HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, December 14, 2011

LEGISLATIVE CHAMBER

Diabetes Care Program and Nova Scotia Renal Program

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Public Accounts Committee

Ms. Diana Whalen, Chairman
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[Hon. Christopher d'Entremont replaced Mr. Chuck Porter]

In Attendance:

Mrs. Darlene Henry
Legislative Committee Clerk

Ms. Evangeline Colman-Sadd
Assistant Auditor General

Ms. Karen Kinley
Legislative Counsel Office

WITNESSES

Department of Health and Wellness

Mr. Kevin McNamara, Deputy Minister
Ms. Katherine Fraser, Director, Acute & Tertiary Care
Ms. Linda Penny, Chief Financial Officer

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, DECEMBER 14, 2011

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Ms. Diana Whalen

VICE-CHAIRMAN
Mr. Howard Epstein

MADAM CHAIRMAN: Good morning everyone. It's just 9:00 a.m. now so we'll get started with our Public Accounts Committee meeting this morning. We have witnesses here from the Department of Health and Wellness, and our subject today is Diabetes Care and Nova Scotia Renal Programs.

Before we begin with the opening statement from the deputy minister, I'd like to have the members of the committee introduce themselves.

[The committee members introduced themselves.]

MADAM CHAIRMAN: During the meeting I'll be leaving the Chair and the vice-chairman will take over for the questioning period. With that, I'll turn it over to you, Mr. McNamara, so that you can give the opening statement for today.

[9:01 a.m. Mr. Howard Epstein took the Chair.]

MR. KEVIN MCNAMARA: Thank you. Good morning, I'd like to start by introducing Katherine Fraser, on my left, who is the director of Acute and Tertiary Care at the Department of Health and Wellness; and on my right is Linda Penny, the department's chief financial officer. They are both here with me today.

I am pleased to be here this morning to speak to you about the department's provincial programs: the Nova Scotia Renal Program and the Diabetes Care Program of Nova Scotia. These two provincial programs advise the department in developing or adopting clinical service standards to improve clinical care province-wide. They also provide advice on service delivery models and the impact of new technologies on patient care.

Provincial programs work with the DHAs to support the implementation of guidelines and care standards to ensure better health outcomes for all Nova Scotians. These programs collect, analyze and interpret disease information to understand the burden of disease in Nova Scotia. This understanding guides the department's chronic disease strategy development.

Both the Renal Program and the Diabetes Care Program work with the goal of providing better health care to Nova Scotians with kidney disease and/or diabetes by working with the service providers in all DHAs. They do not fund these service providers, but they do support their work by developing best practices, establishing guidelines of care, and promoting the uptake and monitoring of adherence to these guidelines. I will now take a moment to speak to each of these programs.

The Diabetes Care Program helps to ensure that the staff working in diabetes centres across the province provide quality care that meets national and provincial guidelines. An example of this is the standardized testing to monitor for the development and progression of diabetes complications like kidney, eye, heart and foot problems. The Diabetes Care Program has one of the best provincial registries in Canada and they use these statistics to inform provincial directions and guide local initiatives.

Because of this data we know what diabetes looks like at the provincial, district, and often community level, and can track changes in practice and referral patterns. They've developed care guidelines for children, pregnant women with diabetes, and seniors with diabetes living in long-term care facilities.

The Nova Scotia Renal Program works closely with renal service delivery programs in Capital, Cape Breton, Yarmouth, and the IWK renal to improve renal health and care for all Nova Scotians. Through their work they have standardized laboratory reporting and implemented a quality monitoring system in all labs throughout our province. This has improved the identification of kidney disease. The Renal Program has also developed guidelines and educational models to provide primary health care providers with the education and tools required to manage individuals who are at high risk of developing kidney disease, including guidelines on when to refer to a kidney specialist.

The program is also working to develop education and assessment standards to ensure that all individuals with end-stage kidney disease are provided with the same awareness and home therapies. Home therapy is dialysis in the convenience and comfort of

your home on your own schedule. Individuals who choose home therapies have higher levels of patient satisfaction and quality of life. In recent studies it's also said that they have less other chronic disease issues. After attending part of a café organized by the Nova Scotia Renal Program last week and hearing Dr. Tennankore from Ontario speak on the success of home therapy, I'm even more convinced we are on the right track to promote this.

Government recently announced three critical priorities to make life better for Nova Scotians living with kidney failure. By addressing these areas we're helping to ensure capacity to meet the growing demand for services. These priorities are:

1. Twelve full-time-equivalent registered nurses to satellite dialysis units across the province so that patients who require more complex care can receive it closer to home;

2. $626,000 to improve access to home dialysis treatments; and

3. Investing $420,000 to support the planned expansion of the Dickson building's dialysis unit.

Even with the serious financial challenges we face as a province, this year the government has announced over $2 million in investments to make life better for Nova Scotians with kidney failure and their families.

To protect the function of your kidneys you must save your heart. High blood pressure can cause kidney damage and kidney damage can cause high blood pressure. The interconnectivity is impossible to ignore. This is why the Diabetes Care Program of Nova Scotia, the Nova Scotia Renal Program, and Cardiovascular Health Nova Scotia have partnered to create the My Blood Pressure Initiative. I believe most MLAs had the opportunity to participate in this program a month or so ago.

This program asks all Nova Scotians to have their blood pressure regularly monitored by a health care provider and to record and track their results. We have seen great success with launching this program province-wide this summer and cards are available across our province. We're aware that as our population ages and people continue to choose more sedentary lifestyles, that need for support for chronic illnesses like kidney disease and diabetes will grow.

Through the continued work of these two provincial programs, we know how much illness to anticipate and to encourage Nova Scotians to become more actively involved in their own wellness. Thank you for the opportunity to share with you. We look forward to answering your questions.

MR. CHAIRMAN: Mr. McNamara, thank you very much for your presentation. As you're aware, our tradition has been to allow each of the caucuses an initial round of 20 minutes each for questioning. We'll start with the Liberal caucus. Ms. Whalen.

MS. DIANA WHALEN: Thank you very much and welcome today. I appreciate having the chance to go over some questions I have on the diabetic care, so for my first 20 minutes I'm going to concentrate on the diabetes program. Thank you very much.

My first question relates to insulin pumps. As you know, I've had a bill before the House asking that the government look at insulin pumps and I know it has been on the government's agenda anyway, it is something that's very important. I noticed that in the *Nova Scotia Diabetes Statistics Report 2011* it doesn't include statistics for those with diabetes who are under the age of 20 and it has a statement that says that diabetes under the age of 20 is relatively rare - I wanted to get the right term "relatively rare."

I wonder if you could give me the number of people who you think have the need for juvenile insulin pumps in Nova Scotia.

MR. MCNAMARA: I'm going to ask Katherine to answer that question.

MS. KATHERINE FRASER: If you could just repeat the question again, please.

MS. WHALEN: Well, let's start with just how many diabetics in Nova Scotia would be under the age of 18. Let's start with just the number of juvenile diabetics.

MS. FRASER: I think we have about 705 under the age of 19.

MS. WHALEN: Okay, that gives us a relative sense. I think I saw a figure of 77,000 Nova Scotians that have diabetes so certainly that would verify the "relatively rare" statement that you had in there.

Given that we have such a well-developed, province-wide Diabetes Care Program, which you did allude to in your opening statement and that gives us an extensive network of diabetic centres across the province, is it your opinion that we're better prepared to deliver a province-wide insulin pump program than other provinces?

MS. FRASER: I think that with the Diabetes Care Program of Nova Scotia we do have some of the infrastructure in place to support that. The piece that we would need to enhance would be at the provider level because as you know, Diabetes Care Nova Scotia is a provincial program that supports providers and they provide support through guidelines, standards and surveillance of people with diabetes.

It's actually the diabetes care centres across the province - and there are 39 of them - that deliver the services, so within those multidisciplinary teams there would need to be

some enhancement in terms of training so that they, in turn, could help families and children who would be on an insulin pump, know how to use it, be there for support if they had issues with the pump.

MS. WHALEN: Thank you, Ms. Fraser. So what you're saying is there's a good network in place but we would need training?

MS. FRASER: Yes. And that would require resources to provide that training to the staff that are in place.

MS. WHALEN: Okay. I wonder if the deputy minister could confirm whether there was any background analysis completed or recommendations from previous Ministers of Health around a publicly-funded insulin pump program, if in the past, in the previous government, if there had been any recommendations.

MR. MCNAMARA: Not that I'm aware of.

MS. FRASER: I think with previous governments we did do some work in exploring the issue but there was never a formal ask put forward by the department.

MS. WHALEN: I wonder if we had the manager for the Diabetes Care Program here today if there might be a bit more information available on that, so maybe it's a question we could pose . . .

MR. MCNAMARA: So what is your question then?

MS. WHALEN: I really wanted to know if there had been any firm information or recommendations made under previous ministers about preparing for insulin pumps.

MR. MCNAMARA: I think as Katherine alluded to, the program would report through her and she would be aware if there had been one.

MS. WHALEN: Okay, thanks. I've got quite a few questions so I'm going to run along to the next one.

There is a document called *Priming for Pumps* - that's the name of it, *Priming for Pumps*. I believe it was provided in our packages - I think so, but anyway, we've seen it. It says: Some diabetic centres would need support for insulin pump therapy or a referral route, while others will not initiate pump therapy but will do follow-up.

Given what it said there, I'm asking whether or not given that adults and young children are using insulin pump therapy right now across the province and have been for some time, why would we have diabetes centres that are not going to be able to support the

insulin pumps? That report, *Priming for Pumps*, says some will support it, some will not, and you said there are 39 in the province.

MR. MCNAMARA: I'm not exactly sure which report you're referring to but anyway, in the case of Nova Scotia we have looked at insulin pumps. The recommendation at this point is not to proceed with adding insulin pumps to our program; we have other programs in place that provide adequate service to youth at an affordable price. For us to move into this we have to consider any expenditure against other priorities.

MS. WHALEN: All right, so that's pretty definitive. Do you have all the information that you need right now to move forward if you choose to, if funding were available, to move forward with insulin pumps?

MS. MCNAMARA: It's not just a case of funding, it's also a case of what's the right method of providing insulin to individuals. Some individuals would not be appropriate for insulin pumps even if the program were available. But we do know that there are others that would be. It is a factor of convenience, we know that. We do know that it is a factor that can assist in a better lifestyle for some children, but we also know that in other cases it is not the best therapy to use.

MS. WHALEN: I don't believe it's good for everybody either, I don't think all 700 children that were mentioned, for example, would be candidates for that but those that have received it, absolutely swear by the fact that their quality of life is many times better than it was before and that their peace of mind is so much higher for parents of children with the need for insulin. So I just think it's something that we can't arbitrarily turn our backs to, we should be looking at a way to achieve it.

MR. MCNAMARA: We're not arbitrarily turning our back on this, we've done an assessment, the advice we've received to date is not to proceed with it based on the existing programs we have in place and other priorities we have to address.

MS. WHALEN: Other provinces, though, are moving forward so that should add more credence to the fact that Nova Scotia should be looking at it.

MR. MCNAMARA: Some things that we're doing in Nova Scotia other provinces are not. Our diabetes care centre is far and wide better than any program in any other province. Other provinces are starting to emulate us.

MS. WHALEN: Which is why I think we're well prepared to introduce a program like the insulin pump support.

I have some questions on drugs, so I'd like to go to the question of the drug Lantus. Could you please inform us how many jurisdictions in the country provide funding for Lantus, which is a diabetic drug?

MS. FRASER: I don't have that answer of how many provinces have gone to it, but again in Nova Scotia we have been taking the advice through the Common Drug Review where Lantus is not one that's being recommended to be on the formulary; although we do know that in the future it may be something that we should look at for a particular patient population.

MS. WHALEN: That makes sense. In each one of these drugs there's a certain group that it's best for. Just the same as the pumps, it's not for everybody. I'm just looking at this based on the calls that I received when I was Health Critic, and also we receive in our caucus office as well, that there's quite a demand for that. I'm wondering if you can tell me if there have been calls received at the department as well; is there any kind of concerted effort from diabetics, asking for access to this drug?

MR. MCNAMARA: I can't remember receiving a lot of lobbying on that particular drug. Many other drugs, I know we get a lot of lobbying.

MS. WHALEN: I know that; I know you do, but I think this one is coming to the fore, so I guess that's something to expect.

MR. MCNAMARA: I would also add that if we had extra dollars, we probably would go with that over the insulin pumps.

MS. WHALEN: Okay, well that's positive for people who are looking for Lantus then. What I was going to mention was that if you're receiving the drug Lantus, there seems to be less need for testing strips. I think it's because it's long-lasting insulin. I wondered if the department has factored in the reduced cost associated with testing strips when they're determining whether Lantus should be available through the Pharmacare Programs.

MR. MCNAMARA: We know that test strips are overused in this province based on the lobbying by drug companies, and through the education of our Diabetes Care Program, we are using the lowest number of test strips in the country right now for our diabetic population, but we do have to put programs in place to reduce it even further.

MS. WHALEN: Another drug that I think is on the formulary is Januvia, which is also a diabetic drug; maybe Ms. Fraser knows that better. It said it was added to the formulary in October, and certainly that's a good thing; it's part of the array of it. But Januvia is made available in the case when insulin no longer works. When I was reading that, I was actually surprised that there is a drug you can use in that instance. But I wanted to make the point that Lantus is less expensive than Januvia and so from a patient perspective a lot of doctors are saying it should be the next drug available in the array of choices for type 2 diabetics.

I wanted to ask since Lantus is cheaper than Januvia and requires fewer test strips, then why is Lantus not being funded now, but we have moved to Januvia which is a more expensive drug?

MS. FRASER: I can't answer that, but I will certainly investigate it for you and provide a response.

MS. WHALEN: That would be good. Are you aware whether Lantus is covered by most private insurance plans?

MS. FRASER: No, I'm not.

MS. WHALEN: Perhaps you could compare that too. I was just checking another one - do you know if it's provided for Aboriginals that are covered under the non-insured health benefit, the federal government - so it would be available if you lived on one of the First Nations?

MS. FRASER: No, I don't know that either, but I will take down the question.

MS. WHALEN: I think it is, in which case I'd say there is a population in Nova Scotia that has access to it, and again I think that adds further rationale to look at it on a cost basis and on the basis that other Nova Scotians are receiving it - so on a fairness basis I would say.

MS. FRASER: Now that you're speaking about it, I do remember that, yes, people who have private insurance can access long-acting insulin, Lantus.

MS. WHALEN: You have a medical committee that would be advising you, as well, on these drugs?

MS. FRASER: The Pharmacare, yes.

MS. WHALEN: I think there's some strong medical evidence that this is an important step in the treatment options that should be available to diabetics. Again, when I looked at it, the fact that it has the long-lasting aspect and it's cheaper than other drugs that we're funding, that it was something we should be considering.

I'd like to ask you a little bit about the diabetic test strips. I know, Mr. McNamara, you just mentioned that you think we're well managed in that regard. Not even two years ago, February 2010, the provincial government made the announcement that they were going to limit the number of diabetic test strips that would be eligible to be covered, they were going to be limited to 100 per year.

At the time there had been, I think, an alarm in the diabetic community. The Canadian Diabetes Association contacted the government and the decision was reversed. Could the deputy please indicate who made the recommendation in February 2010, was it the bureaucracy or the Diabetic Care Program itself?

MR. MCNAMARA: It was made with the advice and support from the Diabetes Care Program and there was a review and an evaluation done. It was based on a report that was done nationally. What ended up happening is we got out-manoeuvred by the drug company, to be quite honest, who used vulnerable patients and the Canadian Diabetes Association, who they fund heavily, to out-lobby us. It is a multi-million dollar industry to the drug company . . .

MS. WHALEN: Test strips?

MR. MCNAMARA: Test strips - across this country. So as I mentioned, we've gone to another route of going to education to reduce them significantly. So now we're the lowest user per capita of people with diabetes but we still have to go further. Even the Canadian Diabetes Association recently has come out with a new report of reducing the number of test strips they're recommending that they use versus their position of two years ago.

MS. WHALEN: My concern would be if people are being responsible and on top of their disease and managing it well, they would be testing regularly and that would prevent them from coming to emergency rooms or having a lot of other adverse incidents that might happen if they're not on top of it. So, you know, it seems counterintuitive to limit the number of strips.

MR. MCNAMARA: The evidence shows - I mean there are certain people that do not have to test at all that do. I know there are certain people, for example, who test to see if they can have another drink. That isn't an appropriate use of test strips, thinking from a medical point of view. But I mean, that doesn't mean we don't test. We test appropriately. We use them to test for their health, not because they just want to test to record something and not use the information to better look after themselves.

MS. WHALEN: Just as a final question, is the reduction of the coverage for test strips under active consideration for the next budget year?

MR. MCNAMARA: I would say it is under active consideration based on the recent report from the Canadian Diabetes Association.

MS. WHALEN: Okay, so that will be something to revisit then in the future.

I wanted to ask you about the classroom policy for children. Again, that has been an issue and I've had the opportunity to meet quite a few parents around the province and get

a sense of their concern about the children in the classroom and just, you know, how they manage their day and what kind of supports are in place.

We know that there was a new guideline document, *Guidelines for Supporting Students with Type 1 Diabetes in Schools*, that came out and that was just November 2010. From discussions with parents in the meantime, they did say at the start of this school year there was just as much - I don't know if chaos is going a little far - but uncertainty, certainly, and a lack of consistency still in place, not only across the province but within single school boards, individual school boards because not every school is doing it the same way. That was one of the things that I know the guideline was intended to correct, was that we would then have a standard in place that every school would maintain.

So I wanted to know, one thing I'd like to ask for would be, could you give us copies of the agreements that are in place with schools? I don't know if it was with individual schools or school boards, but I know that agreements were to be signed and I'd like to be able to see that and I think other members of the committee would as well. We all represent ridings with, you know, children and families that are affected by diabetes so we would really like to see that.

MR. MCNAMARA: That, I believe, is a program through the Department of Education and we will request that from them and forward it to you.

MS. WHALEN: Okay, that was actually one of my questions - who's really monitoring it? So are they monitoring the rollout of it? It was a Department of Health and Wellness guideline, I think, though.

MR. MCNAMARA: Yes. Ms. Fraser.

MS. FRASER: The Department of Health and Wellness worked with the Department of Education to advise on the guideline but the guideline is implemented through the Department of Education. It's interesting because we often hear from families that are having concerns and we haven't heard anything in the last little while, I would say, about that.

MS. WHALEN: So having helped to draft these guidelines, things have been calm in your estimation, at least based on complaints?

MS. FRASER: Yes, and we do from time to time have conversations with Education about how this is going. From what we've heard, I would say in the last few months, it has been going quite smoothly.

MS. WHALEN: Well, that's not what we're hearing on our end in terms of calls to my constituency and to the caucus office. I'd think it would be great if perhaps another question would be just to ask you to review it. Not only would I like to see the agreements

that are in place between school boards and the DHAs, because I thought it was school boards and DHAs that had signed that, but if you could also perhaps give us an update on the status of it. Again, every Fall it's a real worry to parents whose children require monitoring and even for the school administration, they're often unprepared or nervous about what needs to be done. I know we can integrate children and they can participate fully if they have the right supports, so that's very important to us.

Could I ask, Mr. Chairman, how much time do I have left in my time?

MR. CHAIRMAN: Just under two minutes.

MS. WHALEN: I wanted to go quickly to the islet transplant, which I guess is a pancreatic kind of transplant that can actually free people from the need to take insulin. I had one person who has been here at the Legislature - and I read a resolution for him - who went over a year and a half ago - it might almost be going on two years - to Edmonton where the transplant is done and has actually been insulin-free after that. He is someone who had brittle diabetes, which meant that he was often - brittle diabetes means it's very difficult to control, even with the most stringent efforts. This has just been an absolute lifesaver for him; it has changed everything for his life.

I wanted to ask whether or not there's any consideration about offering the transportation and support that we give to other people going away for transplants, if they were to go for the islet transplant.

MS. FRASER: The department does have an out-of-province travel policy. I would have to review it again to see if it would include these people who need to travel for that type of surgery. It's not one that I think we have supported in terms of having it done in our own province. I think the clinical evidence on it is still not clear on the long-term benefit.

MS. WHALEN: It is in Alberta now, a standard of care, using those terms that are common in your department. They've done now over 100 of these. It's also important to note there would be very few Nova Scotians who would be candidates, again going back to the fact that not every one of these procedures or drugs work with everybody, there's only a few people who would really benefit from this. You have to be healthy, you have to meet a whole standard of other criteria, but it has been really phenomenal . . .

MR. CHAIRMAN: Ms. Whalen, time. Thank you.

We'll move now to a second round of 20 minutes and we go to the PC caucus. Mr. d'Entremont.

HON. CHRISTOPHER D'ENTREMONT: Thank you very much, Mr. Chairman. It's a pleasure to have the Department of Health and Wellness in once again to talk about two very important programs in our province. My first, basically looking around the

education aspect of diabetes care in this province - because as we know, as our population continues to age, more and more people are being diagnosed with type 2 diabetes - how are we going to be taking on this larger influx of people, because we know it gets worse and worse every year? How are we going to work on sort of earlier intervention programs, to make sure that they don't get any worse as time rolls on?

[9:29 a.m. Ms. Diana Whalen resumed the Chair.]

MR. MCNAMARA: I guess as you know even in your days as minister, we have a very active group of diabetes education centres around our province. We also know that a number of them also travel out to smaller communities, individuals who will go - I learned this morning, for example, that in the Sheet Harbour area they will travel to Ecum Secum to see individuals in that community.

This happens in other places; for example, people from Yarmouth travel to Shelburne to provide that education, in addition to our fixed centres. Also, many individuals get advice from their own family physicians, nurse practitioners and others. We do provide information to them through various ways. We also try to have a medical adviser in each district who advises the physicians in the community of how to advise their patients who have diabetes, who are in an unfortunate situation of maybe not being able to travel, et cetera.

It is something that we have to be very active and will continue and our program, I think our program, as was mentioned earlier, we're the best in the country in having Diabetes Education Centres and with our standards, we'll just continue to enhance them. With the great leadership of the people in that program, we are very fortunate.

MR. D'ENTREMONT: Do we find that the family physicians understand the full program, allowing for that referral to happen? Are they counselling, as well, the patients on lifestyle changes and things like that? Or is it more they're sort of washing their hands of it as they send it off to the program or are they staying very involved in the care of that patient?

MR. MCNAMARA: I can speak from two roles. First, being a former chair of the Diabetes Care Program in Nova Scotia and also being the CEO in a district, there are certain physicians who embrace it and do a very good job. There are other physicians who, like any of us in life, aren't as embracing of the program. But our job is to continue to promote to physicians how they can assist their patients and the majority of physicians and nurse practitioners and others are good people who want to do the right job and will provide that education.

MR. D'ENTREMONT: What I worry about sometimes is that sort of washing your hands of it, that once you do refer off to the program then it's not my issue anymore kind of

thing. I just hope that circle continues to flow along. That's sort of my last comment on that one, but if you want to cap off before I go on to my next couple of points.

MR. MCNAMARA: It's okay.

MR. D'ENTREMONT: Okay, the last point I want to talk about with the diabetes program is really the issue that the previous member just brought up, the issue of test strips. This is a very odd discussion, really, because you have the department sort of seeing one number and other groups seeing other numbers. The best I've been able to find, talking to people that I sit and have breakfast with or have coffee with and I ask them - it's a standard question now when I see them take out the little pack - how many strips a day do you use? I get a range of numbers from a couple to nine, sort of in that range.

What is the appropriate number on this? I know three sounds a little low, but where is the association or organizations, where are they starting to push things towards?

MR. MCNAMARA: I guess it's fair to say there's no magic number, but we do know that some individuals have to test more frequently than others, depending on the severity of their diabetes. The problem is strips have become a marketing tool. For example, even when you go into a drugstore, you can get the free machine and then the strips are sold . . .

MR. D'ENTREMONT: I heard that this week and it shocked me.

MR. MCNAMARA: Also, even if you look at the recent study by the Canadian Diabetes Association, it was funded by the seller of - I'm sorry, that was the pump one. But they're all funded by the drug companies in different ways which creates issues for us. This past week I met with one of the drug companies that was surprised we were going to look at test strips again, that they believe they can continue to market and sell.

It's a big profit centre for drug companies. Unfortunately, they're in a different business than we are; we're in it to provide good care, they're in a marketing business to make the most money.

MR. D'ENTREMONT: Thank you for that. I'm wondering, too, if through discussions with drug companies, if there's a better medium to find. You can't necessarily cast them out completely because they are the provider of that product. I'm just wondering if in your discussions with them, is there an understanding of what your position is on this?

MR. MCNAMARA: They know our position. We have been very honest with them. Again, where they come from is a different part of the landscape, i.e., their shareholders. We're coming from trying to provide appropriate patient care and at the same time trying to protect the taxpayer. So what we do is base our information on the best

evidence that we can get, whether it's based on reports done nationally and also the work that we do.

I think the education work that has been done in Nova Scotia through the Diabetes Education Centres and through the advice from our nephrologists, we've done a much better job on test strips.

MR. D'ENTREMONT: Okay. If there's any last comment that goes with it is that if we are going to be changing this down the road, make sure we do the communication piece and make sure people understand what's going on before the ball drops. I think that's what happened last time. All of a sudden we're hearing that there was only three a day allowed, the 100 per year, which didn't make a whole lot of sense to anybody. So again, it's just a bigger communication issue.

MR. MCNAMARA: I admit we screwed up the last time.

MR. D'ENTREMONT: Thank you for that. I'm staying on diabetes for a second on the issue of pumps. I can say that when I was minister we did ask for some work to be done to get the data at least ready to look at those younger users of this product. The other night when we were at the dinner, the father who was presenting about getting this pump for his daughter actually said it very well. He said how can a little thing that looks the size of a pager cost $6,000? I think that's an issue where you were going with the test strips, which was kind of the same issue with an insulin pump, why does this cost so much and why do they continue to market it that way?

We've gone along into time on this one and the prices have remained the same. That doesn't seem to be fair to a patient to see that kind of product that we can buy a cellphone that does all these wonderful things for $150 and yet an insulin pump that seems to have the same kind of technology built into it, except maybe a few extra pumps and pieces, that costs $6,000. Do you have any thoughts on that or have you had any discussions with some of these providers to say, come on, let's see what can be done?

MR. MCNAMARA: We haven't had it on the insulin pumps because there hasn't been a willingness to change as far as I'm aware. We do that with some of the drug companies and some of the prescriptions that we do work our way through. We are also even working with some of the drugs that were mentioned earlier, looking at how we can do things better on a national basis and we've been doing some negotiations on a couple of drugs which has had success on one; another is still in the works.

I think there's a lot more work that we've talked about from a minister's basis and from a deputy's across the country, how we can start doing things better together. If we look at the prices that we pay for some of these things versus the U.S., as well, we have to say, how can we get U.S. prices for some of these devices?

MR. D'ENTREMONT: I think that's a good comment for many of the products and services that are provided by the Health and Wellness Department because we are a small province and we belong to a larger country, so why can't we do things a little more together on these things? It's always a difficult thing to do.

My last line of questioning for this round, and I probably won't use up my 20 minutes, but I will finish up with this because I'm basically sitting in for the member for Hants West. I'm going to have to ask the questions around a dialysis unit for Windsor. I'm just wondering have you been aware of the issue - and I'm sure you have - but what kind of approaches have you had and what kind of discussion have you had around a dialysis unit for Windsor?

MR. MCNAMARA: We're very aware of the issue that has been raised in Windsor and it's unfortunate that a number of individuals do have to travel for dialysis. In looking around the province we are trying to enhance programs first that will shore up the ones that we have at the current time, which is why we added the additional registered nurses in those current satellites. We've also had some reviews done and we know that Windsor would not be at the top of the list. There are some other areas that people have to travel much further - for example, Digby - so we have to look at prioritizing.

Secondly, I know the community has started to raise some funds, as I believe has Shelburne in the same vein, but again, the department has to develop its priorities based on the need and if we based it on funding, we'd have a hospital in different places, as you can probably guess.

MR. D'ENTREMONT: We already do.

MR. MCNAMARA: Well, we have a few of them; that's correct. I think the thing we have to look at, which I mentioned in my opening remarks, is home dialysis and this is something I think could be tremendously beneficial to some of the individuals in the Windsor area where they could do it in their own home. Some of it can be done at night, some can be done during the day and so we are starting to concentrate on how we can promote home dialysis more.

We know that roughly 80 per cent of the individuals receiving dialysis currently could have home dialysis, which is a much cheaper form of doing it. It's also more convenient for the patients and it also gives them a better lifestyle. But our culture has been to institutionalize it and so it's going to take a bit of time to change it, but that's one way. Even the funds that are being raised in Windsor could go toward a number of units to help us do some home dialysis.

MR. D'ENTREMONT: I think the discussion around home dialysis, too, is how frequent the person is going to have to be doing it; sometimes it's up to three times a day that they have to hook themselves up to the home dialysis unit. I've heard things. Maybe

I'll ask the question, home dialysis, how does it affect the lifestyle, how many times do they have to be hooked up, how many times do they have to go through the procedure of dialysis when they're at home? Then I'll go to the next piece.

MS. FRASER: There are three types of home therapy and one of them is home hemo, which some patients choose to do at night, so we call it nocturnal dialysis and so they would hook themselves up at night. We also have two types of peritoneal dialysis and one of them is, as you say, you do it more often during the day, but again, the second type of peritoneal dialysis uses what we call a cycler and that can be done at night, as well, when people sleep.

I think we haven't socialized home therapies as well as we could and as we look around the country in terms of what B.C. is doing and now what Manitoba is doing and Ontario, we're realizing that we have an opportunity here to allow people to stay home, especially frail elderly who are trying to travel for these treatments, and give them more freedom and quality of life.

MR. D'ENTREMONT: I think, too, you might have a bit of a Catch-22 there, especially if you're an older patient. You're not comfortable with hooking yourself up to a system like that and you're not comfortable with actually driving to the hospital site, so I can understand the challenge of trying to sell the idea of home dialysis.

I saw the announcements that you have made in trying to move forward on that one, and I wish you luck on that one, but the other issue is that we still hear of too many people travelling in too many different directions in order to receive dialysis. The South Shore is no different. I mean, the deputy and I have had that discussion many times on the issue of Liverpool versus Bridgewater. I know that in the Valley it's always Middleton versus Kentville and now Windsor is thrown into the mix.

Ultimately we do have a community that's waiting for some answers and I know they probably haven't received the ones that they wanted. I had a meeting with them not so long ago but they don't seem to want to back down, so more of bringing a heads-up that I don't think that one is going to go away for some time like many of the other sites haven't gone away.

Where else in the province are we looking at right now for future expansion? I saw the added nurses that we're going to be hiring and maybe some expansion here at the Dickson centre, but where else do we see some movement in the province right now on dialysis?

MR. MCNAMARA: As I mentioned, Digby is one that we have to look at for the future as we do our future planning and as funds become available. I think Bridgewater, as you mentioned, is another obvious area for a couple of reasons. As for opening up the new facility in Truro, it does have the opportunity for expansion in the future, if the need grows,

so at least that was one that had some forethought put into that part of it; not that it would be expanded immediately, but at least the idea is there. That's three off the top of my head.

Also what we're doing at Capital Health is not just to look at the provincial but also to provide more opportunity to be able to train people for home dialysis; the same as we're doing in Yarmouth. Also, I should have mentioned in my comments, Inverness, as we're going through the work there, we'll provide opportunities for additional spaces as well.

MR. D'ENTREMONT: Basically my final question is about the age and quality of the dialysis units themselves, the machines. I remember when I was minister we had the opportunity to go through the Dickson centre and the earful I got was on the amount of hours that were actually on the dialysis machines themselves. I'm just wondering how the replacement of machines has been going and what's our average age going on right now of equipment?

MR. MCNAMARA: I'll get Katherine to answer that.

MADAM CHAIRMAN: Ms. Fraser.

MS. FRASER: I can't tell you the exact age of the equipment, but I can tell you that we have been replacing equipment over the past two years based on what Capital Health's needs are and what Cape Breton's and Yarmouth's needs are.

MR. D'ENTREMONT: If I remember correctly, an average price on one of those is somewhere around $40,000-odd or $60,000-odd, sort of in that range.

MS. FRASER: Yes.

MR. D'ENTREMONT: Thank you very much.

MADAM CHAIRMAN: Those are all the questions you have right now?

MR. D'ENTREMONT: That's all I have.

MADAM CHAIRMAN: Then we'll move to Mr. Ramey for the NDP, 20 minutes starting now.

MR. GARY RAMEY: Thank you for coming here today, Mr. McNamara, Ms. Penny and Ms. Fraser. I guess everybody knows that there are two types of diabetes, type 1 and type 2; certainly people on this committee know that. I'm interested in knowing if you have any statistics as to how many new diabetics get diagnosed each year with type 2.

MS. FRASER: I do have it here on a cheat sheet. I think it's around 2,000 but I'll just check.

MR. RAMEY: Perhaps while you're looking for that, I don't want to lose too much of my time here, but when you get the number I'd like to know it.

I guess my second question would be, I've heard studies that suggest that Nova Scotians are among the most unhealthy people in Canada in terms of our smoking rates, in terms of our weight, in terms of some of our unhealthy lifestyle issues. Is that true or false?

MR. MCNAMARA: We know as a fact that we have one of the highest rates of chronic diseases in the country, which includes diabetes. Some of it comes from lifestyle factors; some of it comes from genetics. The unfortunate part, though, is we do have to address it and that's why through the health promotion and protection side we're trying to do more to be preventive as we're looking at a go-forward basis.

We also know that if we don't start doing more on the prevention side, we will not be able to afford to treat all the people who are going to be impacted by chronic diseases.

MR. RAMEY: Understood. Oh, do you have the number yet?

MS. FRASER: Yes, it's 4,000 newly diagnosed. It's big.

MR. RAMEY: We're going at the rate of 4,000 newly diagnosed diabetics a year?

MS. FRASER: Yes.

MR. RAMEY: Is that added to whatever the figure was - 77,000 did somebody say?

MS. FRASER: We have 80,000 people living with diabetes in our province right now.

MR. RAMEY: And we're adding 4,000 a year, at the present time, to those 80,000?

MS. FRASER: Yes.

MR. RAMEY: That's huge. So in relation to the question that Mr. McNamara just answered, which was about our chronic disease rates and some of the other issues that we have, whether it's genetic or whether it's lifestyle, do we have any kind of statistics that would tell us by what percentage we think we could reduce type 2 diabetes if we could do the preventive stuff that we just alluded to? Is there any speculation on how much we could cut that down if we had some kind of preventive programs to keep us from getting overweight and to keep us from being as sedentary?

MR. MCNAMARA: That's one of the things we're trying to do by trying to promote - we know, for example, that individuals who walk can reduce all number of chronic diseases. I think, if I remember the statistics, 30 minutes a day is a big prevention.

Again, I don't want to imply that we're blaming people for their own illnesses, in some cases they come for different reasons, but with type 2 there are opportunities to at least delay the onset or to minimize the impact of it.

When we talk about the number of individuals diagnosed with diabetes, it doesn't mean that they are all treated with insulin. Some are treated by diet, some can be treated by exercise and diet; there are different ways to get at these individuals. I think the better the job we can do on the promotion side - and we're going to have to, as I mentioned, to reduce the impact. As many of us are getting older, it's also more imperative that we start to do more prevention.

MR. RAMEY: I certainly hear you on that and I would argue that as Nova Scotians, as individuals who are living in Canada, we are responsible to a certain extent for our own health. I think we're responsible to a very high degree for our own health and we had best start paying attention.

On the type 1 diabetes front, my wife is a type 1 diabetic with an insulin pump so I'm not unfamiliar with insulin pumps and some of the issues around them. However, I do watch what my wife has to do in order to use the insulin pump properly, which means that every time she looks at a plate of food that she's going to eat, she analyzes very quickly in her head everything that's on there and knows instantly how many carbs, how many this, how many that. Then she programs the insulin pump to give her the appropriate amount of insulin.

If she were to come in here and walk around the city with me for awhile, that would change everything if she didn't do the exact same walk every day. So using an insulin pump, in my opinion, is a very complicated, intellectual exercise that I don't think everybody is capable of performing.

Now, that's just my opinion so I'm not trying to, you know, make a profound statement here of any kind. I'm just saying from what I've seen that it is a serious issue which I would argue, if you had any kind of irresponsible person - and I'm talking adult or child - who doesn't pay an awful lot of attention to what they're doing, they could end up in a horrible mess using an insulin pump. I do believe a lot of people think it's the pancreas attached to the outside of your body and hooked to your brain somehow and that it automatically tells the insulin pump what to do, which it clearly doesn't. So I would like to hear a little bit more on that.

I'm not anti-insulin pump, obviously, I just indicated my wife has one. However, I'm very concerned about how insulin pumps would be used by people who aren't totally on top of their game. So do you have any comment around that? I know you said awhile ago, or somebody said over there, they're not for everybody, I totally agree with that, but can you say a little more on it?

MS. FRASER: You're quite right. We have had advice from endocrinologists from the IWK and from other district health authorities and, again, you need to be very careful of who is the appropriate patient for an insulin pump. There are patients who feel that they would rather not have one because it reminds them of their diabetes every day, to be attached to a device. But it is exactly that, a device that can support and manage diabetes and provide a quality of life for those who are willing to take on the work of understanding how this pump works and how to use it properly. So, yes, it's not for everyone.

MR. RAMEY: Thank you for that. I'm going to switch gears for a second here and I don't want to chew up all the time myself for my group here but just a couple of questions on dialysis, just a couple of quick ones. Mr. d'Entremont was talking about dialysis and he tweaked my curiosity when he was talking about elderly people and so on, and I know a lot of the dialysis patients are elderly. Do you have any statistics on the average age of a dialysis patient by any chance over there?

MR. MCNAMARA: It's 64, 65.

MR. RAMEY: So around 60 somewhere then, okay, that's interesting. The other question I had on that was about drugs that are available. I take it that dialysis patients need medications as well. What are the medications that dialysis patients need?

MR. MCNAMARA: Do you want to speak to that?

MADAM CHAIRMAN: Ms. Fraser.

MS. FRASER: Dialysis patients can be on a number of medications but one that they usually take is called Aranesp - I can't remember the other trade name, but it's erythropoietin. That drug is provided for them.

MR. RAMEY: It's covered under health plans or whatever by the government?

MS. FRASER: By the government.

MR. RAMEY: The other question was in relation again to something Mr. d'Entremont alluded to in relation to, I think, Mr. Porter who he's sitting in for today and that's, you know, the locations of - where are the satellite units located? I know we have several and I think you maybe listed them already, or I know you've mentioned one or two, but can you tell me where they are?

MS. FRASER: If we start around the province, we have one in Liverpool, Berwick, Truro, Pictou, Springhill, Antigonish, and Strait Richmond. Soon there will be one in Inverness.

MR. MCNAMARA: And Sherbrooke.

MS. FRASER: Oh, in Sherbrooke, sorry, Sherbrooke as well.

MR. RAMEY: So there are quite a few already but I still know there are - and I, of course, admit that there are travel issues because that's something that the diabetes questions referred to awhile ago by Ms. Whalen. She gets lots of calls - I don't get those at all but I do get calls on dialysis. I guess one of the questions that I wanted to ask just before I hand off to my colleagues here is when you're looking at where you might have to go next - I know Mr. McNamara alluded to some places and I think he mentioned Digby and perhaps even Bridgewater, which would be great - do you look at the demographics of these places?

For instance Bridgewater - I'll use it as an example because it's my town, it's in my constituency - it's growing like crazy. The population keeps going up because many people who left there to work in what used to be the west, which was Ontario at the time, and went to the car plants and so on when I was much younger, which was quite awhile ago, they are now retiring and selling their houses in Mississauga, Oakville and Oshawa for many hundreds of thousands of dollars and coming back and buying properties on the South Shore. But they tend to be my age and older and I just got the average age for dialysis, so my concern is, do you look at the demographics - and the demographics of the province seem to be changing - when you look at possible locations for these new satellites?

MR. MCNAMARA: Demographics - when the original ones were set up it was also looking at distance. So for example the one in Liverpool would cover individuals not just from Bridgewater but down towards Shelburne, so it would look at the distance in terms of travelling. Ones from Mahone Bay towards Halifax would probably come to Halifax, so that was one of the decisions. Yes, as we look at new things we look at the demographics in what we're doing and that's why consideration for Bridgewater and also where individuals are now coming from who require dialysis; the age of the population is another thing we look at. But again, we still have to look at those.

The reason I use Digby is because it's the farthest that people have to travel at the moment, either to Yarmouth or to the Valley, which is longer than anyone else and when you think of winter roads, so trying minimize - also, as we can do more home dialysis we can probably start reducing our reliance on some of our institutional in the future as well.

MR. RAMEY: Thank you very much and now I'll hand it off to Mr. MacKinnon.

MADAM CHAIRMAN: Mr. MacKinnon, it's your turn, and I would mention that in the second round we're going to have 20 minutes because the Progressive Conservative representatives weren't able to stay today. So we'll have lots of time to come back to you, Mr. Ramey.

MR. CLARRIE MACKINNON: Thank you very much, Madam Chairman. I would like to zero in for a moment on our 13 First Nations that we have around the province and I

realize that the federal government has so many involvements in so many aspects of First Nation lives, but I'm wondering about the level of diabetes that there is on the First Nations. In the First Nation in my constituency, Pictou Landing First Nation, I have some very, very good friends there that are dealing with diabetes, and the populations on First Nations are certainly growing and I'm very concerned about the levels that exist. Are we doing anything education-wise, service-wise, to our First Nations?

MR. MCNAMARA: Perhaps I'll start and I'll ask Katherine to add the more technical part. I had the opportunity a couple of weeks ago to appear before the Senate Committee in Ottawa and one of the things I talked about was the role of Health Canada in the Aboriginal community. For example, it becomes sometimes sort of who's the last payer to look after the individual and there are not clear guidelines on where Health Canada has its role and where we - and sometimes it leaves the individual out in the cold, which is unfortunate, and we have to recognize that they are all citizens of our country and our province and we have to figure out a better way to know who does what, when and where. I really believe strongly that we haven't done a good job, between both governments, of defining our roles of where things fit in. With that I'll ask Katherine to talk about what we do.

MS. FRASER: Some of our provincial programs have had a relationship with various First Nation communities across the province. I think that the Tui'kn Partnership, which are the three First Nation communities in Cape Breton, have been involved with three of our provincial programs. But at the end of the day the treatments that First Nation communities receive in our acute care facilities, that's where the relationship is, with the district health authorities and the operators of health care facilities. Primary health care is provided in the community and we haven't had a lot of involvement with that, from a government perspective. But I know that the district health authorities work hard to maintain a good relationship with the communities around primary care.

MR. MACKINNON: I'm very pleased to hear the deputy's comments in relation to the interaction that is taking place between provinces and the federal government because we have to - in relation to our First Nations - have a better understanding of who is responsible for what and who is doing a good job and who isn't in our First Nations.

One of the things that I hear repeatedly at the constituency level is distance travelled and so on. I believe I have heard the figure of 39 Diabetes Centres in the province. How many sites are there for dialysis in the province right now and how many do you envisage that there will be in five years time, because you are already talking Digby, Inverness and other locations?

MR. MCNAMARA: I'm going to ask Katherine to talk about where they are now. I'm not suggesting that the new ones will be built in five years, so don't misread my comments because we want to concentrate first on the home dialysis. That has to be our first investment if we're going to utilize our money. The cheapest type of dialysis is home

dialysis; next is the satellite clinic and third is Halifax, so if we can take those resources and provide care for more people where it's appropriate, that's where we're going to go first. I did indicate that if we get to the point of adding, those communities would be the ones that we'd be looking at. Now I'll ask Katherine to talk about where the existing ones are.

MS. FRASER: Again, we have three programs - what we call in-centre programs - across the province and that's where patients would go to start dialysis. They're in Yarmouth, Sydney and Halifax. Then we have satellites across the province and so Halifax, Capital Health, operates satellites in Liverpool, Berwick, Truro, Springhill, Pictou, Antigonish, and Sherbrooke is a collaborative model where the district and Capital Health are working together to manage those two sites. Then we have one at Strait-Richmond and there will be one in Inverness in the Spring. (Interruption) Dartmouth is part of Halifax and in Sydney we have also what they refer to, sort of, as their back-up site. I think it's in North Sydney.

MR. MACKINNON: How do you determine where satellite dialysis units are needed and how much does it cost to set up one?

MR. MCNAMARA: Again, historically it was based on distance and it was trying to keep within the 100 kilometres for people to travel. I think Digby is the one I mentioned that's out of sync with that.

To set up a satellite clinic, my understanding is that the initial set-up start-out cost is about $2 million per satellite; that's not counting any operating costs. Then on top of that would be the staff that we have to put in there and annualize the supplies to go with it.

MR. MACKINNON: I'm really delighted to see that you're spending $626,000 - just announced by the minister - in relation to home dialysis. Where do we rank in Nova Scotia nationally in terms of the number of patients per capita that are involved with home dialysis at this point?

MR. MCNAMARA: We're at the bottom, so lots of room to grow.

MR. MACKINNON: Who is eligible for home dialysis and why aren't more people choosing this option? What about the trends for the future? I believe that this is a real key that we're zeroing in on here and there is a lot of room to grow.

MR. MCNAMARA: I'm going to ask Katherine to talk about the eligibility. The understanding I have is that about 80 per cent of even our current ones could be eligible for home dialysis. The reasons have been many of why we are, not just here, but nationally, in having listened to - I mentioned the cafe I attended last week. Part of it is cultural, the other thing that we found is that individuals who associate with individuals who are on institutional dialysis will continue to want institutional dialysis. The places that had the most success, where they educate before they have a separate section, were those

individuals to go to home dialysis and interact with folks who have home dialysis. They are much more prone to take that because they learned the value of it.

As a matter of fact, I think each of you have in your package a copy of this brochure, which just came out and it's talking about a lady from Sydney who talks about the advantages of home dialysis to her and how much more freedom she has. She has the freedom to travel, to do things on her own, rather than travel to a hospital to get treatment. If you start to think about it, how do we help and that's interesting. I listened to Dr. Tennankore last week. He was talking about an individual who was afraid to get the flu shot, that over time working with him they were able to get him to be able to put the needle in his arm to be able to have home dialysis. It's the culture changing, the education.

The other thing, I don't think that we've been as good, as a system, at promoting home dialysis. We've been much more prone to promoting institutional care and that doesn't matter what it's for. We love our institutions more than doing better primary care and we have to change in everything we do to move more things into the community, including dialysis. Talking about who may not be eligible might be a better way to put it and I'll ask Katherine to speak to that.

MADAM CHAIRMAN: Actually the time has elapsed on that. If everybody would like, we could finish the answer because we have so much extra today. So we'll have your answer then, Ms. Fraser, and then we'll go to the next round.

MS. FRASER: When we look at home dialysis, we in Nova Scotia have had one great benefit and that is that we have one of the better rates of kidney transplant in the country. When there's less than a two-year waiting list for kidney transplant, I think that there has been a tendency for us to think that those who are eligible and are going to be transplanted, we wouldn't offer home dialysis. I think we're changing our thoughts and our perspectives on that and I think as we watched other provinces in the country and who they are targeting, to talk about home dialysis, we're realizing that we have a number of individuals in our province who could benefit from that.

As Deputy Minister McNamara talked about, the Nova Scotia Renal Program is beginning to do a lot of work so that we can socialize home hemo, or peritoneal dialysis through more of a campaign and letting patients know what the options are up front and helping them make better choices.

Even though I know Mr. d'Entremont talked about frail elderly not being able to do home dialysis, we do have home care in our province and there is an ability to have home care assistance, with providers going into homes and supporting patients who would choose that modality. So I think that we do have an opportunity in the province to increase and target and that will benefit patients in the long run.

MADAM CHAIRMAN: Thank you, Ms. Fraser. As I say, the time had gone beyond but we have lots of time this morning. I'd like to turn over for a second round to Mr. Colwell for the Liberal caucus and I'm going to say 20 minutes for both caucuses. Thank you very much.

HON. KEITH COLWELL: Thank you, Madam Chairman. First of all, the Nova Scotia Renal Program Satellite Dialysis Implementation Plan was done on December 15, 2009. A report indicated that a satellite dialysis unit would be opened in Digby. The report indicated it was particularly high on the priority list for patient need and the DHA is ready. The report was done two years ago. What is the status on that setup?

MR. MCNAMARA: As I mentioned, it comes down to again, when we have the resources to move things forward. We are at this time concentrating more on home dialysis and then when we've done some work on that, then we can look at more satellite clinics. Our first preference right now is home dialysis because we see the biggest benefit to patients and the best benefit for taxpayers.

MR. COLWELL: Is there any indication when the Digby satellite may be set up? Do you have plans for it at all?

MR. MCNAMARA: No there is not.

MR. COLWELL: Also, it indicated that the Berwick site be consolidated with the Valley Regional and there have been plans to offer that at the Valley Regional, both haemodialysis and peri . . .

MS. FRASER: Peritoneal.

MR. COLWELL: Peritoneal, I'm sorry about this.

MR. MCNAMARA: That's okay, I have the same problem. (Laughter)

MR. COLWELL: Could the deputy confirm where we are with the establishment of the in-centre dialysis in the Valley Regional?

MR. MCNAMARA: Perhaps I'll ask Katherine to give you the best up-to-date information.

MS. FRASER: So again, Kentville was looked at as a potential site for a satellite, but as Deputy McNamara has indicated there has been no funding to move in that direction right now. We continue with the existing satellite in Berwick that supports the Kentville area, or Windsor, or the Valley, Annapolis Royal area.

MR. COLWELL: Also there has been the same sort of question about the Inverness hospital, for a satellite site there. Is it the same answer there as well?

MS. FRASER: No, that satellite has been constructed and that satellite will open early Spring 2012.

MR. COLWELL: Well that's positive.

MR. MCNAMARA: If I could add to that. Part of the reason was that we were doing renovations at Inverness, changing the emergency room and doing some other work so it made sense to do it all at once rather than going back and doing something a second time.

MR. COLWELL: I would assume what your answer to this question is going to be, but I'll ask the question anyway; I think I know what your answer is going to be. Can anyone please indicate what the province would do with patients that do not meet the one hour travel time or the 100-kilometre travel time that you talked about? We have patients in the system because that seems to be an issue in some rural areas.

MR. MCNAMARA: It is unfortunate there are some individuals that will not, but our aim is to get the majority of patients within that travel time and that's the achievement that we have made. As I indicated earlier, when we would move to a next one we know Digby is the one that would have the first priority in terms of travel time, of doing something different. As we work toward more home dialysis we hope we can reduce the reliance on travel at all and that individuals would be able to have the services in their own homes.

MR. COLWELL: When you talk about Digby, how many people are - well actually not just in Digby, all over the province - over the one-hour travel time? What percentage?

MR. MCNAMARA: I don't know that, but I can try to get that information for you and send it to the committee.

MR. COLWELL: Yes, if you could supply that to the committee we'd appreciate it. One area that comes to mind is the Eastern Shore as they recommended that St. Mary's satellite unit close and these patients travel to Antigonish. Has that been finished or is that going to happen? What's the status on it?

MR. MCNAMARA: No there are still patients receiving treatment in Sherbrooke at St. Mary's.

MR. COLWELL: Is that going to continue for a while or is that . . .

MR. MCNAMARA: There's no current plans . . .

MS. FRASER: The satellite in Sherbrooke has two chairs and between Capital Health and District 7, they have agreed to keep the satellite open as long as there are two patients there.

MR. COLWELL: And that's set up just for two patients?

MS. FRASER: Ye, because you can only do one patient at a time. You always have to have a backup system in place in case something would happen to the system when one patient is on. But it's a very small satellite and when the planning was done to place a satellite in Antigonish, the burden of illness was looked at in that area and the travelling distance and also whether they could recruit and employ staff in Antigonish that could operate a satellite.

So as the population moves and changes, the plan was always that once there were no patients at Sherbrooke, that would close. It's a very difficult area to recruit a lot of staff and to expand the satellite there wouldn't make sense.

MR. COLWELL: Are there other people in that area who have to travel for dialysis that aren't one of the two seats there? Or are there only the two people in the area?

MS. FRASER: There have been from time to time individuals who have had to travel to Antigonish. Originally they were travelling to Halifax and the district was able to get them closer by getting them to Antigonish. I do believe there's one individual who would like to be dialyzed in Sherbrooke, but currently there are two patients there and as I said, you always have to have a backup system so you can only do one at a time.

MR. COLWELL: Those machines, do they operate around the clock or just eight hours a day sort of thing?

MS. FRASER: It depends on the number of people and the size of the clinic. For example, some of our satellites operate six days a week, two shifts a day. Others operate three days a week, two shifts a day, depending on how many patients there are.

MR. COLWELL: It always seems in the health care system, a lot of the equipment isn't utilized after-hours. It doesn't make sense because you have very expensive equipment sitting there. I know it's a resources issue with staff, it just doesn't make sense. You go in and get a test - personally, I'd like to go at two o'clock in the morning when there's not all the traffic and everything. I know a lot of people share that view; it would mean we would have to have less equipment. It would mean more staff but you wouldn't have the huge capital cost of the equipment. Is there any review in this or other areas of health that maybe that's . . .

MS. FRASER: When we're talking about dialysis and we're looking at the burden of disease and the age of the population, we're finding that even doing three shifts a day

means that some patients have to go in the evening and then they're travelling late at night to home. To do any more shifts would not add benefit for patients because we often hear from patients who are on the third shift that that is a struggle for them. We try to keep them, especially in the rural areas, to two shifts a day.

MR. COLWELL: I was wondering, too, you indicated earlier - and it's common knowledge anyway, I believe - that it's cheaper to operate outside of Halifax because the cost in Halifax is extremely high for operating in those areas. Has there been any discussion about establishing a unit in the Twin Oaks Memorial Hospital in Musquodoboit Harbour that could service the needs of the Eastern Shore? Also, people who would be going to the Dartmouth General Hospital, they could travel out instead of into the city, which would probably be better. There's free parking there instead of the parking costs they have to put up with when they go to the Dartmouth General or the QEII. Is there any indication there that that might be possible?

MR. MCNAMARA: The short answer is no. But also when I talk about the cost, you have to remember that in Halifax, the reason for the cost is the more sophistication in the type of patients that they're seeing and what they have to do. It's the type of dialysis that is the cost factor and that's why I said home is cheaper than satellite. Obviously when you're doing it at home, you don't have to have the staff there so that reduces your cost. We would increase our home care to have to do some of it. But no, there are no plans to do Musquodoboit Harbour.

MR. COLWELL: This new in-home system that you have, how many of them do you have out there now?

MS. FRASER: We have approximately 100 individuals on what we call peritoneal dialysis and there are 15 on home hemodialysis.

MR. COLWELL: And how much would you want to expand that? There is a huge number of people who have diabetes and not all of them needing dialysis, of course, but how rapidly do you want to extend the in-home program?

MS. FRASER: The Nova Scotia Renal Program is working with health care providers and others to look at what kind of a target we should set for increasing home therapies and right now we're at 17 per cent and we're looking at 20 per cent as a target over the next two years.

MR. COLWELL: It's an interesting concept to being at home because people are more relaxed at home and there are all kinds of positive things with that. Do the dialysis care centres, or the satellite offices, have any wait periods? Is there any waiting list to get in there for treatment?

MS. FRASER: Yes. In Truro right now we have a satellite that is full and there are about 14 people who are waiting to get back into the satellite in Truro. So for now they travel to Halifax for dialysis.

MR. COLWELL: That's a long old drive every day or every day they have to come and back again, and very expensive too for the people who travel.

MR. MCNAMARA: I should add, Mr. Colwell, just for any of your constituents who travel over 70 kilometres, there is income tax that they can claim, just so some individual may not be aware of that. I mean it's always a little help if they know that there is an avenue they can get some money back through their income tax.

MR. COLWELL: Could you provide that information to our committee in the future? I think that would be something that would be quite helpful for some people in the communities.

MR. MCNAMARA: Sure.

MR. COLWELL: In dollar terms, how much is spent on the provision of dialysis and the renal end care in this province in terms of physician costs, hospitalization costs, ER visits and all that sort of stuff?

MADAM CHAIRMAN: Ms. Penny.

MS. LINDA PENNY: I'll frame it up first thing, it's difficult to get all of the costs associated with a specific disease but we do have $31.1 million that we spent in 2010-11. We need to add to that about $6 million in physician costs and it doesn't include lab tests, in-patient care and some other costs that are really hard to capture by disease state. We are working on getting the fuller number but for now that's what we're estimating.

MR. COLWELL: That's quite a lot of money.

MS. PENNY: It's a lot.

MR. COLWELL: And that's one reason you're going to the in-home system. How much less expensive is the in-home system?

MS. FRASER: Depending now on the type of dialysis that the patient would choose, peritoneal dialysis - after you're all established at home - is about $25,000 to $30,000 per year per patient and home-hemo is more like $40,000 to $50,000 per patient and then in-centre is around $60,000 to $80,000 per patient.

MR. COLWELL: That's quite a significant change. What's the budget that you're going to have, what's your total budget for this? Is that the $31 million you talked about for the 2011-12 budget year?

MS. PENNY: That's actually the 2010-11 actual costs. We do have 2011-12 budget and I can break it into components for you because it spans across the department. So for the dialysis provincial program, it's $778,000; dialysis operating expenses in the DHAs is $27.3 million; we also have a budget in long-term care for peritoneal, $94,000; diabetic needles, $291,000; and we have Pharmacare costs which are difficult to budget exactly for because they're based on usage but the Pharmacare costs in 2010-11 were $23.3 million.

MR. COLWELL: Quite a significant cost.

MS. PENNY: It's quite significant.

MR. COLWELL: Is it the Diabetes Care Program that determines whether we have a sufficient number of Diabetes Centres in the province and whether part-time centres are able to meet all of Nova Scotia's needs?

MS. FRASER: The Diabetes Care Program of Nova Scotia does work with the Diabetes Centres. Now, the Diabetes Centres are operated by the district health authorities, so it would be within their operating budgets that they would have to decide what the length of time is that the centre would be open.

MR. COLWELL: Under the Diabetes Care Program - and you indicated that approximately 77,000 adults in Nova Scotia have diabetes, with the number of cases growing significantly, as you indicated before - do we have enough resources and capability in the number of centres and the hours of operation of the centres to meet the demand and the demand that will be in the future?

MS. FRASER: I think that, again, Diabetes Centres are very important in our primary care provision of care. We also are working with family physicians because primary care physicians are very important in helping with diabetes care as well. I think that the Diabetes Care Program of Nova Scotia is beginning to work a lot more with the primary health care world in regard to collaborative practices and working with family practice nurses and primary care physicians to help have some of the care that has been happening in Diabetes Centres happen in family practice offices as well. I think in the future you'll see more of a partnership of Diabetes Centres with family physicians and collaborative practices.

MR. COLWELL: If someone wanted to go on the home program, is it the patient that requests that or is it the primary care doctor or is it the system within the system that requests that change?

MR. MCNAMARA: Currently, hopefully the recommendation would come from staff to the patient. I think that as patients become more aware of it, they will ask for it. As I mentioned earlier, one of the problems is that we had not promoted as much as we could have, from a department point of view. As well, the current system sort of encourages individuals to go more into the institutional side than to go into looking at home dialysis.

Based on the experience from other provinces, it is telling us we've got to do a better job promoting and exposing individuals to the benefit of home dialysis. But if an individual requests it, we would do everything we could to accommodate them, that's for sure. I think also getting our practitioners to recommend it more is the other thing we have to work on.

MR. COLWELL: If I were going to publicize this in my community, how would I do it? Would I indicate that, number one, it's available and, number two, that little pamphlet?

MR. MCNAMARA: I'll give you some brochures to start with.

MR. COLWELL: That would be a good start but if I write it up - I do periodic newsletters - and I put it in a newsletter, how do I indicate to people what the entrance is? If I was a diabetic, how do I enter it if I want to do it at home - in real simple terms so people can understand it?

MR. MCNAMARA: What we can do is ask the Renal Program to do a brief note that you could then include in your newsletter.

MR. COLWELL: That would be fantastic.

MS. FRASER: In terms of patients with diabetes, we know through our Diabetes Care Program that not all patients with diabetes will proceed to have end-stage kidney disease and progress to dialysis - so just to make it clear that all people with diabetes don't end up having kidney failure.

MR. COLWELL: I understand that, but I just want to make people aware. I know I have several people in my community that are on dialysis. Now none of them may be interested in this, but if I can put the information out there, how they enter it, if they're interested, then maybe they can ask their family doctor and start the process and indeed give them a better lifestyle and cost the province less money, so it's a win/win.

How much time do I have left?

MADAM CHAIRMAN: Actually I was just about to interrupt you, Mr. Colwell, your time has elapsed. We have the final round of 20 minutes to the NDP caucus beginning with Mr. MacKinnon again.

MR. MACKINNON: Thank you very much. In this province we're trying to dig ourselves out of a very deep hole financially, and we do have a real approach to getting back to balance and fiscal responsibility and so on. So I think it is quite significant that the minister and the department has announced a new $2 million - I think that accentuates how important it is to be doing more in the area of diabetes.

One of the aspects of that new $2 million involves 12 full-time equivalent RNs. Where will they be around the province and what exactly is their role? I have a good idea for that myself but there are people listening at home and so on that I think would like to hear that.

MR. MCNAMARA: I'll ask Katherine to respond.

MS. FRASER: The strategy for the registered nurses in satellite units was, we were trying to do this because it will enhance the care that are in satellites and it will allow patients who have more complex needs to go there and get back to their communities. Right now there is a registered nurse employed in the Berwick satellite, so there have been patients who have been able to return and not travel to Halifax any longer for their care. Pictou has a registered nurse employed there now, one in Truro, we're hoping to have one at the Strait Richmond site by the end of this fiscal year, and also one in Springhill by January.

Again, registered nurses who practice in dialysis units require some training and also to recruit registered nurses to certain areas is a challenge but I think that Capital Health has done a great job in moving this strategy forward.

MR. MACKINNON: Thank you very much and I'm pleased to see that there are brochures available on home dialysis and certainly every constituency office should have a few of those. I commend you for what you are doing.

At this point I will turn over, again, to Mr. Ramey.

MADAM CHAIRMAN: Mr. Ramey, please.

MR. RAMEY: Thank you, Madam Chairman. I just have a couple of quick questions on dialysis and I may have missed an answer so if this was asked already I apologize. When we were talking about diabetes, we talked about the fact that there were somewhere in the vicinity of 80,000 diabetics, increasing at the rate of type 2 about 4,000 a year. Am I correct on that? Okay so I'd like to ask the same question about dialysis. Can you tell me how many people are on dialysis currently in Nova Scotia in some form or another?

MS. FRASER: We have a total of 650 people having dialysis;100 of those are on peritoneal, and 15 are on home hemo.

MR. RAMEY: Okay, that's interesting. For some reason I thought it would be more than that.

MS. FRASER: Through the Nova Scotia Renal Program, working with providers we know that there are about 1,000 people seeing nephrologists in pre-dialysis clinics across the province. So again the burden is we're looking at a 3 per cent increase to dialysis starts annually. I think we should also remember that because we have a Renal Program working with providers, there's a fair bit of work being done to slow the progression of end-stage kidney disease, so we're hoping to be able to sustain the numbers that are starting, as well, in the future.

MR. RAMEY: Now we talked a little bit earlier on - I think Mr. Colwell asked the question - about waiting lists for institutional dialysis. Do we have a waiting list for home dialysis? Do we have people who are just chomping at the bit to get on with this or not?

MS. FRASER: There have been wait lists from time to time to do home hemodialysis. I think that's why with the government's investment into purchasing home hemo machines and training and setting up a program in Cape Breton, we'll see those people come off the wait list and we'll also see more people who will take advantage of it.

MR. RAMEY: So the home dialysis, which we've talked about a fair amount this morning, it fits in with the aging-in-place philosophy, I guess, where you're able to not have to leave your home to get the care you need. We've seen the economic benefits of that or we've heard about the economic benefits of that.

The $626,000 that we've invested in the home dialysis program, can you just give me a little bit of a breakdown of how that's to be spent, then? You mentioned Cape Breton so we're obviously doing something there; is there anything else you can tell me about it?

MS. FRASER: In Cape Breton funding will go for machines, as well as putting staff in place that will train patients and also be there for backup and support when they have issues, so that's part of the money. Some of the funding will go to Capital Health to purchase more machines, so at one point they did have a wait list for home hemo. I'm not sure if they do now; if they do, that will help resolve that issue. Then in Yarmouth we're looking at enhancing their peritoneal dialysis program because they're just in their infancy stage of beginning to offer home therapies, so some of the funding will go to create a training space and then for staff and supplies.

MR. RAMEY: I heard Cape Breton and Capital Health and Yarmouth in that answer, so it's across . . .

MS. FRASER: Yes, across the province.

MR. RAMEY: So it's not all being spent in one area or something. My final question before I turn it over to Mr. Epstein, this is a bigger question and I guess it's a question for Mr. McNamara and I hope it's not an unfair question. In some of the remarks Mr. McNamara made, and I totally agree with him, he mentioned that we have to work on this shift from seeing the institution as the answer, the big, expensive, building that you go to, as opposed to other ways of accomplishing the same goal that maybe in the final analysis is not only more cost effective but might be a much better solution.

So my question is, how much progress do you think we're making on that? I mean have you seen any indications at this point that people, the general population out there, are getting it, that they are seeing that the institution isn't the answer to everything and that other ways of doing things may be better alternatives than what they were used to? Have you seen any change in the culture on that at all or are we stuck in the same place as we were when we started?

MR. MCNAMARA: No, we are seeing some progress; we have a lot more to go. For example, with our CEC that we opened in Parrsboro, where individuals can now get to see a physician the same day or the next day, we are having individuals travelling 100 kilometres that they won't go for dialysis to see a doctor now because they can get in faster. So that's one example.

I think as we work through more of that, the emphasis has to be on how we put more resources from acute care into primary care as we're setting up our teams. For example, when we look at collaborative practices, nurse practitioners and physicians, if individuals can get access to a health provider, they are much more satisfied if they can do it quicker. It also prevents illness from getting worse. The thing that we're looking at through our physician manpower plan, which the report will be coming out soon, will help us to decide where we can encourage physicians to locate to be able to do more primary care. We do know that in this province we have - and it's no secret - too many specialists and not enough GPs and we've got to start reversing that trend.

MR. RAMEY: Thank you very much and good luck in that quest. I'll now turn the remainder of the time to Mr. Epstein.

MADAM CHAIRMAN: Mr. Epstein.

MR. HOWARD EPSTEIN: Most of the questioning today, for obvious reasons, has focused on the treatments available for people with renal problems and diabetes. I have to say the efforts of the department are very impressive; it's obvious a lot of effort is going into coming to grips with this.

What I was curious about, however, was the prevalence rate in Nova Scotia. It seems to me in some of the background materials, Nova Scotia was identified as the province with the second-highest prevalence rate, I think Newfoundland and Labrador was

the other province that had the highest prevalence rate. What I don't understand is why that should be. Is there anything you can tell us about why it is that there is such a high prevalence rate in Nova Scotia?

MS. FRASER: I guess one of the things I could say about that is with the good work that the Diabetes Care Program is doing, as well as what providers are doing, we have patients or people living with diabetes longer and managing their disease better so they're living longer. With growing incidence and then people managing themselves, we're having a greater prevalence.

MR. EPSTEIN: You're saying that the better we get at dealing and coming to grips with the disease, it just adds to the prevalence rate?

MS. FRASER: Yes.

MR. EPSTEIN: Is there nothing about the initial occurrence? I guess it's the initial occurrence that I'm wondering about.

MS. FRASER: Yes, so the incidence is what we need to deal with and we need to be really more upstream. Again, as we heard here this morning from many, is that what we really need to deal with for people who acquire type 2 diabetes is we need to start working early around how people are living in regard to their diet, in regard to their lifestyle, not leading such a sedentary life. That doesn't help everyone not get type 2 diabetes, but for a large number of the population we need to change how we're living to help us not get into a situation where we acquire diabetes.

MR. EPSTEIN: I guess, in fact, that's the real focus of what my concern was. I'm wondering about steps that either individuals can take or that the department can take, along with other entities like schools and so on, to try to prevent the onset of the disease in the first place. So you're pointing to exercise and diet - are these the main factors that we should be aware of?

MS. FRASER: Those are the two major factors, yes. It's not within my branch that this work is done, but certainly the Diabetes Care Program works with the wellness part of the Department of Health and Wellness, through public health and healthy living, helping to encourage Nova Scotians to take a look at what they're eating and how much activity they're getting.

MR. EPSTEIN: Is it also fair to say to some extent that it's poverty-related and housing-related?

MS. FRASER: Definitely the social determinants of health play a role in how people are able to eat and provide for themselves.

MR. EPSTEIN: Okay, that's a big help. Thank you very much for that and thank you for the presentation today, very interesting.

MADAM CHAIRMAN: Are your questions exhausted for all members?

MR. EPSTEIN: Yes, we are.

MADAM CHAIRMAN: Thank you very much, I appreciate that and we actually had extra time for us today, so that was good. Thank you so much for being here today. I'll give you an opportunity if you'd like to make any final statement or wrap up.

MR. MCNAMARA: No, just to thank the committee for the opportunity to come here and present this information and we do appreciate the opportunity to be able to talk especially about home dialysis and to start the communication of that to the public. Thank you.

MADAM CHAIRMAN: I'll just note, there have been a couple of requests for further information and our clerk will be in touch with you to just double-check what each of those are; there seems to be four items.

Thank you very much today. It has been very informative and this is certainly an issue that affects many Nova Scotians and one that we'd certainly like to see the incidence and overall numbers drop over time. Thank you.

For committee business, if I could for a moment, there is a notice that we've received information from Labour and Advanced Education. We'd just like to note it there in case there are any further questions. We have an updated list of confirmed meetings; our last meeting that we have scheduled is February 8th. Mr. Epstein.

MR. EPSTEIN: I notice that there is a meeting scheduled for January 25th, the Department of Transportation and Infrastructure Renewal is due in on that date. I've actually just become aware that our caucus is planning a retreat that will cover that date and so our caucus won't be available for the 25th. I'm wondering if we could try to reschedule around that. I'll leave that with you and the clerk, if I may.

MADAM CHAIRMAN: That's good to know. Thank you so much. I think beyond that we have our next meeting in January and I wish everybody a very good holiday. Thank you.

A motion to adjourn, please.

MR. COLWELL: I so move.

MADAM CHAIRMAN: Thank you, Mr. Colwell. We are adjourned.

[The committee adjourned at 10:46 a.m.]