APPENDIX 6
BACKGROUND INFORMATION

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1. HEALTH CARE IN CANADA AND BRITISH COLUMBIA

1.1 Introduction

The Canadian health care system is predominantly a publicly funded system regulated by two senior levels of government. The federal government sets standards of access and availability and the provincial governments administer licensing and services.

Under the Canadian Constitution the provinces are responsible for the provision of health services to their respective populations. Each provincial government decides where hospitals will be located, how many physicians will be needed and how much money will be spent on the health care systems in their respective provinces.

The federal government contributes funds to the provinces to assist in the provision of health services based on a policy of universality which guarantees all Canadians the right of access to health care. The *Canada Health Act*, Consolidated Statutes of Canada Chap. C-6, is the framework of Canada's federal health insurance system. It establishes the criteria and conditions (the national standards) for health insurance that the provinces and territories must meet in order to receive federal contributions towards the administration and delivery of health care services.

1.2 The *Canada Health Act*

1.2.1 Introduction

The *Canada Health Act* was passed in 1984 to replace previous legislation which established Canada's national health insurance program in 1957. The comprehensive new *Canada Health Act* retained and entrenched the basic principles underlying the national health insurance program contained in the earlier legislation and extended these principles in some key areas. The most striking change from the previous legislation was the inclusion in the *Canada Health Act* of provisions aimed at eliminating extra billing and user charges to the patient with respect to insured health services.

1.2.2 Extra-Billing and User Charges under the *Canada Health Act*

The *Canada Health Act* allows the federal government to levy penalties on provinces and territories that allow extra billing and user charges to patients. The *Canada Health Act* discourages extra billing and user charges by providing for dollar-for-dollar deductions from federal transfer payments to the provinces and territories. For example, if it is determined that a province has allowed $500,000 in extra billing by physicians, the

federal transfer payments to that province would be reduced by the same $500,000 amount.

1.2.3 Health Care Services Covered by the *Canada Health Act*

There are two groups of health care services covered by the *Canada Health Act*, insured health care services and extended health care services.

Insured health care services are medically necessary hospital services, physician services and surgical dental services provided to insured persons.

Insured hospital services are defined under the *Canada Health Act* to include:

- Nursing services.
- Drugs administered in a hospital.
- Inpatient and outpatient services, such as standard or public ward accommodation.
- The use of operating rooms, case rooms and anaesthetic facilities.
- Diagnostic procedures such as blood tests and X-rays.

Persons not covered by the *Canada Health Act* include:

- Serving members of the Canadian Forces or Royal Canadian Mounted Police.
- Inmates of federal penitentiaries.
- Persons covered by provincial workers' compensation.

1.2.4 Requirements of the *Canada Health Act*

There are five main criteria that define the *Canada Health Act*: publicly administered; comprehensiveness; universality; portability; and accessibility.

(a) **Publicly Administered**

The health insurance plans of the provinces and territories (not hospitals or the services that hospitals provide) must be publicly administered by the government or a government agency on a non-profit basis and be subject to audits of their accounts and financial transactions.

(b) **Comprehensiveness**

The health insurance plans of the provinces and territories must include all insured health services defined by the *Canada Health Act*.

(c) **Universality**

All insured residents of a province or territory are entitled to the insured health services provided by the provincial or territorial plans under uniform terms and conditions. This requires that residents register with the plans to establish entitlement.

(d) **Portability**

Insured individuals moving from one province or territory to another must continue to be covered for services by the "home" province or territory during any minimum waiting periods imposed by the new province or territory of residence. Portability does not entitle a person to seek services in another province, territory or country, but it does entitle one to receive necessary services in relation to an urgent need on a temporary basis such as during business travel or vacations.

(e) **Accessibility**

The provision of services may not be restricted by user charges or extra-billing or discrimination because of age, health status or financial circumstances. Residents are entitled access to insured health care services at the setting where the services are available.

1.2.5 Health Care Services Not Covered by the *Canada Health Act*

In addition to the hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of services and benefits outside the scope of the *Canada Health Act*. A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health insurance legislation.

Uninsured hospital services for which patients may be charged include the provision of preferred hospital accommodation (unless prescribed by a physician), private duty nursing services, cosmetic surgery, and telephones and televisions.

Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates, testimony in court, and cosmetic surgery.

1.3 Health Care in British Columbia

1.3.1 Introduction

On December 12, 2001 the newly elected provincial government announced changes which were designed to fulfill its stated goal of renewing public health care in British Columbia.

The stated goal of restructuring of the health regions was to create a solid foundation which would support the necessary changes and to remove obstacles which were identified as falling into three categories:

- A history of inadequate planning and management.
- A growing imbalance between what the public wants and what the public health care system can deliver.
- An overall lack of sustainability.

1.3.2 Background

Like most Canadian jurisdictions, British Columbia moved to a regional model of health care delivery in the 1990s. The previous array of 52 regional authorities included:

- 11 regional health boards.
- 34 community health councils.
- 7 community health services societies.

Each of these authorities had its own chief executive officer, and corporate services and administrative infrastructure including its own board of directors. The new government stated that the structure was one of the most complex and costly of its kind in Canada and that it compromised patient care. Examples cited included:

- Administrative duplication diverted resources away from patient care.
- Health authorities were not able to work together effectively to coordinate services, realize economies of scale, and attract and retain experienced managers and health professionals.
- Smaller, rural authorities did not have the population or budget to support the full range of services needed.
- The scattered, inequitable division of responsibilities made the system as a whole unaccountable.

1.3.3 The New Structure

The 52 regional and community authorities were consolidated and reduced, to produce one provincial and five geographic health authorities.

The intention of this new structure is that each new health authority will realize economies of scale in areas such as finance, information technology and other administrative and support services.

The overall provincial authority (Provincial Health Services Authority or PHSA) is responsible for governing and administering provincial programs and specialized services as described in Section 2.2.1 of this Appendix.

Working with PHSA, the five new geographical health authorities established under and pursuant to the regulations to the *Health Authorities Act*, R.S.B.C. 1996, c. 180, are better able to plan and coordinate equitable access to highly specialized services, which represent almost a third of the Province's spending on hospital care.

The five geographical health authorities provide health care services within their defined areas, ensure community participation in health care decision making, and protect local input into the delivery of health services. They reflect provincial geography as well as patient and physician referral patterns. They are primarily responsible for:

- Identifying regional health needs and planning appropriate programs and services.
- Ensuring that programs and services are properly funded and managed.
- Managing the delivery of health services in their respective areas.
- Meeting performance objectives set by the Ministry of Health Services.
- Ensuring community input into health service planning and evaluation for their respective areas.

1.3.4 The Provincial Ministry of Health Services

The Ministry of Health Services works with each of the five regional health authorities and PHSA in the development of provincial standards. This ensures that the standards are uniform across the Province. The ministry has a large role in the planning and funding of provincial health care, and typically pays 60% of the cost of health system capital projects. Specifically, the ministry works towards:

- Developing provincial goals and province-wide standards.
- Holding health authorities accountable for fulfilling their responsibilities.
- Ensuring appropriate health outcomes are achieved province-wide.

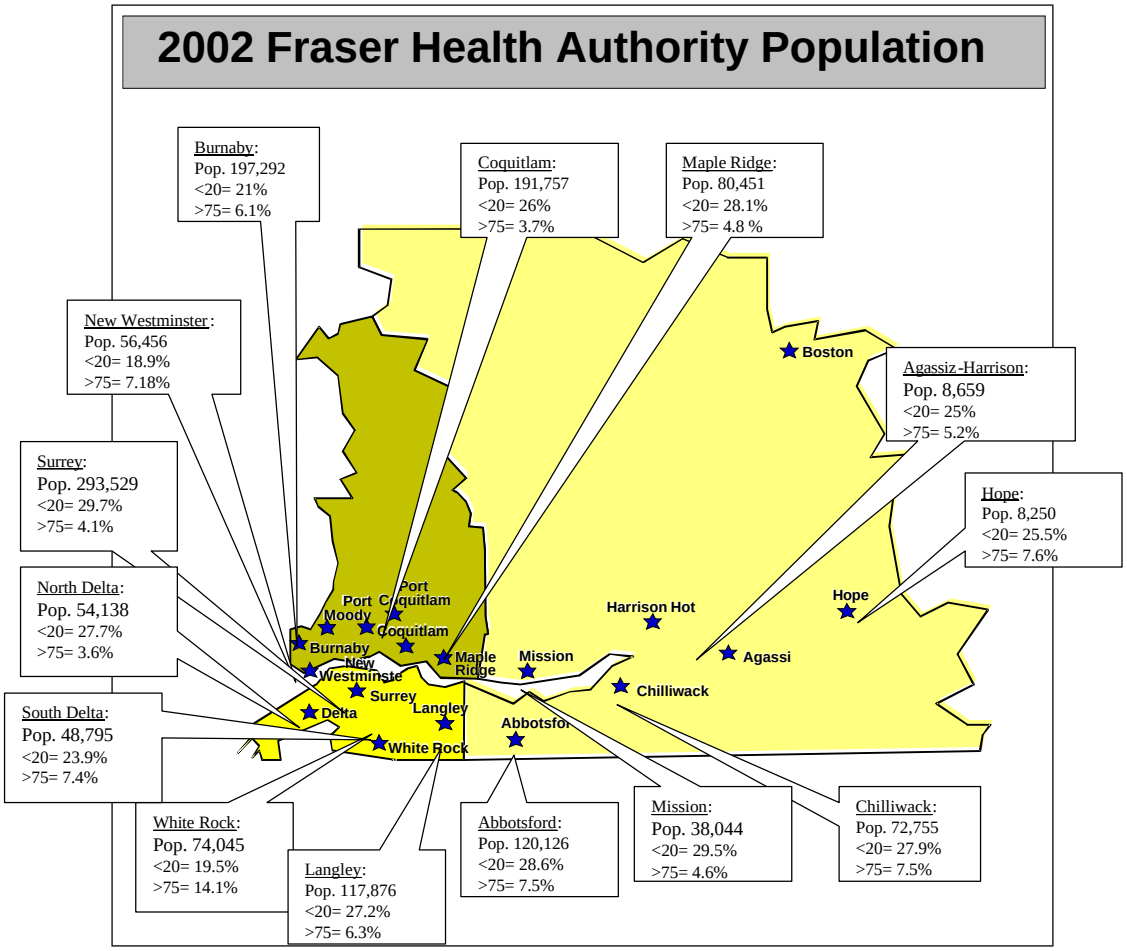
2. AHCC PUBLIC SECTOR INVOLVEMENT

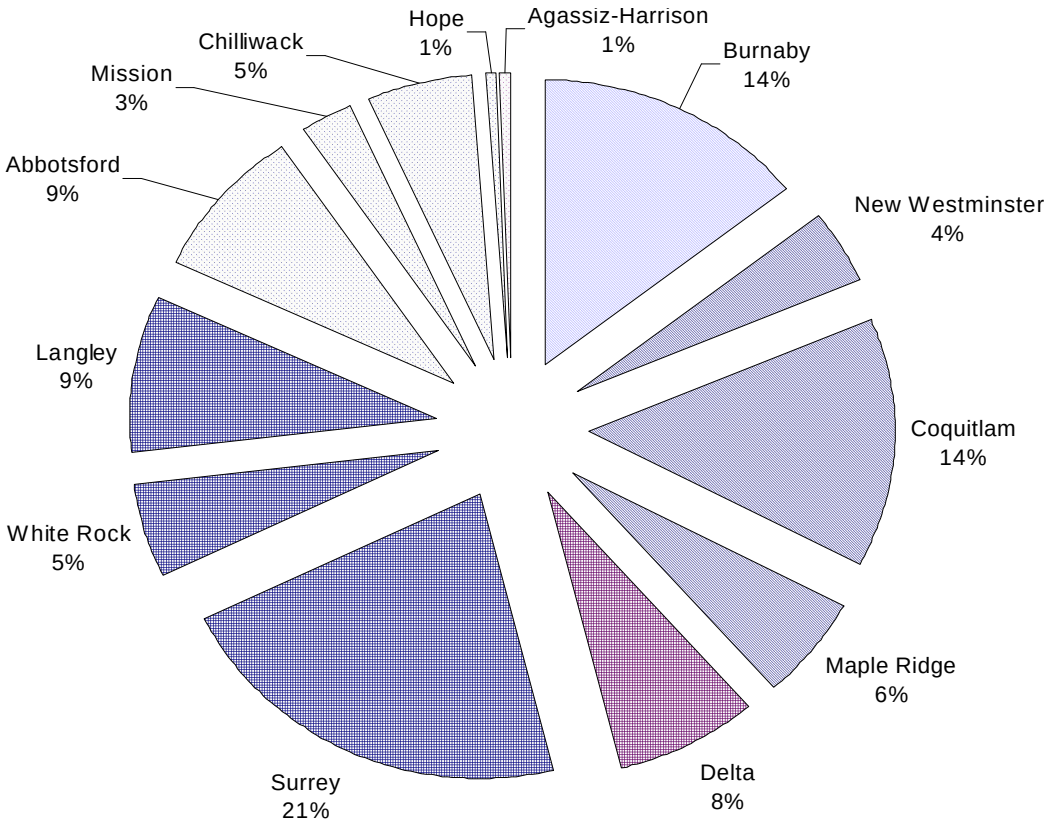
2.1 Fraser Health

2.1.1 Introduction

Fraser Health (or FHA) is one of six new health administrative areas established by the provincial government in December 2001 under and pursuant to the regulations under the *Health Authorities Act*, R.S.B.C. 1996, c. 180. It is governed by a board of nine directors from diverse backgrounds, who oversee and manage health services in more than 18 communities. FHA has about 20,000 staff, 1,700 doctors, and approximately 10,000 staff working in contracted health agencies.

FHA covers a large geographical area, running east/west from Hope to Burnaby, and north/south from Boston Bar to the Canada/US border. The population served by FHA is widely dispersed and resides in communities ranging in size from small rural hamlets to large rapidly growing suburban centres such as Surrey, which accounts for 21% of FHA's total population. FHA's growth rate has been higher than the overall provincial growth rate and the current population of 1.36 million people (equal to 1/3 of the total provincial population). FHA is the largest of the Province's health authorities. The following map and graph show the 2002 population distribution by community.





2.1.2 FHA Service Overview

FHA provides inpatient, outpatient, diagnostic and therapeutic services through 13 hospitals.

Combined, the FHA hospitals have about 2,000 acute beds. Most residential care is provided through approximately 8,000 community residential beds. There are also 800 mental health residential beds. FHA provides the following services:

- Inpatient acute care.
- Outpatient and diagnostic services.
- Community and residential care.
- Public health protection and health promotion, and disease and injury prevention.

2.1.3 Driving Distances Between FHA Facilities

Driving distances between FHA acute care facilities are shown in the following table. The two facilities furthest apart are Burnaby and Fraser Canyon Hospitals (144 km).

(Distances in KM)	BH	CGH	DH	ERH	FCH	LMH	MSA	MMH	PAH	RMH	RCH	StPH	SMH	VH
Burnaby		93	24	19	144	37	62	59	37	33	15	11	18	9
Chilliwack	93		91	85	54	57	32	43	72	68	82	100	76	100
Delta	24	91		37	142	34	60	64	25	48	27	26	24	23
Eagle Ridge	19	85	37		135	32	54	42	33	18	11	26	19	26
Fraser Canyon	144	54	142	135		108	82	93	122	119	133	156	126	150
Langley Memorial	37	57	34	32	108		27	32	20	40	28	47	19	44
Matsqui Sumas Abbotsford	62	32	60	54	82	27		13	41	38	52	70	45	69
Mission Memorial	59	43	64	42	93	32	13		50	27	48	66	50	65
PAH	37	72	25	33	122	20	41	50		41	28	45	18	44
RMH	33	68	48	18	119	40	38	27	41		22	41	28	40
Royal Columbian	15	82	27	11	133	28	52	48	28	22		21	10	20
StPH	11	100	26	26	156	47	70	66	45	41	21		28	4
Surrey Memorial	18	76	24	19	126	19	45	50	18	28	10	28		26
VH	9	100	23	26	150	44	69	65	44	40	20	4	26	

2.1.4 FHA Referral Patterns and Catchment Areas

In 2000/01, adult residents of FHA were provided with care for 192,300 inpatient and day procedure cases. Nearly 155,000 of these cases (or 80%) were provided by FHA hospitals, with the majority of the remainder were provided by hospitals in Vancouver. Referral patterns varied by service area: only 76% of FHA residents' surgical cases were provided within FHA, while treatment was provided for over 83% of medical cases and 88% of psychiatry cases in FHA hospitals.

FHA pediatric visits totalled 4,600 visits in 2000/01. Of these, 8,600 were provided in FHA hospitals, and the remaining 41% (6,000 cases) were provided outside of the FHA catchment area.

In 2000/01, the 13 hospitals in FHA cared for 166,575 adult patients. 93% of these patients were residents of FHA, while 11,700 (7%) were residents of areas covered by other health authorities.

FHA hospitals in the Fraser Valley served the highest proportion of residents from their surrounding communities (Hope, Chilliwack, Mission and Abbotsford). Two percent of cases were residents of areas covered by other health authorities. In 2000/01, there were over 430,000 visits to FHA hospital emergency departments.

2.1.5 FHA Current Expenditure of Resources

FHA has a total annual operating budget for 2003/04 of about $1.6 billion. FHA's estimates of expenditures by sector for 2003/04 are shown in the following table:

	Operating Cost* (000s)	% Total Operating Cost
Acute Care Sites	871,790	57%
Convalescent Residential Care	281,190	18%
Convalescent Community Care	176,750	11%
Mental Health	110,710	7%
Public Health	51,740	3%
Administration & Support	65,820	4%
TOTAL:	$ 1,558,000	100.0%

The following chart shows that most of FHA's resources are spent on acute and residential care.

2.1.6 FHA Direction for Change

The goals of FHA are consistent with those of the provincial Ministry of Health Services. These goals are best described through an integrated health service delivery model which consists of three equally important components: acute care; home and community care; and sub-acute care. FHA has taken the following steps to foster an integrated approach to service delivery:

- Consolidate specialized acute services at fewer sites and provide greater specialization of services within the acute care sites to ensure that scarce specialized health care providers and resources can be deployed in the most efficient and cost effective manner.
- Shift more surgical cases to day surgery and procedures, thereby avoiding inpatient hospital stays.
- Develop specialized inpatient pediatric units to treat children and their families.
- Consolidate intensive and critical care units to fewer sites, of at least 10 beds, to effectively treat patients with complex medical problems who require easy access to sophisticated diagnostics, equipment and specialists.
- Consolidate and maximize scarce inpatient psychiatry resources into regional centres with adolescent, child, adult, geriatric and organic brain syndrome care.
- Improve the utilization of inpatient beds.

- Provide more elder-friendly acute care. Designate acute care beds to treat the frail elderly and have their care coordinated by a geriatrician. The focus of these units is to ensure that older patients are able to return as quickly as possible to the community.
- Implement an integrated FHA information system, to manage access of resources such as operating rooms, costly diagnostic tests, and specialized programs such as palliative care and post-acute rehabilitation.
- Develop an integrated FHA-wide rehabilitation program to address the serious lack of rehabilitation services available to the population.
- Develop an integrated FHA-wide emergency and urgent care program based on the recognition that not all visits to the emergency room are the same. Services are coordinated across sites. Timely emergency transport and ambulances help to ensure that each emergency room is seeing the appropriate type of patient.
- Designate one tertiary referral hospital to operate as the specialized emergency facility.
- Designate two referral hospitals to operate on a "24/7" basis with emergency rooms having the capacity to consistently respond to level III cases.
- Designate "24/7" emergency departments in community hospitals. These emergency departments can address most of the cases that are seen in FHA. They are located within one hour's drive of most who live in the FHA catchment.
- Designate urgent care centres that can provide area residents with a substantial number of services, such as diagnostics and imaging, treatment of minor injuries and illnesses, and selected day procedures. This provides a close link to primary care to facilitate keeping people healthy and able to live independently within their community.
- Develop community health centres in existing and new locations to meet the needs of a growing and changing population of all ages. These centres operate during the day and provide a wide range of ambulatory services, including primary care, to help with minor injuries and illnesses, access to diagnostics, and special care clinics to help to manage chronic conditions.
- Develop an FHA-wide palliative hospice care program which has a full range of hospital and community-based elements. This would build on and expand the work that is currently being done in various parts of FHA.
- Develop supportive housing facilities targeted at clients who have care needs that exceed the capacity of the existing community support systems.
- Develop and co-locate a continuum of respite services in a variety of residential care or transitional care sites.
- Develop assisted living facilities targeted at clients at risk for institutional care because of deteriorating functional and cognitive status.

- Develop geriatric assessment and treatment units and programs across the area covered by FHA.

2.1.7 Existing Hospital in Abbotsford and the AHCC

The growth in population, the increased regional demands, and the age and condition of the Existing Hospital building have all driven the need for a new facility.

Completion of the AHCC will allow FHA to provide the necessary access to quality patient care to the residents of its area, as well as to patients in adjoining regions who seek care closer to their home.

2.1.8 Additional Background Information on FHA

Additional background and other information about FHA can be found at: http://www.fraserhealth.ca.

2.2 Provincial Health Services Authority

2.2.1 Introduction

With close to 10,000 employees and an annual budget of approximately $1 billion, the PHSA is responsible for managing the quality, coordination, accessibility and cost of selected province-wide health care programs and services. This includes selected services provided in facilities governed by other health authorities, as well as those programs and services provided by the following: BC Cancer Agency; BC Centre for Disease Control; BC Provincial Renal Agency; BC Transplant Society; Children's and Women's Health Centre of British Columbia; Forensic Psychiatric Services Commission and Riverview Hospital.

2.2.2 Additional Background Information on the PHSA

Additional background and other information about the PHSA can be found at: http://www.phsa.ca/default.htm.

2.3 BC Cancer Agency

2.3.1 Introduction

Internationally acclaimed as a leader in the areas of cancer research and treatment, the mandate of the BC Cancer Agency (or BCCA) is to provide a cancer control program for the people of BC and ensure that patients have access to programs and services that offer the greatest benefit. BCCA's vision is "a cancer-free society" and its mission is:

- To reduce the incidence of cancer.
- To reduce the mortality from cancer.
- To improve the quality of life for those living with cancer.

BCCA oversees the operation of four existing regional cancer centres, with 13 linear accelerators and 32 chemotherapy chairs, and employs about 1,900 staff and 65 oncologists.

In collaboration with others, the BCCA provides prevention and early detection programs, diagnostic and treatment services, community programs, supportive care, rehabilitation, palliative care, and research and education. It currently operates cancer centres in Vancouver, Surrey, Kelowna and Victoria. The cancer centre component of the new AHCC will be BCCA's fifth cancer centre and will join the Vancouver Cancer Centre and the Surrey Cancer Centre in serving the lower mainland population.

Each outpatient cancer centre provides assessment, diagnosis, chemotherapy and radiation therapy, counselling services and follow-up care. The Vancouver Cancer Centre also provides inpatient and diagnostic services. The other cancer centres at •Surrey Memorial, Royal Jubilee and Kelowna General hospitals ••each provide inpatient and hospital services.

As part of its commitment to providing patients with access to a full range of quality cancer services, regardless of where they live, BCCA operates a communities oncology network. The network links regional and community hospitals, physicians and health care professionals in the Province to BCCA programs and specialists.

Provincial programs such as for hereditary cancer, screening mammography and cervical cytology provide early detection services, which lead to quicker, more effective treatments.

An established provincial cancer registry is the focal point of BCCA's comprehensive data management system, which provides population data, analysis and evaluation of all British Columbia cancer patients' diagnosis, treatment and outcomes. In addition to directing efforts to determine risk factors that lead to cancer, this information supports planning activities, resource allocation and the development of cancer control strategies.

Researchers working in the BC Cancer Research Centre's eight laboratories conduct research to discover what causes cancer, how to improve cancer treatments, and how to develop better ways to control and cure the disease. With a direct link between scientists in its BC Cancer Research Centre and clinicians in its cancer centres, BCCA can take discoveries from the researcher's bench in the laboratory to the patient's bedside where they matter most – to people living with cancer.

2.3.2 BCCA Referral Patterns and Catchment Area

In 2000/01, there were an estimated 10,300 new cancer cases across the lower mainland cancer centre catchment area. Of these, 8,000 (77%) were fully admitted to one of the cancer centres, resulting in 179,000 patient visits.

In 2000/01, 97% of referred cases seen in the Surrey Cancer Centre were residents within its catchment area. In the Vancouver Cancer Centre, 76% of referred cases were from residents within its catchment area. For the lower mainland, the collective rate was 80%.

Cancer projections for the lower mainland indicate an annual increase of approximately 3% in the numbers of new cancer cases in the community. For the Fraser Valley, the percentage is closer to 3.5%. It is expected that there will be over 15,700 new cases of cancer reported annually by 2015. The number of people living with cancer (prevalent cases) and requiring continued care from the cancer system is increasing by 8 - 10% each year.

2.3.3 BCCA Resource Allocation for Lower Mainland Cancer Centres

The BCCA actual expenditures for fiscal 2000/01 were allocated across the programs/services as follows:

Programs/Services	Total Operating Cost* (000s)	% Total Operating Cost
Prevention and Early Detection Programs	5,477	6%
Diagnostic Services	13,704	16%
Outpatient Treatment Programs (incl. CON)	49,461	56%
Rehabilitation Services & Palliative Care	1,515	2%
Other Clinical Services**	5,543	6%
Corporate Support***	12,351	14%
Total	88,051	100%

NOTES:
* excludes depreciation
** includes: Physiotherapy, Quality of Life Outcome, Speech and Language Pathology, MSP Dermatology, and VCC Inpatient & BMT Program
*** includes: Administration, Materiels Management, IT, Housekeeping, Plant/Security, Biomedical Engineering, Respiratory Therapy, Library, and PIM

The allocation shown above is for representative purposes of the lower mainland Cancer Centres only, and must be reviewed in its entirety with the BCCA total operating budget which now exceeds $300 million (including Alternate Payment Branch and Research funding).

2.3.4 Abbotsford Cancer Centre and the AHCC

The two existing cancer centres in the lower mainland, Vancouver Cancer Centre and Surrey Cancer Centre, were designed to accommodate 5,000 and 2,500 new patients, respectively. Based on new patient registrations alone, both cancer centres are working in excess of their designed capacity. These are now considered inadequate because of the number of prevalent cases and the many disease sites for which multiple treatment modalities are required. Thus, the chemotherapy workload is growing at a greater rate than for any other cancer service.

In the lower mainland there are currently 13 radiation therapy machines. The growth in demand for treatment services means that by 2004 the lower mainland will have a shortfall of two treatment machines. This demand for radiation therapy alone makes a compelling case for a new cancer centre in Abbotsford.

The Abbotsford Cancer Centre component of the AHCC will be an integral part of BCCA's lower mainland services, providing a full range of cancer control services including research and education to the community.

2.3.5 BCCA Direction for the Future

The BCCA's direction includes:

- To plan and fund the cancer control program through recognition of:
- growth in existing activities (the consequence of incidence and prevalence);
- recapitalization of existing infrastructure and equipment resources; and
- the initiation of new programs and activities that have established or potential importance in cancer control.
- The underpinning of the cancer control strategy by a mandate to generate new knowledge and establish evidence as a basis for policy and practice.
- The development and acceptance of a jointly-owned, population-based, cancer control program in conjunction with the health authorities.
- To plan human resources to meet the requirements of the cancer control strategy.

Consistent with the BCCA's provincial direction, BCCA has taken the following steps to address the population's needs for the lower mainland:

- Increase treatment, research, and education capacity with the addition of linear accelerators, chemotherapy chairs, and appropriate work space for clinical trials and all health professionals.
- Improve patient access to a BCCA regional centre and reduce travel distance for the residents of Abbotsford, Hope, Chilliwack, Mission, and surrounding areas.
- Collaborate with FHA to develop and regionally implement cancer control programs/services in the communities. Integration opportunities include among others:
- Women's health program.
- Surgical oncology program.
- Rehabilitation and support services.
- Hereditary cancer program.
- Develop a full electronic health record through the integration of clinical and non-clinical information systems.
- Provide for tele-medicine initiatives, including the ability to conduct video-consultations and other expected technological advances.

- Apply new knowledge through BCCA's research, outcomes evaluation, and quality improvement initiatives, into the design and programming of the new AHCC.

2.3.6 Additional Background Information on BCCA

Additional background and other information about BCCA can be found at: http://www.bccancer.bc.ca.

2.4 The Fraser Valley Regional Hospital District

2.4.1 Introduction

Regional Districts in British Columbia provide electoral areas with many of the services normally provided by municipalities, such as fire protection, water, sewer, storm drainage, building inspection, bylaw enforcement, planning and zoning. Regional Hospital Districts are governed by the *Hospital District Act*, R.S.B.C. 1996, c. 202.

Normally, the residents of a Regional Hospital District pay a certain percentage of the capital construction costs for hospitals and equipment needed in the region and the provincial Ministry of Health Services funds the balance. The Regional Hospital District's funds are collected from rural and municipal areas within the regional district on the basis of property assessment.

Where a health authority, such as FHA, extends beyond the borders of a regional district, such as the Fraser Valley Regional District, the applicable Regional Hospital District only contributes funding to those hospitals which are within its regional district. The AHCC is wholly within the Fraser Valley Regional District and the Fraser Valley Regional Hospital District.

2.4.2 Additional Background Information on Fraser Valley Regional Hospital District

Additional background and other information about the Fraser Valley Regional District and the Fraser Valley Regional Hospital District can be found at: http://www.fvrd.bc.ca/.

2.5 Partnerships BC

2.5.1 Introduction

Partnerships BC is a company governed by British Columbia's *Company Act*, R.S.B.C. 1996, c. 62 and is owned by the Province of British Columbia. Partnerships BC is governed by a Board of Directors and reports to its shareholder, the Province's Minister of Finance.

The overall mandate of Partnerships BC is to promote, support and, in some cases, manage Public-Private Partnerships in order to maximize the value of public capital assets such as hospitals and highways. The specific role of Partnerships BC in individual projects is tailored to accommodate the needs of the project sponsor and may include services ranging from business case analysis to management of the procurement process.

Partnerships BC's clients are public sector agencies, including ministries, Crown corporations, and local authorities such as districts and boards. Partnerships BC works with the private sector and various government agencies to explore opportunities for Public-Private Partnerships in sectors such as health care, transportation and resource development. Partnerships BC provides a consistent point of access to government for potential private sector partners.

Partnerships BC combines public sector and private sector expertise and an integrated project management approach. The objective is to protect the public interest while maximizing the value of taxpayers' dollars. This will be achieved by pursuing projects, such as the AHCC, that harness private sector innovation, encourage competition and optimize the allocation of risk.

Partnerships BC operates with offices in both Vancouver and Victoria to effectively meet the needs of partners in both sectors. Core business is carried out by in-house staff, drawing on external advisers and public and private sector expertise in order to serve clients effectively through the establishment of project teams.

2.5.2 Additional Background Information on Partnerships BC

Additional background and other information about Partnerships BC can be found at: www.partnershipsbc.ca.

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