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NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

COMMUNITY SERVICES

Tuesday, February 3, 2009

Committee Room 1

Nova Scotia Association of Health Organizations (NSAHO)

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COMMUNITY SERVICES COMMITTEE

Ms. Marilyn More (Chairman)
Hon. Ronald Chisholm
Hon. Leonard Goucher
Hon. Patrick Dunn
Mr. Gordon Gosse
Mr. Trevor Zinck
Mr. Keith Colwell
Mr. Leo Glavine
Mr. Manning MacDonald

[Hon. Pat Dunn was replaced by Mr. Jamie Muir.]
[Mr. Keith Colwell was replaced by Mr. David Wilson (Glace Bay).]

In Attendance:

Ms. Kim Leadley
Legislative Committee Clerk

WITNESSES

Nova Scotia Association of Health Organizations (NSAHO)

Ms. Mary Lee -
President and CEO

Ms. Mary Baldwin -
Director of Communications

HALIFAX, TUESDAY, FEBRUARY 3, 2009

STANDING COMMITTEE ON COMMUNITY SERVICES

1:00 P.M.

CHAIRMAN
Ms. Marilyn More

MADAM CHAIRMAN: Good afternoon. I call the Standing Committee on Community Services to order and welcome officials from the Nova Scotia Association of Health Organizations today.

Perhaps we'll go around and introduce ourselves, and then I'll give you an opportunity to introduce yourselves and to give us a bit of an overview or a presentation before we open up the meeting for questions and answers. We have regrets from Keith Colwell and Minister Chisholm today. Minister Goucher will be here but he has been delayed for an hour.

[The committee members introduced themselves.]

MADAM CHAIRMAN: Okay, so now we'll give our witnesses a chance to introduce themselves.

[The witnesses introduced themselves.]

MADAM CHAIRMAN: Welcome, both of you. So if you'd like to start with your presentation.

MS. MARY LEE: Thank you, Madam Chairman. First, please let me acknowledge - thank you for inviting us to be here. My understanding is, I think this is the first time NSAHO has had the opportunity to come and speak to this committee and we're very, very pleased to be here.

We put together a very slight - a presentation for you, about 10 minutes or so, and we'll be pleased to answer any of your questions.

Before I start, I have to preface a little bit to let you know that I've only been in this position - it will be a year in March, so I will try my best to answer your questions as best I can. Of course, I have my colleague here who has been with the organization much longer, who will certainly, hopefully, help answer some questions. If we cannot answer them for you, certainly we will commit to get back to you as soon as we can.

What we were hoping to cover - from what we believe we were requested - is to do a little overview of who we are, who we represent, generally what we do and a little bit about our role, mostly focusing on our role in supporting health human resources, which I believe is what we were asked to discuss here today with you. You do have a copy of this in your package as well.

So a little bit about who we are - NSAHO is a non-profit, non-governmental organization. We are member-driven in that we represent our members' collective views on issues concerning health and the delivery of health care and services. We have been incorporated for close to 50 years - actually, next year will be our 50th Anniversary. We've always taken a leadership role in working with our members in promoting and influencing public policy in the interests of better health and health care services.

So who we represent - this is a very busy slide - in a nutshell, we represent all of the DHAs and the IWK. We represent about 88 per cent of the licensed nursing homes in the province, most of the ARCs and the RRCs - actually, seven of the eight within the province - and also other government-funded home care organizations, about 60 per cent. There are also smaller members, foundations and organizations like that, that will also join NSAHO for various reasons of the services that we provide. I guess what you can see is that we cross a wide, wide spectrum of health within the province and that's one of the things that we offer, is our ability to represent the multi-spectrum of health.

If you wanted to kind of put it in a snapshot, our members who are part of us, represent about close to $2 billion of expenditures in health, which is roughly about 60 per cent of the provincial health budget. Our members actually employ more than 35,000 health and community service workers. All of these people come under or are members of our association.

So what is it we do? We provide a lot of services within NSAHO but mostly our role is in supporting our members and we support our members in many, many ways. we

represent their collective views through various approaches; we provide decision support and project planning support for our members; and we also deliver a wide range of quality, cost-effective services. When our members join us, there are services that they receive from their membership fees, such as policy planning and decision support, for example. They can also purchase service from us through organizational development, and one of the things we've focused a lot on in organizational development is governance, and board governance. They can also participate in our pension plan or our benefits. So there are different types of services and different reasons why members would join us.

One of the services - if I may just step back for one moment - which I think is important to point out, when we talk about providing a range of cost-effective services - there is one service, our clinical engineering service, which is a shared service for the province. We actually provide services for seven of the 10 - if you include the DHAs and the IWK - and this is a shared service that we provide for the whole province. So we can do that in a much more cost-effective way than each individual organization providing their own types of services, and it creates that standardization throughout the province.

If you would recall, this is something that was highlighted in the PHSOR report - the intention to actually look at shared service models and ways of effectively providing services to health care.

So this is basically all of our services and programs - everything from the settlors of the pension plan, to the administration of the Continuing Care Assistant Program and the Alzheimer Disease and Other Dementias Care Course. I won't go through every one of those because there are a lot. What is missing from here as well, though, is our IT service. We do provide information technology, and this is something that we are starting to reach out to our members and some of our members are purchasing some types of those services as well.

Just to point out, under our labour relations services, we support approximately 130 collective agreements within health care. We administer a range of benefit programs for more than 22,000 health system employees through NSAHO. Our organizational development service, as I referred to earlier, also works with our members in working with them to create a safe and healthy workplace. That's one of our main reasons, as well as with the governance.

We are also under contract to administer the provincial Continuing Care Assistant Program and the Alzheimer's disease course. So that's just roughly setting the scene of the types of services that we provide.

My understanding is you wanted us to talk a little bit about NSAHO's role in the pension plan so I have just put some points here for you. NSAHO is the settlor of the pension plan. The pension plan itself is governed by a board of trustees and there are certain things which the trustees would consider which would be forwarded on to the NSAHO

board, as settlor, for recommendation. For example, if there was a rate increase or a change in contribution rates, it would go through the settlor, which is the NSAHO.

The plan is currently governed by a board of trustees, as I said. There are 20 of them and that's a composition of employers and employees - the unions - and the day-to-day operation of the plan is actually through the CEO of the pension plan, who actually are also situated within our offices in Bedford.

The NSAHO pension plan, as you know, is a defined benefit plan. We are the largest multi-employer pension plan within Nova Scotia. So that's all I've put together on the pension plan.

Moving on to supporting health human resources - we were asked to discuss about our role in supporting health human resources. I have to say it's probably the leading issue within our members. It's a common priority issue, health human resources, and it's on every agenda and every forum that we support. We do support a multitude of forums for our members. We have a monthly meeting with the DHA and the IWK CEOs at NSAHO, and that is on the foremost of our agenda, health human resources and how are we collectively working together and how can NSAHO facilitate and support them, because they are the leaders in this and our role is to help them through this and to help develop strategies and work with them in meeting this huge need.

We also have a forum called the Academic Health Council, which has been in place for about four years. The Academic Health Council is almost a tripartite. It's composed of academia, so we have the deans of universities and the Nova Scotia college; we have various deputy ministers from government who sit on this; and we also have employers from the DHAs and the IWK. This group meets two or three times a year and their mandate is health human resources and how do we work toward the three prongs of health human resources - planning, sustainability and innovation. So that's their mandate and this collective brain group, if you want to call them that, they meet and develop these strategies and research and policy development.

We also have the NSAHO Continuing Care Council which is a council that meets every two months and is made up of all of our members in relation to continuing care, long-term care and home care. Their strategy, as well again, is looking at health human resources within the continuing care sector. We also have a forum that we host with the ARC/RRC Association - adult residential care and rehab centres. Their strategy, as well, is focusing on health human resources. So our role, again, is to support them and contribute to them in facilitating strategies and approaches in how to deal with health human resources strategies.

We also seek opportunities to support our members in other strategies. For example, we are often invited to participate in various task groups. For example, I am currently sitting on the HR Task Group from the Department of Health, from the Health Transformation office. We also have members who sit on the Integration Task Group, for

the integration of continuing care into the DHAs. So we have throngs in many areas because we can represent our members' views.

Some specific examples, and I've just kind of touched on them. One thing which is very important is under the Academic Health Council - we have a service that we run through NSHO - and it's called HSPnet Project. What this is, it's actually a computer program - a database where we link the employers with the various universities. Right now the scope is for nursing placements. So students who are in the nursing program and they wish to have a placement within the province, they can enter into this system and the employers have identified all the areas where they require help or assistance or they have placements available. This is a process or a database that we operate and our goal is that this will expand to other health professions outside of nursing, but right now is currently only in nursing. This is something that I believe is in about four other provinces within Canada, so we're being very proactive in that way.

[1:15 p.m.]

We also are very involved in leading the way, actually. Nova Scotia is leading the way in health, in quality of work, life and quality health care collaborative. In fact Nova Scotia is probably the first province in Canada in which all of our members have signed on to this charter committing to working toward a safe, quality health care environment and in supporting the quality of work life for the staff. In fact, we have a workshop, a conference being hosted in the next two weeks - I believe it's on February 13th - in which we'll be hosting the first quality council meeting and the chair will actually be coming here and hosting this, showcasing Nova Scotia and its role in this process. So it's very, very exciting for Nova Scotia.

As I said, we have various provincial task groups that we have been invited to participate in, because of our cross-membership and our ability to represent the views across the spectrum, including the HHR Task Group and the DOH Continuing Care Strategy, which again is focusing on recruitment, retention and development. Those are things which we are involved in.

Some other recent activities. I'm sure you're aware of - aware of AWARE - AWARE NS, which rose out of the Safety Advisory Committee, our stakeholder advisory committee, which was established within the province and look at how do we create safe workplaces. They've now come up with the name AWARE NS, and I believe it was in the paper this weekend where they've advertised for the CEO of this.

We've been very involved in working with the development of the safety association. In fact, it's been part of our mandate for the last several years, so we're very pleased to see that and we do have members in our organization who are sitting on the board of directors of AWARE NS for at least the first year, to get this organization up and going.

We also work with our members in assisting them to meet their legislative requirements. One thing that comes up is the workplace violence legislation. You'll see that referenced in our annual report where we talk about our role there and helping our members develop templates for violence risk assessments within their environment and prevention planning and templates for them. So again, we're responding to their needs in helping them meet the needs of legislation.

We also do a lot of work for recruitment around continuing care. As you know, recruitment for HHR is an issue with all of our members, with continuing care as well as with acute care. We recently just developed this recruitment-and-retention tool kit for continuing care that they can take to various fairs and work areas and it's a video. We actually also did some advertising that you may have seen during Continuing Care Month in the Fall, in advertising how important our continuing care employees are to us and to our community. We've also done similar things with the ARC and the RRC community.

So that, in a very quick nutshell, are some of the things that we do for NSAHO and again I just focused on HHR mostly, as I understand that was the question for today. I thank you for the opportunity to present and Madam Chairman, I'll pass it back to you.

MADAM CHAIRMAN: Thank you, Mary. That's a lot of information to absorb and obviously your organization has a very critical role. I'm just wondering, how are you structured? How many staff members do you have?

MS. LEE: We have close to 100 staff members and we are spread throughout the province because, for example, our clinical engineering service, which I mentioned as one of our shared services, is actually located in the DHAs. So not all of us are physically on site.

I have six directors who work with me and then we have staff who work within each of our departments. I believe we're a very lean organization for the services that we provide. We have a board which is representative of our members - myself as a CEO, and we have six directors and we have staff underneath them.

MADAM CHAIRMAN: Thank you. Okay, we'll open it up for questions. Anybody want to go first? Trevor, then Manning.

MR. TREVOR ZINCK: Okay, I thank you for your presentation. The extra knowledge is good as well for us to have. You were one of the groups that participated in gathering data for the Corpus Sanchez report. Part of what came out of that around recruitment-retention was a number of around 1,300 RNs, nurses, who were going to be able to retire by 2010. Can you tell us today how many have retired since 2007?

MS. LEE: Unfortunately, I don't have that specific information. That would be with our members more so than it would be held at our organization. I can certainly try to get

that information for you. I know that they monitor it daily but I'm sorry I can't give you that specific answer.

MR. ZINCK: Okay, so you can try to get us those figures?

MS. LEE: Absolutely.

MR. ZINCK: Okay, that would be great. The data also shows that there's a gap of about 500 RNs who will need to be recruited or persuaded not to retire. Where are we at, as far as that status and as far as your organization trying to stress the importance of that?

MS. LEE: Well, as I had mentioned in my presentation, the HHR recruitment is number one in all of our leadership agendas. The nursing strategy of sorts is actually let out through the Department of Health and then we work with our members in developing retention strategies and working with them. So really it's supporting them in that role.

Again, I can't tell you exactly the numbers that they have done but I know that it is at the top of their agenda. One of the things I did mention is that out of the PHSOR report and all of the recommendations around HHR, they did formulate this task group which reports to this Health Transformation Office and we are a member - I personally sit on that group. We've had only one meeting, which was last month, so we're still working towards specifically how that group will work and looking at a provincial strategy for HHR. So it's more than nursing, it actually will be for a multitude of health professions. I believe that will have a very positive impact - more long-term - in looking at recruitment.

MR. ZINCK: It's quite an alarming number, knowing the task that we have before us and by 2010 have that many people retiring, trying to recruit or retain that many people.

I guess my point in all of it would be the continuous update for the public. I mean that's the perception that we have out there. We know we need more long-term care beds - where are the workers coming from, and we hear that from workers as well, who have the opportunity to retire. That's it for right now. Thank you.

MADAM CHAIRMAN: Okay, thank you. Manning.

MR. MANNING MACDONALD: Thank you, Madam Chairman. Just a couple of comments, I guess, and then if you'd like to respond to some of the comments that's fine but I'm not going to pose them in the way of a question. I'm just going to make some observations here.

The board that I deal more closely with than any is the Cape Breton District Board, under John Malcom and the board down there. I always equate how a service is going or is not going so well by the number of calls I get, as an elected representative. In my district, I'm very fortunate - I don't get many calls at all about the way the health care system is being delivered in the Cape Breton District Health Authority. I think it's being delivered

in nothing short of excellence in the standard, but there are some challenges. You people know what the challenges are, that's for sure.

The costs in health care are like a runaway train. They're hard to stop and it's virtually eating up the entire provincial budget of this province of less than one million people. Our ability to pay, I think, in the future is going to be more critical than it has been in the past. It has been stated by government people and people in Opposition and lay people and people in the health care system that if we're not careful, the health care budget will consume the entire budget of the province in another few years, leaving very little manoeuverability for other services that are also very necessary. So you've got a difficult situation to deal with, there's no doubt about that.

There are some challenges, particularly I believe - and Trevor mentioned this briefly - about the continuing care crisis that is happening in our province. Not only do we have a runaway budget problem, we also have a serious problem in aging in this province and the need to look after those people who need nursing care services, somewhere relatively close to where they live, hopefully. In my area, that is one of the biggest problems. The hospital beds are being taken up by people who should be in a nursing home. There are no nursing home beds. The panel is done on people and then the length of wait time now is a year and a half to two years and even then they're not guaranteed beds in our area.

So just maybe by way of comment, I just wanted toask you - one question would be that your organization is obviously aware of that and how are you going about addressing that, or is there an answer? It has to be the number one problem right now, I believe. The hiring of nurses, the retention of nurses, the doctor situation in the province, they're all very important issues that we have to deal with. But this continuing care business is not only a crisis right now in the province, it's becoming something that is going to literally come down on top of us pretty soon if we don't get a handle on it.

I know that it could be said that maybe it's not a priority of government to build more nursing home beds but I suggest that if it isn't, it should be. The problem, I guess, is the same old problem you run into everywhere - money and the ability to fund these nursing home beds.

The ones that are out there right now in my area - again, I'm blessed. I have The Cove, the MacGillivray Guest Home, and the Harbourstone all within 10 blocks of where I live, and the regional hospital, so I'm very lucky but I'm sure that's not the situation right across the province. In those three homes, everybody is trying to get in them; they're all filled, of course. The beds we do have are excellent and I congratulate people like Shannex - Joe Shannon and his crowd, building nursing home beds in this province.

It's something that we need more of and maybe you want to comment on that. I'll stop there.

MS. LEE: You hit on many, many points, actually. In fact, you're right and the growing number of, if you want to call them ALC patients, which are alternate level of care patients, be they patients who require nursing home or some other type of care - it may not be a nursing home, it could be home support, it could be any number of things - it is growing not only in this province but you see it growing across Canada.

Certainly in our neighbouring provinces, they are faced with very similar issues in beds in hospitals and acute care beds being occupied by these types of patients who actually require care - they just don't require acute patient care in the hospitals.

So there are a number of beds that are planned to be opening, as you know with the announcements. One of the big things that we've been doing in working with these new beds being opened is not only - obviously part of the answer is getting more people to work in the system but it's also looking at how they work and looking at their scope of practice. That's one big piece of work that we've been working with our members on - are staff working to their full scope of practice? Are RNs doing what they should be doing? Are LPNs doing what they should be doing? Are continuing care assistants doing what they should be doing? Is our system set up to enable them to do what they need to do?

So it's more than just an influx of more people into the system, we need to be looking at how people are working. That's one huge piece of work that we at NSAHO have been working with our members in defining the scope of practice and what type of people or worker do you need in the system to provide the best care for these types of patients. That's often referenced as a model of care and how do people work, what is their scope of practice, what types of care do we provide. We're very, very involved in working with our members in doing that.

I work with John a fair bit and he has an excellent relationship there certainly with the homes and that's the other key - how do the district health authorities work with the nursing homes and the long-term care and continuing care sector. That is something that as you know, under PHSOR, continuing care will be integrating with the DHAs, so that in itself is going to enable people to work together collaboratively more. It's going to open a lot more doors, it's anticipated, than maybe how it was in the past. So I think there's a whole system overall you're going to see as a result of us looking not only at putting more people in but also looking at how they work. I don't know if that answers your question.

[1:30 p.m.]

MR. MANNING MACDONALD: Yes, pretty well. Just one final comment, Madam Chairman. Again, I applaud the efforts of everybody who works in my district under very difficult circumstances and we do have some facilities at the regional hospital that are usually reserved for much larger population areas than ours. We're very lucky to have the cancer care units we do have down there and some of the other dialysis equipment and stuff that we have.

One of the big puzzles is that, or one of the big problems, I guess, not a puzzle but a problem is that it's difficult to manage the need for long-term care and the need to open up the active treatment beds in the hospital. A lot of them are being filled by people who should be in another facility, like nursing home facilities. I don't know at what point can we, as elected people, be able to tell people look, your mother or your father is not going to have to go to Annapolis Royal, where nobody can get down to see him for the next two or three years and maybe if he doesn't die in the meantime, get transferred back to Sydney. That's the kind of thing that I hope that some day I can look at people and say, you're going to get a bed in the Sydney area where your people are, where your loved ones are.

That's a pretty sad thing when you have to send loved ones away but there's no alternative right now. So hopefully that will improve, sooner than later, hopefully. I know it's a priority that you're dealing with, it's a priority that John Malcom is dealing with. I mean he's got a serious situation down there with active treatment beds being taken up by people who should be in nursing homes. I just throw that out as a comment. Thank you, Madam Chairman.

MADAM CHAIRMAN: Thank you. Anybody else? Jamie.

MR. JAMES MUIR: Thank you, Madam Chairman. This has really nothing to do with your presentation - who did you succeed as president?

MS. LEE: Bob Cook.

MR. MUIR: I was trying to remember the name and I couldn't remember. . .

MS. LEE: Bob had been with the organization close to 30 years, I believe, so a lot of memory.

MR. MUIR: One of the difficulties that we have in terms of health human resources is a pretty high absentee rate. What is the absentee rate among your members, for nurses?

MS. LEE: For nurses - again, I don't have that exact number but I do know it is of concern to our members. In fact, I referenced earlier this Quality Worklife Quality Healthcare charter - that is in response to recruitment, retention and to enable staff to be present at work.

MR. MUIR: I guess one of the things I think, too, is that here in CDHA I think they had a $6 million gap at some point this winter and most of that gap could be attributed to overtime, because of the high absentee rate.

MS. LEE: It is cyclical, right? If you work overtime then the concern is always if you work a lot of overtime, you can't work your scheduled shifts and then you're sick and then someone else comes - it is cyclical. So as I said, one of the things we're really focusing

on is this quality of work life and healthy workplaces, and we do see that as a main thrust for our members.

MR. MUIR: One of the other things that's going to come into play now, and interested in - I saw the release from the Minister of Labour and Workforce Development the other day about the minimum wage is going to increase by 50 cents, was it - whatever it was. How much was it?

MR. ZINCK: Seventy-five cents.

MR. MUIR: How is that going to affect not so much the nurses - they and the other people who are in - but it seems to me that's going to have an impact on particularly that continuing care sector.

MS. LEE: Well, most of the - through our Labour Relations Department where we do all the contract negotiation, that is something that we plan and we work with the Department of Health on and when we're looking at entering into negotiations, because we would work with - this is with the unionized group now. So we would work with them and understanding what the fiscal impact of that would be, so that's all done in the preparatory work but it is going to have a huge impact certainly with some organizations, some more than others.

Continuing care has struggled in the past in meeting - in the recruitment and retention of staff, so in a way it will be positive if it gives them the ability to increase their salaries so they can recruit and retain staff but it has a fiscal impact on them as well. So again, this is something we would work with the Department of Health on and with the Department of Finance.

In fact yesterday, I was at a pre-budget consultation and a number of issues were identified there, in relation to health, to consider in the upcoming budget as well.

MR. MUIR: Going to continuing care, and I know that there's a fair rotation - I come from Truro and we've got three or four nursing homes there on the way. The new ones get new employees, they take them from the ones that are already there. So it's one year I'm working for Shannex, one year I'm working for the GEM Group, one year I'm working for the Boyles. You know, it's kind of - they're all real good employers.

Also in our area, there is - Shannex is working with the community college to do a thing and there's an outfit called Future Works and they are also into the continuing care. I assume that my community is no different than Sydney or Halifax or anybody else - everybody is trying these various things. I guess what I'm trying to figure out is what works the best to get more people into the field and keep them there. I should also say I had a daughter who was in that business and left.

MS. LEE: I guess to start, mobility is an issue within the province and even leaving the province. People will move around and they can move around because there are opportunities for them to do that. That being said, one of the main thrusts that we're doing is on recruitment and retention.

So how is it that we implement this - and I keep going back to this quality of work life and workplace, quality of workplace and safety. How do we design a system that works with the employees but keeps them safe, as well, as well as the patients and the residents who are there? So we really need to look at both.

One of the things that we've been specifically working on with our members in continuing care is what we call the RN supervision project. So we're looking at how do RNs work within continuing care, for example? How do we provide support to them?

There are various ways of doing that - being physically on-site, being available to be on-site. There are different ways we can help provide support, but I really think one of the keys - and I think our members are seeing that around, how do we keep our employees, and retain and attract more? We have to advertise how important continuing care is to society and to the community and how rewarding it is, so we have launched this huge campaign and are trying to recruit people. We've developed these retention tools or this recruitment tool so that we can advertise how it is and we have to work around creating a safe work environment for patients as well as for staff, and I think you have to bundle those together.

I think through our Continuing Care Council we have the largest majority of continuing cares represented at that council and they meet every two months. They share information and they talk about what they're doing - what works in their facility, what can they borrow from someone, a strategy that works. There's a lot of information sharing that we facilitate through NSAHO which helps them collectively so that we're not robbing Peter to pay Paul.

MR. MUIR: I guess one of the issues we're faced with - and I dealt with it for two or three years, too, in a different role that I had - until we get more bodies than there are spaces, we're not going to cure a lot of these problems, and I think that's relatively true. I don't know how you would do it - I expect if anybody had the right answer it would have been done by now.

Of course we're unique here in Nova Scotia - we don't have a whole lot of young people coming through the system. Right now we're pretty close to zero in terms of our population and indeed, I think last year or the year before there were more deaths than there were births - I see Len nodding his head. That makes the whole thing pretty difficult for people like Mr. MacDonald and myself who are at that point where in about 15 or 20 years, there are going to be more of us than there are young people. It is a real challenge and I know it has to be very difficult on a day-to-day basis to try to get something that actually

works. However, I did have another question and I can't remember what it is, so I'm going to pass.

MR. ZINCK: We'll come back to you.

MR. MUIR: Well, that's the age thing, Trevor. (Laughter)

MADAM CHAIRMAN: Len.

HON. LEONARD GOUCHER: Madam Chairman, I'm sorry I was a little late getting here but I did have another commitment that I had to maintain. If the question has been asked, please cut me off and tell me. I was thinking about the beds when Manning was talking - I was thinking about my parents. My dad's 90, he has Alzheimer's and a few other things going, but I'm trying to keep them at home - my mom's 88. The system has been wonderful to us, I can't even begin to tell anybody here how great it has been.

However, I'm thinking more toward our budget. You can correct me on this, but I think it's around $3.5 billion in our budget for health care right now, somewhere around there, and then if you look at the other couple of monster budgets - I'm talking Education and Community Services - they're chewing up 65 per cent or 70 per cent of the budget and they're not getting smaller. I was just sitting here wondering, have you had any communication - I don't even know where to go with this one, but we're in an economic downturn right now whether we like it or not, there's no trying to shy away from it. Have you had any communication or any talks to any other national counterparts with regard to the upcoming year even - let's pray to God this is going to be a short-term thing - but for delivery of services for the year at least that's coming up and how they're going to handle it?

MS. LEE: Within the province, do you mean, or nationally?

MR. GOUCHER: Well, probably looking at it from a provincial standpoint, but I don't know how the other provinces are dealing with it right now and you three are a national body. Surely to God there must be some conversation over actual maintenance of health care budgets, because it's going to be a tough year all the way around for all of us.

MS. LEE: Absolutely, yes. Certainly, if I may start nationally and then come in, if that's okay. You are right, we are part of the CHA, the Canadian Healthcare Association. Every province has an association similar to ours, the scope and roles of those associations vary per province. We do meet three times a year, all the CEOs of the various associations, usually in Toronto or in Ottawa, and always we're talking about the upcoming health situation, the dollars, what's happening in Parliament, what impact is that going to have. Certainly our story is very similar to other provinces' stories, so we're not going there with something maybe to say we have an issue that nobody else does. So one of the things we do there is mostly strategy planning to say how can we work with the various ministers federally to support health within the provinces.

We have been very vocal through CHA on many initiatives - the health transfer fund, the wait times fund, infrastructure. We just lobbied in the recent budget to have money for infrastructure around information management, IT, electronic health records. So collectively as a group, we actually work with the medical association and the Pharmacy Association and the CHA, and we would come together collectively to say, these are our issues. Are they the same? Generally they are pretty close, so as a voice nationally we are collaborating together and that's how we try to influence the federal dollars at that level.

Then if I come down a little bit more micro and we look at the province, of course, as I said, I meet monthly with the CEOs and then the next day I also sit with them at the advisory council of the CEOs with the deputy. So again, there we have two forums where we are looking at how do we meet the health needs with the upcoming budget, what can we expect for dollars, what are our pressures, what are our challenges, and how do we mitigate them?

Of course, as you know, with the PHSOR report, the Corpus Sanchez report - sorry, I call it the PHSOR report - that came out, there are many, many initiatives and many of them have been launched through the Department of Health. We are working with them on many of them - almost all of them - and we have some connection there that we're working with them. A lot of them are looking at retention of staff, scope of practice and what about service provision - how do we maintain the essential services that we need to provide to our community with the fiscal constraint that we have?

[1:45 p.m.]

I know all of the CEOs are very, very aware of their budget and the limitations that they have. I know their planning is almost very much to the micro level in trying to mitigate and control costs.

MR. GOUCHER: Thank you very much, I appreciate it. Sorry for being so vague on the question, but it's just something where you're looking at a budget the size - even though Nova Scotia compared with many other provinces is probably smaller, it's still, from our perspective, a huge, huge chunk of the puzzle because it represents over 50 per cent of the budget. So I was just wondering from a national level exactly what discussions you have. Thank you.

MS. LEE: Madam Chairman, if I may just add to that. One of the concerns, too, is you related to the economic crisis. One of the things that research will tell you is that when there is an economic crisis, the health of citizens often is challenged even more. So that is something, as well, that certainly we are all discussing - and maybe that falls more into Health Promotion and Protection - but it is a very, very critical point that we need to also keep our thumbs on and be very aware of the stressors on citizens. How do we engage them to try to maintain a healthy lifestyle and to cope with these types of stress? We don't want more burden on the system than what we currently have if we can at all prevent that.

MR. GOUCHER: Thank you, again.

MADAM CHAIRMAN: Thank you. Dave.

MR. DAVID WILSON (Glace Bay): Thank you, Madam Chairman. Thank you, both, for your presentation. I think your organization serves a purpose but I want to try to drill down a little bit deeper to see exactly what your organization is doing, if you don't mind a few questions. But before I do, just a few comments. Several people here have said today that the system is good and it's working - for some it does, for others it doesn't. If you have people who are living in Glace Bay - in my case, I know a gentleman whose wife was just put in a home in Port Hawkesbury, and he travels every day for an hour and a half to visit his wife in that home because there are no long-term care beds in the area, it may never occur.

I had a friend of mine who came to the QE II on two occasions - for one of them, he was on the operating table and was told his surgery was cancelled, there were no beds available. There was a case where a doctor had to declare a Code Orange at the biggest health care facility in Nova Scotia. You have doctors who have left the Annapolis Valley - at least three that I know of in communities - that now have left thousands of people without a doctor, so the system has cracks and now the cracks are leaking and that seems to be the problem. One of those cracks that's leaking is the recruitment and I think that's the major purpose of you being here today, the recruitment and retention of human resources in health care.

So as an organization, if I understand it correctly, you're comprised of DHAs and nursing homes and so on. You advocate on their behalf to government. Do you meet with government on a regular basis? Do you take their concerns to the table? Do you sit down and meet with the Health Minister and say, here is what we have, the problems that we have, and what are you doing about it?

MS. LEE: Yes, we do try to do that as best we can. We do meet - as I said, I meet every month with the Deputy Minister of Health. I have met with the past minister and I do have a meeting scheduled with the new Minister of Health. I have met with the Minister of Health Promotion and Protection. We have regular dialogue with the deputies.

Very much our actions are directed by our members, so when our members come to us and say, for example, rising fuel costs, this is a huge issue for us, we want you to advocate for us on that part. So we would go out to our members, collect all of the data, all the information, and then we would present it at various different avenues. Obviously, a lot of those are with the deputies or with the ministers, depending on what it is. So very much with the support of our members we will go forward and do that.

MR. DAVID WILSON (Glace Bay): On the issue of recruitment, I take it your members have brought that up?

MS. LEE: Absolutely.

MR. DAVID WILSON (Glace Bay): And you've gone to the government and said, what are you doing to recruit? I know physicians are not a member of your organization, but I'm sure DHAs have said, we have a problem with physician recruitment, or whatever the case may be. Give me your opinion then on what you think the government has been doing in terms of recruitment. Do they have a recruitment policy? Until not too long ago, they didn't have a recruitment officer, a person in charge of recruitment - that position went vacant for some time. Do you think the government is doing a good job in recruiting physicians in this province on a provincial basis?

MS. LEE: I know there has been tremendous work recently with the physician master agreement that was just signed. There have been a number of issues where the DHAs have worked with the Department of Health and they've identified various incentives in there in recruiting, retaining and rewarding physician involvement, so I think that's a very, very positive step forward. I think it's probably the most positive step that members have seen for awhile, so yes, I do think they have a plan in place when it comes to physicians.

MR. DAVID WILSON (Glace Bay): Have you seen it?

MS. LEE: I have seen the physician master agreement, yes.

MR. DAVID WILSON (Glace Bay): So you've seen the plan that's there?

MS. LEE: I've seen the physician master agreement and I've seen various things identified and broken out that they have issued as retention issues, yes. They appear to be welcomed by physicians.

MR. DAVID WILSON (Glace Bay): They may identify them as retention issues, but have you seen a provincial plan that said this is what we plan to do next month, six months, one year from now in terms of recruiting physicians? Is there a plan like that?

MS. LEE: I haven't seen that exactly - I've seen the physician master agreement. If I may just add to that, the HHR Task Group that I referred to running out of the Department of Health from the Health Transformation office, it has identified physicians as part of that group where we do need to be developing a provincial strategy. There is one in place for nursing but, as I said, this needs to be well beyond nursing because there are many professions in which recruitment and retention is an issue, and physicians is certainly one of them and they have been identified. But that plan is not developed yet, they just got the project charter in place to start working . . .

MR. DAVID WILSON (Glace Bay): If I may, just a few more comments, Madam Chairman - I'm sorry I'm taking up so much time. When you go to the provincial government, as your organization does - in my opinion, anyway - I think you would bring

a stronger voice to the table than the DHAs who go there. DHAs are usually going to the government with hat in hand, looking for funding. So if they have to go face to face with deputy ministers and health ministers, it could be rather intimidating, I would think, for some DHAs - depending upon the people who are there - to go against government and say no, we need this amount of physicians and we need them right now. Whereas your organization, I'm sure, would have a little bit more clout when you reach that sort of stage.

So if you're doing it on a regular basis - and, as you've said, you've scheduled a meeting with the new Health Minister, I would assume that not only physician but human resources recruitment, period, would be high, if not number one, on the agenda. Is that correct?

MS. LEE: Number one, absolutely. Our members have told us that there are certain things and that is absolutely number one.

MR. DAVID WILSON (Glace Bay): Okay, thank you very much.

MADAM CHAIRMAN: Thank you. Gordie.

MR. GORDON GOSSE: Thank you for your presentation and I have just a couple of short questions. The NSAHO board led the campaign Settlements without Strikes and that was led - well, it says on Page 22 of your handout that the campaign was supported primarily by the president's office, and that was a $350,000 campaign. I'm just wondering, could you give me your opinion on how successful that campaign was or was not?

MS. LEE: That was before my time - I need to first qualify that - that was before I actually started at NSAHO. I think we led the collective views of our members and I believe our members still feel the same way regarding their position on settlements without strikes. I believe our members believe that there are ways to reach resolution to issues without strike and fair ways for employees and employers.

I don't think - we may have been somewhat silent on it lately, but I don't think it means that it's still not an important issue. I think it did raise awareness within the public of what it was, it raised a lot of discussion, from my understanding.

MR. GOSSE: Yes, it did in the Legislature too.

My next question would be, you mentioned pensions earlier in your presentation so I just want to know, what is the funded status of the NSAHO pension plan at this time?

MS. LEE: I want to first qualify my statements by saying that there is a CEO of the NSAHO pension plan who is much more informed of it. I can certainly say that based on everyone's performance of the current economic situation, it certainly is a challenge. We have seen a decline but I can't give you that specific amount because again, that would

come under Mr. Jordan, who actually really administers the day-to-day running of the pension plan.

MR. GOSSE: Can that information be forwarded to the committee?

MS. LEE: Absolutely, yes.

MR. GOSSE: The other thing on the pension was, we hear about these hedge funds. I'm just wondering, what's the hedge fund exposure at right now and is it being reduced at this time? Would you know that information, or would I have to . . .

MS. LEE: I know some of that information. I can't give you the specific ratio but I can, in fact, let you know that as you're aware, we have recently changed investment managers, within the last year, and we do have an investment subcommittee of the trustees. They have looked at all of the distribution of the funds, including the hedge funds and the allegations of that, and there has been some change in that. Again, I can certainly ensure that you get the exact amount.

MR. GOSSE: That would be greatly appreciated, thank you.

MS. LEE: I apologize for not being able to answer specifically your questions.

MR. GOSSE: That's okay. Thank you, Madam Chairman.

MADAM CHAIRMAN: Thank you. I'm going to finish up the first round of questions and I'm actually going to ask a couple from the Chair since the vice-chairman isn't here and I don't want to waste a lot of time selecting someone else. Then we'll do a second round of questions.

I'm sure we don't want to leave the impression that may have come up in the earlier discussion that absenteeism of nurses is the root cause of the overrun costs for overtime. If you talk to any nurse in this province, whether they're in continuing care or acute care hospitals, or wherever in the health care system, they'll tell you that there aren't enough nurses on staff and they're suffering from the stress of understaffing. I've heard horror stories of nurses being recalled in the middle of scheduled vacation time and - I think you referred to this yourself - having to work extra shifts in addition to their regularly scheduled shifts. So it's no wonder that sometimes they can't keep up with the workload.

I'd like to go back to this whole issue of nurse recruitment and nurse retention. You mentioned, I think in response to some earlier questions, that you didn't have the actual statistics on that and yet I understand - and I believe it came from the NSAHO pension plan data - that kind of information was provided to the Corpus Sanchez folks when they were doing their study, how many were currently employed in each line of the medical or health professional category, when they are eligible to retire, et cetera. So as an organization of employers, how do you keep track of the trends? How do you know whether

any of the strategies that you've actually recommended to the government and the Department of Health are working?

There seems to be a gap there in information. How can you make strategies and not track them to see if they're effective?

MS. LEE: Madam Chairman, I'll try to answer that question for you as best I can. Through our Benefits department, we do track benefits - LTD, sick leave, things like this - and we feed that information back to our members. All of our members in there - because we don't have at NSAHO, for example, an HR department, we don't have a provincial payroll system, for example, where we would have all that data in one area. It is all within the various DHAs and the IWK. So they have their own individual systems where they track that.

When we are asked to provide that information, we would collectively get that from our members and provide the data and the statistics, such as, for example, to Corpus Sanchez at that time.

[2:00 p.m.]

Each of the organizations have various strategies in place. Some are different in some organizations than they are in others, depending on what the need is and where the need is. So they, within their departments, do track progress and they feed up to the Department of Health at their monthly meetings when they talk about recruitment and retention strategies. So that would be their way to do that.

They also report back through our forums that we host at NSAHO, where we would pose a question to say okay, what exactly is your number of people who stayed who normally would have retired? Again, that's a number that they can get out of their own individual HR systems - eligible to retire and who actually goes. We can also get that from our pension as well. So there are various times when we would gather that information together. It isn't generally something we would do on a monthly basis but it is certainly something we would do on a yearly basis.

MADAM CHAIRMAN: It's probably been at least, what, six months since the last negotiated settlement with the nurses, and I believe there were a couple of incentives there to retain more experienced nurses - 25 years, plus. Do you have any indication at all whether those incentives are working, how many nurses may have stayed in their field instead of retiring?

MS. LEE: I don't, unfortunately, Madam Chairman. I'm sorry, I don't have that information but again, I can get that and feed it back to this committee. Certainly I can.

MADAM CHAIRMAN: That would be very useful. So you don't have - it takes something to trigger a search for that data, rather than every six months or 10 months, or whatever, that you check to see what's happening.

MS. LEE: We can certainly make that request. That's something we can instigate and have it recurring on an annual basis. We'd be more than happy to do that and provide that information to this committee, if it would be helpful.

MADAM CHAIRMAN: But it doesn't automatically come in on a regular basis?

MS. LEE: Not province-wide. It's more, as I said, managed within each organization.

MADAM CHAIRMAN: You mentioned earlier sort of the national context in which the health care system in Nova Scotia operates. I'm just wondering how, within the last year, the negotiated settlement with nurses across the rest of Canada may have impacted on the availability of nurses here. Some of the settlements have been quite large and I'm just wondering, how do you factor that into the reality of living and working here in Nova Scotia?

MS. LEE: One of the things that we do regularly through our Labour Relations Department is scanning of the system and what is happening, the impact or ramifications of other collective agreements that have been signed. I know from talking nationally, it's certainly something you see more out West - that mobility between neighbouring provinces is a huge issue and I think of Saskatchewan and Alberta and there are huge issues of mobility there. We don't certainly hear that that is as big an issue in the Maritimes as much as we hear it in western Canada. I don't think - and again, I don't have the data - but certainly anecdotal evidence will tell me that we don't see a huge draw of people leaving to go out West because there was a contract signed with a 20 per cent increase, for example. It's more around the neighbouring provinces there that they're seeing that mobility of staff.

MADAM CHAIRMAN: So your association does the negotiations for many of these professional groups?

MS. LEE: Yes.

MADAM CHAIRMAN: Going back to the nurses again, with the incentives in place, perhaps that's on top of their hourly wage, I don't know, but I guess I'm wondering, how do our most experienced nurses rank, if you've done an analysis, how do they rank with similar top steps in other parts of Canada?

MS. LEE: I think we would have to compare more within the Maritimes than comparing nationally. I think you have to compare more like with like than to take that national approach. I know that Nova Scotia is often seen as the leader within nursing and nursing contracts and other neighbouring provinces will follow Nova Scotia in whatever

agreements that they have been received. Generally, Nova Scotia is seen as the leader, particularly in nursing wages.

MADAM CHAIRMAN: Why would you say, compare like with like? A nurse, is a nurse, is a nurse, right? There is a lot of talk lately among provinces and territories about portability of qualifications and professionals, so as people travel more and families tend to migrate to other parts of Canada, don't we need to be looking at the national context?

MS. LEE: I apologize, Madam Chairman, if I meant we didn't look nationally. What I meant by comparing like to like is when contract negotiations occur there are a number of factors that are taken into consideration, such as the cost of living. So when I refer to that, that's what I'm referring to. It's more than a nurse is a nurse no matter which province you are in because there are many factors and they look at the ability to recruit, to retain, their vacancy rate, the cost of living, they look at all of those factors when they're looking at determining - they look at neighbouring provinces - what is their wage rate, why do we need to consider that when we do our collective bargaining. That, Madam Chairman, is really what I meant is that it's more than just a national approach.

MADAM CHAIRMAN: So I wanted to be clear - did you answer the question? Even if we're just using Atlantic Canada, how do our top, most experienced nurses rate with the rest of Atlantic Canada?

MS. LEE: My understanding is that Nova Scotia is either leading or very close to the top within Atlantic Canada.

MADAM CHAIRMAN: Thank you. I'll stop there for round one. Jamie, you have another question?

MR. MUIR: I think one of the questions just answered is that, really, that depends when the contract is up. Typically, Nova Scotia has been the leader in Atlantic Canada and when a contract comes, people are playing catch-up to Nova Scotia. Secondly, just in terms of that, I know that in the negotiations for health care, we can't compete with Alberta, so you have to take them out of the formula. When we're talking national, Madam Chairman, you can't talk about Alberta or in the case of Ontario and then B.C. because the way it works is if you take a group of provinces that are kind of like Nova Scotia, we do very, very well.

The other thing as I understand it - and I'm going back to the former minister's answer, probably to Mr. Wilson or perhaps the other of the Mr. Wilsons, the good Dave and the bad Dave - is there a good Dave? - the retention efforts in Nova Scotia have been pretty good and I think one of the things the government has done in the past number of years was to really increase the number of nursing seats. I think right now I'm told we're about, in terms of numbers of seats, where we were before they decided that, at least in the case of nursing, you had to have a degree to go to work, I mean for an RN as opposed to an LPN, I think you can count them all the way back up there. I think that the retention rate

from the new grads is now over 80 per cent or around 80 per cent or something like that, it's a major shift in the last few years, so that's a good thing.

In particular, the nursing strategy seems to be bringing good benefits to Nova Scotia, there's no question about that, compared to some of our colleagues. I have two questions - I remembered the one I was going to ask the first time that I forgot. In terms of the continuing care sector, are the wages pretty well standard across Nova Scotia now? If you work in Yarmouth in a nursing home down there and work up in Cape Breton, I know that was one of the things as a government we tried to tackle and I'm just wondering what the results were? There used to be huge discrepancies across the province and it was through your organization, I think.

MS. LEE: Certainly, if they're unionized and we would do the collective bargaining it would be standardized. By far, I believe the salaries are very, very similar.

MR. MUIR: That is a very positive change. Secondly, the other question I wanted to ask, Keel Capital Management was your fund manager - and this is building on what Gordie asked earlier - you replaced them in February. I don't know if you're at liberty to get into the details of why that happened, but who did replace them? Who is now the fund manager?

MS. LEE: We actually have, as I mentioned earlier, a subcommittee which is made up of trustees of the pension committee, it's an investment strategy group. We have a whole new strategy in place, so Keel was a manager of managers and we have a completely different strategy in place. Our board of trustees are very involved through the CEO, so we haven't replaced them with a company, we have a whole new strategy and we still have some managers of funds for various different parts of our portfolio, but we don't have a manager of managers anymore.

MR. MUIR: One final question, which is going in the other direction and actually has a dollar figure attached to it. The Town of Digby, I think, was recently offering $100,000 to fund residency for foreign-trained doctors if they go to Dalhousie. What is your organization's opinion of that particular initiative?

MS. LEE: I can't comment on that particular initiative, but I can certainly say that as an organization we have worked with Immigration within Nova Scotia, actually, within the HRM area, recently within the last year. We worked with them to host various conferences of sorts in informing employers of the opportunities that may be there to recruit foreign-trained professionals and how do we ensure the standards of practice are being met and the qualifications are equivalent to what we would expect from Canadian-trained. That is something as a potential answer that is there, that there is a huge resource out there that we can be tapping into, as long as we obviously maintain the safety and standards of the association and safety for our patients. We do believe that is one of the prongs that can certainly help, with appropriate measures.

MR. MUIR: The issue of recruiting doctors is particularly tough. I have always been amazed with how well they did in Cape Breton. Mr. Malcom and Dr. Naqvi seemed to do pretty well there and I'm also very pleased with how well they're doing now in my section of the province, at least in my community. As an MLA, I used to get all kinds of calls about, I can't get a doctor and that's how I gauged that things are going a little bit better, I'm not getting those calls anymore. (Interruption) You have the metropolitan area up there and a core around and it seems to me once you get out of that sort of 100-kilometre radius of Halifax or in the case of Sydney up there, I think it has become a little bit more difficult. How do we sell people that they should go to Digby or they should go to Pugwash?

MS. LEE: I think from working with our members, there are many ways to do that. Some of the things that we're currently working on and I referenced earlier the Physician Master Agreement that was recently signed - there are a number of incentives in there that reward physicians for, for example, being involved in collaborative practices. It rewards them for being involved in complex care of patients who have a multitude of co-morbid conditions - they may have congestive heart failure, they may have arthritis, they may have something else. So there are incentives there to encourage them, incentives for them for a consultation in being available and working in the rural communities.

One of the things that we've also done is working with academia - we've been working with Dalhousie in the residents' seats. There are eight seats there that we have what is almost like a matching program where academia will contact the various DHAs and say, where do you have your greatest need for a medical resident? They will say maybe, for example, it's gastroenterology or maybe it's cardiology. Academia will now match the student to say this is where your placement should be, this is where your need is versus the student choosing to say, I want to be in HRM because this is where I am. So there are those types of strategies as well that are in place that are, again, having the employers say, come to me versus the student choosing, so academia is working with them to meet the need.

MR. MUIR: Thank you.

[2:15 p.m.]

MADAM CHAIRMAN: Thank you. Manning.

MR. MANNING MACDONALD: Just to follow up on what Jamie said there about locating in Nova Scotia, and Halifax being a metro area and Sydney being a metro area. Unfortunately, I guess, in Nova Scotia, people want to follow where the facilities are, they want to follow where the so-called action is and doctors are no different. The incentives have to be wide-ranging and very lucrative in order for young doctors to go to Digby or to Ingonish or places like that. That's not because those are less than desirous places overall, but young medical practitioners and professionals of all kinds want to go where the action is. They want to go where the Rebecca Cohns are, they want to go where the universities are for their children and all that and that's a fact of life.

In Sydney and I shouldn't say Sydney specifically, the Cape Breton area - after a lot of pulling and tugging, we finally got the powers that be in academia in Nova Scotia to realize that Cape Breton University is equal to the other universities in this province. We finally now have a B.Ed. program there, but the unsung hero of programs down there is the nursing program. We now have the nursing program at the university as well, so we're retaining some people who are going to be graduating from the nursing program. They're going to get their degree in Sydney and be able to stay in the Cape Breton area and work at the Regional or some of the other hospitals that are around the area.

My daughter is the nurse manager for the VON in Cape Breton and I'm going to mention the VON here because if I don't, she's going to say, well, you are concerned about nurses working in the hospital, I'm concerned about getting nurses to work for the VON in Cape Breton. One of her biggest challenges is to retain nurses and other professionals, but in the case of the VON, mostly nurses. That is a serious problem they're facing down there and she's out beating the bushes every day looking for nurses and she's in competition with the hospitals. Usually, what's happening now is they're getting nurses from the ORs and from the doctors' offices in the Regional Hospital wanting to get out of that setting and go into a more managed-type of environment, like they can work their own hours. They're actually giving nurses the kinds of hours they want or the kinds of hours they need, whether they want to work the back shift, they don't want to work Tuesdays, they don't want to work Sundays. They're trying to accommodate them, because of a shortage of nurses.

I think just again, by way of comment, Jamie mentioned it again, we're very fortunate in the Cape Breton area that we have Dr. Naqvi, doctor recruitment and we have John Malcom and we have Ron MacCormick, who is one of the best-known oncologists around and he has been able to keep the oncology department strong and alive in the Cape Breton Regional Hospital and people don't have to come to Halifax any more for radiation. We have the linear accelerators at the regional hospital in Sydney, which were only a dream just a few years ago. We do have a strong cancer unit presence and I think that's because of the passion of these people, of the Malcoms and the Naqvis and Ron MacCormicks and a host of others - Norm Connors and all those people down there - so we're very fortunate in our area.

While there are a lot of problems you're going to be facing - just let me wind up by saying you've got a very daunting task ahead of you in the future, in terms of managing the health care system in this province and I wish you well on it. I believe that we have made some strides. Are we there yet? No, we're not but let's hope we keep on going. Thank you, Madam Chair.

MADAM CHAIRMAN: Thank you. Trevor.

MR. ZINCK: I want to move back to the Corpus Sanchez report. I mentioned the RNs earlier, some of the numbers that you also provided were in around the hard-to-recruit allied health care workers - lab techs, x-ray techs, social workers, pharmacists. I'll ask this again if you can't provide it, I'll ask you also, maybe you can present it at some point to

the committee: do we know where we're at? There was a number put out there from that report that stated there were 860 of those hard-to-recruit allied health workers who were eligible to retire in 2010. Do we know how many have retired since that report in 2007?

MS. LEE: Again, I will certainly get back to you. I don't have that information but it is something that the DHAs do track on a regular basis. It will just be something we'll have to collate and I'm more than happy to present those to you.

MR. ZINCK: Okay. So again, with that large a number, can you tell me if there is something in place to address that, a strategy that we know, an education piece where we're encouraging young people to take up that practice, currently?

MS. LEE: I know that the Department of Health is working on various strategies with different health professions, and I'll go back to the HHR task group. We are going to put that provincial strategy in place but I know specifically, for example with medical radiology technicians, there's been a lot of work done on what we would call a simulation where we'd be projecting out, if we keep going at the rate that we're going at, what will the gap be in five years if we don't do something? What will the gap be if we do this and how does this, you know - it kind of incrementally breaks it down on the success rate. I know for medical radiology technicians this is something that the department has funded, that there will be more seats, it is my understanding for this particular profession, to try to meet that gap.

I think what they're doing - and they would have to speak - I believe they're addressing these one at a time and again, having that provincial strategy in place, you will see in the upcoming year a lot more work coming out of that, with more specificities for you, but right now that's probably the best answer that I can give you but I can certainly get those numbers to you; I know that they are looking at various professions one by one.

MR. ZINCK: I don't know if it's happening now or not but if it's not, I think it's something that we should be looking at. That is, going out to our high schools and having the professionals in those trades, the nurses and the lab techs and pharmacists - and again, you mentioned it - promoting how important and RN is to the future of this province, to the future of our own personal care.

If they're not doing it, I'd love to see more of that, I think, letting young people know that there is an opportunity. You know oftentimes we see young people go to university, they adjust to a $20,000 to $40,000 tuition burden that they come out with and they have an expensive piece of paper on the end of it but no job. So if they knew more, if we were educating them to opportunities. They know that there are opportunities in health care but maybe they don't know what the life of a lab tech is, how unique it is and how special it is. So if we can do that, I think it would benefit us.

Going back to those hard-to-recruit allied health workers - in the last round of bargaining, the province provided an extra 1.2 per cent increase for hard-to-recruit

classifications, in each year. Has your organization looked at how effective that was? Could you break that down into the different classifications?

MS. LEE: I wish I had all these questions before I came - I would have come with the data to answer your questions. Again, I apologize, I don't have that information with me but again, I'm more than pleased to go back and gather that information and forward it on to you. Again, this is something we would do collectively with our members because we don't have a clearing house as such at our place but we can certainly get all that information for you.

MR. ZINCK: I think it's very important that if you're leading such a charge, such a big membership, that you know that back then you gave these reports, made these analyses. They're pretty substantial numbers that we're dealing with, looking at our aging population. So knowing that we're not going to wait until 2010 and have you come back and say, well, we have the numbers, but if we have that stopgap, that period where we go back and re-evaluate, okay, we've told you we were here, so I think it's crucial that your organization has those meetings so that you know a year from now this is where we stand; okay, guys, we told you here, in 2007, now it is 2009, we're not that far away. It enables you to better evaluate where the system is actually at. We have all kinds of stories of the successes but with as many successes, we still hear the ill-fated stories of how the system is failing us. So you can better guide your mission by having those numbers.

MS. LEE: I would be more than pleased if the committee would invite us back in a year - and again on a yearly basis - to present this information. You are absolutely right, we have to be measuring our success. We can't just put it out there without measuring what the outcome is and the impact.

MR. ZINCK: Well, I'll just end by saying I hope it's not a year, I hope we don't have to have you back - if you can provide that to the committee, that would be great. We'll have you back . . .

MS. LEE: Oh, we will certainly, every other year is what I was meaning - sorry, future years.

MR. ZINCK: Oh, absolutely, okay, thank you.

MADAM CHAIRMAN: Thank you. Gordie

MR. GOSSE: A very difficult topic, a matter that was discussed earlier around long-term care and in-home care and personal care workers working, it's very hard to recruit now. I notice that the strategy at home has been the private colleges that put on these courses - now is it the district health authorities or - like for a teacher assistant in education, the Cape Breton-Victoria Regional School Board said, look, you know next year we may need 15 TAs so they'll put a course on in January for TAs. I'm just wondering, do the district health authorities or the health authorities in the province determine how many

personal care workers or how many workers they need in those fields that they work in, in conjunction with education to specifically target the numbers needed for those fields?

MS. LEE: Absolutely, actually, and the forum really for us to do that is through the Academic Health Council that I referenced earlier because you have academia sitting there, you have employers, the DHAs and the Department of Health, so you have the three of them working together and that is something that they do regularly report on, to say, this is what our need is, now how do we meet that need? What are you doing in your educational institution to enable that to occur? When is the next course? This is how many people I need. So all that dialogue regularly does happen, to try to address those needs, particularly in long-term care and continuing care.

MR. GOSSE: Yes, in long-term care, I think my riding might be one of the only few ridings in Nova Scotia - I don't have a long-term care bed facility. There's none, and I represent 13,600 people and we don't have a long-term care bed facility. Some day we may. We tried in the last round but we couldn't compete with the big boys, so we'll try again in the next round. Hopefully we'll be successful and we can get one in.

I know when my colleague from Cape Breton talked about Dr. Naqvi, who is the ultimate professional at all times, and John Malcolm and Ron MacCormick and Paul MacDonald also with some of the stuff around hard issues, eventually some day we may be able to - I notice a lot of people coming up from Cape Breton for the dye test for the heart. I notice that seems to be the biggest transfer of patients, to the heart unit at the Queen Elizabeth II Health Sciences Centre, so maybe some day in the future we'll be able to provide those services. I don't know if it's about putting a stent in or somebody for triple bypass who would have to be stabilized, I don't know but I do know that the biggest cost I find within the transfer is from the heart department in the Cape Breton Regional Hospital to the Queen Elizabeth II Health Sciences Centre. Are we trying to do anything in the future to alleviate that cost?

MS. LEE: One of the things coming out of the PHSOR report or Corpus Sanchez is looking at clinical services, which is exactly looking at where services are provided, are we meeting the best need, are we meeting the patients' needs? The particular thing that you talk about around interventional radiology, we would call it, or interventional cardiology and putting in stents, is that it can - there's a whole body of literature out there that says that you can't be doing this procedure unless you have a cardiac OR ready to go, because of the risk. But then again, there's a lot of literature out there that says you can do this without having a cardiac OR available.

Again, that will be - and I know this from my past life of all the evidence that's out there, but the clinical services review is being charged with looking at where services are provided and are we providing them in the best location to the best way to meet the needs of the patients and the people of Nova Scotia. So certainly that review - now the scope of that hasn't yet been determined but it is certainly slated actually to begin, if I'm not

mistaken, in September of this upcoming year, the process will begin looking at clinical services provision.

MR. GOSSE: Very good, because I do know that that is one of the most expensive ones, that transfer one, that piece of it and you're right, if something did happen during that test without having the cardiology lab or the operating room, that they couldn't do those procedures. We're fortunate, you know, I mean the recruitment, I think some of the three doctors from my street actually are here in the Halifax area, the Giacomantonio boys - Nicky, Carman and Michael are all practising and teaching here and yes, and they're involved in their communities and making it better for people all across the province. Thank you very much for coming in today.

MS. LEE: Thank you.

MADAM CHAIRMAN: I just wanted to ask a couple of questions. Does NSAHO have a position on accreditation, the value of it, in terms of raising standards or encouraging best practices?

[2:30 p.m.]

MS. LEE: I don't believe we've come out with a particular statement position on accreditation. I know that Accreditation Canada - its new name now - certainly is taking a really strong focus on safety and quality of work life. That is something that NSAHO is a very, very strong champion for and, in fact, we lead within the province within all of health care in working towards quality of work life, quality of health care practices.

We actually have been invited by Accreditation Canada, I believe recently Mary herself wrote an article about the work that Nova Scotia is doing around quality again of work life but we haven't produced a paper as such, or created a position statement on accreditation but my understanding is our members do see it as important and as a statement to the community to say that we are meeting national standards and quality and safety in health care is extremely important to us. If our members believe that, then we believe that because we represent our members' views.

MADAM CHAIRMAN: Do you have any breakdown as to what percentage of your membership is actually eligible for accreditation or perhaps are accredited or in process of reaching that standard?

MS. LEE: All of our DHAs and the IWK are accredited by Accreditation Canada. All of our members in nursing homes are licensed, so they have to meet specific standards or they would not be a member. We do not have unlicensed homes as part of our membership. Anything else, Mary?

MS. MARY BALDWIN: I would just add that some of our member nursing homes are accredited and a growing number are starting to participate in that program.

MADAM CHAIRMAN: So what does being licensed mean? What would be the minimum standard?

MS. LEE: I don't have the licensing standards with me but there are standards that are issued by the Department of Health and I don't know, Mary, if you have the specifics around licensing but it's an annual thing that they have to do so they have to meet specific - and again, I apologize, I don't have them in front of me - but they are specific standards and requirements that the Department of Health will issue, from around staffing to facilities to safe environment, and they are licensed. It's an annual thing so it's not something that you are given and then you come back in five years, it's an annual thing. Their funding, in a lot of ways, if I'm not mistaken, is linked to this licensing as well.

MADAM CHAIRMAN: But it would be more basic standards whereas accreditation would be best practices and it would be a higher level of standards and performance?

MS. LEE: I think they are different, they are absolutely different. As Mary said, many of our members are working toward achieving that higher level as well, toward Accreditation Canada.

MADAM CHAIRMAN: Is there any possibility of finding out what percentage of your membership are accredited? That would be very interesting to see.

MS. LEE: Absolutely.

MADAM CHAIRMAN: I recently had the opportunity to drop in to a private, for-profit nursing home in the Springhill area and that's why it's on my mind - they're going through that process and spending considerable time, energy and effort on it. I think it's wonderful that they're choosing to do this, obviously not being forced in any way, because I don't believe there are any incentives to accomplish that. It would be interesting to see if either the department or your association had some way of reinforcing that kind of proactive action on behalf of some of your members. Anyone else have a question?

Okay, I'm thinking in view of the weather, it wouldn't hurt to finish a little early today. We give our witnesses a chance to make a closing statement or perhaps add to something they've already mentioned.

MS. LEE: If I may.

MADAM CHAIRMAN: Sure.

MS. LEE: Again, I would like to express my thanks and gratitude for giving me the opportunity to come. I apologize if I appeared a little elusive in some of the answers, but as I said, if I had known the questions before, I would have come with the data. Being our

first time here, I will certainly be more prepared next time when I come. I am a number-cruncher, so that works for me, I will have those numbers for you as best as I can.

Again, I guess I just want to support the fact that all of our members are really doing their best to provide the best care they can. We know it's an imperfect system and nobody would try to say that it is a perfect system, but I do want to reassure you that all of our members are fully committed to providing the best, safest care that we can for Nova Scotians and we are all certainly committed in generations living well in Nova Scotia. We would welcome the opportunity to come back again if you should desire to have us and we will guarantee that we follow up on the questions we didn't have the answers for, for you.

MADAM CHAIRMAN: Great. Mary, is there anything you would like to add to that?

MS. BALDWIN: I think Mary Lee has stated it all quite nicely.

MADAM CHAIRMAN: Okay. We just want to say how much we appreciate you coming here today, especially in such difficult travelling conditions. We do appreciate the critical role that your organization and membership play in the whole social infrastructure in our province. We wish you well and thank you very much for your time and explanations.

I just want to remind the members that our next regular meeting date is Tuesday, March 3rd. We have the Canadian Federation of Students appearing before us and again that is from 1:00 p.m. to 3:00 p.m.

The meeting is adjourned.

[The committee adjourned at 2:36 p.m.]