Provincial Health Services Authority - BC Cancer Agency

2002/03 Budget Management Plan ($millions)

	Total
2001/02 Projected Expenditures	218.0
2001/02 Projected "Structural" Surplus/Deficit before restructuring and 1-time costs	2.0
1-time costs	-
Restructuring Costs Recognized in 2001/02	-
2001/02 Revised Projection	2.00

(note: Do not include MOHS's proposed funding to cover this years deficit)

	2002/03		2003/04		2004/05	
	$	FTE's	$	FTE's	$	FTE's
Projected Surplus / (Deficit) Prior to Management Reduction Strategies	(18.60)		(10.21)		(13.08)	
	-					
Management Reduction Strategies:	-					
	-					
	-					
Revenue Generation						
1. Additional funding from MoHS	6.69					
2. Life support - drugs	5.20		10.00		12.00	
3. Patient Charges	-		0.40			
4. Other	2.00					
	-					
	-					
General Efficiencies (non-clinical)						
1. Exec/Admin (CEO, direct reports, exec)	0.39	1.5				
2. Shared Services	-					
3. Outsourcing	-		0.35	8.3		
4. Business Systems	0.43	8.0	0.35	7.0	0.35	7.0
5. Workplace Initiatives	2.96	14.0	1.03	14.0	0.73	8.0
	-					
	-					
Best Practices (clinical)						
1. Alternatives to Care	-					
2. Clinical Efficiencies	1.94	18.0	0.15	2.5		
3. Environmental & Protection	-					
4. Bed Consolidations (no access reduction)	-					
	-					
	-					
Program Adjustments/Closures						-
1. Bed Reductions	0.38	5.0				
2. Facility/bed conversions	-					
3. Facility Closures	-					
4. Program Consolidation	-					
5. Program Reduction	3.90	0.5	0.50	3.2		
6. Selected Programs	-					
7. Selected Sites	-					
	-					
Total Management Reduction Strategies	23.89	47.0	12.78	35.0	13.08	15.0
Strategies as a % of 2001/02 Expenditures	0.11		0.06		0.06	
Revised Projection Surplus (Deficit)	5.29		2.56		(0.00)	

Provincial Health Services Authority

Detailed Three Year Plan and Impact Analysis – **Revised March 7, 2002**
Fiscal Years 2002/03, 2003/04, 2004/05

BC Cancer Agency
Specific Reduction Strategies
Total 3 Year Reductions - $10,851,000

Yellow highlights strategies with potential adverse consequences

CLINICAL CARE

1. **Outpatient - Radiation Therapy** – 3 Year Total - $1,040,000

   - *Time Line*
     - 02/03 - *$1,040,000*
   - *Description*
     - Reduction in staffing needed to operate the provincial radiation therapy program.
   - *Human Resources*
     - 14 FTE's – Radiation therapists and clerical, through elimination of unfilled positions.
   - *Access and Quality*
     - No impact on access or quality of care.
     - Risk issue: radiation treatment machines are aging and require approval of multi-year replacement strategy to prevent increased wait lists due to excessive machine down time.
   - *Process Redesign*
     - Reductions result from radical process redesign of the radiation therapy process.
     - Continued redesign should allow adequate levels of operation in 03/04 and 04/05.

2. **Outpatient - Systemic Therapy** – 3 Year Total – $367,000

   - *Time Line*
     - 02/03 - *$302,000*
   - *Description*
     - Reduction in relief staffing and other misc. costs
   - *Human Resources*
     - 4 FTE's – Nursing, pharmacy and clerical, through elimination of unfilled positions.
   - *Access and Quality*
     - No impact on access to quality of care and service.

3. **Inpatient Care** – 3 Year Total - $380,000

   - *Time Line*
     - 02/03 - *$380,000*
   - *Description*
     - Reduction of eight (8) inpatient beds from 42 to 34 (many beds unofficially closed already). Nursing shortages prevent opening of beds.
   - *Human Resources*
     - 5 FTE's - Includes consolidation of staffing from three to two wards with associated savings in Clinical Nurse Leadership, RN's and clerical positions.
   - *Access and Quality*
     - No reduction in chemotherapy or radiation therapy treatment will result.
     - Will result in the consolidation of three to two wards.
     - Reduction of 2200 patient days.
   - *Utilization Management*
     - Utilization review, stricter admission criteria, and alternative strategies will allow the continued closure of the beds without adverse impact on patient care. Evaluation and ongoing monitoring is required. Potential closure of oncology beds in Regional Authorities may bring pressure on utilization of these remaining beds.

4. **Screening Mammography Program** – 3 Year Total - $591,000

- *Time Line*:
  - 02/03 - $216,000
  - 03/04 - $175,000
  - 04/05 - $200,000
- *Description*
  - In 02/03 reductions from administrative efficiencies within the screening programs with no impact on services. Growing wait lists will require action in 03/04 and 04/05, necessitating reallocation of funding to 50+ age group, requiring reduction of services or alternative funding for 40-49 age group (where the evidence for benefit from screening is at a less level that in the 50+ age group).
- *Human Resources*
  - No implications in the SMPBC program. May have some impact on staffing in organizations with which the SMPBC contracts, which include health authorities and private diagnostic facilities.

2002/03

- *Access and Quality*
  - adequate service levels will be maintained.

03/04 and 04/05

- *Access and Quality*
  - wait times for screening will exceed national standards.
  - potential for public and physician complaints
  - waiting times will exceed six weeks by 03/04 or 04/05, triggering high cost screening in private diagnostic radiology offices funding on fee-for-service.
  - in order to maintain the integrity of an effective population screening program, reductions in services to the 40-49 year age group may be required so that appropriate access can be provided for the 50+ year age group (see above re. level of survival benefit evidence).
  - There could be an overall reduction of about 7,000 screening mammograms (3%), with the 40-49 year old age group being most affected.

5. **Chemotherapy Drugs**

- *Time Line*:
  - 02/03 - $ 3,000,000
  - 03/04 - $10,000,000
  - 04/05 - $12,000.000
- *Access and Quality*
  - Without ongoing tertiary services funding support, for the next three years, with progressively increasing impact no new cancer drugs will be funded in BC, except for the highest priority therapies, for which funding is made available and determined through a priorities and evaluation process. This may leave many beneficial drugs unfunded.
  - BC drug funding policies will differ significantly from other provinces, creating potential for concerns and criticism from the public and practitioners.
- *Clinical Practice Guidelines and Prioritization Processes*
  - Provincial tumour groups establish evidenced based guidelines and a provincial priorities and evaluation committee evaluates the strength of evidence and benefit.
- *Patient Self Pay*
  - With changes in policy, self-payment arrangements may be considered by government to allow access to beneficial drugs for patients, which do not have sufficient priority to be publicly funded.

6. **Communities Oncology** – 3 Year Total - $577,000

- *Time Line*
  - 02/03 - $ 577,000
- *Description*
  - Postponed implementation of non-essential community programs originally intended as a part of a Health Action Plan project. No HR impact.
- Access and Quality
  - No significant impact anticipated.

SUPPORT SERVICES

1. **Rehabilitation** – 3 Year Total - $828,000

- *Time Line*
  - 02/03 - $328,000
  - 03/04 - $500,000
- *Description*
  - Targeted reductions in Dentistry, Nutrition, Physiotherapy, Patient & Family Counselling, Pain & Symptom Management and Quality of Life staffing support.
- *Human Resources*
  - 02/03 - 0.5 FTE relief
  - 03/04 - 3.2 FTE's – allied professional staffing.

2002/03

- *Access and Quality*
  - Core rehabilitation will be maintained without significant impact.

2003/04

- *Access and Quality*
  - Restorative dentistry will become a largely self-pay program with means testing, similar to payment policies for this kind of treatment in other areas of the health care system.
  - Additional reductions in other rehabilitation programs may require patient self-payment, such as for music therapy, art therapy, and relaxation therapy.
  - While the Agency will move closer towards the practices of other parts of the health care system for similar services, patients and practitioners may express concerns in relation to historical practices.
  - Overall impact in relation to total patients is small. These are relatively small volume services, where the impact will be primarily on convenience of access and therapeutic alternatives.
- *Patient Self-Pay*
  - Opportunities for use of private insurance plans and means tested direct patient pay.

2. **Diagnostics** – 3 Year Total - $678,000

- *Time Line*
  - 02/03 - $528,000
  - 03/04 - $150,000
- *Description*
  - Reduction of Laboratory Services Costs
- *Human Resources*
  - 03/04 – 2.5 FTE's (to be determined)
- *Access and Quality*
  - No significant changes in quality and access to laboratory services.

- *Utilization Management*
  - Reduction in laboratory services costs through utilization reviews of cancer centre patterns and purchased services contract specifications. As well, to review opportunities for private sector relationships, fee for service billing, and other revenue generation opportunities. For patient convenience and better clinic scheduling, there will be greater use of community labs for procurement and reporting of tests.
  - Evaluation and ongoing monitoring is required of reductions in laboratory service levels at Vancouver Hospital where the Agency has a shared service. If Vancouver Coastal reduction plans proceed, repatriation of services to BCCA may be required.

3. **Patient Information Management** - 3 Year Total - $1,130,000

- *Tine Line:*
  - 02/03 - $430,000
  - 03/04 - $350,000
  - 04-05 - $350,000
- *Description*
  - Reduction in staffing for handling and management of patient records.
- *Human Resources*
  - 02/03 - 8.0 FTE's clerical
  - 03/04 - 7.0 FTE's clerical
  - 04/05 - 7.0 FTE's clerical
- *Process Redesign*
  - Reductions result from radical process redesign and movement toward the Electronic Health Record.

4. **Hotel Services** – 3 Year Total - $575,000

- *Time Line:*
  - 02/03 - $225,000
  - 03/04 - $350,000
- *Description*
  - Reduction in cafeteria, food services, housekeeping, security, plant maintenance.
- *Human Resources*
  - 02/03 – 2.0 FTE's clerical
  - 03/04 – 8.3 FTE's clerical/trades
- *Contracting out/ASD's*
  - In 02/03 existing services will be maintained at the same level with reorganization and streamlining.
  - In 03/04, In cooperation with others, these services will be contracted. A minimum benefit of 10% of current costs is anticipated. In the Agency's three regional cancer centres, the Agency will work with host regional authorities to contract out the services as a part of the Purchased Service agreements with the Authority.

5. **Agency-wide Administration** – 3 Year Total - $2,363,000

- *Timeline:*
  - 02/03 - $1,487,000
  - 03/04 - $350,000
  - 04/05 - $526,000
- *Description*
  - 02/03 - Reductions in travel, leadership, clerical/secretarial staffing, education funding for quality improvement, and relief
  - 03/04 and 04/05 – Continued management and corporate services restructuring, including shared services.
- *Human Resources*
  - *02/03*
    - 2.1 FTE - Senior secretarial positions

- 3.0 FTE - Population and Preventive Oncology Management Positions
- 2.0 FTE - Regional process leader positions
- 3.0 @ 0.50 FTE - Regional vice president positions
- 1.0 FTE Advanced Practice Nurse Educator

- *03/04 and 04/05*
  - 12.0 FTE's – management and supervisory staff to be determined.

OTHER INITIATIVES

2002/2003

6. Reductions in Secretarial staffing - Agency wide

- *Time Line*:
  - 02/03 - $338,000
  - 03/04 - $500,000
- *Description*
  - Adjustment in professional staff support ratios, levels of secretarial support to non-contract staff, and reductions in relief staffing.
- *Human Resources*
  - 02/03 - 5 FTE's clerical
  - 03/04 -10 FTE's clerical

7. Planned Hiring Freeze and/or Delayed Hires - $422, 500

8. Strategic Spending for future years savings - $661,000

2003/2004

9. Revenue Generation from BC Residents - $100,000 (Primarily from use of diagnostic facilities)
- The Agency has the potential to provide clinical and specialized diagnostic services to BC residents that are not insured and may be acceptable to government to charge directly. PHSA organizations should exploit opportunities that are acceptable to government for revenue generation.

10. Revenue Generation for Treatment Services to Out of Province Patients - $300,000
- The Agency provides many specialized cancer diagnostic and treatment services for which there is a substantial market outside of BC. These services could be provided to out of country residents in a way that does not compromise access for BC residents. Government approval is required to proceed with these business opportunities.

Addendum

Severance Accrual Costs:
The following severance costs have been accrued for fiscal year 2001/2002, to be implemnted in 2002/2003:

Contract Staff	10.0 FTE's	20 months	$ 78,764
Non Contract Mgmt.	3.0 FTE's	36 months	$343,406
TOTAL:			$422,170

Oncology Drugs in British Columbia
Overview and Funding Impact Statement
Fiscal Years 2002/03 to 2004/05

Current State:

The British Columbia Cancer Agency (BCCA) funds all drugs prescribed for the active treatment of cancer in British Columbia. Cancer is the most common cause of death in British Columbia and half of all people suffering from cancer require drug therapy at some point in their disease.

For 2001/02, $48,171,721 will support treatment for more than 22,000 patients. While this is a significant cost, the Pharmacare Trend 2000 document reveals that the 1999 cost for cardiac drugs was five times that of cancer drugs. In addition, the cost of hormones (for menopausal symptoms and contraception) exceeded the cancer drug budget and one drug for gastritis, omeprazole, costs two thirds of the cancer drug budget. AIDS drugs treat fewer than one sixth of the number of patients and cost more than cancer drugs.

Cancer drugs can cure cancer, prolong life or relieve symptoms and improve quality of life. Most drugs are prescribed by specialists to treat genitourinary cancer (especially prostate cancer), breast cancer, colorectal cancer, lymphomas, leukemias and ovarian cancer. All cancer treatment policies are evidence-based. Patients are registered by diagnosis and access to new drugs is restricted to specific clinical indications. Reimbursement is adjudicated for compliance with guidelines. BCCA policies and protocols are linked to formal education programs and posted on the Agency's web-site for use throughout the province.

All drugs are dispensed by hospital pharmacies. These include (1) intravenous injections of chemotherapy, targeted biological therapies and immunotherapy which are principally given to ambulatory patients in specialised outpatient clinics in hospitals, and (2) oral or injectable chemotherapy, hormone therapy, immunotherapy or biological therapies taken home by the patient (44% of the drug budget). Frequently, multidrug regimens involve complex admixtures of drugs from both of these categories, which may cause serious and even fatal side effects. As a result, patients require close monitoring and supervision by oncologists, pharmacists and nurses.

The Future of Oncology Drug Management in BC

Cancer drug costs are predicted to rise at 20-30% per annum. The rapid development of effective new drugs for cancer coincides with the growth in incidence and prevalence of treatable cancer in our population. Changes in regulatory procedures at Health Canada, resulting from pressure from AIDS and cancer advocates as well as drug companies, will result in provisional approval of new drugs, based on early data. Oncologists will be faced with the difficult task of evaluating optimal therapy on the basis of too little information; patients will hope for greater benefit, even if there is a risk of toxicity. We

consider it unlikely that the public purse will be able to support all of these choices, indefinitely.

In view of the above realities, we recommend that the strategy most likely to contain costs and provide reasonable choice will be to develop a "basket" of publicly funded drugs that are deemed essential for quality population-based health care. In addition, a separate user-pay list of treatment options deemed too early to evaluate or of only marginal benefit, can be offered. This approach requires a scientific and ethical framework supported by the public, the Ministry of Health and the professional staff at the BCCA and our Community Oncology Network. Collaboration with insurance companies is an essential component of this approach.

A potential barrier to the above approach is the Canada Health Act, which, in its most strict interpretation, may preclude the BCCA from charging patients and their insurance plans for intravenous drugs administered in an ambulatory setting in a hospital clinic. This practice already occurs in some community hospitals in BC, where patients buy drugs at retail pharmacies and have them administered in hospital. We will need to seek the advice of the Provincial Ministry of Health in assessing the tolerance of the Federal Ministry of Health to the concept of patients paying for treatments that are considered to be outside the boundaries of "essential" services.

It is already feasible to consider this approach for the outpatient drugs we dispense, but targeting this segment of cancer drugs alone is inequitable and disruptive of the progression of patients between various different single and multidrug protocols.

We are now in the process of carefully studying whether charging deductibles is likely to be cost-effective for our outpatient drugs. If we attempt to blend a deductible with Pharmacare, it is not clear if there will be significant savings, since many cancer patients will reach their maximum deductible due to use of other symptom-management drugs. The processes of blending deductibles with Pharmacare are challenging for a number of technical reasons and the inability to predict whether the deductibles will accrue to the BCCA or to Pharmacare would destabilise our budgeting processes. Patients would also find it difficult to meet the full deductible expense at diagnosis or for the first one or two prescriptions of each year (as would be the case with many cancer drugs).

An option we do NOT recommend would be to transfer responsibility for all outpatient cancer drugs to Pharmacare. This is likely to significantly increase the cost of cancer drugs, partly since we would lose the ability to contract for drugs at bulk prices but also because utilisation would be difficult to control once these drugs are listed for general use. Other disadvantages include risks to patient safety when combining complex oral and intravenous regimens, displacement of BCCA's scientific expertise from the drug management process and loss of valuable data to track outcomes. While transfer to Pharmacare of certain drugs that are fairly simple to prescribe, such as prostate hormones, would facilitate applying deductibles, it is likely to result in overuse of multidrug hormone therapy by urologists and family doctors (a costly and ineffective approach, widespread in other provinces). In September 2001, Pharmacare transferred all their remaining prostate drugs to the BCCA ($2.7 million per year) in order to consolidate the management of these drugs in one budget.

Overall, the advantages of charging deductibles may be offset by the disadvantages of fragmenting cancer drug management. Provinces such as Ontario and Quebec, who

have not incorporated outpatient oncology drugs into a formal cancer system, have greater difficulty in controlling costs. BC and Alberta have comprehensive provincial cancer drug budgets which support equitable access and have the best outcomes for a lower cost.

Impact of Limiting Expenditures of the Provincial Cancer Drug Budget

The impact of constraining the drug budget to zero growth over three years will result in the deletion of programs that are effective in terms of increasing cure rates, prolonging life or improving quality of life in a range of patients but have substantial financial impact of several million dollars. Examples would be:

1. Deletion of funding for prostate cancer drugs in favor of surgical orchiectomy in 2,000 to 3,000 men with metastatic prostate cancer (savings of approximately $10M/year). Evidence indicates that the clinical outcomes of either treatment strategy are equivalent, but the psychological impact of irreversible surgical orchiectomy has led to organ preservation and chemical orchiectomy being the standard of care, funded throughout Canada.

2. Elimination of first-line irinotecan therapy for 500 patients with metastatic colorectal cancer for whom this drug relieves symptoms and prolongs life by a few months (savings of approximately $3M/year). This would result in a standard of care lower than other provinces.

3. Elimination of funding for third and fourth line treatment of breast and ovarian cancer in 600 or 700 patients per year would result in several million dollars of savings at the cost of shortening their lives by several months and adversely affecting symptom management. These therapeutic options are already confined to those patients who have benefited from earlier treatments and are likely to respond to another drug. They are available in all other provinces.

4. Curative programs such as the addition of rituximab to CHOP chemotherapy for advanced stage aggressive lymphoma (approximately $2-3M/year), or the substitution of epirubicin for doxorubicin for newly diagnosed breast cancer (approximately $1M/year) enhance the cure rate of standard chemotherapy. Deletion of the newer and more expensive drugs in favour of our older regimens would inevitably result in loss of life of 5-10 out of every 100 patients treated. Such an impact would clearly be unacceptable.

Essential (Life Support) Requirements for Cancer Drug Funding

In light of fiscal constraints, the BCCA among other initiatives, has taken the following steps:

- The BCCA has formed a pharmacy working group to evaluate the opportunities and barriers to applying deductibles or user fees to outpatient prescriptions.
- The Provincial Tumour Groups have been asked to review and establish the priorities for all their new and existing treatment policies. The result of this process will be to provide government with a ranking of the benefit of cancer drug therapies,

and in particular to identify those publicly funded drugs that are essential for quality population-based cancer care.

The most profound impact of constraining the oncology drug budget to zero growth would be the inability to fund the effective, but expensive, new drugs that will become available over the next 3 years that are deemed to be essential for quality population-based cancer care. Both patients and physicians are anxious to have access to evidence-based new therapy and the failure to fund such opportunities would be deleterious to the health of British Columbians.

It is not feasible to achieve a balanced budget with no increases for three years without introducing adverse health care outcomes for patients with treatable cancers. This would limit our ability to fund newer and more effective drugs for three years, thereby offering a lower standard of cancer care in British Columbia in comparison to other provinces in Canada. At present, cancer outcomes in BC are the best in Canada. We cannot provide funding for new drugs without disadvantaging several large groups of patients with common cancer diagnoses who are receiving existing drugs.

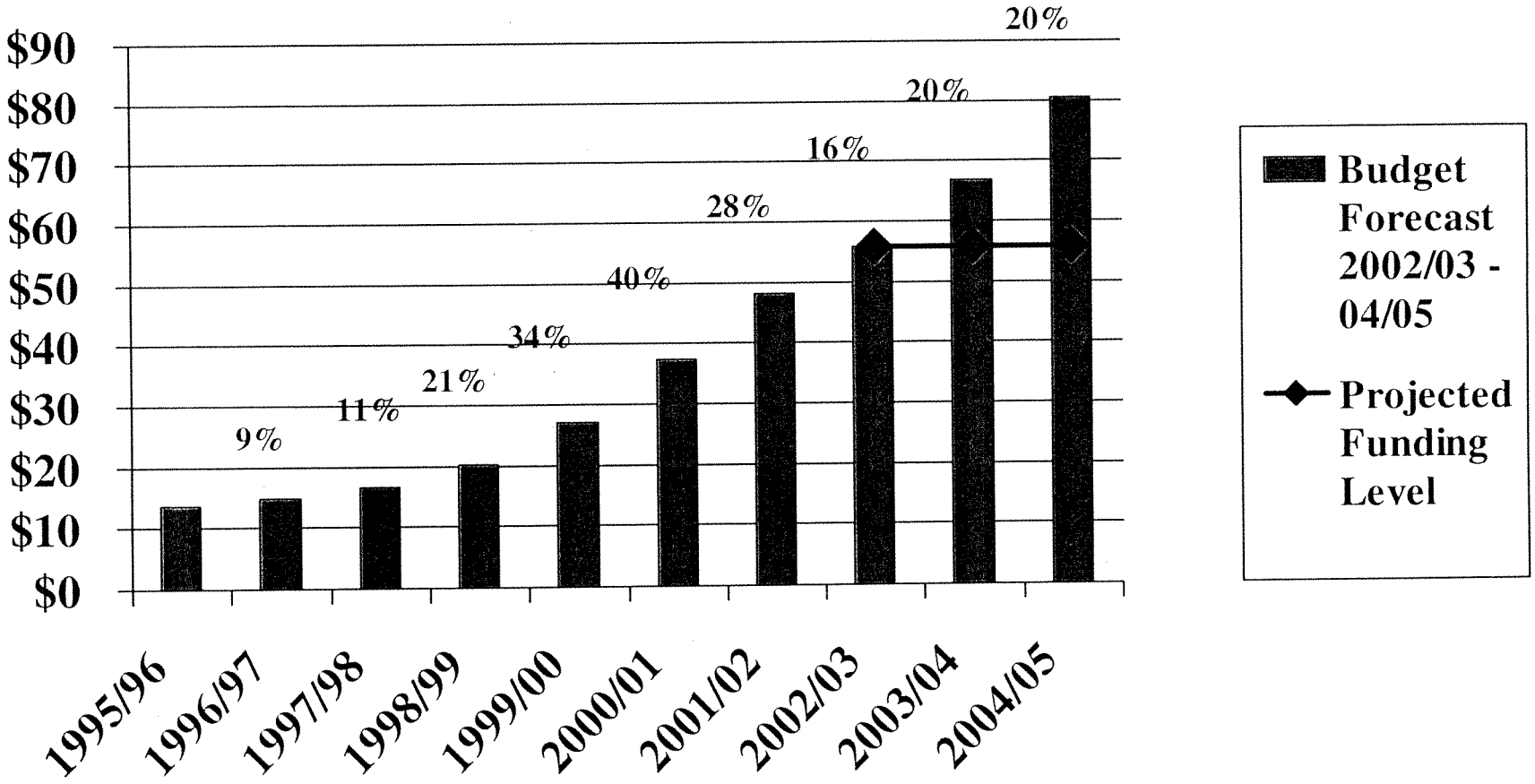
With the receipt of the $5.2 million new funding earmarked for 2002/03, the Agency's priority-setting initiative will allow management within a total funding envelope of $55.8 million without adversely affecting population health. However, our most conservative estimates for growth would require a total budget of $67 million for 2003/04 ($10-11 million additional dollars) and $80 million for 2004/05 ($12-13 million additional dollars). (see attached graph). The proportion of these additional funds required for publicly funded therapies that are essential for quality population-based cancer care will be determined through the completion of the evaluation and impact statements from each of the BCCA's Tumour Groups.

BC already has one of the most cost-effective oncology drug management systems in Canada. We are ready and willing to develop creative funding opportunities but very reluctant to erode the excellence we have achieved in delivery of evidence-based, universally accessible cancer therapy.

March 11, 2002

BC Cancer Agency

Conservative Growth Projections in Provincial Drug Costs ($ Millions)



Health Service Redesign Plan
Current and Proposed Service Levels

CANCER CONTROL AGENCY OF B.C.

INDICATOR	Utilization/Workload Fiscal Year 1998/1999	1999/2000	2000/2001	2001/2002 Projected Year End	% Change 98/99 to 99/00	% Change 99/00 to 00/01	Target as Identified by HA Fiscal Year 2002/03	2003/04	2004/05
VCC									
Radiation Therapy									
Completed Treatments									
·Fractions (Visits)	61,392	63,722	68,624	58,531	4%	8%	60,287	62,096	63,958
Completed Courses (First and Subsequent)	3,988	4,259	4,379	3,854	7%	3%	3,970	4,089	4,211
Chemotherapy (Ambulatory only):									
· Appointments (Visits) (Excl. Nanaimo)	7,673	9,041	11,021	13,209	18%	22%	14,266	15,407	16,640
Ambulatory Care Follow-Up Visits:									
· Provincial Systemic Program - Patients Receiving Drug Treatment	na	na	na	na			na	na	na
VICC									
Radiation Therapy									
Completed Treatments									
·Fractions (Visits)	23,911	23,203	25,472	35,316	-3%	10%	37,208	38,324	39,474
Completed Courses (First and Subsequent)	1,746	1,806	1,917	2,262	3%	6%	2,330	2,400	2,472
Chemotherapy (Ambulatory only):									
· Appointments (Visits) (Excl. Nanaimo)	5,066	5,136	5,362	5,640	1%	4%	6,091	6,578	7,105
Ambulatory Care Follow-Up Visits:									
· Provincial Systemic Program - Patients Receiving Drug Treatment	na	na	na	na			na	na	na
FVCC									
Radiation Therapy									
Completed Treatments									
·Fractions (Visits)	33,772	35,948	38,837	35,999	6%	8%	37,079	38,191	39,337
Completed Courses (First and Subsequent)	2,030	2,159	2,309	2,138	6%	7%	2,202	2,268	2,336
Chemotherapy (Ambulatory only):									
· Appointments (Visits) (Excl. Nanaimo)	5,409	6,339	6,469	7,774	17%	2%	8,396	9,068	9,793
Ambulatory Care Follow-Up Visits:									
· Provincial Systemic Program - Patients Receiving Drug Treatment	na	na	na	na			na	na	na
CCSI									
Radiation Therapy									
Completed Treatments									
·Fractions (Visits)	18,304	26,409	24,176	26,542	44%	-8%	27,338	28,158	29,003
Completed Courses (First and Subsequent)	1,087	1,535	1,456	1,609	41%	-5%	1,657	1,707	1,758
Chemotherapy (Ambulatory only):									
· Appointments (Visits) (Excl. Nanaimo)	2,382	2,557	2,933	3,226	7%	15%	3,484	3,763	4,064
Ambulatory Care Follow-Up Visits:									
· Provincial Systemic Program - Patients Receiving Drug Treatment	na	na	na	na			na	na	na
INPATIENT DAYS	11,917	10,574	10,287	9,500	-11%	-3%	9,000	9,000	9,000
TOTAL BCAA									
Radiation Therapy									
Completed Treatments									
·Fractions (Visits)	137,379	149,282	157,109	156,388	9%	5%	161,912	166,769	171,772
Completed Courses (First and Subsequent)	8,851	9,759	10,061	9,863	10%	3%	10,159	10,464	10,777
Chemotherapy (Ambulatory only):									
· Appointments (Visits) (Excl. Nanaimo)	20,530	23,073	25,785	29,849	12%	12%	32,237	34,816	37,601
Ambulatory Care Follow-Up Visits:									
· Provincial Systemic Program - Patients Receiving Drug Treatment	17,620	19,465	20,499	21,934	10%	5%	23,469	25,112	26,870
Inpatient Days	11,917	10,574	10,287	7,266	-11%	-3%	7,000	7,000	7,000