HANSARD

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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, April 10, 2013

LEGISLATIVE CHAMBER

Department of Health and Wellness
Hospital System Capital Planning

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Public Accounts Committee

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Mr. Chuck Porter
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[Hon. Christopher d'Entremont replaced Mr. Chuck Porter]

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Legislative Committee Clerk

Mr. Jacques Lapointe
Auditor General

Ms. Evangeline Colman-Sadd
Assistant Auditor General

Mr. Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Mr. Kevin McNamara, Deputy Minister
Mr. Bryan Darrell, Director of Infrastructure Management
Ms. Anne Yuill, Acute and Tertiary Care
Ms. Linda Penny, Chief Financial Officer

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, APRIL 10, 2013

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Hon. Keith Colwell

VICE-CHAIRMAN
Mr. Howard Epstein

MR. CHAIRMAN: Good morning. Just before I call the meeting to order, I'd like to remind everybody to make sure their cellphones are on silent or vibrate, so we don't have any ringing in the Chamber.

Good morning, everyone. I'd like to call the meeting to order. I'm going to start by asking the members to introduce themselves.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: I'd like to welcome our guests this morning and I'd ask the deputy minister to make his presentation, if you would.

MR. KEVIN MCNAMARA: Thank you very much, Mr. Chairman. Good morning everyone. Everyone has introduced themselves, but Bryan Darrell is our Director of Infrastructure Management, just to add his title.

As Deputy Minister of Health and Wellness, my priority has been, and always will be, the safety of patients who rely on our systems for care. With that priority in mind, we made strategic investments to ensure that Nova Scotians have access to the quality care they need, from Sydney to Yarmouth. With 41 per cent of the provincial budget, I can assure you that my executive directors, and I, are fully aware of the importance of delivering the best health care services to the people of this province.

This year we will invest $3.9 billion in health care. That includes programs, money for our nurses, doctors and other health care workers, expensive drugs, continuing care, and the equipment and infrastructure needed to support a high-quality health care system. Yet even with a budget of this size, we know that improvements are still needed to the funding and planning of equipment and infrastructure projects.

The Auditor General's Report on hospital systems capital planning highlighted that the department could be doing a better job with long-term capital planning for equipment and infrastructure repair, along with the need for improvement to the scoring system the department uses to rank funding requests. I welcome the opportunity to be here today to update you on the actions of our department that we have taken to improve planning for hospital system capital spending.

We accept the Auditor General's recommendations and have worked hard to address these points, and we continue to work on improving them. We do this while balancing the many competing priorities for funding requests from district health authorities and the IWK. Everyone wants the latest technology - it's human nature - whether it be the machine that tests for disease or the most modern hospital bed. We have tough and strategic decisions to make in dealing what equipment we purchase and where it goes.

Historically the funding process for capital infrastructure was oversimplistic. We recognized this is an issue and took the initiative to bolster the funding process, to make it more robust and based on certain criteria. We began that work prior to the Auditor General's Report which was issued last November. Now decisions on funding capital or infrastructure projects are based on many of the criteria which are weighted and put through a scoring system to determine its ranking among other funding requests.

Each year the DHAs and the IWK recommend their top 10 priorities to the department, and a committee with representation from the DHAs scores each submission on established criteria such as safety, status, useful life, utilization, access, patient impact and efficiencies. The department then uses the Pairwise scoring system which is a tool used to determine the ranking of a group of items. The rank list is reviewed by several branches within our department. We have changed the scoring criteria to look forward to the future needs and to be more specific about cost-savings and efficiencies.

In addition, the submission forms provided to the DHAs and the IWK was modified to capture more information on this criteria. Health and Wellness also modified the weighting system, which resulted in a higher-weighted value for the efficiency criteria. This revised Pairwise process was used by the department's Medical Capital Equipment Submission Committee for the 2013-14 fiscal year. The finalized ranking was submitted to the department's Infrastructure and Equipment Committee for review and finally submitted to me for approval - and, as you know, any project over $1 million is sent to Cabinet for approval.

Furthermore the scoring approach for equipment funding was revised to ensure consistency by scoring requests by groupings of similar equipment. The examples include grouping beds and lifts, pharmacy requests, lab, diagnostic and so on. Grouping requests in this manner allowed the department to be more constant if scoring within groupings. The Auditor General also pointed out in his report that there wasn't enough consideration for the relative size of each district, when requesting equipment funding submissions. The department has since revised the submission form to capture more information regarding such things as an impact on access, utilization, and the use of equipment. In addition the criteria used for the scoring process, and the width of each criterion revised, clearly reflect the use of population and patient impact, use of equipment, access, and utilization information.

The ranking process is based on a provincial view but takes into account the best interest of the entire system. Funding requests for equipment and infrastructure are reviewed by different committees in our department, including Infrastructure Repair Renewal Committee for project requests for under $90,000; the Infrastructure Management Repair and Renewal Committee for projects between $90,000 and a million; and the equipment group for all equipment requests.

In an effort to better understand DHA spending request, I am pleased to report that as of November 2012 the DHAs and IWK are now represented at all three of these department committees. Having them more directly represented at these tables has made a tremendous and positive difference in our funding process. During the Equipment Committee's meeting in January the DHAs were able to provide input into the scoring and ranking process for the 2013-14 fiscal year. They were also able to contribute to the discussion around medical capital equipment allocation through the lab and diagnostic imaging initiative. We also recognize the hard work of our hospital foundations and hospital auxiliaries who fundraise across Nova Scotian communities in order to help us provide the best quality care we can.

In the Spring 2010 the council of CEOs approved a 75/25 per cent cost sharing agreement for equipment between the department and the DHAs, on an annual formula going forward. This formula allows for more equipment items to be funded and provides for more predictability for DHAs, when working with local foundations through auxiliaries and the communities for our local chair. The Auditor General identified the need for a more efficient capital planning system through a multi-year capital planning for the DHAs.

While provincial budgets, and therefore DHA budgets, are determined on a yearly basis, the department is moving towards the implementation of the multi-year capital planning. In fact, components of the multi-year capital planning are already underway for several provincial initiatives including provincial lab and diagnostic imaging initiative, palliative care, surgical services, and orthopaedic surgery. The lab/DI initiative in particular is examining the inventory of equipment throughout our province and working on a multi-year capital planning framework for replacement. For larger construction

projects the planning process has already begun for 2014-15, so the department is already engaged in capital planning for the next few years.

The department's infrastructure management team currently has a robust system that provides an evaluation of the condition of every facility for the next 20 years, identifying such things as the replacement of underground oil tanks, infection control modelling, fire and life safety inspections, and lifting device inspections, to name a few. While we have made the move towards multi-year planning, I will note that we have learned through our continuing care records that multi-year planning will actually increase overall costs for the department, as concurrent tendering for projects actually reduces the number of bidder per project and with less competition, bids do increase.

The Auditor General mentioned in his report that the province will need to spend about $600 million over the next 10 years, to maintain the health care system as it currently stands. I would like to reassure the committee that we are spending taxpayers' dollars wisely. Health infrastructure spending has been an average of $70 million over the past three years, in line with the Auditor General's recommendations. We are strategically investing in much-needed infrastructure and upgrades and projects that are more important to Nova Scotians. It is important to note, however, that this number also includes new projects and the results of new projects will help alleviate the amount needed for maintenance going forward.

For issues needing immediate attention, the department always plans for emergency situations. We are prepared should an unforeseen issue arise such as an urgent equipment repair, like badly-needed repairs to the Bethune Building at Capital Health or the generator at the IWK. Each year the department sets aside money for funding of emergency equipment. For example, in 2012-13 we reserved $2 million for emergencies and contingencies. We plan to reserve $2 million, again, for 2013-14 for the same purpose.

Any hospital that has a requirement for emergency equipment will not go without. That also gives us an added level of protection in ensuring our hospitals are in fine working order and safe for the people of the province. In the 2013-14 budget, for example, the department has announced funding for a new generator for the IWK and has funded repairs to the Bethune Building in Capital Health.

Another area the department is looking deeper into is energy-saving projects. These projects are already an integral part of the repair and renewal process within our infrastructure group. In fact, in 2011-12 our department, along with the Department of Transportation and Infrastructure Renewal, completed three significant energy-saving projects in South West, Valley and Capital districts. In 2012-13 the team assisted all DHAs with energy-saving projects; 54 projects were completed at a total value of $3.5 million. The department is currently considering the risks and rewards of energy-saving contracts and will analyze the results when they are ready.

As I had stated earlier, our number one priority is ensuring a quality health care system to all Nova Scotians. Like any system across government, there's always room for improvement and we have taken the Auditor General's recommendations to heart. We have made significant progress on his recommendations and continue to work to ensure they are fully implemented in a timely manner. Thank you, Mr. Chairman.

MR. CHAIRMAN: Mr. Younger, you have 20 minutes.

MR. ANDREW YOUNGER: Thank you, Mr. McNamara, for your remarks. This is obviously an enormous topic, the subject of health system infrastructure, and I have no doubt that over the next couple of hours we won't get to everything or every project or all the different issues, but hopefully we'll be able to touch on a few.

I'd like to start by talking about one of the major projects that the department and Capital Health keep talking about, but it seems to keep getting delayed, which is the Dartmouth General project. In December 2011 the government - in fact, the Minister of Labour and Advanced Education, the member for Dartmouth South-Portland Valley, on behalf of the Health Minister - announced that the tender would go out in January of that year and the cost estimates would be available by summer of last year. My understanding is those are not available. I've recently been briefed by the Dartmouth General Hospital Foundation which is extremely concerned that they are being asked to raise money but have no clue how much money they're being asked to raise, what the project scope would be, and they feel they're not getting any information from the department. Could you tell me - we'll go through it piece by piece - what is the status of that tender at this point?

MR. MCNAMARA: I will get Bryan to talk to this, but before I do, I have met with the foundation a couple of times. They understand the process that we're going through. It is not as easy as someone thinks of just designing a piece of . . .

MR. YOUNGER: I think they recognize that but they're being asked to raise millions of dollars without having a total price tag or even knowing what the project is, which is pretty well an impossible task.

MR. MCNAMARA: We will get there and they will know the final price. With that, I'll get Bryan to do a status update.

MR. BRYAN DARRELL: Actually the tender was awarded, as you know. It's actually with a design team at this time. They've come back to us with an initial design which is being reviewed by the Department of Health and Wellness.

There are a number of options that are available in this design and it's very complicated in terms of the number of rooms, the way it's going to be awarded. Hospitals are built quite a bit differently today than when the Dartmouth General was originally built and one of the key areas is in the amount of space between floors. Just getting the amount

of room in there is very complicated and so it means that we're almost giving up a floor in order to get the amount of space we require.

So how we get the best maximization out of this is really one of the things that is driving the delay - well, not a delay, it's driving the analysis. So that, the number of rooms, the whole design - because standards have changed so much in terms of the way facilities are built now as opposed to when the Dartmouth General Hospital was originally built. So you almost want some sort of parity between the rooms on one floor as opposed to the rooms on another floor. How can you do this and manage to keep it without the scope of the project just boiling over? So that is what is actually being considered now within the department.

MR. YOUNGER: Let's talk about the scope of the project then. This was announced with much fanfare, and I'll even point out that, in 2007, the person who is now the Premier said that something needed to be done to address the overcrowding - and I don't disagree with him. It is a regional hospital, although there seems to be some debate depending on who you talk to in Capital Health whether it's considered a regional facility or not, but we can get into that later.

We've since heard two stories and people are - when you talk to some of the doctors and staff there, they hear two stories. One is that really now this is just going to be a shift of capacity from perhaps the Victoria General Hospital or the Centennial site over to the Dartmouth General Hospital, which ultimately will create no new net capacity, which may have benefits within the system but does absolutely nothing to stop the overcrowding problem there, which was the whole point of this. Then there are other people who say, no, no, they're going to add capacity, which will address the overcrowding and the fact that you can't move people through the hospital system. So what is the goal of this in terms of the scope now?

MR. MCNAMARA: In planning through the project, there are two things happening, as you know - it's the Dartmouth General Hospital, plus the work we're doing to replace sections of the VG. In order to make this happen, you have to - it's sort of like moving one thing to make something happen so you can move space to another. So it is going to be a bit of moving patients around until we get the final two projects done because we have to put the patients who are in the VG somewhere while you do the work to get the new facilities in place. Overall, looking at some additional capacity, but until we see the final design, I can't tell you where it's going to be, there will be an impact on Dartmouth.

The other thing we have to look at is other avenues to reduce the reliance on using hospital beds, as we talked about home care and other ways. We recognize that's a bigger issue than just building capacity for acute care.

MR. YOUNGER: I don't disagree with you that there are a number of different avenues needed to attack this, but this is a hospital which has, at some periods in the past

couple of years, routinely been in the Code Census situation. That has a trickle-up or -down - whichever way you want to look at it - effect on the other hospitals, whether it's Cobequid or the QEII. In my neighbourhood alone, there are people who will drive to the QEII and avoid the Dartmouth General Hospital or they'll go to the Dartmouth General Hospital, see how overcrowded it is and continue.

They have made some changes - as I'm sure you're aware - where they can move some people who need to be in nursing home beds into a separate area of the emergency room, but home care is not going to solve the number of traumas and that sort of stuff that is coming in that is increasingly as a hospital that serves Dartmouth, Eastern Shore, Eastern Passage - it serves a very large geographic area.

I guess the question becomes - and I understand that, well, Chris Power called it "shuffling the chairs on the deck" is what she called the project, which obviously didn't give people a lot of comfort, but if there is going to be an impact on the ability of the Dartmouth General Hospital to deal with overcrowding, and that won't come until after both projects are complete, what is the timeline that people can expect to see a measurable difference at that hospital?

MR. MCNAMARA: Again, going back, the issue of overcrowding is not going to be addressed by building new facilities. It's going to be addressed by . . .

MR. YOUNGER: I understand that, but at the Dartmouth General Hospital even your department has acknowledged that part of the solution there is a capacity issue. The Premier has said that's part of the problem; the minister has said that's part of the problem. They held a press conference and the member for Dartmouth South stood up at the press conference and said we are announcing this preliminary design study and this will help solve the overcrowding at the Dartmouth General Hospital. So while I agree with you that there are other issues, the government that you are representing and the department, their official line from the ministers is that this will address the issue, so are you saying that this won't address the issue then?

MR. MCNAMARA: Okay, may I answer the question, please?

MR. YOUNGER: Sure.

MR. MCNAMARA: Thank you. First, as I was saying, the issue of overcrowding will not be addressed just by building a facility. We have to do other things. We're working with Capital Health right now, and also looking at the overcrowding in Halifax. We have to look at new ways of moving individuals who are occupying beds who can be better looked at in a different way, whether it's utilizing some of our veterans' beds that become available, whether it's home care, whether it's other things. The work that we're doing, in terms of the new construction, will enable other patients to be looked at, and reduce overcrowding, and be able to look after the type of patients who are there.

We also have to look at Dartmouth General as part of a system, which includes Cobequid and the facilities in Halifax. It's not a single entity that just looks after patients from one area. Patients are moved about. I can go back to my experience at South Shore. When I first went there, patients were in Bridgewater or Liverpool or in Lunenburg, and we had to put a system in place that the beds were district beds, not community beds.

Once you start changing that, it does give you the ability to transfer patients and to utilize your facilities much better. Also, in talking to Capital Health and talking with the physicians there, beds have been designated for services, so there are certain areas of the hospital that may have empty beds while other areas do not. So they are looking at that whole process. How do they utilize those empty beds to move patients around, to better facilitate the overcrowding issue that occurs both in Dartmouth General and in Halifax?

MR. YOUNGER: Well, I don't disagree with some of what you're saying, but I don't think it's really answering the question, because I actually said the same thing. I said that fixing some of the issues at the Dartmouth General will help at the QEII and so forth, because people are driving over to the QEII, which then causes issues there.

I also agree they're utilizing the beds, because you can go into Dartmouth General on a Code Census day and they are now utilizing beds in hallways, in waiting rooms - not the public waiting room, but some of the waiting rooms for families and so forth. So they have created and put beds in places where you would not really, in an ideal situation, want beds. That might be okay in the case of an emergency.

The question that I was asking was a timeline. When are people at the Dartmouth General going to notice a difference as a result of this project? Because at the moment, construction hasn't started, obviously the scope hasn't been finally decided, the cost hasn't been finally decided, and when it was announced in December 2011, we were supposed to be seeing something happening now and we're not. I understand that things change, but I think it's a fair question to ask, because there's going to be a trickle-down effect. What is the date that we can say to people, listen, this is going to take some time, but - 2014, 2015, 2016, what timeline are we looking at?

MR. MCNAMARA: A fair answer is that we have to evaluate the plans, and knowing what the cost is . . .

MR. YOUNGER: Okay, but that's the answer that the department has been giving since - my God - since the fifth floor was built, which was in the mid-1990s. That's the answer we get every year. That was the answer we got two years ago. At some point, somebody has to give an answer.

MR. MCNAMARA: The answer was that we have started the plan, and you know that, the announcement was made . . .

MR. YOUNGER: But it isn't funded, is it? There's no funding in the budget that says, if you approve the plan, you've still got to come up with the capital money to actually build this thing. Right?

MR. MCNAMARA: It isn't in a state to be able to fund, at this point in time. The planning . . .

MR. YOUNGER: Right. So there's no commitment that it's going to go ahead yet. There's a commitment that you're going to do the design, and then make a decision . . .

MR. MCNAMARA: The commitment is that the design will be done, and it will be built following the design, and the cost.

MR. YOUNGER: How can you make that commitment when you don't have it funded?

MR. MCNAMARA: One of the problems of the past is that people rush into projects . . .

MR. MAT WHYNOTT: Point of order, Mr. Chairman. The honourable member knows that these sorts of questions about future spending are in the budget right now. He can ask those questions in estimates. We are specifically here to talk about the Auditor General's report and the presentation the department has brought forward today. Thank you.

MR. CHAIRMAN: Thank you. Mr. Younger?

MR. YOUNGER: Thank you. I will continue on this because this is exactly what this Auditor General's report is about, which is how capital funding decisions are made. This is a perfect case study for this report, and the honourable member knows it. I'm sorry the questions are embarrassing to his government.

The fact is (Interruptions)

MR. CHAIRMAN: Order. Order, please. Mr. Younger is in order with the questions that he's asking.

Mr. Younger, continue.

MR. YOUNGER: The question is - and it's interesting that you've just said that the project will be built, and the member, in his attempt on a point of order, just said, well, he knows it's in the capital budget - which it isn't, thus the question. It's not a budget question because it's not - this is something that's out a number of years and that's why the question is how many years are we talking about? I mean you must have an idea of when - there

must be some kind of flow chart or timeline. That's part of what this Auditor General's Report was actually about, which was that things just sort of happen and then they get dropped and that's the concern with this project.

I'm going to give some other examples after but this is one of the biggest ones that we've been hearing about since the fifth floor was built.

MR. MCNAMARA: We've seen the initial plans that are brought forward by Capital Health. They were expanded from what our expectations were, so we have to go through a full review to make sure what the plans are, what we can approve, and how we can move it forward with the services that are being looked at, not just in Dartmouth but in Halifax and also on a provincial basis.

MR. YOUNGER: All right, let me ask about a different project, one that you mentioned in your opening remarks and in the budget briefing that the Health and Wellness Minister gave, which is the generator for the IWK. I don't think there's anybody who would say that that generator doesn't need to be replaced - I'd be surprised, especially given the past year.

It was interesting that it was being called by your department as an investment in children and families when it seems like something that, when you look at the issues that the Auditor General has raised about scoring and so forth, this is obviously a piece of infrastructure that has been failing for a number of years but somehow didn't make it up the priority list until it actually failed. Why did that happen?

MR. MCNAMARA: When we look at equipment, when we look at the IWK submissions, it never made the top of their priority list or the top three, until after it failed. I can't explain why the IWK made that decision, I can only respond to the things that we look at. When somebody brings it to the top of the list, it's obviously something we seriously consider. They had other projects that they consider more important to fund.

MR. YOUNGER: Was it on their list at all?

MR. MCNAMARA: Yes, it was.

MR. YOUNGER: Where was it ranked? It wasn't in the top three.

MR. DARRELL: It has been on their list for three years but it has never reached a position above seven.

MR. YOUNGER: So when a district health authority or a hospital sends in a list, does anybody look at that and look at their list and say gee, you know we could have another Hurricane Juan, for example, so that generator, that is a piece of infrastructure we can't afford to have fail. I'm just wondering, what would happen when that comes in?

MR. DARRELL: Actually I'm really glad you brought that up because when the district actually sends in their list, we compare their list with what we have, because we have, within the department, a fairly detailed program that actually spells out the various components of a hospital, everything from the windows, the roofs, the generators, the oil tanks, you name it, it is actually identified.

On that list, as well, we actually talk about when that particular piece of equipment should be repaired, replaced or maintenance that needs to be identified on it. The generator has been on their list for a number of years and it is still ranking reasonably low on our list. In fact, if you were to look at that generator, at the present moment it has only about 530 hours of running time of it. For a generator with that age, with 530 hours, it's very minimal. So it's not a case of the generator failing but it's the actual equipment that connects that generator to the rest of the system.

If you were to just look at the generator, the generator itself is fine. How you actually transfer the power from that generator to the rest of the hospital is what actually failed and has failed at the IWK.

It has been on the list, yes. It has never made it to the top few that are funded, correct. The IWK did not actually have it as a priority, in terms of what their top ones were.

MR. YOUNGER: Let me give another example in the IWK. I was there the other day - for something else - but one of the nurses pulled me aside and said listen, could I show you something? They are moving walls around downstairs and rejigging stuff. It's obviously probably not as expensive as a generator, and I don't want to suggest that, but that obviously had to be approved at a capital level as well, the work they're doing down in the X-ray department and stuff to rejig things. Assuming that that would also have to be on the capital list, is that on a different type of list or does that compete with the generator?

I don't know, and this nurse obviously did not know, all the reasons why that was being done, and there may have been very good reasons, but there is the impression sometimes that walls get moved around a lot while some of these bigger things, like a generator or the connection, get missed.

MR. MCNAMARA: Not having visited the IWK recently, I'm not sure exactly what walls you're speaking about, but what I can tell you is that the IWK has approval to do work around mental health in children and that was totally funded by external sources. They had gifts that were given to them for that specific project and that's where the money would have . . .

MR. YOUNGER: Yes, you're right. In fairness, you don't know, you would have to see it, and I understand that.

This is in the X-ray department where the X-rays and CTs and MRIs and all that are. It was just an observation by the nurse on a Friday night when I was there that she said, she had heard this, they announced the generator and she thought that was great, but we were trying to understand whether something of that scope would be on a separate list or whether that would be in the same competing list.

MR. MCNAMARA: I can tell you, as a CEO, sometimes you do minor renovations within the hospital budget without going to the department for approval. It might be to change patient flow, it might be to do things in a better way. You don't bring minor projects to the department.

MR. YOUNGER: The Auditor General in his report pointed out a machine that was leaking radiation, it was taken out of service and then the ranking changed because it wasn't being used so therefore it wasn't a threat - not a threat, I'm sorry - a risk. I think it was Page 71 of the report. So how does that happen that something - you take something out of service because it's dangerous and all of a sudden it doesn't rank as high on the list?

MR. MCNAMARA: I will ask Anne Yuill to respond to that for you.

MR. CHAIRMAN: Order, please. Unfortunately Mr. Younger's time has expired.

Mr. MacMaster.

MR. ALLAN MACMASTER: I would like to thank the department for being here this morning.

My first question is one that involves the hospital in Inverness, the area I represent. A recent review of surgery there recommended the purchase of a CT scanner for the hospital. I know CT scanners have been coming down in price, but I think it's safe to say they would be in the order of $1 million for a CT scanner. Right now the district health authority is paying about $700,000 a year to transport patients from Inverness to Sydney to have a CT scan completed; in fact, I think it's over $700,000 a year. My question is why not accept the recommendation to purchase a CT scanner because it will pay for itself within a year and a half and it will bring the department savings somewhere in excess of $700,000 a year and save transportation costs?

MR. MCNAMARA: I'll start and then turn it to Anne to talk about it. I have never seen something from the district showing those operational costs, so that's new to me, number one. Number two, our CT scanners are only in regional hospitals to date, they haven't been in community hospitals and even when you do have them it's trying to find the staff who can operate them that is a big issue for us. You have to be aware that even having the equipment doesn't mean that you have it in operation, so it's something we have to be very careful about.

Perhaps on the actual equipment, I'll ask Anne to make a few comments.

MS. ANNE YUILL: There are a number of factors that are reviewed when we score and rank equipment. We need to take into consideration the needs across the province, not just what individual communities would like to see. Unfortunately, for a piece of equipment like a CT scanner in Inverness compared to other pieces of equipment in the province, there are other CT scanners that need to be replaced at regional hospitals. It just doesn't rank as high and, as you can appreciate, we have limited funding and can only do so much with the funding that we have.

I would also say that we do consult with other groups, provincial groups, provincial programs such as Cardiovascular Health Nova Scotia, to get their best advice on what is required to be in place in the province to make sure that we can provide the best and safest quality care for patients. We follow their advice and, if at some point in time the standards change, that we are in a position that we have to look at that, we will. Until then it will go through the ranking system, with all the other priorities in the province, and will fall where it falls when it is scored.

MR. MACMASTER: I'm hearing some answers to my question but I'm hearing things like, it's not a regional hospital. I recognize it's not categorized as a regional hospital but it is responsible for a very large geographic area. The distance from Inverness to Sydney is roughly two hours; the distance to Antigonish is roughly two hours. There are people, before they get to Inverness, who may travel an hour, at least a half an hour, so you're probably looking at two and a half hours for some groups of the population.

I'm also hearing about staff but if we're going to save over $700,000 a year in transportation costs, there is obviously - I see this as not an expense but as actually a way to save money. I noticed in your opening statement, you talked about patient impact and you had just mentioned about safe care. In the area of Inverness County the age of the population puts it in a category that fits with having a high incidence of stroke. In that area a CT scan would be very beneficial to make a positive patient impact and also save more money because the earlier a stroke is diagnosed, the earlier action can be taken with respect to treating it, and the better the outcome for the patient, which usually means less expense for the health care system as well. So why don't we get on with saving the money and having better outcomes for patients and purchase the CT scanner for the hospital in Inverness?

MR. MCNAMARA: Again, I would go back and review the $700,000 because, as I said, that is new information to me. The second thing I should say, we are working with Dalhousie University, the IWK, Capital Health, and others to set up a health technology assessment unit and what that would do is help us look at the overall because we've done some of the work, as mentioned in the department, of what we're starting with, but we need to do a full assessment - what are the needs of the patients in the area? And it's going to take us a little time to get that together. We have provided some funding in this year's

budget to start that process and I believe that that will give us a much better tool to be able to do assessments on things like this.

MR. MACMASTER: Mr. Chairman, I've been elected now for three and a half years and this has been an issue, certainly within the last three years. We keep hearing, in the community, about having to talk to the DHA; the DHA does a report, it recommends the purchase of the CT scanner. There always seems to be an excuse or a reason not to do it. From what I've seen, it seems to be a no-brainer. We are saving the government money. In fact, if you look in terms of savings, I notice in the presentation that the Auditor General has identified about $600 million, over the next 10 years, to maintain the health care system. Well, if the department can save 700,000 in transportation costs in Inverness in having the scan done at the hospital and not transporting those patients back and forth to Sydney, over 10 years that's $7 million, which is a little over one per cent of that $600 million. I noticed in your opening presentation, you talked about setting aside money for funding of emergency equipment. There is $2 million in the budget for that. Well if you want to take the $700,000 and add it to that budget every year, you have a 40 per cent increase in your funding available to fund emergency equipment needs. I guess I'm just seeing - I can't see why the department would say no to this.

MR. MCNAMARA: Well Mr. MacMaster, you've identified step one in an assessment, which is doing a CAT scan. If the patient requires treatment, they are still going to be transferred - so we still have to look at the difference. If for example we still spend $600,000 in transfers because of an identified issue - I don't know the answers so I'd have to explore it - but there are also significant operational costs to having a CAT scanner in a facility, as well. It's not just the savings; you have to look at the offsets as well.

MR. MACMASTER: Would the department complete a return on investment analysis on the purchase of a CT scanner for Inverness?

MR. MCNAMARA: What I said is that I would go back and look at the information you provided and talk to the district.

MR. MACMASTER: That doesn't give me much confidence that it's going to happen. You may have a conversation . . .

MR. MCNAMARA: That's my commitment, I made the statement.

MR. MACMASTER: Yes, you can make the commitment and the statement, but I fear that we're still going to be waiting for a CT scanner. The other reason I bring this . . .

MR. MCNAMARA: That doesn't mean you get a positive answer.

MR. MACMASTER: No, that's right. Well, we're trying to get positive answers for the people. I'm also thinking about the physicians who are trying to work in the hospital

and their need to have tools available to them, when they're in an area where they're serving people who are over two hours away from a regional hospital, to try to do their job. It puts a lot of pressure on them.

Of course, if you have a new physician or somebody who has recently graduated, are they going to want to go to an area where they don't have the tools that give them the confidence to do their job? I'm thinking about that, too. Do you have anything to say about that? There's the importance of having a hospital like Inverness in the area, because it's serving a population so far from a regional hospital, and this equipment would help to attract physicians who are going to be needed to replace the current physicians.

MR. MCNAMARA: In terms of attracting physicians, we know there are various reasons why physicians will go to different areas. We do know that there is a difficulty in getting physicians to come to rural areas, and we are doing a lot of work on that to see how we can improve that.

At the same time, as I mentioned in my opening remarks, we are doing an initiative looking at labs and DIs. What is the best way across the province to provide services? It is a provincial project. We have a project lead, Ken Baird, who used to be a VP at Capital Health, leading that project, involving all districts, and saying, are there ways we can do things better? It would look at things like the Inverness, plus other facilities. There are some opportunities to do things in a different way and yet use our money to the advantage of Nova Scotians, at the same time providing better care.

MR. MACMASTER: Another question I have, Mr. Chairman, are you aware that the local health foundation has raised upward of $2 million? The community has been very supportive of the hospital traditionally, and that's a significant amount of money to be raised in a small, rural area of the province. Are you aware that that money has been raised and is available to support the purchase of a CT scan?

MR. MCNAMARA: Yes, I am aware. I am also aware of other communities that have raised money for equipment. It doesn't mean that we can approve it, due to the operational cost or needs of the area, so we still have to look at that. If we equipped hospitals by the way people raised money because they thought it was a good idea, we would have a horrible system in this province. We have to look at some type of system that connects how we provide care across our province, plus having the resources to staff it.

MR. MACMASTER: Mr. Chairman, I think it's fair to say that a lot of people locally think the system is terribly run, because they look at the need for a CT scan in the area and they can't figure out why the district health authority and the Department of Health and Wellness don't see the value in saving those transportation costs, paying for the equipment, and improving the care for the local residents.

I think in fairness, you may think that the people don't know what's best for them, but I think we've outlined a case this morning that's pretty clear. There's a way to save money here and improve care. The physicians who have made a commitment to the area - I know some of the physicians have been there for 30 and 40 years; I know I'd trust my life with them, and many others have - they feel that it's critical for us to have it. So that's what's winning in my mind.

I'm going to move on to another subject, and that is that in your presentation you mentioned the risks and rewards of energy-saving contracts and talking about analyzing results as a way to save money at hospitals. I'd just like to ask you if you're looking at using natural gas, because we've seen other large entities - I think Michelin has a line into their plants now, and Oxford Frozen Foods has a line in. They are obviously making the decision because natural gas is a cheap source of power and an alternative to what they're able to purchase from Nova Scotia Power, where they're using all kinds of other inputs that are much more expensive, and that's driving up the cost of the power. Are you looking at this as a way of saving money?

MR. MCNAMARA: Mr. MacMaster, as you may know, the hospital in Amherst is run using natural gas, which was approved a number of years ago when that facility was built. We do currently have an RFP out as well, looking at natural gas, even where we can utilize the new system approved by government of trucking natural gas to facilities. That's being reviewed as well, to see if that is a real possibility for our districts. It's under active consideration, yes.

MR. MACMASTER: Can you specify any area specifically where you'd be looking at that, or maybe the first?

MR. MCNAMARA: The RFP includes every district in the province.

MR. MACMASTER: That's dependent, I guess, on the supplier being able to get it to the hospital.

MR. MCNAMARA: My understanding is with the new vehicles that have been approved that the supply can happen, so what we're looking at is the viability and the cost payback.

MR. MACMASTER: Does that mean you're looking at maybe trucking the natural gas in?

MR. MCNAMARA: That's right - for those areas that don't have a pipeline.

MR. MACMASTER: You mentioned the figure of about $600 million. How does the department plan to address that infrastructure need that has been identified by the Auditor General?

MR. MCNAMARA: There are a number of things taking place, and as I also mentioned in my opening remarks, as we build new facilities - for example, take the new Colchester hospital, we'll take some of that off the list because when you build a new facility, obviously you don't need to do the replacement. As we're looking at Dartmouth General Hospital and Capital Health, that will provide some opportunities as well. At the same time, we're using our dollars judiciously to look at where we replace.

Also, I think I'm going to ask Bryan to talk about the assessments we're doing in terms of boilers and other things around the province because I think that's something else that's crucial - looking at oil tanks so that we don't get into messes.

MR. DARRELL: I'm glad you brought up the issue on natural gas because one of the challenges that we're facing is a number of the boilers in the province are reaching a stage where it's critical. This gives us an ideal opportunity when we do the conversion to natural gas to go in and make not only a system upgrade, but almost a generational or a regime upgrade as we move to natural gas.

That's not the panacea that we might want it to be. Because it's a hospital, we actually have to have redundancy in it so we will still need to keep the number two furnace oil on-site as a backup for it. But where there is a systematic plan to look at all regional hospitals - and not just regional but all community hospitals, as well, in terms of when we actually change out the equipment on those. We have that project moving along and it's actually going quite well.

We have a similar sort of project looking at the storage of the number two fuel where we've been systematically removing all the underground storage tanks because those tanks are almost time bombs waiting to go off on us and so we're actually removing the underground tanks, replacing them with above-ground ones that have a safety liner on them. We're actually going through the whole generator spec so there's quite a sophisticated process going on looking at that.

MR. MACMASTER: That's good to hear and as you say, it's at a point in time where you actually have the chance to make a transformational change by moving to a cheaper source of power. It looks like natural gas prices will be low for quite some time given the volumes that have been uncovered.

MR. DARRELL: It's a very attractive option at this time.

MR. MACMASTER: Just looking at the infrastructure needs of the department, the Department of Transportation and Infrastructure Renewal has come out with five-year plans. Is the department looking at that? I know you mentioned in your presentation that you want to be careful about grouping too much stuff together because it eliminates the amount of competition on each tender. Can you give us some background on that?

MR. MCNAMARA: We are looking at a multi-year plan with the district health authority, even though our budget is annual, so we are looking at that. What I was really referring to is when you let projects go - when the tenders went out for long-term care, the prices went up significantly because of a large number of facilities going out to tender at the same time. That's something we have to really guard against in the future and we have to make sure that we do it in a timeline that industry within our province can support at an affordable price for the taxpayer, so that's what I was referring to. But, yes, the longer term plan is being evaluated and will be part of our system.

MR. MACMASTER: Mr. Chairman, how much time do I have left?

MR. CHAIRMAN: About three minutes.

MR. MACMASTER: What considerations are given to projects that will save money over 10 to 20 years, but might cost money in the short term?

MR. MCNAMARA: That's one of the recommendations the Auditor General made to us and that is something we will be evaluating. Again, one of the things the Auditor General did point out - there are companies that can help us do that. I can also tell you that we have to do cautions with that as well. For example, when I was at South Shore Health, we did an energy audit using a company. What they took into the savings were things that we already did ourselves and then we ended up in a lawsuit because they were trying to get the profits, so we have to make sure that when we do that, we do it in a way that we don't risk giving up what we've already gained ourselves - at the same time, making sure that we get true value for the dollars we spend.

We're working on another project provincially where we're into the same, and so the argument right now working with that company is trying to get them to bring it down to - these are the things that we're willing to consider for payment but we are not willing to consider the benefits we have done ourselves previously.

MR. MACMASTER: What preventive maintenance is being done to lengthen the life of capital assets that you have now?

MR. MCNAMARA: That was preventive maintenance, I would have to say that that is up to each district health authority, and I even noticed in the Auditor General's Report, for example, a reference to South Shore Health. I can tell you when I was there as CEO, we had done a project and with every piece of equipment we knew the age of the equipment, how long we could help it last by doing certain preventive maintenance, what its useful life would be in doing things differently. I can't speak to what happened after I left; I can only say that was done. I know some districts are better at it than others and that's something we will be working on with our DHAs, and through the shop that Bryan has, to make sure that is better in the future.

MR. MACMASTER: I know there is a lot of communication, there is almost like two levels of decision making. There is something going on at the DHA level and there is something going on at the department level. I guess that makes me worry about people having different priorities, competing interests. How do you communicate and how do you make that work efficiently?

MR. MCNAMARA: In the larger projects there is always involvement with the departments; in the small ones there are sometimes differences, and sometimes there are opportunities. Again, I am going to go back to my experience at South Shore Health. For example, when there was money, provided by the government of the day, to redo the area for chemotherapy and obstetrics - and it was a great project - we managed to talk to the auxiliary and got approval from the department to also set it up in an area so that the air flow could be changed. If we ever had a pandemic, we had an area we could corner off, and so it was an opportunity to do something different. Also, as it was mentioned . . .

MR. CHAIRMAN: Order, please. Mr. MacMaster's time is completed. Mr. Ramey.

MR. GARY RAMEY: Thank you folks for coming in this morning. I noticed in listening to the questions, a lot of them relate to capacity and planning and that sort of thing. I do know that in the 1990s one of the ways that health care was dealt with was laying off nurses and closing hospital beds and significantly reducing the capacity to the health care system. I can assure you that none of us here are interested in doing that again. But on that particular topic I would like to know how long our current hospital system capital-planning process has been in place, the current one.

MR. MCNAMARA: When I became deputy, just after this government came into place and Minister MacDonald was minister at the time, and she asked me what the process was for approval of equipment. At the time we had to look at what was being done. It was being done in a different way than it is now so we've put a more robust system in to be able to make provincial decisions rather than district by district. I can't speak for how all decisions were made but it wasn't as robust as it is now and we still have some more work to do so I'm not saying we're perfect. We've got a long way to go but at least we do have a system; we do have a points system to be able to come up with some appropriate decisions on a provincial basis.

MR. RAMEY: So we're saying that the point system is in place and I think you alluded to that in your remarks here.

MR. MCNAMARA: And I believe some of the information is also in your package.

MR. RAMEY: Yes. Just maybe a wee bit more elaboration on how it used to happen then. I'm sorry, I think you said it wasn't as robust but do you have any information on that?

MR. DARRELL: On the infrastructure side, we were actually doing it on a district by district basis where the districts would supply what they saw as their top three or top five projects, and we would actually compare that to what we had in notes and then actually look at whether or not we could afford to fund it and then we would proceed from that point. Approaching it that way was good because the districts got what they wanted but in many cases we weren't actually addressing the needs of the province. Even though they said that maybe the number one issue - and I'm just using it as an example - would be the replacement of the parking gates for the parking lot, we might have felt that it was really the roof that was blowing off that needed to be addressed, but the district felt that the parking lot was more important because it was providing revenue, so there was constantly a bit of bickering there.

MS. YUILL: Yes, the previous method for allocating funding for equipment was a very simple method where each DHA and the IWK submitted their top three requests via the business plan, and a simple allocation of funding was made based on a calculation of the overall funding for the district or the resource intensity weights, which is kind of a measure of acuity or a complexity of care.

So each district received funding for some of their top priorities. It wasn't approached on a criteria basis, it wasn't approached on a provincial basis, so some districts that had great needs for equipment and had older, failing equipment, sometimes those needs were higher needs than some of the districts that received some of the funding. So we recognized that we needed to make some changes in the system to improve that.

MR. RAMEY: Okay, so it doesn't really matter to me which person over there answers this, but it is safe to say that the old process was much more localized and fragmented than the current process?

MR. MCNAMARA: Yes, it is.

MR. RAMEY: Now I may have this wrong, so I'll stand corrected if I need to be, but it's my understanding that a number of years ago the federal government made some funding available to the provinces for medical equipment. First of all, I think that I'm correct on that, but I'm not sure, so I will listen to what you have to say about that part but, also, if that is correct, can you provide some information about that funding program and whether we took advantage of it?

MR. MCNAMARA: Yes, the answer is correct. Linda can give the total dollars. What happened is that when the Martin Government made the agreement with the provinces, it included an equipment fund. Nova Scotia did get its share.

One of the really great things that happened in Nova Scotia during that time is that an agreement between the district health authorities, between the Department of Health, and also using Canada Health Infoway dollars we were able, for example, to make our

province PAX - PAX means picture archival for X-rays - so that all the equipment was digitalized throughout the province in the X-ray departments. So when an X-ray was taken it could be read by a radiologist in his office, a GP in his office could see it, and a specialist could look at it at the same time. We were the first province in Canada to achieve that.

We just recently upgraded our breast screening to also add to that system, so that was utilizing those federal dollars in a very strategic way, along with support from the province and the district health authorities to make that happen.

At the same time I remember, because I was part of the CEO Council at the time, we also made an agreement to set aside a certain amount of dollars to be used by long-term care facilities for beds, so that they could replace some of the aging beds in their facilities rather than us taking it all in the acute care system. There were other projects funded, but that's the - I think the picture archival or PAX system with the X-ray was probably our best that came out of that fund, and it was very useful.

Also some of that money is what was used to provide funding for the Queen's General Hospital project, which is just undergoing now. There were other projects throughout the province as well. Linda, you can give the total dollars, I believe.

MS. LINDA PENNY: The total amount of the fund was $60 million and it came into place in 2003-04 and ran until 2010-11, where we used all of the available funding.

MR. RAMEY: And therefore, it is no longer in effect?

MS. PENNY: No longer. It was a nice supplement.

MR. RAMEY: Okay. I know that some of my colleagues want to ask questions, too; I am cognizant of that. I know the member for Halifax Chebucto wants to ask one, but I have one more and then, with the chairman's permission, I'll hand off to my colleague.

The Auditor General who, of course, is with us today, said it would cost, I guess, $600 million over 10 years to meet all of Nova Scotia's infrastructure needs. I'm just wondering, what are your thoughts on this figure - can you comment on that and how the figure was arrived at?

MR. MCNAMARA: As I mentioned earlier to some degree, that information was provided by our staff based on the information we had available in the department at the time. We also recognize that we're working through that on an annual basis, as we have funds available to us.

Also, some of that need will be not required, because as we build new infrastructure - and I use Colchester Hospital as an example, or what is being done in Queens General -

those replace those needs, so it becomes something that we can reduce from that figure. But I also think it's fair to say that as you reduce your list you know there are going to be new things added to it as well, as our equipment gets older. So it's something we have to be very diligent about, and it's why we're putting in place a number of groups to be able to deal with it. One of the problems is if we don't keep preventative maintenance up, our equipment can wear out faster, so we have to make sure there's due diligence done with the DHAs to ensure that occurs at the same time to expand the useful life of equipment.

I also noticed in the Auditor General's Report, for example, that Capital Health writes off its equipment over ten years. That's one method that you can say is reasonable, but I also know that certain pieces of equipment last longer - for example, a boiler is a 30-year piece of equipment, not a 10-year. So there are different lifespans that we have to look at in how we can make things expand.

MR. RAMEY: Okay. Well, thank you very much. I'll now, with the chairman's permission, hand it off to my colleague from Halifax Chebucto.

MR. CHAIRMAN: Mr. Epstein.

MR. HOWARD EPSTEIN: Mr. Chairman, thank you, and thank you to the witnesses for being here. I wonder if we could turn first to the Auditor General's Recommendation 4.12 - this is the recommendation that has to do with energy savings projects. I note my colleague from Inverness asked some questions about this, and I just wanted to follow up with a bit more detail, if we could.

I see in the response from the department and what the Auditor General noted that a certain amount of money had been spent - I think about $3.5 million was spent on some 54 projects. To my mind, mostly it's not so much about the money that's actually spent but the money that might be saved, and whether there's been a shift to a less polluting form of energy use. So could I ask, first, about these 54 projects - could we have some examples of what exactly that money was spent on?

MR. DARRELL: I'm delighted to talk about energy projects, because that's one of my areas of interest. That actually goes very deep, from things such as replacing light fixtures - moving from the T-12s to the T-8s saved the districts a great deal of money there, replacing the fixtures in the hospitals, and we then went to a system where we looked at the amount of ventilation that's in the hospitals. As you know, in an operating room, the code actually calls for there to be between 12 and 16 air changes per hour, and so that means you're constantly moving in fresh air, removing the old air. That's great in the sense that you want fresh air in an environment when you're operating, but when you're not, when that room is not being used, it means that you're losing a lot of heat and burning a lot of energy moving the air in and out.

You can do that a number of ways, by either increasing the size of the ventilation system, so that you can have it run at a consistent speed and just move the volume out, or you can look at going to - staying with the older system - a smaller-sized ventilation system and increasing the speed of the drive. By shutting off that system, or at least reducing it from the 12 to 16 cycles per hour down to a nominal area of 4 to 6 cycles per hour when the room is not being used, you can save tremendous amounts of energy, not only in terms of the energy moving the air but in terms of heating it. We heat these rooms to get them to an ambient temperature and spend tremendous amounts of money in terms of keeping them at the right humidity, only to suck it out when no one's using it.

MR. EPSTEIN: So if I could just ask, have changes along these lines you've just described - lighting fixtures and the air ventilation systems - been part of these 54 projects?

MR. DARRELL: That's correct. In fact, I have another simple one, just a simple nozzle in terms of in washing down utensils. We replaced these nozzles with a high-velocity, low-flow unit that saved us a lot of money in terms of the amount of water that was being used - I should have brought one along, because they're really quite nice - the department purchased them and gave them to all of the acute care units and continuing care units.

MR. EPSTEIN: See, one of the things I wondered is that the system that was described to us earlier was essentially a system in which the district health authorities make proposals for various capital expenditures and they're reviewed by the department, and then an agreement is reached as to which projects are going to go forward. When it comes to energy matters, I'm wondering if that is the same way it works or whether there's an ongoing program in which the DHAs are engaged with the department in a system of being moved along to different kind of energy systems, or does it go as part of the priority system - could you just explain that a bit?

MR. DARRELL: You're putting me on the spot here because I'm in front of my boss, but when the district comes in with an energy savings project - many of these projects are low cost but yield high returns - we don't go through that formal process. If it's something that is reasonably low cost - as the member for Inverness said, what we consider a no-brainer - we just say go ahead and do this and we'll find the money somehow to do it.

MR. EPSTEIN: That leads me to another point I really focused on at the beginning, which is that it seems the issue here isn't so much the dollars that are spent, which seem to be pretty small - $3.5 million - but the money that's saved. I am just wondering if you can tell us anything, or if you really have a feel for what kind of energy savings there might be associated with some of this spending.

MR. DARRELL: You know, that's an area that's really somewhat of a mystery. We know that these projects save dollars - we see the drop in the amount of oil that's being burnt; we see a decrease in the amount of power that's being consumed - but in terms of the

actual return we don't go after the district and say because you've saved X number of dollars, we're cutting that off your budget, because there is some other piece of equipment that comes in or there's something else that goes on within this facility that seems to absorb it.

MR. EPSTEIN: I have to say, if dollars were freed up from the energy budget and reallocated to something else, I would regard that as a saving and an efficiency inside the system. That's good.

There was another aspect of this that I wondered about. I know that it happens a lot in businesses, and sometimes in homes, that energy consulting companies will come along and say to a building operator or owner, let us have a look at your building because we think we can save you energy costs, and the way we'll get paid is by taking a percentage of what your savings are.

I had the impression, reading some of the materials, that the Department of Health and Wellness and the health authorities worked with Transportation and Infrastructure Renewal, another government department, and I'm wondering if any of the DHAs or individual hospitals work with consultants who come along and make those kinds of proposals, or is all of this happening in-house - can you tell us a bit more about this?

MR. DARRELL: Certainly, I'd be delighted. We did do that, as the deputy minister talked about in terms of South Shore, where they had a consultant in who made a series of recommendations and then wanted to claim some of the things that were already done.

We went to another district and had a recommendation where we could - this is one that was really kind of interesting, where the consultant recommended dramatic savings that could be achieved by reducing the amount of humidity in the environment. Now, if you were to look at the CSA Standards - it's C317.10 - it focuses on the HVAC systems in the hospital. If you follow that it says that the percentage should be between 30 and 60 percent humidity in the room. The consultant reported that we could save a great deal of money by reducing that down to about 35 per cent humidity. That sounds like a no-brainer - I hate to use your term again, but it sounds like it's a no-brainer.

By reducing it to 35 percent, it's still within the range, but what we found was that by reducing the amount of humidity in the actual patient rooms, wounds and incisions and cuts did not heal as quickly. The surface skin dried out and the patients were in the rooms for longer, so it saved us energy, but we had people staying in the hospital longer. Yes, from an energy perspective it was great, but from an overall cost perspective, it drove up the cost of the facility.

MR. EPSTEIN: Naturally enough, you have to look at the whole interaction in terms of all health outcomes.

MR. DARRELL: Exactly. This is where it gets very critical, because the whole thing in terms of energy programs is about moving the risk, and they want to move the risk from the DHA to the consultant or to the firm that is providing this energy-saving program. But they would consider this as not part of their risk, and so it's increased the risk of the hospital while saving them dollars.

MR. EPSTEIN: Going back to the 54 projects, were any of them as simple as putting in insulation in buildings that perhaps didn't have any, or needed an upgrade, or is that something that is really not an issue?

MR. DARRELL: No, your point is well taken. Something as simple as caulking around windows, replacing them, actually trim around roofs, yes, a number of them were very simple, cost-effective measures.

MR. EPSTEIN: What about switching to other forms of electrical generation? Do any of the buildings operated by the DHAs have solar panels that are generating electricity for them and is that under contemplation if it's not in place already?

MR. DARRELL: Yes, some of the districts do. It's not widespread but alternate means of generating energy has been one of the things considered, yes.

MR. EPSTEIN: I wasn't sure about the answer earlier about gas or propane. Was it just the fleet of vehicles that you were looking at or was it also for heating and cooling inside the buildings?

MR. DARRELL: The conversion to natural gas at the regional hospitals is - we're looking at the facilities, the actual hospitals.

MR. EPSTEIN: What about the fleet? What about any of the vehicles? I use the word fleet to mean the vehicles that are operated by any of the hospitals or the DHAs - patient transfer units and so on.

MR. DARRELL: That one I cannot actually address because that's not my area.

MR. EPSTEIN: That would be EHS, I guess.

MR. DARRELL: It would either be EHS or it would be the actual district hospital that would look after the fleet. I'm sorry, I cannot address that.

MR. CHAIRMAN: Order, please. Unfortunately, Mr. Epstein's time has expired. Mr. Younger, you have 14 minutes.

MR. YOUNGER: I'm going to get back to the question from before, but before, I just want to follow up on something that the member for Halifax Chebucto was asking

about, on energy efficiency. Unavoidably, a lot of the equipment that you run in the hospital uses an enormous amount of electricity - an MRI, CT scanner. Those big-ticket items are all so extremely costly to run and they have to be run all the time and ramped up and stuff like that. How is that managed in terms of decision-making, given, obviously, the hospitals are facing increases in power rates and all that sort of thing, which then goes to their bottom line. I'm wondering whether there is a link between capital purchase decisions and ultimate operating costs and whether - I know you can buy MRIs and stuff that have different bore widths and stuff like that, but I don't know if you can buy one that is more energy efficient - but whether there is some sort of matrix that says, we will purchase the more expensive yet more energy-efficient MRI, CT, whatever, because it will save operating costs for the hospital. I'm just wondering whether that factors in at all.

MS. YUILL: The DHAs and the IWK are responsible for operations and they would be looking at those opportunities all the time in order to be able to achieve as much of the savings as they can. They do this on a regular basis.

We also have two provincial initiatives underway that help the DHAs and the IWK in looking at those opportunities. One is the provincial lab/DI initiative where all the DHAs and the IWK participate together in this initiative, along with representation of the Department of Health and Wellness. They are assessing the technology needs for diagnostic imaging, so those bigger pieces of equipment that you were mentioning in terms of MRIs and CT scanners. The plan is that they will be able to develop a multi-year plan for what needs to happen in the province with those pieces of equipment and be able to capitalize on group purchasing and looking at the specific technology that would be required and what is the best practice in the sector, at the moment, in order to be able to achieve operational savings when purchasing equipment.

There is also the merged services initiative where, again, the DHAs and the IWK participating in some group purchasing now with supplies and medications, and that will expand to look at other pieces of equipment potentially, as well as contracts for maintenance, and look at other opportunities for savings.

MR. YOUNGER: I guess what I was wondering, though, that's on the operational side and I understand that, but ultimately they're responsible for the - I mean the department gives them money but then they're responsible for the operational costs based on whatever budget the department gives them, but the department is largely responsible for the capital side of things. I know I'm simplifying it, but what I'm wondering is if I go to you and say we want to buy this piece of equipment and it's $1 million but it's $1.2 million if we buy the one that is going to save us, will use electricity, is there anything in the scoring matrix for the capital things that would say it's worth the extra $200,000 because it will ultimately save on the operational side?

MS. YUILL: The answer is yes. In the criteria for scoring, one of the criterion is efficiencies so we're looking at not only cost savings but cost avoidance for the future and

potential enhanced capacity, because some of the new technology is able to put more patients through per hour. That is also an enhancement that we consider in the scoring system. So all of those considerations are part of the scoring system and play a great part in the ranking.

MR. YOUNGER: Thank you. I want to go back to where I left off last time, which was about the example of the piece of equipment. There was a funding request, and this was an example, to replace a piece of equipment that had been removed from service due to levels of radiation exposure. It was noted that because the scoring criteria is around potential harm to patients or staff, by removing it from service it had the inadvertent impact of reducing its score in terms of getting replaced.

If you follow that logic, it sort of sounds like - and I don't want to suggest that somebody wants to have a patient or employee harmed because obviously nobody does, but if somebody had been it actually would have bumped up the list, but because somebody had made the smart decision and said this is not safe, we're going to remove it from service, now we don't have that unit and we need it replaced, it actually had got a lower score.

I'm wondering how that situation happened and whether that has been corrected for the future?

MS. YUILL: Yes, we did recognize at the time when the committee was going through a very new scoring system that there were issues in the way that the scoring worked for the safety scores in terms of the potential versus the actual incidence of harm. We have worked very hard over the last few months to revise the scoring system and try and recognize the potential for harm in a different way than what we did at that point in time.

I also want to say that it is not unusual for DHAs and the IWK to recognize a potential issue in the system and to remove a piece of equipment from operations to protect patient care and safety. That's a day-to-day decision that they make at the time. This particular piece of equipment was an older diagnostic imaging piece of equipment, which had the potential to have excess radiation exposure that they couldn't control at the time, so they removed it from service.

What we also consider in the scoring system is what the impact would be on patient care by removing a piece of equipment. So is there another piece of equipment that can be used? Will the wait times increase? Do patients have to travel elsewhere? How critical is that piece of equipment for care? Is it a lifesaving piece of equipment? Is it a routine test? All of those things are considered in the scoring.

MR. YOUNGER: You brought up wait times. How much of an impact, if a DHA or a hospital takes out a piece of equipment, for safety or other reasons it just stops working, how much do wait times and the impact on wait times factor into the decision?

MS. YUILL: Again, it depends on the individual situation. Occasionally that piece of equipment was old and there are other pieces of equipment that can be used. . .

MR. YOUNGER: Well one assumes those would have been being used. I assume that we don't have MRI and CT scanners sitting around not being utilized.

MS. YUILL: No but there are many pieces of general diagnostic imaging equipment in use, epically in the bigger centres, so that the districts manage that flow and if there is a critical issue, it will be documented in the request for funding, when it comes to us.

MR. YOUNGER: I understand what you're saying, that there is a lot of equipment around, but for example the IWK is now doing MRI scans at night for adult patients, which is a good thing because obviously it is utilizing a piece of equipment in off-hours to help address an issue. But that would suggest to me that if an older piece of equipment goes down that obviously we were already using all those other diagnostic pieces of equipment to their maximum utilization, unless you bring people in at 2:00 in the morning - maybe they do I don't know, but they are certainly doing them at night - that would obviously have a huge impact on the wait times. That is where I'm wondering - I understand they can manage the flow, that's what their business is, managing the flow, but we also know that wait times have increased in many areas over the past few years for a lot of services, a lot of procedures, a lot of diagnostic imaging, so if a piece of equipment comes out of service that almost has to increase the wait time, unless it wasn't being used at all. That's why I'm wondering how fast that can move up the criteria list.

MS. YUILL: Again, it would depend on the type of equipment. As you say, if there are very few pieces of that particular equipment in the province, it would probably have a higher score in terms of patient impact, compared to a piece of equipment where there is a similar piece of equipment on the same unit, in the same building. We consider that in our scoring system.

MR. YOUNGER: But if the same piece of equipment, in the same building, is being fully utilized, it doesn't really make much difference if it's in the same building, if there isn't space to pick up those patients.

MS. YUILL: Again, in the submission that the DHAs and the IWK submit to us, they are asked to provide specific information on the impact of wait times and if patients will have to travel elsewhere to get the service required. So we consider all of that and sometimes the wait times increase on a temporary basis because it can fix the piece of equipment in question.

MR. YOUNGER: Or you have to order a new piece and I understand that.

MS. YUILL: And other times a piece of equipment is not repairable and we have to look at that.

MR. YOUNGER: In the same part of the Auditor General's Report, and a related issue, it talked about looking at 20 tests of sample equipment and looking at how they were rated under the scoring criteria. The report noted on Page 71 that there was huge variation. There was variation, maybe I won't use the word huge because I don't want to state how much; that's a judgment. Now that raises questions as to why pieces of equipment in arguably the identical condition and situation would have different scores, which gets into this whole wait time and everything. Why would that happen?

MR. MCNAMARA: One of the things the Auditor General did identify was that our scoring system was not perfect and that's why we have changed it to buy into a new system that will allow us to be more robust in our decision making. I think it's also important to recognize, we have to look at utilization of our equipment as well. One of the things I do know, for example, is that there is a fair number of lower back X-rays done for back pain. We do know that in most cases those X-rays are useless and so we are working with our physicians talking about how we can change our utilization and use our equipment more expeditiously and more efficiently for patient care.

Frequently tests are ordered as a way of doing something immediate rather than doing a diagnostic in another way, so we have to do things. We know that there are many efficiencies we can do. We also know - and Anne was referring to that - sometimes when you take an old piece of equipment out, there is other equipment in the facility that can do it that isn't being utilized to maximum. But if something is critical, and I'll give you a good example, I had a call from Cape Breton District Health Authority at the end of the fiscal year. They had a couple of pieces of equipment in their cancer unit that had reached a critical stage and they were looking for emergency funding. My answer to them was to replace the equipment and then we'll figure out how to pay for it. That's the right decision in that case - that was a critical piece of equipment, it is different than the one that you are referring to.

MR. CHAIRMAN: Order, please. Mr. Younger, your time has expired.

Mr. d'Entremont, you have 14 minutes.

HON. CHRISTOPHER D'ENTREMONT: Thank you, Mr. Chairman, and I want to thank you folks for being here to answer these questions.

What I am finding interesting about the discussion is that, as we talk about infrastructure, we are sort of lumping it all together, and when we are talking about $600 million worth of infrastructure I'd like a bit of a breakdown of how many billion dollar

buildings like the VG and how many dialysis units are there - is there a breakdown of what this infrastructure is going to look like over the next 10 years? I know it's a pretty general question but I think it would explain to a larger degree what we're actually talking about, because there's a big range of what we're qualifying here as being infrastructure or medical equipment.

MR. DARRELL: That $600 million figure over the next 10 years was based on the existing plant, just the plant . . .

MR. D'ENTREMONT: Just the plant - okay.

MR. DARRELL: Spread across the province. It actually looked at the major components of it in terms of the boilers, the electrical systems, the generators, roofs and what I consider major projects - not painting walls and that sort of thing. That was based on if we did nothing in terms of upgrading the system other than just focus on those projects, no replacements. That's what we would actually have to be spending in order to keep the system running.

MR. D'ENTREMONT: What kind of projects are there? We talked a little bit about a windblown roof and we talked about windows and sheathing, those kinds of things - what kind of projects would fit within that, beyond just big projects? More specific . . .

MR. DARRELL: You want more specifics?

MR. D'ENTREMONT: I want more specifics, yes.

MR. DARRELL: Okay. We actually have - I'm functioning from memory - but we have something like 11 generators that need to be replaced. These are facilities where we have a window that our generators should actually serve us for.

What's really sad is that in most cases these generators don't get nearly the amount of running hours that they should, because we typically start them running once a week for an hour and yes, they work, and then we shut them off. We can have a generator that actually has been in a facility for 10 years and only has in the neighbourhood of 530 hours . . .

MR. D'ENTREMONT: Just like at the IWK.

MR. DARRELL: Exactly. So we have facilities where those generators need to be replaced. We have boilers that need to come out, and if you look at some of the facilities like the New Waterford Hospital, that boiler needs to actually go; it needs to be replaced.

Now we are getting into a whole new series of events there in terms of indoor air quality - we have infection control projects, asbestos removal projects, lifting appliances -

and don't get me started on elevators - ordered fire marshal issues, dust collection. That's a relatively new project that has come on the agenda recently in terms of . . .

MR. D"ENTREMONT: Dust collection . . .

MR. DARRELL: Yes, dust collection, because I'm sure at home you probably have a skill saw that you run, and we tend to run these things and not think anything about it, but if you're actually working with these in a carpentry shop on a daily basis, you're building up a fair amount of dust particles in the air. That has become a very critical thing that we have to address.

MR. D'ENTREMONT: All right. Those are the infrastructure issues, so . . .

MR. DARRELL: Those are some of them, yes.

MR. D'ENTREMONT: Okay, so we have $600 million sitting over on this side, what kind of projects or replacement issues do we have - and I am going to look over at Ms. Yuill - what do we have for equipment that's sitting out there? We talk about a couple of million dollar MRI/CT scanners, but there is a lot of other stuff that needs to be on a cycle of replenishment or replacement - where are we with that part of the process and what kind of dollars are we looking at over on that side?

MS. YUILL: As you can appreciate, there are many, many pieces of equipment in this system and some of them are large pieces and easier to count and others are very small pieces required for surgery.

Years ago there was an initiative that had looked at the diagnostic imaging and lab and biomedical equipment and estimated there was $500 million worth of equipment at that time - that was probably six years ago now. I can tell you that the provincial lab/DI initiative, they are currently undertaking that work and looking at the inventory of all the DI and lab equipment in the province and calculating out what the replacement costs would be, again based on where they are today and straight replacement costs, not looking at what would be required for proper utilization. That work is underway and it's not complete yet, but should be complete in the near future.

MR. D'ENTREMONT: I remember visiting lots of hospitals and a lot of times you would be brought into the X-ray suite and you could see the old X-ray machine sitting there with a couple of pieces of duct tape holding this piece on or that piece on. I think a lot of that has been addressed through the digitization project, through PACS, and trying to get that stuff all up to date. I think that's going well.

But little pieces, and I guess "little pieces" is sort of a misnomer, too, because if we take let's say a dialysis unit, which is about a $60,000 item - I remember my visit it was to either the Bethune building or just to Capital Health here and the machines at that time

were almost all over their operational limit - where are we with that kind of renewal of equipment, they have just been working so many hours now that we don't know when they're actually going to fail?

MS. YUILL: I can tell you that the DHAs and the IWK are undertaking significant efforts to keep track of all those pieces of equipment and to be able to rank them within their system so they can either submit a request to us for funding or request to their foundation sometimes for funding, or they use some of their operational funds that they've set aside for regular updating of those smaller pieces of equipment that never make it to the top of the list.

MR. D'ENTREMONT: Is there a central data tracking piece for the department itself at this point of knowing where that is, or do you still sort of depend on the districts to provide that list to you?

MS. YUILL: Right now we depend on the districts and the IWK. Again, I want to remind you that the lab/DI initiative will have a really significant portion of the equipment in the province once that work is complete.

MR. D'ENTREMONT: I think part of it was trying to figure out the capital items, and when do we get to that 50 per cent usage that they start moving up the list before they expire. What we found at a lot of places in a lot of a districts, because they don't make it to their lists or they're not high on their list, that they've kind of almost got to their expiry before we're into, all of a sudden, crisis mode and spending the $2 million emergency fund in order to cover failures and those kinds of things.

How are we going to know when we reach 50 per cent of the life expectancy of some of these pieces of equipment going into the future? If you're starting to replace stuff now, are we putting that on a better tracking list so that we know what's going on and we can actually sort of reach out to the districts and say hey, I see that this machine or that machine is starting to get a little old - are we going to be doing some of that work?

MS. YUILL: The answer is yes, certainly, for the lab/DI initiative. That is the purpose of why that group is coming together, so that they can look at things proactively and give advice to the DHAs and the IWK in terms of what should be replaced and when.

The equipment group is working with the lab/DI initiative in reviewing the submissions from the DHAs, from that perspective, to inform our rankings.

MR. D'ENTREMONT: Maybe this is more for the deputy - how much money is being provided to the districts now to do the preventative maintenance, especially on a lot of this equipment?

I don't know how much is going on in that one, but I think a lot of times if you are providing some funds and trying to keep it up to date, we're not paying a lot of money on replacements for a while.

MR. MCNAMARA: Mr. d'Entremont, I don't have the figures here, so I'll have to get them for you. I know we do provide it through the budget, but I can't tell you specifically right now.

MR. D'ENTREMONT: Well maybe that will be a question that I'll probably ask when those estimates do hit the floor of the Legislature. I'm sure we'll get that, so maybe Linda could just make a note and I'll ask that question again as we roll closer to that one.

You talked about three tables of review where the districts are now a part of some of that decision making. Can you explain those three tables - or was it two tables? I think it was in your opening speech - and just how, let's say how South Shore Health can help make a decision in what's happening in Cumberland?

MR. DARRELL: Actually this is a process we implemented almost three years ago and it has almost been an evolutionary type of process; it has been wonderful to watch. This is where, when the districts came in to make a request for repair renewal projects, they would actually have to present their project to the rest of the table. At the table the group would be my district engineers as well as the other people sitting around the table from the various DHAs, and they would actually have to defend what their project was and how it actually met the criteria in terms of safety, longevity, and a number of different factors - I don't remember them all at this moment - and the project would be ranked.

We started off doing that on the under $90,000 projects, and it was an interesting process because originally the districts were very much positioning themselves and it was a matter of how I want to get this one in. Over time they actually recognized that maybe it's not as important to have this project approved as what is best for the province, and maybe another district project is more important than this one. So it was more a case of evolving to that state where we're looking at it on a provincial-wide basis as opposed to just a district one. We have now, thanks to the Auditor General, rolled that out to our over $90,000 as well and that seems to be working well and there is a similar sort of process that is going through with the equipment side of the house.

MR. D'ENTREMONT: Knowing that we do have a large number of DHAs in the province, does that make it difficult? Are you having districts competing against each other or do they get the idea that what's good for one district is probably going to be good for my district in the long run?

MR. DARRELL: It's actually having the reverse effect because now the districts are saying aha, this is what we learned from that one, how can I actually employ that technology over here? It has had almost an expanding - the opening, the communal kind of

approach where districts are sharing information, so instead of competing they are working much more closely together.

MR. D'ENTREMONT: Maybe this one's for Kevin - I'm sorry, the deputy - that if this is working so well that way then why do we need all the DHAs to do this? Maybe we could do with a lesser number of DHAs now, if this is how things are actually starting to work.

MR. MCNAMARA: Well the number of DHAs is not my decision, but what I will say is that working with the DHAs we have put together a lot of work on merging services. Many of the districts have reduced the number of VPs. They are sharing VPs between districts; in fact another is going to take place between South Shore and Annapolis Valley with the operations VP from South Shore retiring, and the one from the Valley is going to do both jobs, so it's going at it in a different way.

I think that if we had also put our energy into merging DHAs that would be the issue. By doing it the way we're doing it, I think we are setting the stage for potential for the future. A lot of work has gone into looking at merged services in this way and I think you'll see more of it. I have to give a lot of credit to the DHAs, both from the boards and the CEOs. They totally bought into this; they have worked hard to make it happen. There has not been resistance and they recognize that in the future there probably will be fewer of them, and they are not turf-protecting.

MR. D'ENTREMONT: I too have to say that my involvement with DHAs and working with the CEOs was always a good one. They did understand the larger picture of what had to happen in health care in Nova Scotia. As much as I would like to go at a whole bunch of other issues, I think I have my questions done for today, so I want to thank the folks for being here and thank you, Mr. Chairman.

MR. CHAIRMAN: Mr. Skabar.

MR. BRIAN SKABAR: When you made your opening remarks, I noticed that there was - well speaking of diagnostics, back, I think it was close to 2008, we had to go to Sherbrooke, Quebec, to get at PET scan; we didn't have a machine in Nova Scotia. Now, subsequently, I understand we have one. Is there any other diagnostic equipment, are there any other reasons that people from Nova Scotia would have to go to a different province to get that kind of service?

MR. MCNAMARA: I'm not aware of any. One of the things that has been mentioned a number of times is that, going into this project of looking at lab and DI, we can see ways of doing things much better in the future. For example, there are ways to use equipment so that there can be bedside testing rather than having to send it to a lab. So that's one of the things that we will be looking at putting in place as we work our way through this. We can see it providing care faster and more safely in the long run, but it will

take time. It does take a cultural change, because you are using different staff in different ways. We have to go through the training. And as you know, anything we do in health care impacts the income of someone, so it always takes a little bit of time to get there.

MR. SKABAR: I have noticed in the last few years that things are moving along for the better - largely, I think, because the district health authority in Cumberland is responsive. I get a call back the same day or the next day, and they do take the time to explain these things to me, and that has helped me.

I'm just going to move on quickly to new facilities. I understand an announcement has already been made that a new hospital or primary health care facility in Pugwash will be initiated. What does this involve - like, from yes we acknowledge that there is a need for a new primary health care facility or hospital, now what? How does this work?

MR MCNAMARA: Well, the first step is getting a plan from the district. Usually it's telling us what they want to provide, then it involves getting an architect to put together initial drawings. For example, in talking about Mr. Younger's question regarding Dartmouth General and Capital Health earlier, they've put together some initial drawings and they've had some public input by going out and talking to the public to see what this means. I know they've done presentations in Dartmouth and Halifax that individuals could attend, plus staff, to get an idea of what's taking place. They take that input and bring it back to us, and then what we have to do is go through an analysis of looking at what they're suggesting versus what we know is taking place in other parts of the province, or being aware of new things coming down.

The other thing we're trying to do is work with other provinces in doing things better than we have in the past. We have recently signed a memorandum, for example, with P.E.I., and providing 811 service in P.E.I. We also signed a memorandum to look at how we can provide joint IT systems between us, because we have to transfer patients from P.E.I. to Halifax, particularly for those who require greater care. So, can we do things better and cheaper?

On a national basis - and I'm a little bit off the topic - we're also looking at how we can purchase things, particularly high-end equipment, for all of Canada at the same time, if it makes sense. As we develop our plan over a number of years, it will make it easier for us to fit into that system.

MR. SKABAR: Without putting you on the spot, because you probably don't know where every single brick of every single new hospital is coming - how far are we along on the Pugwash hospital, does anybody know?

MR. CHAIRMAN: Mr. Darrell.

MR. DARRELL: We're at the stage now where we've directed the district to go back and come back to us with schematic design plans. So they've told us what they want to have in the facility, we've agreed with that, and now they'll be going out to hire an architect to do the schematic on it.

MR. SKABAR: Okay, thank you very much. With that, I'll pass to my colleague from Pictou East.

MR. CHAIRMAN: Mr. MacKinnon.

MR. CLARRIE MACKINNON: Thank you very much, Mr. Chairman. I have a series of questions and very limited time, so I will make them very, very quick, and perhaps the answers can be as well.

In relationship to capital planning, there are three major committees. All three now have representation from the DHAs and the IWK. This is something new - are we actually seeing that there is more agreement when decisions are made?

MR. MCNAMARA: There has definitely been added value to the decisions of all the committees. As I've indicated a number of times, the DHAs have really bought into working with the Department of Health and Wellness and with each other, and they're recognizing that they're part of a provincial system and not a local system. That has made a big difference in how we're moving forward, so it's very positive.

MR. MACKINNON: In capital planning, the AG's Report indicated that we needed $600 million over the next ten years to maintain our system. In the last three years, it's an average of $70 million that is being spent. If that is continued, does that mean we are meeting the AG's Report?

MR. MCNAMARA: As I mentioned earlier, that will address some of it; as we build new facilities we'll address some. I think we also have to be cognizant that there will be new issues come on the table as we're addressing the old ones. So it is going to be a lot of work and it is not going to happen quickly, it's going to take multiple years to get there.

MR. MACKINNON: Deputy, I got some real assurance from you this morning in relation to emergencies because, and I will quote you: "Any hospital that has a requirement for emergency equipment won't go without." Is that an assurance that you're giving to the people of Nova Scotia? I think you felt pretty strongly about that.

MR. MCNAMARA: Definitely.

MR. MACKINNON: One of the things mentioned in your remarks this morning was the Pairwise scoring system. I don't know much about that, how long has it been in existence, and how good is it? And, if we could, fairly quickly.

MR. DARRELL: We started using the Pairwise scoring system about four and a half years ago. We started off using it on the under-$90,000 group and it worked very successfully. We've started moving it up over $90,000 and it is now being used in the equipment as well.

MR. MACKINNON: With new purchases, replacements, repairs, more effort is being concentrated on actually the concentration of various services within hospitals to ensure there is not duplication with nearby hospitals - is this part of what you're looking at, that you're working toward and so on?

MR. MCNAMARA: Yes, it is. Also, we have to look at what staff we have available, too. One of the things we do know, for example, and we've mentioned the diagnostic imaging and lab projects, that there are fewer technicians available as people are retiring and less people are going into that training. So we have to come up with new ways of being able to provide that service on a province-wide basis and how we can do things differently.

And I mentioned also, the point of care testing, another way that we would consider how to provide it, but we also looked at what's available next door, what's in the next district and some of it is we have to do more sharing. We're also looking, for example, how you can do things even in one district that may assist another district. That's something I think that makes sense.

Sometimes it may be an inconvenience to travel, but if you can travel and reduce the wait time significantly and get your procedure done, many people will do it.

MR. MACKINNON: How much time do I have left, Mr. Chairman?

MR. CHAIRMAN: You have about five minutes.

MR. MACKINNON: Okay. I have a series of more questions, but Mr. Epstein has a request to have another question or two as well.

MR. CHAIRMAN: Mr. Epstein.

MR. EPSTEIN: Thank you, Mr. Chairman. I wonder actually if we could go back to a discussion about the generator at the IWK. I'm not sure I followed the information that came forward before. I thought I heard Mr. Darrell say that the problem wasn't so much the generator itself, which I think he indicated hadn't been excessively used, but it was something to do with how it connected with the rest of the system and delivered its power.

I have to say that that sounded to me more like a repair than a capital expenditure, but in any event, however it's classified, could you just clarify what exactly is going to get

repaired, replaced, or reworked - is it the generator, is it the connection, is it both, what's happening, please?

MR. DARRELL: Actually all three, okay. The issue at the IWK, and we keep on saying the generator but it wasn't really the generator that faulted, generators typically in those hospitals run for one hour a week - they just start them up to make sure that the generator starts and that's great.

Unfortunately, though, when they start those generators they don't actually get a chance to do the load testing. They're supposed to start them up and run them under load, but in many cases they don't, physicians don't want to test it when they're doing an operation so they want them checked at night. If you are the person who is on the operating table, you might agree.

The issue, though, is that when we actually start this up and it is then manually transferred over to the load we don't get the chance to check the actual mechanical-electrical system that's supposed to electronically transfer it over when there's a power failure. We don't actually get a chance to see if this switch is working so this switch sits in place there for maybe 10, 12, in some cases 35 years, and it's only tested once or twice, very infrequently. The whole aspect of actually getting this switch tested on a regular basis was not something that was being done. We have now put in a procedure to make sure that we test the mechanical-electrical transfer of power, on a regular basis, so hopefully we'll reduce that.

Once again, when we fire up this generator and we let it run for an hour a week, we never really get a chance to see if it is cooling properly and what actually failed at the IWK was the cooling system for the generator, so it overheated. We had the switch that actually failed and that was a problem. The generator was almost not an issue at all, but nevertheless, it is time for it to be replaced.

Now we get into another series of issues in terms of the generators currently located in the sub-basement of the facility. The new building code doesn't allow for that because you have the generators in the lowest spot. If there is a flood you know where the water will collect. We now have to move those facilities and it just cascades in terms of the issues that come up.

MR. EPSTEIN: I think that clarifies it, thank you. That was the very problem at the sewage treatment plant over the way. In any event, back to Mr. MacKinnon.

MR. DARRELL: This one doesn't smell as bad.

MR. MACKINNON: Very quickly, one local question. In Pictou County we have two great trust funds; we have a very active auxiliary; and we have municipal units that are very supportive of projects. The 75/25 formula that is being used, do we stick to that

formula, because when one health authority is coming up with the 25 per cent and another one can get away with 15 or 17 per cent, it gets rid of some of the incentive - can you perhaps quickly respond to that?

MR. MCNAMARA: Yes, we do stick to that policy. The only exception is when a district is willing to pay more.

MR. MACKINNON: Thank you very much for that. I think at one time years ago there was quite a variance and I know that some of the people who have been very involved in Pictou County, like the Sobey family and others, who have contributed so much over so many years, there is an actual concern that there should be that incentive to raise the full 25 per cent and not go with less. I thank you very much for that and I think I'm going to be ruled that my time has gone, is that correct, Mr. Chairman?

MR. CHAIRMAN: You only have a few seconds left.

MR. MACKINNON: Okay, many questions, but a few seconds. Thank you.

MR. CHAIRMAN: I would ask the deputy minister if he would like to make wrap-up comments.

MR. MCNAMARA: Sure. Again, it's a pleasure to be here. I am also pleased to have my staff with me. I learn from them as well as they are answering your questions, so that's always very useful.

There's one thing, when I do interviews hiring new staff, there is always one question I ask the people. The question is: What question did you prepare for? Then I ask them to give me the answer. I did prepare for a question and I didn't get it, so I'm going to answer my own. The question is regarding the mouldy mattresses that were at Capital Health. Just so you know, that is being addressed there. I also want to assure the members that I've gone out to every district to find out if this is a problem in other districts and I can answer to date, it is not. We have had that done. I'm using this only as a point to make, once an issue is identified in one district we go to other districts to make sure that's not reoccurring.

My final comment: When I was here on another appearance regarding the Colchester hospital, and after the additional funding was provided one of the statements I made was that the additional funding would cover the cost - there would not be any overspending and, if there were, I would not be here. I'm pleased to tell you I'm still here, so that tells you the results. Thank you very much.

MR. CHAIRMAN: Auditor General, Mr. Lapointe, do you have any comments?

MR. JACQUES LAPOINTE: Yes, I think I should add that, just on the basis of what we've seen so far, I can say that it appears to us that the department has been doing a commendable job of taking action on the recommendations that we made and are moving quite strongly to implement them, and some of those recommendations, as you know, are not simple ones. Thank you.

MR. CHAIRMAN: Thank you very much. I would like to thank the department for coming, and your staff. We found it very informative and, indeed, I know it's a difficult job you have to do with the budget you have and the huge demand on our health care system.

Again, thank you so much for coming today. Our next meeting will be next week and it's going to be the Capital Health Authority and the IWK Health Centre Personal Health Information Systems. We will follow that next week with another in camera briefing, Office of the Public Trustee. Immediately following this meeting we're going to have another in camera meeting regarding that.

A motion to adjourn would be in order.

MR. MACKINNON: So moved.

MR. CHAIRMAN: We stand adjourned.

[The committee adjourned at 10:55 a.m.]