to evolve over time, with continuous collaboration among stakeholders. This work will also support additional actions to enhance seniors' care, including the recently announced Aging with Dignity Funding from the federal government, which will help strengthen access to high-quality, safe, and dignified home and community care, stabilize the LTC workforce, and support LTC in communities.

CURRENT SITUATION

- The Framework applies to all publicly funded LTC homes including HA owned and operated facilities and contracted providers except for those providing only short stay services. The Framework sets expectations for quality, improves government oversight of the sector, inform policy, and is in alignment with key initiatives to improve LTC services, including:
  - the development of a standardized LTC funding model,
  - the implementation of the LTC financial reporting tool,
  - strengthening of Resident and Family Councils,
  - expansion of LTC capacity,
  - the reduction of inappropriate use of antipsychotic in LTC
  - quality initiatives (QI) led by Health Quality BC and health authorities (HAs) within their regional jurisdictions; and,
  - strategic priorities and goals outlined in the Ministry Plan and the Ministry of Health 2023/24 – 2025/26 Service Plan, specifically Objective 1.2: increase access to community-based care, including specialized services for adults with complex care needs and frailty
- The Framework utilizes a structure, process, and outcome approach to assess LTC services to ensure high quality, culturally safe, person-centered, dignified and continually improved LTC services.
- (Not publicly disclosed) The LTC Quality Dashboard hosted in the Ministry's Health System Performance Portal (HSPP) went live in December 2024. The dashboard provides a series of

interactive reports capturing data from 2021/2022- 2023/24 on LTC quality indicators at the provincial, HA, CLHA and facility level, where applicable, and is accessible to the Ministry and HAs. The dashboard will be updated quarterly beginning with data from Q1 2024/25.

- The Ministry is developing a Baseline Report to present results on the outcomes of quality indicators for the 2023/24 fiscal year and QI initiatives (QI) made both in the Ministry, and across HAs to support QI. Annually, LTC Quality Reports will be developed and will include progress on quality indicators, measured against the baseline, and will highlight key QI initiatives at the Ministry and across HAs.
- The Ministry is working on an LTC Indigenous community collaboration strategy/plan to ensure the development and implementation of culturally safe quality indicators and initiatives.

FINANCIAL IMPLICATIONS

- The Aging with Dignity federal funding agreement provides $40 million to support resources for Licensing and QI over the next 4 years.
- There is an anticipated potential financial implication in the development of future indicators and to support HAs resourcing toward Framework's QI leadership structures, monitoring, and reporting as the Framework evolves further.

KEY BACKGROUND

- Ministry of Health staff from the Seniors Services Division, developed the Framework in consultation with key partners in the LTC sector, comprising of representatives from the HAs, First Nations Health Authority, Health Quality BC, Office of the Seniors Advocate, contracted LTC service providers, advocacy groups, residents, and family members.
- The Framework has an initial series of 16 quality indicators which are informed by the Canadian Quality & Patient Safety Framework and the BC Health Quality Matrix dimensions of quality. The 16 indicators were selected from data resources currently collected in BC and commonly analyzed within HAs as indicators of quality and/or indicators of areas where improvement is required.
- The implementation of the Framework contributes to the Seniors' Services Division 2024 Objective and Key Results, Objective C: Reasonable access to Assisted Living and LTC services; ensuring residents are provided with people-centered, quality, dignified, and culturally safe care.
- The implementation of the Framework supports foundational principles and service outcomes identified in the HSO Long-Term Care Service National Standard.
- The reporting and analysis enabled by the Framework will inform and monitor actions identified in the request for Aging with Dignity federal funds by enabling identification of issues and impact of initiatives intended to enhance quality of LTC services in the province.

LAST UPDATED

The content of this estimates note is current as of February 12 2025, as confirmed by Danielle Prpich

APPROVALS

2025 03 25 – Ross Hayward, ADM, Seniors' Services Division
2025 02 12 – Danielle Prpich, ED, Seniors' Services Division
2025 02 26 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Long-Term Care Funding Model

Topic: Development of the Provincial Long-Term Care Funding Model

Key Messaging and Recommended Response:

- With a growing and aging population in B.C., it is important seniors and Elders have the care and support they need to live a healthy and happy life, including long-term care.
- To improve seniors' care in B.C., our government is committed to creating a standardized approach to public investments in the long-term care sector.
- The ministry is working with the health authorities and long-term care sector partners to develop a funding model for long-term care, with the goal of achieving greater transparency, equity, consistency and sustainability.
- This work will improve the efficiency and effectiveness of seniors' care in our province, ensuring seniors and their loved ones receive the best care possible.

CURRENT SITUATION

- In September 2023, a LTCFM Advisory Committee was established by the Seniors Services Division (SSD) to discuss and inform the development of the LTCFM. The Advisory Committee is led by SSD with membership from Finance and Corporate Services Division, the BC Care Providers Association, Denominational Health Association, HAs, and LTC home operators.
- In November 2023, the Advisory Committee assembled three Sub-Working Groups to gather expert advice and operational expertise from HAs and LTC home operators to inform the Ministry's policy objectives and service delivery expectations. The three Sub-Working Groups are: Policy, Funding Accountabilities, and Funding Methodology.
- In December 2023, the Ministry awarded a contract to PriceWaterhouseCooper (PWC) to support the Advisory Committee and Sub-Working Groups.
    - PWC were awarded a contract for a maximum amount of $1,500,000, for the period of December 2023 through November 2025.
    - PWC provided project management and research support, including jurisdictional scans.
- Since the establishment of the LTCFM Advisory Committee and Sub-Working Groups, there has been progress in the following areas:

Advice/Recommendations

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Work on the LTC Funding Model began prior to the COVID-19 pandemic but slowed while Ministry and HA staff focused on the pandemic response and other urgent issues.
- Background work in preparation for the detailed development of a LTCFM included a national review of current practices, a review of recommendations from the Office of the Ombudsperson, a review of reports from the Office of the Seniors Advocate, and recommendations from the BC Care Providers Association, Denominational Health and other LTC sector partners.
- In collaboration with the health authorities and sector partners, the Ministry has committed to developing the LTC Funding Model in three phases, with specific funding policy and accountabilities for specific categories of operating expenditures (i.e., direct care).
- The three phases of the LTC Funding Model development are:
    - **Phase 1 – Direct Care**. Focused on determining the appropriate funding approach for staffing in LTC, incorporating aspects such as direct care hours per resident day (HPRD), wage levelling, staffing ratios, and other pressing health human resource challenges. This is the highest cost area in the operation of a LTC home.
    - **Phase 2 – Non-Direct Care**. Focused on the development of a standardized funding approach for support services such as environmental services, nutrition care & food services, laundry, and administration.
    - **Phase 3 – Capital**. Focused on the development of policies and funding methodology for capital costs in LTC such as rent, lease, mortgage, and principle.
- The development of a LTCFM model is in alignment with other key initiatives to improve LTC, including:
    - Increasing funded direct care hours to achieve 3.36 Hours Per Resident Day.
    - Implementing a refreshed LTC Financial Reporting Tool.
    - Implementing the LTC Quality Framework.
    - Minister's 2025 mandate commitment to improve the delivery of care for seniors and steward public investments made in seniors' care to improve efficiency and effectiveness given the growing population of seniors in our province.

LAST UPDATED

The content of this estimates note is current as of March 25, 2025, as confirmed by Danielle Prpich, ED, LASP.

APPROVALS

2025 03 28 – Ross Hayward, ADM, Seniors Services Division
2025 03 25 – Danielle Prpich, ED Seniors' Service Division
2025 03 26 – Rob Byers, ADM, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Multi-Bed Rooms

Topic: The Ministry of Health has a mandate commitment to reduce the number of multi-bed rooms in health authority operated Long-Term Care (LTC) facilities

Key Messaging and Recommended Response:

- We respect people's privacy; as much as possible, we want LTC residents in single-occupancy rooms.
- The Ministry of Health made a commitment in 2020 to reduce the number of multi-bed rooms in LTC facilities, and we continue to work toward that goal.
- Of the 37 approved LTC projects in BC, 20 (or 54%) included redevelopment plans to replace many multi-bed rooms in outdated facilities.
- 2023/24 reporting of publicly subsidized facilities (health authority owned and operated and contracted facilities) shows 91% of all resident rooms are single occupancy, with 79% of residents occupying these rooms - both figures have increased from the previous year.
- Unfortunately, the publicly funded long-term care sector in our province suffered a generation of neglectful underfunding.
- We are committed to improving aged infrastructure that should have been renovated years ago, and adding thousands of new, state-of-the-art long term care beds at dozens of new facilities on the way across BC.

CURRENT SITUATION

- There are 359 total LTC homes as of December 2024 (including Acquired Brain Injury homes (ABI), 382)[1],and 32,070 total regular LTC beds for BC (including ABI 32,248)[2].
- There are 309 (including ABI 330)[3] LTC homes across BC that are publicly subsidized serving seniors with 28,390 beds (including ABI 28,535).[4]
- Monitoring the number of multi-bed rooms in LTC measures the impact of initiatives over time to reduce multi-bed rooms in aging facilities.
- As of November 2024, 79% of residents are in a private room based on Ministry of Health data (publicly subsidized facilities, excluding ABI)[5]. While this is the same percentage as December 2023, these numbers are rounded, and there is a 0.8% increase from December 2023. As seen below, the number of private rooms increased by 555.

Table 1. December 2024 Multi-Bed Rooms in LTC excl ABI, publicly funded)[6]

LTC Type	Single LTC Rooms		Double LTC Rooms		3-Bed LTC Rooms		4-Bed LTC Rooms		> 4 Bed LTC Rooms		**Total**	
Health Authority	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total	**Count**	**% of Total**
1 Interior	4,972	93.99%	193	3.65%	8	0.15%	117	2.21%	0	0.00%	**5,290**	**100.00%**
2 Fraser	7,040	89.83%	647	8.26%	18	0.23%	132	1.68%	0	0.00%	**7,837**	**100.00%**
3 Vancouver Coastal	4,843	86.96%	523	9.39%	39	0.70%	164	2.94%	0	0.00%	**5,569**	**100.00%**
4 Vancouver Island	4,596	92.09%	215	4.31%	30	0.60%	150	3.01%	0	0.00%	**4,991**	**100.00%**
5 Northern	998	95.14%	37	3.53%	0	0.00%	14	1.33%	0	0.00%	**1,049**	**100.00%**
Total	**22,449**	**90.75%**	**1,615**	**6.53%**	**95**	**0.38%**	**577**	**2.33%**	**0**	**0.00%**	**24,736**	**100.00%**

[1] Ministry of Health. Report ID: RMS 1228. Home & Community Care Bed/Facility Inventory. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/home-and-community-care-bedfacility-inventory-report. Last accessed on: 2/6/2025 9:22:50 PM
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Calculation based on information from the Ministry of Health. Report ID: RMS 1228. Home & Community Care Bed/Facility Inventory. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/home-and-community-care-bedfacility-inventory-report. Last accessed
[6] Ministry of Health. Report ID: RMS 1228. Home & Community Care Bed/Facility Inventory. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/home-and-community-care-bedfacility-inventory-report. Last accessed on: 2/6/2025 9:22:50 PM

LEGISLATIVE SESSION – ESTIMATES NOTE

LTC Type	Single LTC Rooms		Double LTC Rooms		3-Bed LTC Rooms		4-Bed LTC Rooms		> 4 Bed LTC Rooms		Total
Health Authority	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total	Count
1 Interior	5,072	94.10%	193	3.58%	8	0.15%	117	2.17%	0	0.00%	5,390
2 Fraser	7,028	89.80%	621	7.94%	45	0.58%	132	1.69%	0	0.00%	7,826
3 Vancouver Coastal	4,838	86.97%	523	9.40%	38	0.68%	164	2.95%	0	0.00%	5,563
4 Vancouver Island	4,603	92.10%	215	4.30%	30	0.60%	150	3.00%	0	0.00%	4,998
5 Northern	998	95.05%	38	3.62%	0	0.00%	14	1.33%	0	0.00%	1,050
Total	**22,539**	**90.78%**	**1,590**	**6.40%**	**121**	**0.49%**	**577**	**2.32%**	**0**	**0.00%**	**24,827**

- From the Office of the Seniors Advocate's report Long-*Term Care and Assisted Living Directory 2024* the below table presents their collection of bed-type information from 2019/2020 to 2023/24:

LONG-TERM CARE FACILITY DEMOGRAPHICS, 2019/20-2023/24

INDICATOR	2019/20	2020/21	2021/22	2022/23	2023/24
NUMBER OF FACILITIES	295	296	293	296	298
NUMBER OF PUBLICLY-SUBSIDIZED BEDS*	27,432	27,858	27,628	27,991	28,364
% SINGLE OCCUPANCY ROOMS	89%	90%	90%	90%	91%
% DOUBLE OCCUPANCY ROOMS	7%	7%	7%	6%	6%
% MULTI-BED ROOMS	4%	4%	3%	3%	3%
% OF RESIDENTS IN SINGLE OCCUPANCY ROOMS	76%	77%	77%	77%	79%

- Further progress in increasing the number of residents in private rooms will come as a result of new LTC capacity planning, as all projects in development in BC will provide single-bed rooms.

KEY BACKGROUND

- On October 6, 2021, the OSA released the report: *Review of COVID-19 Outbreaks in Care Homes in British Columbia*. The review made recommendations, including the *elimination of shared rooms* to limit the spread of COVID-19

LAST UPDATED

The content of this estimates note is current as of February 12, 2025 as confirmed by Danielle Prpich

APPROVALS

2025 03 26 – Ross Hayward, ADM, Seniors Services Division
2025 03 07 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

OSA Billions More Reasons to Care Report

Topic: Office of the Seniors Advocate Report – *Billions More Reasons to Care: Contracted Long-Term Care Funding Review Update" (September 2023)*

Key Messaging and Recommended Response:

- We appreciate the Seniors Advocate's important work and advocacy throughout the province, and for their efforts to ensure government supports the needs of seniors and older people in BC.
- These are shared priorities for government. That's why the Province has invested over $3.5 billion since 2018/19 to improve care for seniors, including investments in primary care, community-based services, home health, long-term care, assisted living and respite services.
- We want to ensure that the money we invest in improving seniors care is put to good use and is used for that purpose.
- Consistent with Mandate Letter direction, the Ministry is working to support the delivery of better care to seniors by holding LTC operators more accountable for the public funding they receive, including:
    - Development and implementation of a LTC reporting tool to standardize reporting of direct care hours and financial information across all LTC homes in the province; with the expectation the final year-end report will be an audited financial statement
    - Setting a minimum standard of 3.36 Hours per Resident Day (HPRD) and providing funding for all publicly funded LTC facilities to meet the standard. As of Q4 in 2022/23, all five health authorities exceeded the HPRD target in 2022/23 based on resident days (i.e., actual bed occupancy) resulting in an average B.C. level HPRD of 3.57.
    - Actively working with health authorities on the development of a LTC Funding Model which will create a consistent, fair, equitable and transparent approach to funding in the sector.
- In addition, the Ministry continues to fund the wage levelling measure to ensure that healthcare workers in LTC receive fair compensation, allowing them to continue delivering high-quality care for seniors.

CURRENT SITUATION

- On September 25, 2023, the Office of the Seniors Advocate (OSA) released a second report on Long-Term Care (LTC) funding, "*Billions More Reasons to Care* (BMRC), following up the "*A Billion Reasons to Care: A Funding Review of Contracted Long-Term Care in BC" report (2020).*
- The BMRC report focuses on the funding and delivery of Direct Care Hours (DCH) and reports a significant gap in the for-profit sector of non-delivered DCH.
- In addition, the BMRC notes the following trends:
    - A 13% decrease in LTC beds/1000 age 75+.
        - This is because of a growing aging population.
    - A 48% increase in wait times from 2018 for placement into LTC.[1]
    - A 45% increase in total spent by HAs on LTC in the last 5 years.
        - Of this, 65% ($1.9B) was for the NFP and FP sector, noting this as "one of the largest annual transfers of public funds to the private sector across government".

[1] Please see Estimates Note: Access and Admission to LTC

        - Increased funding in response to COVID-19 initiatives in LTC, wage levelling, visitation.
    - A 23% increase in the last 5 years in the base per diem.
        - This is attributable to increased funding for 3.36 HPRD, wage levelling, and other COVID-19 initiatives in LTC.
    - Cost per hour worked increased by 22% in the FP group, and 15% in the NFP sector.
        - Wage levelling, overtime, and agency staffing costs all impact the cost per hour worked across the sector, regardless of ownership type.
    - Cost per hour worked in the NFP sector is 17% higher than FP.
        - The higher cost per hour of work in NFP is attributable to the costs of benefits in the NFP sector.
- A 32% increase over 5 years in HA base funding.
    - Reflecting increased care hours, pandemic funding, and a reduction in the proportion of revenue from resident co-payments.
- A 7% increase over 5 years in resident co-payment fees.
    - The relatively smaller increase in resident co-payments will shift more of the cost for LTC to HAs who will require increased base funding.
- A 21% increase in private-pay bed revenue.
- A 281% increase in revenue from other sources.
- A 400% increase in "other" revenue.
    - This represents additional funding provided to respond to COVID 19.
- FP spent 15% of revenue on building expenses, with NFP spending 9%. Overall FP spent 66% more per bed on building costs than NFP.
- 113% increase in profit/surplus over the 5-year period.
    - The actual profit/surplus increased from 3% in Billions of Reasons to Care to 4% in BMRC.

KEY BACKGROUND

- In 2020, the OSA published the report "*A Billion Reasons to Care"* which was the first provincial review of the $1.4 billion-dollar contracted long-term care sector in British Columbia.
- The 2020 report examined 174 contracted LTC homes' 2016/17 and 2017/18 financial statements and expense reports submitted to health authorities by LTC home operators.
- The OSA report "*A Billion Reasons to Care"* noted in 2017/18: "For-profit care homes failed to deliver 207,000 hours of funded direct care hours while not-for-profit care homes over-delivered by providing an additional 80,000 hours of direct care beyond what they were funded to deliver."
- The OSA report "Billion *More Reasons to Care: Contracted Long-term Care funding Review Update*" noted in 2021/22: "Not-for-Profit (NFP) facilities delivered 93,000 more care hours than they were funded to deliver, while for-profit (FP) facilities delivered 500,000 less hours than they were funded to deliver".
- Health Authorities (HAs) submit information on direct care hours (DCH) delivered to the Ministry based on what the HAs hold operators contractually accountable to deliver related to publicly funded LTC beds only. In 21/22 HAs reported NFP facilities delivered 41,000 more DCHs than they were funded to deliver, while FP facilities delivered 96,000 less DCHs than they were funded to deliver in 2021/22.

LAST UPDATED

The content of this estimates note is current as of 12 February 2025 as confirmed by Danielle Prpich, ED LASP- SSD

APPROVALS

2025 03 25 – Ross Hayward, ADM, Seniors Services Division
2025 02 12 – Danielle Prpich, ED, Seniors Services Division
2025 03 02– Brenda Rafter OBO ADM Rob Byers,, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Palliative Care

Topic: Palliative and end-of-life care services are provided across the continuum of care with the goal of improving the quality of life for people with life-limiting illnesses and supporting caregivers.

Key Messaging and Recommended Response:

- It is important for people at the end of their lives to have peace, comfort and choice related to their own health.
- Palliative and end-of-life care services are provided across a variety of settings in B.C., with the goal of improving the quality of life for people with life-limiting illnesses and supporting caregivers.
- Thanks to a 2023-24 bilateral agreement with the federal government, B.C. is receiving $52 million over five years to improve access to palliative and end-of-life care.
- In addition, we continue to invest in other services such as BC Palliative Care Benefits, which support palliative care at home for B.C. residents at the end stage of an illness.
- Our government is committed to providing a public health system that includes a full range of palliative care options for people at home and in their communities.

CURRENT SITUATION

- Palliative and end-of-life care services are provided through a coordinated system of care that prioritizes the provision of palliative care at home and in community settings (e.g., hospice, assisted living, long-term care, and ambulatory care) where appropriate.

Palliative Care and Hospice Beds

- There are currently 474 palliative/hospice beds in B.C., including 345 community hospice beds (both dedicated and designated community hospice beds) and 129 acute beds.[1,2,]
- Currently, the provincial palliative care bed to population ratio is 11 hospice beds per 100,000 adults.[3] International best practice is 8-10 beds per 100,000 adults.[4] A higher ratio can support palliative care closer to home in rural communities and/or regional variation in population characteristics such as age and complex chronic conditions/frailty.

Client Charges by Setting

- Palliative and end-of-life services are charged differently based on care setting. There is a daily client fee ($48.20) for in-facility/short-stay hospice care that is not incurred by patients receiving palliative care in an acute care hospital.
- BC Palliative Care Benefits provide coverage for home support, medications and equipment for eligible individuals receiving palliative care at home (see below).

Provincial Services/Initiatives

- BC Palliative Care Benefits (PCB) support B.C. residents of any age who have reached the end stage of an illness to receive palliative care at home. PCB includes coverage for eligible palliative care medications, medical supplies, and equipment. Since inception in 2001, to Dec. 31, 2024, over 181,000 clients have received PCB. In 2023/24, $22.6 million was spent on PCB medications and pharmacy services.[5]
- The After-Hours Palliative Nursing Service is a provincial telephone service that provides palliative nursing support to eligible clients living at home, and their caregivers, available in four regional

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[1] HCC Long-Term Care & Assisted Living Summary Report, as of November 2024, HSIAR, BC Ministry of Health. **Dedicated end-of-life beds:* beds reserved for end-of-life care (and may not be used for anything else). *Designated end-of-life beds:* beds allocated for end-of-life care as of the survey date but may at other times be allocated to different bed category.

[2] Acute Care Beds Report, as of 2024/2025, P09, HSIAR, BC Ministry of Health.

[3] HCC LTC & AL Summary Report, as of August 2024.

[4] European Association for Palliative Care (2010). White Paper on standards and norms for hospice and palliative care in Europe: part 2. European Journal of Palliative Care, 17(1): 22-32.

[5] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting Division, Ministry of Health. February 20, 2025.

health authorities (Interior, Island, Northern and Fraser). Vancouver Coastal Health has its own telephone-based service.

- A palliative care incentive payment of $100.62 (PG14063) compensates family physicians to create a care plan to support the quality of life for patients who are in the last six months of life expectancy.[6]
- Regional and provincial specialized services delivered by providers such as the Provincial Health Services Authority and BC Cancer support the full spectrum of cancer care including prevention, screening, diagnosis and treatment, research and education, as well as palliative care.
- My Voice: Expressing My Wishes for the Future Health Care Treatment (My Voice) is the B.C. government's resource to assist the public with advance care planning. The online My Voice guide is available in eleven languages, including English, French, Chinese, Punjabi, Korean, Farsi, Hindi, Vietnamese, Tagalog, Spanish and German.[7]

FINANCIAL IMPLICATIONS

- In 2023/24, BC and Canada entered into the Aging with Dignity bilateral agreement that provides B.C. with $733 million over five years to help British Columbians age with dignity, closer to home. This includes $52M in funding for palliative care.
- Government provided $9.1million to the Institute for Health System Transformation and Sustainability (IHSTS) between 2013-2015 to establish and support the BC Centre for Palliative Care (the Centre) of which $2.1 million was allocated to advance best practices in palliative care service delivery. Between 2018/19 and 2021/22 the Ministry provided $6 million to IHSTS in support of the Centre, to continue to improve access to palliative care, support implementation of provincial care policy and partnership initiatives, education, and local community-based initiatives.
- In 2023/24, The Ministry provided $140K to the BC Hospice Palliative Care Association (not yet announced but reported in Public Accounts) to promote leading practice, capacity building and delivery of high-quality hospice palliative care provided through B.C. hospice organizations.

KEY BACKGROUND

- The 2019 Federal Action Plan on Palliative Care lays out Health Canada's five-year plan for palliative care in Canada and complements support provided to the provinces and territories under the Common Statement of Principles on Shared Health Priorities.[8]
- In 2023, Health Canada published "The Framework on Palliative Care in Canada – Five Years Later: A Report on the State of Palliative Care in Canada".[9]
- The 2024/25 to 2026/27 HLTH Service Plan outlines government's commitment to improve access and co-ordination of care for seniors with complex medical conditions and/or frailty including professional services, home support, caregiver supports, and palliative care with a focus on affordability and integration of services to enable individuals to remain living at home longer.[10]
- In 2013 the Province published a palliative care action plan.[11]

LAST UPDATED

The content of this fact sheet is current as of February 2, 2025, as confirmed by Alix Adams, SSD.

APPROVALS

2025 03 12 – Rhiannon Pretty obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 14 – Brenda Rafter obo ADM Rob Byers, Finance and Corporate Services Division
2025 03 28 – Ross Hayward, Seniors' Services Division

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[6] GPSC. Palliative Care Planning Fee (PG14063). (2022). Retrieved from https://fpscbc.ca/sites/default/files/GPSC-Palliative-Billing-Guide.pdf.
[7] Contract Issue Note, My Voice Translation, December 31, 2021, Seniors Services, BC Ministry of Health.
[8] Government of Canada. (2019). *Action Plan on Palliative Care.* Retrieved from https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care.html.
[9] Government of Canada. (2023). *The Framework on Palliative Care in Canada – Five Years Later: A Report on the State of Palliative Care in Canada.* Retrieved from https://www.canada.ca/en/health-canada/services/publications/health-system-services/framework-palliative-care-five-years-later.html.
[10] Ministry of Health (February 2024). *2024/25-2026/27 Service Plan*. Retrieved from https://www.bcbudget.gov.bc.ca/2024/sp/pdf/ministry/hlth.pdf.
[11] The Provincial End-of-Life Care Action Plan for British Columbia. BC Ministry of Health. March 2013. Available at: Provincial End-of-Life Care Action Plan for British Columbia (gov.bc.ca).

LEGISLATIVE SESSION – ESTIMATES NOTE

Resident and Family Councils

Topic: Resident and Family Councils are an opportunity to ensure greater voices for residents and their families on decisions that affect them and their loved ones in long-term care.

Key Messaging and Recommended Response:

- Long-term care (LTC) residences are people's homes and it's important that residents and family members have a place to share concerns and ideas when it comes to decisions about how the homes are operating.
- Resident and Family Councils (RFCs) are independent, and member driven. They strengthen the partnerships between residents, families, LTC home operators, health authorities, and the Ministry of Health.
- At least twice a year, a LTC home operator must meet with RFCs for the purpose of receiving feedback and involving them in decision making that affects their day-to-day experiences.
- Operators must also respond in writing to recommendations from the RFC and provide administrative support as requested by the RFC. These are important provisions as they require that operators acknowledge, support, and communicate with RFCs.
- As of November 2024, out of 306 publicly subsidized LTC homes, 284 (93%) had either a resident or family council (or a combination of both). 22 (7%) were found to have no resident or family council.
- The Ministry has hosted three Provincial Forum meetings, and health authority-led Regional Resident and Family Councils meet regularly, which ensures the voices of residents and families in the local councils are being heard at all levels.

CURRENT SITUATION

- The Ministry of Health has taken steps to increase support for Resident and Family Councils (RFCs) in all licensed long-term care (LTC) homes, as announced by the Minister on November 3, 2022.
- As of November 2024, out of 306 publicly subsidized LTC homes, 284 (93%) had either a resident or family council (or a combination of both). 22 (7%) were found to have no resident or family council.[1,2]
- Each health authority has established a Regional RFC, which meets at least twice annually. These meetings provide an ongoing opportunity for RFC representatives to discuss successes, common issues of concern, and share experiences and information to improve quality of life for LTC residents.
- All health authorities have had at least three Regional RFC meetings in 2024/25.
- The Ministry hosts twice-annual Provincial Forums for RFCs to discuss systemic issues, promote best practices and advance quality of life for residents of LTC homes.
- There have been three Provincial Forums since June 2023.
    - Some issues discussed at the three Provincial Forums included food quality, staffing concerns, services provided, structure of RFC system and the complaints processes.
- The number of LTC homes that have an active RFC is an indicator in the LTC Quality Framework.

KEY BACKGROUND

- In September 2022, the Residential Care Regulation (RCR) was amended to enhance the requirements related to RFCs in LTC homes, ensuring a greater voice for residents and their families,

[1] HCC Bed/Facility Inventory Report, as of November 2024. Excludes standalone ABI, standalone short-stay, and fully private sites.
[2] BC LTC & AL Directory 2023 – Office of the Senior's Advocate.

and strengthening the partnerships between residents, families, LTC home operators, health authorities and the Ministry.
    - The RCR requires LTC home operators to, at least twice a year, meet with an RFC for the purpose of promoting the collective interests of residents and involving them in decision making that affects their day-to-day experiences.
    - LTC home operators are required to respond in writing to the recommendations made by the RFC.
    - In order to promote the intent of RFCs to be independent and member driven, LTC home operators only attend RFC meetings by invitation from Council members.
    - While the level of LTC home operator involvement is determined by RFC members, the RCR requires LTC home operators to provide administrative support for RFCs, such as a room for meeting and equipment to allow members to participate virtually.
- Policy 6.H in the Home and Community Care Policy Manual was revised in February 2024 to integrate feedback received from Regional RFCs and the RFC Provincial Forum and to ensure cultural sensitivity and inclusivity with the diverse population of BC.
- The Guidelines for RFCs, *Developing, Supporting and Maintaining Resident Councils and Resident and Family Councils*, previously published in 2011, were updated and published in June 2024 based on the new requirements and some best practices shared by local and regional RFCs since the regulations were amended.

LAST UPDATED

The content of this fact sheet is current as of March 2, 2025, as confirmed by Danielle Prpich, ED, SSD

APPROVALS

2025 02 27 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2025 03 06 – Ross Hayward, ADM, Seniors Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Seniors, Rural

Topic: Home and Community Care (HCC) services are provided in all regions across the province, including rural and remote communities.

Key Messaging:

- The Province is committed to ensuring that all people living in British Columbia have the health-care services they need, including patients and seniors in rural and remote communities.
- Government has invested approximately $3.5 billion since 2018-19 to expand and improve quality care for seniors in British Columbia, including investments in primary care, home health, long-term care and assisted living.
- As a rural resident and a former rural mayor, I understand the challenges rural seniors face in accessing healthcare while wanting to age in their communities, close to their loved ones and families.
- This is why we are supporting our seniors to age at home or at LTC facilities within their communities.
- Budget 2024 provides more than $354 million over three years in both community-based seniors' services and home health services in all geographic regions of B.C., whether urban or rural.
    - The Better at Home (BH) program supports seniors with day-to-day tasks, helping them to live at home for as long as possible without compromising their health and safety.
    - Work is underway to guide HA in supporting the delivery of culturally safe home health services in First Nations communities, many of which are rural and remote.
- In addition, the government continues to invest in LTC home development projects, including 331 LTC beds (net new and replacement) in rural areas such as Nelson, Fort St. James, and Sechelt.

CURRENT SITUATION

- On February 15, 2024, the Office of the Seniors' Advocate (OSA) released *Resilient and Resourceful: Challenges Facing B.C.'s Rural Seniors*[1]. Findings note inequities in access and provision of services in rural BC as compared to urban centres, including:
    - While there are proportionally fewer clients, the average hours of home support (HS) received per client (for people 65+ who receive HS hours) is 19% less in rural BC.
    - Approximately 3 publicly subsidized AL site units per 1,000 rural seniors' population (65+) in March 2023, compared to 4 publicly subsidized AL site units per 1,000 urban seniors' population (65+).
    - ~55% fewer publicly subsidized long-term care (LTC) beds per 1,000 rural population (65+).
- Fewer workers, less infrastructure, and a proportionally higher and faster growing seniors' population are all factors the OSA notes as contributing to inequities in services and supports in rural BC.
- The OSA report calls for a rural health human resource strategy, rural seniors home and community care strategy, and a provincial LTC and assisted living (AL) plan based on equity throughout the province.
- The OSA's findings and recommendations align with work underway to improve health services and Budget 2024 investments aim to improve care for seniors in all regions of BC.

Community-Based Seniors' Services (CBSS)

- Budget 2024 provides $127million over 3 years to expand and evolve non-medical home support services and health promotion programming for seniors throughout the province.
- The CBSS sector uses a community development approach that enables local participation in program planning to leverage assets and adapt programming to address local needs. Funded agencies are community-based non-profits, such as neighbourhood houses, seniors' centres, and community centres, run by local staff and volunteers. Approximately 23% of HLTH-funded agencies are in consolidated local health areas (CLHAs) considered rural / remote; 47% are in CLHAs considered mixed urban-rural.
- The Better at Home (BH) program supports seniors with day-to-day tasks, such as light housekeeping and

[1] Office of the Seniors Advocate British Columbia. (2024). Resilient and resourceful: Challenges facing B.C.'s rural seniors. Retrieved from: https://www.seniorsadvocatebc.ca/osa-reports/resourceful-and-resilient-challenges-facing-b-c-s-rural-seniors/

grocery shopping, helping to maintain independence at home. Currently, 97 BH programs (31% in rural CLHAs and 44% in mixed urban-rural CLHAs) operate across more than 260 communities in BC

- Investments in CBSS are expected to benefit seniors in rural communities by: 1) Increasing Community Connector positions from 19 in 2023/24 to approximately 90 in 2025/26. Community Connectors provide one-on-one support to seniors, ensuring coordinated access to community resources and facilitating healthcare referrals. Where appropriate, Community Connectors split their time across multiple smaller communities to ensure more seniors can access services; and 2) Expanding the Family and Friend Caregiver Support Program and Therapeutic Activation Program for Seniors by 6-7 program sites annually, starting in 2025/26. Areas of BC that demonstrate highest need and lack of comparable services will be prioritized.
- Transportation and food security are critical challenges for many seniors. To bridge this gap, starting in 2024/25, CBSS agencies can apply for funding to expand targeted transportation options and social meal programs. This funding is prioritized in areas identified as transportation or food deserts.

Home Health

- Budget 2024 provides $227million over 3 years to improve the quality, responsiveness, and effectiveness of home health (HH) services through optimizations in service delivery. This includes building improved connections between the HH and CBSS sectors across the province.
- Workforce shortages are a challenge in rural areas and health authorities are working to address gaps in service availability across the province. Budget 2024 aims to expand the overall HH workforce to meet growing demand (approx. 400 net new community-based professional FTEs and 500 net new HS community health worker FTEs). The HLTH HHR strategy and continued investment in the Health Career Access Program (HCAP) has resulted in 1,990 hires into HS across the province since September 2020[2].
- Investments in HH are expected to benefit seniors in rural areas through expansion of service hours for client intake and service availability, improved overnight coverage, and standardized response times.
- Policy development is underway to guide HA in supporting the delivery of culturally safe home health services in First Nations communities, many of which are rural and remote. This work was undertaken with First Nations partners including representation from 92 First Nations communities and is aligned with BC's reconciliation mandate and HLTH objectives to address health inequities.
- HAs continue to expand the use of virtual health technologies to overcome distance and workforce challenges with the aim of increasing the availability of seniors' care closer to home.

Assisted Living and Long-Term Care Services

- The Ministry provided a non-wage funding lift to publicly funded AL operators to lessen the inflationary pressures and feasibility for maintaining current service deliveries, including in rural AL sites.
- Phase 1 of HLTH's AL strategy includes standardization of AL services across the province.
- LTC home development projects include 311 LTC beds (replacement and net new), in rural areas, defined by the OSA report[3], including Vernon, Nelson, Fort St. James, and Sechelt. There are 783 LTC beds (replacement and net new) near rural centers in Comox, Cranbrook, Campbell River and Prince George.

FINANCIAL IMPLICATIONS

- Over $3.5 billion has been invested since 2018/19 to expand and improve care for seniors in all geographic regions of BC, including investments in primary care, community-based services, home health, long-term care, assisted living and respite services.
- Budget 2024 provides $354 million over 3 years to support seniors to age comfortably and safely in their own homes and maximize their quality of life, including $227 million over 3 years to improve the quality and responsiveness of home health services and $127 million over 3 years to stabilize and expand CBSS.

KEY BACKGROUND

- The OSA[3] notes that as of 2023, there were ~182,000 seniors aged 65+ in rural BC (25% of BC's rural population and 17% of all seniors in BC); by 2032, seniors will represent 29% of BC's rural population.

APPROVALS

2025 03 24 – Ross Hayward, ADM, Seniors Services Division
2025 03 10 – Brenda Rafter OBO ADM Rob Byers, Finance and Corporate Services Division

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[2] *HSWBS, Report on HCAP Hires for Long-Term Care & Assisted Living and Home Health Settings, Data range: Sept 9, 2020 - Dec 31, 2024*

[3] Office of the Seniors Advocate British Columbia. (2024). Resilient and resourceful: Challenges facing B.C.'s rural seniors. Retrieved from: https://www.seniorsadvocatebc.ca/osa-reports/resourceful-and-resilient-challenges-facing-b-c-s-rural-seniors/

LEGISLATIVE SESSION – ESTIMATES NOTE

Artificial Intelligence in the Health System

Topic: An overview of artificial intelligence (AI) current state in the provincial health system.

Key Messaging and Recommended Response:

- AI has many clinical and non-clinical applications in health care, including in the areas of administration, service delivery, diagnostic imaging and disease detection, research and analytics.
- For example, AI can enhance the quality of services that patients receive such as enhanced speed and accuracy in the analysis of imaging and diagnostics, resulting in improved triage and quicker access to care.
- AI can also support health care professionals to reduce the time spent on administration, leaving more time available to do what they do best – deliver clinical care to their patients. This can be done through AI scribes, AI assistance in scheduling or even analysis of past physicians' notes to predict forthcoming care pathways.
- With coordinated policy direction and a guiding framework, AI can be a safe and effective enabling tool that can enhance patient experience, patient outcomes, provider experience and access to quality care.
- The Ministry is developing a policy framework to guide the responsible use of AI in the health system, in alignment with federal and provincial guidance.
- As with all medical care, the ministry is committed to patient safety. This commitment extends to ensuring data accuracy, privacy and data security.

CURRENT SITUATION

- The increasing prevalence of AI across all sectors, as well as growing public interest and concern about AI impacts, has led to rapid mobilization across different industries and partners to responsibly develop, implement, guide and govern AI.
- BC recognizes that there are strong alignments and opportunities for AI in the health system. While certain risks exist, including privacy and ethical considerations, these can be addressed through appropriate use guidelines and policies.
- BC recognizes that AI has many clinical and non-clinical applications in health care, including in the areas of administration, service delivery, diagnostic imaging and disease detection, research and analytics.
- With coordinated policy direction and a guiding framework, AI can be a safe and effective enabling tool that can support health human resources to keep pace with the growing needs of people in BC and deliver better, faster care.
- BC's Health Human Resources Strategy (HHR) acknowledges AI's potential to shift healthcare delivery, improve productivity and ease the administrative burden on health-care workers. Action 29 of the HHR calls for the development of a strategy for AI and workforce-enabling technology.
- Advice/Recommendations

- All BC health authorities have an interest in AI strategies and policies for their workforces as AI is already being explored in various applications and settings across the provincial health system, including clinical documentation, cancer screening and patient intake processes.
- Specific examples include testing AI tools for more rapid disease diagnosis, including cancer (Northern Health Authority, Vancouver General Hospital, St Paul's Hospital, BC Cancer); predicting cancer patient survival by analyzing doctors' notes (BC Cancer, Provincial Health Services Authority); leveraging AI to

assist with scheduling (Fraser Health Authority); hospital discharge predictions (Fraser Health Authority); supporting faster stroke care (Vancouver Coastal Health Authority); and reducing MRI wait times (Vancouver Coastal Health Authority).

FINANCIAL IMPLICATIONS

- Ernst & Young has been contracted to develop the Ministry's AI policy framework and implementation toolkit. The contract commitment, funded from the HHR Strategy budget, is $200,000 in 2024/25.

KEY BACKGROUND

- In Canada, a national AI strategy was released in 2017, and the federal *Artificial Intelligence and Data Act* was tabled in June 2022 (pending endorsement). The proposed *Artificial Intelligence and Data Act* aims to develop a framework as a first step toward federal regulations intended to protect Canadians, ensure the responsible use of AI, and prominently position Canadian firms in AI development.
- In June 2021, the BC and Yukon Ombudsperson and Privacy Commissioners released a joint report, *Getting Ahead of the Curve*, with recommendations around fairness and privacy for AI use in public service delivery.
- In August 2023, the BC Office of the Chief Information Officer released interim guidance regarding generative AI (e.g., ChatGPT) for the internal audience of BC Public Service employees followed by a set of guiding principles in November 2024.
- The Ministry recognizes that the Chief Information Officer and the Ministry of Citizens Services are the provincial lead for AI technology strategy, policy and standards. The Ministry works in collaboration with these partners to ensure alignment.

LAST UPDATED

The content of this estimate note is current as of March 6, 2025, as confirmed by Breanna Chandler.

APPROVALS

2025 03 07 - Ian Rongve, Service Redesign, Research and Innovation Division
2025 02 24 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Long-Term Care at Home (LTC@Home) Pilot Project

Topic: Long Term Care at Home (LTC@Home) Pilot Project

Key Messaging and Recommended Response:

- The population of BC is aging rapidly, and innovative models are needed to meet the demand for seniors' health services and long-term care (LTC) in a way that is cost-effective and preserves dignity for our valued elders.
- LTC@Home equips seniors' homes with technology for virtual care that is customizable to an individual's needs and monitored by a care team who checks-in if an alert is received. It also includes respite care to help alleviate family caregiver burnout, extending their ability to care for a loved one in the home longer.
- The program's technology can monitor for fall detection, activity levels, medication adherence, wandering and vitals.
- Supporting seniors to age at home where it is appropriate to do so is essential to reducing physical space pressures on the healthcare system, improving care delivery and efficiency, and aligning with the preference of most seniors to remain in their homes.
- The Ministry of Health is collaborating with additional health authorities to implement sites across Island Health, Fraser Health and Vancouver Coastal Health in spring 2025. By the end of 2027/28 fiscal, the program is targeting to support up to 2,700 seniors to age safely and independently in their homes.

CURRENT SITUATION

- LTC@Home is an innovative seniors' care program launched by the Service Redesign, Research and Innovation Division that leverages technology to support seniors to age in place.
- Fundamentally, all LTC@Home projects provide[1]:
    - **24/7 remote monitoring:** Ensuring continuous connection, passive monitoring, and a personalized escalation pathway for seniors for wellness alerts, providing peace of mind to families.
    - **Connection to social activities:** Facilitating access to day programs or other social support.
    - **Predictable respite support:** Offering up to a 1-week period of respite every 4 to 6 weeks to alleviate family caregiver burnout.
- Technologies are customized to meet the senior's needs and may include electronic medication dispensers, geo-fencing technology for wandering prevention, fall-detection in the home, and radar tracking of movement to monitor activity levels.
- The technology is monitored by a central agency; any alert will trigger a personalized care pathway as determined by the senior and their care giver.
- The first point of contact can address any questions or check-in with the senior and escalate accordingly to the predetermined pathway of the family, friends or neighbours, or escalate to the community care team or emergency services if required.
- The program was publicly announced and launched at two long-term care (LTC) homes in July of 2024: Broadmead Care Society in Saanich (Island Health) and KinVillage in Delta (Fraser Health)[2].
    - The existing sites collectively support over 100 seniors and are continuously onboarding new participants.

[1] BC Gov News
[2] BC Gov News

- The Ministry of Health is collaborating with additional health authorities to implement additional projects across Island Health, Fraser Health and Vancouver Coastal Health in spring 2025. Conversations with additional health authorities are under way.
- By the end of 2027/28 fiscal, the program is targeting to support up to 2,700 seniors to age safely and independently in their homes[3].
- A third-party contractor was hired in September 2024 to measure program outcomes, identify improvement opportunities, and inform provincial expansion planning. The final report is due in March 2026.

FINANCIAL IMPLICATIONS

- From 2024/25 to 2027/28, LTC@Home will be funded through the Canada-BC Aging with Dignity Bilateral Agreement[4] , with funding of up to $47 million over 4 years of the Agreement. Funding allocations per year are $3 million in 2024/25, $10 million in 2025/26, $17 million in 2026/27, and $17 million in 2027/28.

KEY BACKGROUND

- The population of BC is aging rapidly, and the demand for senior health care and LTC beds is growing.
- From 2019 to 2023, the number of LTC beds increased by 3% while the senior's population aged 85+ grew 8%[5].
- Innovative models are needed to address the increasing demand for LTC while providing support to the eligible applicants currently on the waiting list.
- Approximately 5% of BC's population aged over 65 reside in a LTC or assisted living facility. As per the preference of general population, most seniors still live independently at home or in the community.[6]
- BC Seniors Advocate has noted that 12.8% of newly admitted long-term care residents in BC potentially could have been cared for at home, and that 60% of seniors admitted to long-term care in BC received no home support in the 90 days prior to admission[7].
- BC Seniors Advocate reported in 2024 that more than 1 in 3 family caregivers are distressed.[8]
- Supporting seniors to age at home where it is appropriate to do so is essential to reduce physical space pressures on the system, improve care delivery and efficiency, and align with the preference of most seniors to remain in their own homes.
- With the pressure on health human resources, the LTC@Home model should enhance the provider's experience and alleviate pressures by leveraging technological supports to create efficiencies in care and prioritize in person supports where they are needed most.

LAST UPDATED

The content of this estimate note is current as of January 31, 2025, as confirmed by Breanna Chandler.

APPROVALS

2025 03 05 – Ian Rongve, Service Redesign, Research and Innovation Division
2025 02 26 – Brenda Rafter obo Rob Byers, ADM, Finance and Corporate Services Division
2025 02 20 – Health Sector Information, Analysis & Reporting Division

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[3] BC Gov News

[4] Canada-British Columbia Aging with Dignity funding agreement (2023-24 to 2027-28) - Canada.ca

[5] Office of the Seniors Advocate 2023/24 Annual Report

[6] BC Office of the Seniors Advocate. Monitoring Seniors Services 2024 Report. December 2024.

[7] Office of the Seniors Advocate. Aging Matters Report. June 2024.

[8] Office of the Seniors Advocate. Aging Matters Report. June 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE
Ministry Approach to Climate Change

Topic: The Ministry of Health and health authorities are advancing a proactive, coordinated approach to climate change and sustainability across the health system.

Key Messaging and Recommended Response:

- BC is experiencing health challenges posed by climate change, including risks to health and well-being, disruptions to essential health services, damage to hospitals and critical infrastructure, and pressures on an already strained health workforce.
- The health impacts of extreme heat, wildfire, flooding and drought are expected to escalate in the coming years as our climate continues to change. These impacts will be felt most by populations that are already vulnerable or underserved, including seniors; people living with disabilities or chronic conditions; those experiencing mental health challenges; and Indigenous, rural and remote communities.
- Climate action can enhance the health and well-being of our communities while strengthening the stability and sustainability of the health systems they rely on.
- In response, the Ministry and health authorities are taking a proactive, coordinated approach to climate change and environmental sustainability.

CURRENT SITUATION

- Climate action offers an opportunity to improve the health of British Columbians and protect the services they rely on while transitioning away from inefficient models of health care.
- A coordinated systems approach to climate change is critical to ensure our collective actions are impactful, cost-effective and equitable while optimizing co-benefits for other strategic priorities.
- To meet provincial climate action targets and accountabilities, plans are in place (or in development) at the Ministry and all health authorities, including:
    - **Ministry's** Climate Action Plan (2023-2025);
    - **Interior Health Authority's** Climate Change and Sustainability Roadmap 2023-2028;
    - **Fraser Health Authority's** Planetary Health Strategy; and
    - **Vancouver Coastal Health Authority's** Planetary Health Strategy.
- The Ministry is working with health authorities to strategically align efforts around 3 key goals:
    1. climate preparedness, resilience and adaptation;
    2. climate mitigation and greenhouse gas reduction; and
    3. environmental sustainability.

Climate Preparedness, Resilience and Adaptation

- The 2022 Climate Preparedness and Adaptation Strategy (CPAS) committed >$500 million in associated funding under BC Budget 2022, including $13 million over 3 years (2022/23 – 2024/25) for foundational health actions[1] led by the Ministry and health authorities to initiate the shift to a "low carbon, climate resilient health system."
- CPAS funding supported the Ministry to establish a Climate Resilience Unit to lead strategic policy and initiatives to promote health system climate resilience, including the coordination of CPAS implementation. The funding also supports regional health authorities, Provincial Health Services Authority and the First Nations Health Authority to deliver and report on CPAS commitments.
- Key CPAS activities in 2022/23-2024/25 include:
    - Developing governance and organizational structures.
    - Building workforce capacity via climate literacy training, policy and communication tools.
    - Development of regional climate risk and resilience assessments and surveillance.

[1] Assess climate impacts on health and the health system; build health workforce knowledge and capacity to prepare and respond; public communications and awareness campaigns.

- Development of a provincial report to guide the health system's approach to climate change.[2]
- Launching of a funding program that supports health authorities to test and assess new innovative approaches to build health system climate resilience and sustainability.
- Initiation of a 4-year partnership to develop and evaluate evidence-based and community-driven interventions to address the mental health impacts of climate change.
- Support for Indigenous and community-led interventions to reduce climate risks to health through grants and partnerships.

Climate Mitigation and Greenhouse Gas Reduction

- The Ministry and health authorities continue to make progress on provincial greenhouse gas reduction targets as part of our commitments to CleanBC.
- The provincial Environmental, Social and Governance Framework for Capital Projects means new public sector buildings, including health facilities, are designed to meet CleanBC objectives.
- The Carbon Neutral Government Program supports health authorities to achieve carbon neutrality.
- The Ministry's Health Capital Policy Manual sets expectations for low-carbon, resilient health facilities, supported by health authority guidelines.

Environmental Sustainability

- Health authorities are adopting environmentally sustainable practices and models of care, such as:
  - Integrating environmental consideration into procurement and supply chain management.
  - Prescribing low-carbon options for pharmaceuticals, such as inhalers.
  - Shifting to reusable products, e.g., gowns, and low carbon anesthetic gas in perioperative care.
  - Consuming energy and other resources, such as water, more efficiently.
  - Virtual care and remote monitoring which reduces patient/provider travel and emissions.

FINANCIAL IMPLICATIONS

- In Budget 2022, the Ministry received $13 million over 3 years to support the CPAS.
- A total of $1.94 million in 2022/23, $2.11 million in 23/24, and $3.59 million in 24/25 was allocated across all health authorities, including the Provincial Health Services Authority (BC Centre for Disease Control) and the First Nations Health Authority.
- $1.85 million in 23/24 shared cost arrangement with Mental Health and Climate Change Alliance
- $1.29 million in 24/25 to support 11 climate innovation projects across all health regions.

KEY BACKGROUND

- The health care sector is a significant contributor of greenhouse gas emissions that drive climate change; the Ministry and health authorities are accountable for provincial greenhouse gas reduction targets under CleanBC.

Climate Accountability

- CleanBC Roadmap to 2030 and CPAS set the Province's goals for climate mitigation (emissions reduction) and adaptation (preparedness), including Ministry and health authority accountabilities.
- The *Climate Change Accountability Act* (2007) requires BC's public sector, including the Ministry and health authorities, to publicly report on actions to mitigate and manage climate risks and meet legislated emission reduction targets through annual Climate Change Accountability Reports.[3]
- The *Emergency and Disaster Management Act* requires the Ministry and health authorities to develop, implement and test emergency and business continuity plans, including an all-hazards approach to prepare for, respond to, and recover from climate-driven and other emergencies.

LAST UPDATED

The content of this estimate note is current as of January 31, 2025, as confirmed by Breanna Chandler.

APPROVALS

2025 03 25 - Ian Rongve, Service Redesign, Research, and Innovation Division
2025 03 07 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2025 02 14 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division

[2] The report, *Climate Change and Health in British Columbia: From Risk to Resilience*, is pending public release
[3] BC Climate Change Accountability Act (2007).