

HANSARD

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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, April 9, 2014

LEGISLATIVE CHAMBER

**Department of Health and Wellness
Department Administration Costs**

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Public Accounts Committee

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[Mr. Iain Rankin was replaced by Mr. Keith Irving]

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Legislative Committee Clerk

Mr. Gordon Hebb
Chief Legislative Counsel

Mr. Alan Horgan
Acting Auditor General

Ms. Evangeline Colman-Sadd
Assistant Auditor General

WITNESSES

Department of Health and Wellness

Ms. Frances Martin, Acting Deputy Minister

Ms. Paula English, Acting Assistant Deputy Minister

Mr. Kevin Elliott, Chief Financial Officer



House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, APRIL 9, 2014

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN

Mr. Allan MacMaster

VICE-CHAIRMAN

Mr. Iain Rankin

MR. CHAIRMAN: Good morning everyone, I call this meeting to order. I would like to begin by reminding everyone to place their phones on silent and we'll begin with introductions.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Ms. Martin I would like to give you an opportunity to give an introduction today, our topic is administrative costs for the Department of Health and Wellness. I would like you to give an introduction of what you have to present today and then we will begin with questioning from the members.

MS. FRANCES MARTIN: Thank you, just to make a few opening remarks to give you an overview of what we do at the Department of Health and Wellness. First, I'd like to thank you very much for being here today. It is a pleasure to speak to the very important things we are doing at the Department of Health and Wellness.

I'm supported here by my colleague, Ms. English, who has worked many years on the front line of health care and has substantial experience in health system leadership. As well, Kevin Elliott who is our chief financial officer and has a very busy job in ensuring that we are providing the services that we need and keeping an eye to the dollars that we're spending.

We're here today to guide you through what we do at the Department of Health and Wellness, particularly the administrative aspects of our work. I should start by explaining a little bit of what we do. As you know, our mandate includes the delivery of health care and just as importantly, working on the prevention of disease and injury. We promote health through healthy living as well. Our department is mandated to set the strategic direction and the policy for the health care that is delivered across this province, to ensure that patients, regardless of where they live in this province, have access to consistent, timely, quality care. We do that by developing standards, by monitoring system performance, by measuring and evaluating quality of programs and services that are being delivered both provincially, locally and at the district level.

By way of example, one area that we are focusing on is the new surgical wait times website, which provides greater transparency to Nova Scotians who are waiting for surgery and various other services. We also hold responsibility for mental health and addiction services across the province. As well, we monitor, track and evaluate human resource needs in professions across the health care sector. One important area in terms of the health care sector that we are leading on is the implementation and progress under our physician recruitment and retention.

We also offer pharmaceutical programs such as the Family Pharmacare and Seniors' Pharmacare to assist Nova Scotians to pay for the drugs that they require. We also implement new programs like the Nova Scotia Insulin Pump Program.

Overall, we monitor patient safety and wait time improvements. One part of our system that we've recently introduced is adverse events reporting, which requires the districts to let us know when a serious adverse event happens in their facility so that we can monitor, we can track and, most importantly, we can continue to improve the quality of our services for all Nova Scotians.

We are responsible for important public health programs such as our extremely helpful and successful flu vaccination campaign that we delivered throughout the winter. We fund, as well, long-term care facilities and home care service providers to assist our seniors. We set and enforce standards for those services and work to find new and better ways for people to get the care that they need at the right time and the right place.

We fund as well recreational facilities, community groups, schools, community health boards and many other partners who are instrumental in ensuring that we are doing our best to ensure that Nova Scotians live longer and healthier lives.

Underneath all of this, we do things like deliver payments to physicians for services across the province through our Medavie contract, and we have one of the country's best ambulance services, which we offer through a contract with Emergency Medical Care Incorporated.

Of course we provide funding to the district health authorities and the IWK Health Centre. We monitor budgets and work in consultation with them to ensure that the taxpayer dollars are being spent in the best possible ways.

We are, as a department, a \$4.1 billion organization. Our administrative spending over the last year was 1.6 per cent of our budget, which is \$62.6 million. All of the work I have just described requires administration and administrative staff. Without this administrative staff we would not have the ability to respond to research, to continue to improve the programs and services that are offered to Nova Scotians. We would not be able to provide new programs that Nova Scotians want - one example would be the recent announcement that we made on gender reassignment - and we would not be able to oversee the effectiveness of the programs that we are offering.

You may wonder, of course, how our costs compare to other provinces. It is hard to compare costs from one jurisdiction to the other. Not all provinces, their Departments of Health, include long-term care. For example, long-term care and continuing care does make up 14 per cent of our budget. Other provinces do not include the wellness in the health and wellness, which includes our Public Health Division, our physical activities, sport and recreation.

I do want you to know, though, that we are always looking for ways to improve the balance of administration to program spending. Over the last two years we have reduced our administrative spending by 0.3 per cent from 1.9 per cent in 2011-12 to 1.6 per cent in 2013-14. This translates into almost \$10 million.

We have achieved this by reducing 50 full-time equivalent positions in the department, we've cut back on travel, meeting expenses, and cut down on professional services budgets. We will continue to examine every position, and keep an eye to ensure that we are continuing to keep our administrative costs in check. This is our responsibility and we do take it very seriously.

We know that Nova Scotians want to know their health care system is high quality, it is consistent care, and they want to know that we are keeping our eye on the system to ensure it works well and to improve the access to quality services. We work every day at the Department of Health and Wellness to carry out the mandate I described earlier, and I'd be very happy to take questions. Thank you.

MR. CHAIRMAN: Thank you, Ms. Martin. We'll begin with the PC caucus and Mr. Porter for 20 minutes.

MR. CHUCK PORTER: Thank you, Mr. Chairman, and thank you all for being here this morning. I look forward to asking a few questions. We all know that this particular department probably affects every Nova Scotian at some point. It's obviously the

largest, it's the most costly, and it's always interesting to have you before us to talk about a few of the issues and the costs that go along with that, and people are interested in it.

I'm going to jump around a little bit as there are a number of topics I want to cover. I want to go to something that you've taken the time to mention in your opening comments this morning, which was how you manage issues that might occur by way of safety or adverse effects and such like that.

I'm sure you all heard much last week with all of the nurses and others who were in who talked quite a bit. I sat through Law Amendments Committee for quite some time and I listened to a number of new, six months to a couple of years, to ladies and men who have been working in this profession for 30-plus years talking about some of these adverse effects that take place, whether they are mistakes by way of medication or other things. That was quite concerning to me, as a long-time health care professional myself who would spend many hours in an ambulance - along with my friend, the member for Sackville-Cobequid here, we worked together at one point in time years ago.

This is a job where you're not 75 per cent, you don't write an exam here and pass at 75 per cent or you don't do your job at 75 per cent or 50 per cent or 90 per cent, you need to be accurate. If you're drawing a drug up and you're going to give it through someone's IV, or whatever you're going to do, whatever that treatment is that you are going to provide, or whether you are just physically caring for somebody or their family member, that is still required at 100 per cent - at least in my opinion as someone who has been there.

I'm really concerned about what I heard last week, I really and truly am. I wonder, one of the things that concerned me more than anything was the fact that it seems as though there was only a small percentage of these adverse effects, if you will, reported. I want to know - how are you tracking that? Do you really know what the number is? I've seen something written, I think as recently as yesterday, somewhere around 40,000 annually - is that just a Capital Health number? Is that a provincial number? How did we arrive at that number and is that really a true number? I think people are interested in knowing that.

I've had a lot of calls I should say, too, and I have questions to ask later on of the minister as well about this, because of course families will report to us, as critics obviously, and as members, to say, look, this has happened and we're not happy, how could this possibly be?

We'll deal with that after, but I'm curious, as a department, someone who is in your role, how are you monitoring, measuring - can you give us what we think is an accurate number? I know there's a bit in there, so take your time, please, to answer that.

MS. MARTIN: I'd be very happy to address that question. There's no question that quality is front and centre in terms of much of the work we do at the department. It is a central part of the discussion when we meet with the districts on an ongoing basis, whether

that's me meeting with the CEOs of the district health authorities or whether that's our staff who are working with our partners in the long-term care sector. It is fair to say that the quality of care is something that is pervasive in the work we do, whether it be in establishing priorities around leadership, whether it's putting systems in place to ensure that we do have that good reporting and the proper standards in place, as well as ensuring that the staff that are delivering front-line care are engaged in discussions on quality of care and safety to ensure that our patients get the benefit of the best opportunity for quality care.

Just to describe in round terms - because really, this is a very large body of work - but maybe what I'll do in addressing your question is just give you a few key points on some of the work that is underway.

In Nova Scotia we have a council in place. It's a Quality and Patient Safety council. It was chaired by Dr. Pat Croskerry. He was the initial chairman of this council, and Dr. Croskerry is recognized as a national expert in quality and patient safety. It started under his leadership, and it continues today and meets on a regular basis.

The current chairman is Dr. Peter Vaughan, who is the CEO of the South Shore District Health Authority. Peter Vaughan has worked at the national level in many capacities. Just to give you one example, he is the former head of Accreditation Canada, which is the organization that oversees quality, establishing standards and auditing for quality in many of the facilities throughout Canada. So the work continues under him in terms of identifying priorities to ensure that all care providers have the proper direction and system of support in place to ensure that they can provide quality care.

In your question you did reference the adverse events reporting. That is a policy that the department developed in partnership with the district health authorities and others, and with the input and guidance of people across the system, as well as nationally, in terms of what is the best standard to put in place, in terms of ensuring that we have what we refer to as "sentinel events" reported to the Department of Health and Wellness.

One of the points that I would like to make in terms of the development of that policy and the conversation that occurs around it is that we know at the end of the day what is going to serve as well is to ensure that we have a culture of safety. So it's not just the leadership and not just the management. Everyone in the organization knows that quality is important. We want to be careful as we go forward that we don't establish a blame-and-shame dynamic around quality. We do want people to be comfortable, to come forward when they see a concern, to know who they can report it to, and to know that they will in fact be rewarded for making sure that we are aware of these events.

Just to give you a brief overview, we do have a standard set of directions for the district health authorities to report to the department on what key events we need to know about. Through reporting to us, we are then able to take the experience of that one facility, or that one district, and examine it carefully and say, are there lessons learned in this event

that we should be looking at across the system to ensure that we're improving quality for all?

That is one aspect of it. There are many, many other aspects that I could detail, right through to our information systems. For example, we are developing a drug information system. That would be another instance where in about a year's time we'll have a fully functioning system that would give many of the care providers, physicians, nurse practitioners, and others the ability to look at an individual's full drug profile, have flags in there for allergies, have flags in there for drug interactions, and so on. So I just throw that out as one example. We do have a great variety of work that's happening on the quality front.

MR. PORTER: I guess it's interesting because we've heard from a lot of staff that did appear before us how this was happening, and people are only human, you're tired, it's a 12-hour day you're dealing with and, if you are short-staffed, you're obviously dealing with many patients in the run of a day. It's certainly a different scenario than it was for us, we would treat our patient and drop them at the hospital, perhaps never to see them again unless in the case of a future transfer or something like that, whereas the folks working in the hospitals are dealing with them all day, every day, numerous events going on. I can certainly understand how mistakes and errors can happen, that's just, I think human nature is part of that and you have to expect it.

At the same time I think we have to look at that and go, okay, if we have a certain number of something happening, obviously there's a true problem here that exists. I would think the department looks at that and then says we know this is ongoing or there has to be an immediate kind of fix here - for lack of a better term. How are we addressing that and how long does it go on? Is it a year's worth of reporting before we look at that number and say now we have to create some action to resolve it or is it a month, a week, six weeks? What is that process if there's an ongoing issue? I'm not talking about a staffer of any kind or disciplinary - I'm looking at resolving the issues around patient safety. Your words were "culture of patient safety," which couldn't be any better - I agree with that 100 per cent. I think that's a great policy to have in place, and certainly the right direction when it comes to looking after all Nova Scotians.

That's an easy term to say, but how do you maintain, more importantly how do you get there, but how do you maintain that and what is that work-around, if you will, and the measurement tool? How long are you measuring before you're acting I guess is really what I'm coming down to here?

MS. MARTIN: Just to address your piece around the reporting. We do now have a standardized approach to reporting - we do get immediate reporting from the district, and our staff when we receive those reports, we immediately investigate. I think it's fair to say that we do take sort of immediate action to ensure that we understand fully the event that occurred. We engage in discussions with experts on that particular event, whatever it may

be, and then we make decisions in terms of does that mean we do some initial training, do we make some immediate changes?

We've had events that have occurred, for example, we will just issue an immediate directive that we would ask all districts to pay extra attention and report back in certain areas if we have an immediate concern. When the reports come in, they don't lie latent, we act on them immediately.

MR. PORTER: One of the issues I always found with district health authorities was there were different policies, different ideas, different ways of managing them - whether it was equipment or what have you, and procurement, there were a variety of differences and never quite understanding that, given where we are now in the ambulance service, if you will. It doesn't matter if you get an ambulance in Yarmouth or in Sydney, you are getting in the same style of unit with the cabinet with the same equipment in the same place. It's very easy to standardize something such as that. It took a couple of years, but we got there and we do it well as we know - we're certainly world-renowned in what we do in this province by way of emergency health care.

You talk about your standardized policy, is that the same within all district health authorities, or is this a - it's not a fair question to say is this a Capital issue, I don't believe it is, I think it probably happens across the board, but is your standardized reporting the same process across the board?

MS. MARTIN: That is correct and that is a measure that we implemented just a few months ago, and so it is the same for every district health authority now. Yes, that is the step that we've taken to ensure that it is the same for all in terms of the requirements to report, how they report, that's correct.

MR. PORTER: I quoted a number a few minutes ago, I think it was 40,000 - and I don't have that document in front of me, but I did read in recent days there were around 40,000 errors. I don't know if that number is accurate or not; I guess you would know best. What have you received in a year, any year for that matter, which would be an accurate number to reflect what we're dealing with?

MS. MARTIN: I'm not really familiar with the source of the 40,000, but I'll certainly follow up and find out the source. I guess the point is that we have just recently implemented the new system so that has really put everybody on a level playing field in terms of - there are events large and small. Some of the smaller events are ones that a unit manager or a given facility can take on and address, but what we are focused on at the Department of Health and Wellness is ensuring that it's the key events that we need to make a system-wide, provincial direction in and that could be, ultimately, a change in regulation, or it could be a change in policy, or it could just simply be issuing a directive to the districts to change some of their practices.

That is strictly around reporting, but I guess I go back to - there are a great variety of measures in place to focus on quality. I mentioned earlier Accreditation Canada. That is a national body that searches the globe in terms of what is the best practice, what is the safest practice. All of our district health authorities participate in that accreditation program. You would have seen the reports in the media; Capital Health recently has gone through their accreditation.

I do know that staff work very hard and take it very seriously in terms of ensuring that they do well in these reviews. That is just one measure in addition to the reporting that is in place to ensure that safety is first and foremost.

MR. PORTER: I want to add that - knowing a little something about accreditation, having been through both in the street and as well in communications where I worked as well, it is the staff who make or break that opportunity to be accredited. The credit does, indeed, go to them. It is they who are accredited, who are doing the hard work, and who do care out there, and we understand that. There is never a doubt there.

I quoted that number a few minutes ago, around 40,000. Again, I don't know whether it is accurate or not. I just want to go back to something you said a moment ago. You just began a reporting structure or standard within the last few months so would it be safe to assume then that there is no real accountable number, if you will, going backwards, that we really don't know what those might be? Until you began this structured or standardized reporting, you really didn't know, in previous years, what the numbers might truly be?

MS. MARTIN: We do know that facility by facility they would have systems in place, absolutely. There are aspects of quality that we have been monitoring for some time. As I mentioned in some of my earlier comments, quality really goes broad and deep in terms of the health care system and so when we refer to the new policy that's in place, that doesn't mean that we don't have additional data that may be housed in the district, but the measure that we've taken is to have one step forward for the province where we have consistency in terms of what's being reported.

For example, you referred to the ambulance service. We know that they keep metrics. We look at those metrics in concert with the management of that service and we also know that they have very regular training for their staff where if some event has occurred or a near event, they will make that a priority in their regular and ongoing training for their staff so that's an important feature.

MR. PORTER: I did want to go there. It's that example yet again, knowing, as a former paramedic, every so often there were upgrades, there were standards that you had to meet and you had to retrain and go through to ensure that you were keeping your skills, which is all very good. I mean, that really makes the system what it is. I think back, my wife was a nurse, my sister, my nieces. I never asked them the question, perhaps I should,

whether paying their dues annually or something to register, I'm not sure that there are a whole lot of those kinds of repeating your skills to - like we do as paramedics, you know what I mean? Is that something that's in place that I'm just not aware of? How do we manage that?

And the other piece - I know I'm running out of time; I think I'm down to 30 seconds - so maybe I'll just finish with, I'm going to also assume - I think about home in the Hants community, and Sherry Parker, who is the nurse manager there - I guess that would be her title; maybe it's a different title now - but she would then, going back to those issues, probably deal with them at a local level then and keep the statistics on those, and how many and what was done by way of a regional or more local-type process. Is that accurate, if I understood you correctly?

MS. MARTIN: Yes. Just a few points on that I want to draw attention to - for example, our ER standards. Again, these are newly-developed standards. Nova Scotia is one of the few jurisdictions to be establishing those standards, and we are working with our partners in the system to put those standards in place. An important part of those standards is training for all of these . . .

MR. CHAIRMAN: Order, please. I do apologize, but we've run out of time for you to continue your response.

MR. PORTER: Thank you very much. We'll come back to it.

MR. CHAIRMAN: We'll now move to the NDP caucus and Mr. Wilson.

HON. DAVID WILSON: Thank you, Mr. Chairman, and I want to welcome our guests, Ms. Martin, Ms. English, and Mr. Elliott, for being here with us. It's great to see you again. We know over the last number of years the debate and the discussions around administration costs in every department - but especially Health and Wellness. We know and realize the importance of ensuring that we're funding front-line services, that we don't see an increase in health and administration costs as we continue, as the government continues to implement programs and support those programs. I don't believe that until you actually sit in the seat of the Health and Wellness Minister, as my colleague and I have done, you fully get an understanding and appreciation of the work that you and your colleagues do.

We know first-hand that when there is an emergency, when there is chaos, when something is wrong in Health and Wellness, it ends up in the minister's office, and the minister and his or her staff deal with it. There are a lot of people who want to take credit when things are going well, but we know that's the reality. That's the job, and that's fine.

What I'd like to do is just run down some of the costs. This Public Accounts Committee looks at past expenditures of the government, and that's what some of my

questions will relate to over the next little bit that we have time to ask questions. We know that in the last number of years health administration and reducing it has been important. I believe, and I've gone on many times, I've talked about this, go to third-party resources like CIHI that keep track of charts and costs right across our country. If I look at the more recent CIHI charts on health administration costs - it goes back to, I believe, 2008-09 - that's the last one I pulled off, and we noticed that at that time Nova Scotia had one of the highest health administration costs in the country. I think Nunavut and Yukon had higher than us, which is quite evident because of the sheer mass and the location of those two territories.

I know that under the former government the initiative was to try to get those costs down. We've seen - and I would hope you would agree - a significant effort on reducing those costs and trying to improve the balance between health administration costs and services costs.

So my first quick question is - and I know all three of you have been around for a number of years - has it been a priority for the department to lower health administration costs over the last, I'll say, five years in the Department of Health and Wellness?

MS. MARTIN: I would say absolutely it has been a priority, and continues to be a priority. There is no question that we recognize that in Nova Scotia we have a growing burden of illness, and in order to address that, we need to ensure that to the greatest extent possible the budgets of the Department of Health and Wellness are going for direct front-line care for Nova Scotians, whether that be drug care, nursing care, long-term care, home care and so on.

You may well be aware, if you've looked at some of the CIHI data, that some of the numbers, for example, going back to 2007-08 and looking forward to some of the more recently published numbers, 2011-12 fiscal years, that Nova Scotia ought to be proud that we've gone from about 6 per cent administrative costs to 4.8 per cent administrative costs. That means that we are running more efficient systems, continuing to provide the leadership, but at a reduced cost so that we can increasingly put our share into front-line quality care.

It is first and foremost in terms of our annual budgeting processes at the Department of Health and Wellness, and we have worked hard, as I indicated in my opening comments, to reduce meeting costs, to reduce travel, to reduce the number of staff, recognizing that there is a lower point beyond which we have to be careful not to pass.

MR. WILSON: That has resulted in - I think figures that I've had in the past are upwards about \$20 million in savings. Those percentages, even though they may seem small to the general public, when you are dealing with \$3.9, \$4.1 billion budget, those figures are significant. Thank you for confirming that because I know there has been a lot of hard work over the last number of years to reduce health care administration costs. At

the same time, the most important thing along that journey the department has gone over the last number of years is to ensure that health care services are continuing to be supported and chaos doesn't occur when - you just mentioned it - if you fall below that line of how much and how many health administrators we need in the province to make sure we can support the services.

Within the same data that we just spoke about, we recognize and we've seen that jurisdictions across the country that have chosen to amalgamate health boards - that's where I'm going to now - that we've seen an increase in health administration costs. I've been at the table with other Health Ministers who have gone through amalgamation and the creation of a superboard who have advised me that it is not a great avenue to go down because it costs more at times. The most important thing that I took from the discussions I had with those ministers was that it created some chaos within the health care sector because of the time and energy that it takes to amalgamate these boards.

I've said this publicly before, for many years I was very supportive of reducing the number of district health authorities until I got the facts in front of me, until I realized that it can create chaos within the health care sector. We've seen an increase in Alberta, for example, of their health administration costs, after creating a superboard. We've seen an increase in health administration costs in New Brunswick after creating two boards there to deal with, I think French health services and English health services.

You have mentioned in your opening statement that over the last little while there was a reduction of, I think you said maybe 50 staff over the last couple of years, and I know how hard each and every staff within the department works and the areas that they work in. We know with the new government, their initiative has been out there for a number of years, is to create a superboard within our system. First question is, how many of your staff are designated now to work on implementing the amalgamation or restructuring of the district health boards that I think the minister said he wants in place by January 2015? Do you have a number of staff in your department who are working directly on that restructuring?

MS. MARTIN: Actually the date that the minister would have referred to is April 1, 2015, to have the board fully in place.

First, to address the experience from other jurisdictions - one of the advantages of not being a front-runner in this arena, but going in terms of looking at this now at this stage in Nova Scotia is that we do have the absolute benefit of the experience from the other jurisdictions. We have certainly been in touch with the jurisdictions that do have the experience and have gone before us, and they have been very forthcoming in providing advice in terms of what worked well and, if they were to do it again, what they would do differently, and so that's some of the important sharing.

We also do have some people in this jurisdiction who would have actually worked in some of those other provinces, and we've certainly benefited from their advice and insights in terms of what has worked well.

We do know that in terms of costs, in terms of bringing nine organizations into one that absolutely there will be some one-time costs, but the question really is, what is the trend over the longer term? The other important element is that this is not a race to see how fast we can do it. We do need to make this change on a timely basis, but in touring the province with the minister - we are most of the way through that tour, we've been able to go to all of the districts except Capital Health and the IWK. Noting how snowy it was this winter, I think that is quite an achievement in terms of covering the province.

The important direction that we've laid down in terms of working with the district health authority, and all the various important partners like the community health boards and so on, is to ensure that we hear their concerns, that we weigh their concerns in terms of our go-forward in bringing these nine districts into one - so just to remind that we are still in the consultation phase of this effort.

We do have a core staff that do meet on this issue and are supporting us through the tour and are anticipating some of the next steps. When we enter into the next phase of course we'll no doubt add to that complement because we'll be getting into the detailed work.

MR. DAVID WILSON: I know that if you do have a core staff - I know you didn't give me a number - but from my experiences over the last number of years, any time you start up an initiative, it takes away from another initiative. You mentioned in your opening comments that we have a number of important initiatives that the department has been working on in the last couple of years, so how are you going to manage not allowing these core staff, who are working on important projects, a reduction in their time and energy in ensuring these programs are continuing to move forward?

This isn't any small task - and I thank you for the correction, I do remember saying April 1st; January 1st popped into my head - that's going to happen quickly. I know that there is going to be a lot of energy and time put into the restructuring here, so how can you guarantee that these other programs aren't going to suffer when so much of your time - and the minister's time, and the core staff's time - is going to be on the restructuring of the district health authorities?

MS. MARTIN: That's really a matter of priority and that is a matter of managing in terms of ensuring that staff is aware. In an organization as large as the Department of Health and Wellness, there are always projects that are coming to a close, as other projects are starting to ramp up. We fairly regularly reassign priorities to staff. That is a pretty typical management function in the day or year of the Department of Health and Wellness.

We recognize this is an important change for the province. We feel we are at a time in the history of Nova Scotia that this is an appropriate change, so we will ensure it gets the dedicated resourcing that it requires and, at the same time, be able to carry out some of the other important priorities that are still on the books for the department.

MR. DAVID WILSON: Of course that's exactly how the department works, they prioritize what's in front of them and you start listing off and trying to accomplish as many as you can. Have you been advised by the minister that this is a top priority for the next year, to amalgamate the district health authorities?

MS. MARTIN: Yes, I think it's fair to say that the minister has this as a top priority. Certainly he has been quite public, as well, that he has a number of priorities. One of them is bringing together the districts and consolidating them. I guess what is really important, beyond the administrative piece, is just understanding why consolidate the districts. At the end of the day it is about providing better quality care, front-line care. In addition to this important and significant piece is then ensuring that we also are looking at our wait times for surgery, hip and knee specifically, as well as doing a refresh on the Continuing Care Strategy because we know we have a growing number of seniors in this province who do need assistance and we have a strategy that is now approximately nine years old and in need of refreshing.

All of those priorities, when you bundle them together, are really looking at how we provide better front-line care that is more timely and pays attention to those wait times, with an administrative structure that is the most appropriate structure to ensure that those services are available.

MR. DAVID WILSON: That's the challenge that is before you. It is great that you are having discussions with other jurisdictions but I know, not only from staff who work within the Departments of Health across the country and the ministers themselves who have indicated that it wasn't an easy task to get to where they're at today. I still don't think many of the jurisdictions are seeing the savings that were anticipated.

I feel, and I believe in your comments when I initially started, that the approach over the last four years was working well. It didn't place the top priority in the Department of Health and Wellness on going towards restructuring but all the other avenues and services that need work and need a lot of attention, that's our fear, that we will see time and energy spent on a process that over the last four year, five years, we've been getting good results from.

You indicated there is a one-time cost. That was what really stood out for me, especially with the Alberta example, the sheer cost. The Minister of Health and Wellness hasn't said what the cost will be. The Minister of Finance recently has indicated that there will be.

I've looked through the budget. I know this isn't Budget Estimates, we'll get to that maybe on Thursday. What is the anticipated cost? I mean there has to be something down on paper because I've seen it right after the election, before I left office, that there was some work being done. What is the anticipated cost of this restructuring?

MS. MARTIN: I think what's important here is to recognize that the phase that we're in, we are going out to every district. When we go out to the districts we're meeting with the boards, we're meeting with the CEO and their senior management, we're meeting with a great variety of front-line staff including union leaders, community health boards, people who are running long-term care facilities, and people who are operating home care agencies - and I may well have left some out but that's generally who we're going out and meeting.

What's really important in this instance is the commitment to really ensure that we are getting the best advice and hearing the opportunities and concerns from people who are, day-to-day, either leading the system or providing front-line care, or volunteering and working with communities, and so we haven't finished that phase yet. We do know though that this is a province that, for example, has made significant investments in some of its IT systems, notably its finance system and so on.

When we've met with these districts, and of course we know that right now between districts they share in some of the senior leadership positions and continue to look for opportunities in terms of where they can share a senior person, be it a director or VP of corporate services or finance . . .

MR. CHAIRMAN: Order, please. I do apologize, but we've run out of time again. We will now move to the Liberal caucus and Mr. Irving.

MR. KEITH IRVING: Thank you, Mr. Chairman, and thank you, Ms. Martin, and your colleagues for all of your work and your presentation today - obviously health is a huge part of our tax dollar and I appreciate all the work that you do.

I have somewhat of a specific question to start off with. I was recently visited in my office by a doctor and nurse who were proposing an idea on a fracture monitoring program, which would prevent hip fractures - basically the premise being that you can identify - there are indicators such as a broken wrist that can identify people with bone density problems and receive treatment before they go on and have a broken hip, which is a huge cost of \$20,000 to \$44,000 per hip replacement.

They had considerable evidence that they presented in terms of the significant cost savings that this could lead to in our health care system. So my question is this, how do new ideas like this, which appear to have some merit to me as a layperson, find their way into the health care system, receive consideration, and possibly be implemented?

MS. MARTIN: Thank you for that piece. It is an interesting one and it's one that when I was in Antigonish recently I had received information on this, and you are correct, certainly for some of our seniors, notably our frail seniors, there is a sort of known connection between the initial slip and fall that may result in a fractured wrist, a broken wrist, and then sort of a pattern in terms of sometimes that follows through in terms of a hip fracture. Of course, given that this is happening to frail seniors it does have, certainly, consequence in terms of how they can then later recover and the length of time it takes to recover.

We are doing some work in the department in terms of identifying matters related to slips and falls and bone density and so on, so I'm going to ask my colleague, Paula English, to address some of the detail that would be helpful in addressing your question.

MR. CHAIRMAN: Ms. English.

MS. PAULA ENGLISH: Thank you. One of the areas that we've been working on at the department for the last couple of years is setting targets for chronic disease management, and one of the areas that came to the fore as we worked with experts were some targets around osteoarthritis and working in that way. The Fracture Liaison Clinic was identified as one of those ways where intervention can have benefit in the end.

As we do our budgeting, what we are looking at are ways to, as you speak to, fund innovative new programming that is cutting edge and that keeps us moving forward in a way to be able to achieve positive outcomes. There are some years that were able to move forward, for example, as we look at the wait times for hip and knee replacements, there's a whole quality program that's going to be initiated in looking at hips and knees and how to start to reduce some of those wait times. It's not all about doing new surgeries; it's also about looking at quality pieces that come in as well.

We will continue to work with the rheumatology community. They have been working with us on our committees, working in a positive way and we'll continue to look for ways to identify funding opportunities for those new things. The challenge, of course, as we fund new things, is what is it that you don't do so that you're able to be able to keep funding within a reasonable level of increase. We continue to work with that community to find ways to move forward.

MR. IRVING: Just before I turn it over to my colleague, I guess the root of my question is, is there a system that allows these ideas to percolate up from the front lines as opposed to needing to come to an MLA's office to get these ideas in the system?

I know it's a very complicated system and there are probably more ideas than you can deal with but I'm thinking in terms of the Premier creating a Premier's suggestion box which allows the Public Service to bring forward interesting and innovative ideas. Is there

something in the health care system that is there now or could be there that would allow this to be facilitated?

MS. ENGLISH: Sure, there are a couple of ways. One is that, for example, within the business planning cycle, district health authorities bring forward ideas for new and expanded programs and so those new and expanded programs make their way to us in that way. We also have a Chronic Disease Management and Advisory Committee and that group also brings forward initiatives and ideas to be able to address chronic disease as an example. Within our quality council they also make recommendations to the deputy on initiatives that will make a difference in the end.

Then, as you are probably aware, there are vendors, there are lots of people who come forward to say there's a new and bright idea. I've just been at a national conference that talked about assessing these new ideas and what it is that the assessment needs to go forward to make sure that things that are coming forward are backed by evidence and bring value to the health care system and to patients. Making sure we have that ability to be able to assess the ideas as they come forward is an important one, as well, what is the opportunity within the envelope that we have to be able to fund these ideas coming forward? It is a challenge to balance that and to ensure that innovation is supported and funded into the future.

MR. CHAIRMAN: Mr. Stroink.

MR. JOACHIM STROINK: My question today is, we are hearing a lot of health practitioners indicating that processes and paperwork have been duplicated from computer and then they have to go down to handwritten so there seems to be a lot of redundancy and with this there seems to be a huge cost associated with this, not just in dollars but in time. Is anything being done to streamline the processes to improve efficiency? If we improve efficiency then we improve costs, we improve time and all that kind of stuff.

MS. MARTIN: Yes, there has been a fair amount of dialogue as of late in terms of health care providers and the time that they spend documenting. What is implied is certainly in terms of the impact that has in terms of the time available for patient care. I'd say it's fair to say we are putting a considerable amount of effort into the development of information management systems.

We're at the early stages of looking at replacing some of our older systems, rolling out some of our newer systems like, for example, the drug information system that I mentioned earlier. What underlies a lot of that is ensuring that, rather than putting in some information - because we do know we have some disconnected systems, and what happens from time to time is that as a patient moves from one area of the health system to the other, that time is spent in putting in some of that basic information time and time again.

As our systems are developed, what we work on is ensuring that information is entered only once, but the information is available to be used many times.

I guess I'd just make a minor point, though, in terms of some of that documentation. Again, we need to have the right balance points, in terms of time that is spent documenting, as opposed to patient care. Documentation is an important part of the quality aspect of the system, that when procedures are provided and when care is provided, that becomes part of the patient record.

I do acknowledge that in terms of our efforts, we need to continue to ensure that we have the information entered once and used many times. That's an important feature that drives much of the systems that we're developing.

MR. STROINK: Thank you.

MR. CHAIRMAN: Thank you, Mr. Stroink. Mr. Horne.

MR. BILL HORNE: Thank you for coming today. I think it's wonderful you are here. It's a big operation to try to really get under control. I'm just wondering, administrative costs compared to your program costs, I note that it has been coming down. I'm just wondering how that compares nationally or with other provinces. Do you have any comments on that?

MS. MARTIN: In my opening comments that's where we indicated it is sometimes a little difficult, especially where we have the funding for the long-term care sector, and we know in other jurisdictions that's not with the provincial Department of Health and Wellness. Similarly, sport and recreation is not necessarily always held with the Department of Health and Wellness.

In answer to one of the questions earlier, it's best that the CIHI - the Canadian Institute for Health Information - which is a nationally recognized organization that is very experienced and skilled with looking at information and comparing provinces, we compared to sort of the middle of the pack - just looking at 2011-12, compared to the other jurisdictions, we're at 4.8 per cent. The Territories, understandably, are a little higher. Some of the other bigger provinces tend to be a little lower, like B.C., for example; Ontario tends to be a little lower, simply because they have the population and benefit of the volume effect, so to speak.

Nova Scotia is the Atlantic centre for a number of services. The IWK is the Atlantic centre for many procedures for children, and in the Capital District we have a number of services that we know Atlantic Canadians rely upon. Some of those are cardiac procedures, some of them relate to organ transplants and so on, so understandably we may be running a little bit higher than New Brunswick, but it's really reflective of the type of service we're providing in the Atlantic centre.

MR. HORNE: I noticed in the report that there are a lot of reductions because of vacancies and so on. Are those going to have problems in the future with not being able to complete programs or have new programs?

MS. MARTIN: We're quite confident in terms of the priorities that we've taken on that we have the capacity to deliver on them. In some instances in terms of some of vacancies, there are a number of instances where we have combined management functions and so what we have are the staff of those units who are still in place and are able to carry out the important work for the department.

MR. HORNE: Thank you. One quick one you might be able to answer quickly is on diabetes and the new program that the department has taken over in supplying pumps for type 1, and I'm just wondering if you can give me a general idea, are these pumps costing the patients or are they free?

MS. MARTIN: I'll address part of that answer and maybe my colleagues can supply some additional detail. What's important about that program, of course, is that in terms of the insulin pumps it is really under a physician's determination as to whether or not that is inappropriate for a patient. In other words, pumps are a tremendous assist for the patients that a physician considers that as a useful adjunct to their course of treatment but, of course, it's not something that will necessarily assist every diabetic, so we rely upon physicians' input to make that determination.

This insulin pump is administered, similarly to our drug plans, in that there is a portion of it that is co-pay by the patient themselves but then there is also a portion that is paid by the province. In terms of who we see at least forecast for 2013-14 - granted some of this is a projection - but we have approximately 80 people in Nova Scotia who are benefiting from this program at the cost of what we're projecting about \$350,000. That is the contribution of the province to this important new program.

MR. HORNE: I know in the past a number of community groups have raised money towards pumps. They give them to the hospital, or at least the money portion, and the person that gets it generally wouldn't be paying for those pumps. Is that a bit of a change even though the doctors have given the okay to give the pumps to the patients?

MS. MARTIN: In terms of the community that provides that valuable contribution, that may be happening in certain parts of the province but not throughout the province, is my understanding. What we have is an opportunity for all Nova Scotians to be able to participate in this program, where the province is able to provide a significant financial contribution to their care.

MR. HORNE: Thank you.

MR. CHAIRMAN: Thank you Mr. Horne. Ms. Lohnes-Croft, you have just about three minutes.

MS. SUZANNE LOHNES-CROFT: Three minutes, okay. I'd just like to continue and welcome this morning, and I'd like to just go further with the insulin pump program, which has really changed the lives of diabetics. One of the concerns I have heard is that people have had problems accessing the application process. Could you explain, has that been rectified and what is the application process for getting into this program?

MS. MARTIN: Just to give you the immediate, they certainly can call the department. We have a front desk number that will ensure that anyone who wants additional information on the program can call our front desk. Also, if people are looking for information they may be more familiar with how to contact the district health authority that they live within. They can certainly call that number so that's sort of the general number.

Certainly I will take your point back to the department when I return and make sure that I have a conversation with the people who are close to this program, to find out what they may be hearing and see what we can do to make it that much easier.

MS. LOHNES-CROFT: Many have been told to look for the application online and haven't been able to find it. I think that has been a real concern.

MS. MARTIN: We'll definitely take that back, yes, for sure. Thank you for that, I appreciate it.

MR. CHAIRMAN: Okay, I guess that concludes the round for the Liberal caucus. We'll now move back to the PC caucus with Mr. Porter.

MR. PORTER: Thank you, Mr. Chairman. We have 10 minutes, is that correct?

MR. CHAIRMAN: You actually have 14 minutes.

MR. PORTER: Oh, even better, great. That will go by just as quickly anyway. I want to pick up on the restructuring a little bit for the district health authorities. There has been a figure in the budget, \$275 million approximately, for restructuring. How much of that is allocated to this health board amalgamation, if you will?

MS. MARTIN: That number you are referring to is in the Department of Finance's budget so I really don't have the detail on that piece. What I would say, though, is that we are in the first phase of bringing the nine districts into one so we are really not at the stage where we have done or, in fact, are in a position to do any of the detailed costing for the restructuring. That's detail that will have to be developed over time.

MR. PORTER: So are you saying then that money that has been set aside in the Department of Finance budget is just a guesstimate? I hate to use that word but I'll use it for lack of a better one. Nobody has costed out what this is going to be then, is that what you're saying?

MS. MARTIN: Well, in order to get into the detail, we have some additional design work to do in terms of what that management structure will look like when we bring nine districts into one. In our approach on this piece we are taking the time to ensure that we are speaking to everyone from board chairs to front-line workers and volunteers in the district. It's extremely important to hear what they see as important to this overall piece.

Even though we haven't completed the tour, certainly one thing we are hearing is that as we go forward into one provincial board that it's extremely important there be the proper kind of management in place at the local level, because people who are providing care need direction at the local level. Even though we're working in one system where we want to provide front-line care - timely, quality care - it is at the end of the day serving local populations and that needs to be taken into account, in terms of not only the type of care but how the care is delivered. We will have those more detailed numbers in time but we are at the very early stages.

MR. PORTER: If I'm not mistaken, the time frame for implementation is now less than a year away, is that correct?

MS. MARTIN: In terms of the full implementation of the new board it's April 1, 2015, so we do have a number of months that this work will be taking place.

MR. PORTER: I just made a note here. What you described by way of design work and taking the time, now within the year - a little less than a year that we have - is that adequate time to take and go through, or is that enough time? Also, it sounds like from what you're saying, by way of administrators, if you will, that there's no real number, we could have the exact same number of administrators we have today - that's what I took from what you said. I may have misread that, so please feel free to clarify that for us all. But that's what I took from what you said - we're going to go through this step and we may end up with the exact same number even though we may have one health board. If you want to take a couple of minutes to tell me about what this design looks like - there must be some idea at this point what we are, in fact, looking like - I'd appreciate that.

MS. MARTIN: Thank you for that clarifying question. Before I provide some additional detail in terms of what it would look like into the future, one of the points that I think is extremely important to be clear on is the direction, that we know when we have finished bringing the nine district health authorities into one, that we will have a leaner management structure than we do today.

We're not at the point where we can kind of put the exact detail on that, but our direction and commitment is extremely clear in terms of it will be a leaner structure than we have in place today. In fact, we know that on an ongoing basis, districts understanding that we are moving toward a consolidation, and I have to say that through the course of our tour we have had tremendous support and input from the board chairmen, the various boards and as well the CEOs and various others, in terms of understanding that this is a step that's necessary and important for Nova Scotia to take, and there is plenty of opportunity in terms of how we can provide better care.

Just to be clear, the structure into the future, it will mean that there will be more sharing across the current districts that are in place. Just to describe - there will be one board for the nine districts that are currently in place and then a board for the IWK. There will, however, be four zones, which are reminiscent of the zones that were in place in the 1990s, so fair to say that we want to take a very measured step in terms of figuring out exactly what sort of presence do we need to have from an administrative leadership level in those zones, so that they can ensure that they are providing the appropriate care at the local level, but doing that with the direction and benefit of one provincial board.

MR. PORTER: Time goes by quickly, and I have a couple of other things I want to get to - how many administrators are there right now in the health system in Nova Scotia?

MS. MARTIN: At the very senior level for all of the nine districts as well as the IWK, we have CEOs and we have vice-presidents who are responsible for a range of activities, from looking at the maintenance budgets in HR; leadership for the physician community; as well as leadership for the clinical and community programs. Our numbers indicate that as of April 1st of this year that is a total of 46.6 FTEs.

MR. PORTER: That's the total of administrators in the Department of Health and Wellness provincially?

MS. MARTIN: Sorry, that's for the district.

MR. PORTER: Can you just give me an overall number? Again, we're running close in time so just quickly if you can, the overall number of what is classified as FTE administrators?

MS. MARTIN: For the district or the department?

MR. PORTER: For the province; for the department.

MS. MARTIN: We can follow up with that detail; we don't have the exact numbers in front of us today.

MR. PORTER: Do you have a cost associated with what the administration is costing the department?

MS. MARTIN: That is the 1.6 per cent of our budget.

MR. PORTER: Sixty-two, was it, I saw in your notes?

MS. MARTIN: That's correct. That is the 1.6 per cent of our budget, \$62 million.

MR. PORTER: Can you please table the documentation that you have, based on the questions I just asked a few moments ago? That would be great.

Time does go by here quickly; I only have a few minutes left. I want to go to dialysis for a few minutes, if I can. The previous government made some changes, provincially, and certainly in the Valley there was a plan to put 12 beds, I believe, in Kentville. That caused Berwick to have them removed at some point and I had asked the minister in Question Period last Fall, again, as he came in as a new minister, whether some consideration could be given to that or reconsideration to that plan.

As you may be aware, I've been asking for a very long time about Hants Community Hospital and their geographical location and we serve a number of dialysis clients that do travel. Where are we with that plan, as far as Kentville goes? Is there any reconsideration being given to how that plan could potentially be laid out and opportunities to cover the entire Valley versus one spot and still people travelling?

MS. MARTIN: Just to quickly answer your question, in case I run out of time, we have ongoing discussions with the Valley in terms of that proposal. I am certainly quite aware that you have been key in raising our awareness in terms of the community and how they've been involved in fundraising in your local area. As well, the minister did make the commitment that we would review that piece and so we expect to have that review completed this summer.

MR. PORTER: Does that mean the previous plan that was put in place around Kentville, Valley Regional Hospital, with the implementation of 12 new beds, is that on hold or what is the status of that or is that moving along with the reconsideration? I don't really know how you would do both at the same time. You either have to stop and rethink the plan or you don't, so I'm just curious - has that stopped?

MS. MARTIN: No. I would describe the status as: it's under active discussion between the Department of Health and Wellness and the district.

MR. PORTER: But nothing has actually been physically started on that at all?

MS. MARTIN: No, that would be premature. We're still in discussions.

MR. PORTER: Can you tell me what the cost of that plan was for the 12 new beds and the elimination - again, clarify if I'm wrong on this, but I understood to be the elimination of Berwick and everything moving to Kentville - what is the cost of that, overall, do you know?

MS. MARTIN: While the discussions are ongoing, that is still under discussion in terms of what is - when we get to the stage where we have a final plan and agreement between the Department of Health and Wellness and the district, we'll be able to address that detail.

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

MR. CHAIRMAN: You have until 10:26 a.m., just shy of three minutes.

MR. PORTER: On that plan, part of what I had talked about to the minister and others was if Berwick is there, and it services a fair number as well, and Kentville has the room, Windsor has the room - I'll ask this question, is consideration being given to spreading out the wealth? I've heard every story there is to tell about this by way of why we can't and none of them, yet, have really been believable.

They say we have no staff. We know staff who are from the area who want to come back home and work, as an example. Would it not make more sense by way of treatment and ease and financial burden for everyone who is doing this - I have somewhere in the vicinity of 40 people who are travelling, some of them not easily. I guess my view was a little in Windsor, a little in Kentville, a little in Berwick and you've covered the entire Valley and you've eased the pain and the financial burden and the physical pain that goes along and stress for families all at one time.

It seems the physical resources are there, in our case. We have come up with our foundation, with finances to assist even in the capital purchasing. I'm sure the department has probably never had that offer before. This is a standing offer and still is there and still people are talking about this. It's probably fair to say it is not going away and I would ask your thoughts on that as well as is that part of the discussion, this kind of opportunity?

MS. MARTIN: A couple of aspects that are really quite important in terms of how we've done our planning is that when we've looked at the services that you know going back a few years when we first started doing this planning, one thing that was really important was looking at the driving distances and looking at how we ensure that we provide services within an hour's drive for patients, for the very reason that you just made: it's not only the patient who is under the stress and discomfort of having to travel back and forth for this significant service, but equally important for their family members or care providers. So that's one aspect of it.

The other aspect of it is that in terms of this service, like many others, it's not just simply the physical infrastructure - be it the chairs in this case, or whatever - it's ensuring that we have the proper medical oversight. We need to have nurses in place because of the quality of care, and while these procedures go well for many there is the odd occasion when a patient will be in distress and need immediate access to a physician and emergency care.

MR. PORTER: Thank you very much.

MR. CHAIRMAN: Order, excuse me - we will move on now to the NDP caucus for 14 minutes. Mr. Wilson.

MR. DAVID WILSON: Thank you, Mr. Chairman. Getting back to health administration and the superboard that we're going to have for our health authorities here in the province - our time is very limited so hopefully you will answer very quickly. Did the Liberal Party and the current Minister of Health and Wellness come with a plan about the restructuring of the district health authorities or did they just bring the concept and ask the department to find best practices to move forward?

MS. MARTIN: Great question, and it's one that the minister has addressed many times on the tour. Certainly in undertaking something like this, on the one hand we field questions in terms of why aren't you doing it faster; on the other hand it's, hey, you can't go forward so fast because you really haven't taken the time to ensure that you take people's views into account. I have to say that the minister is certainly demonstrating his commitment to ensure that he takes the appropriate time and takes the time to ensure that he hears from Nova Scotians across the province, detailed by all of the people, the hundreds of people that we've now spoken to and we certainly have some other people that we intend to speak to.

He has many times indicated that he was not undertaking this change by just simply tabling a plan and saying now the job is to move as quickly as possible to make that happen. He was certainly well aware that this is an important change, that these services are extremely important to Nova Scotians, and what is working well now across the province is something that we need to keep in place and, in fact, we have to do what we can to ensure that we strengthen those services. So to answer your question directly, we are deriving the important points through our consultation and, in fact, some of those key things will drive the ultimate design and detail.

MR. DAVID WILSON: Thank you. So what I take from that is there was no plan placed on your desk or the desk of any of the staff within the Department of Health and Wellness, which is interesting. I mean the Liberal Party has been advocating this initiative for a number of years and I know the commitment the department has that they started to work on the details the day after the election and hence the details of some of the figures that you provided to my colleague around the number of FTEs in the province.

I find it - well, I'm not surprised to hear the current government didn't bring a plan and, listen, we all understand you need to tailor it to the province, to our province. So out of the 46.6 FTEs that you mentioned, which were the CEOs and the VPs that are across the province, what dollar figure - each and every single one of them is under contract with the district health authority or the province. If the government was to get rid of every single one of them, what would be the dollar figure attached to, say, severance, as many of them, if not all - I think all of them are under contract. So if 46.6 of those CEOs and VPs were let go, no matter what the number is, what would be the number of severance that the province would be on the hook for?

MS. MARTIN: Some are under contract in that group and others aren't. Many are under contract, but some aren't, just on that point. I think one of the key points that the minister has made with every group that he has met with - and he certainly made it many times when he and I have spoken privately about this important undertaking - is the importance of wanting to take the time to work with the current leadership, which I would like to note in my answer that they have been tremendously supportive in undertaking this change. They recognize that there is a real opportunity and it is the right direction to go, so in my discussions with them, they have been working hard to ensure that they support us in this change and that's similar, as well, when the minister meets with the board chairs, as he does regularly, in terms of undergoing this change.

MR. DAVID WILSON: I don't mean to cut you off, Ms. Martin, but we're very limited on time. I understand the commitment from all of them, I appreciate it. The question was, is there a dollar figure? I know the gentleman next to you who deals with the figures of the Department of Health and Wellness that there would be a dollar figure attached to this. I know for a fact that there is. Can you provide me with the dollar figure - because many of them are under contract, if those under contract were let go, what would that cost be?

MS. MARTIN: Sure. To address your specific point, we have not calculated that because we intend to work with the leadership that is there. We do know that, like any other segment of our workforce, there are opportunities and decisions they make in terms of their careers, and we can anticipate that with that many people there are also opportunities to retire. Within that group, we know there are some licensed professionals - be they in nursing or physicians and so on - so the minister has said many times that we intend to work with the leadership that's there. They've worked hard day in, day out. They're committed to this change; therefore, we haven't pursued the angle that you're referring to.

MR. DAVID WILSON: You mentioned earlier about making sure that the same mistakes aren't made with other jurisdictions - we know the figures coming out of Alberta. I believe they put well over \$100 million in transitional funding to create a superboard and I think \$43 million of that went directly to severance. So we know that this is a significant cost and what the government will need to do is tell Nova Scotians that, yes, we may have spent tens of millions of dollars firing CEOs and VPs - where are the benefits in the end?

We know many of them are under contract and they're significant and it's going to be a significant cost to the province, which in my view and our Party's view is that's money that should be going to enhancing the Insulin Pump Program. That's money that should be going to reducing wait times across the province. That's why we supported the avenue forward of health administration costs, doing it in a responsible way.

I'm going to go back to a question I asked you before and hopefully it's really quick - it's quick, just give me the figure. You mentioned that you have a core group of people working on this within the department. Can you give me the number of senior staff that you have working on restructuring? Do you have a number or does it fluctuate?

MS. MARTIN: I'll give you a round-figure number. We have a small committee of seven or eight people that would be sort of core coming together on this matter. That's not their full-time job. Right now, at this stage, that's the appropriate dedication of time and staff from across the department to dedicate to this. That will change as we go closer into the next phase.

MR. DAVID WILSON: I'll hand my questions off to my colleague.

MR. CHAIRMAN: Ms. MacDonald.

HON. MAUREEN MACDONALD: Earlier, Ms. Martin, you indicated there are lessons that were learned from elsewhere. Quickly, what are those lessons? What worked well and what would they do differently? I know those are probably two big questions but it would be good to get a sense of what those lessons are that are going to be applied.

MS. MARTIN: Just very quickly, at least one of the key things coming back - and this is in reference to earlier, in terms of the speed at which we're going through this piece - is don't go too fast, take the time to ensure that you're studying it carefully and take the time to consult those who know best in the system.

I think in some of the other jurisdictions we've seen there were decisions that were made so it was a very rapid change, so that's certainly one of the lessons. Another piece that we've heard from the other jurisdictions - and it's a consistent theme that we're hearing here - is pay attention to the local level. The minister is very clear in terms of this change that this is not about consolidating services. We do have a regional centre in Halifax that can perform certain procedures but this is also about a strengthening of the services that are available all across the province, be they regional centres across the province or community hospitals or connections with the long-term care and so on. Those are, fairly quickly, two of the strong themes that we've heard from elsewhere and we're hearing similar things here as well.

MS. MACDONALD: Earlier you indicated there will be some one-time costs. Can you outline what those one-time costs will be?

MS. MARTIN: Just certainly a very high level. As organizations come together, and I'll just generalize in terms of organizational change, it's not necessarily unique to the health sector. The district is an employer so there are system changes that may be necessary, just from how offices function, potentially in terms of the financial system, some of the backbone computer systems that are now sort of running in terms of providing information separately to districts. When we pull that together as one, there may be some system costs there. That will have a more specific answer to it when we sit down and do some of the details over the summer and into the early Fall.

MS. MACDONALD: Knowing the work of people in the department, I find it hard to understand, I guess, because you're a fairly thorough group that springs into action pretty much immediately when an issue presents itself - in my experience, having started when H1N1 was going on in the province. So I find it hard to believe that you don't have any ballpark figure whatsoever about what this would cost. There must be a general amount of money.

Now, I don't know if you have been advised to stay away from saying any particular amount but realistically, a ballpark figure of what the costs will be for amalgamation of boards.

MS. MARTIN: No, we don't have the ballpark figure and that is consistent with the approach that we're taking. I appreciate your comment and I can appreciate what it was like coming into the department during H1N1, which was really a public health crisis, for lack of a better term.

MR. CHAIRMAN: Order. I do apologize; we've run out of time once again. We will now move to the Liberal caucus for 14 minutes and we will begin with Mr. Maguire.

MR. BRENDAN MAGUIRE: I'd like to thank you all for coming here today - I just had a quick question. You stated there is a core group of individuals working on the amalgamation of this board. With that group working on the board, is that having an adverse effect on other programs within the health care system; with them working on the amalgamation - as you stated - part time, is that taking away from other programs?

MS. MARTIN: No, I think it's fair to say that any time we assign duties in the department, which is a pretty fundamental managerial function, that we do it with an eye to who is best skilled, who has the capacity to take this piece on. We have very capable people in the department and I'll say as the acting deputy, over the last number of months, I'm very proud every time I have turned to staff and asked them for assistance on issues that are complex - there's a tremendous amount of detail and we need answers or direction on a fairly timely basis - that they've been available. It's through those skilled professionals that they are able to take on significant new priorities and at the same time ensure they are providing the direction to their staff to continue with some of the other important work, many of which are articulated in our business plan.

MR. MAGUIRE: So it's also safe to say that comparing Alberta to Nova Scotia - the economy, the health care system, and population - is like comparing apples to oranges.

The final question from me, and one of the big concerns for most Nova Scotians, is the aging population and the reduction of the transfer payments coming from the federal government, so our programs have to be leaner, especially on the administrative side, in order to continue to provide health care services, and to look forward to providing other programs to the people of Nova Scotia. I'm assuming, and tell me if I'm wrong, that this is a big concern for your department with the transfer payments being cut. So what is the department doing to prepare for this?

MS. MARTIN: If I can just take that question in terms of speaking to what we're doing at the national level. You would probably be well aware that under the Premier's direction, following the discussions on the health accord a couple of years ago, the Premiers convened and they identified some priorities for the provinces and the territories to participate in. Some of those priorities include looking at our expenditures on drugs, the pharmaceutical programs, how we could work as jurisdictions in a partnership where we could derive better value for the taxpayer dollar on the purchase of pharmaceuticals, which we know are important for Nova Scotians.

In that regard I'm very proud to say that our head of Pharmaceutical Services is a lead on that effort with one of the other provinces, and in recent announcements, we've actually been able to save \$6 million in this province through the result of some of her work and the partnership that's going on there. There are other areas where we're looking at some of the more clinical aspects in terms of preventing costs in the system, looking at working with our national partners on clinical standards for foot care, which is often a complication of those who are suffering from a chronic disease like diabetes.

So those are some of the efforts that we're working at the national level and bringing those savings back to Nova Scotians. Certainly on the drug piece, virtually every time the cash register rings some of those drugs that we've negotiated the price down are the ones that Nova Scotians are using the most, so that's having a very practical benefit for a lot of Nova Scotians.

At the provincial level I had mentioned earlier that in terms of the Department of Health and Wellness, we're looking at our administrative costs and bringing those down, be they meetings and travel and the number of staff that we have in the department. As well, when we look out to our partners, we have Doctors Nova Scotia that is looking at things. I know that it's really centred on patient care but it is about choosing wisely, so we're looking at all of our services to ensure that the care is there when people require it and that there's good guidance in terms of the standards in place, to ensure that there's the appropriate utilization of these services.

MR. MAGUIRE: Thank you very much.

MR. CHAIRMAN: Thank you, Mr. Maguire. We'll now move to Mr. Irving.

MR. IRVING: Thank you very much, Mr. Chairman. I just wanted to follow up on my colleague's question in terms of the demographic challenges that we face. I think you've addressed the question with respect to the impacts of the funding changes and the pressures that it's putting on our health care system. I just wondered if there was a correlation, as well, into the administrative costs of our province; in other words, is the aging demographic a driver for our administration costs, or is it really just the size of the organization that drives the administration costs? Does the burden of an aging population demand more resources in administration in this province than they would in other provinces?

MS. MARTIN: I would say no, that one is not connected to the other but yes, Nova Scotia does certainly have an aging population. We know that every month in this province there are about 1,000 people who turn age 65, and as they go beyond that age, certainly there's no question in terms of some of our correlation with the burden of illness, especially chronic disease, becomes part of that.

We then turn our attention to important efforts like refreshing the Continuing Care Strategy and are looking at increasing our efforts around improving the availability of home care support so that seniors, who we know primarily want to stay in their home as long as they possibly can, are afforded that opportunity.

I think it's fair to say that when we look out to the population we serve, as a department, we're increasingly looking at innovative ways to ensure that we're getting best value for our money to provide quality care and are working regularly to drive down the associated administrative costs.

MR. CHAIRMAN: Ms. Lohnes-Croft.

MS. LOHNES-CROFT: What is the current government doing to ensure that rural areas are provided with doctors? Could you talk about the recruitment process and retention strategies that are being worked out right now?

MS. MARTIN: Sure. We know that is an area that is extremely important all across the province and certainly, particularly for some of our rural areas that are in need of primary health care professionals. We have put in place a committee that is chaired by Dr. Celina White. Among other things, she was the former VP of Medicine in Cumberland District, which certainly is one of the rural parts of the province, so she would have very real experience in understanding what it takes to attract and retain physicians to those types of practices.

In addition to that, on the committee we have a Doctors Nova Scotia representative, and a representative from the College of Physicians and Surgeons which does many things,

including working with us in establishing programs where we can ensure that we're retaining a greater number of foreign-trained physicians since the college is involved in the licensing aspect. As well, on that committee we have a representative from the municipality and a citizen who has a long experience in volunteering because we know that in addition to attracting physicians, in addition to their connection to the other physicians and other health care providers that a welcoming community becomes really important in terms of not only the physician but their spouse, if they have them, and the rest of their family.

This committee is reviewing what we are currently supporting in terms of recruiting and retaining physicians, looking at what the districts are doing in terms of recruiting and retaining, and is asking what can we do additionally or what can we do better, are there other partners that we can work with to ensure that every community that needs a primary care physician has one and that our retention rates are higher? That work will take another few months to conclude, but we are very optimistic in terms of some of their recommendations that they'll come out with.

The other point that I would identify is that we've also over the past few years put a fair amount of effort into establishing collaborative practices in a variety of communities across the province. What we know in speaking especially to the younger graduates coming out of medical school is that they want to work in a collaborative practice, they want to have colleagues, and they want to have the electronic systems in place, the benefit of a nurse practitioner or maybe dieticians, depending upon the community need. We have certainly been involved in the construction of some of these centres and are involved in others. Having that style of practice is pretty fundamental to how physicians do their work these days, so that's certainly an important part in terms of recruiting and retaining physicians. That's some of what we're doing.

MR. CHAIRMAN: Thank you and you do have about one minute left if you'd like to ask another question. Mr. Stroink.

MR. STROINK: You guys have done a lot in reducing costs but what are some highlights for you, some wins that you've done to reduce costs?

MS. MARTIN: Knowing that time is limited, just one example is on procurement. We have put new agreements in place in terms of the companies that we're working with to purchase supplies. We have worked across sectors, so not only the acute care sector but long-term care sector and others, to increase our buying supplies. That is just one very quick example in the time available. (Interruption) I hear \$6 million was saved in 2013-14, so that's a significant contribution to front-line care for sure.

MR. CHAIRMAN: Thank you, Ms. Martin, and that is the end of the time for the Liberal caucus. I'd like to give you a couple of minutes to provide some brief closing comments.

Before you begin, I would like to mention that our committee clerk will follow up with you on a number of pieces of information that were requested today, including: Mr. Porter asked for an overall number of FTEs for the department; he also asked for documents to be tabled regarding 46.6 FTEs in one of the districts; and I also believe that the deputy minister had stated that she would look into the 40,000 number regarding error. But again, our clerk will follow up with you in greater detail.

I'd like to give you an opportunity to provide closing comments.

MS. MARTIN: Great. First of all I'd like to thank you for the important questions that you have asked, an opportunity made available to address those in the time that we've had here. We do know, and what I'd like to reiterate in terms of some of the themes in addressing your questions, is that Nova Scotians want to know that the health care dollars that are allocated are spent wisely; that we know that the ultimate goal that we are working on as a department, with the various providers and volunteers in the system, is high quality, consistent care across the province regardless of where people live.

We do know that Nova Scotians want to know that their provincial Department of Health and Wellness is planning for the future, and that we are monitoring for quality and patient safety. As well, they do want more timely access to services, which is why we are pleased to have dedicated efforts in terms of reducing the wait times for hip and knee surgery, as well as looking at the refresh and the Continuing Care Strategy. We are striving to make advances there.

In conclusion, I want to assure you that the Department of Health and Wellness is constantly looking at our programs and determining if there are better ways that we can provide front-line care for Nova Scotians. Thank you for your questions today.

MR. CHAIRMAN: Thank you, Ms. Martin, and for your colleagues as well, thank you for being with us this morning. We do have some committee business. We have five items here that we'll try to run through quickly. The first is something that we had come to agreement within the subcommittee of this committee yesterday, and that is on topics that will be coming forward at future meetings.

I do want to call attention - there were three topics that were approved that are very similar. I've spoken to the Liberal caucus, and they have recommended that we do consider them as one topic, so I would ask that you look at your topics list and I will identify the three.

The first one is, Nova Scotia Pension Agency; then the third one, the Public Service Commission; and on the second page, Controller and Department of Finance. Those three will now become one topic, and they will be looking at the Public Service Superannuation Plan. I just wanted to draw your attention to that.

I would ask, if there are no questions on that, for a motion to approve the record of decision being these topics.

MR. PORTER: So moved.

MR. CHAIRMAN: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

We do have topics now that our committee clerk will be moving forward on arranging for future dates for the committee.

The subcommittee also explored the recommendation from the Liberal caucus to begin ranking recommendations that are accepted by departments, to have the Auditor General rank them in order of importance. We had some discussion on that yesterday, and it was agreed upon that that would not be the action taken for a number of reasons. There was agreement all around on that. I think the insights of the Auditor General proved helpful in us evaluating that. So, going forward, we won't be ranking the recommendations.

The third item: we also have a template that you have with you now. This is a template that we are going to start using. It's something that has been suggested to us by the CCAF to help to improve our functioning as a committee and to hold departments accountable for commitments that they've agreed to. Of course, it's also helpful for the government to ensure that departments are following up on things that they've agreed to for their purposes.

The fourth item was some information that was requested from the Department of Transportation and Infrastructure Renewal. I believe you've all received that, so I just want to draw your attention to that.

The fifth item is: following this meeting, we are going to have an in camera meeting with the Auditor General to talk about public health surveillance. We will begin that as soon as we can. I see the clock is about to strike 11:00 a.m., and if everybody can remain in their seats, we'll begin that right away. We'll take a short recess so the Auditor General can get ready for that and begin as soon as we can. Thank you.

[The committee adjourned at 11:00 a.m.]