JAMES A. NIELSEN, Minister

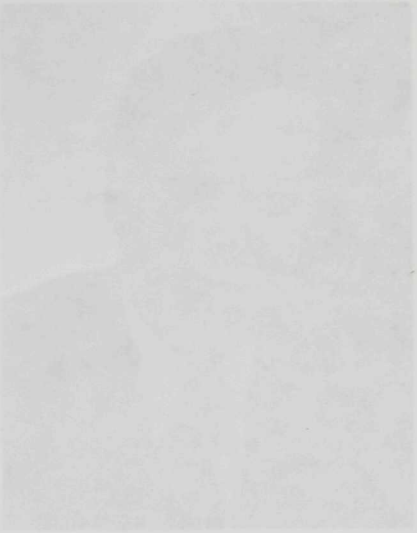
To the Honourable Henry P. Bell-Irving, D.S.O., O.B.E., E.D.,
Lieutenant-Governor of the Province of British Columbia.

MAY IT PLEASE YOUR HONOUR:

The undersigned respectfully submits the Annual Report of the Ministry of Health for the year 1980.

JAMES A. NIELSEN
Minister of Health

Office of the Minister of Health
Victoria, B.C., May 1, 1981.



MINISTRY OF HEALTH, VICTORIA, B.C., MAY 1, 1981

The Honourable James A. Nielsen,
Minister of Health, Victoria, B.C.

SIR: I have the honour to submit the Annual Report of the Ministry of Health for 1980.

PETER BAZOWSKI
Deputy Minister of Health

PETER BAZOWSKI,
Deputy Minister

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MINISTRY OF HEALTH

THE HONOURABLE K. RAFE MAIR, MINISTER OF HEALTH[1]

THE HONOURABLE J. NIELSEN, MINISTER OF HEALTH[2]

C. KEY, DEPUTY MINISTER

SUPPORT SERVICES

J. BAINBRIDGE
Assistant Deputy Minister

R. A. MUNRO
Senior Director (Comptroller)
Financial Services

J. P. B. LANGRAN
Director,
Management Services

W. F. LOCKER
Director of Personnel

J. H. DOUGHTY
Director of Administration

W. O. BOOTH
Executive Director,
Supply and Services

COMMUNITY HEALTH SERVICES

G. H. BONHAM
Senior Assistant Deputy Minister

PREVENTIVE SERVICES

H. M. RICHARDS
Assistant Deputy Minister

A. R. ROSS
Senior Director, Preventive Clinical Services

L. M. CRANE
Director, Division of Public
Health Nursing

A. A. LARSEN[3]
Director,
Division of Epidemiology

D. ZINK
Director, Division of Speech
and Hearing

A. GRAY
Director, Division of Dental
Health Services

F. M. M. WHITE[4]
Director,
Division of Epidemiology

A. HINDLEY
Director, Division of Public
Health Inspection

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1 Resigned January, 1981.
2 Appointed January, 1981.
3 Retired January, 1980.
4 Appointed April, 1980.

VANCOUVER BUREAU

J. H. SMITH
Assistant Deputy Minister

W. A. BLACK
Director, Division of Laboratories

J. MALLOW [5]
Director, Community Vocational Rehabilitation Services

W. BOYD [6]
Director, Community Vocational Rehabilitation Services

E. A. ALLEN [7]
Director, Tuberculosis Control

H. K. KENNEDY
Director, Division of Venereal Disease Control

W. E. GUEHO
Executive Director, Pearson Hospital

DIRECT CARE COMMUNITY SERVICES

I. KELLY
Assistant Deputy Minister

HOME CARE/LONG TERM CARE

P. SCOTT [8]
Director

L. AUSTMAN [9]
Regional Manager Home Care/Long Term Care

P. KERR
Regional Manager Home Care/Long Term Care

M. A. RHODES
Manager Administrative and Licensing

L. DAVIS
Manager, Finance

M. HALL
Manager Information Systems

D. OUSTON
Home Care Consultant

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5 Resigned November, 1980.
6 Appointed August, 1980.
7 Appointed April, 1980.
8 Appointed March, 1980.
9 Appointed December, 1980.

MENTAL HEALTH PROGRAMS

J. E. GRAY [10]
Director

J. B. FARRY
Regional Program Director

R. S. MCINNES
Regional Program Director

E. LUKE
Consultant in Psychiatry

D. FERNANDEZ [11]
Planning & Research Officer

A. G. DEVRIES
Consultant in Psychology

SPECIAL CARE SERVICES

B. C. GEE [12]
Director

M. BEECHING
Grants Coordinator

W. NORTON
Planning and Evaluation

PROFESSIONAL AND INSTITUTIONAL SERVICES

R. H. MCDERMIT
Senior Assistant Deputy Minister

HOSPITAL PROGRAMS

J. GLENWRIGHT [13]
Assistant Deputy Minister

D.S. THOMSON [14]
Assistant Deputy Minister

P. BREEL [15]
Senior Director

R. GOODACRE
Director of Research

J. D. HERBERT
Director of Administrative Services

H. R. MCGANN
Director, Hospital Consultation and Inspection

G. F. FISHER
Director, Construction and Planning Division

C. F. BALLAM
Senior Medical Consultant
Medical Consultation

A. C. LAUGHARNE
Director
Finance

---

10 Appointed February, 1980. 11 Resigned April, 1980.
12 Appointed February, 1980. 13 Retired January, 31, 1980.
14 Appointed May 26, 1980. 15 Resigned August 31, 1980.

MEDICAL SERVICES COMMISSION

D. H. WEIR [16]
Chairman

D. M. BOLTON[17]
Chairman

R. B. H. RALFS
Director, Salaried & Sessional Programs

A. W. BROWN
Director
Plan Operations

R. MCMANAMAN
Director,
Financial Services

N. FINLAYSON
Senior Medical Consultant

EMERGENCY HEALTH SERVICES COMMISSION

D. H. WEIR [16]
Chairman

P. BREEL [18]
Chairman & Executive Director

P. RANSFORD
Senior Medical Consultant

HEALTH PROMOTION AND INFORMATION

M. CHAZOTTES
Executive Director

J. MATTERS
Chief, Information Services

P. WOLCZUK
Director, Nutrition & Health Education

L. D. KORNDER
Director, Occupational Health

E. WOODWORTH
Librarian

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16 Retired February, 1980. 17 Appointed June, 1980.
18 Appointed September, 1980.

PLANNING AND DEVELOPMENT SERVICES

C. BUCKLEY
Executive Director

P. PALLAN
Director, Planning & Policy Analysis

J. TALBOT
Director, Program Development

W. DIETIKER
Director, Management Information Services

S. BLAND
Consultant in Geriatrics

W. BURROWES
Director,
Vital Statistics

COMMISSIONS ETC.

H. F. HOSKIN [19]
Chairman, Alcohol & Drug Commission of British Columbia

J. BAINBRIDGE
Chairman, Provincial Adult Care Facilities Licensing Board

M. DAHL [21]
Chairman, Provincial Child Care Facilities Licensing Board

G. H. BONHAM [20]
Chairman, Alcohol & Drug Commission of British Columbia

J. DUFFY
Executive Director
Forensic Psychiatric Services Commission

F. J. BLATHERWICK [22]
Chairman, Provincial Child Care Facilities Board

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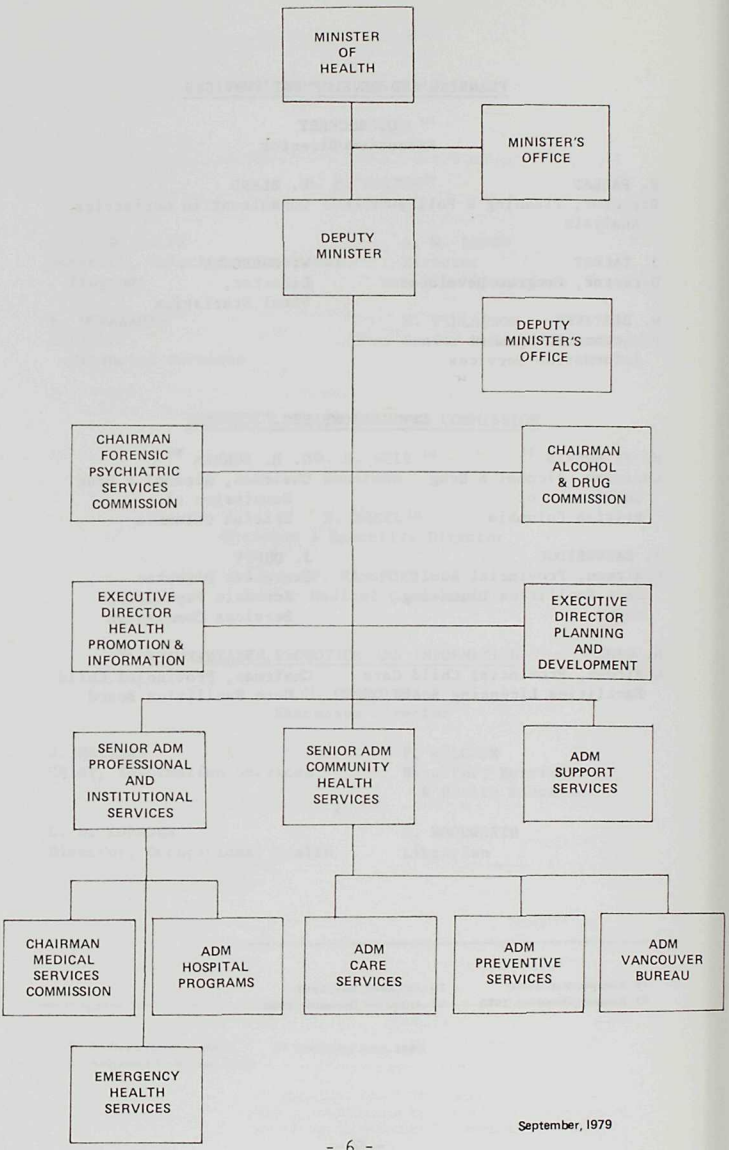
19 Resigned May, 1980.
20 Appointed May, 1980.
21 Resigned December, 1980.
22 Appointed December, 1980.

MINISTRY OF HEALTH



September, 1979

DEMOGRAPHIC FEATURES

The population in the province in 1980 was estimated at 2,640,000 at the mid-year. This is a 2.8 per cent increase over the 1979 figure of 2,567,000 and represents the highest rate of growth recorded in recent years.

While the number of births which occurred during the year was slightly higher than for 1979, because of the population increase the rate was somewhat lower, being 14.8 per 1,000 population compared to 15.0 in 1979. Illegitimate births continued at a high level and represented 15.5 per cent of all births, about the same as in 1979.

Marriages registered for the year were higher in number in 1980 than the previous year and the rate was also higher, 8.5 per 1,000 population compared to 8.3 in 1979.

Deaths in 1980 were about the same in number as in 1979 and the rate per 1,000 population was down to 7.3 from the previous year's figure of 7.5. The 1980 figure is a record low.

Among the individual cause of death groups, heart disease continued to rank as the leading cause, although the death rate per 100,000 population declined to 233 from the rate of 241 recorded in the previous year. In contrast, cancer mortality, the second leading cause, continued to register an increase and the rate was up to 174 per 100,000 population in 1980, compared to 171 in 1979. Little change was recorded in mortality from cerebrovascular lesions of the central nervous system ("strokes"), the third leading cause. The death rate in 1980 was 73.1, slightly less than 73.5 for 1979.

Accidental deaths were again at the somewhat lower level of recent years in 1980; there were 60.2 deaths per 100,000 compared to 65.3 in 1979. Rates in the early 1970's were much higher, and a figure of 83.3 was recorded in 1974. Motor vehicle accident deaths increased as a proportion of all accidental deaths, representing 47 per cent in 1980 compared to 44 per cent in 1979. Falls accounted for the same proportion of accidental deaths in both 1979 and 1980, namely, 19 per cent. Drownings made up 9 per cent of accidental deaths in 1980, and 7 per cent last year, while poisonings accounted for 6 per cent, a decline from the 1979 figure of 8 per cent.

Suicides increased slightly in 1980 to 17 per 100,000 population, compared to 16 in 1979.

The infant mortality rate was substantially the same in 1980 as in 1979, 11.4 per 1,000 live births.

THE YEAR IN REVIEW

Announcement of a major dental program to benefit one million British Columbians was the highlight of 1980, a year which saw health service costs continue to mount substantially, with the Ministry's budget consuming 30 per cent of total Provincial spending.

The Ministry's range of services broadened significantly with the introduction of the Dental Care Plan of B.C. on January 1, 1981, as announced in July last year. Unique in Canada, the plan covers basic dental services and dentures for low-income earners, all senior citizens and all children 14 and under. It will help to protect people without private dental insurance from the high costs associated with basic dental care, and will give complete access to a full range of preventive sevices.

The pressures of rising costs were felt throughout the year. On July 1, the Ministry introduced increases in direct charges for several health services to bring them into line with general cost-of-living trends, and announced a policy of indexing these charges to reflect future changes in the economy. The increases applied only to treatment and residential programs; preventive and basic home support services were not affected.

For Medical Services Plan premiums and daily hospital charges, the increases were the first since 1976. Premiums rose approximately 15 per cent, and the daily charge for acute in-patient hospital care was raised to $5.50 from $4. Daily charges were also increased for day care surgery and long term and extended care, and ambulance charges were raised.

As part of the revision of direct charges, the Ministry abolished the $1-a-day charge for day clinical services at hospitals and for extended care for children under 19.

To reduce the burden of higher medicare premium costs on low-income earners, the premium assistance program was broadened to include roughly 550,000 persons, effective July 1, 1981.

The hospital insurance and medicare plans, dating back to 1949 and 1968 respectively, continued to enhance their benefits. Hospital insurance coverage was extended to include day care surgery and emergency treatment provided to British Columbians while in other provinces. Medicare benefits were boosted by 25 per cent for senior citizens receiving chiropractic and physiotherapy services.

Hospital operating expenditures remain a major obstacle to containing the upward spiral of health care costs, especially since some 80 per cent of this spending comprises staff wages and benefits.

A settlement between the Health Labour Relations Association and the bargaining agents for registered nurses, amounting to some 49 per cent over 27 months, was reached last year. While the Ministry is not a party to negotiations between hospitals and their employees, it is ultimately responsible for providing the funds to meet the negotiated labour contracts. The nurses' settlement had an immediate impact on the 1980/81 budgets already set for hospitals, and substantial special warrants were required to make up the shortfall. Grants to hospitals from the Ministry now exceed one billion dollars, making the achievement of greater operating efficiencies more essential than ever.

The Ministry continues to emphasize day care and home care as alternatives to in-patient care that are both better for the patient and less costly to the taxpayer. For example, more than 92,000 surgical procedures were provided on a day care basis last year, compared with 13,450 in 1968, the year such surgery began in B.C. hospitals as an insured benefit.

One consequence is a declining need for acute care hospital beds in proportion to the population. In 1966, there were 5.62 beds per 1,000 population in B.C. This had dropped to 5.01 by 1976, and it is estimated that only 4.25 beds will be needed by 1986.

Nevertheless, there remains a need to replace out-dated hospital facilities, and 1980 saw the continuation of an ambitious program of hospital construction and renovation that began in 1976, and will extend to 1986. Last year, 13 major projects were completed. At year-end six major projects were under way, at an estimated total cost of $246 million, and 22 smaller projects were in progress.

The Long Term Care Program's third year of operation was marked by a partial amalgamation of Long Term Care and Home Care into a single program under one director. The program re-emphazised its policy of serving clients in their homes where possible, with admission to an institutional facility considered as a back-up to in-home services. More than 24,700 clients are receiving care at home, compared with nearly 16,000 in facilities.

Preventive services were strengthened in 1980, through both program expansion and renewal of facilities. Speech and hearing clinics were added in Nanaimo and North Delta, with each expected to serve more than 1,000 new clients a year. New community health centres were opened in Prince George, Nanaimo, Terrace, Vernon and Parksville, each housing local services in one building, other centres are being built in North Delta, Cranbrook and Gibsons.

A major step was taken to improve the training of ambulance crews by merging the training facilities of the Emergency Health Services Commission with those of the B.C. Justice Institute, which trains firefighters, police, and court and corrections personnel. The new Emergency Health Services Academy, situated at Jericho Beach in Vancouver, will enhance the training that has given B.C.'s emergency health attendants an international reputation for excellence.

During, 1980, the commission doubled the strength of its infant transport team, which transfers critically ill infants from all over the province to the neo-natal intensive care unit of Vancouver General Hospital.

The Alcohol and Drug Commission underwent significant changes in its structure and terms of reference late in the year. The newly appointed commission will operate independently from its previous day-to-day operations and programs, which will be administered directly by the Ministry, with considerable use of funded agencies to provide treatment services. This separation will free the commission from any vested interest in existing programs, allowing it to provide the government with independent advice on broad program and policy issues.

Concrete steps were taken to improve care for disturbed adolescents. Construction of a 26-bed facility with out-patient services is under way at the B.C. Youth Development Centre in Burnaby, with completion scheduled for late 1981. In the meanwhile, arrangements were made to provide 10 places for disturbed teenagers at the Malahat Educational Community, near Victoria.

An innovative approach to the care of terminally ill patients was introduced to British Columbia in 1980. Pilot hospital programs in Vancouver and Victoria were started to help dying persons cope with their situation, and assist their families, and professionals and lay workers involved with their care. The programs are sponsored by the Ministry, with services provided by a hospital in each city, the local community health department, and homemaker and volunteer agencies.

Another pilot program with Ministry sponsorship was aimed at relieving nursing shortages by offering refresher courses for nurses who have not practised for some time. Based on the successful results at Royal Jubilee Hospital in Victoria, the program will receive Ministry funding in any area of the province where the need exists.

One of the most newsworthy events of 1980 was the attempt by amputee Terry Fox to run from coast to coast to raise money for cancer research. In December, the Ministry announced that $75,000 had been allocated to the planning of the Terry Fox Cancer Research Laboratory in Vancouver, to be financed through a $1 million grant from the Province. The laboratory will initially house a team of four researchers and their support staff in 9,000 square feet at the B.C. Cancer Research Centre, and it is hoped that eventually the staff can be increased to 30.

The Ministry made a contribution toward the future direction of Canada's health care delivery system in its briefs to the federal Health Services Review conducted by Special Commissioner Honourable Emmett Hall. In his address to the commission, the Minister of Health outlined the accomplishments of the Ministry under the more flexible block funding arrangement that superseded federal cost sharing grants in 1977, and urged that the new system be continued. The Minister also presented British Columbia's contention that the federal government should relinquish responsibility for providing health care services to registered native Indians living on reserves.

The submissions to the review provided an opportunity for the Ministry to express its vision of the future of health services. British Columbia has been a leader in the development of many forms of service delivery, and the Ministry of Health looks forward to continuing its leadership responsibilities to meet the challenges of the 1980s.

Chapin Key, M.D.
Deputy Minister of Health.

SUPPORT SERVICES

The primary role of Support Services is to provide managerial support to members of the Ministry who are responsible for the delivery of services to the public.

Support Services includes financial services, personnel services, central shared services, management services and legal services.

In addition, Support Services provides background material and papers at the direction of the Deputy in matters of current concern, such as the Ministry's position on intergovernmental relations as they affect health care. Support Services is also responsible for co-ordinating the Ministry's relations with the B.C. Buildings Corporation, B.C. Systems Corporation, Government Employee Relations Bureau, and Treasury Board.

1980 was the second year in which Support Servies has been responsible for managerial support, and there was significant development of this area of the Ministry. Support Services are committed to the provision of effective services, to enable the Deputy Minister and Service Managers of the Ministry to concentrate on the provision of efficient and effective health services to the public.

Legal Services

The Health Legal Unit acts as the focal point between the Ministry of Attorney-General and the Ministry of Health. The members of the unit provide the whole range of legal services to the Ministry of Health and to its several Commissions. The duties of the Unit reflect the entire practice of law, namely: provision of advice to the executive of the Ministry of Health; development of legal opinions and memoranda; preparation of agreements between the Crown and other groups; development of policy and proposed legislation and regulations, and initiation of legal actions on behalf of the Crown.

Since the Ministry of Health possesses one of the largest aggregations of personnel within the Government, it is intended that the Health Legal Unit will grow to fulfill the needs of the Ministry.

Management Services

During the year the division had the following responsibilities:

MANAGEMENT ENGINEERING SERVICES

These services were provided to the senior management of Community Health Services, Professional and Institutional Services, and Support Services. The consultants and analysts were involved in studies, and in the provision of consultative services concerned with the better utilization of the Ministry's resources. Included were projects such as the development of staffing methodologies for hospitals, the establishment of a records management system for the Ministry, and the study of clerical work in field clinics. Improvements were made to supply and photocopier operations, as a result of studies of these areas.

BUILDING OCCUPANCY RELATED MATTERS

This involved the co-ordination of the Ministry's accommodation needs, and the representation of these needs to the B.C. Buildings Corporation, providing assistance with the resolution of problem areas, and liaison with the Corporation, on all matters affecting space occupied by the Ministry. A five-year projection of the Ministry space needs was prepared.

OPERATION SUPPORT SERVICES

This included the management of those services which were involved in the support of the Ministry's headquarters operations, such as printing and photocopying, warehousing, security, and space planning. During the year the renovation program for the Ministry's headquarters accommodation in Victoria was completed, and a Records Management Unit was established at the Support Services Centre.

Personnel Services

A personnel officer to lead the Ministry's staff training and development activities joined the staff during the year. The new program became effective very quickly through the arranging of professional upgrading for management staff. An expert in the management field was engaged to lead a pilot group through a number of discussions of major topics.

The busy field of recruitment and selection required additional attention from personnel, when a government hiring freeze was declared in the latter part of the year. All staffing action required a prepared defence and submission to Treasury Board, and this situation continued through much of the reorganizational phase of the Ministry staffing.

A new provincial dental program was developed with heavy personnel input in staffing, and in leading the negotiations for a fee structure with the B.C. College of Dental Surgeons. Two groups -- Dental Technicians and Dental Mechanics -- were added to those already in regular fee bargaining.

Agreements with the various para-professional health care associations were renegotiated during the year, and in all cases reasonable fee structures were developed for billings under the provincial medical plan. Relations with all of these associations were kept at the highest level and good information exchanges developed as part of the negotiating process.

Bargaining with the government professsional employees opened during the year, and representing the Ministry in these sessions added to the labour relations tasks, which included all grievance investigations.

The three-phased program for student hiring - summer students, Quebec exchange students, and university co-op student program -- continued to be administered by Personnel Services, as was the growing and important rehabilitation field.

Input into the Personnel Policy Advisory Committee of G.E.R.B. was maintained through the Director, who served as Chairman of the multi-ministry group during the latter part of 1980.

The generalist officers assigned to serve mental health and community health centres continued the program of field trips as time allowed, with the dual benefit of upgrading knowledge of the field operations while allowing person to person input from Health Centre staffs.

Full personnel capability was extended to central shared services through the placement of a new personnel officer in Essondale. The planned transfer of the Hospital Programs personnel function of the Headquarters' organization was finalized, allowing the complete services of the personnel organization to support the Hospital group.

Executive appraisals, merit pay, and executive benefit plan details, were administered and co-ordinated during the third and fourth quarters of the year. Continuous attention to organizations, establishments, and classifications was given, with great emphasis on the latter, as responsibility moved from central agencies to the Ministries.

There were 23 personnel officers in the Ministry (including commission, government hospitals, etc.) serving almost 7,000 staff members throughout the Province.

Financial Services

The program environment and the organizational structure which the financial service division was originally set up to support, changed considerably over the year.

The Ministry of the Provincial Secretary and Government Services established its own Comptroller's Office in mid-1979, with the resulting loss of a number of finance personnel and related functions formerly administered by this Ministry for other government services. Furthermore, as a result of re-organization, the structure of the Ministry of Health underwent a period of consolidation, and it became apparent there was a need for improved Ministry-wide co-ordination of the financial function to make the optimum use of the funds available.

Finally, the traditional incremental approach to budgeting and the allocation of government resources would soon be replaced by a zero-base budgeting review procedure.

As an end result of these changes, the role of the division was undergoing a considerable change in emphasis at the year end focusing on an increased need to assist in planning, budgeting, financial control and program analysis.

Accordingly, the division was re-structured to respond to pressures for a more flexible and responsive organization. The division was segregated into two main functional areas:

- Ministry Financial Operations - responsible for payroll, accounts payable and receivables.

- Budget, financial analysis and planning - responsible for co-ordination of budgets, financial analysis, re-allocation of resources, expenditure control, and financial information systems.

The Ministry of Health is responsible for the management of a variety of complex and related health care programs. To facilitate the effective management of the Ministry resources at all levels there was a need to improve the quality of financial information, and to develop and implement a comprehensive, integrated financial information system. At the same time, while the Office of the Comptroller-General continued its work upgrading the central accounting system of the government, ministries were encouraged to take initiatives on their own to improve internal financial management reporting.

Accordingly, the Ministry of Health decided to undertake a consultant study aimed at a comprehensive identification of the Ministry's financial information requirements.

The study reviewed the Ministry's existing financial systems and defined the current information requirements. The results of the study will serve as a basis for the planning of the Ministry's financial systems development projects over the short and immediate term. It was expected that the development of the new financial system over the next 15 months would be a large undertaking, requiring a high degree of resource commitment from the Ministry.

Central Shared Services

This division provides a Ministry logistical support program which, in addition to materials management, includes transportation, mechanical services, specialty equipment repair and manufacture, and audio visual services.

The materials management division experienced an exceptional 61 per cent volume increase in medical supplies, and a 30 per cent growth in pharmacy and surgical issues. These growth rates indicated the acceptability of the program and the benefits of the user committee structure now in effect in each supply and service division. Persons throughout the province suffering from hemophilia, Crohn's Disease, and kidney failure continued to receive personalized support from the staff in this section. Much credit was due the staff who have, through better work methods and personal effort, been able to absorb added work loads and new programs without establishment increases.

The Coquitlam Regional Linen Service is a unique facility in that it issues and processes a very large volume of clothing for patients. A major refit and construction program completed in 1980, coupled with staffing problems, created a considerable challenge for Mr. K. Akroyd, newly appointed laundry administrator.

During the year the Victoria Regional Linen Services experienced production difficulties, due to staff shortages and plant renovations. The renovations and new equipment will permit an extension of services to the Oak Bay Manor and several other smaller clients.

The mechanical superintendent's office was transferred from Victoria to the Mainland to permit consolidated and improved services. Improvements made to the physical facilities at Coquitlam will allow an expansion of mechanical repair services.

A catalogue of available industrial services, prepared in 1980, created an awareness of this resource centre and resulted in increased volume. The shoe repair section was closed to allow better utilization of staff and facilities. The audio visual divison, located in the Blanshard Building, Victoria, was amalgamated with the audio visual department of the industrial division at Essondale on the Mainland.

Much needed administrative support was provided by Mr. Tom Cox, who joined our administrative staff in June, and Mrs. C. Watts, Personnel Officer, who commenced in November.

THE PROVINCIAL ADULT CARE FACILITIES LICENSING BOARD

The planning and development of new licensed facilities under the Long Term Care Program showed a steady growth in 1980. The volume of work for field staff to meet the statutory requirements of licensing constantly increased.

A number of licensed care facilities changed hands and some ceased operation abruptly, affecting the care of the residents and placing a strain on services to provide alternate accommodation.

During the year the Adult Care Regulations, 1977, were revised. Amendments to areas of building design, staffing, care and activity requirements were incorporated. Two new sections were added, requiring financial and statistical reporting and notice of change of operation of facilities.

TABLE I - ADULT CARE FACILITIES

	ISSUED				SURRENDERED			
	Interim Permits		Licenses		Interim Permits and Licenses		Net Total	
Year	Facility	Adults in Care	Facility	Adults in Care	Facility	Adults in Care	Facility	Adul in C
1975 ...	59	1,792	453	14,534	130	1,928	382	14,3
1976 ...	53	1,291	449	15,085	78	1,281	424	15,0
1977 ...	51	1,734	465	15,008	30	511	486	16,2
1978 ...	58	1,805	481	15,407	--	---	539	17,2
1979 ...	65	1,892	531	15,933	47	995	549	16,8
1980 ...	60	1,735	565	16,839	27	359	625	19,1

THE PROVINCIAL CHILD CARE FACILITIES LICENSING BOARD

The Child Care facilities continued to expand at a rapid rate with frequent openings, closings and change of operator. The Board reviewed 675 licensed applications, interim permits and amendments in 1980 compared with 347 in 1979.

In 1980 the Board became more involved in the issuing of certificates registering people to work in Child Care facilities. An ongoing problem facing the Board is the reluctance of neighbours to accept a Child Care facility in their area even when all licensing requirements are met.

The Board continued to review the Child Care Regulations and related policies with the assistance of the Board representatives from the Ministries of Human Resources, Education and Health.

TABLE II - CHILD CARE FACILITIES

	ISSUED				SURRENDERED			
	Interim Permits		Licenses		Interim Permits and Licenses		Net Total	
	Facility	Children in Care	Facility	Children in Care	Facility	Children in Care	Facility	Children in Care
...	155	2,229	909	16,786	267	4,130	797	14,885
...	192	2,694	929	16,869	308	4,034	813	15,529
...	235	3,063	1,005	17,866	75	900	1,165	20,029
...	291	3,675	1,028	18,370	30	364	1,289	22,045
...	300	3,633	1,228	19,187	177	2,065	1,351	20,755
...	334	3,372	1,417	21,355	177	1,587	1,751	24,667

COMMUNITY HEALTH PROGRAMS

Community Health Programs Highlights

... During 1980 there was a decline in measles incidence, but an increase in reports of whooping cough.

... The incidence of tuberculosis continued to decline, but there were important variations in the characteristics, such as age, sex, and race, of the more seriously affected population groups. Some three-quarters of active cases were being treated on an ambulatory basis.

... New cases of gonorrhea detected continued to increase, and demand for information on sexually transmitted diseases (S.T.D.) was heavy.

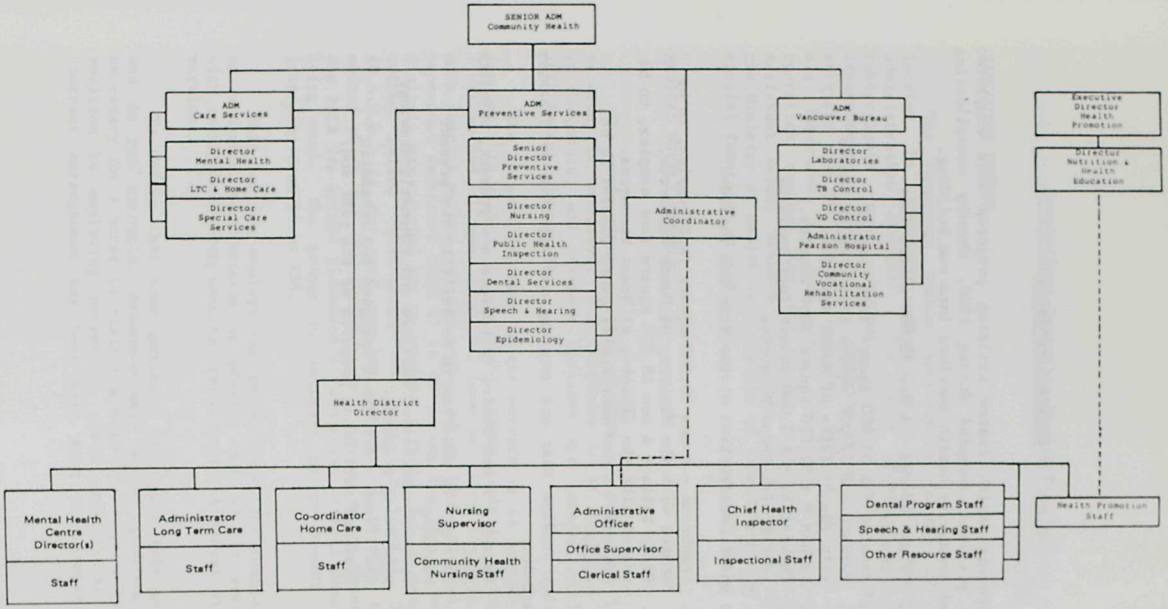
... Approximately 94 percent of the province's population in provincial health districts had access to an audiology clinic.

... Increased demand necessitated a 34 percent increase in the parent education classes presented by the public health nurses.

... "Outreach" projects established in several Health Districts appeared to be achieving positive results for the "at risk" expectant mothers, who were provided concentrated service by nursing and nutrition staff.

... A randomly selected sample of 10,000 school children throughout the province was examined orally, and the survey is expected to provide extremely useful data on the dental health of children in the province.

... Work performed by the Division of Laboratories continued to increase, and there was a dramatic rise in examinations for intestinal parasites in 1980.



Province of
British Columbia
Ministry of
Health

Building Projects

The following health centre building projects were completed and the premises occupied during 1980, thereby consolidating all local community health services into one building.

1. Prince George - A new 38,000 square foot complex.
2. Nanaimo - A 35,000 square foot complex.
3. Terrace - A 32,000 square foot complex shared with the Ministry of Human Resources.
4. Vernon - A 32,000 square foot complex.
5. Parksville - A 5,000 square foot building shared with Human Resources.

Projects under construction at the year end included:

1. Cranbrook - A new 28,000 square foot complex, to be shared with the Ministry of Human Resources.
2. North Delta - A new 18,000 square foot complex, to be shared with the Ministry of Human Resources.
3. Gibsons - A new municipally-owned complex to be leased.

Feasibility studies that are ongoing and approved by Treasury Board included:

1. Nelson - A new centre to replace the present, obsolete one.
2. Surrey - An addition to be built to the present building.
3. Kelowna - Architect assigned and schematic drawings were being prepared.
4. Chilliwack - Architect assigned and schematic drawings were being prepared at the year end.

Specialized Community Health Programs

VANCOUVER BUREAU

The Vancouver Bureau includes a variety of services located in Vancouver which are grouped together for administrative purposes. The major services included are tuberculosis and venereal disease control; provincial laboratories; vocational rehabilitation; kidney dialysis services and the Pearson Hospital. Several of these services e.g. laboratory and the control services, act as support or operation centres for the total provincial program. The Assistant Deputy Minister in charge of the Bureau represents the Ministry of Health on a variety of committees, and performs special functions as required.

MEDICAL SUPPLY SERVICE

The headquarters of this service is located at 1159 West Broadway in Vancouver. The warehouse is at Riverview Hospital in Essondale, and Pharmacy Services are located at 828 West 10th Avenue, Vancouver.

The largest function of the service is to provide support for patients wishing to carry out kidney dialysis at home. The first method of home dialysis, hemo or blood dialysis, is the more complex method and the number of patients at home on this procedure decreased from 53 to 48 during the year. Peritoneal dialysis was carried out by various methods, but at present the method called "*Continuous Ambulatory Peritoneal Dialysis*" (C.A.P.D.) is the most popular method. A sterile technique method which was introduced by Dr. Oreopoulos in Ontario, and the Beta Cap method pioneered by Vancouver General Hospital are being used. The number of patients on peritoneal dialysis increased from 71 to 128.

This service employs two technicians, and contracts with an equipment manufacturer to provide some of the service and with technicians from hospital renal units to assist with local services.

To ensure that home patients carry out safe procedures and do not encounter insurmountable social problems, it is necessary for a nurse to visit the home on a regular basis. In addition to employing nurses to visit patients at home, a contract arrangement has been made with the hospital renal

units to provide this service from Trail, Victoria, Kamloops and New Westminster.

Dietary supplements were provided to patients with renal disease in order to delay the requirement for dialysis, to assist children with growth, and to provide weight gain in debilitated patients. These supplements are high calorie but are low in protein, sodium and potassium.

1980 was the third year in which the Kidney Foundation supported a summer camp. This was a national project and the Kidney Foundation collected the funds and bought the supplies from this Division.

There were 15 kidney transplants during the year. This Division arranged transportation when necessary to carry this out. A co-ordinator for this program has been employed to ensure that it could function throughout the province. She also participated in a public relations program in order to encourage the donation of kidneys and other organs.

The Willow Dialysis Unit located at 1159 West Broadway, Vancouver, had an average of 15 patients dialysing themselves with minimal assistance. Nurse assistants were employed to support one patient each, in up to 10 locations around the province. Hospital Programs is cooperating with the Kidney Dialysis Service by providing space for some patients who were unable to dialyse in their own homes and lived too far away to commute to one of the six renal units.

There were 50 patients who were deficient in Factor 8 (Classical Hemophilia), eight patients deficient in Factor 9 (Christmas disease), and one patient deficient in Factor 7, all of whom provided their own treatment at home. The Medical Supply Service provided the intravenous materials, and the Canadian Red Cross Society provided the plasma products required. A grant was provided to the B.C. Hemophilia Society so that it could employ a part-time nurse co-ordinator, physiotherapist, and social worker for the Hemophilia Assessment Clinic. A physician volunteered his service to operate this program.

Some patients with a severely diseased bowel were unable to absorb food. It was necessary to feed these patients by the intravenous route, called Total Parenteral Nutrition. Six patients were trained to carry out this procedure and feed themselves at home. This Division supplied their requirements.

HEARING CONSERVATION PROGRAM

The Division of Speech and Hearing delivers a comprehensive, cost-efficient community hearing conservation program across the Province providing complete hearing services, including diagnostic testing and hearing aid fittings, to an age-group ranging from new-borns to 100-plus years. These 19 clinics continued to develop their services during the year on a phased development basis. In addition, the Division was, through contractual agreement, providing these services to two independent boards of health.

The success of these programs is based on the high level of local community and medical input achieved through the use of medical advisory committees in each hearing clinic locality. In addition, programs are closely co-ordinated with other community facilities and services such as hospitals, school boards, other public health personnel and local offices of other provincial ministries.

The prevention of hearing loss and its secondary effects, and provision for the earliest possible detection of unavoidable hearing loss, are the primary objectives of the hearing program. Efforts towards these aims are provided through:

1. the High Risk Hearing Register for identifying hearing impairment in newborns;
2. the pre-school and school hearing screening program;
3. the Industrial Hearing Conservation Program for Government workers exposed to high noise levels;
4. environmental noise control and analysis;
5. British Columbia Hearing Aid Program.

Children and adults who are evaluated at the Ministry audiology clinics and who are at risk for secondary language and communication disorders are eligible for the following services:

1. Hearing aid evaluation, selection and fitting: If indicated, the individual may purchase a high quality durable hearing aid, scientifically selected to provide maximum hearing enhancement. Other integral services provided are comprehensive repair services, battery service, earmold services and individual case follow-up and counselling service.

2. Selection of classroom amplification systems: Upon request, a detailed analysis of individual school auditory training needs will be provided. A cost-benefit analysis is provided to the school district.
3. Development of auditory potential: Training to help the individual maximize the use of the level of hearing either with or without the use of artificial amplification.
4. Speech Reading: Training the hearing impaired individual to make the best use of other senses of communication.

In a co-operative program with the Ministry of Education, the Division is providing specialized auditory training equipment to hearing impaired students throughout the Province.

As well as working closely with the Ministry of Education, the Ministry of Health also works with other agencies such as the Ministry of Human Resources, the Department of Veterans' Affairs and Health and Welfare Canada to provide all services to individuals covered by these agencies.

VISION SERVICES

In 1980 the orthoptist visited 10 health district main offices and 32 branch offices. During these visits she carried out vision screening, in conjunction with the public health nurses in the district. She also attended meetings with doctors, optometrists and public health nurses, which included slide showings and demonstrations of various testing procedures.

The vision services learning module was again updated and distributed to all health district offices in the province, so that all health district staff has access to up-to-date information.

From June to September, a follow-up study of vision referrals from Kindergarten to Grade 3 students during the 1979/80 school year was carried out in three separate districts. The statistics derived from the study provided a valuable evaluation of the vision services program, and it is hoped to repeat this type of study each year in a different area and with various age groups.

In the area of public education and awareness, two posters and several pamphlets were prepared for distribution. One pamphlet, Refractive Errors, covers the common eye problems

with very simple explanations, in order to give the public a better understanding of their eyes.

The vision services display, prepared last year, travelled extensively throughout the province during 1980, and was set up in schools, community centres, shopping malls, health district offices, and at meetings of the Canadian Ophthalmological Society, and so on.

Speech Therapy Program

The Speech Pathology program provides speech and language assessment, therapeutic and preventive services, to all age groups residing outside of Vancouver and the Capital Regional District. These services are provided from local Health District Speech and Hearing Clinics, and through school board programs. Continued services were given to school populations during the year, resulting from a co-operative agreement previously reached with the Ministry of Education, Science and Technology. The Program for Communication Disorders was delivered, on a contract for service agreement, to nine school districts within seven local health regions. School districts not participating in the program continued to apply for services.

All program services were provided to communicatively handicapped populations, within a framework of standardized guidelines. These policies resulted in increased effectiveness and consistency of client services throughout the province. Twenty four speech pathology positions were available to provide services to local health districts, and 15 speech pathlogists delivered speech and language services through the school program.

On the average, clients were referred for speech and language services at a rate of 300 clients per month. Of the individuals receiving assessments, 70 percent were recommended for treatment programs. Each month, an average of 820 communicatively handicapped individuals received at least weekly treatment from the Division of Speech and Hearing. Nine percent of all treatment cases were dismissed each month. Seventy percent of staff time was devoted to direct client treatment, and 41,000 individual therapy sessions were conducted during the year. This was a significant increase in direct remediation of communication disorders.

Local staff were utilizing advanced techniques and procedures in a variety of program areas, which improved the

quality and effectiveness of service to speech and language handicapped individuals. Sixty percent of these severely handicapped clients were reported to have achieved their therapy goals upon dismissal.

Division of Tuberculosis Control Highlights

... Lower incidence of active tuberculosis (25.7 per 100,000 population in 1972; 15.0 in 1979)

... Continuing high rates among selected population groups in the province, i.e. males 55 years and over, the unemployed male and persons not born in Canada.

... Fewer admissions to hospital, and a greater use of ambulatory antimicrobial therapy.

... Close supervision of 'At Risk' cases, especially contacts of active cases.

Division of Tuberculosis Control

The Division of Tuberculosis Control is charged with the responsibility of correlating and directing all phases of tuberculosis prevention and treatment in British Columbia. In maintaining this responsibility, the Division recognizes the assistance given by private physicians, Community Health, the Division of Laboratories, and other health agencies in the province, including the valuable co-operation with the Director and staff of the Medical Services, Pacific Region, who are responsible for the health services of Native Indians. It would be remiss if recognition was not given to the many volunteers who render invaluable support and to the B.C. Lung Association, whose assistance in the form of grants for special projects relating to respiratory diseases is acknowledged.

Although the overall incidence of new active tuberculosis continued to decline, there were important differences within the population when such variables as age, sex, race, country of origin, residence and duration of residence in British Columbia are considered. The highest rates of new active disease in relation to age and sex continued to be found in males 55 years and older, and among women 35 - 44 years of age. Males listed as unemployed and living in Vancouver City continued to pose a problem from the viewpoint of case finding, treatment, and control. However, it is now possible to identify these high risk persons in the population, and to concentrate the efforts of control towards the isolation and treatment of the infected individuals. The effect of this has been an increase in the population of ambulatory treated active cases of approximately 76 per cent. Very close supervision is maintained by the Division of contacts of new source cases of tuberculosis, and selected high-risk persons. Many in these two groups are placed on a programme of chemoprophylaxis. At the end of the year, 328 contacts with a positive tuberculin were taking this form of therapy.

Recently, 3401 contacts were identified and examined by the physicians of the Division; 48 new active cases of T.B. were diagnosed from this group. Recent statistics suggest that close supervision and medical treatment have been effective in controlling reactivations. Some years ago it was estimated that approximately 1 per cent of persons with inactive tuberculosis who previously had active disease reactivated. In 1979, only 58 persons, or about 2 per/1000 inactive cases reverted to active status.

Geographically, the largest number of new cases continues to come from Metropolitan Vancouver, although the highest rates

of new active tuberculosis occur in the central, north central and mainland coast areas of the province.

Division of Venereal Disease Control

INTRODUCTION

The new approach to the control of sexually transmitted infections initiated in 1977 was continued in 1980. It entailed introducing a new term (sexually transmissible disease, or STD) to better convey the fact that there are many more diseases at issue than just gonorrhea and syphilis. Other diseases which are now considered problematic include non-gonococcal urethritis (NGU), candidiasis, herpes simplex virus, trichomoniasis, chlamydia and two parasitic infectations, pubic lice and scabies.

PUBLIC AWARENESS

The public awareness campaign that had been developing since late 1977, and which reached a zenith in 1979, was substantially reduced in 1980. One brief campaign was carried out in the late summer/early fall, in five major centers outside of Vancouver.

Clinic attendance, particularly at the main Clinic in Vancouver, did not drop over the previous year, despite the absence of advertising. There was, furthermore, a noticeable increase in the number of new cases of gonorrhea being detected, especially among male patients.

Information demand continued to be heavy, with approximately 50,000 pamphlets on STD being distributed during the year, and some 50,000 new calls to the STD Information Line. Since its inception in September of 1977, the STD Information Line has received a total of over 200,000 calls.

VANCOUVER CLINIC

Due to increased patient load, an additional male nurse was hired in 1980, bringing the staff complement during regular clinic hours to one physician, four male nurses, and two female nurses. An examination of the feasibility of introducing an

appointment system for the Clinic, in contrast to the "drop-in" basis on which it had operated, was also undertaken, with the anticipation that appointments would be initiated early in 1981. This again, became necessary due to the large numbers of people seeking examination and treatment at the Clinic.

To further facilitate handling of the patient load, a preliminary draft for developing a computerized record system shared by the Divisions of V.D. Control, T.B. Control and Laboratories, was prepared by the B.C. Systems Corporation. Computerization of V.D.Control records will permit separation of the Control center from the Clinic, allowing more space for the Clinic. It will also allow for longer retention of patient records and more information inputs for research purposes, especially with respect to recording the incidence of STD's such as NGU, herpes, vaginitis and cervicitis.

HEALTH EDUCATION

A summer project saw the development of several new pamphlets on individual STD's. In addition, a wholly new Physician's Manual on the Diagnosis and Management of STD's was prepared and distributed, and a paralled manual for use by community health nurses was printed.

During the year the grant obtained from the Federal Division of Family Planning was transferred from the education consultant position in the Division of V.D. Control, to the health educator working with the Planned Parenthood Association of B.C. Future program developments in the area of STD, contraception, and adolescent sexuality, were being planned at the year end.

COMMUNITY HEALTH NURSES

The Division of Venereal Disease Control continued to provide nursing time and clinics throughout the province, to ensure that local needs were met with respect to screening, diagnosis and treatment of STD. Full or part-time nurses were provided in Victoria, New Westminster, Kamloops, Dawson Creek, Prince George, Prince Rupert, Quesnel, Williams Lake, Vernon, Kelowna and Penticton. The responsibilities of these nurses include liaising with private physicians involved with STD patients, and providing them with services for interviewing, contact tracing, and the diagnosis and treatment of named contacts. The center of the V.D. Control Program, located in

Vancouver, provided the same services to physicians in Greater Vancouver, and offered telephone consulting services to physicians throughout the province.

PHYSICIAN AWARENESS

Physicians are still reluctant to report the positive cases of STD which they treat. Without such reporting, attempts to notify infected partners (who may be asymptomatic) are severely constrained.

The Vancouver Clinic physician continued his involvement in promotional and educational seminars with the UBC Faculty of Medicine, and local medical associations. On-going dialogue was maintained with the British Columbia Medical Association. By the year end, these approaches in themselves had not had a noticeable impact.

During the year an arrangement was made whereby patients attending clinics at peak periods are referred to physicians in their community who are prepared to accept new patients and diagnose and treat STD's. It was also hoped that the new Physician's Manual would serve as an incentive to increase physician co-operation with the Control Program of the Division.

CHLAMYDIA AND NON-GONOCOCCAL URETHRITIS

The Division of Venereal Disease Control continued research into the etiological role of chlamydia in non-gonococcal urethritis. This project is co-sponsored by the U.B.C. Faculty of Medicine and the Division of Venereal Disease Control.

Community Vocational Rehabilitation Services

This Division is the provincial authority responsible for the administration of the federal Vocational Rehabilitation of Disabled Persons Act. Under this Act, the Ministry of Health has an agreement with Health and Welfare Canada which enables the Province to recover fifty percent of all costs incurred for designated vocational rehabilitation programs.

The purpose of the Vocational Rehabilitation of Disabled Persons Act is to provide assistance for the development, within the province, of a comprehensive and co-ordinated

program of vocational rehabilitation services for disabled persons.

SOURCES OF REFERRALS

The Division accepts referrals from community agencies, physicians, parents and self-referrals.

The Division carries out its responsibilities in two complementary streams:

1) Individualized Rehabilitation Process - this process is designed to assist persons disabled as a result of accident, disease or congenital defect, to obtain the services they require to become capable of obtaining a substantially gainful occupation. These occupations include employment in the competitive labour market, the practice of a profession, self-employment, homemaking, farm work (where payment is in kind rather than in cash), sheltered employment, home industries or other homebound work of a remunerative nature. In carrying out this process, Community Vocational Rehabilitation Services functions as a 'focal point' and as a 'broker' on behalf of the individual, assisting him to identify his needs and to utilize all existing assessment, treatment, training and job placement resources in an organized and co-ordinated manner, providing continuity and follow-up throughout with a view to the individual attaining maximum social and economic functioning in his community. The success of the process is directly related to the involvement and participation of all relevant community resources. Accordingly, Community Vocational Rehabilitation Services works through a number of local rehabilitation committees, which include representatives from government and non-government agencies.

2) Resource Development - it is apparent that in carrying out this individualized process, Community Vocational Rehabilitation Services identifies many unmet needs. Following identification, Community Vocational Rehabilitation Services, in conjunction with relevant government and non-government agencies, associations, etc., tries to develop new programs and facilitate funding.

REGIONAL ACTIVITIES

Examples of some of the activities pertaining to resource development that took place in 1980 include:

- the Rehabilitation Consultant in the Terrace region was directly involved in the establishment of an Advisory Committee on the Educational Needs of Disabled Persons, in the Northwest Community College region. In addition, he participated in the development of a dynamic work incentive program.

- in the Kootenays, the Rehabilitation Consultant was an active participant in the development of improved and increased services for mentally retarded persons.

- in the Upper Vancouver Island region, the Rehabilitation Consultant was involved in the establishment of a special workshop located at Courtenay, to serve young adults classified as "slow learners" with accompanying physical or emotional disability. The objective of this workshop is to assist these young people to successfully bridge the gap between school and the labour market.

- in the Upper Fraser Valley region, Community Vocational Rehabilitation Services was instrumental in developing the Winslow Works Cafeteria Program, at Douglas College in Port Coquitlam. This program provides work adjustment and skill training for a number of mentally retarded adults, in preparation for the competitive labour market.

REGIONAL OFFICES

The Division operates through a network of regional offices located in Nanaimo, Victoria, Terrace, Prince George, Vernon, Port Coquitlam, Surrey, Cranbrook and Vancouver, which covers greater Vancouver. The Central Office is located in Vancouver.

EXAMPLES OF CLIENTS SERVED

- A 25-year-old man, severely disabled by the congenital absence of both legs and left arm, was in receipt of public assistance. Following extensive assessment, he was provided with an electric wheelchair, a short period

of training on-the-job, and specialized computer word processing equipment, adapted to his employment needs. The end result is full-time employment at a local radio station as a copywriter. His long term objective is to be a broadcaster.
For an investment of approximately $7,000, this man has become a member of the work force.

- A 35-year-old woman, disabled by a spinal injury, and was confined to a wheelchair. Prior to her accident, she was trained as a computer operator and, subsequently, offered employment in that field. However, transportation presented a major barrier. On her own, she purchased a van and requested assistance with the cost of hand controls and a hydraulic lift. These items were provided and her economic independence is assured. In addition, she is the sole support of her dependent child.

GENERAL DEVELOPMENTS

Recent technological advances placed a number of new pieces of special equipment on the market, including visual teks, opticons, etc. This new equipment made it possible for many severely disabled persons to benefit from vocational training and to enter competitive employment. A few disabled persons were provided with this type of assistance, and a marked increase in demand was anticipated.

During 1980 Community Vocational Rehabilitation Services was actively involved in planning for the International Year of Disabled Persons. The Director of the Division is a member of a provincial Inter-Ministry Committee, and the B. C. Government representative on the Canadian Organizing Committee.

During the year, Community Vocational Rehabilitation Services continued to provide funds in the form of salary subsidies, to a number of designated voluntary agencies engaged in special vocational rehabilitation services.

Community Vocational Rehabilitation Services would like to gratefully acknowledge the continued and valued co-operation of the Provincial Ministries of Education, Human Resources, Labour; the Federal Department of National Health and Welfare and the Canada Employment and Immigration Commission; and the many voluntary agencies throughout the Province.

Division of Dental Health Services

The Division of Dental Health Services continued to expand its services throughout the Province, and for the first time was able to extend service to the Peace River and Skeena Health Districts.

The field staff was comprised of 6 dental officers, 19 dental hygienists and 26 dental assistants. One dental officer returned from public health training to assume his role in the Northern Region of the province.

THREE YEAR OLD BIRTHDAY CARD PROGRAM

The Three Year Old Birthday card program operated in 49 school districts. Through this program, approximately 12,000 three year old children received a free examination and parental counselling by the family dentist. A provincial participation rate of almost 70% of eligible children was achieved, with some regions achieving almost 90%.

DENTAL EXTERN PROGRAM

Two years ago 13 dental externs formed the largest dental extern service in the program's history. At the same time, the dentist/population ratio improved, and more dentists are moving into rural locations, improving accessibility to resident dental service. In 1980, seven dental externs were appointed; two of them to the semi-permanent dental facility in Prince Rupert. These dentists visited 20 separate communities, provided routine dental care, and rendered treatment to 6,075 citizens. The new Dodge Maxivans, which carry packaged equipment to augment the mobile dental units, functioned well.

SCHOOL DENTAL HEALTH PROGRAM

Provincial dental hygienists and dental assistants provided oral hygiene instruction, education, prevention and motivation, to almost 90,000 elementary school children, an increase of about 3,000 from 1979. Of this total, 66,000 used the self-applied fluoride paste and rinse, on a twice yearly basis. In addition, 73,139 children received dental inspections, an increase of almost 18,000 from last year. Of

these, 23,840 children were referred for dental decay, and growth and development problems. Parents voluntarily carried out many of these referrals, and a further 13,143 were followed up at home by the health district dental staff. Over 12,000 children were also referred to their parents as having poor oral hygiene.

From inspection data collected over the years, a dental health profile of children became discernible. Many school districts showed that 90% of the children have dental disease under control, and regularly visit the family dentist. Records indicated a steady improvement in dental health in many areas, and a great reduction in loss of teeth in children. Continued improvement depends upon the close co-operation developed between the dental profession, teachers and parents, with the health district dental staff, and the quality of the program delivered to the public, especially the inclusion of an effective follow-up system that is essential to secure treatment for children who need it.

LONG TERM CARE

Dental care of the physically and mentally handicapped, and the long term care/extended care patients, particularly those institutionalized or otherwise not able to visit the dentist, was becoming an increasing concern. Approximately 600 such persons (long term care residents, and homemakers' clients) were surveyed during the year for dental needs.

METRO HEALTH UNITS

Autonomous dental services exist in the metropolitan health units such as Victoria, Vancouver, Burnaby, West Vancouver, North Shore and Richmond. Some health units operate dental treatment centres for certain age groups. Others operate educational and motivational programs that include thousands of children, in addition to those serviced by the provincial health districts.

PROVINCIAL CHILDREN'S DENTAL HEALTH SURVEY

From March to June of the 1980, over 10,000 children randomly selected from schools around the province were part of an on-going dental health survey. Dentists from provincial and

metropolitan staffs travelled extensively to examine these students. The 1980 survey will be the most complete dental survey of children ever carried out in B.C., and will rank the Province in the forefront of dental epidemiology.

UNIVERSITY OF BRITISH COLUMBIA

The Ministry provided funds to support a dental department for the extended/acute care units of the University Hospital. In addition, a dentist was appointed to augment this service in a hospital residency program. This hospital department will serve as a special resource to the community, as well as a provincial referral centre.

SCHOOL HEALTH SERVICES

The comprehensive school program was augmented by the Teacher Information Kits, and teacher workshops. Classroom teachers were provided with specially designed kits complete with lesson plans, dental supplies, follow-up and reference material, and audio visual aids. The aim of these kits is to have teachers reinforce the dental program, and provide dental input into the areas and the classrooms not receiving the program.

OTHER ACTIVITIES

In-service training programs that provided positive learning experiences for staff; the development of various pre-school programs that focus on early detection of dental diseases; and the development of a perinatal tape/slide series, were a few of the activities that took place over the year. A successful fluoridation referendum occurred in Campbell River; unfortunately this did not occur in Kimberley. Special consultative/teaching services were provided to Medical Services staff, Department of National Health and Welfare, and to the Dental Therapist staff in Fort Smith.

Public Health Nursing

During 1980 the volume of preventive nursing services increased due to:

- The growth (approximately 50,000) in the general population.
- The focus on the benefits of good perinatal health, which resulted in an increase in the number of parents attending classes.
- The work involved in inspection and licensing of an additional 62 community care facilities with an increased capacity of 515 beds for children and adults.
- The interest in, and requests for, additional preventive health services by the general public.

Public health nurses attempted to cope with the increased demands and needs for services, while maintaining effective programs already well established and accepted. Effective management of staff time in the delivery of public health programs was essential, and a study was commenced to identify specific tasks by program areas, and to measure related units of performance time. When completed in 1981, this time study will not only identify procedures and practices which may be improved, but will also provide base material by which program objectives and outcomes can be reviewed for cost effectiveness.

PERINATAL PROGRAM

The services provided to expectant parents, and to the family after the baby's birth, continued to expand. A 34 per cent increase in the number of parent education classes offered, was needed, in order to accommodate the number of parents enrolling for service. Many voluntary nurses, working closely with experienced public health nursing staff, made it possible to cope with the additional class sessions required.

Statistical data for the period January to August 1980 showed that public health nurses had contact with over 90 per cent of all parents of new infants within 28 days following birth. A similarly high percentage of new infants were brought to Child Health Clinics for health counselling, supervision, and for primary immunization against diptheria, whooping cough and tetanus.

Special "Outreach" projects in the Cariboo Health District at Williams Lake, and in the Upper Island District in

the Comox Valley and Campbell River areas, were still in progress. These projects were funded by the International Year of the Child and the Family Fund. A preliminary report of the results achieved by the nursing and nutrition staff, working with expectant mothers considered to be "at risk", showed that an improvement in the birth weights of the babies was achieved by the provision of concentrated services to meet specific needs. It also indicated that the professional services were well received by these "at risk" mothers, many of them teenagers or non-English speaking immigrants.

A new exercise manual entitled Perinatal Fitness was in the final stage of production and will be available in early 1981. It will be an adjunct to the 1979 publication, Baby's Best Chance, to be used with it during prenatal class instruction to encourage healthy lifestyle for the whole family, and special prenatal exercises as preparation for labour and childbirth. Perinatal Fitness will be available free of charge to expectant parents in British Columbia.

PRESCHOOL PROGRAM

Preventive health services for preschoolers were provided at Child Health Conferences; in assessment clinics where vision, hearing, speech, dental health, safety and overall growth and development were the aims of screening and health education; in day care centres and nursery schools, and in the family homes.

Provincial statistics indicated that upon completing Grade I 85 per cent of the children were up to date for diphtheria, pertussis, tetanus and polio immunizations; and 79 per cent were protected against measles. Although specific statistics were not available for children aged two or three years of age, there was an indication that the immunization status of these younger preschoolers was inadequate, and Health Districts are working to promote the completion of basic immunizations by the time the children reach two years of age. During the first eight months of 1980, public health nurses completed a total of 58,887 immunization series for preschoolers of which: 11,937 were for diphtheria, pertussis, and tetanus; 12,456 for polio; 13,364 for measles; 13,530 for rubella, and 7,600 for mumps.

Public health nurses continued their active participation in parenting groups, believing that all parents should have access to the necessary information, encouragement, and

support, which other parents and professionals can offer to enhance productive parenting practices.

As in the perinatal program, public health nurses made home visits to, or on behalf of, thousands of preschoolers to help parents in the identification of preschool health problems, and to work with them in obtaining the necessary treatment, support and resources. They also made many visits to community care facilities for children, to ensure that licensing standards were being met, and to work with the staff in providing a healthful environment.

In contacts with preschoolers and their families, as well as with day or family care workers, public health nurses emphasized their commitment to a healthy lifestyle; and demonstrated their belief that the concept of fitness, good nutrition and health must begin with children from one to five, if the best results throughout life are to be achieved.

SCHOOL HEALTH PROGRAM

The public health nurse contributed to the School Health Program through the following areas of activity:

- Co-ordination of the school health services provided by the local health district.
- Communicable Disease Control, including immunization and necessary epidemiological investigation and surveillance.
- Early identification of health problems and planning with parents for appropriate care.
- Nursing support to students with acute, or chronic health, or family problems, in order that they might achieve and function at their optimum levels.
- In co-operation with parents, school and other health personnel, the development and implementation of effective health education projects appropriate to the particular school and community.

During the year a review of the nursing time required to effectively carry out the above activities was undertaken. Further studies were being conducted to verify or correct these estimated time requirements, and to identify essential nursing activities not previously included.

With the increased number of handicapped children attending regular schools, and the increasing number of personal and family problems identified among the secondary school population, new methods of assuring appropriate follow-up of these students were being explored.

The public health nurse's involvement in health education in elementary and secondary schools showed that, in addition to individual student and parent health counselling, nurses were heavily involved with group classes in discussing a wide variety of health related topics. Health personnel believe that opportunities to influence student attitudes and behavior regarding healthy lifestyles, and individual responsibility for personal health, can be encouraged by comprehensive education programs in schools. Public health staff were working closely with school personnel to develop such programs, which will encourage students to participate in health promotion activities, and to use the resources of the health care system appropriately and effectively.

COMMUNITY CARE FACILITIES

As the number of facilities and capacity continued to grow, the public health nurse's work grew proportionately. In addition to the functions and procedures involved in licensing facilities for adults and children, the nurse was involved in investigations related to complaints, inquiries from families and operators, and in the development of new accommodations. She worked in close co-operation with the public health inspector, medical health officer, staff of the Ministry of Human Resources, as well as many others, to ensure that adequate care and accommodation was being provided. This required on-going surveillance and work with staff and operators, to promote adequate programs within each facility. In addition, inspection of camps and mental health boarding homes was also included in the activities involved in this time consuming but challenging program.

Public Health Inspection Services

Public Health Inspection Services contribute to the Preventive Program by carrying out a series of specific environmental health programs.

Table III indicates the trends of Public Health Inspection Services over a period of five years. The statistics in this table do not include activities of the municipally-employed public health inspectors in the cities of Vancouver and New Westminster, the districts of Burnaby and Richmond, and the North Shore Health District.

By the year end it was possible to make a comparison of present activities with those one decade ago. This showed a five-fold increase in food control work; the quadrupling of activities on private sewage disposal; a fifty percent increase in public water supply monitoring, and an increase in community care facilities control by a factor of fifteen.

The increase in food control was consistent with the trend in utilization of dining facilities. Private sewage disposal activity was greatly influenced by development on properties considered boderline for this purpose.

Communicable Disease Control

The incidence of communicable disease remained stable during 1980. Vaccination coverage by Grade I, for the province as a whole, was estimated at between 80 and 85 percent. A major decline in measles incidence was observed, reflecting the underlying cyclic pattern in this disease. By contrast, a greater than two-fold increase in pertussis (Whooping Cough) was reported, and lower levels of incidence can be achieved through increasing vaccination coverage. In order to assist in further promoting immunization, a steering committee for this purpose was developed. In addition, a detailed review of all immunization procedures and communicable disease regulations was initiated.

Laboratory Services

The British Columbia Provincial Health Laboratories, with the main laboratory in Vancouver and branches in Nelson and Victoria, perform routine, referral and consultative services, for investigation, diagnosis, treatment and control of communicable disease, and for amelioration of environmental problems. These services include advice and laboratory tests for diseases caused by bacteria, fungi, parasites, viruses and other communicable agents, related immunology and serology, and environmental microbiology. Tests are available to registered physicians, hospitals, and health-related agencies at all levels of government; specimens are shipped by courier from all parts of the province.

Between 1979 and 1980 the work load of the Division of Laboratories increased by 3.5 per cent. In Table V the numbers of tests performed at the Main Laboratory and at the Branch Laboratories in Nelson and Victoria during 1980 are compared

with the corresponding figures for 1979. Slight increases in work performed occurred in several laboratory sections but examinations for intestinal parasites increased dramatically --- 42 per cent.

Bacteriology Service

CORYNEBACTERIUM DIPHTHERIAE

The number of patients from whom toxigenic Corynebacterium diphtheriae was isolated decreased from 61 in 1979, to 30 in 1980. The number of patients from whom non-toxigenic C. diphtheriae was isolated in 1980 totalled 120.

BORDETELLA PERTUSSIS

The number of patients from whom Bordetella pertussis was isolated increased from 20 in 1979, to 96 in 1980.

HAEMOPHILUS INFLUENZAE AND H. PARAINFLUENZAE

Haemophilus isolates increased from 77 in 1979, to 81 in 1980. Most organisms were isolated from genital sources and the eye. Other sources included nose and throat, ear, cerebrospinal fluid and blood.

NEISSERIA GONORRHOEAE

In 1980, 5,139 cultures yielded N. gonorrhoeae, 9 per cent more than in 1979. The number of genital smears showing gonococci microscopically increased from 4,700 in 1979, to 4,992 in 1980. Bacteriological confirmation of gonococcal infection represents only about 50 per cent of reported cases.

NEISSERIA MENINGITIDIS

The number of first isolates of N. meningitidis was 416 in 1979, and 329 in 1980. Of the 329 cultures, 261 were recovered from nose and throat specimens, and 68 from other

sources such as blood, cerebrospinal fluid and genito-urinary tract. The serogroups of 156 isolates were A (8), B (39), C (10), D (1), X (10), Y (8), Z (22), 29c (22), and W135 (36).

OPPORTUNISTIC PATHOGENS

Opportunistic infections are often caused by micro-organisms, formerly considered non-pathogenic. Such infections are common in immuno-suppressed patients. In 1979, 2,700 opportunistic pathogens were identified, but only 2,500 were recovered in 1980, a decrease of more than 7.4 per cent. The three most often recovered were Acinetobacter calcoaceticus, Acinetobacter lwoffi and Escherichia coli.

ANAEROBIC BACTERIA

Of 232 anaerobic strains identified, the three most common were Bacteroides fragilis, Clostridium perfringens and Peptostreptococcus anaerobius.

ENTERIC BACTERIA

The number of specimens submitted for culture for Salmonella, Shigella and enteropathogenic Escherichia coli (EEC) increased by 9 per cent. First isolations from 1,456 persons included Salmonella (880), Shigella (260), and EEC (316). One hundred and forty-six (146) Campylobacter jejuni coli were isolated from 13,247 specimens. The common human Salmonella types were Salmonella typhimurium and S. typhimurium var. copenhagan (333), S. saint paul (124), S. heidelberg (50), S. infantis (46), S. blockley (37), S. haardt (33), S. schwarzengrund (29), S. hadar (26), S. typhi (23), S. agona (16), S. newport (15), S. enteritidis (14). Types isolated for the first time in British Columbia were S. archeveleta, S. dublin, S. grumpensis, S. miami, S. minnesota, S. saarbrucken, S. waycross; for the first time in Canada were S. manila. Twenty-three (23) cases of typhoid fever were confirmed bacteriologically. Salmonellae were identified from 148 non-human sources; animals such as bovines, dogs, felines, hogs, horses, mink and moose; birds such as chickens, pigeons and turkeys; reptiles such as chameleon, iguana, knightanole, snake and tegu lizard; food and fertilizer such as shrimp and fish meal; and enviornmental swabs. Of 34 types identified, most common were S. typhimurium (36), S. infantis (22), S. saint paul (18) and S. blockley (12).

The 260 Shigella strains included Sh. sonnei (171), Sh. flexneri (81), Sh. boydii (6) and Sh. dysenteriae (2). The most common enteropathogenic E. coli were 018:K77 (56), 02:K56 (38), 026:K60 (37), 0111:K58 (26), 0126:K71 (22), 055:K59 (15) and 0125:K70 (8).

FOOD POISONING

During the investigation of 249 incidents of suspected food poisoning in 1980 (compared with 218 in 1979) 478 specimens were cultured. Food poisoning organisms were isolated in 33 incidents - Staphylococcus aureus (9), Bacillus cereus (7), Salmonella (7), (S. typhimurium (3), S. hadar, S. schwarzengrund, S. montevideo and S. blockley); Clostridium perfringens (4), double contamination of Staphylococcus aureus and Bacillus cereus (3), enterococci (2) and one double contamination of Staphylococcus aureus and Clostridium perfringens.

The Food Poisoning Section reported 167 incidents of food-borne disease in 1976. Health Protection Branch, Ottawa, collected and collated such information from all parts of Canada and published "Food-borne and Water-borne Disease in Canada - Annual Summary 1976" in 1980.

MYCOBACTERIUM TUBERCULOSIS

The number of specimens cultured for Mycobacterium tuberculosis and other mycobacteria increased 7.8 per cent from 29,660 in 1979, to 31,988 in 1980. The number of microscopic examinations increased from 27,465 in 1979, to 29,430 in 1980. The number of other mycobacterial isolates investigated rose 33.6 per cent from 292 in 1979, to 390 in 1980. Drug susceptibility tests increased 17.4 per cent from 964 in 1979, to 1132 in 1980.

BACTERIAL SEROLOGY

Serological Tests for the Diagnosis and Control of Syphilis

Screening tests for syphilis increased by about 8 per cent from 180,000 in 1979 to 195,000 in 1980. The Confirmatory Microhaemagglutination-Treponema pallidum (MHA-TP) test increased by 3 per cent from 7,200 in 1979, to 7,400 in 1980,

and the Fluorescent Treponemal Antibody-Absorption (FTA-ABS) test remained the same, 7,200 in 1979 and 1980.

During 1980 exudates from 357 patients were examined by darkfield microscopy and by the Direct Fluorescent Antibody-Treponema pallidum (DFA-TP) technique. In 31 patients (9 per cent) the examinations were reactive.

Other Serological Procedures

Serological tests for the diagnosis and control of febrile illnesses decreased by 3 per cent from 11,500 in 1979 to 11,100 in 1980.

534 sera sent to reference laboratories for titration of bacterial antibodies yielded 85 reactive specimens which included: Yersinia (41), Bordetella pertussis (29), Legionella pneumophilia (9), Neisseria gonorrhoea (4), Pseudomonas pseudomallei (2).

Mycology

The number of specimens examined for fungi increased by 4.55 per cent from 4,068 in 1979, to 4,253 in 1980. Fungi identified were:

DERMATOPHYTES

Trichophyton rubrum (241), Malassezia furfur (101), Trichophyton mentagrophytes (78), Microsporum canis (64), Epidermophyton floccosum (26), Trichophyton verrucosum (10), Trichophyton tonsurans (8), Scopulariopsis brevicaulis (6), Trichomycosis axillaris (4), Cladosporium werneckii (1), C. minutissimum (Erythrasma) (1).

SYSTEMIC AND SUBCUTANEOUS FUNGI OR DEEP MYCOSES

Candida albicans (339), Candida spp. (320), Aspergillus fumigatus (20), Aspergillus spp. (11), Torulopsis glabrata (10), Aspergillus niger (8), Geotrichum candidum (3), Nocardia asteroides (2), Coccidioides immitis (1), Nocardia spp. (1), Sporotrichum spp.(1).

FUNGAL SEROLOGY

Fungus antibodies were demonstrated in 29 of 343 serum specimens submitted to reference laboratories: Histoplasma (25), Blastomyces (2), Coccidioides (2).

Parasitology

The number of specimens examined for parasites increased from 34,455 in 1979, to 49,583 in 1980, or 43.9 per cent. The additional 15,128 specimens included 9,000 from South East Asia refugees.

The protozoan parasites identified from faeces, asperates and urine specimens were: Giardia lamblia (2,369), Entamoeba coli (2,304), Endolimax nana (2,112), Entamoeba hartmanni (910), Entamoeba histolytica (446), Iodamoeba butschlii (216), Cysts of Entamoeba spp. (not further identified) (95), Chilomastix mesnili(71), damaged cysts (32), Enteromonas hominis (1).

The number of helminthic eggs identified from faeces and urine were: Trichuris trichiura (2,758), Ascaris lumbricoides (2,235), Hookworm (1,441), Clonorchis sinensis (785), Hymenolepis nana (142), Enterobius vermicularis (118), Trichostrongylus spp.(108), Schistosoma japonicum (18), Diphyllobothrium latum (17), Schistosoma mansoni (15), Fasciola/Fasciolopis spp.(14), Taenia spp. (13), Schistosoma haematobium (11), Echistoma spp. (7), Strongyloides stercoralis (3), Heterophyes heterophyes (2), Dicrocoelium spp. (1), unidentified eggs (13). Helminth larvae identified were: Resembling Strongyloides stercoralis (249), Hookworm (127), damaged (unidentifiable) (42). Worms or worm segments identified were: Ascaris lumbricoides (37), Diphyllobothrium latum (4), Taenia saginata (2), Enterobius vermicularis (1). Insect parasites identified or referred for identification were: Ticks - Dermacentor andersoni (1), Ixodes pacificus (3), Nits (2), Lice - Phthirus pubis (1), Pediculus humanus (1) Mite - Western fowl mite (1) Bedbug (1).

BLOOD AND TISSUE PARASITES

The number of specimens submitted for examination for parasites of blood or tissue was 600 compared to 438 in 1979, an increase of 37 per cent.

Of the 600 specimens, 597 were blood films for malaria; 211 for diagnosis of the disease and 386 for confirmation. The malarial species identified were: Plasodium vivax (444), Plasmodium falciparum (4), unidentified or too few for speciation (8).

SEROLOGY OF PARASITES

Antibodies to parasitic helminths and protozoans were demonstrated in 27 of 270 serum specimens sent to reference laboratories. Helminthic parasites - Toxocara spp. (9), Trichinella (8), Ascaris) (1), Echinococcus (1), Filaria (1) Paragonimius (1) Taenia (1); Protozoan Parasites - Amoebae (5).

The Indirect Haemagglutination (IHA) and Indirect Flourescent Antibody (IFA) tests for Toxoplasmosis decreased by 10 per cent from 1,060 in 1979 to 954 in 1980.

Tropical and Parasitic Diseases Reference Service

The Tropical and Parasitic Diseases Reference Service provides advice on preparation for travel to the tropics, and on the diagnosis and treatment of tropical and parasitic diseases acquired by travellers returned from the tropics, and immigrants to Canada.

During 1980 the Tropical Disease and Travel Clinic was opened, operating on a once weekly basis. This Clinic will greatly enhance the Tropical and Parasitic Disease Reference Service, and the Exotic Drug Depot, which have operated in the Provincial Laboratories since 1972.

During the year, exotic drugs not available commercially in Canada were supplied for the treatment of 19 patients with parasitic diseases, such as amoebiasis, filariasis, malaria and schistosomiasis.

ENVIRONMENTAL MICROBIOLOGY OF WATER

The number of water samples examined by the Coliform Test decreased from 40,120 in 1979, to 39,713 in 1980. The decrease was partly due to interruptions in postal service, causing a 16 per cent increase in the number of unsatisfactory samples received at the Laboratory (not tested, too long in transit).

Three thousand, two hundred and thirty four (3,234) samples labelled drinking water were also examined by the completed coliform test, an increase of 7 per cent from the previous year. More importantly, there was an increase of 166 per cent in the number of 5/5 confirmed test results for drinking water samples, from 499 in 1979, to 1,327 in 1980. The faecal coliform test was done on 9,090 samples, a decrease of 12 per cent from the previous year. It is also of interest to note that in 1980, 451 samples of drinking water, positive at the presumptive test stage, were tested for the presence of faecal coliforms. This test is done on request, in cases where faecal contamination of a water supply is suspected. The number of bathing beach samples submitted and examined by the faecal coliform test was 2,665. The standard plate count was done on 3,582 samples, an increase of 2 per cent from 3,509 in 1979.

Virology Service

A diagnostic and consultative service in medical virology is provided for physicians in British Columbia, through the Provincial Laboratories. During 1980 over 850 viral and other agents were identified as causes of human disease. Included were adenovirus (29) cytomegaloviruses (17) enteroviruses (80) herpes simplex virus (494) influenza A and B (67) measles (14) mumps (8) mycoplasma pneumoniae (33) parainfluenza virus (1) psittacosis (2) lymphogranuloma venereum (1) respiratory syncytial virus (2) rotavirus and other viruses of gastroenteritis (48) rubella (44) varicella-zoster (10) Legionnaires' disease (1).

The epidemics of measles and rubella experienced during 1979 had waned by the new year.

INTRAUTERINE VIRAL INFECTIONS

A number of common viruses, such as cytomegalovirus, enteroviruses, herpes simplex virus and rubella virus can infect the developing fetus if the mother contracts the disease during pregnancy. The results may be abortions, stillbirth or live born infants with congenital anomalies.

While the number of babies born with congenital anomalies due to rubella virus are rarely seen now, due to the rubella vaccine, cytomegalovirus was isolated from 17 patients, the majority of which were newborn infants, many with anomalies.

Herpes simplex virus infection was also responsible for a number of infant deaths.

POLIO, COXSACKIE AND ECHOVIRUSES

Although no illness due to wild poliovirus was identified during the year, a number of strains of polio vaccine virus were isolated from patients. Several coxsackie and echo viruses were prevalent in the community, coxsackie A9 and echo 9 predominating. Illness associated with these viral infections varied from peculiar rashes to meningitis, encephalitis, myocarditis, pericarditis, and acute gastroenteritis.

INFLUENZA

The influenza epidemic in British Columbia during 1980 was almost entirely due to influenza type B. (Influenza B/Singapore/222/79).

HERPES GENITALIS ("LOVE BUG")

Herpes simplex virus was isolated from 494 patients during 1980. The vast majority of these infections were genital in nature, again underlining the increasing importance of herpesvirus infections acquired by sexual contact.

On at least two occasions herpes simplex virus was isolated from brain tissue acquired at brain biopsy, in patients suffering from encephalitis.

RESPIRATORY INFECTIONS

The organism most commonly associated with acute respiratory disease, i.e. pneumonia, during the past year was mycoplasma pneumoniae. However, two cases of psittacosis and one of Legionnaires' disease were diagnosed.

TOXOPLASMOSIS

Although the organism responsible for this disease is not a virus, it can cause serious anomalies in the developing fetus if the mother acquires the infection during her pregancy. At least two toxoplasmosis babies were diagnosed during 1980, each with severe developmental anomalies.

HEPATITIS

The Virology Service now offers a number of tests for detection of patients suffering from hepatitis type A and B infections. This service will assist physicians who do not have access to these tests from other sources, and will operate as a reference service for the province.

STAFF APPOINTMENTS

Three senior scientists and a new administrative officer were appointed to the staff of the Division of Laboratories in 1980. Ms K. Bernsohn, Ms L. Cunningham, Dr. P. McMyne and Dr. E. Proctor will assist in reorganizing and up-dating the laboratories.

VISITS

In March Dr. Peter Gill, Director of the Bureau of Microbiology, Laboratory Centre for Disease Control Directorate, of the Department of National Health and Welfare, Ottawa, visited the British Columbia Provincial Laboratories.

On August 29, 1980, Dr. Alan Woodruff, Director of the London School of Hygiene and Tropical Medicine, London, England, visited the British Columbia Provincial Laboratories and delivered a lecture on "Imported Tropical Diseases."

ACKNOWLEDGEMENTS

The services, biological reagents, expertise and advice provided by reference laboratories in Canada and elsewhere are gratefully acknowledged. These reference laboratories include:

1. Laboratory centre for Disease Control (Ottawa) and its reference laboratories:
   - Internal

     Bureau of Microbiology

     National Enteric Reference Centre
     National Reference Centre for Hepatitis
     National Influenza Reference Centre
     National Reference Centre for Neisseria
     National Reference Centre for Tuberculosis
     National Reference Service for Staphylococcal Phage Typing
     National Reference Service for Streptococci

     Bureau of Medical Biochemistry

     National Centre for Hemoglobin Standards
   - External

     National Reference Centre for Arbovirus
     University of Toronto
     National Reference Centre for Parasitology
     McGill University
     National Reference Service for Treponema-Pallidum Immobilization Test
     Ontario Ministry of Health
     National Reference Service for Yersinia
     Ontario Ministry of Health
     National Reference Centre for Leptospira
     Toronto Western Hospital
     National Reference Service for Diphtheria
     University of Alberta

2. Other Canadian Laboratories

   Ontario Agricultural College,
   University of Guelph

   Environment Canada,
   Vancouver, B.C.

   City Analyst,
   Vancouver, B.C.

   University of British Columbia,
   Vancouver, B.C.

3. Foreign Laboratories

   Centre for Disease Control,
   Atlanta, GA.

   National Jewish Hospital,
   Denver, CO.

   Royal Infirmary,
   Edinburgh, Scotland.

Pearson Hospital

Pearson Hospital, located in South Vancouver, provides several unique programs for both the local community and the citizens of the province as a whole. Programs include in-hospital and out-patient services for persons suffering from severe respiratory disabilities mainly from poliomyletis or spinal cord injury; an enriched extended care program for severely physically disabled young adults and younger middle-aged persons; an in-hospital program for treatment of tuberculosis patients and a theraupeutic out-patient program for persons eligible for either intermediate or extended care, but not yet hospitalized.

During 1980, negotiations continued with Hosptial Programs, the Vancouver Bureau and the Vancouver General Hospital to re-open the Willow Chest Centre in-patient unit for treatment of the tuberculosis patients presently at Pearson Hospital. It was anticipated that the move would take place early in 1981.

Pearson Hospital continued to work closely with G.F. Strong Rehabilitation Centre in planning longer term care and maintenance therapy for younger physically disabled people who no longer required intensive therapy at that unit.

The number of respiratory dependent, high lesion quadraplegics transferring from the Spinal Cord Unit at Shaughnessy Hospital was less than anticipated, but even these strained the available space in the polio-respiratory program at Pearson Hospital to its limit. It was expected that this program would be able to cope with the number of admissions currently anticipated, provided some space reallocation could be arranged.

The average age of patients in the hospital's extended care program continued to drop from 49.8 in 1978 and 47.4 in 1979 to 46.8 in 1980.

Considerable progress was made during 1980 in proceeding with long planned structural alterations and physical plant up-dating. The centralized food service system got under way with the commencement of construction of a new main kitchen. The replacement of the old, inefficient, and labour intensive power plant was all but completed, with the construction of a much smaller packaged unit. Funds were approved for the long overdue renovations of two extended care wards, and work was expected to begin soon and be completed early in 1981, leaving only two more wards requiring major renovations.

On May 26th, 1980, Premier Bennett officially opened the Stan Strong Pool for the Disabled at the hospital. The Pool was designed and constructed from the proceeds of a Lottery Fund donation, and was furnished through a donation from the Marpole Women's Auxiliary to Pearson Hospital.

The long-planned patient's hairdressing salon was completed, providing shaving, haircutting, manicure and hair styling services to the patients. While the hospital prepared the physical facility, the services are for the most part funded by the Women's Auxiliary and are very much enjoyed by the patients.

New and continued staff development programs, along with improved communications within the Nursing Division, and the continuing development of better team philosophies and practices, considerably improved staff morale in all departments, and in the Nursing department in particular. The attrition rate among registered nurses was a good indication of this, as there were no vacancies during a year when many Lower Mainland hospitals were closing beds because of a shortage of registered nurses.

The Social Service department experienced a very active year with Asian refugees, increased liaison with Human Resources and Long Term Care staff as well as, for the first time in many years, participation in the field instruction program of the School of Social Work masters level program and the University of British Columbia. During September, the Canadian Council of Hospital Accreditation conducted a survey of the hospital. The Council Program and Standards Committee recommended full accreditation for a three year period, and this was then awarded to Pearson Hospital by the Council.

The hospital has gradually obtained recognition from other centres throughout the province of the special skills it offers in the treatment of particularly difficult cases of chronic neurological diseases.

TABLE I – REPORTED COMMUNICABLE DISEASES, BRITISH COLUMBIA, 1976 – 1980

(Rate per 100,000 population)

	1976		1977		1978		1979		1980	
	Number of cases	Rate	Number of cases	Rate	Number of cases	Rate	Number of cases	Rate	Number of cases	Rate
Amoebiasis	1	0.1	1	0.1	15	0.6	21	0.8	77	2.9
Bruceliosis	–	–	2	0.1	–	–	–	–	–	–
Diarrhoea of the newborn (E. coli)	52	2.1	57	2.3	35	1.4	23	0 9	29	1.1
Diphtheria	11	0.5	7	0.3	17	0.7	9	0.4	11	0.4
Dysentery, type unspecified	93	3.8	70	2.8	58	2.3	56	2.2	67	2.5
Food infection –										
Salmonellosis	321	13.2	307	12.3	908	35.9	810	31.6	857	32. 5
Unspecified	3	0.1	–	–	3	0.1	–	–	29	1.1
Food intoxication -										
Staphylococcal	–	–	–	–	1	0.1	–	–	–	–
Botulism	–	–	1	0.1	–	–	–	–	–	–
Hepatitis -										
'A' Infectious	745	30.7	884	35.4	794	31.4	459	17.9	33	1.3
'B' Serum	12	0.5	15	0.6	12	0.5	7	0.3	17	0.6
Leprosy	–	–	–	–	–	–	–	–	2	0.1
Meningitis –										
Bacterial	47	1.9	40	1.6	43	1.7	76	3.0	37	1.4
Viral	11	0.5	14	0.6	15	0.6	14	0.5	37	1.4
Pertussis	77	3.2	45	1.8	104	4.1	286	11.1	534	20.3
Poliomyelitis	–	–	–	–	1	0.1	1	0.1	–	–
Rubella	69	2.8	78	3.1	90	3.6	237	9.2	102	3.9
Rubeola	181	7.4	310	12.4	129	5.1	1,801	70.2	242	9.2
Shigellosis	120	4.9	101	4.0	105	4.2	163	6.3	–	–
Streptococcal throat infection & scarlet fever	698	28.7	539	21.6	1,297	51.3	1,784	69.5	1,808	68.6
Tetanus	2	0.1	1	0.1	–	–	4	0.1	–	–
Trichinosis	–	–	–	–	–	–	1	0.1	–	–
Typhoid & paratyphoid fever	7	0.3	9	0.4	16	0.6	18	0.7	9	0.3
Total	2,450	100.8	2,482	99.4	3,643	144.0	5,769	244.7	3,891	147.6

TABLE II- REPORTED INFECTIOUS SYPHILIS AND GONORRHOEA
BRITISH COLUMBIA,
1946, 1951, 1956, 1961, 1966 and 1971 - 80

Year	Infectious Syphilis		Gonorrhoea	
	Number	Rate[1]	Number	Rate[1]
1946.....	834	83.0	4,618	460.4
1951.....	36	3.1	3,336	286.4
1956.....	11	0.8	3,425	244.9
1961.....	64	3.9	3,670	225.3
1966.....	71	3.8	5,415	290.8
1971.....	73	3.4	7,116	325.7
1972.....	98	4.4	7,921	353.4
1973.....	101	4.4	8,955	388.9
1974.....	146	6.1	9,284	390.8
1975.....	174	7.2	9,793	402.5
1976.....	106	4.3	9,728	394.4
1977.....	70	2.8	9,800	393.0
1978.....	121	4.8	9,004	355.9
1979.....	125	4.9	9,961	368.1
1980[2].....	140	5.4	10,010	383.5

[1] Rate per 100,000 population.

[2] Preliminary.

TABLE III SELECTED ACTIVITIES OF PROVINCIAL PUBLIC HEALTH INSPECTORS

ype of Inspection or Activity	1976	1977	1978	1979	1980(2)
nspection -					
Food premises -					
Eating and drinking places	10,525	17,294	19,281	19,665	25,212
Food stores	2,366	4,594	4,878	5,013	5,810
Other	1,972	2,811	3,881	3,795	4,782
Factories	156	157	224	213	456
Industrial camps	348	345	497	388	221
Community care[1]	2,464	3,294	4,337	4,670	5,998
Schools	587	1,058	1,237	770	1,431
Summer camps	312	318	487	338	321
Housing	1,308	1,803	1,967	1,618	2,094
Mobile home park	1,355	629	583	334	324
Campsites	1,138	1,273	1,350	1,423	1,633
Other housing	474	713	879	573	981
Hairdressing places	396	874	906	944	1,479
Farms	309	364	346	389	449
Parks and beaches	300	740	851	994	1,464
ater and waste investigation -					
Swimming pools					
Inspection	2,126	3,585	4,137	4,077	4,938
Samples (Pools & Beaches)	1,626	3,060	5,420	5,914	7,740
Surveys (Sanitary & Other)	425	713	976	1,780	2,364
Waste Disposal	616	705	711	657	777
Public Water Supplies					
Inspection	1,861	2,876	3,633	3,609	4,998
Samples	7,790	11,524	14,367	14,200	18,464
Private Water Supplies					
Inspection	3,221	4,094	4,427	4,221	5,891
Samples	3,273	4,414	4,317	4,527	6,033
Pollution and survey samples	512	1,782	1,864	1,318	1,330
Private sewage disposal	26,608	35,986	36,134	35,247	48,335
Municipal outfalls and plants	320	262	323	247	315
Other sewage control	4,749	8,308	7,868	6,212	9,529
and Use Investigation -					
Subdivisions	6,225	8,355	9,522	9,000	12,606
Site inspections	13,749	13,589	14,964	14,636	19,820
uisance Investigation -					
Sewage	3,370	3,699	4,273	4,192	5,409
Garbage and refuse	1,373	2,168	2,595	2,261	3,071
Other (pest, etc.)	2,345	3,998	4,553	4,503	5,933
isease Investigation	609	1,056	1,530	1,393	2,214
ducational Activities	1,255	1,511	2,043	2,154	2,636
eetings	2,819	3,433	3,599	3,554	4,672

OTE: Activities of the Capital Regional District Community Health Services Inspectors are included for 1977 to 1980 only.

1. Includes boarding-homes, youth hostels, day care centres, hospitals and other institutions.
2. Preliminary.

TABLE IV- CASELOAD FOR COMMUNITY VOCATIONAL REHABILITATION SERVICES
January 1 to December 31, 1980

CASES CURRENTLY UNDER ASSESSMENT OR RECEIVING SERVICES, January 1, 1980		117
New cases referred to C.V.R.S. Committees in Vancouver Metropolitan Region (7 Committees)	226	
New cases referred to C.V.R.S. Committees outside Vancouver Metropolitan Region (41 Committees)	655	
Cases re-opened (all regions)	217	
Total new referrals considered for services, January 1, 1980 to December 31, 1980 (includes re-opened)		109
Total cases provided with service in 1980		227

ANALYSIS OF CLOSED CASES
January 1 to December 31, 1980

EMPLOYED:			
Employment placement made:			
Canada Employment & ImmigrationManpower	12		
C.V.R.S.	16		
Self	146		
Other	77		
TOTAL		251	
SERVICES COMPLETED:			
Referred to Other Service	133		
Competitive Employment not Feasible	75		
Vocational Rehabilitation not Feasible	158		
Increased Independence	23		
Maintained Employment	25		
Self Care	0		
Sheltered Employment	4		
Other	51		
TOTAL		469	
SERVICES NOT COMPLETED:			
Declined Services	171		
Unable to Locate Client	117		
Left Province	35		
Other	33		
TOTAL		356	
OTHER:			
Consultation Only	21		
Decreased	2		
TOTAL		23	
Total cases closed in 1980			10
Cases remaining in assessment or receiving services			11
GRAND TOTAL			22

TABLE V - TESTS PERFORMED BY DIVISION OF LABORATORIES IN 1979 and 1980
Main Laboratory, Nelson Branch Laboratory and Victoria Branch Laboratory

ITEM	1979			1980		
	Main	Nelson	Victoria	Main	Nelson	Victoria
CTERIOLOGY SERVICE						
teric Section:						
Cultures - Salmonell/Shigella	17,654	179	6,546	17,478	86	5,399
- Enteropathogenic E. coli	4,074	-	1,732	3,921	-	1,508
- Sensitivity tests	704	-	-	782	-	-
od Poisoning Section	422	-	-	478	-	-
scellaneous Section:						
Cultures - C. diphtheriae	1,757	70	1,353	2,351	22	1,008
- Haemolytic Staph/Strep	4,717	751	468	3,485	831	241
- Miscellaneous	43,772	719	43	52,043	1,021	89
- N. gonorrhoeae	28,502	200	8,125	33,169	156	8,154
Smears - N. gonorrhoeae	99,460	1,278	358	71,738	548	163
Immunofluorescence - N. gonorrhoeae	8,297	-	-	8,583	-	-
- other	2,892	-	-	3,658	-	-
Anaerobes	416	-	-	398	-	-
Animal Virulence	471	-	-	291	-	-
berculosis Section:						
Cultures - M. tuberculosis	29,660	-	2,452	31,988	-	2,376
Smears - M. tuberculosis	27,560	-	2,279	29,430	-	2,160
Sensitivity test	964	-	-	1,132	-	-
Atypical Mycobacteria	292	-	-	390	-	-
rasitology Section:						
Faeces	34,455	-	4,881	49,583	-	5,878
Pinworm swabs	1,129	33	-	1,163	37	-
Malaria blood film	903	-	-	965	-	-
ology Section	4,068	-	-	4,253	-	-
ter Microbiology Section:						
Presumptive/Confirmed coliform test	40,120	3,680	6,655	39,713	2,888	6,960
Completed coliform test	3,037	390	208	3,234	588	-
Faecal coliform test	10,377	-	59	9,090	-	-
Faecal streptococcal test	-	-	-	-	-	-
Standard plate count	3,509	-	-	3,582	-	-
Other tests (Algae, Shellfish)	2	-	-	-	-	-
rology Section:						
Syphillis						
Screening	184,608	-	-	196,988	-	-
Confirmatory	14,803	-	-	18,379	-	-
ASTO	7,381	-	796	7,110	-	497
Febrile Diseases	4,169	-	925	4,060	-	669
Toxoplasmosis	2,424	-	-	2,323	-	-

continued

TABLE V - TESTS PERFORMED BY DIVISION OF LABORATORIES IN 1979 and 1980
Main Laboratory, Nelson Branch Laboratory and Victoria Branch Laboratory
Continued

ITEM	1979			1980		
	Main	Nelson	Victoria	Main	Nelson	Vic
VIROLOGY SERVICE						
Virus Isolation:						
Tissue culture	7,027	-	-	9,840	-	
Rubella	657	-	-	898	-	
Embryonated egg	663	-	-	135	-	
Mouse	-	-	-	22	-	
Serological Identification:						
Haemagglutination inhibition						
Rubella	74,785	-	-	78,462	-	
Other viruses	10,497	-	-	11,045	-	
Reverse Protein Haemagglutination	601	-	-	-	-	
Complement fixation	21,693	-	-	22,337	-	
Neutralization	5,973	-	-	6,815	-	
Radioimmuneoassay (Hapatitis)	-	-	-	3,356	-	
Electron Microscopy	1,614	-	-	803	-	
Fluorescent Microscopy	895	-	-	1,319	-	
TOTALS	707,004	7,300	36,880	736,790	6,177	35,
COMBINED TOTAL	751,184			778,069		

TABLE VI- NEW ACTIVE CASES OF TUBERCULOSIS

(Rates per 100,000 population)

	Under 25	25-34	35-44	44-54	55 and over	Total
Males	6.7	13.8	21.2	29.2	41.0	18.4
Females	7.5	13.4	18.9	11.4	13.6	11.6
Total	7.1	13.6	20.1	20.4	25.9	15.0

TABLE VII CONTACTS TO PULMONARY ACTIVE TUBERCULOSIS SOURCE CASES, 1980

	Close or Household	Non-Household	Total
TOTAL CONTACTS	819	2,582	3,401
Ratio of Contacts to Total Active Cases (385)	2.1:1	6.7:1	8.8:1
Contact with Positive tuberculin	280	717	997
Percent of Contacts with Positive Tuberculin	34.2%	27.7%	28.1%
NEW ACTIVE CASES FOUND	24	24	48
Percent of New Active Cases from Contacts	2.9%	0.9%	1.4%

CARE SERVICES

Home Care/Long Term Care Program

The Long Term Care Program was introduced on January 1, 1978 as an innovative and ambitious effort to produce a universally available service to those persons who could no longer function independently as a result of a health related problem. The Program assumed responsibility for a wide range of both community and residential programs and provides an integrated service with strong emphasis on community-based programs.

Since the introduction of the Program, public demand for services has continued to increase and the Program has experienced a substantial rate of growth. Combined with the rapidly shifting age distribution of the population to include a higher proportion of the elderly, the Home Care/Long Term Care Program will undoubtedly continue to be in great demand.

Highlights

... During the year the Long Term Care and Home Care Programs were partially amalgamated into one single Program. The new position of Director of the Home Care/Long Term Care Program was established, and given responsibility for the Long Term Care institutions (formerly Government Health Institutions) of Valleyview, Skeenaview and Dellview, as well as Community Physiotherapy Programs.

... The consulting firm of Deloitte, Haskins and Sells was commissioned to review the financial and operating results of a sample of proprietary long term care facilities. The review was initiated to determine the adequacy of the per diem rates and the need for further rate increases, as well as to make recommendations to ensure an equitable rate setting structure. It was anticipated that their recommendations of a revised rate setting structure could be implemented by the beginning of the new fiscal year.

... The Minister announced the formation of the Long Term Care Review Team, which examined the quality of care being provided in Long Term Care institutions. This team visited a number of facilities throughout the Province and their report and recommendations were under staff review at the year end.

... During the year, the client contribution charge of $6.50 per day was increased to $8.50 per day. This was the first increase in the per diem contribution since the introduction of the program.

... The consulting firms of Deloitte, Haskins and Sells, and Western Health Care Associates, were commissioned to perform an organizational and financial review of homemaker agencies.

... During the year, computerization of the extended care waitlist management system was completed, and work on the homemaker payments subsystem was initiated.

... A project to develop specific standards of residential care was initiated in order to implement a clearly defined statement of quality of care.

ORGANIZATION

The nature of the Long Term Care Program has required the establishment of a decentralized professional organization, with the central office providing overall policy direction and control. The program is divided into 17 provincial health districts and five municipal districts. A Long Term Care administrator is based in each of these 22 health districts and is responsible, through the health district director, for the implementation and development of the program in the community served. This responsibility includes the identification of service needs, the development of societies or volunteer groups to initiate or expand resources, and the co-ordination of services and resources available within the local community and Health District.

The senior official responsible for the overall development, implementation, and operation of the Home Care/Long Term Care Program is the director, Home Care/Long Term Care. The director reports to the Assistant Deputy Minister, Care Services.

The Provincial Adult Care Facilities Board, established under the Community Care Facilities Act, is the organizational body responsible to the Minister of Health for the licensing and inspection of community care facilities participating in the Program, recommending approval of the construction of new long term care facilities in the various communities, and liaison with other programs that may have desirable input to the Long Term Care Program.

SERVICES PROVIDED

Entry into the Long Term Care Program occurs following an assessment performed by Long Term Care staff in the health district office. This assessment determines eligibility, assesses the nature and severity of the health problem, and identifies the appropriate level and type of service.

The services available through the Home Care/Long Term Care Program are as follows:

HOME SUPPORT SERVICES

Emphasis is placed on supporting the individual in their own home as opposed to admission to a residential care facility. Only when personal, family and community resources have been exhausted, will the Long Term Care Program provide assistance and then only at the minimum level necessary. The objective of this policy is to encourage the individual to retain maximum independence and avoid institutionalization for as long as possible. Component home support services include:

- Homemaker Services. A homemaker assists the client in performing household tasks of which he or she is no longer capable, e.g. bathing, heavy cleaning, washing, cooking, minor house repairs and maintenance. As of November, 1980, there were 102 non-profit homemaker agencies and 21 proprietary homemaker agencies providing service to over 24,000 homemaker clients.

- Community Physiotherapy Services. Physiotherapists provide direct treatment, consultative and preventive services to clients in their own homes, arrange provision of required equipment to cope with physical disability and train family members in assisting clients.

- Home Care. Home Care provides required professional nursing services in the clients' own homes. These services allow the client to remain in the home, rather than being admitted to a residential facility or acute care hospital.

- Adult Day Care. These centers provide a formal program of social and health services for people who require assistance and are a major component of a supportive service plan which allows clients to remain at home. There were 20 Adult Day Care Centers in operation as of November, 1980, with an additional 13 centers planned for the 1981-82 fiscal year.

RESIDENTIAL CARE

Admission to a Long Term Care facility or institution is considered a back-up service to home support services. If maintenance in the community becomes impossible, the client is admitted to one of the following types of Long Term Care facilities or institutions:

- Community Care Facilities. These facilities, licensed under the Community Care Facilities Act, are totally funded by the Long Term Care Program and consist of both private and non-profit operators. As of November, 1980, there were 94 non-profit facilities and 291 private facilities, providing care services to 15,972 clients. These facilities accommodate a wide range of dependencies, including residents who are very seriously debilitated and require heavy nursing and medical care.

- Mental Health Boarding Homes. These homes are also licensed under the Community Care Facilities Act but are intended specifically for the client experiencing psychiatric difficulties. In 1980 there were 220 proprietary mental health boarding homes receiving funding through the Long Term Care Program.

- Licensed Private Hospitals. These facilities, licensed under the Hospital Act, are privately operated hospitals providing care primarily to severely debilitated residents at the extended care level. There were 37 licensed private hospitals operating in November, 1980.

- Family Care Homes. These are unlicensed homes, providing care to a maximum of two Long Term Care clients. The emphasis is on creating a home-like supportive environment, usually operated by a couple or family in their own home.

- Assessment and Treatment Centers. In difficult cases where multiple aetiology is present and formulation of an appropriate care plan is difficult, the client may be referred to an Assessment and Treatment Center. These centers operate in public hospitals, provide short stay (up to six weeks) intensive assessment services, and diagnose multiple disorders. The goal of the center is to rehabilitate the client to an optimum level of functioning, and define a care plan which can then be followed either in the community or other Long Term Care setting. There were three such centers in operation in the 1980 fiscal year, two in Vancouver, and one in Victoria.

- Group Homes for Independent Living. The Program funds the direct care component of these homes to provide increased health and maximum independence of eligible Long Term Care clients. Residents retain responsibility for the normal activities of daily living but co-operative pooling of available care resources result in the most appropriate provision of care. In 1980 17 group homes were receiving funding and providing services to both the physically and mentally handicapped.

- Long Term Care Institutions. The Long Term Care Program directly operates the institutions of Valleyview, (Coquitlam); Dellview, (Vernon); and Skeenaview, (Terrace). The latter two facilities will be closed over the next two or three years. These institutions cater primarily to the severely psychiatrically disturbed and often aggressive resident, who frequently possesses multiple dependencies.

Statistical Data

The tables which follow present statistical data which provides an overall view of the Home Care/Long Term Care Program.

Table I - Indicates the size and complexity of the Home Care/Long Term Care Program. In total, an estimated 44,152 clients received services at any one time.

Table II - Provides a historical review of the growth of the Long Term Care Program over the last three years. Since the introduction of the Program in 1978, the number of facility and homemaker clients has increased by 122 per cent, while the budgetary costs over the same period increased by 67 per cent. (This does not include Home Care, Physiotherapy or Long Term Care Institutions).

Table III - Indicates the growth in the number of facility and homemaker clients, by level of care, over the periods November 1, 1979 to November 1, 1980.

Table IV - Compares the cost of administrating the Program versus the actual payment for services in the 1980-81 fiscal year. Administration costs include all objects of expenditure (e.g. staff salaries, travel, office expenses, etc.) other than direct payment for services to outside agencies.

Table V - Illustrates facility and homemaker clients by age group.

Table VI - Shows the number of new intermediate care facilities constructed since January, 1978, and in full operation, those scheduled for opening in the 1980 fiscal year, and the number of beds under construction or in the planning stage.

Home Care Program

The Home Care Program provides, or assists in co-ordinating, the variety of professional and non-professional services required to help patients remain in their own homes. The patient's medical care continues to be directed by his or her physician while on the Home Care Program.

ORGANIZATION

The Home Care Program is provided at the community or local level, by the 17 provincial health districts and five municipal health departments.

The Home Care Nurse is a Registered Nurse, working under the administration of the local health district director or health department, and is the major provider of care to patients on this program.

- The estimated number of nursing visits made during the 1980 calendar year was 691,253, or an average of 57,604 visits per month.

SERVICES

The Home Care Program consists of two categories:

- The hospital replacement category is for patients who are discharged early or as an alternative to admission to an acute care hospital. This category has the potential for making efficient use of hospital beds by enabling more patients to be cared for in their homes. Patients admitted for hospital replacement receive the necessary services, such as nursing, physiotherapy, homemaker, meals on wheels, medication and equipment. The services are co-ordinated and paid for by the Home Care Program. Approximately 20 per cent of the population of British Columbia do not have the hospital replacement category available to them.

- The non-hospital replacement category is for patients who do not need acute hospital care but require nursing and/or other services in order to remain at home. This category is available in most areas in the province and provides nursing care and a limited amount of physiotherapy, at no charge to the patient.

The patient is responsible for payment of other services such as homemakers, medication, or equipment that may be required.

RELATIONSHIP OF HOME CARE PROGRAM TO ACUTE CARE HOSPITALS

The following statistics were derived from the 1978-79 annual Home Care Program computer data:

- Of the 49,144 patients admitted to the Home Care Program, 16,908 or 34.4 per cent were in the hospital replacement category: i.e., those patients would have remained in an acute care hospital or been admitted to hospital if the Home Care Program had not been available to them.

- 6.59 persons per 1,000 population (B.C. population estimated at 2,566,900) were admitted to the hospital replacement category.

- 16,908 patients replaced 202,020 acute care hospital inpatient days, or 78.7 hospital patient days replaced per 1,000 population (B.C. population).

- The 202,020 patient days replaced would have cost hospital programs in 1980, using an average hospital per diem rate of $175, a total of $35,353,500, whereas the total Home Care budget was $11,127,000.

The Home Care staff continued to develop close liaison with the acute care hospitals by making regular rounds on the wards to discuss referrals, sharing in joint orientation, inservice programs, and participating on hospital medical and nursing committees.

RELATIONSHIP OF THE HOME CARE PROGRAM TO THE LONG TERM CARE PROGRAM

The Home Care Program provided professional nursing care services to assist many clients who were on the Long Term Care Program to remain in their own home.

- During 1980 an average of 4,644 Long Term Care clients received home care nursing visits.

- The 4,644 patients received an average per month of 22,334 nursing visits, for an estimated total of 288,914 nursing visits during 1980.

- Of the 49,144 patients on Home Care during 1978/79, 17.6% (8,666) were also on the Long Term Care Program.

The availability of Home Care nursing services to Long Term Care clients delayed, or eliminated, the need for admission of many of these clients to Long Term Care facilities.

Community Physiotherapy Program

During 1980 the goal of the Community Physiotherapy Program was the promotion and maintenance of the population of a given area at the highest possible level of functioning, through the provision of services directed towards treatment at the primary care level, active participation in health maintenance programs, and involvement in the preventive aspects of health care.

Community Physiotherapy Programs, organized under the present health district structure, have defined their own central principles of action under the broad guidelines of the provincial plan. These principles have required the community physiotherapist to be a multi-faceted community health care worker, involved in administration, education, consultation, research and clinical practice.

The scope of activities of the community physiotherapist for the year was broad and diversified, and the demand for physiotherapy services from the communities in general continued to increase. During the year the Community Physiotherapy Program continued to provide direct treatment, consultative, and preventive services to patients, families, physician, public health staff, hospitals, government ministries, and the general public, through 12 health districts representing 16 office locations. These services were provided to the three major program areas, namely Home Care, Long Term Care, and preventive programs.

The demand for community physiotherapy services by physicians and the public generally continued to outpace the available resources within the Program. In all health districts in the province where community physiotherapists are employed, services were utilized to their maximum.

During the year there were a total of approximately 2,276 new patients referred to the service, with an approximate total of 17,439 individual visits, (an increase of 230 over 1979). In addition to the treatment oriented visits, 10,530 (an increase of 230 over 1979) separate services were provided through the Preventive Program, including 376 Long Term Care

program assessments, and 318 separate visits to schools in the Province. An analysis of the 1980 caseload statistics by age shows the following distribution:

under 1 year	-	1.93%	19 - 64 years	-	36.1%
2 - 5 years	-	2.5%	64 and over	-	53.64%
6 - 18 years	-	5.79%			

In 1980 there was an increase of approximately 11% in the services provided, which is a direct result of being better able to offer services in the patient's home where medical status, geographical location, transportation, and cost, make home or facility care more appropriate.

The establishment of new services, and the evaluation of present services, will be the major focus for 1981 in Community Physiotherapy Programs. All efforts will be made to make Community Physiotherapy program services available in all Health Districts, and to a degree which will satisfy the demands of the referring physicians and the community.

Special Care Services

This new Division was established in April and is responsible for the provision of primary health care in rural communities throughout the Province and administers the Ministry's community grants program.

GRANTS

The purpose of community grants is to provide, or supplement through non-government agencies, preventive, therapeutic, rehabilitative or promotional health activities, consistent with Ministry priorities, objectives and funding capabilities. During the year, funding was approved for a variety of community-based agencies, providing a wide spectrum of health services.

Agencies funded by the Ministry were requested to complete an application form for each program requiring financial support, and to set measurable objectives for the programs. Based on a score of 0 - 10, each program was rated on six categories -- low cost alternative; record of effectiveness; limited or short term; use of volunteers; innovative/unique, and community support. The score in each category was multiplied by a weighing factor, which reflected the relative priority of each category within the Division's terms of reference.

The Division is moving towards the implementation of a contract system, which will allow the Ministry to negotiate with individual agencies for a specific health service on an annual basis.

RURAL HEALTH

Special Care Services is responsible for the provision of primary health care to rural and isolated communities in British Columbia. The Division functions as a planning, funding and coordinating body, in mobilizing those services within the Ministry which can be utilized in providing services to rural communities.

TABLE I

HOME CARE/LONG TERM CARE

	Type of Service	Number of Service Providers	Number of Active Clients (November, 1980)	Budget Estimates 1980-81
OME UPPORT ERVICES	a) Homemaker	123	24,268	36,250,000
	b) Community Physiotherapy	-	215	621,000
	c) Home Care	-	2,693[1]	11,127,000
	d) Adult Day Care	20	273	1,688,000
ESIDENTIAL SERVICES	a) Community Care Facilities	412[2]	12,667	82,204,000
	b) Private Hospitals	37	2,016	20,996,000
	c) Mental Health Boarding Homes	229[2]	1,170	6,780,000
	d) Assessment/Treatment Centres	3	45	3,157,000
	e) Group Homes	17	141	1,317,000
	f) LTC Institutions (Dellview, Valleyview, Skeenaview.)	3	664	19,227,000
TOTAL			44,152	183,367,000

1. Average monthly caseload for Long-Term Care clients receiving Home Care.

2. This includes Family Care Homes of 2 or less clients.

TABLE II

LONG TERM CARE PROGRAM

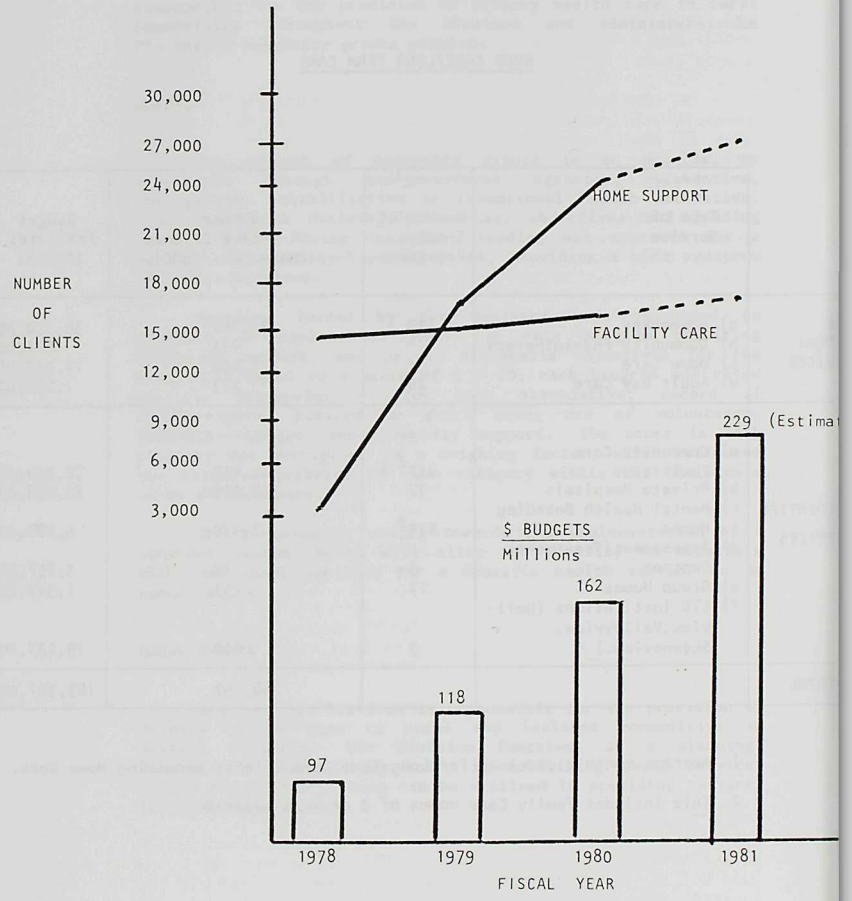
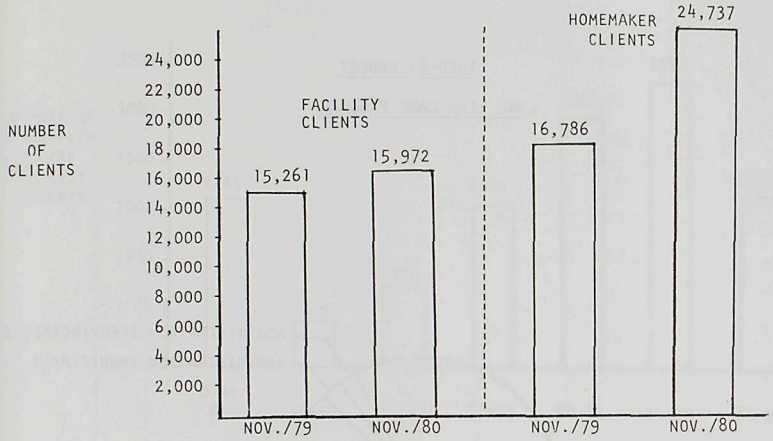


TABLE III

NUMBER OF LONG-TERM CARE CLIENTS

NOVEMBER 1979 - NOVEMBER 1980



	Facilities		Homemaker	
	Nov./79	Nov./80	Nov./79	Nov./80
Personal Care	5,567	5,067	10,125	14,463
Intermediate Care I	3,983	4,324	3,179	5,143
Intermediate Care II	2,584	3,110	1,855	2,891
Intermediate Care III	2,056	2,445	751	1,095
Extended Care	1,073[1]	1,026[1]	876	1,145
Total	15,261	15,972	16,786	24,737[2]

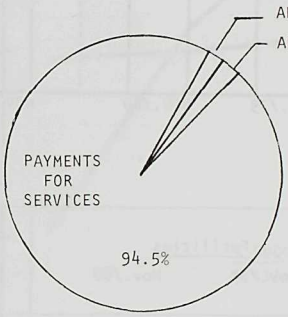
[1]Does not include extended care clients in public extended care units.

[2]Subject to 10% over estimation.

TABLE IV

1980-81 BUDGET

LONG TERM CARE PROGRAM

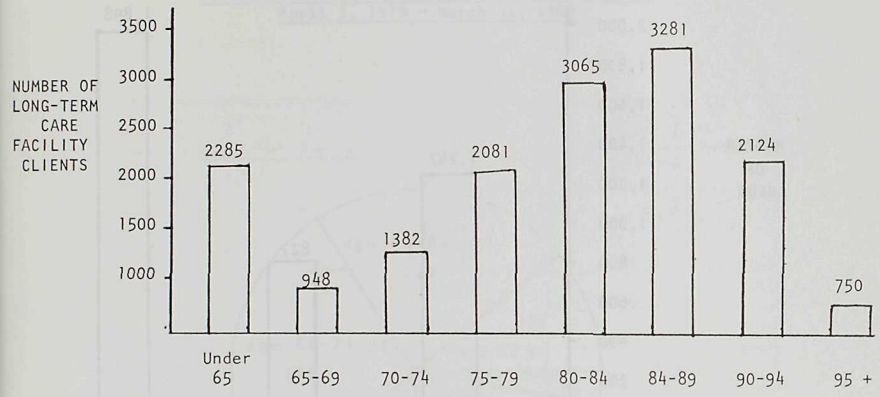


SALARIES & ADMINISTRATION (PROVINCIAL)	4.407,000
SALARIES & ADMINISTRATION (MUNICIPAL)	4,564,000
PAYMENTS FOR SERVICES	153,002,000
TOTAL	161,973,000

TABLE V

CLIENTS BY AGE GROUP

October 31, 1980



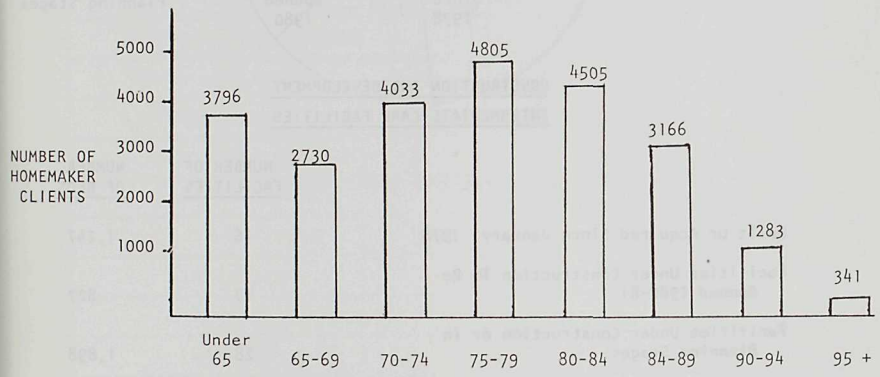
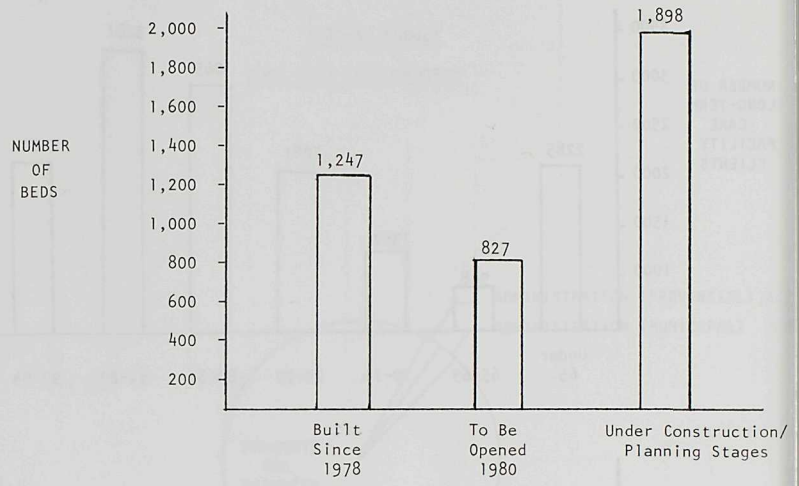


TABLE VI

CONSTRUCTION AND DEVELOPMENT
INTERMEDIATE CARE FACILITIES



CONSTRUCTION AND DEVELOPMENT
INTERMEDIATE CARE FACILITIES

	NUMBER OF FACILITIES	NUMBER OF BEDS
Built or Acquired Since January, 1978	16	1,247
Facilities Under Construction To Be Opened 1980-81	17	827
Facilities Under Construction or in Planning Stages	28	1,898

CHART I

Percentage Distribution by Age Groups
of Patients Admitted to the Home Care Program.
April 1, 1979 - March 31, 1980

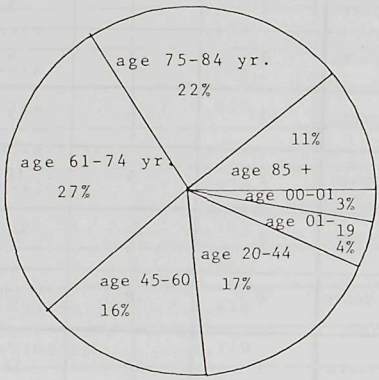


CHART II

Percentage Distribution by Age Group and Category of Patients Admitted to the Home Care Program
April 1, 1979 - March 31, 1980

AGE	Percentage Hospital Replacement	Percentage Non-Hospital Replacement	Total Percentage
00-01 years	2	1	3
01-19 years	2	2	4
20-44 years	11	6	17
45-60 years	7	9	16
61-74 years	8	19	27
75-84 years	4	18	22
85+ years	1	10	11
TOTAL	35%	65%	100%

CHART III

Percentage Distribution and Number of Home Care Patients by Major Diagnostic Groups in Descending Order.
April 1, 1979 - March 31, 1980

Diagnosis	No. of Patients	Percentage of Total Patients
Circulatory	8,239	16.80
Neoplasms	6,150	12.50
Accidents	5,354	10.90
Digestive	4,984	10.00
Symptoms-Undiagnosed	4,577	9.30
Musculo-skeletal	3,216	6.60
Endocrine	2,702	5.50
Skin	2,544	5.20
Nervous System	2,464	5.00
Genito-urinary	2,310	4.70
Childbirth	2,053	4.20
Respiratory	1,887	3.80
Blood Disorders	1,174	2.40
Mental Disorders	725	1.50
Infective	418	.87
Congenital	242	.51
Perinatal	105	.22
TOTAL	49,144	100.00

MENTAL HEALTH SERVICES

Mental Health Services Highlights

... The Ministry of Health consolidated its services to the chronically and acutely mentally ill through further development of the four priority programs in Mental Health Services. This development included the refinement of services for care to the chronically disabled, the acutely ill, children and their families, and clients with adjustment problems.

... The year also saw an increase in therapy and consultative services by the staff of the Province's 30 mental health centres, where clients were provided with nearly 11,000 therapy sessions per month, and agencies received approximately 8,000 hours of consultation per month.

... Sub-offices and travelling clinics delivered service to clients in the outlying regions. The British Columbia Youth Development Centre, the Burnaby Children's Team, and Victoria's Integrated Services for Child and Family Development continued to provide specialized services to children and their families.

... Inservice workshops, under the organization of the Continuing Education Committee, increased to 150 over the year, and the Annual Provincial Conference was held at U.B.C. in June, with a wide participation by staff from other agencies.

... There was a slight increase in the admission rate to the Greater Vancouver Mental Health Services with 1,653 clients being admitted, and the year-end caseload increased minimally to 3,007 cases.

SERVICES FOR THE CHRONICALLY DISABLED MENTALLY ILL ADULT

In October 1979 new priorities for Mental Health Services emphasized the chronically disabled mentally ill adult as a first priority for services. Since that time services to this group have been enhanced largely by shifting staff time from other activities. The chronically disabled mentally ill tend to be characterized by a diagnosis of schizophrenia, affective psychosis or an organic brain syndrome. They usually had multiple hospital admissions and often a gross deficiency in the ability to care for self, or to engage in work either paid or unpaid (for example, as a student or responsible for home management). To manage these individuals out of hospital requires psychiatric supervision, medication, and a variety of psycho-social programs.

During the year a special focus in Mental Health Services headquarters was developing for the promotion of services to this group, and a Chronically Mentally Ill Adult Services Advisory Committee was established, consisting of eight field staff representing the disciplines of psychiatry, mental health nursing, psychology, and psychiatric social work. The committee began to define the target population and necessary community services, and was developing means of surveying the prevalance of these individuals and the availability of community services.

MEDICATION

Community Services for the chronically disabled are not new in B.C. One of the cornerstones, the pharmacy service, has been in operation for many years. It was established originally to make certain that former Riverview patients released to the community would be able to continue on necessary psychotropic medication. In the majority of Mental Health Centres it is provided by a part-time pharmacist who dispenses on site, and specializes in mental health drugs and the centre caseload, providing a much needed drug compliance and interaction monitoring. Many of the most disabled patients are resistant to medication taking, so any service which helps to overcome that resistance is a critical link in community maintenance of these individuals.

In addition to the work of the pharmacist in drug

compliance, this is also a major area of concern for other Mental Health Centre staff, particularly nursing in the case management of the chronically disabled. Increasingly, schizophrenics are being maintained by an injectible form of phenothiazine, with results lasting for a week or more, which obviates many of the problems of daily oral drug taking compliance. In most Mental Health Centres where there is a mental health nurse on staff, injection clinics were organized. These clinics usually were held in conjunction with social activities, and provided a general time of social support and patient assessment.

The overall drug program was monitored by a Pharmacy Committee, setting policy and standards. It consisted of field representatives of psychiatry, pharmacy, nursing, and administration. There was no regular reporting on the pharmacy program, but surveys indicated that the majority of recipients of drugs were the chronically disabled mentally ill, and that approximately 3,000 persons were serviced with some 60,000 prescriptions per year. The chronically disabled residing in licensed community care facilities were provided medication through the Pharmacare Community Facilities Program.

SHELTER

Another cornerstone of services for the chronically disabled is the Mental Health "Boarding Home" Program which provides case management, facility consultaton and activation, for individuals residing in facilities licensed by the Provincial Adult Care Facilities Licensing Board, unlicensed two person family homes, and minimally supervised independent living residences. In the Mental Health Centre areas a typical team consisted of a boarding home social worker, an occupational therapist or activity worker, and a case aide. Additional clinical services were provided by other Mental Health Centre staff including psychiatry, psychology, psychiatric social work, and mental health nursing. In the Mental Health Centre areas, the program carried a caseload of approximately 2,400 in 1980. Of that number approximately 800 were mentally retarded, usually with some degree of behavioral difficulty and serious health problems. Approximately 600 placements were made during 1980. The program was sustained by a specifically dedicated staff of 40 professionals. The Greater Vancouver Mental Health Service had approximately 700 mentally ill clients in living arrangements similar to those discussed previously for the Mental Health Centre Program.

On September 15th a new nine-bed resource for psychiatrically disabled adults was opened in Duncan. It is staffed to provide a program of intensive rehabilitation. The capacity of facility operators to give better service is enhanced by a regular consultation and structured learning situations. In Kelowna, for example, the occupational therapist assisted workshops for the activity workers employed by the boarding homes. These efforts, combined with consultation, resulted in three of the homes providing more in-depth therapeutic programs for their clients, using behavioral management techniques, and behavioral contracting and cooperative self-care management. Another pattern represented by Langley were monthly in-service events, representing mental health, boarding homes and long term care staff. Topics included treatment of depression, death and dying, difficulties of the aged, and specific treatment models. Operators with perfect attendance received a certification of acknowledgement. Mental Health Centres and Community Teams were increasingly involved in providing some type of mental health service to the elderly and their families, when decisions about the requirements for sheltered residential care were being considered. There were 17 psychiatric social workers assigned specifically to work with the Long Term Care Program in this regard. Increasingly services from other team members, particularly psychiatrists, were being called upon for this group. Further, centres were frequently asked to evaluate the competence of the elderly for the public trustee, under the Patients Property Act.

ACTIVITY

Providing meaningful activity, whether paid or unpaid, is a critical factor in the quality of life and maintaining the chronically disabled person in the community. In this regard, Community Mental Health Services provides a broad spectrum of programs. The Greater Vancouver Mental Health Service has activity staff for each of its teams. Their activities include exercise, relaxation, swimming, hiking and bowling groups, for clients of various ages and treatment requirements. Most areas with the Mental Health Centre Boarding Home Program have an activity coordinator, concerned with promoting activation through community resources, and organizing activities specifically for sheltered care residents on their caseload.

As part of its Adult Day Program, the Burnaby Mental Health Centre offers a part-time re-educative and socially rehabilitative program. Included are structured courses on communication, assertiveness training, cooking and nutrition,

stress management, and creative job search. Several centres have helped to organize and sustain community activity programs, operating with minimal funding and volunteer help. Typically, these provide lifeskills activities, recreational crafts, socialization, and inter-personal relationship activities, for some of the most severely chronic adult population. Examples include the Creative Centre in Chilliwack, and the open door program in Duncan. Where a community activity centre for the handicapped exists, most centres are involved in consultation, joint planning and coordination. The Saanich Centre, cooperatively with the Victoria Centre, had a special self-development group, to provide a service for those so disabled by their mental illness that they were not able to attend any other day program. During the year the Victoria Centre started a modest day program with regular staff and students, with an emphasis on socialization and communication skills.

During the summer, students provided to the centres were often involved in enlarging the spectrum of activities available to the chronically disabled. Many of the activity programs were not simply diversional but offered training components. Two programs specifically aimed at training were developed by the Port Coquitlam Centre, one for woodworking, and the other a cafeteria program.

WORK

Finding suitable work for the chronically disabled continued to be a problem, but several steps were taken during the year to increase opportunities. The Kamloops Centre instituted a survey of business and industrial concerns, to determine willingness to receive mentally handicapped persons in jobs. A new work program of recycling waste paper was developed in Mission. In Nanaimo, largely through Centre efforts, a woodworking shop was set up for 15 persons. In Trail, the Centre undertook a collaborative effort with the major employer, to place a limited number of persons in competitive employment.

SUPPORTIVE SERVICES

It was in the area of general supportive services that centres were able to offer a variety of special programs. Burnaby developed a special group for parents of schizophrenic patients. Courtenay has a men's group for young schizophrenics. Several centres developed special homemaker

services for the psychiatrically disabled, utilizing the existing program. Examples included Kimberley, Golden and Penticton. In Osoyoos, in a one person office, considerable time was spent in meeting with families of the chronically disabled to assist them in coping with the home living situation. In Trail, a strong hospital and home visiting program was achieved, through close working relationships with the local Mental Health Association.

Most of the chronically disabled do not own cars or drive. Consequently, the availability of public transportation is a key element in their lifestyle. A research project was established with the aid of summer students to investigate general transportation to and from the health centre. Though labelled a survey for seniors, the chronically disabled mentally ill share the same problem, and will benefit from the survey results.

Services for the Acute Mentally Ill Adult

Reports from Mental Health Centres emphasized the importance of early intervention in acute illness to prevent hospitalization wherever possible. Those centres which lacked sufficient psychiatric sessional time found themselves at a disadvantage, in that the lack of a bio-medical evaluation hampered community management of the acutely ill patient, and therefore, otherwise avoidable admissions to in-patient services occurred. This lack of psychiatric input was felt most keenly by those centres which did not have a local psychiatic unit.

The value of the availability of an acute psychiatric in-patient unit was emphasized in reports from various centres. During the year there was a concentration of effort on improving communication and liaison with the local psychiatric units, involving scheduled meetings between the hospital and community staff. This resulted in the facilitation of placement of patients in hospital where appropriate, and in continuity of care.

Several centres established a community psychiatric service planning group, consisting of local hospital administration, nursing and medical representation, and other community agencies including volunteer groups. The focus of the study was the quality and availability of resources to plan and maintain comprehensive community based psychiatric programs. Position papers were submitted by these planning groups, indicating local needs.

In many centres there was a focus on clarifying procedures for emergency intervention for the acutely ill patient, in particular, an attempt to co-ordinate rapid assessment, evaluation, and treatment. The expediting of hospitalization for the seriously disturbed patient required planning, especially in the densely populated areas. The local psychiatric units find co-operation with Riverview Hospital, and other intensive care units, of great value for the more unmanageable patients requiring short-term highly specialized treatment.

The consensus of reports from the various mental health centres was that of a multiaxial diagnostic system, which emphasized psychosocial factors with the support of medical knowledge, both within the community and hospital systems. There was an emphasis on the philosophy of community oriented, comprehensive, mental health services. The lack of supportive out-patient services and supporting staff was emphasized in several centres. Adequate support systems can prevent hospitalization for certain patients who become acutely ill.

The role of the community mental health movement must be actively promoted with support from the universities. Research is needed to plan and carry out a broad based community program of prevention, maintenance, and cure.

Services for Families and Children

Family and Children's Programs are the third priority of the Ministry. The long term objective for this priority is to develop a multi-agency community based service system for children and families, in each Mental Health Centre area, with clearly specified roles for Mental Health staff. The short term objectives are:

To establish a twenty-six bed secure adolescent unit and a day care unit at the Maples in Burnaby.

To ensure that other community agency staff are co-participants in the case management of 90 percent of child and family cases.

To establish at least one non-statutory family support service in each Mental Health Service area.

To establish a short term crisis service for children and adolescents in each Health District.

To have a neuro-psychology assessment capacity in at least ten Health Districts.

Although Family and Children's Programs are third in priority, the demands for service are the greatest for these types of problems in many, if not most, of the Mental Health Centres. The most serious problems for which assistance from the Mental Health Centre staff is requested include developmental delay, speech problems, learning problems, sexual abuse, child abuse, hyper-activity, the use of alcohol and drugs, pregnant teenagers, single parents, separation and divorce, and marital and family malfunctions.

Providing appropriate services to children and adolescents takes special training. Unfortunately, childhood problems do not magically disappear when a person reaches adulthood. Minor problems which could have been handled relatively easy at the time of occurrence, if let alone, are likely to develop into major problems which are difficult to deal with and may affect a child for many years or all its life. The increase in the degree of seriousness of problems which come to the attention of the various Mental Health Centres in the past few years, attests to the fact that more attention must be paid to prevention and early intervention programs.

The current range of services focus primarily on such services as Assessment and Differential Diagnosis, Individual and Group Counselling, Individual and Family Treatment, Marital Therapy, Case Management, the provision of Consultation Services to other Community Resources, the Training of Personnel dealing with these types of problems, including the use of workshops and the media, such as newspapers and television. Special services may include Court Appearances, providing Screening Services for such problems as Development Delay, Emotional Disabilities, Speech and Language etc., Crisis Intervention, School Programs, including Learning Assistance Programs, the provision of Parent Resource facilities, Follow-up Services, Participation in Inter-Agency, and in Co-ordinating Planning Groups.

In addition to the Services provided by the Mental Health Centres, there are three specialized facilities which provide services to families and children. These facilities are the Psychological Education Clinic, and the Residential and Day Care Centre, both located in the British Columbia Youth Development Centre in Burnaby, and The Integrated Services for Family and Children in Victoria.

The Psychological Education Clinic is a provincial resource for children and their families, and focuses primarily on providing a therapeutic training program for children with emotional and learning problems. The Clinic has a teaching and treatment staff, who act as the change agents for both the children and their families. They can accommodate at any one time, forty children between the ages of six to thirteen. The average length of stay for the types of problems seen in this Clinic is slightly over one year. The Clinic also provides services to parents, the family, and to the school system. In addition, the Clinic provides specialized neuro-psychological assessment services for a limited number of referrals, to assist in differential diagnosis for both children and adults.

The Residential and Day Centre programs of the British Columbia Youth Development Centre provide in patient and day care treatment for psychological, social and learning problems in adolescents. Services are stressed which focus on inter-personal relationships, personal growth, life skills, and the development of assuming responsibilities. The services center on both the individual, the group and the family. This Centre also has a school attached to the program, which is attended by all the adolescents on a regular basis. A major goal of the Centre is to equip adolescents with the skills necessary to re-enter the regular school system, to attend courses, or to achieve job placement. Centre programs are designed to enhance a sense of accomplishment, self worth, independence, and bring the adolescents into contact with the community. In order to ensure high standards of clinical practice, a formal training program for their child care counsellors is also provided. In addition, the unit is used for field placement training for students from the University of Victoria, U.B.C. and Douglas College. In November, 1980, a community based Transition Home for six adolescents was opened. This will allow a more effective flow of the residents, and help reduce the long admission waiting list.

The Integrated Services for Child and Family Development Centre in Victoria provides services primarily to the Capital Regional District. This area comprises about 70,000 children. In addition, the staff provides some consultation, assessment, and training services for the province as a whole. Besides client service, the Centre is actively involved in community development of coordinated services. Client services focus on general and specialized assessment, including neuropsychological, psychoeducational, psychiatric etc., on family therapy, counselling and consultation, on individual and group therapy for both children and parents, and on consultation and case management services to schools and other community agencies and resources. A changing pattern of referral sources

has taken place over the past few years. Referrals from other community resources decreased, while "walk-in" referrals increased. Twice as many children between the ages of 6 to 12, and 13 to 17, were referred to the Centre, as there were in ages 0 to 5. During the year there was an increasing awareness, however, of the importance to provide service to the pre-school aged child. Because of the changing parent population it is important to insure that the community is kept informed of the types of services available especially for this age group. The demand for services from the Centre increased considerably, and the waiting period for admission by the year end was approximately four months. Special liaisons were set up with the Saanich and Sooke School Districts, to promote the coordination and effectiveness of educational and mental health services offered to children in these school districts. Discussions with the Victoria School Board were underway to initiate a similar service in that School District. Services include the identification of suspected mental health and education disorders, supportive counselling to those children with social and behavioural problems, family intervention and consultation to school personnel, especially in relation to the early recognition and management of mental health and educational disorder.

The Greater Vancouver Mental Health Services, which is funded by the Ministry of Health and administered by the Metropolitan Board of Health of Greater Vancouver, is an integral part of the Mental Health delivery system for Vancouver and Richmond.

During 1980, this Service was responsible for the operation of eight Community Care Teams providing treatment in the community to a total caseload of approximately 6,000 seriously mentally ill patients, a significant number of whom included families and children. Treatment services provided for families and children included medications, individual and family therapy, as well as life skill programs for dealing with stresses within the family unit, at school, and in the community. In addition, the Greater Vancouver Mental Health Services also offers a specialized treatment program for emotionally disturbed pre-school children and their families. This program is called Blenheim House and was relocated during the year in the Dunbar area, Vancouver. Besides direct therapy of clients, Blenheim House staff offer treatment and consultation services to those community agencies which also are involved in the care of young children.

Adjustment Reactions and Prevention Services

Although Mental Health Services' priorities were redefined by the Ministry of Health to emphasize services to the acute and chronic mentally ill during 1980, nevertheless, the pressure to respond to personal and situational crisis still constituted the major demand for mental health services during the year. These pressures confirmed the appropriateness of the Ministry's overall concern for the development of more innovative programming in the areas of prevention, stress management, and lifestyle enrichment.

As the result of the redefined priorities, resources for the purposes of responding to personal, situational and family crisis diminished. Particularly affected were rural areas, where resource alternatives are not as readily obtainable. In these instances it is often left to the family physician of the hospital outpatient services to cope with heavy service demands.

However, it was still possible to maintain a modicum of service in a number of Mental Health Centres. It is interesting to note in retrospect that B.C.'s mental health services have been able to develop many effective and innovative program modules for intervention at this level. For example, in the area of prevention, programs still being provided include workshops with couples in distress; stress management and assertiveness training groups; life skill and communication effectiveness programs, and the recognition and treatment of psychosomatic disorders.

In the area of crisis management and early intervention, mental health services offered short term counselling to individuals and families in distress. Consultation was provided to other community resources, such as the school system, law enforcement services and family court, especially with regard to problem recognition and case management. In the area of encouraging the development of, and working with, self help and volunteer groups, mental health services were provided to such groups as single parents, separated and divorced, adolescents, parents in crises, and to various chapters of the Canadian Mental Health Association and its associated projects throughout the Province of British Columbia.

At the year end a consultant in Social Work was appointed to this program area of prevention, and a Preventive Services Committee comprising both field as well as headquarters representatives was to be established.

Riverview Hospital

At Riverview Hospital, the patient population, admission rate, and general range of services remained relatively constant over the year. Successful efforts were made to shorten response times for admissions, especially in critical priority areas such as patients from jails.

Throughout the year Riverview continued to make progess in improving standards of patient care, as well as in responding to community needs. This was reflected in the hospital's primary goal of attaining accreditation. Much work was done on the quality assurance aspects of care, the development and refinement of Hospital Policy and Procedures Manuals, the updating of disaster plans, and the preparation of extensive accreditation awareness materials for staff education.

Other highlights of the year included the work of the Utilization Committee, engaged in an ongoing study of patient movement, length of stay, and bed utilization.

The restructuring of pharmacy services at Riverview resulted in an increase in the practice of clinical pharmacy at the hospital, and allowed for standardization of drug distribution.

The Riverview Hospital Volunteer Assocation became a legal entity during 1980, with formal ratification of the Society's Constitution and Bylaws. The Social Learning Program underwent extensive reorganization, including the revision and clarification of administrative and reporting relationships; the development of a staff training program; and the distribution of standards, policies and procedures.

In addition, numerous administrative changes were implemented at the hospital, including the relocation of the Radiology and Rehabilitation Departments to more convenient locations on campus; the utilization of a new thermal tray system by the Dietetics Department; and a study involving a proposed central commissary kitchen for the hospital.

In 1980 Riverview continued to strive for increased community involvement in the planning and delivery of Mental Health Services. To this end staff dietitians increased their emphasis on diet consultations to include not only patients receiving treatment at Riverview, but also the planning and follow-up for patients discharged into the community. Also,

the Outreach Program continued to provide outreach consultation, education and direction to psychiatric services in the community. Finally, the hospital was active in resource planning, through participation on many community-based meetings with staff from other service agencies.

Greater Vancouver Mental Health Services (G.V.M.H.S.)

During 1980 the G.V.M.H.S. was funded by a Ministry of Health grant and it continued to deliver a high calibre of treatment to the acutely mentally ill. The treatment involved a total rehabilitation program involving care of the patient's biological, psycho-social and environmental needs.

The acutely mentally ill, or those suffering from exacerbation of a chronic illness, may be admitted to the ten bed short stay emergency residence 'Venture' when the necessity for hospitalization is unwarranted or uncertain. The operation of this service continued to require solid psychiatric experience, sound judgement and knowledge of community resources.

The G.V.M.H.S. was very actively involved in research in 1980.

Burnaby Mental Health Services

Burnaby Mental Health Services provides a regionalized, decentralized, integrated, and comprehensive program of psychiatric services for adults, families, and children resident in the community.

INPATIENT UNIT

The 25-bed acute psychiatric Inpatient Unit treated large numbers of seriously disturbed patients, usually with brief hospitalization and without loss of ties with family, friends and community. Although the unit is small, rapid intensive treatment maintains high turn-over.

Assistance and co-operation is provided by Riverview Hospital Intensive Care Unit, and Burnaby General and Vancouver General Hospital Emergency Departments, for the occasional care of dangerous, unmanageable patients.

ADULT DAY PROGRAMS

Burnaby offered three distinct Adult Day Programs during 1980: an intensive 5-day per week milieu program designed to produce major behavioural change; a part-time more gradual re-educative and socially rehabilitative program; and a series of structured courses including Communication, Assertiveness Training, Cooking and Nutrition, Stress Management, and Creative Job Search. The summer gardening group and Monday evening social club continued to be popular additions to the regular programs. Regular liaison meetings with the Outpatient Teams, the Inpatient Unit, and the Burnaby Achievement Centre continued to facilitate interactions with these programs.

A new project in 1980, entitled the "Happy Age Club", was initiated by Day Program staff to provide community activities and outings for a group of shut-in elderly patients resident in a large senior citizens' complex. An imaginative program of social activities, occupational therapy, life review therapy and sharing sessions, recreational activities, and out-trips was instrumental in increasing the level of activity and preventing withdrawal of this group of the elderly, who were seen to be at special risk for development of depressive illnesses.

ADULT OUTPATIENT DEPARTMENT

The three geographic Adult Outpatient Teams continued to consolidate their position in the community, treating the acutely disturbed, as well as participating in the rehabilitation of the chronically mentally ill. Specialized group treatment programs for patient groups with special needs, such as abusing spouses, parents of schizophrenic patients, and widows, were continuing to be developed.

CONSULTATION PROGRAM

The psychiatric consultation program to Burnaby General Hospital functioned at a high level with a regular consultant, who continued to improve the quality and continuity of the service, as well as the relationships with physicians and nurses in Burnaby General Hospital and the community.

CHILDREN'S OUTPATIENT SERVICES

The Children's Outpatient Department remained somewhat overloaded during 1980, in spite of the development of additional group programs for disturbed children. Consultation work with Burnaby schools, and the Ministries of Human Resources and the Attorney General, was continued. The popular summer programs for preschoolers, latency children, and their parents, were continued with the assistance of summer students.

BOARDING HOME PROGRAM

The Boarding Home Social Worker was extremely busy with placements, especially from the Inpatient Unit. Attempts were underway to foster the development of additional alternative housing resources for the mentally ill, which were seriously depleted by increased activity in the local real estate market.

LONG TERM CARE PROGRAM

The Long Term Care Social Worker, added last year, developed a close liaison between the Outpatient Teams and the Long Term Care Service; assisted in the assessment of many patients with emotional problems referred for long-term care; and embarked on an ambitious educational program for operators of Long Term Care facilities.

CONSULTATION AND EDUCATION SERVICES

Burnaby Mental Health Services continued to consult with community groups and organizations, including Burnaby physicians, Canadian Mental Health Association, Burnaby Health Department, Long-Term Care Program, Burnaby General Hospital, Burnaby Preschools, Dogwood Lodge, Burnaby Achievement Centre, Parents in Crisis, etc. As well, many staff members served on advisory boards for community organizations, a gratifying recognition of the skills and service they provide the community.

Burnaby continued to offer educational placements for students in registered and psychiatric nursing, psychology, social work, and occupational therapy.

Regular in-service training experiences offered during the year included half-day workshops on the following topics: The Elderly, Medication Review, Family Therapy, A Cognitive Approach to Anger Management, and The Narcissistic Personality. Most staff members attended the annual Mental Health Programs Workshop held in June at U.B.C., which had as its theme the care of the chronically mentally ill. A number of staff also received educational time to attend individual upgrading programs.

British Columbia Youth Development Centre, "The Maples", Burnaby

RESIDENTIAL AND DAY CENTRE PROGRAMS

The adolescent Residential and Day Centre Programs provide a variety of services which include comprehensive consultation, assessment, inpatient and day care treatment of psychological, social, and learning problems in adolescents. While in treatment, the adolescents interact in a milieu which promotes interpersonal relationships, personal growth, life skills, and responsibilities. Staff serve as healthy role models by encouraging appropriate activities such as school, athletics, recreation, and arts and crafts. Problem areas are worked on in individual, group, and family therapy.

All adolescents in the program attend the school on a regular basis. Most of the adolescents in care have experienced difficulty in the regular school system because of behavioural, emotional, or learning problems. The adolescents are given a comprehensive educational assessment, and are then placed in individual programs that allow them to progress at their own rate. When indicated, some adolescents attend classes in nearby community schools. A major goal is to equip adolescents with the skills necessary to re-enter the regular school system, to attend courses, or to achieve job placement.

A variety of appropriate activities and programs are provided for the adolescent in care. These programs are designed to enhance a sense of accomplishment, self-worth, and independence. A gymnasium, swimming pool, and arts and crafts centre are located on the grounds. Regular activities in these areas are provided for the adolescents by child care and residential staff. Special individualized programs such as art and dance therapy, drama, gymnastics, and swimming, are designed to improve motor and expressive skills. Socialization is an important goal in the activities program. Camping,

skiing, movies, social events, and regular outings promote and develop social skills by bringing the adolescents into contact with the community.

The Residential and Day Centre Programs endeavour to ensure high standards of clinical practice by providing an ongoing, in-service training program leading to a diploma in child care. The planning and implementation of this program is under the direction of a training coordinator, who works with the unit psychiatrists, social workers, psychologists, and child care counsellors, in developing a curriculum which stresses an integrated approach to the treatment of adolescents. The inservice training program aims at skill development in the area of milieu, family, individual and group therapy; interpersonal and group dynamics, assessment, supervision, administration, and personality and growth development. The Residential Unit is also affiliated with the University of British Columbia and provides field training to the students from the University of Victoria and Douglas College. Field placement training is provided to psychiatric residents, students in social work, child care counselling, nursing, psychology, education and recreational therapy.

Private physicians, psychiatrist, school counsellors, social workers, probation officers, and those working in mental health centres refer their clients to the Residential and Day Centre Programs. Once received, the referrals are assigned to an interdisciplinary team for assessment and diagnostic recommendation. During the year, the Residential and Day Centre Programs of the B.C. Youth Development Centre received 175 referrals. Throughout the year, all of the residential beds and Day Centre places were filled. There was a continual waiting list of between 30 to 40 adolescents. Approximately 30 percent of all admissions during the year came from outside the Lower Mainland.

In November, 1980, a community based Transition Home for six adolescents opened to service those adolescents who have been in the residential cottages. This program provides more effective patient flow, thereby making the residential cottages more accessible to needy adolescents.

Construction was under way to expand the unit so as to provide secure services for acute crisis intervention and longer stay care, an outpatient department, expanded Day Centre, and educational and recreational facilities.

Psychological Education Clinic

The Psychological Education Clinic is a provincial resource for children and their families. The main thrust of the Clinic is to operate a therapeutic school for children with emotional and learning problems. There is a teaching and treatment staff who act as the change agents for both the children and their families.

The Maples school accommodates 40 children between the ages of 6 to 13 years, with the average length of stay just over one year. The major academic problem encountered is concerned with reading. First, there is the child who is unable to read even after the special services within the school system have been exhausted. This requires using a variety of specialized programs to meet the child's unique problems. Next, is the child who lacks the motivation to learn, even though thought to be capable. In both cases, an emotional component is present and exists to a debilitating degree. Another category of child is the one with no learning problem, but with emotional problems within the home and school. A final group of children are those with an individual psychopathology where no external cause is noted.

Treatment of these children involves working with their learning disability, which takes considerable time as it entails one-to-one therapeutic tutoring. This is necessary because of the uniqueness of the child, which required the program to be altered almost daily. Also these children function best when they have immediate and accurate feedback of their performance. The approach is a pragmatic behavioural one, using task analysis, rewards, and helping the children accept responsibility for their behaviour and that they possess the ability to change. Social relationship experiences are provided on an individual, group, and milieu basis. The families are seen by psychologists who offer counselling in child management techniques, family relationships, marital and individual problems.

When treatment has been successfully terminated, it is essential to follow a child, to ensure that the disturbance does not occur again. Maintenance of improved behaviour has always been a problem in treatment programs, and a liaison worker was appointed to cope with this. Every child is monitored during their re-entry into the school system, and every family is continued in treatment until they can cope with their own resources.

There was a close liaison with residential treatment units, and a service was provided for the children that are too disturbed to be in the school system. There also appeared to be a shift in the degree of pathology that the children presented, and the referrals indicated that they were more disturbed and the families harder to treat than a few years ago.

During the year specialized neuropsychological assessment service was available to Mental Health Centres for a limited number of referrals, to assist in differential diagnoses for both children and adults.

Consultative Services

CONSULTANT IN PSYCHIATRIC EPIDEMIOLOGY

During the year organizational changes in the Mental Health Services, placed emphasis on an integrated total care system at the community level. The Consultant in Psychiatry assisted with administrative decisions which affected the needs for expansion and quality of patient care facilites.

The Consultant answered a number of enquiries directed to the Ministry regarding patient treatment. These questions either concerned individual patients or involved the discussion of broader issues regarding certain types of treatment modalities.

During the year other ministries were advised of trends in mental health services, such as the expansion of comprehensive community care and the need for more psychiatric in-patient units in general hospitals.

A field research study on the aged was completed, and the report was available from the library within the Ministry of Health. An abridged version was accepted for publication.

A community follow-up of patients discharged from Riverview Hospital was undertaken during the summer. The purpose was to evaluate the contact between discharged chronic mental patients and community support services, and the patient's psychosocial adjustment in the community.

Two other research proposals were submitted for funding next year. Research for unambiguous evidence as to what constitutes adequate care, including placement, treatment and

their duration, remained an abiding overall aim of research in psychiatry.

As a result of attendance at administrative and planning meetings, including inter-ministerial meetings, various reports and position paper were submitted following the evaluation and discussion of issues.

As a member of the Clinical Records Committee, an evaluation was done of a pilot project on Data Base Recording at a mental health centre. The clinical staff using the system reported favourably in their experience with a more standardized system of record keeping, and offered further suggestions for improvement in the system.

The Consultant attended the American Psychiatric Association convention, and a two day seminar on a comprehensive review of trends in psychiatry.

Educational workshops were given to several mental health centres. The subjects dealt with the use of medications in psychiatric illness, and mental health in the non-western world.

CONSULTANT IN PSYCHOLOGICAL SERVICES

The year saw a significant increase in requests for Psychological Services in the various Mental Health catchment areas. Fortunately, it was possible to effect some alleviation of this through sessional services in a number of Centres, contracted for specific purposes for a temporary period of time.

The increased demands for Psychological Services were partly the result of changes in Mental Health Services priorities. These changes were aimed at providing, in order of priority, services to the chronically emotionally or behaviourally disabled, to the acutely emotionally or behaviourally disabled, to children and families, and to persons with adjustment problems.

The provision of Psychological Services reflect the new focus, especially in terms of requests for more differential psychological assessment and diagnostic services; for more specialized psychological treatment procedures of emotional behavioural disabilities; as well as for consultation services to both Mental Health staff, community agencies, and other professional resources.

The changes in Mental Health priority also saw greater utilization of Psychological Services in planning, program definition, and program analysis and evaluation. In addition, there was a major involvement by psychologists in a variety of training and continuing education programs.

In the area of accountability, Mental Health Services followed the lead of the B.C. Psychological Association by adopting the same standards for the provision of psychological services as those set by the Association. The assistance of the Association was also requested to provide guidelines to enable the determination of which Mental Health facilities are appropriate settings for Psychological Interns and Practicum Experiences.

CONSULTANT IN SOCIAL WORK SERVICES

During 1980, the Consultant was engaged in a number of functions involving the social work profession and its relationship to the Mental Health System.

Recruitment of clinic social work personnel, assisting in panelling, and adjudication on matters of a professional and interprofessional nature, comprised a considerable portion of the Consultant's time during the year. In addition, the Consultant was involved in two ongoing professional committees in the interest of Mental Health Services: the Series Review Committee, and the Committee on Social Work Education. In reference to the latter committee, a symposium was carried out to assist the two professional schools, and the two professional associations, to better understand the relevant issues for social workers who function within health care settings.

In addition to program responsibilities for the Okanagan Thompson Region, the Consultant functions also as the director of the Continuing Education Committee and in this capacity coordinated a 1980 Provincial Mental Health Conference dealing with the chronic mentally ill patient. It was a further responsibility to develop the 1980/81 Electives Program in continuing educational workshops for mental Health professionals serving both urban and rural communities. Approximately two hundred workshops will have occurred under this program's auspices by the end of the 1980/81 academic year.

Statistics

Throughout the year, the main duties of the statistician revolved around the statistical systems in use at Mental Health Services. Maintenance of the Management Information System is a major facet of the statistician's responsibilities, and in September, the system was enlarged with the addition of Fort Nelson as a new sub-office.

Another change to the system involved the creation of a more accurate inventory of the tape library. To accomplish this, all Mental Health tapes were reviewed by the B.C. Systems Corporation and were copied onto new "D" tapes, re-cataloged, and assigned a new common identification prefix.

During the year more progress was made on the client-record microfilm project and on the care conversion project, and because of the assiduous checking required, a summer student and a temporary assistant were hired to assist the regular staff.

The organization and the dissemination of statistical data continued to occupy much of the statistician's time. A considerable amount of time was spent bringing the Annual Statistical Report up to date, and by the year end the 1978 Report was completed and the 1979 Report was nearing Completion.

Other activities of the statistician included participation on the Joint Clinical Records Committee, and liaison with Statistics Canada, the Division of Vital Statistics, and the B.C. Systems Corporation.

TABLE I - PATIENT MOVEMENT DATA[1] FOR MENTAL HEALTH FACILITIES, 1980

MENTAL HEALTH FACILITIES	ENTRIES				EXITS				
	TOTAL	DIRECT ADMISSIONS	RETURNS FROM LEAVE	PERMANENT TRANSFERS	TOTAL	DISCHARGES	LEAVES	PERMANENT TRANSFERS	DEATHS
All Mental Health Facilities	13,003	12,671	288	44	10,296	9,322	755	17	202
Hospital Programs, Riverview	1,293	972	285	36	1,296	520	723	4	49
Geriatric Facilities	179	178	1	--	244	90	1	--	153
Valleyview	91	91	--	--	124	51	--	--	73
Dellview	76	75	1	--	84	32	1	--	51
Skeenaview	12	12	--	--	36	7	--	--	29
Mental Health Services[2]	9,868	9,858	2	8	7,167	7,123	31	13	--
Total In-Patients	398	388	2	8	392	348	31	13	--
Burnaby	325	320	1	4	323	280	31	12	--
B.C.Y.D.C.	73	68	1	4	69	68	--	1	--
Total Out-Patients		11,133				8,364			
All Mental Health Centres		9,283				6,567			
Abbotsford		339				336			
Burnaby Central		216				129			
Burnaby Children's		99				40			
Burnaby Day Program		115				93			
Burnaby North		155				108			
Burnaby South		161				77			
Burns Lake - Vanderhoff (Feb.79)[3]		53				9			
Campbell River (Aug.79)		16				3			
Chilliwack		132				117			
Courtenay		173				184			
Cranbrook		216				59			
Dawson Creek (July 79)[3]		191				8			
Duncan		209				177			
Fernie-Sparwood (Apr.79)[3]		77				68			
Fort St. John		255				76			
Grand Forks		92				65			
Kamloops		488				111			
Kelowna		363				755			
Kitimat		119				85			
Langley		165				151			
Maple Ridge		187				99			
Merritt (Apr.79)[3]		47				--			
Nanaimo		267				256			
New Westminster		73				71			
North Delta		276				72			

continued

TABLE I - PATIENT MOVEMENT DATA[1] FOR MENTAL HEALTH FACILITIES, 1980
continued

MENTAL HEALTH FACILITIES	ENTRIES				EXITS				
	TOTAL	DIRECT ADMISSIONS	RETURNS FROM LEAVE	PERMANENT TRANSFERS	TOTAL	DISCHARGES	LEAVES	PERMANENT TRANSFERS	DEATHS
Osoyoos (Aug.79)[3]		97				5			
Penticton		336				497			
Port Alberni		325				97			
Port Coquitlam		307				192			
Port Hardy (Mar.80)[3]		120				4			
Powell River		116				152			
Prince George		93				96			
Prince Rupert		115				108			
Queen Charlottes (June 79)[3]		35				24			
Quesnel (Mar.79)[3]		44				49			
Saanich		244				184			
Salmon Arm (Mar.79)[3]		136				47			
Sechelt		124				77			
Smithers (May 79)[3]		43				23			
Squamish		90				68			
Surrey		268				247			
Terrace		156				100			
Trail		248				135			
Vernon		452				232			
V.I.S.C.		559				508			
Victoria		244				285			
Whalley		237				67			
Williams Lake		83				56			
1 Community Care Teams		1,663				1,589			
Blenheim House		45				56			
Broadway Clinic		223				211			
Kitsilano		187				157			
Mt. Pleasant		199				220			
Richmond		148				113			
Secure		68				40			
South Vancouver		153				157			
Strathcona		199				215			
West End		264				219			
West Side		177				201			
C.Y.D.C. (Out-Patient)		187				208			

Table compiled from actual data through September 1980 and projected for the remainder of the year. NOTE: For Centres opened in 1980, table compiled on basis of available data.
Sub-total does not include Community Care Teams.
Month sub-office commenced reporting.

TABLE II - PATIENT MOVEMENT TRENDS FOR MENTAL HEALTH FACILITIES, 1978 - 1980

MENTAL HEALTH FACILITIES	Yearly Sum of Entries[1]		Resident of Caseload	
	Oct. 1978 to Sept. 1979	Oct. 1979 to Sept. 1980	End of Sept. 1979	End of Sept. 1980
All Mental Health Facilities	10,902	12,831	17,139	19,523
Hospital Programs, Riverview	1,362	1,314	1,098	1,113
Geriatric Facilities	276	175	805	687
Valleyview	207	98	534	452
Dellview	48	65	153	139
Skeenaview	21	12	118	96
Mental Health Services[2]	7,448	9,634	12,280	14,712
Total In-Patients	738	394	55	52
Burnaby	377	326	23	17
B.C.Y.D.C.	62	68	32	35
Venture[3]	299	---	---	---
Total Out-Patients	8,526	10,948	15,181	17,671
Mental Health Centres	6,545	9,062	12,126	14,573
Abbotsford	318	354	348	341
Burnaby - Central	160	220	289	366
Burnaby - Children's	60	94	129	176
Burnaby - Day Program	102	112	21	28
Burnaby - North	160	152	477	518
Burnaby - South	106	140	245	292
Burns Lake-Vanderhoof (Feb. 79)[4]	17	42	17	46
Campbell River (Aug. 79)[4]	10	14	10	22
Chilliwack	101	137	244	177
Courtenay	169	146	212	198
Cranbrook	105	187	114	235
Dawson Creek (July 79)[4]	132	211	132	335
Duncan	56	230	112	187
Fernie-Sparwood (Apr. 79)[4]	37	81	31	59
Fort Nelson (Sept. 80)[4]	---	6	---	6
Fort St. John	92	264	209	400
Grand Forks	71	97	33	87
Kamloops	307	445	785	1,117
Kelowna	339	341	705	438
Kitimat	44	125	112	161
Langley	199	165	446	409
Maple Ridge	124	169	467	531
Merritt (Apr. 79)[4]	2	37	2	39
Nanaimo	139	291	315	330
Nelson	305	358	325	460
New Westminster	82	98	308	329
North Delta (Aug. 79)[4]	41	281	41	259
Osoyoos (Aug. 79)	42	98	42	134

continued

TABLE II - PATIENT MOVEMENT TRENDS FOR MENTAL HEALTH FACILITIES, 1978 - 1980
continued

MENTAL HEALTH FACILITIES	Yearly Sum of Entries[1]		Resident of Caseload	
	Oct. 1978 to Sept. 1979	Oct. 1979 to Sept. 1980	End of Sept. 1979	End of Sept. 1980
Penticton	353	350	782	721
Port Alberni	109	331	242	457
Port Coquitlam	264	334	407	461
Port Hardy (Mar. 80)[4]	---	86	---	83
Powell River	134	127	200	177
Prince George	50	97	355	374
Prince Rupert	75	141	62	38
Queen Charlottes (June 79)[4]	7	38	6	25
Quesnel (Mar 79)[4]	57	44	56	47
Saanich	81	234	184	233
Salmon Arm (Mar 79)[4]	40	112	40	109
Sechelt	95	127	213	239
Smithers (May 79)[4]	26	58	25	66
Squamish	7	67	115	131
Surrey	201	258	776	800
Terrace	63	148	98	161
Trail	179	244	443	505
Vernon	488	425	780	925
Victoria	212	223	415	394
V.I.S.C.	614	419	459	472
Whalley	85	208	210	344
Williams Lake	85	85	87	131
All Community Care Teams	1,816	1,708	2,956	3,011
Blenheim House	35	42	83	78
Broadway Clinic	250	240	660	686
Kitsilano	186	188	236	256
MHBH North Shore[5]	63	---	2	---
Mt. Pleasant	149	190	256	325
Richmond	195	161	287	306
Secure	59	73	65	87
South Vancouver	173	147	253	247
Strathcona	237	211	331	317
West End	239	269	295	357
West Side	230	187	388	352
B.C.Y.D.C. (Out-patient)	165	178	99	87

1. For the residential facilities, this includes permanent transfers, admissions from the community, returns from leaves and escapes.
2. Sub-total does not include Community Care Teams.
3. Venture stopped reporting as of July 1, 1979.
4. Month Sub-office commenced reporting.
5. Opened in September, 1978 and closed in September 1979.

HOSPITAL PROGRAMS

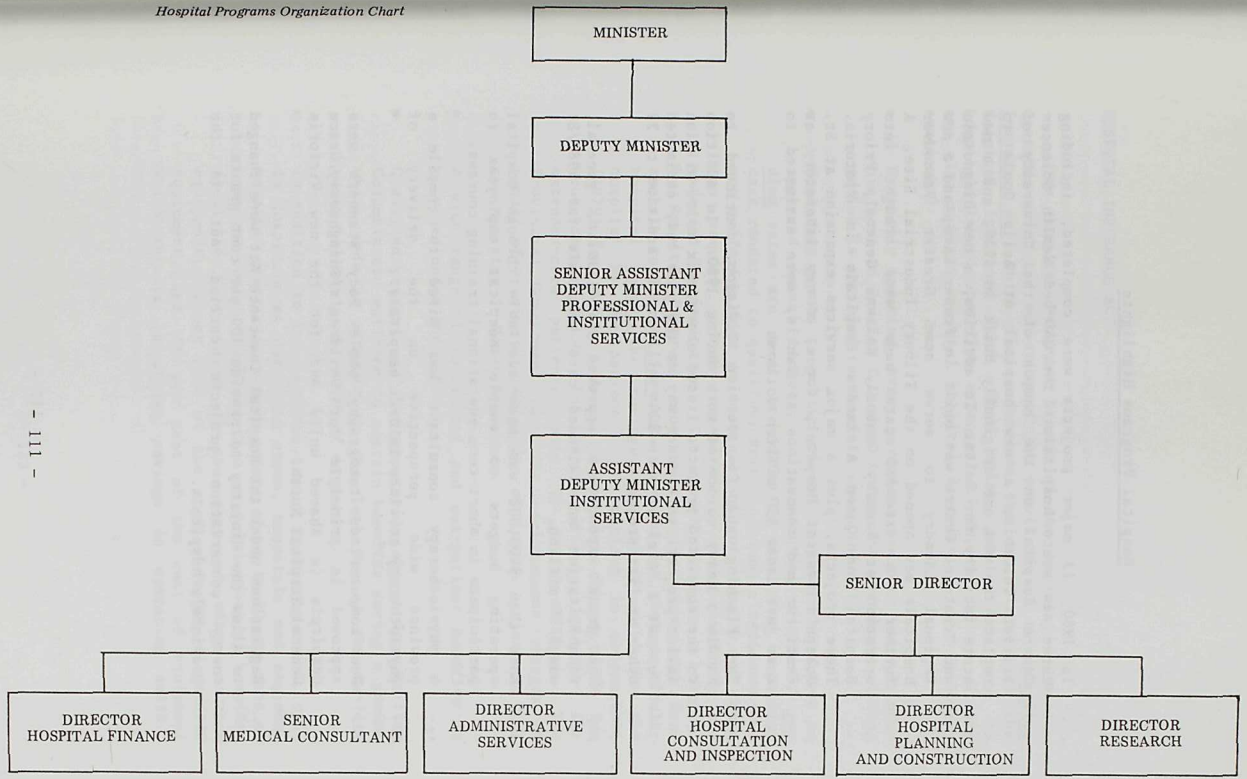
Prior to the introduction of the British Columbia Hospital Insurance Service on January 1, 1949, the Province had been interested in developing a comprehensive program for many years. In 1932 the findings of a Royal Commission had recommended that a compulsory health insurance maternity plan be considered and in 1936 a Health Insurance Act had been placed on the statutes but never proclaimed. In 1937, British Columbians voted in favour of health insurance in a referendum held in conjunction with a Provincial general election. Finally, in 1948, the Hospital Insurance Act was passed, establishing a Hospital Insurance Service which, when implemented on January 1, 1949, provided coverage for acute care in approved general hospitals.

The funding of the operating costs of the service (Hospital Programs) was a 100 per cent responsibility of the Province until 1958 when the Federal Government agreed to share on a Canada-wide basis approximately 50 per cent of the approved cost of certain hospital services. Subsequent to March 31, 1977, Hospital Programs was brought under the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977, when shared-cost arrangements under the Hospital Insurance and Diagnostic Services Act were terminated.

In March 1975 the name of the service was changed to Hospital Programs as part of a reorganization within the Ministry of Health.

The following pages contain individual reports of the divisions which comprise the administrative structure of Hospital Programs, and brief reviews of pertinent legislation and statistical data.

Hospital Programs Organization Chart



Hospital Programs Highlights

... In 1980, 13 major projects were completed, including three new acute hospitals: the 240-bed Health Sciences Centre Hospital on the campus of the University of British Columbia; a new hospital at Bella Coola to replace the old one originally built in 1930, and a new acute facility for Delta. In addition, a new Diagnostic and Treatment Centre was built in Fraser Lake, and a new Regional Laundry to serve some Greater Vancouver hospitals was opened on the Tilbury Industrial Site. A further 176 extended care beds were brought into operation at Burnaby General, Kelowna General, Priory Hospital and Queen Alexandra Hospitals in Victoria. These projects, plus a major services expansion at St. Joseph's General Hospital, Comox, a new laboratory at Penticton and renovations at Tahsis, were estimated to cost just under $50 million dollars.

... The Planning and Construction Division continued to handle a heavy volume of work during 1980. In addition to the completed projects listed above, six multi-million dollar projects were under way at the year end, estimated to cost a total of over $246 million, in addition to 22 other smaller projects.

... The gross expenditure approved for public, general, rehabilitation and extended care hospitals for 1980/81 was $795 million.

... More than $400,000 was made available through hospital operating budgets to enable hospital employees to participate in short-term educational training courses.

... A physiotherapy consultant was hired to compile a province wide perspective on the delivery of physiotherapy services in B.C. hospitals.

... New computerized tomography whole body scanners were approved in principle for Children's/Shaughnessy/Grace Hospitals (a shared unit) and for the new Victoria General Hospital North.

... Regulations under the Hospital Insurance Act were changed to allow the Ministry to provide 100 per cent grants for energy conservation projects carried out in the province's hospitals.

HOSPITAL INSURANCE ACT

The Hospital Programs branch of the Ministry of Health operates under the authority of the provisions of the Hospital Insurance Act, which also authorizes the establishment of the Hospital Insurance Fund, from which grants are made to hospitals toward operating expenses and capital costs. Grants are also made to regional hospital districts. (See following sections.)

- Generally speaking, every permanent resident who has made his home in British Columbia during the statutory waiting period is entitled to benefits under the Act.

- Operating grants to public general hospitals are based on approved annual budgets; for accounting purposes, per diem rates are used for medically necessary in-patient care rendered to qualified British Columbia residents who are suffering from an acute illness or injury, and those who require active convalescent, rehabilitative and extended hospital care. The payment made to a hospital by Hospital Programs from the Hospital Insurance Fund amounts to the per diem rate approved for that particular hospital minus the co-insurance charge paid to the hospital by the patient. The patient is responsible (1979) for paying a daily co-insurance charge of $4 for acute-care, $6.50 for extended-care, or $1 for extended-care patients under 19 years of age. The Provincial Government pays the co-insurance charges on behalf of Provincial recipients of Income Assistance from the Ministry of Human Resources.

- A wide range of in-patient and out-patient benefits is provided under the Act.

- Qualified persons who are temporarily absent from British Columbia are entitled to certain benefits during a period which ends at midnight on the last day of the twelfth month following the month of departure.

- In addition to the payments toward operating costs, paid to hospitals as described above, hospitals and regional hospital districts receive grants of up to 60 per cent of approved costs of construction or acquisition of hospital facilities, one-third of the cost of minor movable equipment, 75 per cent of the cost of major diagnostic equipment, and 100 per cent of the cost of equipment which results in proven savings in operating costs.

- Also, the Province may provide additional financial assistance in respect of the approved cost of equipment for facilities which have been designated by the Minister as Provincial referral centres. The grants are made on the basis of 100 per cent of the initial or first purchase and installation cost of equipment, and 75 per cent of the replacements costs of existing equipment, where the Minister classifies it as being of a type required for operating a Provincial referral centre.

HOSPITAL ACT

One of the important functions of Hospital Programs is the administration of the Hospital Act. The Assistant Deputy Minister of Hospital Programs is also the Chief Inspector of Hospitals for British Columbia under the Act.

The Hospital Act controls the organization and operation of hospitals, which are classified as follows:

- Public hospital: Non-profit hospitals caring primarily for acutely ill persons.

- Private hospital: This category includes small hospitals, most of which are operated in remote areas by industrial concerns primarily for their employees, and licensed nursing-homes which are not under hospital insurance coverage.

- Rehabilitation and extended-care hospitals: These non-profit hospitals are primarily for the treatment of persons who require long-term rehabilitative and extended hospital care.

HOSPITAL DISTRICT ACT

The Hospital District Act provides a mechanism for financing the capital cost of hospital buildings and equipment. The Act provides for the division of the province into large districts to enable regional planning, development, and financing of hospital projects under a formula which permits substantial financial assistance from the Provincial Government.

Each regional hospital district is, subject to the requirements of the Act, able to pass capital expense proposal by-laws authorizing debentures to be issued covering the total

cost of one or more hospital projects. Once a capital expense proposal by-law has been approved by the Lieutenant-Governor in Council the district is able to proceed to arrange both temporary financing and long-term financing on a favourable basis. The long-term financing is provided by the Regional Hospital Districts Financing Authority (see below), which purchases debentures issued by the various districts as required.

Each year the Provincial Government pays through Hospital Programs from the Hospital Insurance Fund a portion of the principal and interest payments required on the debentures issued by the Regional Hospital Districts' Financing Authority in accordance with section 22 of the Act. The balance of the principal and interest requirements are raised by the district through taxation.

Under the sharing arrangements the Province pays annually to or on behalf of each district 60 per cent of the approved net cost of amortizing the districts' borrowings for hospital construction projects after deduction of any items which are the districts' responsibility, such as provision of working capital, funds for hospital operation, etc. If a 4-mill tax levy by the district is inadequate to discharge its responsibility in regard to annual charges on old debt for hospital projects as well as the remaining 40 per cent of the charges on new debt resulting from hospital projects, the Province will provide 80 per cent of the funds required in excess of the 4-mill levy.

The affairs of each regional hospital district are managed by a board comprised of the same representatives of the municipalities and unorganized areas who form the board of the regional district (incorporated under the Municipal Act) which has the same boundaries as the regional hospital district.

The board of each regional hospital district is responsible for co-ordinating and evaluating the requests for funds from the hospitals within the district, and for adopting borrowing by-laws subject to approvals and conditions required under the Act, in respect to either single projects or an over-all program for hospital projects in the district.

The purposes of a regional hospital district, as described in section 20 of the Act, are basically to acquire, construct, enlarge, operate and maintain hospitals; to grant aid for these purposes; and to act as an agent of the Province in receiving and disbursing monies granted out of the Hospital Insurance Fund. In order to exercise these powers that board is authorized, with the approval of the Minister, to raise by

taxation an amount not exceeding the greater of $200,000 or the product of one-quarter of a mill on the assessed value of lands and improvements within the district.

HOSPITAL DISTRICT FINANCING ACT

The Hospital District Financing Act establishes an authority to assist in the financing of hospital projects, medical and health facilities, community human resources and health centres, and any other community, regional, or provincial facilities for the social improvement, welfare and benefits of the community or the general public good approved by the Minister of Health.

The financing authority purchases sinking fund debentures issued by regional hospital districts to finance approved hospital construction projects. The financing authority obtains its money by marketing its own debentures. The raising of funds by a Provincial Authority helps ensure a better market and, on average, a lower interest rate.

HOSPITAL BUDGET REVIEW BOARD

The Hospital Budget Review Board, appointed by Order in Council, is responsible for advising the Assistant Deputy Minister in regard to hospitals' operating budgets and rates of payments to hospitals for both in-patient and out-patient benefits.

METHODS OF PAYMENT TO HOSPITALS

A system of firm budgets for hospitals, which, with modifications, has been in use since January 1, 1951, provides for a review of hospitals' estimates by the Board. Under the firm-budget procedure, hospitals are required to operate within the total of their approved budgets, with the exception of fluctuation in days' treatment and other similar items. They are further advised that deficits incurred through expenditures in excess of the approved budget will not be met by the Provincial Government. However, hospitals retain a portion of surplus funds earned as a result of keeping expenditures within the total amount approved.

The value of variable supplies used in patient-care has been established. It is generally recognized that the addition of a few more patient-days does not add proportionately to

costs because certain overhead expenses (such as heating etc.) are not affected. However, some additional supplies will be consumed, and it is the cost of these variable supplies which has been determined.

When the number of days' treatment provided by the hospital differs from the estimated occupancy, the budgets are increased or decreased by the number of days' difference multiplied by the patient-day value of the variable supplies. Individual studies and additional budget adjustments are made in those instances where large fluctuations in occupancy involve increases or reduction in stand-by cost.

Policies to be used in the allocation of the total funds provided are approved by the Government. The Hospital Budget Review Board reviews the detailed revenue and expenditure estimates forwarded by each hospital and applies the policies in establishing approved budgets.

About 96 per cent of all in-patient hospital accounts incurred in British Columbia are the responsibility of Hospital Programs. Cash advances to hospitals are made on a semi-monthly basis, so that hospitals do not have to wait for payment until patients' accounts are submitted and processed by Hospital Programs. The co-insurance charges paid by patients are deductible when calculating payments to hospitals from the division.

Nonqualifying residents are charged the hospitals' established per diem rate, which is all-inclusive; that is, the daily rate covers the cost of all the regular hospital services, such as X-ray, laboratory, operating-room, etc., provided to patients, in addition to bed, board, and nursing care.

Administrative Services Division

The division provides a variety of administrative services to the other divisions of Hospital Programs, and to outside agencies. These services include the following:

ADMINISTRATION

Personnel functions, including payroll, recruitment, promotion and labour relations matters.

Requisitions and vouchers are reviewed for all divisions, including travel expenses and requisitions for supplies and equipment.

All incoming cheques are received and deposited. Handling and distributing all hospital forms, and sorting and distributing mail.

Co-ordinating the preparation of the annual estimates for Hosital Programs.

Preparing and publishing the Hospital Programs Bulletin.

Preparing and distributing information pamphlets for Hospital Programs.

LEGISLATION

The drafting of legislation, regulations, and Orders in Council, related to the various statutes administered by Hospital Programs. In performing these duties the division works closely with the Ministry of the Attorney-General.

Statutes which relate to the Division's activities include:

Hospital Insurance Act;
Hospital Act;
Hospital District Act;
Hospital District Financing Act;
Practical Nurses Act.

SOCIETIES

Hospital Societies -- Providing assistance to hosital societies in connection with the drafting of hospital constitutions and by-laws, and their interpretation and application.

Reviewing hospital by-laws, or amendments to hospital by-laws, prior to their submission for government approval as required under the Hospital Act.

The processing, in collaboration with the Hospital Consultation and Inspection Division, of transfers of private hospital property, and transfers of shares in the capital stock of private hospital corporations.

Co-ordinating the acquisition and disposal of hospital sites and private hospitals.

In conjunction with the Land Title Office, maintaining control over the property of hospitals and private hospitals, to ensure that the property records are suitably endorsed, so that land transfers may not be made until they are approved under the Hospital Act.

Long Term Care Societies -- The Administrative Services Division is also responsible for reviewing society matters and land transactions for long term care societies.

FEDERAL-PROVINCIAL HOSPITAL ARRANGEMENTS

The drafting and processing of the necessary amendments to the Federal-Provincial Agreement and associated matters.

REGIONAL HOSPITAL ARRANGEMENTS

In conjunction with officials of other divisions, other government ministries, and the various regional hospital districts, the division assists in processing capital expense proposals and in arranging for the necessary by-laws and Orders in Council for temporary borrowings and related matters.

ELIGIBILITY

Reviewing applications for benefits made by or on behalf of persons admitted to hospitals.

Maintaining uniform standards of eligibility in all hospitals and providing assistance to hospitals in training admitting staff.

Handling applications to the Health Insurance Supplementary Fund.

THIRD-PARTY LIABILITY

This section is responsible for the review of all hospitalization reports for patients admitted to hospitals with accidental injuries. This also includes the processing and verification of the reimbursement from public liability companies, for hospital expenses paid on behalf of accident victims. During the year ended March 31, 1980, a total of $4,758,938.24 was recovered through this process.

Hospital Finance Division

The Hospital Finance Division is responsible for assembling relevant information and preparing data, for the use of the Hospital Budget Review Committee in its review of the annual and pre-construction operating estimates of hospitals. During this process, estimated revenues and expenditures are examined in detail, and adjustments to estimated amounts are recommended. The gross expenditure approved for public general, rehabilitation, and extended-care hospitals for 1980/81 amounted to approximately $795 million.

The financing of new construction, additions and major alterations and improvements, is also handled by the division. Until 1980, all financing had been provided through the processing of twenty year sinking fund debentures. With rising interest rates, a short term of financing with chartered banks, usually three to five years, was encouraged.

Debentures lodged as security with the British Columbia Financing Authority totalled $530 million as at December 31, 1980.

The annual budgets of the Hospital Districts which determine the mill rate levy for the year, are examined and approved by this division. This levy provided funds for 45.7% of the interest and sinking fund requirements for 1980. The remaining 54.3% is paid by Provincial Government Grants, which exceed $30 million.

The Finance Division is responsible for the approval of equipment grants given to hospitals for purchases of approved major moveable depreciable equipment. During the 1980/81 fiscal year, hospitals received grants in excess of $12,000,000 to assist them in the purchase of equipment which totalled approximately $23,000,000; with the major purchases being in the Radiology, Pathology, Nuclear Medicine, Ultrasound and Biomedical fields.

During the year progress was made to revise and reduce the volume of work involved, by the introduction of a policy allowing hospitals to purchase items or equipment up to a unit value of $750, with certain provisions entailed. A Hospital Equipment Review Committee was created, and the recommendations containing the new procedures and policies were forwarded to the Senior Deputy Minister, who had initiated the Committee.

In order to ensure that plans for new hospitals or hospital additions are prepared with economical and efficient operation in mind, pre-construction operating estimates are completed by hospitals at the final sketch-plan stage. It is essential that the estimated operating costs of the new hospital, or any new addition, compare favourably with other hospitals actually in operation. Where the hospital's pre-construction operating estimates do not indicate a reasonable operating cost, it may be necessary for the hospital board to revise its construction plans to ensure efficient and economical operation. Once a satisfactory pre-construction operating budget has been agreed upon by the hospital officials and Hospital Programs, the hospital board is required to provide written guarantees relative to the projected operating cost. It is considered that this method of approaching the operating picture for proposed hospital facilities ensures more satisfactory planning, efficient use of hospital personnel, and an economical operation.

As a means of assisting hosital staff to maintain and develop health care skills, Hospital Programs provided more than $440,000, included within hospital operating budgets during the year, to enable hospital employees to attend or participate in short-term educational training courses.

The following is a summary of comparative expenditures of Hospital Programs (including capital) for the Calendar years 1976-80 inclusive.

ADMINISTRATION & PAYMENTS TO HOSPITALS, 1976-80

	1976	1977	1978	1979	19
	$	$	$	$	$
Administration	3,556,066	3,619,325	4,253,000	4,640,000	5,06
Grants to hospitals	483,107,890	536,939,951	606,186,000	707,398,000	865,48
Totals	486,663,956	540,559,276	610,439,000	712,038,000	870,54

Another function of the division is the processing of admission/separation records (accounts), which hospitals submit for each patient, and approving for payment all acceptable claims and coding for residential data, etc. Also included are out-patient, day care, and out-of-Province accounts.

FINANCE CLAIMS SECTION

More than 2,200 patient accounts were processed each working day during 1980, as well as more than 3,500 emergency and minor surgery accounts.

The staff of Admission Control reviews each Application for Benefits under the Hospital Insurance Act. Patient accounts are checked to ensure that proper signatures appear on the forms and that sufficient information for verificaton purposes and related matters has been provided. During the year approximately 4,800 claims had to be returned to the hospitals because they were incomplete or unacceptable and more than 2,300 letters were written regarding more involved problems with specific claims.

The In-Patient Claims Section pre-audits the charges made to Hospital Programs and ensures that all information shown on each claim is complete, so that it can be coded for statistical purposes, and charged to the correct agency, such as Hospital Programs, Workers' Compensation, the Department of Veterans Affairs, or other provinces and territories. This section returned more than 3,000 claims for clarification of inforation

during the year and preliminary figures for 1980 show that more than 450,000 accounts (excluding out-of-province) were processed.

The day-care surgical services, day-care/night-care psychiatric services, out-patient psychiatric services, day-care diabetic services, and dietetic counselling accounts again increased in volume during 1980 to more than 18,000 per month. Payments for out-patient physiotherapy patients were also provided and preliminary figures indicate that accounts for more than 490,000 treatments were processed. During the year more than 23,000 renal dialysis treatments were given for out-patient treatments of chronic renal failure. The service continued to provide a quarterly statistical run of day-care surgical services for the hospitals of the Province.

The Out-of-Province Section processes all claims for hospital accounts incurred by British Columbia residents in hospitals outside the Province. This involves establishing eligibility and the payment of the claims. During 1980 approximately 7,000 in-patient accounts, and more than 14,000 out-patient accounts, were processed for payment. On April 1, 1980, day care and emergency and minor surgery out-patient services performed elsewhere in Canada were added as a benefit to B.C. residents.

The Claims Distribution Centre receives, sorts and distributes all the forms, correspondence and documentation for the Hosital Claims Section; approximately 15,000 claims, documents, etc. were handled daily in this section during the year.

Hospital Consultation and Inspection Division

This division provides consulting services to public and private hospitals, and to other areas of the Ministry of Health, in all aspects of hospital organization, operation and management. It is also responsible for an inspectional program to ensure that minimum standards of care, safety and licensure are met.

The services of the division are provided by consultants in hospital administration, biomedical engineering, dietetics, clinical laboratory, laundry and housekeeping, nursing, pharmacy, physiotherapy, social services and X-ray. During the year the consultant in biomedical engineering accepted employment with one of the province's larger hospitals, and the division was without consulting services in this area for the latter part of the year.

The ongoing work of consultation and inspection saw every hospital in the province visited at least once. A total of 360 visits were made to general and extended care hospitals, and 140 to private hospitals.

Division personnel continued to participate actively on advisory and working group committees, at both the federal and provincial levels.

A review of Hospital Programs hospital staffing policy guidelines was started during the year, and an initial draft proposal was near completion by the year end.

Consultation in hospital pharmacy matters commenced in June following the appointment of a new consultant. Thirty-three hospital reviews and on-site visits were accomplished, along with special projects at Valleyview and Riverview Hospitals, for Long Term Care and Mental Health Services. Work was started on standards and guidelines. A task force on pharmacy services to extended care patients was appointed.

In the area of biomedical engineering real progress was achieved through the two-year Lower Fraser Valley project. This project provided a complete biomedical program of combined engineer and technician services to six hospitals. The review and evaluation demonstrated clearly the need for, and value of, the utilization of both engineers and technicians in the programs. The Clinical Engineering Committee, established as a standing committee of the Biomedical Engineering Advisory Council in November of 1979, actively pursued its functions relating to professional standards, clinical engineering

activity, staffing needs and criteria, regulations and other appropriate procedural matters.

Nursing consultants of the division continued their involvement in support of expanded perinatal care, quality assurance programs and patient classification systems, in hospitals throughout the province. Ministry financial assistance was provided to hospitals conducting graduate nurse refresher courses, which allowed some alleviation of the provincial nursing shortage.

The development of a quality assurance program for the Department of Dietetics was commenced during the year, in collaboration with the B.C. Dietetic Association. The planned expansion of large hospital food service facilities prompted increased research into new systems for food production and service. The dietetic department methodology, distributed throughout the province last year, received wide acceptance at a meeting of provincial dietetic consultants.

A physiotherapy consultant was added to the division's staff in August. The initial objective of this consultant is to compile a total perspective on the delivery of physiotherapy service in B.C. hospitals, including staffing, scope of service and local conditions.

During 1980, the division's consultant in social work assisted the B.C. Society of Hospital Social Work Directors in initiating a monthly newsletter called INFORM. This newsletter facilitates the dissemination of pertinent issues in the practice of medical social work, and it was well received in the field. Work still continued on the development of a uniform reporting system for hospital social work services. Revisions were planned for the quality assurance and accountability paper, developed jointly by the consultant and the society, and circulated to hospitals early in the year.

New C.T. whole-body scanners were approved in principle for New Children's Hospital, Vancouver; as a shared unit for Children's/Shaughnessy/Grace Hospitals, and for the new Victoria General Hospital North. Ultrasound services were approved in many more locations, and were extended into suitable hospitals with less than 100 beds, resulting in a general expansion in the scope of service provided by this technology. The concept of including all imaging modalities in new and expanded radiology departments was continued. Greater provision was also being given to the incorporation of dental radiological facilities. In the field of radio-therapy, a new, additional high-energy 20 meV treatment machine was approved for A. Maxwell Evans Clinic, Vancouver, which will be

functional in the new Radio-therapy Department in approximately three years.

Hospital Planning and Construction Division

During 1980, the Planning and Construction Division continued to work closely with hospital boards of management or project building committees, and their consultants, as well as regional hospital districts, to develop programs for new facilities by acquiring, adding to, or renovating existing buildings, including minor building improvements. In advising hospitals, the Division worked towards its objective of providing a service to hospitals to facilitate the development of optimum facilities in the most cost-effective way. This became increasingly difficult as inflation continued to rise at a very high level.

The first step for many of these programs is the development of an overall master plan, based on that hospital's role in relation to the provision of hospital services for that area. In order that planning may progress in an orderly manner, once approval-in-principle has been given by the Minister of Health, the Division has established a number of procedures, which recognize the importance of financial control and ensure the regional hospital district's full involvement in the development of the project. These procedures include financing arrangements, and the assurance that the resulting facility meets National Building Code requirements and can be operated economically. During these planning stages, assistance in reviewing the hospital's functional program and design drawings is given by various professional groups represented in the Hospital Consultation and Medical Consultation Divisions, as well as such organizations as the Laboratory Advisory Council, the Radiological Advisory Council, and the Nuclear Medicine Advisory Council. When these recommended procedures are followed it results in a smooth progression of the project.

The Division is responsible for recommending Ministerial approval of project financing through regional hospital districts, and works with the Administrative Services Division of Hospital Programs so that the capital expense proposal may be finally approved by Order-in-Council. During the year, new acute hospitals were opened on the campus of the University of British Columbia, in Bella Coola and Delta, as well as a new Diagnostic and Treatment Centre at Fraser Lake, and a new regional laundry for the Greater Vancouver Regional Hospital District. Other hospitals completed renovation programs, some

of which provided extended care beds. For details, please see further in this report.

During the year the Planning and Construction Division maintained and fostered a close working relationship with several professional agencies, including the Architectural Institute of B.C., and the Consulting Engineers' Division of the Association of Professional Engineers of B.C. Division staff met monthly throughout the year with representatives of these two professional associations, to discuss many items of common concern on which mutual agreement had been reached. It was felt these meetings greatly improved relations between the members. At year-end discussions continued on a new client/architect agreement, and a basic fee structure which would be satisfactory to all groups. The Division also maintained its good relationship with the B.C. Construction Association and the industry, as well as various trade organizations. Staff members participated regularly in the semi-formal meetings of the Public Construction Council, and together with members of the construction industry, resolved problems, particularly in the tendering process. The publication of the document "Guidelines for Quantity Surveying Services, Tendering Procedures, Insurance and Bonds in Acute and Extended Care Facilities", to which staff members contributed, was of assistance in resolving some of these problems.

Before the end of 1980, "Guidelines for Project Brief Submissions and Facility Programming of Acute Care Facilities in British Columbia" were issued, and work was nearly completed on a revised design and program guideline for Extended Care Units. Design guidelines for surgical suites, radiological, laboratory and physiotherapy departments were also nearing completion. Space programming methodologies for 16 departments were developed, in consultation with the Federal Government and other provinces, and a British Columbian edition will be produced in 1981. The Registered Nurses' Association of British Columbia, the Physiotherapy Association of British Columbia, the British Columbia Health Association, and various advisory groups assisted in the development of several of these documents.

The Division's consultants (engineering) continued to promote energy conservation. Due to a change in the Hospital Insurance Act designed to reduce operating costs, it is possible for Hospital Programs to provide 100% grants for energy conservation projects, if the savings in the cost of energy can be recouped within a period deemed reasonable by the Minister of Health.

Hospital Programs also produced a manual entitled "Management of Energy in Health Care Facilities", which was distributed to all hospitals, in conjunction with a series of very successful two-day seminars held throughout the Province for all hospital maintenance personnel. These workshops were designed to outline the concepts contained in the manual, and provide maintenance staff with a basis for developing their own energy management programs. Following the workshops, the group worked in conjunction with the B.C. Health Association in preparing a basic tape-slide presentation to introduce the techniques of energy management to administrators and hospital board members.

Members of the Division continued to work with the Canadian Standards Association in the production of standards in health care technology. The Division also has representation on the Standing Committee on Fire Safety in Buildings, which is developing a draft of the 1985 issue of the National Fire Code of Canada. A staff member also serves on the Task Group dealing with health care facilities' requirements, in connection with revisions to the National Building Code.

The new *Plumbing Code for British Columbia*, mentioned last year, was completed and the staff member on that committee is also a member of the National Research Council's Standing Committee on Plumbing Services, which is working on aligning the Provincial Code with the plumbing portion of the National Building Code, with emphasis on health and safety.

In May, hospitals were asked to change over to new accounting forms so that the Division could start putting current information on computer, as part of the Capital Budget and Cash Flow Monitoring System (C.B.C.F.M.). It was expected this entire system would be operational by early 1981.

Projects Completed in 1980

Bella Coola General Hospital

On September 20, 1980, Dr. Chapin Key, Deputy Minister of Health, opened a new hospital which replaced an existing facility. The new hospital has a complement of 10 acute beds, 2 extended care beds, and 3 intermediate care beds.

Burnaby General Hospital

A project which made possible the temporary redesignation of 72 acute beds for extended care use, was completed in April, 1980. The total number of extended care beds at the hospital is 219.

St. Joseph's General Hospital, Comox

A services expansion project was completed in June, 1980, and included emergency, laboratory, radiology, central sterilizing, and physiotherapy service.

Delta Centennial Hospital

A new 75-bed acute addition was opened by the Honourable K. Rafe Mair, on September 5, 1980. The first patients were admitted to the facility on September 30, 1980.

Fraser Lake Diagnostic & Treatment Centre

A new diagnostic and treatment centre with 2 overnight stay beds was completed in March, 1980.

Boundary Hospital, Grand Forks

A project involving the expansion of radiology, laboratory, medical records and administration departments, was completed in April, 1980.

Kelowna General Hospital

On May 24, 1980, the first patients were admitted to 50 additional extended care beds that had been left unfinished at the completion of the Cottonwoods project in 1977.

Penticton Regional Hospital

A laboratory expansion project was completed in October, 1980.

Princeton General Hospital

An addition of 6 extended care beds was opened to patients in January, 1980.

Richmond General Hospital Annex

The first patients were admitted to the renovated facility on April 1, 1980. The project provided 20 extended care beds and 16 psychiatric beds.

Tahsis Hospital

Alterations to provide administration, morgue and storage facilities were completed in July, 1980.

Cancer Control Agency of British Columbia, Vancouver

Phase II, the parking structure, was completed in September, 1980.

Tilbury Regional Laundry, Vancouver

A new regional laundry which will serve the needs of the new Children's Hospital, the new Grace Hospital, and Shaughnessy Hospital, was opened on August 15, 1980. The

laundry has a capacity of 15 million pounds of linen per year, with room for expansion to 20 million pounds.

University of British Columbia Health Sciences Centre, Vancouver

A new 240 acute bed hospital, including teaching facilities was opened by the Ministry of Health on May 16, 1980.

Priory Hospital, Victoria

An additional 40 extended care beds, made available by renovations to the House of Peace, were opened to patients on June 9, 1980.

Queen Alexandra Hospital, Victoria

The completion of a previously unfinished area in the first week of June, 1980, provided accommodation for 14 additional paediatric extended care patients.

Projects Under Construction at Year End

Matsqui-Sumas-Abbotsford General Hospital

An expansion project, including an additional 54 acute beds, and enlargement and upgrading of services.

St. Michael's Extended Care Hospital, Burnaby

A new 40-bed extended care unit is being constructed, in conjunction with a 40-bed intermediate care unit.

Campbell River and District General Hospital

Completion of an additional 15 beds in the extended care unit. Only 10 beds will be opened initially.

Chilliwack General Hospital

Fire protection upgrading project. Interim improvements, including the addition of 1 intensive care/coronary care bed.

St. Joseph's Hospital, Comox

Construction of a new 75-bed extended care unit to replace the existing 45-bed unit.

Cranbrook and District Hospital

Phase I, expansion of services including radiology and emergency departments, and administration areas.

Enderby and District Memorial

Addition of a 12-bed extended care unit.

Hudson's Hope

New Diagnostic & Treatment Centre.

Royal Inland Hospital, Kamloops

Stage II addition including a new tower for 90 acute care beds, and service areas. Also operating suite renovations, and expansion of outpatient waiting area.

Kelowna General Hospital

New emergency/outpatient department, and provision of space for ambulatory care.

Langley Memorial Hospital

Additional 50 extended care beds and 25 in "shell".

Maple Ridge Hospital

A new addition of 32 acute beds plus construction of one unfinished floor; new service areas including radiology, laboratory, surgical suite, and central sterilizing facilities.

Nanaimo Regional Hospital

Electro-diagnostic laboratory.

Slocan Community Hospital, New Denver

Replacement of existing facility with a health care centre, including 10 short-term and acute care beds.

Royal Columbian Hospital, New Westminster

Renovations to Sherbrooke Building (old Nurses' Residence) to accommodate a 30-bed psychiatric unit.

Port Hardy Hospital

A new 23 acute bed hospital to replace existing facility. Services being constructed to accommodate further acute and extended care accommodation.

Prince George Regional Hospital

Stage III addition for expansion of services including surgical, obstetrical and radiology suites, central sterilizing and laundry. Stage IV expansion of emergency/medical day care, laboratory, psychiatric inpatient and outpatient services.

Richmond General Hospital

Expansion of acute beds to 229, including 26 paediatric and 30 obstetrical beds, plus one additional patient floor in "shell". Services are being constructed for 300 acute beds.

Shuswap Lake General Hospital, Salmon Arm

Expansion of central supply and operating rooms.

St. Mary's Hospital, Sechelt

A dietary upgrading project.

Children's Hospital/Grace Hospital, Vancouver

New replacement hospitals on Shaughnessy site with 200 paediatric and 122 obstetrical beds, and some service areas to be shared jointly by these two hospitals and Shaughnessy Hospital. The new Children's Hospital will also replace the existing Health Centre for Children at the Vancouver General Hospital.

St. Paul's Hospital, Vancouver

Phase I, replacement of 261 acute beds, and renovations to existing structure and services.

Shaughnessy Hospital, Vancouver

Development of shared services' facilities for Children's/Grace/Shaughnessy Hospitals. Also the construction of a 150-bed extended care unit for Veterans, and interim improvements and Building Code upgrading of existing structures.

Sunny Hill Hospital for Children, Vancouver

An expansion program, including the provision of 45 activation/rehabilitation beds, 30 extended care beds and 30 day care spaces. Also expansion of treatment and service facilities.

Vancouver General Hospital

A new emergency department and coronary care unit; completion of emergency basement to house central sterilizing, morgue, stores, housekeeping; general upgrading of Centennial and Heather Pavilions to meet the requirements of the Building Code.

Royal Jubilee Hospital, Victoria

Short-stay surgical program in three Phases. Phase II includes 6 inpatient beds.

Victoria General Hospital North

New 496 acute bed facility to replace the present Victoria General Hospital.

Project at Tendering Stages at Year End

Trillium Lodge, Parksville

A 55-bed extended care unit, to be built in conjunction with 50 intermediate and personal care beds.

Projects in Advanced Stages of Planning

Dr. Helmcken Memorial Hospital, Clearwater

Addition to, or renovation of, emergency, laboratory, radiology and storage areas.

Overlander Hospital, Kamloops

Addition of 50 extended care beds.

Kimberley and District Hospital

Expansion of emergency, physiotherapy, radiotherapy, laboratory, and provision of space for in-service education.

Lions Gate, North Vancouver

Renovations, final phase of services expansion project.

Surrey Memorial Hospital

Addition of 72 acute beds in the "shelled"-in space of the 5th floor plus minor improvements to services. Addition of 78 extended care beds. Renovations to the former King George Private Hospital for 75 extended care beds.

Vernon Jubilee Hospital

A new extended care unit containing 25 paediatric beds, 38 adult beds, 50 beds for patients with behavioural disorders and 15 beds in "shell" on Dellview site.

Lions Gate Hospital, North Vancouver

Renovations, final phase of services expansion.

Additional Projects Approved and In Various Stages of Planning

Additional and/or Replacement Acute Beds

Alert Bay (10), Duncan (12 psychiatric), Kamloops, Royal Inland (90 additional), Kelowna (45 rehabilitation), Langley (40), Nanaimo (number undetermined), New Westminster, Royal Columbian (340), Penticton (45), Squamish (21), Vancouver, Cancer Control Agency of British Columbia (100), Port Moody (200), Vancouver General (number undetermined), Vernon (73), Victoria - Royal Jubilee (redevelopment).

New Extended Care Facilities

Squamish (8), Vancouver, St. Paul's (50).

Additional and/or Replacement Extended Care Beds

Abbotsford, Matsqui-Sumas-Abbotsford (50), Abbotsford,

Menno (50), Alert Bay (2), Creston (20), Grand Forks (20), Kelowna (100), Maple Ridge (50), Mission (25), Penticton (87), Saanichton (50), Salmon Arm (deferred), Summerland (35), Vancouver - Lions Gate (125), Victoria - Aberdeen (150), White Rock (150).

Expansion and/or Updating of Services

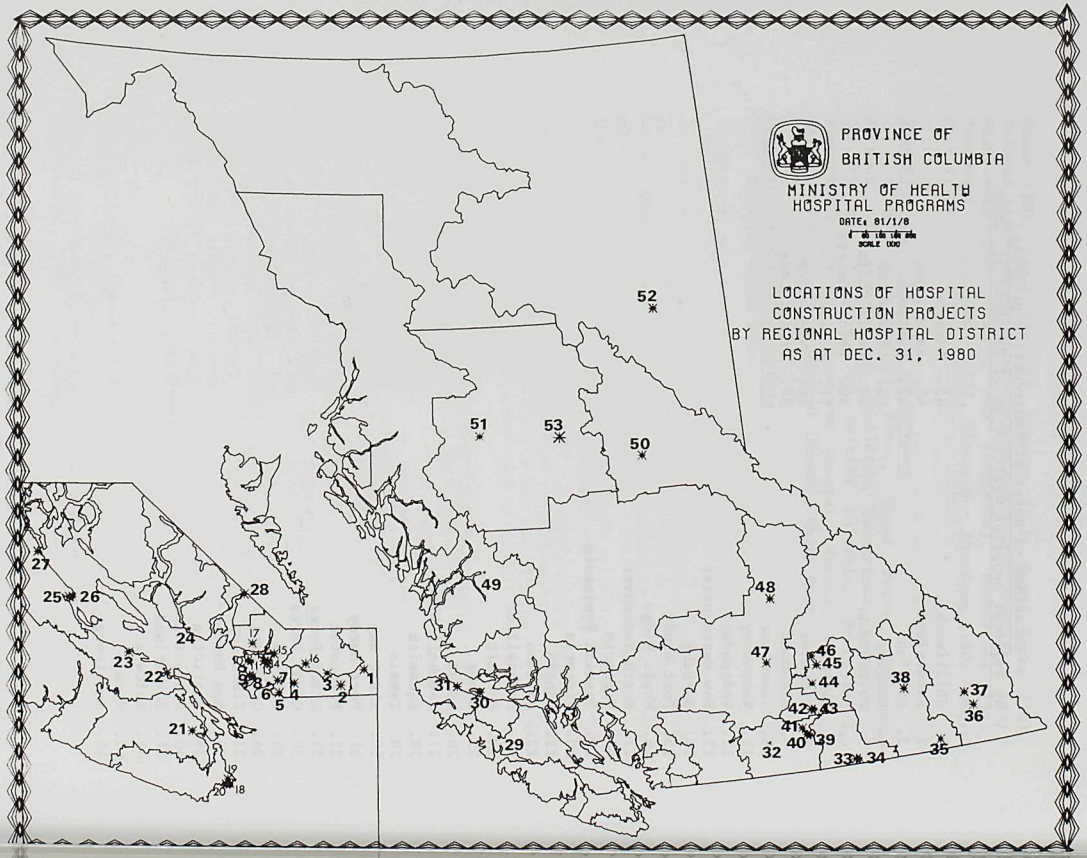
Abbotsford, Campbell River, Grand Forks, Kamloops, Kelowna, Langley, Nanaimo, Penticton, Summerland, Vancouver - Cancer Control Agency of British Columbia, Port Moody, Shaughnessy, Surrey, Vancouver General, Vernon, Victoria - Royal Jubilee, Victoria General (South), White Rock.

Diagnostic & Treatment Centres

Houston, Logan Lake.

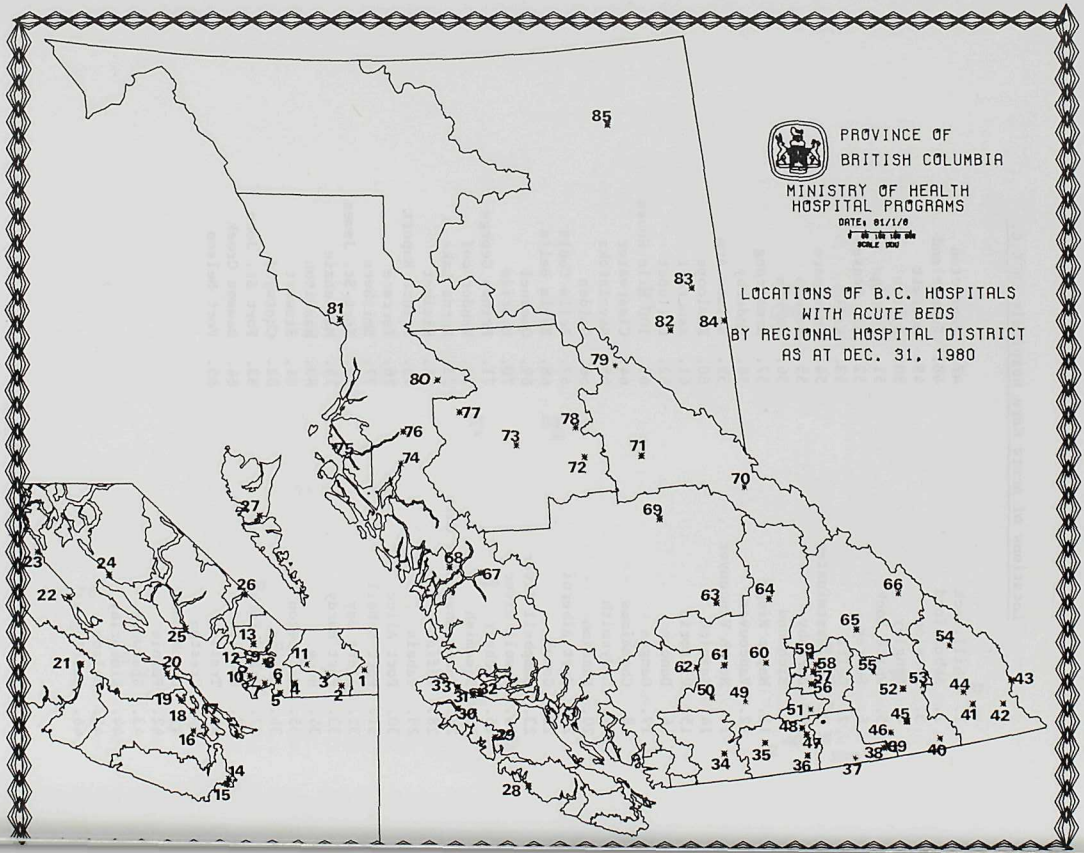
Locations of hospital construction projects
by regional hospital district as of December 31, 1980.

1. Chilliwack
2. Abbotsford
3. Mission
4. Langley
5. White Rock
6. Delta
7. Surrey
8. Richmond
9. Richmond
10. Vancouver
11. Vancouver
12. Vancouver
13. New Westminster
14. Burnaby
15. Port Moody
16. Maple Ridge
17. North Vancouver
18. Victoria
19. Saanich Peninsula
20. Victoria
21. Duncan
22. Nanaimo
23. Parksville
24. Sechelt
25. Comox
26. Comox
27. Campbell River
28. Squamish
29. Tahsis
30. Alert Bay
31. Port Hardy
32. Princeton
33. Grand Forks
34. Grand Forks
35. Creston
36. Cranbrook
37. Kimberley
38. New Denver
39. Penticton
40. Penticton
41. Summerland
42. Kelowna
43. Vernon
44. Armstrong
45. Enderby
46. Salmon Arm
47. Kamloops
48. Clearwater
49. Bella Coola
50. Prince George
51. Houston
52. Hudson Hope
53. Fraser Lake


PROVINCE OF
BRITISH COLUMBIA
MINISTRY OF HEALTH
HOSPITAL PROGRAMS
DATE: 81/1/8
SCALE 1000
LOCATIONS OF HOSPITAL
CONSTRUCTION PROJECTS
BY REGIONAL HOSPITAL DISTRICT
AS AT DEC. 31, 1980

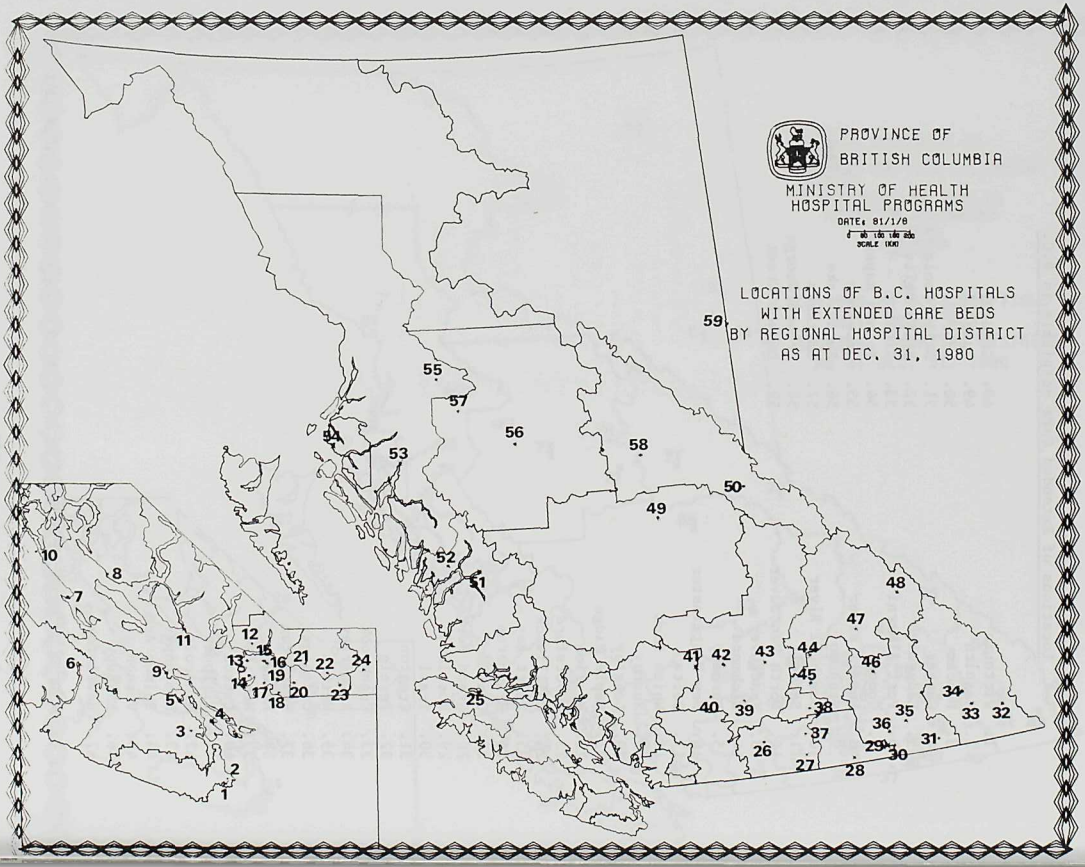
Locations of Acute Care Hospitals in B.C.

1. Chilliwack
2. Abbotsford
3. Mission
4. Langley
5. White Rock
6. Surrey
7. Delta
8. New Westminster
9. Burnaby
10. Richmond
11. Maple Ridge
12. Vancouver
13. North Vancouver
14. Saanich
15. Victoria
16. Duncan
17. Ganges
18. Chemainus
19. Ladysmith
20. Nanaimo
21. Port Alberni
22. Comox
23. Campbell River
24. Powell River
25. Sechelt
26. Squamish
27. Queen Charlotte City
28. Tofino
29. Tahsis
30. Port Alice
31. Port McNeil
32. Alert Bay
33. Port Hardy
34. Hope
35. Princeton
36. Oliver
37. Grand Forks
38. Rossland
39. Trail
40. Creston
41. Cranbrook
42. Fernie
43. Sparwood
44. Kimberley
45. Nelson
46. Castlegar
47. Penticton
48. Summerland
49. Merritt
50. Lytton
51. Kelowna
52. New Denver
53. Kaslo
54. Invermere
55. Nakusp
56. Vernon
57. Armstrong
58. Enderby
59. Salmon Arm
60. Kamloops
61. Ashcroft
62. Lillooet
63. 100 Mile House
64. Clearwater
65. Revelstoke
66. Golden
67. Bella Coola
68. Bella Bella
69. Quesnel
70. McBride
71. Prince George
72. Vanderhoof
73. Burns Lake
74. Kitimat
75. Prince Rupert
76. Terrace
77. Smithers
78. Fort St. James
79. Mackenzie
80. Hazelton
81. Stewart
82. Chetwynd
83. Fort St. John
84. Dawson Creek
85. Fort Nelson


PROVINCE OF
BRITISH COLUMBIA
MINISTRY OF HEALTH
HOSPITAL PROGRAMS
DATE: 81/1/8
LOCATIONS OF B.C. HOSPITALS
WITH ACUTE BEDS
BY REGIONAL HOSPITAL DISTRICT
AS AT DEC. 31, 1980

Locations of Extended Care Hospitals in B.C.

1. Victoria
2. Saanich
3. Duncan
4. Ganges
5. Ladysmith
6. Port Alberni
7. Comox
8. Powell River
9. Nanaimo
10. Campbell River
11. Sechelt
12. North Vancouver
13. Vancouver
14. Richmond
15. Burnaby
16. New Westminster
17. Delta
18. White Rock
19. Surrey
20. Langley
21. Maple Ridge
22. Mission
23. Abbotsford
24. Chilliwack
25. Alert Bay
26. Princeton
27. Oliver
28. Grand Forks
29. Rossland
30. Trail
31. Creston
32. Fernie
33. Cranbrook
34. Kimberley
35. Nelson
36. Castlegar
37. Penticton
38. Kelowna
39. Merritt
40. Lytton
41. Lillooet
42. Ashcroft
43. Kamloops
44. Salmon Arm
45. Vernon
46. Nakusp
47. Revelstoke
48. Golden
49. Quesnel
50. McBride
51. Bella Coola
52. Bella Bella
53. Kitimat
54. Prince Rupert
55. Hazelton
56. Burns Lake
57. Smithers
58. Prince George
59. Dawson Creek


PROVINCE OF
BRITISH COLUMBIA
MINISTRY OF HEALTH
HOSPITAL PROGRAMS
DATE: 81/1/8
SCALE 1:XXX
LOCATIONS OF B.C. HOSPITALS
WITH EXTENDED CARE BEDS
BY REGIONAL HOSPITAL DISTRICT
AS AT DEC. 31, 1980
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Medical Consultation Division

This division provides medical consultation within Hospital Programs, to other Government ministries, to hospitals at all levels of care, and to regional hospital districts. Within Hospital Programs, in addition to medical consultation, the division assists in planning and implementing new services by having representatives in the Planning Group, on the Equipment Committee, on the Functional Program Review Committee and the Hospital Budget Review Committee (formerly known as Rate Board). Development of standards of care; evaluating the effectiveness of present programs, and estimating the probable effectiveness of those proposed is a special interest of this division.

The Medical Consultation Division is responsible for a general auditing of the quality of medical care for hospitals. This function is performed by on-site visits, and by a central review of discharge diagnosis and related information, prevalence statistics, lengths of stay, and patterns of care. The staff includes a physiatrist, as well as occupational therapists and physiotherapists, in order to provide similar functions in the rehabilitative field. Regular visits by the Medical Records Librarian consultants assist hopitals in maintaining a high standard of medical documentation. The auditing process also involves assessment of eligibility for acute care, and other types of care or insured benefit. During 1980, registered nurses within the division audited and medically coded abut 514,000 admission/separation records and day care surgical services records. The coded information is used by the Research Division to produce both the regional and hospital profiles needed for planning and auditing functions.

During the year the division continued to maintain liaison with other health agencies, such as the College of Physicians and Surgeons of British Columbia, the B.C. Medical Association, the B.C. Health Association, and the Faculty of Medicine at U.B.C. Understandably, in a Province with more than 100 hospitals, problems relating to medical staff activities occasionally occur. The Joint Hospitals Committee, with representation from the B.C. Health Association, the College of Physicians and Surgeons, the B.C. Medical Association Hospitals Committee, and this division, made visits to assist hositals in reviewing problem areas. Participation on the Medical Advisory Committee of the B.C. Medical Association, with advisory sub-committees to the Government on many subjects, continued to be very worthwhile. A new sub-committee to study allergy services in the province was struck during 1980.

The Medical Consultation Division has responsibility for both the program and eligibility status of extended care patients. Physiotherapy and occupational therapy consultants continued to make regular visits to extended care units, to carry out these functions and perform a consultative role.

The policy of short term admission of extended care patients continued to be very useful, as more and more units become active in supporting and encouraging relatives who wish to take care of extended care patients in their own homes, but who require an occasional holiday or other relief.

Research Division

The Research Division is responsible for assessing the need for acute and extended care hospital beds and services, and for the provision of a co-ordinated management information service for Hospital Programs. Through the establishment and management of a comprehensive data base, the Research Division assists in meeting Hospital Programs' responsibilities for program and facility planning, medical audit, and expenditure control.

In order to determine the need for facilities, the Division carries out studies both on an individual hospital and a regional basis. These studies involve a comprehensive analysis of hospitalization data, as well as economic and demographic information.

The preparation of recommendations for additional hospital capacity, in the face of an ever-increasing range of benefits and services covered by Hospital Programs, requires close liaison at the hospital, regional and provincial levels. In spite of a greater emphasis being given to alternatives to acute in-patient beds, the population growth of the Province necessitates a continuing review of general hospital bed requirements. Reports and proposals for revised hospital capacity are reviewed by the Hospital Programs' Planning Group and, if approved, are submitted to the Minister. During the course of the year, a number of meetings were held with representatives of regional hospital districts and hospitals, to review their 1981 and 1986 acute care bed requirements.

The Division also compiles statistical data relating to all hospitalization in the Province. The admission/separation records submitted by hospitals for each patient form the basis of this information. All diagnosis and operations are coded according to the Ninth Revision of the International

Classification of Diseases, and the Canadian Classification of Diagnostic, Therapeutic, and Surgical Procedures. Through this classification system, the incidence of disease is analysed by age, sex, and geographical location, as well as other variables.

In connection with morbidity analysis, the Division publishes a number of annual reports. "Statistics of Hospital Cases Discharged" includes the standard morbidity tables consistent with other provinces, affording an opportunity to make interprovincial comparisons of hospital data. "Statistics of Hospitalized Accident Cases", also prepared annually, provides a broad analytical coverage of hospitalized accident cases by circumstance, type of accident, and nature of injury. "Day Care Surgery in British Columbia Hospitals" is prepared by the Division to show the potential and development of this type of service. In addition to these reports, the Division supplied data to many agencies, both inside and outside the Government. The demand for hospital morbidity data continued to grow and has become particularly useful in planning specialized hospital services.

Approved Hospitals

Hospitals as defined under the Hospital Insurance Act designated by Order in Council 2044, 1977, published as B.C. Reg. 233/77.

PUBLIC HOSPITALS (ACUTE CARE)

A. Maxwell Evans Clinic, Vancouver.
Armstrong & Spallumcheen Hospital, Armstrong.
Arrow Lakes Hospital, Nakusp.
Ashcroft and District General Hospital, Ashcroft.
Bella Coola General Hospital, Bella Coola.
Boundary Hospital, Grand Forks.
Bulkley Valley District Hospital, Smithers.
Burnaby General Hospital, Burnaby.
Burns Lake and District Hospital, Burns Lake.
Campbell River & District General Hospital, Campbell River.
Cariboo Memorial Hospital, Williams Lake.
Castlegar and District Hospital, Castlegar.
Chemainus General Hospital, Chemainus.
Chetwynd General Hospital, Chetwynd.
Children's Hospital, Vancouver.
Chilliwack General Hospital, Chilliwack.
Cowichan District Hospital, Duncan.
Cranbrook and District Hospital, Cranbrook.
Creston Valley Hospital, Creston.
Dawson Creek and District Hospital, Dawson Creek.
Dr. Helmcken Memorial Hospital, Clearwater.
Enderby and District Memorial Hospital, Enderby.
Fernie District Hospital, Fernie.
Fort Nelson General Hospital, Fort Nelson.
Fort St. John General Hospital, Fort St. John.
Fraser Canyon Hospital, Hope.
G. R. Baker Memorial Hospital, Quesnel.
Golden and District General Hospital, Golden.
Kelowna General Hospital, Kelowna.
Kimberley and District Hospital, Kimberley.
Kitimat General Hospital, Kitimat.
Kootenay Lake District Hospital, Nelson.
Lady Minto Gulf Islands Hospital, Ganges.
Ladysmith and District General Hospital, Ladysmith.
Langley Memorial Hospital, Langley.
Lillooet District Hospital, Lillooet.
Lions Gate Hospital, North Vancouver.
McBride and District Hospital, McBride.
Mackenzie and District Hospital, Mackenzie.
Maple Ridge Hospital, Maple Ridge.
Mater Misericordiae Hospital, The, Rossland.

Matsqui-Sumas-Abbotsford General Hospital, Abbotsford.
Mills Memorial Hospital, Terrace.
Mission Memorial Hospital, Mission.
Mount Saint Joseph Hospital, Vancouver.
Nanaimo Regional General Hospital, Nanaimo.
Nicola Valley General Hospital, Merritt.
100 Mile District General Hospital, 100 Mile House.
Peace Arch District Hospital, White Rock.
Penticton Regional Hospital, Penticton.
Port Alice Hospital, Port Alice.
Port Hardy Hospital, Port Hardy.
Port McNeill and District Hospital, Port McNeill.
Powell River General Hospital, Powell River.
Prince George Regional Hospital, Prince George.
Prince Rupert Regional Hospital, Prince Rupert.
Princeton General Hospital, Princeton.
Queen Charlotte Islands General Hospital, Queen Charlotte City.
Queen Victoria Hospital, Revelstoke.
Richmond General Hospital, Richmond.
Royal Columbian Hospital, New Westminster.
Royal Inland Hospital, Kamloops.
Royal Jubilee Hospital, Victoria.
R. W. Large Memorial Hospital, Waglisla.
St. Bartholomew's Hospital, Lytton.
St. George's Hospital, Alert Bay.
St. John Hospital, Vanderhoof.
St. Joseph's General Hospital, Comox.
Saint Mary's Hospital, New Westminster.
St. Mary's Hospital, Sechelt.
St. Paul's Hospital, Vancouver.
St. Vincent's Hospital, Vancouver.
Saanich Peninsula Hospital, Saanichton.
Salvation Army Grace Hospital, The, Vancouver.
Shaughnessy Hospital, Vancouver.
Shuswap Lake General Hospital, The, Salmon Arm.
Slocan Community Hospital, New Denver.
South Okanagan General Hospital, Oliver.
Sparwood General Hospital, Sparwood.
Squamish General Hospital, Squamish.
Stewart General Hospital, Stewart.
Stewart Lake Hospital, Fort St. James.
Summerland General Hospital, Summerland.
Surrey Memorial Hospital, Surrey.
Tahsis Hospital, Tahsis.
Tofino General Hospital, Tofino.
Trail Regional Hospital, Trail.
University Health Service Hospital, University of British Columbia, Vancouver.
University of British Columbia Health Sciences Centre Hospital, Vancouver.

Vancouver General Hospital, Vancouver.
Vernon Jubilee Hospital, Vernon.
Victoria General Hospital, Victoria.
Victorian Hospital, Kaslo.
West Coast General Hospital, Port Alberni.
Windermere District Hospital, Invermere.
Wrinch Memorial Hospital, Hazelton.

REHABILITATION HOSPITALS

G. F. Strong Rehabilitation Centre, Vancouver.
The Gorge Road Hospital, Victoria.
Holy Family Hospital, Vancouver.
Pearson Hospital (Poliomyelitis Pavilion), Vancouver.
Queen Alexandra Hospital for Children, Victoria.
Sunny Hill Hospital for Children, Vancouver.

EXTENDED-CARE HOSPITALS

Delta Centennial Hospital, Delta.
Fellburn Hospital, Burnaby.
Juan de Fuca Hospitals, Victoria.
The Louis Brier Hospital, Vancouver.
Menno Hospital, Abbotsford.
Mount St. Francis Hospital, Nelson.
Mount Saint Joseph Hospital (top floor), Vancouver.
Mount St. Mary Hospital (excluding top floor), Victoria.
Overlander Extended Care Hospital, Kamloops.
Pearson Hospital (excluding facilities for tuberculosis patients), Vancouver.
Pouce Coupe Community Hospital, Pouce Coupe
Queen's Park Hospital, New Westminster.
St. Vincent's Arbutus Hospital, Vancouver.

DIAGNOSTIC AND TREATMENT CENTRES

The Arthritis Centre of British Columbia, Vancouver.
Cumberland General Hospital, Cumberland.
Elkford and District Diagnostic and Treatment Centre, Elkford.
Fraser Lake Diagnostic and Treatment Centre, Fraser Lake.
Gold River Health Clinic, Gold River.
Houston Hospital, Houston.
Keremeos Diagnostic and Treatment Centre, Keremeos.
Ocean Falls General Hospital, Ocean Falls.
Pemberton and District Diagnostic and Treatment Centre, Pemberton.

OUTPOST HOSPITALS

Red Cross Outpost Nursing Station, Alexis Creek.
Red Cross Outpost Nursing Station, Atlin.
Red Cross Outpost Nursing Station, Bamfield.
Red Cross Outpost Nursing Station, Blue River.
Red Cross Outpost Nursing Station, Edgewood.
Red Cross Outpost Nursing Station, Kyuquot.

FEDERAL HOSPITALS

Canadian Forces Station Hospital Holberg, San Josef.
Canadian Forces Station Hospital Masset, Masset.

PRIVATE HOSPITALS

Cassiar Asbestos Corporation Private Hospital, Cassiar.
Mica Creek Private Hospital, Mica Creek.

HOSPITAL FACILITIES

Division of Laboratories, Community Health Programs,
Vancouver.
Provincial Drug and Poison Information Centre, Vancouver.
Tilbury Regional Hospital Laundry, Delta.

TABLE I

Patients Separated and Proportion Covered by Hospital Programs, British Columbia Public General Hospitals[1] *Only (Excluding Federal, Private, Extended Care and Out-of-Province Hospitalization), 1975 - 1980/81*

	Total Hospitalized in Public Hospitals			Covered by Hospital Programs		
	Adults and Children	Newborn	Total	Adults and Children	Newborn	Total
Patients Separated–						
1975	415,805	36,538	452,343	398,279	35,700	433,979
1976	408,278	36,117	444,395	390,641	35,292	425,933
1977	406,180	36,980	443,160	386,872	36,119	422,991
1978/79	408,606	37,938	446,544	389,922	37,293	427,215
1979/80[2]	410,648	39,880	450,528	390,513	39,125	429,638
1980/81[3]	410,224	42,036	452,260	390,533	41,279	431,812
Percentage of Total Patients Separated–						
1975	–	–	–	95.8	97.7	95.9
1976	–	–	–	95.7	97.7	95.8
1977	–	–	–	95.2	97.7	95.4
1978/79	–	–	–	95.4	98.3	95.7
1979/80[2]	–	–	–	95.1	98.1	95.4
1980/81[3]	–	–	–	95.2	98.2	95.5

[1] Includes rehabilitation and Long Term Care Statistics.
[2] Amended as per final report received from hospitals.
[3] Estimated, based on hospital reports to September 30, 1980.

TABLE II

Total Patient-days and Proportion Covered by Hospital Programs, British Columbia Public General Hospitals[1] *Only (Excluding Federal, Private, Extended Care and Out-of-Province Hospitalization), 1975 - 1980/81*

	Total Hospitalized in Public Hospitals			Covered by Hospital Programs		
	Adults and Children	New-born	Total	Adults and Children	New-born	Total
Patient Days–						
1975	3,565,532	213,846	3,779,378	3,413,630	207,471	3,621,101
1976	3,488,179	207,316	3,695,495	3,343,172	201,111	3,544,283
1977	3,473,838	208,574	3,682,412	3,337,330	202,751	3,540,081
1978/79	3,565,659	208,969	3,744,659	3,428,709	203,299	3,632,008
1979/80[2]	3,603,701	232,226	3,835,927	3,460,477	225,992	3,686,469
1980/81[3]	3,433,580	231,352	3,664,932	3,299,670	225,800	3,525,470
Percentage of Total Patient Days–						
1975	–	–	–	95.7	97.0	95.8
1976	–	–	–	95.8	97.0	95.9
1977	–	–	–	96.1	97.2	96.1
1978/79	–	–	–	96.2	97.3	96.2
1979/80[2]	–	–	–	96.0	97.3	96.1
1980/81[3]	–	–	–	96.1	97.6	96.2

[1] Includes rehabilitation and Long Term Care Statistics.
[2] Amended as per final report received from hospitals.
[3] Estimated, based on hospital reports to September 30, 1980.

TABLE III

Patients Separated, Total Patient-Days, and Average Length of Stay According to Type and Location of Hospital for Hospital Programs Patients Only, and Days of Care Per 1,000 of Covered Population, 1975 - 1980/81

	Total (Excluding Extended Care)		B.C. Public Hospitals		Other B.C. Hospitals Including Federal and Private		Institutions Outside British Columbia		
	Adults and Children	Newborn	Adults and Children	Newborn	Adults and Children	Newborn	Adults and Children	Newborn	Extended Care Hospitals
Patients Separated–									
1975	406,000	36,059	398,279	35,700	1,425	72	6,296	287	3,022
1976	400,675	35,832	390,641	35,292	475	80	9559	460	3,592
1977	394,727	36,496	386,872	36,119	350	65	7,505	312	4,026
1978/79	397,273	37,636	389,922	37,293	213	31	7,138	312	3,483
1979/80[1]	398,457	39,516	390,513	39,125	256	24	7,688	367	3,553
1980/81[2]	397,148	41,622	390,533	41,279	216	16	6,399	327	3,560
Patient Days–									
1975	3,486,573	209,631	3,413,630	207,471	15,517	336	57,426	1,824	1,357,352
1976	3,424,979	204,156	3,343,172	201,111	1,647	390	80,160	2,655	1,498,797
1977	3,397,729	205,059	3,337,330	202,751	1,615	250	60,784	2,058	1,734,227
1978/79	3,488,887	205,431	3,428,709	203,299	718	130	59,460	2,002	1,841,089
1979/80[1]	3,521,692	228,587	3,460,377	225,992	892	94	60,323	2,501	1,886,567
1980/81[2]	3,352,183	228,375	3,299,670	225,800	510	74	52,003	2,501	1,897,831
Average Days of Stay–									
1975	8.59	5.81	8.57	5.81	10.89	4.67	9.12	6.36	449.16
1976	8.55	5.70	8.56	5.70	3.47	4.88	8.39	5.77	417.26
1977	8.61	5.62	8.63	5.61	4.61	3.85	8.10	6.60	430.76
1978/79	8.78	5.46	8.79	5.45	3.37	4.19	8.33	6.42	528.59
1979/80[1]	8.83	5.78	8.86	5.78	3.48	3.92	7.85	6.81	530,98
1980/81[2]	8.44	5.49	8.45	5.47	2.36	4.63	8.13	7.65	533.09

[1] Amended as per final report from hospitals.

[2] Estimated, based on hospital reports to September 30, 1980. Estimated patient-days (including newborn) per 1,000 of population covered by Hospital Programs: 1975 - 1512; 1976 - 1474; 1977 - 1432; 1978/79 - 1460; 1979/80 - 1459; 1980/81 - 1358; (because the Armed Forces, Royal Canadian Mounted Police and some other groups are not insured under the Provincial Plan, the actual incidence of days would be somewhat higher than shown.) In addition, estimated patient-days per 1,000 population for Extended Care amounted to 555 in 1975, 603 in 1976, 639 in 1977, 728 in 1978/79, 734 in 1979/80, and 720 in 1980/81. Population figures according to latest census figures.

TABLE IV

Summary of the Number of Hospital Programs In-Patients and Out-Patients, 1975 - 1980/81

	Total Adults Children and Newborn In-Patients	Estimated Number of Emergency Minor Surgery Day Care and Out-Patients	Total Receiving Benefits
1975	445,081	1,191,650	1,636,731
1976	440,099	1,228,723	1,668,822
1977	435,249	1,303,679	1,738,928
1978/79	438,392	1,464,799	1,903,191
1979/80 [1]	441,526	1,678,768	2,120,294
1980/81 [2]	442,330	1,839,126	2,281,456

[1] Amended as per final report received from hospitals.
[2] Estimated, based on hospital reports to September 30, 1980.

TABLE V

Summary of Hospital Programs Out-Patient Treatments, by Category 1975 - 1980/81

	1975	1976	1977	1978/79	1979/80	1980/81 [3]
Psychiatry–						
Out-Patient	17,915	22,352	23,974	26,222	24,481	27,378
Day Care	34,219	40,392	46,323	53,725	57,209	63,054
Minor and Emergency	571,055	542,223	575,000	645,634	814,317	945,716
Day Care Surgery	62,019	66,663	76,405	82,979	89,312	92,358
Diabetic Day Care	2,354	3,426	4,126	4,515	4,949	6,378
Physiotherapy	338,583	368,867	387,993	454,697	484,110	491,370
Dietetic Counselling	5,937	10,218	12,942	18,189	22,077	25,170
Renal Dialysis Day Care [1]	–	10,481	18,351	19,717	20,253	22,832
Other [2]	159,568	164,101	158,565	159,121	162,060	164,870
TOTALS	1,191,650	1,228,723	1,303,679	1,464,799	1,678,768	1,839,126

[1] Commenced June 1, 1976.
[2] Other includes (a) Cancer Out-Patients and (b) Rehabilitation Day Care.
[3] Estimated.

TABLE VI

Patients Separated Total Days' Stay and Average Length of Stay in British Columbia Public Hospitals for Hospital Programs Patients Only Grouped According to Bed Capacity, 1980/81[1] (Excluding Extended Care Hospitals).

	BED CAPACITY					
	Total	250 & Over	100 to 249	50 to 99	25 to 49	Under 25
Patients Separated–						
Adults & Children	390,533	204,683	101,019	46,747	27,951	10,133
Newborn	41,279	19,862	9,736	8,233	2,532	916
Patient Days–						
Adults & Children	3,299,670	1,982,704	789,137	313,561	160,712	53,556
Newborn	225,800	119,464	50,178	41,326	10,878	3,954
Average Days' Stay–						
Adults & Children	8.45	9.69	7.81	6.71	5.75	5.29
Newborn	5.47	6.01	5.15	5.02	4.30	4.32

[1] Estimated, based on hospital reports to September 30, 1980.

TABLE VII

Percentage Distribution of Patients Separated and Patient-Days for Hospital Programs Patients Only, in British Columbia Public Hospitals, Grouped According to Bed Capacity, 1980/81 (Excluding (Extended Care Hospitals).

	BED CAPACITY					
	Total	250 & Over	100 to 249	50 to 99	25 to 49	Under 25
	Per Cent	Per Cent	Per Cent	Per Cent	Per Cent	Per Cent
Patients Separated–						
Adults & Children	100.0	52.41	25.87	11.97	7.16	2.59
Newborn	100.0	48.12	23.59	19.94	6.13	2.22
Patient Days–						
Adults & Children	100.0	60.09	23.92	9.50	4.87	4.87
Newborn	100.0	52.91	22.22	18.30	4.82	1.75

[1] Estimated, based on hospital reports to September 30, 1980.

CHARTS

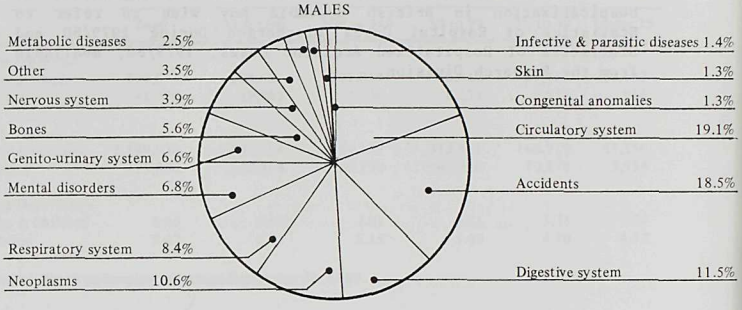
The statistical data shown in the following charts prepared by the Research Division are derived from admission/separation forms submitted to Hospital Programs. Note that the figures given are for fiscal 1979/80.

Readers interested in the more detailed statistics of hospitalization in British Columbia may wish to refer to Statistics of Hospital Cases Discharged During 1979/80 and Statistics of Hospitalized Accident Cases, 1979/80, available from the Research Division.

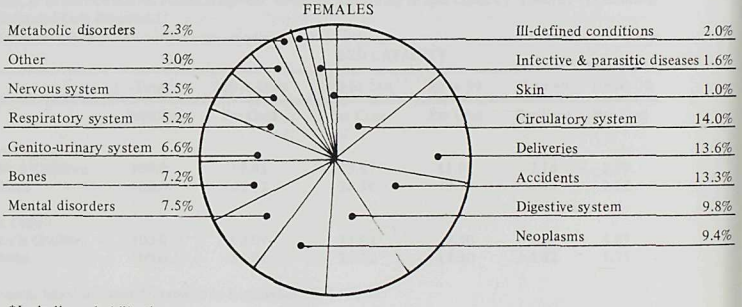
HOSPITAL PROGRAMS

Chart I — Percentage Distribution of Days of Care by Major Diagnostic Groups, Hospital Programs, 1979/80*

MALES

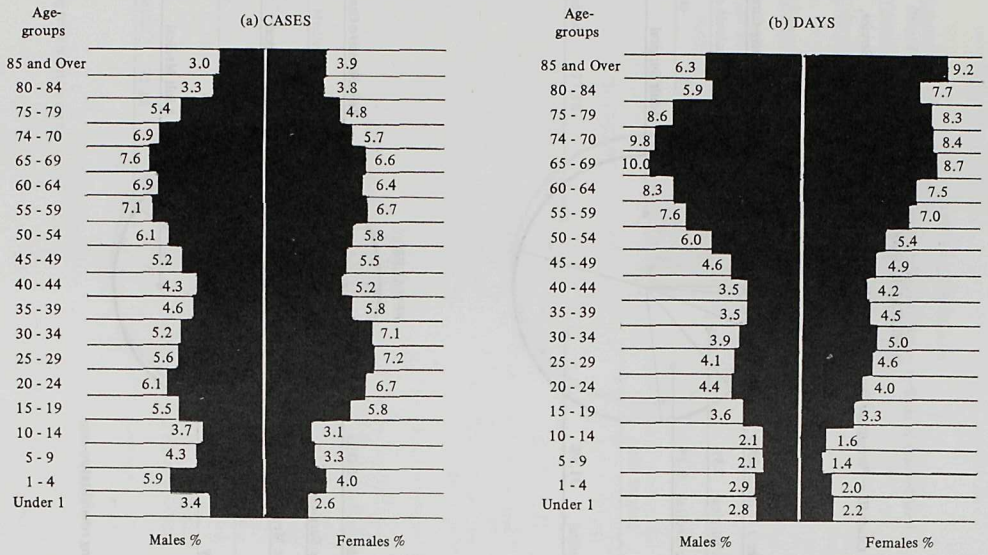


FEMALES



*Including rehabilitative care.

Chart II — Percentage Age Distribution of Male and Female Hospital Cases and Days of Care,† Hospital Programs, 1979/80*

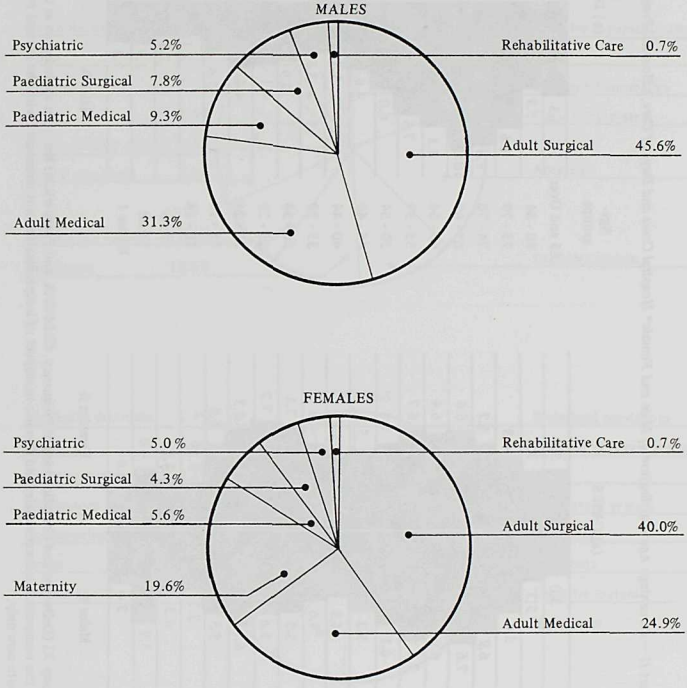


*Group XI (Deliveries and Complications of Pregnancy, Childbirth, and Puerperium) has been excluded so as to bring out more clearly the comparison between males and females in respect of hospitalization not connected with the natural process of childbirth.

† Acute care only.

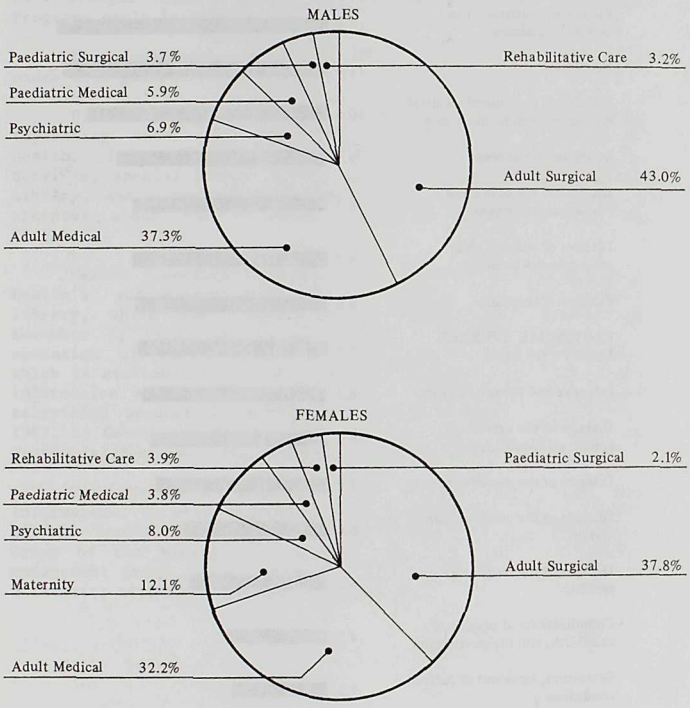
HOSPITAL PROGRAMS

Chart III — Percentage Distribution of Hospital Cases by Type of Clinical Service, Hospital Programs, 1979/80*



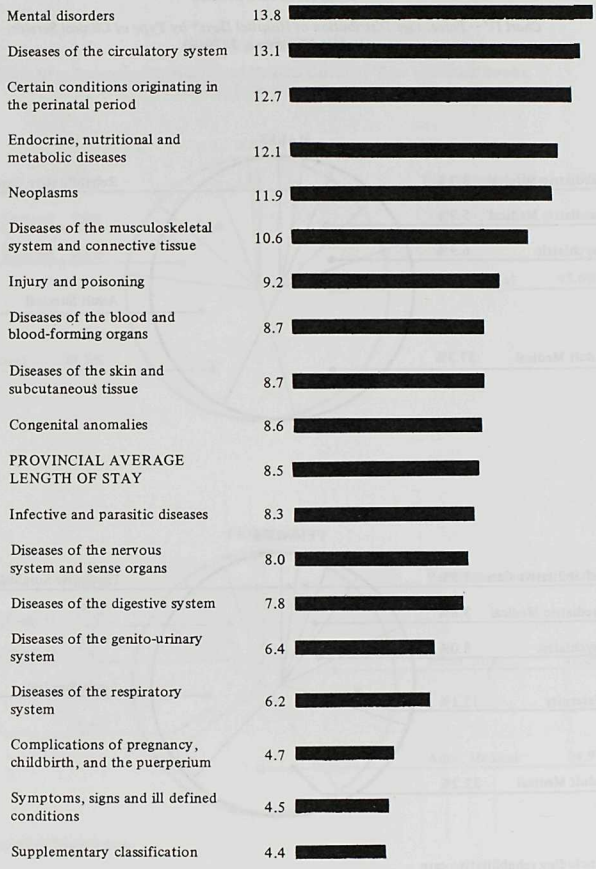
*Including rehabilitative care.

Chart IV — Percentage Distribution of Hospital Days by Type of Clinical Service, Hospital Programs, 1979/80*



*Including rehabilitative care.

Chart V — Average Length of Stay of Cases in Hospitals in British Columbia, by Major Diagnostic Groups in Descending Order, 1979/80 (Excluding Newborns).*



*Including rehabilitative care.

HEALTH PROMOTION AND INFORMATION

Introduction

As part of the Ministry of Health's growing commitment to improving the health of residents of British Columbia, those sections of the Ministry concerned with health education and information and the general improvement of personal lifestyle were brought together under the heading of Health Promotion Programs early in 1979.

The constituent divisions and sections now operating under this general title are:

Division of Nutrition and Division of Health Education (operating under one director), Division of Occupational Health, Information Services, Art Services, Photographic Services, Special Events and Displays, the Ministry of Health Library, and a government funded agency, Action B. C., which operates under the Societies Act with its own board of directors.

Health Promotion Programs also operates the Ministry of Health's audiovisual services (including the audiovisual library, which was transferred to Supply and Services on November 1, 1980) and is responsible for the staffing and operation of the centralized television production centre, which is available to all government departments for videotaped information and education programs. (Responsibility for the television production centre was to be transferred April 1, 1981, to Government Information Programs under the Ministry of Provincial Secretary and Government Services).

The Executive Director of Health Promotion and Information, to whom the above operations report, is a member of the Deputy Minister's advisory committee; the Executive Group of the Ministry of Health; and the Community Health management group, with a view to integrating health promotion activities with all sections of the ministry.

Information Services

Maintaining public awareness of the large social issues confronted by the Ministry of Health was the responsibility of information services staff. The public cannot be expected to use the health system responsibly without greater general awareness of its problems and policies.

During the year, a large volume of printed materials were developed or processed by information services. Included were more than 180 press releases, which is a reflection of both the scope and intensity of this Ministry's activities.

The introduction of the Dental Care Plan, major hospital improvements, and refinements to the Long Term Care Program, all required special publicity and promotion efforts.

Staff with public information skills also regularly consulted health professionals, administrators and others on how local involvement in the Ministry's services might be heightened.

Division of Nutrition and Health Education

HEALTH EDUCATION

The focus of Health Education for 1980 was to increase contact with those not usually involved in health district programs, in order to increase their participation. The health topics of special interest were smoking, prenatal health, school health, and weight reduction. Despite limited resources progressive steps were made.

In order to become more aware of effective processes for initiating and maintaining positive health practices in British Columbia communities, inservice programs on health education skills were made available. A workshop on the effect of cultural norms on health related behaviours was conducted for the health education staff. Workshops were also held on the use of audio-visuals, program planning and evaluation, and group instructional techniques.

Initiatives were made in the area of school health education. A series of study prints and lesson plans for elementary school teachers were developed. A discussion paper on school health education was prepared, outlining the needs, issues, and barriers to progress in developing health education programs for children.

In the North Okanagan Health District a pilot study was designed to stabilize the population of grade 8 non-smokers. The research study, entitled Project Non-Smoker was based upon a Stanford University design and adopted the use of peer leaders from high school to deliver the intervention sessions. The project used a psycho-social approach to the problem, emphasizing the need for students to recognize pressures to smoke, as well as ways in which they could refute the pressure situation verbally. There were 1250 students involved in the initial testing phase, which will be repeated at the end of the 1981 school year, to evaluate the program.

A new "Kick-It" smoking cessation group was initiated by the health educator in the North Okanagan Health District, who assisted in the training of volunteers to run the program. Inservice training was organized for the staff of the health district. In Vernon a seminar on "Effective Communication Skills" and "A Positive Response to Stress" took place, in addition to a workshop for the dental staff on "Creating New Approaches to Teaching Grade Ones".

The Planning of a Health Education Telephone Access

Service was completed in 1980, in the Vernon area. Consumers will soon be able to phone a local number and receive a 4 minute talk on a variety of different health topics.

Local community television productions were undertaken during the year. In Vernon a series entitled "Lifestyle Education" was produced. This included half hour programs on such topics as "Foods That Make You Ill", "The Simplicity of Staying Healthy", and the "Process of Making Lifestyle Changes". In addition, an 8-part series on nutrition was developed, to guide wary consumers through a variety of topics from food additives to vegetarianism.

A number of school initiates were taken, and in Vernon the educator worked with counsellors to establish new approaches to preparing the educational readiness of students to sex education topics. The renewed interest in sex education prompted demands to assist in planning of this important curriculum subject.

Summer students, under the guidance of the education consultant, produced some useful studies. In the North Okanagan area one student surveyed and compiled an interesting booklet of "Elderly Educators". Various organizations in the community were sent a listing of these resource people, and asked to stimulate the involvement of the elderly in their subject area. A second student compiled an analysis of pre-school nutrition, creating a survey-based report useful in assessing the nutrition education needs in this area.

During 1980, Health Education in the Selkirk Health District undertook a variety of programs to encourage utilization of preventive programs offered by the health district, as well as developing self-learning tools on health for isolated communities.

Starting in January and February a weight reduction campaign called the "Flab Fite" was conducted throughout the towns and villages within the Selkirk Health District and West Kootenay Health District boundaries. With support from four local radio stations (CKKC - Nelson, CJAT - Trail, CKGF - Grand Forks and CKQR - Castlegar) a competition was held between towns. Over 700 people registered and reported a loss of nearly a ton of fat during the four weeks. A main educational tool was the Fat Kat Fit Kit, which included lifestyle and promotional materials to aid with home weight reduction.

During the spring, staff from both the Selkirk Health District and West Kootenay Health District designed and produced a Community Health Services Information Package, which

clarified programs, roles, relationships and interactions of health district services with other services in the community.

In May, a grant from the Federal Health Promotion Directorate enabled a staff of three to investigate the home birth phenomena in the Selkirk Health District. An important relationship with the Kootenay Childbirth Counselling Centre was established, which resulted in an interesting and informative study. Perhaps the most important result was the relationship developed by the two groups in information sharing and analysis.

During the summer, staff at Selkirk Health District were involved in the production of a preventive health newspaper, called "Rural Route", which was distributed to all residents living in posted rural routes within the area. Topics included environmental health, nutrition, self care, and child care segments, along with coupons for further materials and current book reviews. Published tri-annually, "Rural Route" will also recreate the Flab Fite in 1981 in more isolated areas, by developing a mail order weight reduction campaign throughout the District based on mail-in requests and mail-out kits. This will aid in overcoming geographical and inclement weather problems, encountered earlier in 1980.

Further to these activities, various inservice workshops were presented to a cross section of area professionals. The main focus was the development of program planning and promotion aspects of rural community development.

Activities continued throughout the year to encourage staff to utilize health education resources for programs. Future plans include the development of a waste water/sewage systems design course, developed in conjunction with the Public Health Inspection Division, to educate homeowners, contractors, real estate and land developers, to properly install adequate disposal systems.

Health education services were made available to the Northern Interior Health District in June of this year. These services took the form of assisting all health unit programs to improve the health education being carried out. In the Northern Interior Health District a special emphasis was placed on the evaluation of health education activities.

Prenatal classes provide an opportunity to influence the smoking behavior of pregnant women. Pregnant women and their partners attending prenatal classes were asked what they knew about smoking and pregnancy, what they had done during their

pregnancy, and what assistance should be offered to prenatal classes for women who smoke. The information will be used in 1981 to develop educational strategies to reduce smoking among pregnant women.

In conjunction with the home care staff, a campaign was organized to promote the Early Maternity Discharge Programme. Materials which emphasized the under-utilization of the programme in Prince George were sent to local general practitioners and their receptionists, hospital nursing staff, and prenatal class teachers. Evaluation indicated this campaign increased public contact with the health district office concerning available home care services.

NUTRITION

In 1980, the Nutrition component of the Division of Nutrition and Health Education continued with the refinement and improvement of current programs. It also undertook to assess or survey selected portions of the population, in order to determine the direction that nutrition should take during the 1980's. Pregnant women and infants continued to be the major risk group receiving nutritional attention. Another group showing a growing need on which to focus was the school-age population, including the adults (parents and teachers) who have direct contact with that group.

Activities directed toward the high risk maternal and infant population included two outreach programs with major nutrition components, which were planned in co-operation with Public Health Nursing, located in Williams Lake and Courtenay. Funded with International Year of the Child money, these two programs established a referral network, nutritional assessment, and nutrition education, to those high risk portions of the population who do not routinely seek out available prenatal health care. The major group contacted in Williams Lake were East Indian women; those contacted in Courtenay included teenagers, Native Indians and women with low income. The results were impressive, with a significant increase in birth weights over the normal average observed for these risk groups. A final report on the project will be available following the birth of the last baby, early in 1981.

Several surveys on infant feeding practices in British Columbia were conducted during the year. Selected communities in the Boundary and Central Fraser Valley Health Districts were surveyed during the summer, to obtain information on the amounts and types of foods offered to infants, as well as the

time of introduction of solid foods. When the results were compared between mothers who attended regular prenatal classes and those who had received no formal prenatal education, a larger precentage of the prenatal class attendees fed their infants in accordance with nutritionally sound infant feeding practices. A comprehensive survey on the practices and attitudes of parents on breast feeding was under way in the North Okanagan Health District at the year end.

A member of the Division participated in the Nutrition Committee of the British Columbia Medical Association to help develop an Infant Nutrition Policy. This policy was accepted at the British Columbia Medical Association Annual General Meeting, and adopted by the Ministry of Health, in December, 1980.

The Division recognizes there is a growing need for establishing a nutrition education component in the school curricula. Many of the field nutrition personnel were active in making overtures in this direction during the year. Several activities included nutrition assessment surveys directed at students' eating habits (Kamloops), breakfast-eating habits of school children (Mission), and foods served in schools (Cranbrook). A breakfast campaign was under way in selected schools in North and South Okanagan, East Kootenay, and Northern Interior Health Districts. The campaign is directed towards elementary schools and focused on K-3 students and teachers. Breakfast kits containing a teacher resource sheet, posters, stickers, and a new publication on nutritious breakfasts were provided to teachers in the selected schools. The initial response was enthusiastic, and a comprehensive evaluation of the project continued.

The Community Nutritionist in the East Kootenay Health District presented a brief on nutrition education and school foods to the Honorable Brian Smith, Minister of Education, at a regional education meeting. Another nutritionist, from South Okanagan, was working on a film promoting the use and sale of nutritious foods in our schools. In addition to these activities, there was a strong nutrition education component in the draft of the School Health Education policy. As a result of these and other similar activities, a growing number of schools were adopting the "Guidelines for Accessory Foods Served in Schools", prepared by the Division.

Additional nutrition support was provided for the Long Term Care system in the province. New Adult Care Regulations were adopted, which included considerable changes to the Food and Nutrition section. These new regulations will assist ministry staff to better ensure a high level of care for all

Long Term Care residents. Field nutrition personnel working primarily in the area of Long Term Care focussed on nutrition workshops for facility operators, as well as continuing to do annual assessments and consultations. The first workshop for Meals-on-Wheels co-ordinators was organized by provincial nutritionists located in the lower mainland, and was presented in the fall. Nutrition was the main topic on the program, which was well attended by co-ordinators from the surrounding area.

During 1980, time was spent developing tools that would result in a more effective use of nutritionists' time. The major item is a computer program for nutrient analysis. Due to the time and money required to perform even the most limited nutrient analyses by hand, a computer program was developed and added to the divisional resources. All nutrition staff received initial training on the operation and use of the program, which has many applications, including assessment of one or more days' diets of high risk groups such as pregnant women or school age children, or assessment of menus or recipes used in care facilities. The program can provide very specific information on diets of select groups, such as vegetarians or infants, and it can provide assessments both on individuals or on groups of individuals. At the year end, the major limitation of full utilization of the program across the province was the lack of computer terminals available to the field nutrition staff.

The second annual food pricing survey, conducted in November, will provide data useful in counselling low income families and establishing monthly food cost guidelines for food budgeting. The data on food costs for individuals of different ages and sex, also has implications for facility operators when establishing their food budgets.

Publications have long been used as tools to augment nutritionists' time. Additional items developed and produced by the division in 1980 include: all the items used in the breakfast campaign; School Nutrition Calendar for 80-81; a pamphlet on vegetarianism and pregnancy; an East Indian Food Guide; the pamphlet, Food for the Trail; Nutrition Guidelines for Refugee Sponsors; and Nutrition Reports: Volume I. Another publication, the "B.C. Diet Manual", underwent a major revision in 1980 and was published in a new format. This manual has been adopted by all major hospitals in British Columbia, and is to be used as the primary diet therapy reference by Ministry staff.

The "Senior Chef" program has a fifth series that will be aired on commercial television beginning in January, 1981. To augment the new series the cookbook was revised and extensive guidelines were developed for use in group teaching situations. The "Senior Chef" program has been aired across Canada and in selected parts of the United States during recent years, and is well accepted by the senior viewing audience.

The very successful Nutrition Aide project, begun in 1979, was continued into 1980. This federally funded program provided training for the aides in a basic nutrition information and educational methodology to non-professionals during a one month session. The eleven aides were then placed in various health district offices under the supervision of a community nutritionist, and effectively augmented the nutrition program. The termination of the project created a gap in the nutrition program.

Publicity for the division was obtained through a number of channels. 1980 saw the third provincially sponsored Nutrition Week in March. Most of the activities carried out during Nutrition Week were aimed at promoting good nutrition, and making people aware of the services and materials available through the Division. Nutrition Week will be going national for the first time in 1981 and, because of experience and past organizational success, B.C. is being called upon to provide leadership at that time.

Nutrition promotion also took the form of a major display outlining nutrition programs in B.C. which was exhibited at two conferences in 1980. As a result, the division was recognized at both a national and an international conference as a leader in the area of promotion and education.

Future directions of the Nutrition component of the division include continued work on the expansion of nutrition education and services into the schools. The division staff will also be actively involved in refining and expanding the use of the nutrient analysis computer program. There is a need to do a comprehensive nutrition survey of the population of B.C., to establish the current nutrition status of select age groups. This information is necessary for detetmination of those people who are nutritionally at risk, and will enable more effective program plans to be made for the future.

SPECIAL EVENTS AND DISPLAYS

1980 saw continued progress and expansion of the Displays Section. Major events included Career Days in Terrace and

Courtenay, as well as Health Fairs in Victoria, Chilliwack and Maple Ridge. Once again the Provincial Ambulance Service presented major displays at Victorias' Jaycee's Fair, the Pacific National Exhibition, the Abbotsford International Air Show, and the British Columbia Summer Games in Kelowna.

Representatives of the Speech and Hearing Division attended the Washington Speech and Hearing Conference held in Spokane, Washington, and mounted an impressive display in the education and institutional division.

The Public Health Nurses were represented at the Canadian Public Health Association Convention in Ottawa, Ontario, and presented a display on perinatal programs available in the Province.

Representatives of the Division of Nutrition attended the Canadian Dietetic Association Conference in London, Ontario, and the Society of Nutrition Education Convention in Montreal, Quebec. In co-operation with the nutritionists, a display was developed for use at these conferences.

On going projects at the year end included providing services for the opening ceremonies for health district offices at Terrace, Prince George, Nanaimo, Vernon and Parksville. New displays constructed during the year included Public Health Nursing, Physiotherapy, Radiation Protection, Speech and Hearing, Perinatal, Victoria Hospice, and six new Ambulance displays which were distributed throughout the province.

During the summer months, Special Events and Displays employed five summer students and transformed the old T.B. Society X-ray tractor-trailer into a Mobile Display Unit. The new year will see this travel throughout the province. Special Events and Displays had 556 display days through the 1980 year, a considerable increase over 1979.

On January 1, 1981, the offices of Special Events and Displays will move to a new location in Victoria, in order to provide additional services.

Library Services

The library enjoyed a very active year, aided by its three summer students, and by an addition to its regular staff.

The project of converting the catalogue from the Dewey Decimal system to the National Library of Medicine system is now complete, with all of the Library's post 1970 titles (about 3,700) on a computer print-out catalogue. These catalogues lend themselves easily to photoduplication or microfiche format, and will soon be distributed to the health districts and other offices. Additionally, the Chilliwack and Nanaimo health districts were brought into this system, with the librarian acting as consultant.

The library published a serials holdings list of its 500 periodical titles and distributed copies to all Ministry of Health offices.

Circulation and other figures include:

- Books ordered.....750
- MEDLINE AND ORBIT literature searches.....216
- Book and report circulation....2,278
- Photocopy service.....1,512
- Interlibrary loans.....652

These figures indicate a very progressive use of published information by Ministry of Health staff.

Division of Occupational Health

The Division of Occupational Health, through a broad variety of programs and a multidisciplinary staff of physicians, nurses, counsellors, radiation specialists and supportive staff, has as its objective the encouragement of a safe and healthy work environment, and the prevention of occupational and non-occupational diseases and injuries. The major goals of the Division are the placement of individual employees in positions compatible with their total health, and insuring that high quality treatment and rehabilitation are obtained. Consultation services on occupational and environmental problems are provided to both government and non-government agencies. Offices are located in Vancouver, Victoria and Kamloops. Major centres such as Prince George, Vernon, Cranbrook, Nelson, Terrace and Nanaimo are visited on a regular basis by physicians, nurses and counsellors.

In 1980 there were seven full-time and one half-time Occupational Health Nurses on staff. Twelve thousand six hundred (12,600) employees were seen. Pre-employment screening, audiology testing, immunizations, tuberculin testing, and indiviudal counselling services were provided. In addition, nursing staff were involved in group seminars for employees as members of a multidisciplinary team of physicians and Employee Development counsellors, covering topics such as the function of occupational health services, the management of stress, and the identification and management of the troubled employee. On an on-going basis, classes were given on body mechanics, cancer detection, non-smoking, cardiopulmonary resuscitation, survival first aid, and preparation for retirement. The nursing staff were in frequent contact with supervisors and personnel officers, regarding the management of employees in need of occupational health services, on a pre-referral and follow-up basis, accounting for approximately 15,000 telephone calls during the year.

The Employee Development Service works very closely with medical and nursing personnel to provide appropriate counselling assistance for government employees and their families affected by marital, family, parental, financial, legal, stress, alcohol or drug problems. This assistance with psycho-social problems as they affect the employee's job is a totally confidential service. The staff of two provides diagnostic counselling and referral to appropriate community resources, for all employees and all ministries throughout the province. During the year over 1,600 such interviews were conducted, an increase of approximately 10 percent over 1979, with a highly significant and gratifying increase in the number of employees who referred themselves, or a member of their

family. An evaluation of the program carried out in the summer indicated that at least 75% of all employees whose job performance had been affected by their personal problems returned to at least a satisfactory work performance, which is both a social and financial benefit to the employer and the employee.

The Employee Development Service provided supervisory and shop steward training seminars in the identification of troubled employees, and their referral to the counsellors. During the year over eight such seminars were presented, for a total of 1,500 supervisors, personnel officers and shop stewards throughout the province. Because stress management is crucial in the prevention of most psycho-social problems, the counsellors began a series of stress management seminars for all government departments. The Director of the program was invited by the Government Employee Relations Bureau, and the B.C. Government Employee's Union, to act as a consultant in the establishment of a greatly expanded and province-wide employee assistance program. It is recognized that the troubled employee is a major concern of both management and union, and his proper management will benefit all concerned.

In 1980, opportunities in fitness and nutrition were provided for employees in Victoria by the Employee Fitness Program. Exercise and nutrition counselling were the core of the program, with a variety of other services such as exercise classes, fitness assessments, individual activity programs, obesity reduction programs, educational workshops and recreational events. There was a notable increase in those attending the programs during the year.

The Division continued to develop a nurses resource kit, which will provide fitness information to public health nurses around the province. A fitness motivation project in the summer of 1980, a follow-up to a similar program in 1979, attempted to determine a change over the previous year. A third project was the October FitFest 80, which resulted in over 3,000 government employees in the Victoria area taking part in physical activities of various forms, an increase of 5% over 1979.

A nutrition profile was developed and sent to approximately 2,900 employees in Victoria. The profile increased awareness of nutrition, as 22% of those circulated requested and received more nutritional information. The Employee Fitness Program continued to reach more and more employees, and there was an increasing demand for similar programs throughout the province.

The Ministry of Health, through its Radiation Protection

Service, was a major participant in the Royal Commission of Inquiry into Uranium Mining. Members of the Radiation Protection Service were present at all the hearings and participated fully in the discussions, and prepared four briefs. Three technical briefs were presented to the Royal Commission: a) Backgroud Radiation, b) The Ministry of Health's Concerns for Worker and Public Health, and c) The Toxicity of Uranium.

Natural radiation sources continued to interest the general public and the Radiation Protection Service during the year. A collection and monitoring program of water sampling was carried out in cooperation with the Ministry of Energy, Mines and Petroleum Resources, and a report was issued in April 1980. Investigations were also conducted into post-glacial uranium deposits, and the uranium content of water in the Okanagan Region. Uranium uptake studies were carried out with the assistance of Simon Fraser University. The radioactivity levels of road beds and home site material were measured and studied, to safeguard the health and safety of workers and the public at large.

Safety surveys of the numerous X-ray units located throughout the province continued to be a major responsibility of the Radiation Protection Service, in order to ensure safety of equipment operators and to keep radiation exposures to the patient as low as is reasonably achievable. The introduction of computerized tomographic units in B.C. hospitals created an additional demand.

The increased use of industrial and domestic microwave ovens, radio-frequency equipment, video-display terminals and lasers has aroused public curiosity regarding possible health hazards and personal safety. This has put an additional burden on the staff of the Service, and numerous radiation safety slide presentations were given throughout the year to interested groups.

Activities of the Radiation Protection Services included:

	1980	1979
Radiation surveys (X-ray, radioisotopes and microwaves)	1462	1419
Consultations and visits	1840	2132
Talks and lectures	60	55
Radioisotope leak tests	510	379
Analyzed water samples	400	419
Air samples	40	75

Planning for the establishment of a computerized health information system continued during the year. When in

operation, this system will be an extremely important activity of the Division of Occupational Health and will provide a much needed epidemiologic capability. It will be possible to provide up-to-date information on employee health and health trends within each government department, and to evaluate associations between employee classifications and adverse health effects. At the end of 1980, in cooperation with the Department of Highways, Transportation and Communications, and the Division of Vital Statistics, the Division of Occupational Health had completed plans for the study of motor-vehicle mechanics who had been employed in the government service from 1960 to 1970. It is anticipated that the Division will become more involved in this type of study in the future.

Action B.C.

When Action B.C. was organized in 1973 it was given the following aims and objectives:

- to develop and foster public awareness of health in its broadest aspects, both preventive and curative;
- to provide a vehicle for two-way communication between the community and government in relation to health matters;
- to provide a vehicle for inter-disciplinary communication between disciplines concerned with the aspects of health;
- to provide to communities and interested groups information and resources concerning health and related matters;
- to provide for such other charitable purposes as may, in the discretion of the directors of the Society, appear to contribute to the promotion, advancement, encouragement or development of a high level of fitness in British Columbia.

These goals have been adhered to closely, with pehaps only the term "curative" being in question.

The original emphasis on physical activity has expanded over the years to include nutrition, smoking cessation, tension awareness and relaxation.

In 1980 the Health Promotion Program for business and industry was refined to include the following items:

- Cardiovascular test
- Flexibility
- Strength
- Skinfold
- Health Hazard Appraisal (computer printout)
- 3-Day Nutrition Analysis (computer printout)

These items have been conducted at the work site and, together with the individual lifestyle counselling, take one-hour of the employee's time. In all cases follow-up testing was recommended for six months, one year after the first visit, with periodic workshops, as requested, on back care, smoking cessation, aquatic exercises, sporting activities, running/jogging, relaxation, and health and fitness for retirement.

Using the three vans donated by Kiwanis, this program has been taken throughout the province at the request of companies and groups. In the new year a computer printout is to be developed to

complement the testing and counselling. This will make use of portable micro computers, which can be taken to the test-site and provide the "instant feedback" important in motivation.

The highlight to the program in 1980 for industry was the 2nd Annual Action B.C. Corporate Cup, held in May at Swangard Stadium in Burnaby. This event brought together 60 teams from local businesses (900 participants), in the spirit of friendly competition, and was videotaped by the Health Ministry Audio-Visual Production Department. The showing of this tape has provided the incentive for other cities and provinces throughout the country to hold similar events of their own. Greater participation is expected at the 1981 Corporate Cup, to be held in May.

The Health Promotion display, developed in co-operation with the Ministry's Special Events and Displays department, toured the province throughout the year, visiting malls, fitness festivals, Community Days, Recreation Centres, and Conferences, etc. This provided a cardiovascular test, a 1-day nutritional analysis or lifestyle appraisal or stress assessment (the last three having printouts on the micro-computer). To set up these displays, co-operation from local Health Units, the Heart Foundation, service clubs, recreation commissions and health professionals was required to help with the extra staffing needed for these popular events.

As in other years, the community program highlights were the Sea Festival and the Pacific National Exhibition, both of which drew huge crowds to the many lifestyle programs Action B.C. offered.

Having a nutritionist on staff enhanced the quality of the nutrition program, and improved liaison with nutritionists throughout the province. The computerized nutrition analysis (1--7 days) underwent extensive revisions and 1981 will see the time of day in which food is consumed playing a role in trying to tackle the problems of no breakfasts and overeating at night. This program was used increasingly by the public and schools in 1980 (approximately 10,000), and Action B.C. continued to try and expand its utilization.

In 1980 two leadership training programs were used by Action B.C.:

- "Butt Out" for teenagers.
- "Target" for adults.

Also, a "Do-It-Yourself" booklet, originally written for the Cassiar Asbestos Co. was reprinted by Action B.C. and widely distributed throughout the province.

Tension Awareness and Relaxation Training workshops were of growing importance in Action B.C.'s programming.

The Action B.C. newsletter, "Optimum", provided a communication link with the public, focussing on commentary and news in the various health and fitness fields.

In all areas of Action B.C.'s involvement it was stressed that the methods are neither diagnostic or clinical, but serve to emphasize the awareness and motivation role, essential in guiding the individual to a healthier lifestyle.

PLANNING AND DEVELOPMENT

Planning and Development Services is responsible for providing leadership and support in the following areas: planning and policy analysis, program development, research and evaluation, management information systems, consultation, manpower planning and educational liaison. In addition, the operation of the Vital Statistics Division is an integral part of Planning and Development Services. A separate report on the Vital Statistics Division's activities during the year follows.

The year 1980 could best be described as being developmental in nature. The Planning and Policy Analysis Division, with Paul Pallan as director, and the Program Development Division, with John Talbot as director, were established. The position of Director of Research and Evaluation was posted and should be filled in early 1981. Considerable progress was made developing a consultation policy for the Ministry, and determining the number and types of consultants that will be located in Planning and Development.

The Management Information Systems unit was reorganized, in order to give line management more direct control over the regular operation of their EDP systems. Responsibility for the planning, development and the integration of the information systems was allocated to Planning and Development Services, where the management information systems group was assigned responsibility for developing a health planning and development data base and computer based modelling.

Planning and Development Services directed, co-ordinated, or was extensively involved in the following projects during 1980:

- Hospital Role Study - Phase I of this study was discussed at regional B.C. Health Association meetings throughout the province for comments, feedback and suggestions. All comments had been received by August and the process of revising Phase I was started.

- Provincial Handicap Study - This inter-ministerial (Health, Human Resources and Education) review of the services to severely handicapped children and adolescents was carried out and a report will be presented in January, 1981.

- Workshops and educational activities - Planning and Development Services organized and sponsored a major

seminar on program evaluation for senior managers in the Ministry of Health, in early spring.
In addition, workshops were presented throughout the year on planning, objective-setting, program development, budgeting, and related subjects.

- Objective setting - Planning and Development Services was actively involved in other aspects related to objective setting within the Ministry. This included providing assistance to divisons in developing objectives, the ranking and priorizing of objectives and in integrating the objective setting process with the budgetary process of the Ministry. A document entitled "Setting Objectives: A Manager's Guide" was produced to assist Ministry staff in developing sound objectives.

- Provincial Rehabilitation Study - This study, aimed at reviewing the rehabilitation services within B.C., began in 1980. Initial organization and terms of reference were developed and a consultant, Dr. Joyce MacKinnon, was appointed to conduct the major review.

Planning and Development was also involved in the following projects or studies:

- Two Hospice Projects (Vancouver, Victoria).
- Position papers on consultation services within the Ministry, alternative health care systems, interns and residents.
- Review of health care boundaries.
- Development of a "Data Handbook" for the Ministry of Health.
- Review of vision care services on the Queen Charlotte Islands.
- Development of geo-coding units for Ministry of Health data collection.
- Development and monitoring of assessment and treatment centres.
- Review of the objectives and operational procedures of the B.C. Health Care Foundation.

A number of changes were made in the representation on the Health Manpower Working Group (H.M.W.G.), which reflected more emphasis on policy orientation. The research unit of the H.M.W.G., located in the University of B.C., was engaged in the following projects on behalf of the Ministry:

- 'Difficult-to-Fill' Monitoring.
- Post Basic Nursing Study.
- Rehabilitation Personnel (PT/OT).

- Physician's directory and GMSS (General Manpower Stock Simulator).
- Ultrasound technicians.
- Health record personnel.

In order to better define and clarify the roles and responsibilities of Planning and Development Services, a document describing these roles and responsibilities was prepared at the end of 1980 and circulated to senior managers within the Ministry.

Vital Statistics

The Division of Vital Statistics administers the Vital Statistics Act, the Name Act, the Marriage Act, and the Wills Act, Part II, and provides a centralized statistical service to various community health programs within the Ministry, and to certain other health agencies.

REGISTRATION SERVICES

Although registration services constitute the major part of the Division's responsibilities, they are not detailed in this report. An outline of these activities, together with extensive statistical data, is presented in the statutory Annual Report of the Division of Vital Statistics.

A substantial part of the Division's responsibilities is connected with the administration of the Vital Statistics Act, which governs the registration of births, stillbirths, marriages, deaths, adoptions and divorces, as well as the issuance of documentation from the registrations on file, in accordance with the conditions laid down in the act. The total number of registrations accepted and certificates issued under this Act continued to rise steadily in 1980.

Under the Marriage Act, the Division registers ministers and clergymen of recognized religious denominations for purposes of the solemnization of marriage in this Province, and administers the issuance of marriage licences in accordance with the prescribed requirements of the Marriage Act, as well as the solemnization of marriages by civil contract throughout the Province.

Under the provisions of the Name Act several thousand residents of the Province changed their given names or surnames, and the names of their children. The recent steady increase in numbers of applications under this Act continued during 1980.

The Registry of Wills Notices is maintained under the provisions of Part II of the Wills Act, whereby a testator may file with this division a notice indicating the existence of a will and its location, and information therefrom may be released after decease of the testator. The number of wills notices filed maintained its steady increase in 1980.

Table 6 shows the number of registrations of vital events, and the number of certificates and other forms of documentation issued under the acts administered by this division, for the years 1979 and 1980.

BIOSTATISTICAL SERVICES

Research offices in Victoria and the Health Surveillance Registry in Vancouver, under the supervision of the assistant director, provided a wide range of statistical information as well as extensive collaborative and independent research. Recipients of these services included divisions within Planning and Development Services, sectors of Community Health Services, other sectors of the provincial and federal governments, universities and hospitals, and members of the general public.

In 1980, the research and data processing sections were relocated adjacent to other Ministry research and data processing services. This required a change of technology from IBM card machines to Mohawk key-on-tape methods. Data control functions of the division were also integrated with Ministry data control functions in the Victoria offices. These moves and changes necessitated considerable adjustment regarding communication and function but did not delay the Division's essential services to the public.

This was the first year annual runs were accomplished on the Honeywell computer following the 1979 conversion of the 35 divisional information systems by B.C.S.C. from the IBM to the Honeywell mainframe computer. Special maintenance and extra study was required among the more complicated systems (e.g. the legal registers and the Health Surveillance Registry), but, except in the case of the community care system, service was not disturbed to any appreciable extent despite the conversion.

The Health Surveillance Registry office in Vancouver received approximately 15,500 reports of cases in 1980. Fifty-six percent of these were reports on new cases of birth and genetic defects, the remainder being follow-up reporting on cases which were already on file. A major task, the conversion of the medical codes on particular cases from the eighth to the ninth revision of the International Classification of Diseases, was completed during this year and a paper was published in Medical Informatics concerning the methodology inherent in converting such a large historical file. The Registry office in Vancouver was moved by the B.C. Building Corporation from the Public Health building to 660 West Seventh Avenue. A report for year-end statistics for 1978 for the Registry was published and distributed.

The Cancer Register, a longtime responsibility of the Division of Vital Statistics, was transferred to the Cancer Control Agency of B.C. as of April 1, 1980. A statistical report of cancer in B.C. for 1977 was produced and distributed to interested clinicians and agencies.

The Health Surveillance Registry provided information in a number of areas, including statistics on the prevalence of mental retardation, data on rubella syndrome, foetal alcohol syndrome, as well as on a variety of genetic conditions including Huntington's Chorea and Down's syndrome. It provided prevalence statistics regarding the full range of disabilities for particular parts of the province for concerned agencies, both within and beyond the confines of the Ministry. A sample from some 35 subjects on which the Registry was called upon to contribute follows: provincial handicapped study, Usher's syndrome, multiple sclerosis, arthritis, diabetes, cerebral palsy, musculoram deformans, an amniocentesis register, X-linked mental retardation, pyloric stenosis, neural tube defects, retinitis pigmentosa, frequency of the coincidence of visual and hearing impairment, etc. The growing interest in monitoring and surveillance of birth defects, and also of chronic and handicapping diseases, continued, with requests for information from 15 other geographical locations. This was a reflection of the wider recognition that the Registry has achieved beyond the province. UNICEF, an agency of the United Nations, made one of these inquiries.

The staff of the research office in Victoria fulfilled a heavy demand for perinatal and mortality information, based on information that is provided to the divison by the registration of vital events. They offered consultation services in the areas of the feasibility of particular research problems, as well as in the design and planning of particular studies being attempted by health officers, health educators, nutritionists, and others, including those in the Division of Occupational Health. They assisted in the improvement of research applications, as well as in the correction and improvement of other Ministry and government files, through the provision of regular lists and statistics pertaining to vital files. They performed a study to assess the appropriateness of Table Producing Language (TPL), a computer "package" which can be used by research officers to analyze and create tabulations of vital events.

Reports and tabulations were regularly provided to Statistics Canada, the Drug and Poison Information Centre, medical health officers on the status of communicable diseases, public health inspection, public health nursing, Home Care, the

G.F. Strong Centre, and Community Care. The office maintains a rheumatic fever prophylaxis register for use by private physicians through the local health district office.

Individual research Officers gave service to the Inter-Ministerial Children's Committee, the health record Administration project, and to the Task Force on Geocoding and Geographic Boundaries.

The Victoria office maintained files on some 97,000 individuals who have had tuberculosis or who are at high risk of getting this disease. Indexes and an annual statistical report were produced, as well as information relevant to a number of research questions, such as the association of tuberculosis to the condition of silicosis.

The research section contributed to the Perinatal Program of B.C. through an executive member on the continuing advisory sub-committee. Concerns in 1980 included the high rate of caesarian section, Sudden Infant Death Syndrome, teenage pregnancy, low birth-weight babies, and perinatal mortality. The prevention of stillbirths was the subject of two articles published in the B.C. Medical Journal. A new revision of the Physician's Notice of Birth was introduced on January 1, 1980, and the data provided on this form is used to assess the validity of information which is being provided on abortion, and on the stimulation of respiration immediately after birth. A standard package of perinatal records to be used by physicians throughout the province was devised and was under development at the year end.

Three studies concerning water quality reached completion in 1980. One of these studies monitored the effects of treatment facilities on the bacteriological content affecting the water in the Columbia-Kootenay Rivers in the Trail-Nelson area over a period of 12 months. A second study of the bacteriological content of water at the major bathing beaches in the Okanagan Basin was done in collaboration with the Okanagan Basin Implementation Board. The report identified sources of contamination and other problems that diminish the quality of the bathing beaches. A third study concerning the water in Christina Lake was completed in response to local concern over the effects of growth and development around the lake. This study, done in collaboration with the Ministry of Environment, and the Regional District of Kootenay Boundary, analyzed the bacteriological, chemical and biological aspects of the water and additionally obtained information on sewage disposal practices, aquatic plant infection, and residency patterns.

A great deal of assistance was given to Dental Health Services in the execution of a province-wide children's dental health survey. Ten thousand children were sampled from 12 different areas and detailed dental charts were created for each child. Data was analyzed and a comprehensive report was being prepared at the year end.

An evaluation of the Kelowna Coronary Exercise Group produced neutral or positive answers to the questions asked of this study. The final report of this study of the effects of a defined exercise program upon cardiac patients was under consideration in December. A previous program evaluation concerned with parenting roles was presented to the Canadian Psychological Association.

Monthly and annual reports were compiled and presented to the Divison of Venereal Disease Control.

The Research Office responded to a diverse number of requests and inquires for vital and population data from the general public.

TABLE I - REGISTRATIONS, CERTIFICATES, AND OTHER DOCUMENTS PROCESSED BY DIVISION OF VITAL STATISTICS, 1979 AND 1980

egistration accepted under Vital Statistics Act --	1979	19801
Birth registrations	39,077	39,860
Death registrations	19,282	20,510
Marriage registrations	22,136	23,960
Stillbirth registrations	312	320
Adoption orders	1,610[2]	2,220
Divorce orders	8,283[2]	8,580
Delayed registrations of birth	320	260
egistrations of wills notices accepted under Wills Act	50,854	53,750
Total registrations accepted	141,874	149,460
egitimations of birth effected under Vital Statistics Act	289	270
lterations of given names effected under Vital Statistics Act	372	350
ıange of name applications granted under Change of Name Act	3,827	3,900
aterials issued by the Central Office --		
Birth certificates	102,437	146,330
Death certificates	8,859	8,370
Marriage certificates	12,189	10,560
Baptismal certificates	13	13
Change of name certificates	3,419	3,440
Divorce certificates	298	240
Photographic copies	13,876	14,750
Wills notice certification	12,374	13,050
Total items issued	153,465	196,753
onrevenue searches for Government ministries by the Central Office	10,976	28,210[3]
otal revenue	$660,396	$940,222

1. Preliminary (excepting Wills Notices Registrations).

2. Preliminary.

3. Commencing in 1980, includes free searches relating to church marriage registers, numbering about 14,300 in 1980.

MEDICAL SERVICES COMMISSION

On July 1, 1968, the Government established the Medical Services Plan of British Columbia, which is administered and operated in accordance with the Medical Services Act and regulations, under the supervision of the Medical Services Commission. The Commission is empowered to function as the public authority, appointed by the Government of the Province, to be responsible to the Minister in respect of the administration and operation of the plan established under the regulations.

The Medical Services Plan of British Columbia provides prepaid medical coverage upon uniform terms and conditions for all residents of the Province and their dependents. Insured services under the plan are paid for insured persons regardless of age, state of health, or financial circumstances, provided the premiums fixed by the Commission are paid. Payment for the services provided is made, on a fee-for-service basis, according to a tariff of fees approved or prescribed by the Commission, or on a salaried, sessional, or contract basis at levels approved by the Commission.

Medical Services Commission Highlights

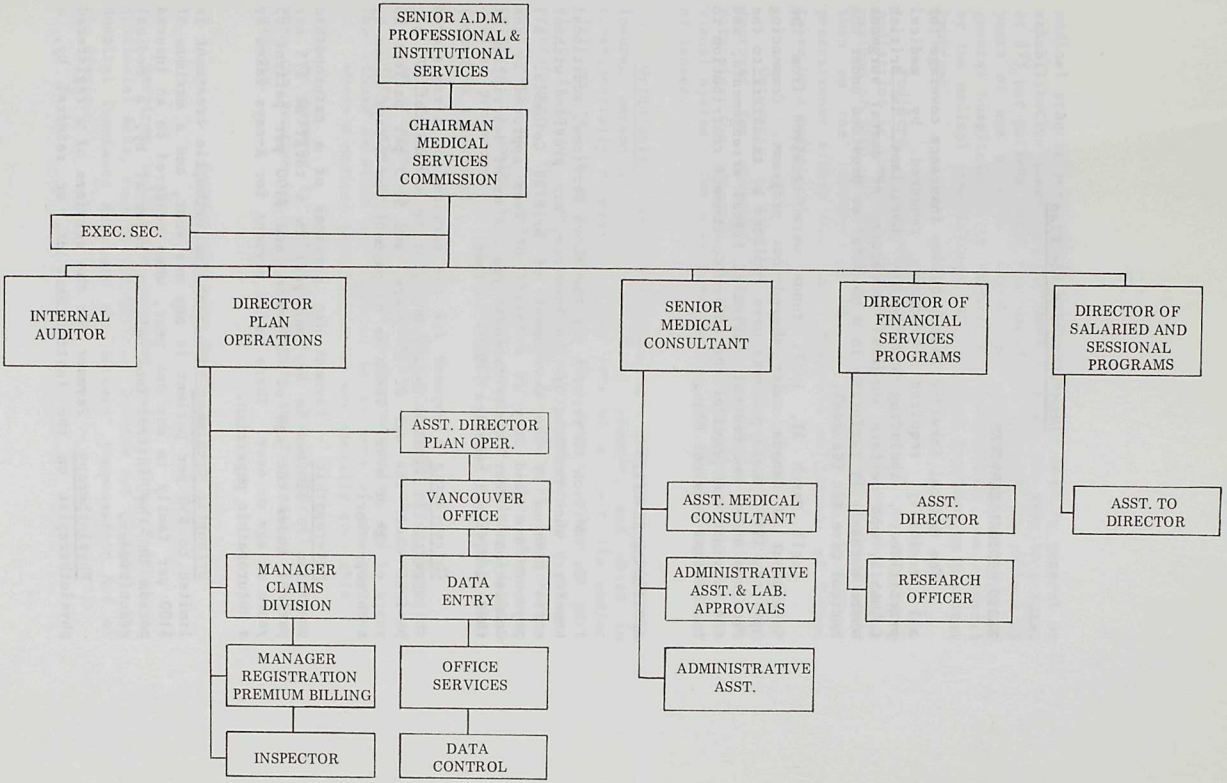
... During the year the Commission continued to provide a high quality of service to residents of the Province, with emphasis on prompt payment of practitioners, and improved relations with the public and health professions.

... The taxable income ceiling for premium assistance was raised during the year from $1,720 to $1,770.

... The total expenditure for insured benefits under the Medical Services Plan rose 14.11 percent to $431,471,022 in 1979/80, from $378,130,607 in 1978/79.

... The increased costs to the Medical Services Plan were a result of upward revisions to the fee schedule, increased utilization of benefits, changes in the practitioner/population ratio, and increased population.

General overview of the reporting lines for the Medical Services Plan and the Medical Services Commission



Benefits Under the Plan

BASIC MEDICAL SERVICES

The Medical Services Plan provides insurance coverage for all medically required services rendered by medical practitioners, including osteopathic physicians, in British Columbia, and certain surgical procedures of dental surgeons where necessarily performed in a hospital as provided under the Medical Care Act (Canada).

Until March 31, 1977, funds were received from the Government of Canada under shared-cost programs. Commencing April 1, 1977, these programs were replaced by transfers to the Province under new Federal-Provincial fiscal arrangements, and the Province now provides the entire Government contribution to the Medical Services Plan.

ADDITIONAL BENEFITS

In addition to payment for the above services, additional benefits, when rendered in the Province, are provided without extra premium by the Government of British Columbia. All payments are paid only at a tariff of fees approved by the Commission. "Year" means calendar year. A brief description of these additional benefits (1979) follows:

Chiropractic - Payment for the services of a registered chiropractor is limited in any one year to a total of $75 per patient under the age of 65 years, and $100 per patient 65 years of age or over. There is no payment for X-rays taken by a chiropractor.

Naturopathic - Payment for services of a naturopathic physician is limited in any one year to a total of $75 per patient under the age of 65 years, and $100 per patient 65 years of age or over. There is no payment for X-rays taken by a naturopathic physician.

Orthoptic treatment - Payment for orthoptic treatment is limited to $50 per patient in any one year, and a maximum of $100 per family in any one year, when rendered to an insured person on the instructions of, or referral by, a medical practitioner.

Physiotherapy - Payment for the services of a registered physiotherapist on the instructions of, or referral by, a

medical practitioner, where performed other than in general or rehabilitative hospitals, is limited in any one year to a total or $75 per patient under the age of 65, and $100 per patient 65 years of age or over. Out-patient physiotherapy services in general hospitals or in rehabilitative hospitals, on referral by the medical practitioner, are benefits provided by Hospital Programs.

Podiatry - Payment for services of a registered podiatrist is limited to $50 per patient in any one year, and a maximum of $100 per family in any one year, when rendered other than on the instructions of, or referral by, a medical practitioner within the year. There is no payment of X-rays taken by a podiatrist.

Optometry - Services of registered optometrists are approved for required diagnostic optometric services, to determine the presence of any observed abnormality in the visual system. The plan does not pay for the fitting or cost of lenses.

Orthodontic - Service provided by a dental surgeon for an insured person 20 years of age or younger, and which is consequentially necessary in the case of a cleft lip and/or cleft palate, is paid only where that service arises as part of, or following, plastic surgery repair performed by a medical practitioner. There is no payment for dentures, appliances, prostheses, or for general dental services, other than those referred to under basic medical services involving certain medical procedures of dental surgeons, where necessarily performed in a hospital.

The extended role services of a registered nurse where:

(a) an arrangement for the rendering and for the payment of these services is approved by the commission, and

(b) these services are rendered in an area of the province where a medical practitioner is not normally available.

No payment is made for any of the additional benefits when the service is performed outside the Province of British Columbia.

Services Excluded Under the Plan

Services which are provided under other Federal or Provincial Acts, such as the National Defence Act (Canada), the Hospital Insurance Act, and the Workers' Compensation Act of the Province.

Pathology, radiology, and/or electrodiagnostic services, performed within the Province at a laboratory that, at the time the service is rendered, is not an approved laboratory for the performance of the service.

Services which are not considered to be medically required by the patient, e.g., cosmetic services, examinations at the request of a third party, medico-legal services, advice by telephone, travel charge of a practitioner.

While unexpected medical services arising when an insured person is temporarily absent from British Columbia are covered at British Columbia rates, prior authorization in writing from the senior medical consultant of the plan is required where the insured person elects to seek medical attention outside the Province. Otherwise payment may not be made under the plan.

Premium Rates and Assistance

For those persons having maintained a permanent residence in British Columbia for the 12 consecutive months immediately prior to making application, and who otherwise qualify as eligible under the Medical Services Act regulations, premium assistance is available as follows:

(a) Applicants who had a taxable income (combined taxable income of subscriber and spouse) for the immediately preceding taxation year, not in excess of a specified amount determined each year, qualify for a subsidy of 90 per cent of the full premium rate. (This amount was $1,770 for the 1979 tax year.)

Monthly premiums payable by subscribers, effective July 1, 1979, are as follows:

	If Qualified for -	
	Full Premium $	90 per cent Subsidy $
One person.....	7.50	0.75
Family of two.....	15.00	1.50
Family of three or more.....	18.75	1.87

(b) Temporary premium assistance is available for a three-month period under unusual circumstances which, by reason of illness, disability, unemployment, or financial

hardship, render an eligible person unable to pay his currently required premium for coverage under the plan. Temporary premium assistance is at 90 per cent of the full premium rate.

Laboratory Approval

A six-member Advisory Board on Laboratories, appointed by the Commission, continued to provide advice and recommendations to the Commission with regard to its determination of approval of laboratories for the performance of insured services, under the regulations set down by the Lieutenant-Governor in Council in September, 1971. The Commission is responsible for ensuring the reasonable availability of quality laboratory services for insured persons throughout the Province, for controlling the expansion of facilities or provision of new facilities until there is reasonable utilization of existing facilities, and for requiring that, where approved public facilities provide service of equal quality and availability, priority consideration be given to the services provided by such approved public facilities.

Professional Review Committees

As in the past, the Commission continued to work closely with the peer review committees of physicians and other practitioners providing services under the plan.

The Commission provides data to the professional licensing authorities, or other relevant practitioner bodies, with respect to the volume and type of services rendered under the plan, and various other statistical information on an annual basis. The commission also provides various statistical information to them on a request basis.

Salaried and Sessional

While most medical services in British Columbia are paid for on a fee-for-service basis, there is, nevertheless, a substantial volume of services paid on a salary or sessional fee basis.

Apart from the Provincial Government, which employs physicians in this way, there are many other organizations within the Province which make arrangements with physicians to

provide insured services on this basis, and arrange with the Medical Services Commission for reimbursement of their costs.

When the Medical Services Commission reimburses an organization which employs a doctor performing insured services on a salaried basis, a payment is made to the organization for the shareable portion of the doctor's salary; that is, the proportion of the approved salary which represents the time he spend on providing insured services to individuals. An additional amount is paid to cover the relevant overhead costs of the organization employing the doctor.

A sessional fee is a payment of a set amount of money for the part-time services of a physician for half a day (three and one-half hours), and the sessional fee includes, where pertinent, a payment for overhead to compensate the physician for continuing overhead costs in his or her additional private practice.

In the year 1979/80 the total expenditure on insured services by the Medical Services Commission was $431,471,022, of which $408,270,633 was in the form of fee-for-service payments, and $23,200,389 for salary and sessional payments.

Statistical Highlights

... The total expenditure for insured services under the Medical Services Plan for the 1979/80 fiscal year was $431,471,022, up $53,340,415, or 14.11 percent, from the prior year.

... A similar increase was reflected in the per capita costs for insured services, which rose from $149.53 in 1978/79 to $167.93 in 1979/80, an increase of 12.3 percent.

... Administration costs at $19,883,088, representing 4.41 percent of total plan costs for 1979/80, showed little change from the previous year.

... Since all statistical tables related to claims payments for the two years were compiled on a cash basis, the data is not truly comparable.

SUBSCRIBER STATISTICS

TABLE I - Registrations and Persons Covered[1] by Premium Subsidy Level at March 31, 1980.

Subsidy (Per Cent)	Subscribers	Persons
90	271,221	424,120
50	---	---
Nil	932,099	2,169,582
Total	1,203,320	2,593,702

TABLE II - Persons Covered by Age-group at March 31, 1980.

Age-Group	Persons
Under 1	33,324
1 - 4	148,532
5 - 14	400,417
15 - 24	460,947
25 - 44	759,737
45 - 64	508,210
65 - 69	99,830
70 - 79	119,990
80 - 89	46,962
90 and over	9,820
Unknown	5,933
Total	2,593,702

1. Coverage data do not include members of the Canadian Armed Forces, RCMP and inmates of Federal penitentiaries.

TABLE III- COVERAGE BY FAMILY SIZE AT MARCH 31, 1980

Family Size (Persons)	Number of Families
1	542,324
2	290,412
3	134,358
4	149,317
5	61,439
6	18,628
7	4,644
8	1,477
9 or more	721
Total	1,203,320

MEDICAL SERVICES COMMISSION
FEE-FOR-SERVICE PAYMENTS
MEDICAL PRACTITIONERS AND DENTAL SURGERY IN HOSPITAL

BLE IV - Distribution of Fee-For-Service Payments for Medical Services (Shareable)

SPECIALTY	AMOUNT PAID(1)		PERCENTAGE OF TOTAL		COST PER PERSON (2)	
	1978/79	1979/80	1978/79	1979/80	1978/79	1979/80
	$	$			$	$
neral Practice	140,155,866	158,141,797	42.47	41.77	55.4239	61.5505
rmatology	3,812,576	4,298,941	1.16	1.14	1.5077	1.6732
urology	2,580,532	3,043,580	0.78	0.80	1.0205	1.1846
ychiatry	9,407,347	10,328,785	2.85	2.73	3.7201	4.0201
uropsychiatry	273,477	304,089	0.08	0.08	.1081	.1184
stetrics and Gynaecology	11,816,717	13,513,293	3.58	3.57	4.6728	5.2595
hthalmology	12,213,994	13,933,539	3.70	3.68	4.8299	5.4231
olaryngology	5,505,183	6,242,783	1.67	1.65	2.1770	2.4298
e, Ear, Nose, Throat	33,075	147,775	0.01	0.04	.0131	,0575
neral Surgery	19,085,898	21,353,556	5.78	5.64	7.5474	8.3110
urosurgery	1,708,942	2,028,378	0.52	0.54	.6758	.7895
thopaedic Surgery	8,747,494	10,267,676	2.65	2.71	3.4591	3.9963
astic Surgery	2,364,869	2,821,731	0.72	0.75	.9352	1.0983
oracic Surgery	1,971,525	2,404,774	0.60	0.64	.7796	.9360
ology	5,106,208	5,724,521	1.55	1.51	2.0192	2.2280
diatrics	6,939,687	7,687,211	2.10	2.03	2.7443	2.9919
ternal Medicine	21,539,981	25,440,626	6.53	6.72	8.5179	9.9018
diology	24,222,560	27,760,750	7.34	7.33	9.5787	10.8048
thology	30,312,532	37,725,287	9.18	9.96	11.9869	14.6831
esthesiology	12,641,778	14,722,177	3.83	3.89	4.9991	5.7300
ysical Medicine	450,160	545,440	0.14	0.14	.1780	.2123
blic Health	93,033	99,686	0.03	0.03	.0368	.0388
crobiology	---	15,575	0.00	0.00	.0000	.0061
ital Surgery In Hospital	1,342,282	1,467,182	0.41	0.39	.5308	.5710
teopathy	316,588	259,830	0.10	0.07	.1252	.1011
clear Medicine	540,887	684,686	0.16	0.18	.2139	.2665
classified	6,822,768	7,595,621	2.06	2.01	2.6980	2.9563
TOTAL	330,005,959	378,559,289	100.00	100.00	130.4990	147.3395

1 Includes only those payments which have been made during the respective fiscal periods.

2 Based on insured population as at October 1, as derived from Statistics Canada Data (October 1, 1978 = 2,528,800; October 1, 1979 = 2,569,300).

TABLE V - DISTRIBUTION OF MEDICAL FEE-FOR-SERVICE PAYMENTS AND SERVICES, BY TYPE OF SERVI

Type of Service	Number of Services		Amount Paid	
	1978/79	1979/80	1978/79	1979
			$	$
General Practitioners				
Complete examination	1,012,441	1,078,055	22,879,223	26,21
Partial examination	5,525,403	5,902,427	61,583,091	70,79
Subsequent office visit	1,705,156	1,675,979	11,114,876	11,37
Night, Sunday, holiday, or emergency visit	569,289	604,699	14,578,519	16,28
First house visit	117,823	119,771	2,295,510	2,49
Subsequent house visit	46,772	46,655	714,542	76
Hospital visit	1,459,770	1,513,018	9,415,535	10,64
Subtotals	10,481,654	10,940,604	122,581,296	138,56
Specialists				
Consultation	918,500	981,533	37,107,785	42,94
House visit	9,989	12,598	379,597	50
Office visit	489,264	509,275	4,585,093	5,16
Hospital visit	608,049	671,237	5,874,640	6,96
Subtotals	2,025,802	2,174,643	47,947,115	55,56
Other Medical				
Anaesthesia	2,086,612	2,173,584	15,520,742	17,78
Obstetrics	56,002	59,459	9,093,187	10,46
Surgery	466,236	490,450	40,578,248	45,41
Special procedures	743,536	801,200	13,417,304	15,71
X-ray	1,181,870	1,199,295	22,314,634	24,32
Laboratory	7,572,020	8,359,432	36,986,381	45,13
Common office procedures	1,192,658	1,229,612	7,805,471	8,92
Psychotherapy	198,582	207,926	7,250,994	8,14
Electrodiagnosis	45,870	64,978	2,279,461	3,51
Pulmonary function	25,664	32,788	309,788	40
Miscellaneous	15,803	17,071	3,921,338	4,51
Subtotals	13,584,853	14,635,795	159,477,548	184,41
TOTALS	26,092,309	27,751,042	330,005,959	378,51

ADDITIONAL BENEFITS

FEE-FOR-SERVICE PAYMENTS

TABLE VI - Distribution of Fee-For-Service Payments for Insured Services, Additional Benefits

y of Service	Amount Paid (1) (2)		Percentage of Total		Cost Per Person (3)	
	1978/79 $	1979/80 $	1978/79	1979/80	1978/79 $	1979/80 $
pial Nursing	2,060	710	0.01	.00	0.0008	0.0003
iorian Order of Nursing. . .	2,274	322	0.01	.00	0.0009	0.0001
eCross	14,636	4,242	0.07	.02	0.0058	0.0017
ropractic.	8,924,459	9,970,672	43.46	42.91	3.5291	3.8806
ropathic.	407,686	430,704	1.98	1.85	0.1612	0.1676
hiotherapy (Office).	3,985,386	4,770,381	19.41	20.53	1.5760	1.8566
hiotherapy (Hospital). . . .	---	---	---	---	---	---
optic	3,295	1,926	0.02	.01	0.0013	0.0008
atry.	2,155,797	2,497,322	10.50	10.75	0.8525	0.9720
hetric.	4,916,627	5,420,004	23.95	23.33	1.9442	2.1095
odontic	110,470	134,133	0.54	.58	0.0437	0.0522
assified.	9,520	4,392	0.05	.02	0.0038	0.0018
Totals	20,532,210	23,234,808	100.00	100.00	8.1193	9.0432

(1) Includes only those payments which have been made during the respective fiscal periods.

(2) These amounts are fee-for-service payments made under the plan only, and in no way reflect the total for the services of these practitioners.

(3) Based on insured population as at October 1, as derived from Statistics Canada Data (1978 = 2,528,800; 1979 = 2,569,300).

TABLE VII - Summary of Expenditures, 1969/70 to 1979/80.

	Medical Fee-For-Service $	Salaried and Sessional $	Additional Benefits $	Administration $	Total $
1969/70	105,700,011	3,677,387	6,929,779	5,687,035	121,994,212
1970/71	122,818,267	4,375,798	6,611,815	6,030,059	139,835,939
1971/72	127,000,505	4,788,365	5,534,520	6,567,847	143,891,237
1972/73	139,532,341	6,022,920	7,897,244	7,320,137	160,772,642
1973/74	159,614,356	7,991,062	8,963,080	8,581,794	185,150,292
1974/75	190,452,494	10,424,602	11,089,892	12,501,015	224,468,003
1975/76	250,026,093	15,437,520	15,045,516	12,659,521	293,168,650
1976/77	268,496,749	14,880,410	17,090,707	13,040,063	313,507,929
1977/78	298,900,495	17,749,957	17,436,161	13,207,188	347,293,801
1978/79	337,513,465	19,484,932	21,132,210	16,856,376	394,986,983
1979/80	384,735,825	23,200,389	23,534,808	19,883,088	451,354,110

Whereas preceding statistical tables are prepared on a cash basis, the above summary is compiled on an accrual basis.

CHART I - COVERAGE BY AGE-GROUP AT MARCH 31, 1980

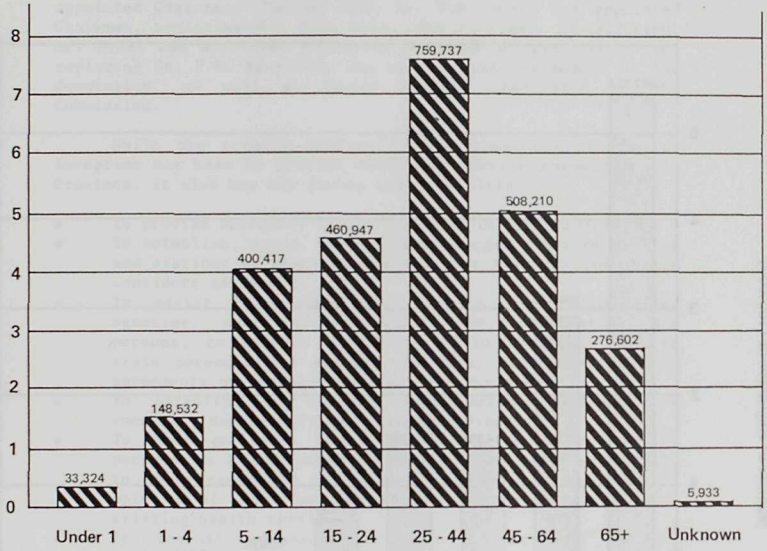
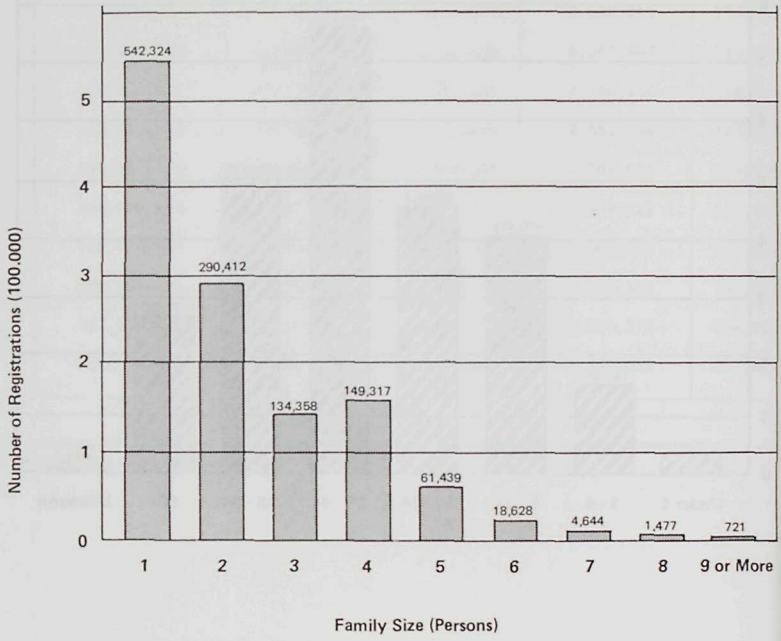


CHART II - COVERAGE BY FAMILY SIZE AT MARCH 31, 1980

Number of Registrations (100,000)
Family Size (Persons)



EMERGENCY HEALTH SERVICES COMMISSION

On July 1, 1974 the Emergency Health Services Commission was established under the Emergency Health Services Act, Chapter 30, Statutes of British Columbia, 1974. With the consolidation of Provincial statutes in 1979 the name of the Act was changed to Health Emergency Act, Chapter 162, R.S.B.C. 1979. The Commission comprises five members, one of whom is appointed Chairman. During 1980, Mr. P.M. Breel was appointed Chairman, replacing Mr. D.H. Weir, who retired. In addition, Mr. Breel was appointed Executive Director of the Commission, replacing Dr. P.M. Ransford, who was appointed a member of the Commission, as well as Senior Medical Specialist to the Commission.

While the primary concern of the Commission since its inception has been to provide ambulance service throughout the Province, it also has the powers and authorities:

- To provide emergency health services in the Province;
- To establish, equip, and operate emergency health centres and stations in areas of the Province that the Commission considers advisable;
- To assist hospitals, other health institutions and agencies, municipalities and other organizatons and persons, to provide emergency health services, and to train personnel to provide services, and to enter into agreements or arrangements for that purpose;
- To establish or improve communications systems for emergency health services in the Province;
- To make available the services of medically trained persons on a continuous, continual, or temporary basis, to those residents of the Province who are not, in the opinion of the Commission, adequately serviced with existing health services;
- To recruit, examine, train, register and license emergency medical assistants;
- To perform any other function related to emergency health services as the Lieutenant-Governor in Council may order.

During the year the Commission assumed responsibility for the medical aspects of disaster planning, as well as responsibility for the maintenance, inspection, replacement and storage of Federal emergency medical supplies which are stockpiled in various locations around the Province. To meet these added responsibilities a nurse consultant, a specialist in public health planning, and a storesman were employed to assist the director in establishing long range disaster plan programs as they relate to health.

In 1980 two full-time crew members were posted to Dawson Creek, where the service had been totally operated by the Dawson Creek Fire Department; a second full-time crew member to 100 Mile house and Fernie; and one full-time crew member to each of the following: Houston, Cumberland, Tofino, Enderby, Osoyoos, Creston and Fraser Lake. New stations operated by part-time personnel were opened at Bridge River (Shalalth), Whistler and Willis Point. Twenty crew members were also added to the Greater Vancouver and Victoria areas.

The Vehicle Modification Depot in Victoria produced fifty-one standard ambulances and four 4-wheel drive units, enabling the Commission to retire some of the older, high mileage units from service.

Mechanical inspectors were placed in Prince George and Cranbrook, to provide regular inspection and establish better maintenance programmes for the ambulance fleets operating in the Northern and Kootenay zones.

All aspects of training ambulance crews, both full-time and part-time, were "subcontracted" to the Justice Institute of British Columbia in September. Commission instructors now operate out of the Justice Institute in Vancouver. Two Emergency Medical Assistant I and II courses were held at the new location, with sixty candidates graduating. During the year additional crews graduated from the Advanced Life Support program, enabling the Commission to expand this specialized service to the public with the result that there are now four Advanced Life Support teams operating on a 24-hour basis in the Lower Mainland area; two 24-hour crews in Victoria; one 24-hour crew in Kamloops, and one Advanced Life Support team member available on a 24-hour basis in Chilliwack.

In 1980 the air ambulance service was extensively used for the movement of patients, involving 3,432 flights and 3,577 patients--an increase of 30 per cent over the previous year.

Road ambulance call volume also increased with appoximately 201,000 patients being carried--an increase of 10 percent over 1979.

Adequate station accommodation for crews and ambulances continued to present problems to the Commission. However, during the latter part of the year additional funds were made available to alleviate this situation, and progress was made toward improving accommodation at several locations. In addition, ten prefabricated garages were constructed at the Vehicle Modification Depot, designed to allow the Commission to provide temporary cover for ambulances. Three 10-by-28 foot

office trailers were acquired and are being modified into self contained ambulance stations for placement in those locations where permanent accommodation is currently not available.

FORENSIC PSYCHIATRIC SERVICES COMMISSION

The Forensic Psychiatric Services Commission operates two out-patient clinics, located in Vancouver and Victoria, and the Forensic Psychiatric Institute, a 130 bed secure hospital situated on Crown land within the District of Coquitlam. All of the Commission's services to the courts and mentally disordered persons emanate from these three components.

During 1980, the Vancouver and Victoria Clinics provided assessment and treatment of persons charged/convicted of offenses, upon receipt of a court order. Travelling clinics to Duncan, Nanaimo, Courtenay, Campbell River, Port Alberni, Prince George and Kamloops were maintained on a weekly to monthly basis as required.

The numbers of court referrals to both clinics showed a slight increase over 1979. Persons conditionally discharged from the Forensic Psychiatric Institute were supervised closely by both clinics, with the Vancouver Forensic Psychiatric Clinic providing follow-up for the majority. The on-going problem of not having Commission supervised transition rehabilitation settings, coupled with a lack of appropriate and adequate community housing, added to the adjustment and integration problems facing those patients whose hospitalization period was lengthy.

The number of remand admissions to the Institute, for psychiatric assessment of fitness to stand trial, continued to increase during the year. However, the number of persons admitted by the courts as unfit to stand trial decreased. Numbers of persons admitted to hospital, because of a court finding of not guilty by reason of insanity, remained stable.

In 1980 there was a marked increase in legal challenges relating to commitment and treatment of mentally disordered offenders. The Supreme Court of British Columbia ruled that persons serving sentences in correctional centres, who became certifiably mentally ill under the Mental Health Act, could be transferred from a prison to a mental health facility only by Lieutenant Governor's Order as per Section 25 of that Act. Neither British Columbia's Mental Health legislation, nor the Criminal Code of Canada, provide authority to treat persons admitted under this particular section who are also too ill to provide informed consent. The Commission therefore, faced the dilemma of having statutory responsibility to provide treatment, without any statute which authorizes other persons to consent on behalf of a patient.

The Commission recognized the problems confronting personnel of the justice system dealing with individuals whose behaviour causes concern about their mental condition, and the telephone consultation service was increased to 24 hours, seven days a week to help meet this need.

Education and research activities expanded and became more refined in 1980. In-service and inter-agency educational programmes were further developed, without adding to the staff. An educational committee consisting of representatives of the Commission, Federal and Provincial Corrections, was formed under the chairmanship of the Commission's Co-ordinator of Forensic Education. This committee organized monthly workshops for staff in forensic facilities in the Lower Mainland. The demanding nature of forensic psychiatric work was reflected in the number of direct care staff enrolled in advanced training programmes. Twenty-five percent of the Services' professional staff were participating in advanced post-basic courses, most of which required heavy commitments of off-duty time. Partial or total financial assistance was approved in all these instances. Commission staff continued to lecture regularly at the Justice Institute, Douglas College, the British Columbia Institute of Technology, and the University of British Columbia.

During the year work continued on the joint research project with Simon Fraser University's Criminology Research Centre on fitness to stand trial, and funding was received from the Federal Department of Justice and the Solicitor General of Canada. The University of Toronto, through its affiliation with Metropolitan Toronto Forensic Services (METFORS) and the Clarke Institute of Psychiatry in Toronto, agreed to participate. In a year marked by east-west dichotomy, it was gratifying to be part of a British Columbia-Ontario collaboration which is unique in the history of forensic psychiatry in Canada.

In May, the Commission organized a national conference on the current status of research in forensic psychiatry. Approximately twenty delegates were expected, since only a handful of persons are actively involved in this research field. Instead, fifty persons of national and international repute attended. An 85 percent return of evaluation forms showed a unanimous opinion that such a meeting of minds should occur annually, with provinces taking turns hosting the event.

In August, five persons were appointed to replace outgoing Commissioners who had served a three year term. Dr. John Duffy was named Chairman of the Commission, as well as

Executive Director of the Service. Dr. Frederick Tucker, the former Chairman who had served since the first Commission was formed in 1974, was named Vice-Chairman. The six members of the reconstituted Commission represent a cross-section of the public and private sector.

The model of delivery of forensic psychiatric services developing in British Columbia continued to attract international interest. Visitors to the service came from Australia, New Zealand, Japan, England and the United States, and from several Canadian provinces.

During the year many of the legitimate requests for expanded forensic psychiatric assistance could not be met. However, in keeping with Commission philosophy of providing services in exemplary fashion, activities will be expanded only as staff are trained and programmes are funded.

ALCOHOL AND DRUG COMMISSION

1980 was a year of both accomplishment and review for the Alcohol and Drug Commission. The number of patients in the alcohol programs increased, while the quality of service throughout British Columbia continued to improve. A detailed peer review of all programs was continued throughout the year in order to develop recommendations for service improvements.

Two residential treatment programs, Crossroads in Kelowna and Pacifica in New Westminster, moved into new facilities during the year. These programs acquired permanent homes in first rate accommodation, consistent with the need to treat alcoholism as a condition that affects individuals in all walks of life.

The Drug Treatment Program continued to offer treatment to individuals with a wide variety of drug problems who entered treatment voluntarily or on referral from the courts. Caseloads in the program increased steadily. Modifications of the program at Brannan Lake resulted in a better retention of clients and stabilization of the caseload at 45 clients.

Throughout the year, preventive programs continued to be emphasized. During the first quarter of the year, the Commission developed a television campaign promoting moderation in alcohol consumption. An independent survey confirmed that the message was recognized by a high proportion of British Columbians. In the last quarter of 1980, a campaign which promoted consumption of non-alcoholic beverages in licensed premises and at private parties received the wholehearted support of the hospitality industry.

The programs and structure of the Commission were thoroughly reviewed during the year resulting in a change in the structure of the Commission and a renewed mandate for its programs. As a result of this review, an independent Commission will be created to advise government on policy and program development. The treatment services will be integrated and more emphasis will be placed on providing services through funded agencies.

In 1980, H.F. Hoskin resigned as chairman of the Commission. While serving in this capacity between February 1976 and April 1980, Mr. Hoskin was responsible for the development of many new programs for the residents of British Columbia.

Alcohol and drug abuse will continue to be a major problem in the foreseeable future in British Columbia. While

the tremendous impact that these problems have on individual health, families, the health care system, the criminal justice system and other institutions is still not fully appreciated, the potential benefits of effective prevention and treatment are substantial.

Support Services

MEDICAL SERVICES DIVISION

Throughout 1980, the salaried and sessional physicians associated with the Commission continued to provide medical evaluation and treatment services to patients with alcohol and/or drug dependencies. Services included outpatient care, detoxication and residential treatment. The physicians held regular meetings to provide a forum for discussions of medical recommendations to the Commission and to update them on recent advances in the medical treatment of dependencies.

During the year, the Commission continued to develop a working relationship with physicians practising in British Columbia. Several initiatives were undertaken to achieve this goal, including a letter sent to all physicians outlining the programs operated by the Commission and explaining the new direct referral system for drug dependent clients. In addition, the chairmen of the British Columbia Medical Association's drug dependency and alcohol dependency committees were invited to a conference which was designed to develop a more co-operative effort in the treatment of those suffering the effects of chemical dependency. Also, the medical staff of the Commission participated in an interdisciplinary committee, which examined possible solutions to problems created by the abuse of prescription drugs.

PROFESSIONAL DEVELOPMENT DIVISION

Throughout the year, the Professional Development Division continued to develop educational and training workshops for professionals and para-professionals, whose work brings them into contact with alcohol and other drug dependent people.

In 1980, the Division made 264 community presentations, lectures and consultations. Over 1,500 people attended 64 training workshops in every region of the province. In

addition, staff were involved in many consultations with Commission staff and agencies.

The Division continued to emphasize the promotion and development of employee assistance programs. Services provided to employers and unions included 158 presentations and consultations, an increase of 300 percent over 1979. The Division also organized 15 training programs, developed new contacts with 17 organizations and maintained contact with established programs.

In 1980, the Nanaimo Employee Assistance Program began operation with $25,000 allocated through the Commission and additional funds from five participating employers and unions. In addition, Interlock Vancouver, Interlock Prince George, and the MacKenzie Community Rehabilitation Society received funding for similar services.

The major emphasis during the year was the organization of the Conference on Occupational Programming Assistance (COPA '80), which the Commission hosted in October. Outstanding speakers from New Orleans and Toronto, in addition to experts from British Columbia, gave a variety of talks and workshops. The conference was attended by 150 participants from a variety of organizations.

INFORMATION AND EDUCATION SERVICES DIVISION

During the past year, the Information Services Division of the Alcohol and Drug Commission performed a variety of tasks designed to increase public awareness of problems created by alcohol and other drug abuse, and the services provided by the Commission and its funded agencies.

The 1979 Alcohol Awareness campaign was extended to March of 1980 with considerable success. The theme of the campaign: "You Can Say No to the Drink You Don't Need" achieved its purpose to the extent that a Gallup Poll showed public awareness of the theme increased from 62.2 to 83.3 percent between October 1979 and April 1980.

The 1980 Alcohol Awareness campaign, which started in November and will continue in 1981, promoted the serving of non-alcoholic drinks in licensed premises. In co-operation with National Health and Welfare, the Division distributed 150,00 copies of recipe pamphlets for "The Great Entertainers", non-alcoholic cocktails and punches which can be served at social functions.

In addition, two television commercials were developed, as well as posters for bus shelters in the Vancouver area and tear off recipe sheets posted on the billboards of public transportation. A number of articles on a variety of topics related to treatment of alcohol and drug problems were also written and distributed to the media.

Editorial and writing services were provided by Information Services to other divisions of the Commission. This included the preparation of letters directed to every physician in the province regarding the growing problem of the abuse by patients of over-the-counter and prescription drugs. In addition, articles were prepared and published in the British Columbia Medical Association newspaper, as well as the British Columbia Government News and other publications outlining the problem and listing the referral and treatment services available through the Commission and its agencies.

The Division handled media arrangements for the Conference on Occupational Programming Assistance, which was held in Vancouver during the month of October. This consisted of preparing and placing advertising in the media announcing the conference, preparation of copy and biographical material for distribution to the media, arranging press, radio, and television interviews in advance of and during the course of the conference.

The Division also handled media arrangements for the opening of Crossroads in Kelowna and the Pacifica Treatment Centre in New Westminster.

An early intervention program, initiated and funded in 1979 and designed to identify and refer elementary school students at risk of developing drug problems, was continued in 1980. The Western Education Development Group project, funded in 1979 to prepare four teachers' guides and two parents' manuals on home drugs, was also continued. The grades four and five trial teachers' guides were completed and are ready for pilot testing. The Information Services Division also continued to act as the liaison in the matter of youth and education initiatives within the Commission and on behalf of the Commission.

The Information Services library continued to serve as an important resource to Commission and treatment agency staff, as well as to students, professionals and the general public. The increase in the number of book orders, reference questions, general information inquiries, and circulation in 1980 was conservatively estimated at 35 percent.

As well as printed materials, the Division was

responsible for the purchase, maintenance and allocation of audio-visual materials and equipment.

RESEARCH DIVISION

In 1980, the Research Division worked on a variety of projects. A number of internal reports were prepared for other Divisions, and several major projects continued throughout the year.

The Epidemiological Research Section continued its work on a comprehensive data base of health, social, criminal justice, and demographic indicators. This project, called the Geographic Profiles, contains data on a school and regional district basis and will be used for long-range planning purposes. A report on long-range trends in alcohol and drug use entitled Alcohol and Drug Statistics for Canada and British Columbia: 1955-1976, completed in late 1979, was released in 1980. Other reports published were PCP: A Review of Current Knowledge; Trends in Heroin Use; and Fastfacts III: A Summary of Answers to Frequently Asked Questions. Work was continuing on Gallup Poll data, and on a project examining the costs of alcohol use for British Columbia.

The Evaluative Research Section worked on a large number of internal reports for other Divisions related primarily to treatment and training and also undertook a comprehensive evaluation of the Commission's 1979/80 advertising campaign. A survey of the Directors of treatment agencies funded by the Commission was conducted, regarding the Commission's Alcohol Awareness Week, and the report Evaluation of the ADC Advertisement Campaign: II Survey of Directors on Alcohol Awareness Week was published. A summary of this report was sent to all participating agencies. Work was continuing on an extensive survey of expectant parents' responses to the advertising campaign, and a report on this project will be released in the spring of 1981.

The Monitoring and Data Systems Section continued work on the commission's two major information systems: the Client/Agency Monitoring System, and the Drug Treatment Program Information System. The existing backlog of data was completed and progress was made on programming master files for both data systems, which will enable analysis of the characteristics and outcomes of clients in treatment, as well as their movement within the Commission's network of treatment services. Work also continued on the development of a new, integrated data system for the Commission's treatment services.

The Commission's research director was one of two provincial research representatives on the Expert Committee on Alcohol Statistics, a national committee with representatives from provincial commissions and foundations, the federal government and the academic community. The paper Issues Related to Information Systems was presented at Symposium I on Alcohol Information Systems in Canada, sponsored by the Expert Committee. These and the other major addresses were reproduced and published in the journal Toxicomanies.

AGENCY RELATIONS DIVISION

Throughout the year, the Agency Relations Division continued to serve as the communicating link betwen the Alcohol and Drug Commission and the Boards and staff of the 50 funded programs.

The twice yearly regional workshops which began in 1979 proved invaluable in the continued orderly development of the system of care treatment network, providing interagency co-operation and better referral networks.

Significant senior staff turnover in funded agencies increased board requests for assistance in selecting and evaluating appropriate staff.

STAFF DEVELOPMENT AND TRAINING DIVISION

The Staff Development and Training Division serves as a consultant to the programs funded by the Alcohol and Drug Commission in identifying training needs related to specific programs. During 1980, activities included organizing sessions of the Cardio-Pulmonary Resuscitation Course, as well as a program on working with the alcoholic client in detoxication centres.

Other activities included developing workshops for hospital workers providing a detoxication service to the community and community people providing follow-up services for hospital clientele. These workshops will be available in package form.

PROGRAM DEVELOPMENT AND EVALUATION DIVISION

In 1980, the co-ordinator of Program Development was

involved in investigating the need for services, as well as evaluating existing services throughout the province. The need for service in the Port McNeill/Port Hardy area was investigated, and direct service was commenced in the area with priority activities at the St. George's Hospital in Alert Bay. A review of service was conducted for the Vanderhoof/Fort St. James area, and service needs were assessed in the Terrace area and the Burns Lake/Vanderhoof area.

In Fort Nelson, the Fort Nelson General Hospital became responsible for the administration of a new service. Extensive reviews of existing services were conducted in Kelowna and Merritt and plans were concluded for the opening during fiscal 1981-82 of a "detoxication holding facility" in Kamloops.

During the year, other areas investigated for service needs and expansion included the Richmond/Delta area as well as the East and West Kootenay areas.

The Division co-ordinated two workshops for detoxication supervisors, which resulted in an extensive review of the existing components of service. A detoxication resource manual will be produced with the advice of this group.

The development and evaluation of the Round Lake Treatment Centre for native people continued to have a high priority.

The evaluation of out-patient services funded by the Alcohol and Drug Commission was commenced in the East and West Kootenays. This process will continue with the evaluation of all out-patient services.

Of special interest was the development and promotion of closer co-ordination between hospital, medical and out-patient services throughout the province. Areas involved included Kelowna, Salmon Arm, Kamloops, Fort Nelson, Alert Bay, and the Queen Charlottes.

Direct Treatment Services

ALCOHOL AND DRUG COUNSELLING SERVICE

The Commission provided alcohol and drug out-patient counselling through clinics in Vancouver, Burnaby and Kelowna. The isolated Kelowna unit was moved into the program direction of the Greater Vancouver units, to provide closer liaison and unified direction for that service. The former

hypnotherapy unit in Vancouver, which had operated under the Drug Treatment Program, was shifted into the Alcohol Program and integrated into the out-patient counselling services. The year's experience attested to the value of this level of co-ordinated program planning for greater thrust and service integrity.

The Kelowna unit doubled its over all client case load with an increase of referrals from the general hospital and corrections services. This was a direct consequence of the liaison agreement worked out with the hospital to provide assessment and counselling back-up to their detoxication experiment. The project with corrections, and the impaired drivers courses, provided closer co-ordination of these two government services.

The Greater Vancouver out-patient service continued to be the focus of an increasing demand for direct service for clients and liaison with the funded agencies within the system of care. In order to maintain quality and effectiveness of service, it was necessary for the first time in the program's history to establish a waiting list. This meant that new client referrals had a three to four week waiting period for assessment and on-going service. Since the point of referral is often a critical period for the individual, the family, and frequently, the employer, these waiting periods often result in interim intervention, which may lead to further complications.

The out-patient units began the year with 530 active clients. During the year, a further 776 cases were opened, for a total of 1,306 clients served. Also served were many families, collaterals, industrial representatives, other health and social service agencies, as well as medical, legal, and training institutions.

The 14 counsellors in the three units provided a total of 6,193 individual and family treatment sessions. In addition, these clients received 5,541 group treatment hours.

The medical component provided a further 666 treatment sessions in the out-patient clinics, in addition to consultation. Also, regular daily coverage at Maple Cottage Detoxication accounted for a further 628 treatments in that facility.

YOUTH AND FAMILY COUNSELLING SERVICES

The Youth and Family Counselling Services in Vancouver continued to maintain an active caseload of young people and

family members, while operating as the major early intervention program of the Commission. In 1980, the program was utilized by over 330 individuals and their family members. Most service users were engaged on an intensive basis, with about 45 percent of the clients receiving family counselling an average of two to three times per month, and about 10 percent receiving individual counselling an average of twice per week. The remaining 40 percent were involved with the agency's comprehensive services, which included tutorial assistance, group work, and social skills development, in addition to the basic individual and family counselling.

During the year, the Youth and Family Counselling Services made many adjustments in the program's attempt to provide back up and consultative services to other community and governmental youth services. Support to Lower Mainland youth services and other Alcohol and Drug Commission programs, which have regularly worked together with the program in the past, was reduced by approximately two-thirds due to a shortage of four staff members.

In 1980, requests for brief services and family problem intervention increased significantly, compared to the same period during 1979. During the last quarter of 1980, the service was required to implement a family service waiting list, while attempting to develop multiple family group programs in an effort to maintain responsiveness to families requiring assistance.

MAPLE COTTAGE DETOXICATION CENTRE

During 1980, Maple Cottage Detoxication Centre provided service to approximately 1,500 people. Throughout the year, the proportion of females rose from 20 percent to 24 percent. The majority of clients, 58 percent, remained in the Centre an average of two and two-third days. About 21 percent stayed for an average of six days, and 80 percent of this group continued treatment elsewhere following withdrawal.

It was encouraging to note that 60 percent of all clients admitted to the Centre accepted a referral to on going treatment services. Of all treatment referrals made, 42 percent were to agencies funded wholly or in part by the Alcohol and Drug Commission.

The daily exercise program, weekly groups, and relaxation sessions were continued and were well received. In addition, medical backup for the program continued to be provided through regular visits by physicians.

PENDER DETOXICATION CENTRE

As a detoxication program within the system of care, the Pender Detoxication Centre provides the first phase of a comprehensive program aimed at the treatment of alcoholism and other addictions. The primary goal is to provide around-the-clock supportive care for clients suffering from the toxic effects of alcohol or other addictive drugs. The secondary goal is to help motivate these clients, as they recover from the physical illness, to seek further treatment for their addictions.

Clients are encouraged to seek long term treatment for their alcoholism or other addictions through small group discussions, films, tapes, literature on chemical dependencies, and client staff interaction. Most clients stay in the centre for an average of four days. During this time, the staff attempt to create an atmosphere of acceptance, accentuating possible strengths, and helping clients to face reality.

Group discussions focus on helping clients deal with emotional problems, with the goal of having an individual accept greater responsibility. These approaches are useful in a short term group setting in a detoxication centre.

Two and a half years ago, an Alcoholics Anonymous closed discussion group began as a pilot project one evening a week. This group was increased to two evenings each week for interested clients who were either in detoxication, or had been discharged from the Centre. The intention was to try and encourage clients to become aware of Alcoholics Anonymous as a resource both for continued involvement, and while awaiting entry to a treatment centre, supportive recovery centre, or out-patient program. Between 20 and 48 individuals participated in this group on a weekly basis.

During the year, 1,390 clients were admitted to the Pender Detoxication Centre. Of these, 65 percent were referred to continued treatment within the System of Care. In addition to clients admitted to the facility, there were 247 drop-ins (individuals who utilized the service for a short period of time but left prior to being admitted) whose average length of stay was 5.9 hours.

Funded Treatment Programs

The majority of the Commission's treatment services are provided by private societies, which are registered under the

Societies Act and funded by the Commission.

Residential detoxication programs were provided by:

Salvation Army (Vancouver),

Drug and Alcohol Rehabilitation Society (Victoria),

Parents Alert Society (Kamloops),

Prince George Regional Hospital Board, and

Nicola Valley Friendship and Counselling Society (Merritt - This service was terminated on October 31, 1980).

Residential treatment programs were provided by:

Fraser Valley Alcoholism Society (New Westminster),

Victoria Life Enrichment Society,

Crossroads Treatment Centre Society (Kelowna),

Prince George Regional Hospital Board,

Maple Ridge Halfway House Society,

Aurora House Society (Vancouver),

Dallas House Society (Victoria),

Kakawis Family Development Centre (Tofino),

Round Lake Native Alcohol and Drug Treatment Centre Society (Armstrong),

Fraser House Society (Mission),

Charlford House Society (Burnaby),

Kiwanis House Society (Kamloops),

Charlottes Alcohol and Drug Society (Tlell),

M.S.A. Halfway House Society (Abbotsford)

Outpatient counselling programs were provided by:

Native Courtworkers and Counselling Association of British Columbia (Vancouver),

Chilliwack Community Services,

Richmond Alcohol and Drug Abuse Team Society,

Surrey Alcohol and Drug Program,

Upper Island Chemical Dependency Society (Courtenay and Campbell River),

Nanaimo Chemical Dependency Centre Society (Nanaimo and Duncan),

Port Alberni Friendship Centre,

Port Alberni Family Guidance Association,

Powell River Civil Liberties Society,

Drug and Alcohol Rehabilitation Society (Victoria),

St. George's Hospital Board (Alert Bay),

Parents Alert Society (Kamloops),

Central Okanagan Indian Friendship Society (Kelowna),

Nicola Valley Friendship and Counselling Society (Merritt),

Nelson District Community Resources Society,

East Kootenay Union Board of Health (Cranbrook),

South Okanagan Alcohol Education and Rehabilitation Program (Penticton),

Salmon Arm Society for Shuswap Alcohol and Drug Programs (Salmon Arm and Revelstoke),

Prince George Community Resources Society,

Dawson Creek and District Hospital Society (Dawson Creek and Fort St. John),

Fort Alcohol and Drug Society (Fort St. James),

Terrace & District Community Services Society (Terrace, Prince Rupert and Kitimat),

Cariboo Indian Friendship Society (Williams Lake),

Alcohol and Drug Counselling Service (Fort Nelson).

Drug Treatment Program

During 1980, the Drug Treatment Program continued to offer rehabilitation services for the treatment of a variety of drug abuse clients in British Columbia. The Drug Treatment Program also continued to treat the methadone maintenance clients previously cared for by the Narcotic Addiction Services.

All clients coming into treatment were voluntary. Clients were either self-referrals or were referred from various community agencies, physicians or the criminal justice system.

Clients first arriving for treatment presented themselves at regional centres located in Vancouver, Kelowna, Prince George, Nanaimo, and Victoria. They underwent a complete assessment to determine their drugs of abuse, their current physical and psychological status, and whether treatment should take place on an in-patient or out-patient basis. The approach of the Drug Treatment Program was completely drug-free, except for the initial detoxication procedures. Only the remaining Narcotic Addiction Services clients received methadone.

In-patient care took place at the Brannan Lake Residential Treatment Centre near Nanaimo. The Brannan Lake facility is a 150 bed hospital for clients who require extended detoxication regimens and for those individuals who benefit from the maximal support present in a residential treatment setting away from the stresses of their own community. Out-patient care occurred at the community clinics throughout the province: four in the Lower Mainland; three on Vancouver Island in Victoria, Nanaimo and Campbell River; and one each in Kelowna and Prince George. Treatment consisted of a structured approach emphasizing counselling, physical and psychological health, vocational training, social skills, and effective use of leisure time.

The final phase of the program emphasized the re-entry and integration of the client back into the community, with the support of community workers.

Backing up the treatment services were the laboratory and pharmacy. The pharmacy provided the medication used in the medical management of drug addiction. The laboratory provided analysis of urine specimens for a variety of drugs of abuse. This urinalysis was crucial in the diagnosis, treatment, and follow-up of drug abuse clients. The urinalysis service was also used occasionally by physicians, corrections officials, and other social agencies in the province.

TABLE I

STATEMENT OF EXPENDITURES

FOR THE FISCAL YEAR

1979-80

EMERGENCY HEALTH SERVICES COMMISSION

Salaries	$16,959,444.
Travel Expense	384,803.
Professional and Special Services	1,792,559.
Office Expense	132,278.
Office Furniture and Equipment	13,422.
Advertising and Publications	8,095.
Materials and Supplies	1,752,120.
Motor Vehicles	1,112,893.
Rentals	671,961.
Acquisition/Construction Land, Buildings and Works	10,329.
Acquisition/Construction Machinery and Equipment	676,956.
Other Expenditure (Employee Benefits)	2,848,503.
Recoveries (Non-Revenue)	199,799.CR
TOTAL EXPENDITURE	$26,163,564.

TABLE II

MINISTRY OF HEALTH REPORT, 1980

EXPENDITURE BY PRINCIPAL CATEGORIES IN THE MINISTRY OF HEALTH FOR FISCAL YEAR 1979/80

	Total Expenditure Fiscal Year Ended March 31, 1980 $	
Minister's Office	174,320	
Administration & Support Services	21,042,258	
Preventive & Special Community Services	33,691,485	
Direct Care Community Services	194,684,730	
Mental Health Services	16,803,417	
Hospital Programs	700,643,828	
Medical Services Commission	451,354,110	(1)
Emergency Health Services Commission	26,163,570	
Forensic Psychiatric Services Commission	4,213,117	
Alcohol & Drug Commission	12,330,546	
Building Occupancy Charges	26,221,233	
Computer & Consulting Charges	2,904,400	
	1,490,227,014	
Statutory		
Refugee Settlement Program of B.C. Act	325,294	
TOTAL	1,490,552,308	(1)

SEE ATTACHED SHEET FOR CHART

Footnote:

(1) The expenditure of $451,354,110 shown for Medical Services Commission is the gross operating cost as shown in the detailed statements in Section F of the Public Accounts. The actual charge to Vote 134 was $289,000,000 and covered the subsidy by the Province for low-income residents and the estimated deficits not covered by premiums and other revenues.

As approximately half the expenditures of the Financial Services office were made on behalf of the Ministries of Provincial Secretary and Government Services and Tourism and Small Business Development, 50% of the expenditure of the Financial Services office - $456,658 has been deducted from the total expenditure of the Ministry of Health as shown in Section D of the Public Accounts.

TABLE III

DETAILED EXPENDITURE BY PRINCIPAL CATEGORIES IN THE MINISTRY OF HEALTH

FOR THE FISCAL YEAR 1979/80

		Total Expenditure Fiscal Year Ended March 31, 1980 $
Minister's Office		174,320
Administration & Support Services		21,042,258
Preventive & Special Community Services:		
Preventive Programs	24,035,396	
Special Health Services	9,656,089	
Total		33,691,485
Direct Care Community Services:		
Long Term Care	143,011,017	
Government Hospitals	51,673,713	
Total		194,684,730
Mental Health Services		16,803,417
Hospital Programs:		
Administration	4,459,302	
Payments to Hospitals etc.		
Claims	660,982,515	
Grants in Aid of Equipment	8,247,803	
Capital & Debt Service	26,954,208	
Total		700,643,828
Medical Services Commission:		
Benefits		
Medical Care	407,936,214	
Additional Benefits	23,534,808	
	431,471,022	
Administration	19,883,088	
Total		451,354,110
Emergency Health Services Commission		26,163,570
Forensic Psychiatric Services Commission		4,213,117
Alcohol & Drug Commission		12,330,546

continued

TABLE III

DETAILED EXPENDITURE BY PRINCIPAL CATEGORIES IN THE MINISTRY OF HEALTH

FOR THE FISCAL YEAR 1979/80 - Continued

	Total Expenditure Fiscal Year Ended March 31, 1980 $
Building Occupancy Charges	26,221,233
Computer & Consulting Charges	2,904,400
Statutory	
Refugee Settlement Program of B.C. Act	325,294
TOTAL, MINISTRY OF HEALTH	1,490,552,308

MEDICAL SERVICES PLAN

Financial Statement

AUDITOR'S REPORT

To the Chairman of the
Medical Services Commission of British Columbia, and

To the Minister of Health
Province of British Columbia:

I have examined the statement of financial position of the Medical Services Plan of British Columbia operating under the direction and control of the Medical Services Commission of British Columbia as at 31 March 1980 and the statement of operations and working capital deficiency for the year then ended. My examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as I considered necessary in the circumstances.

In my opinion, these financial statements present fairly the financial position of the Plan as at 31 March 1980 and the results of its operations for the year then ended in accordance with generally accepted accounting principles, as modified by note 1 to the financial statements, applied on a basis consistent with that of the preceding year.

ERMA MORRISON, C.A.
Auditor General

Victoria, B.C.
6 June 1980

TABLE IV EXHIBIT A

MEDICAL SERVICES PLAN OF BRITISH COLUMBIA

OPERATED BY AND UNDER THE

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

STATEMENT OF FINANCIAL POSITION

31 MARCH 1980

	1980	1979
ASSETS		
Cash	$ 4,197,353	$ 828,880
Accounts receivable	1,588,640	1,842,049
Due from the Province of British Columbia	-	16,200,000
	$ 5,785,993	$18,870,929
LIABILITIES		
Bank overdraft	$ -	$14,111,966
Accounts payable	527,503	318,978
Premiums received in advance	15,923,522	15,457,223
Estimated liability for unpresented and unprocessed benefit claims	52,500,000	45,500,000
	68,951,025	75,388,167
WORKING CAPITAL DEFICIENCY - EXHIBIT B	63,165,032	56,517,238
	$ 5,785,993	$18,870,929

The two accompanying notes are an integral part of these financial statements.

Approved by the Commission:

D.H. WEIR, CHAIRMAN.

TABLE V

EXHIBIT B

MEDICAL SERVICES PLAN OF BRITISH COLUMBIA

OPERATED BY AND UNDER THE

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

STATEMENT OF OPERATIONS AND WORKING CAPITAL DEFICIENCY

FOR THE YEAR ENDED 31 MARCH 1980

	1980	1979
REVENUE		
Subscribers' premiums (Note 1)	$155,217,061	$148,424,227
Province of British Columbia premium assistance	31,456,261	31,531,322
Interest income	-	150,332
	186,673,322	180,105,881
EXPENDITURE		
Benefits		
Medical care	407,936,214	356,998,397
Additional benefits	23,534,808	21,132,210
	431,471,022	378,130,607
Administration		
Salaries and employee benefits	10,750,191	9,903,520
Data processing expenses	6,356,216	5,285,151
General office expenses	1,723,919	1,667,705
Occupancy expenses (Note 2)	1,052,762	-
	19,883,088	16,856,376
	451,354,110	394,986,983
EXCESS OF OPERATING EXPENDITURE OVER REVENUE	264,680,788	214,881,102
CONTRIBUTIONS		
Province of British Columbia	258,032,994	195,342,053
	6,647,794	19,539,049
WORKING CAPITAL DEFICIENCY - beginning of year	56,517,238	36,978,189
WORKING CAPITAL DEFICIENCY - end of year - EXHIBIT A	$ 63,165,032	$ 56,517,238

TABLE VI

MEDICAL SERVICES PLAN OF BRITISH COLUMBIA

OPERATED BY AND UNDER THE

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

NOTES TO FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 MARCH 1980

1. Significant Accounting Policies

These financial statements have been prepared in accordance with generally accepted accounting principles except that:

(i) Premiums from individual subscribers are included in revenue only when cash is received. Premiums from other sources are recognized as revenue on an accrual basis.

(ii) The cost of furniture and equipment is charged to administration expenses in the year of acquisition.

(iii) No accrual for holiday pay is provided for salaried employees.

2. Occupancy expenses

Occupancy expenses reflect charges by the British Columbia Buildings Corporation for the space occupied by the Medical Services Plan. In prior years these charges were absorbed by the Ministry of Health.

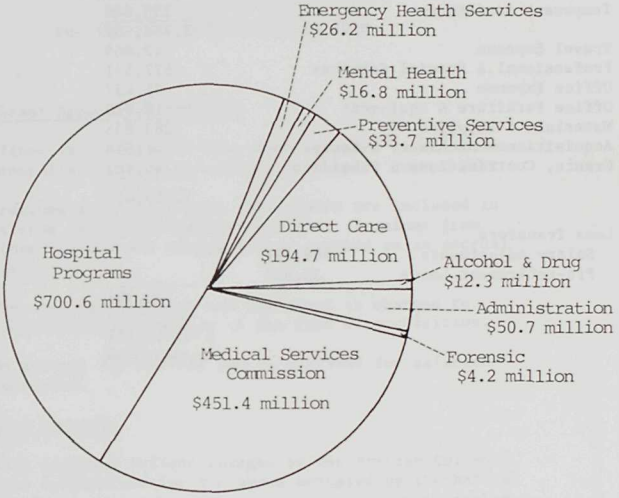
FORENSIC PSYCHIATRIC SERVICES COMMISSION

STATEMENT OF EXPENDITURES FOR THE PERIOD
APRIL 1, 1979 to MARCH 31, 1980

Expenditure by Standard Classification:

Salaries		3,502,959
Temporary Assistance		253,648
		3,756,607
Travel Expense		42,469
Professional & Special Services		577,521
Office Expense		21,437
Office Furniture & Equipment		18,810
Materials & Supplies		283,835
Acquisition - Machinery & Equip.		7,558
Grants, Contributions & Subsidies		45,181
		4,753,418
Less Transfers		
Salary Adjustments	509,398	
Pre-retirement Leave	30,903	
		540,301
		$ 4,213,117

CHART I - EXPENDITURES BY PRINCIPAL CATEGORIES IN THE MINISTRY OF HEALTH FOR THE FISCAL YEAR 1979/80



TOTAL HEALTH SERVICES
IN 1979/80 - $1,490.6 Million