HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, October 22, 2014

LEGISLATIVE CHAMBER

Department of Health and Wellness
Physician Alternative Funding

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Public Accounts Committee

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Mr. Gordon Hebb
Chief Legislative Counsel

Mr. Michael Pickup
Auditor General

Ms. Evangeline Colman-Sadd
Assistant Auditor General

WITNESSES

Department of Health and Wellness

Dr. Peter Vaughan, Deputy Minister
Ms. Eleanor Hubbard, Chief of Partnerships and Physician Services
Mr. Kevin Elliott, Chief Financial Officer

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, OCTOBER 22, 2014

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN: Good morning, I'll call this meeting to order. Before we begin, I would remind everyone to place their phones on silent. I'd like to begin with the introduction of the members on the committee.

[The committee members introduced themselves.]

MR. CHAIRMAN: Today we have with us the Department of Health and Wellness with a topic that was covered by the Auditor General in a recent audit chapter. The subject is Physician Alternative Funding Plan. We have with us Dr. Vaughan - could you begin by introducing yourself and allow others with you to introduce themselves, and open with your comments?

DR. PETER VAUGHAN: Thank you very much and good morning everyone, happy to be here. To my left I have Eleanor Hubbard, who is Chief of Partnerships and Programs, and to my right I have Kevin Elliott, who is Chief Financial Officer for the department.

Once again, good morning and thank you. It's a great pleasure to be here and thank you for inviting the Department of Health and Wellness to appear before you today. I am very pleased to be here, as I said, along with Eleanor Hubbard, our Chief of Partnerships and Program Services, and Kevin Elliott who is our Chief Financial Officer, to talk about the importance of alternative payment plans and academic funding plans. Both of these programs help bring accessible and quality health services to Nova Scotians.

I'd like to thank the Office of the Auditor General for their report and their recommendations. Their work helped to bring focus and validation to the work underway at the department and to develop new models for our AFP and APP programs, which will strengthen these programs. This work comes at a time when the health care system is entering a phase of transition toward a single, unified provincial health care system.

In all areas of the health care system we are being streamlined so that the much-needed health care resources can be allocated where they are needed most, to improve front-line patient care. The department recognized, as with any program, it is important to ensure that they are continuing to meet their objectives, and a review was conducted along with recommendations.

The new AFP model was approved in April 2012 and, the following month, work began to implement it. At the same time work was underway to develop an updated APP model. During this time the Office of the Auditor General also conducted a review of the programs. The AG's Report confirmed the need for the work underway and also helped provide greater focus with their own set of recommendations. The department agreed with those recommendations and they are being implemented as part of the overall program implementation.

Earlier in this legislative session the Minister of Health and Wellness tabled the Emergency Department Accountability Report 2013-14. That report reinforced that the province needs to continue to compete for and recruit more doctors for rural communities. The APP program is one way the province can help level the playing field and recruit doctors to our rural communities. By moving outside the traditional fee for service arrangement, the province can negotiate and contract doctors to serve a rural base that may have different demands than a base in an urban centre.

The province has worked hard to improve the APP and AFP programs and while progress has not come as fast as everyone would hope, the department has made significant progress. Today, approximately 137 of 244 APP contracts have been signed, using the new model, and 15 AFP contracts are currently in place. The revised APP and AFP programs focus on improved accessibility, planning, accountability, and transparency. When taken together, these are also key dimensions found in providing quality and safe health care. This is the end goal of the health care transition - quality and safe patient care for Nova Scotians provided through a unified and streamlined health system.

At the end of the day, Nova Scotians want to know that their health care dollars are being invested so that regardless of where they live, they and their families will have access to quality and safe health care. The APP and AFP come with a cost, and the province has the responsibility to make sure those costs translate into better accessibility for patients and accountability for doctors, and is conducted in a transparent way for taxpayers.

I welcome your questions. Thank you.

MR. CHAIRMAN: We will begin with Mr. Houston for 20 minutes.

MR. TIM HOUSTON: Thank you for those opening comments. I want to make sure I'm looking at the right numbers here. I understood from the audit report that there were about 220 physicians paid via alternative payment plans and about 550 under academic funding plans. In your opening comments, you said today approximately 137 of 224 APP contracts have been signed, so that seems like that's in the same ballpark. But then you went on to say that 15 AFP contracts are in place, whereas I was thinking there were maybe about 550. Can you kind of jive those numbers for me first?

DR. VAUGHAN: The APP contracts are primarily contracts with individual physicians or groups of physicians, often in primary care or specialty areas, primarily in rural areas. The AFP contracts are academic funding contracts and include the academic groups within the capital area and the IWK, so there may be a number of physicians in that academic group.

MR. HOUSTON: Right. From the audit report I understood that there were about 550 physicians under academic funding plans, but in the opening comments you mentioned there were 15 contracts in place. I'm trying to understand - if there are 550, do the 15 that have contracts - that must reference some type of contract? Presumably there are hundreds more under a different type?

DR. VAUGHAN: There are over 500 doctors who are included in the academic universe, if I can describe it in that way. They're all clustered within those 15 AFPs.

MR. HOUSTON: Okay, I understand. Now, if we use the rough numbers that I had of 220 physicians paid via alternative payment plans and 550 under the academic funding plans, that's about 770. They said that together that accounts for 45 per cent of payments to physicians. How many doctors are there in the province all together?

DR. VAUGHAN: It varies from day to day, but there are around 1,940.

MR. HOUSTON: Okay. That's good, that's helpful. Do the rates paid out under alternative payment plans vary by location throughout the province? Is each one of those an individual negotiation between a physician and the department, or are there standards that they follow?

DR. VAUGHAN: The alternative payment plans are primarily used for physicians in rural areas as an incentive for physicians to practise in sometimes more difficult or challenging areas, to recruit physicians. Those are individual contracts that have several parties to them - they have the physician, and obviously the department is a party to that, as well as Doctors Nova Scotia and the health authority. There are four parties to those APP contracts.

MR. HOUSTON: Would the rates paid come off a table that says if you're in the northern region, this is what you're eligible for, if you're in - is that kind of how that works?

DR. VAUGHAN: There are standard amounts for the family physician. Let's talk about that one for a second. There would be a standard amount that has been negotiated with the department and Doctors Nova Scotia in the master agreement contract for a family physician. They would get what would be part of that standard contract.

MR. HOUSTON: Is there any deviation from that? Is it down to the negotiation skills of the individual physician?

DR. VAUGHAN: No, it's not a free market in that sense. There's a set amount that they are given. Sometimes communities can then have the opportunity to consider housing or office space, those kinds of things, but that's not a part of the APP contract, specifically. Physicians get the APP contract amount for a family physician, say, and that would include their overhead costs or any other costs. Remember that most physicians are independent, incorporated small business people, so those dollars include all of their other costs.

MR. HOUSTON: So if they were getting something in addition to the fee, let's say housing as an example, would they be negotiating that with the local district health authority?

DR. VAUGHAN: Maybe. Often the communities have a recruitment team. Communities that are very successful in recruiting physicians often have a recruiting team of folks to introduce the physician, and not just the physician but the physician's family and sometimes the children, into the community - what the advantages are of coming to practice in a particular area.

MR. HOUSTON: Do you mean, like, the foundations that various hospitals have?

DR. VAUGHAN: It can include foundations. Often these are groups of communities. It may include municipalities, other small business members, foundations, but these are grass roots; various communities that are strong in recruiting have a grass roots foundation.

MR. HOUSTON: So, traditionally at least, would there have been any involvement of the DHAs in identifying or, maybe, managing physicians?

DR. VAUGHAN: In terms of the recruitment part?

MR. HOUSTON: The recruitment part and then once they are there, would the DHA have had any role in managing a physician who is under an alternative payment plan?

DR. VAUGHAN: The DHAs work with the communities and the department, and the community of physicians, as well, because they're an important component to not only attracting but retaining physicians, so the health authority has a role to play in that, often bringing folks together, often understanding what the community needs are, and often in the advertising. So they do have a role, as I said, in terms of the APP. They are signatories to that. We have a role; the DHAs have a role. In my previous life I had a role in making sure the physicians did commit to what they were doing as a part of their deliverables.

MR. HOUSTON: So with the transition of the DHAs, presumably there's more falling on your plate at the moment. What's happening with the state of flux that that's in, now?

DR. VAUGHAN: Sure, that's a good question. Well, as you have heard, there will be zones, management zones, operational zones, so really those are a clustering of what are currently DHAs. Those same sorts of functions fall within the management zones.

MR. HOUSTON: Okay. But those zone management teams are not really in place yet, at the moment, are they?

DR. VAUGHAN: Well, currently the DHAs still exist, so they won't be operational until after April 1st when the new organization stands up.

MR. HOUSTON: I am just trying to get my head around - the boards for those DHAs are gone and, in some places, like, I know in Pictou County, there have certainly been some changes at the management of - we don't have our own guy there anymore. I'm just wondering who is watching the store, I guess. I presume it's falling back to your department.

DR. VAUGHAN: All the DHAs still have folks who are responsible for physicians, who recruit physicians, who manage the physician contracts. Those folks are still in place and will continue to be in place.

MR. HOUSTON: We have six per cent of Nova Scotians that do not have a family doctor. I know I have certainly heard some real sad stories about people seeking family doctors and participating in lotteries and all this type of stuff, so these alternative funding

arrangements are a way to close that gap. Would that be the biggest tool in the toolbox to close that gap?

DR. VAUGHAN: It's an important tool to be able to recruit physicians, as I said in my opening comments, to rural and places hard to place physicians in. It gives them a base. A fee-for-service model can be challenging in some smaller communities to be able to bill enough to attract and retain physicians, so it's an important element. Communities, as I said earlier, do play a significant role in showcasing what's available to communities. Money will get them, but it won't keep them, as we always say. We need to make sure that the communities also showcase what's really the plus side of rural Nova Scotia - and many communities are very successful in doing that.

MR. HOUSTON: So in terms of trying to recruit physicians to rural Nova Scotia, who do you see as the big competitors to that - would it be rural New Brunswick? Would that be our biggest competitor? Do you kind of look at it and how do you - if the money is kind of the base thing, who are you comparing the money against in terms of other jurisdictions?

DR. VAUGHAN: I think it's a really a national comparator; I know it's just not a regional comparator - and it's an urban/rural comparator. One of the challenges is that we're not just appealing to physicians, it's their families and so the challenges that physicians' spouses and partners face is part of the magic of attracting to a particular rural community.

MR. HOUSTON: Do you have a sense - I'll just refer to it as the "fee table" for Nova Scotia - how does that compare to just our provinces in the Atlantic area? Are we higher or less or kind of . . .

DR. VAUGHAN: From the APP environment? We're probably in the middle of the pack when it comes to that. We do very well I think comparatively for the general practice rural audience, those who are interested in practising in rural areas. I think the other piece we'd like to articulate a little bit, related to your question, is that currently with the number of DHAs there has been historically a bit of a competitive environment between DHAs - some having more resources and some having less to be able to apply to recruitment and focus. The benefit of the unified approach has developed that unified standardized approach to be able to recruit physicians where they are needed in a standardized way.

MR. HOUSTON: So, yes, that's a good point. So if I'm a physician and I'm looking to come to Nova Scotia and I'm looking at different communities around the province, rural communities, from one end to the other, what I'm going to get paid, what my ability to earn is different in those communities, right?

DR. VAUGHAN: Well, no, you're coming into an APP environment again. That's not a requirement, physicians can choose to come into an APP or they choose, and many

do, to have a fee-for-service environment; it's their choice. Some may choose a three-month trial of an APP and then choose to either continue with that or choose to go into a fee-for-service environment. But it's important to understand that that APP is a standardized amount throughout the province; fee-for-service of course is totally dependent on what you're billing.

MR. HOUSTON: That's fair enough. Now, you came to the job in April I think, so you're kind of getting your feet wet there. What were your initial reactions when you saw the AG's Report?

DR. VAUGHAN: We were pleased to see the AG's Report. There are a number of significant recommendations that we agree with. The issue of accountability and performance management is something that we strongly believe is something that is important moving into an era of value for money and accountability generally. As you know in Bill No. 1, the New Health Authorities Act, there's a framework for accountability generally for the new health authority, so going forward we very much believe it's an important part to help us not just manage physicians, but the entire health care system.

MR. HOUSTON: Were you surprised by some of the findings? The lack of contracts, the lack of monitoring of deliverables - is that something that …

DR. VAUGHAN: I can't say I'm surprised. I think it was something that was known. I think the department had been trying to work on that, so I think the department would probably have agreed with the recommendations and it just added more grist to the mill why we need to have a new way of managing physician contracts.

MR. HOUSTON: And the new way is a work in progress?

DR. VAUGHAN: I think the department has made significant progress. There's always room for improvement, and I think that's a philosophy that needs to be in play. We're constantly looking for new ways to improve, but we've consolidated all of the templates for all of the AFPs going forward, all of the new APP programs have been put in place, and they're making significant progress - remembering that we're talking about physicians and having to sit down with individual physicians whose primary job it is to look after patients, so these are busy folks. You need to have agreements with the department, Doctors Nova Scotia, and the health authorities.

It takes time to move those pieces along. The benefit of having the clear deliverables is good for physicians as well as for patients and for those of us trying to manage the care that is being delivered.

MR. HOUSTON: I'm just wondering, on monitoring those deliverables, that's one area where it seems to have been a little lax - probably for some of the reasons that you've mentioned, but I assume that's something you want to tighten up. Do you see over time, if

you look out into the future, if there are about 220 physicians on APPs now, of 1,900-something, I think you said - do you see that number going up over time, or where do you see this going?

DR. VAUGHAN: It's a good question. There's a general trend among new, emerging physicians coming out of training, looking for that kind of payment process. I'm loath to predict the future, but I think it's probable that we'll see more physicians wanting to have that kind of an approach to practising.

It's particularly helpful because what we're trying to really do is change the delivery of health care to a collaborative model, and it's probably the only way that really works. It can be done on fee-for-service. It's more challenging in a fee-for-service environment to have physicians be part of that collaborative team. There are some that do it, but it's more challenging. So I think it's probable that we'll see more of those kinds of contracts.

MR. HOUSTON: So you would see more going forward, more of those CECs - emergency centres and that type of thing?

DR. VAUGHAN: We'll see more Collaborative Emergency Centres, for sure.

MR. HOUSTON: I'm wondering about the academic funding plans. How key are those in the future of health care in Nova Scotia?

DR. VAUGHAN: Thank you for that question. They're incredibly critical. We're talking about tertiary and quaternary care that serves not just Nova Scotia and the important needs of Nova Scotians but Atlantic Canada in many cases - certainly the Maritimes, but sometimes the entire Atlantic region.

These are over 56 subspecialty areas that are highly specialized in a very competitive environment - not just nationally but sometimes internationally. So to be able to deliver the services that we need to deliver in these tertiary care centres, quaternary care centre in Halifax, we absolutely need to be able to have those academic funding plans, which include not just the clinical care, which is the most important component, but also teaching new physicians of our future, and also the research. Research is an important component of those APPs.

MR. HOUSTON: I assume that they would help improve the retention rate of physicians in the province over time.

DR. VAUGHAN: I would say it's critically important that physicians who are coming into that academic environment know and have a security that they're going to be able to have the patient care, but also be able to have the resources and time to do the research and the teaching, which so many of them really thrive on.

MR. HOUSTON: What is the retention rate of physicians in Nova Scotia? Is that kind of a statistic - if you can get them here, do they usually stay?

DR. VAUGHAN: I don't have a number off the top of my head. I'm sure we can get you a number. We generally have a good rate of retaining physicians here. I don't have a number off the top of my head.

MR. HOUSTON: I'm probably going to run out of time, but I'll come back to it next time. I was wondering on the link on academic funding. One thing I often hear about is the number of seats available at Dalhousie and people saying they wish there were more opportunities for Maritimers or Nova Scotians to get in there. I'm wondering if we can make sure that the academic funding portion is helping to get more locals - for lack of a better word - trained and staying here. I don't know if you have any thoughts on that, quickly.

DR. VAUGHAN: Well, just to be clear, the academic funding plan does not fund medical school seats; that's a separate budgetary exercise.

MR. HOUSTON: But they are training the people who come out of those seats. I guess what I'm trying to think about is if you come out of Dalhousie and you get under the wing of somebody who is maybe under an academic funding program and they are teaching you a specialty, is that effort then lost when that person leaves? I think it would be less likely for them to leave if they were a Nova Scotian, to begin with. I don't know if there is a loop there to close but I'm trying to close it.

DR. VAUGHAN: I see where you're going with that and it's a good point. I think we're always trying to retain people who practise here. It's clear that students who train here - not just physicians, nurses and others - those who train in communities stay in communities. Dalhousie has made significant progress in what is called distributive learning, which is an approach to the not just trained physicians in Halifax but there are training programs now in Sydney and Kentville.

MR. CHAIRMAN: Order. I'm sorry but we've gone beyond the time. I'll move now to the NDP caucus and Ms. MacDonald.

HON. MAUREEN MACDONALD: Thank you very much, Mr. Chairman. I'm really looking forward to an opportunity to talk with you on this topic. As you probably know, I know the two people who are with you now; when I was in the department the AFPs and APPs were probably my steepest learning curve. It's just tremendously complex and although I learned a lot, there is still so much to be learned.

I want to start first of all by saying that the staff in the department - and you have Ms. Hubbard, in particular, with you, who has worked on this area for a long time - are very capable but we have gone through this process here in our House of Assembly recently

around all of the contracts in the health care sector for other groups of workers and the idea of getting that down to a manageable group and not being constantly in negotiations.

My experience in the brief time I was at the Department of Health and Wellness - three years - was that we were constantly in negotiations on the AFPs and the APPs. When I look at the Auditor General's report, the deficiencies that have been identified, the remedies to deal with those deficiencies, and my knowledge of how many staff we have in the department to work on these things, I ask myself, is it realistic that the work that needs to be done to tighten up and get the kind of processes in place that assure we're getting value for our dollar can actually be developed while we are in this constant process of ongoing negotiations and adjustments?

I'd like to hear, first of all, how that is being addressed, just the question of the manpower issue and the number of contracts to be negotiated, the complexity of those contracts and where that stands now.

DR. VAUGHAN: Sure thing, thank you for that question. There has been a lot of work done to streamline and I think that coming out of this whole process, to devise a common approach to all of those 15 AFPs, for example, which can sometimes be the more complex of this discussion, because of the complexities we just talked about and research, academic teaching, patient care, all of those things have now been brought together with a common, template approach. So they are all being streamlined, they will all be negotiated together, starting in the new year.

All these processes now will all be wrapped up within the master agreement contract negotiation with Doctors Nova Scotia so as you can see, all being wrapped together, which will begin in the new year. Gone are the days when all of these factors are all over the place, they are all going to be brought together under one negotiation process.

MS. MACDONALD: Thank you. I know that was something we were working toward and we had a consultant do a piece of work who was working, I think, in one of the other provinces as well, who had very similar problems. It is good to know that is coming to a focal point.

The Auditor General has identified issues around - this was always the big conversation when we looked at the AFPs - the deliverables. Were we actually getting the value for the millions of dollars we were putting in and how were we tracking that; how could we be confident that we were getting the kind of service, I guess, the amount of service that we had hoped to be able to acquire through the various AFPs. There was a very distinct lack of monitoring, a difficulty in monitoring. Can you explain what has been put in place to address that and to improve the record-keeping that will allow us to measure what we are actually getting from some of these AFPs?

DR. VAUGHAN: I'll talk about the AFP and then the APP because we are talking about two things, sometimes the same and sometimes a little bit different.

The AFP environment, that academic environment, that tertiary environment focused on those three elements that we talked about - the clinical care, the most important role here, we need physicians to be a part of that collaborative team in the academic areas more commonly today than ever. These are collaborative teams. There is the teaching and there is the research component. They now have all of those templates laid out. We have a resource at the department that is responsible for overseeing all of that component.

There is a governance group, and that is a group that's made up of Dalhousie and IWK and Capital Health, Doctors Nova Scotia as well as the department. This is the first in Canada of that kind of oversight and governance that is really quite impressive in its desire to move forward, increasingly focusing on patient outcomes, which is what we all really want to see at the end of the day. That process is in play.

Are we there yet? No, but we know where we want to go so we are on that journey and we do have resources in place to manage that once we start. The new contracts will be signed by April 1, 2015. I think we are well on our way. We would all like to see it done yesterday but these things, with all those parts - and remember, physicians are busy folks. They are seeing patients and it is not something we can just take them away from now when we have such scarce resources, particularly in the academic environment.

On the APP, the alternate payment plan, we have those deliverables in place. We have the resources that I spoke to earlier in the districts, currently, and they will continue to be in place within the zones, work with those physicians and manage those deliverables and make sure those deliverables are adhered to. One of the mechanisms that we have to ensure and track is called shadow billing, which is not a perfect tool. It is a surrogate tool of productivity but it's an activity tool. That is the tool that we use; there is not always a fee code for all of the activity, especially in the collaborative environment, there isn't a fee code, which is one of the challenges with the fee-for-service environment when you are trying to collaborate. Those shadow billings are monitored and conversations can occur with physicians.

Often, it's office staff perhaps not knowing what code to bill or there isn't a code to bill, but the activity is taking place - that is, doctors are seeing patients and sick people are being treated, which is the most important thing here.

MS. MACDONALD: If memory serves me right around the AFPs, there was a considerable concern about the amount of revenue in an AFP that was being spent on administration and that perhaps you would have a specialty group who would have a number of administrative support staff booking appointments and record keeping and whatever, and that this was duplicated over and over and over again.

I can't remember the exact quantification of that, I think one of the things that was difficult to do was actually get it quantified, but there was a concern that it could be as high as the low 30 per cent of an AFP going into administrative costs in that if the specialty services were more collaborative, I guess I would say, that the degree of duplication and inefficiency could be considerably reduced and that would mean freeing up money for more front-line patient care. It tends to be in these areas where our wait times are the greatest or they can be pretty bad in some areas.

So my question is, has any of that work been completed or is it ongoing - are we changing the AFPs in a way to make the internal administration more transparent and a way to get at that, and requiring more collaboration?

DR. VAUGHAN: That's a great question and one there is a lot of history to, as you well know. A lot of these historical arrangements were bolted on to individuals who had their own approaches to things and staff, so over time that opportunity to consolidate the administrative resource that you talk about is very much part of the conversation that is taking place, and that opportunity to consolidate, whenever those opportunities arise, is taking place. It's because you're dealing with a lot of history that it takes longer than one would like sometimes, but that is being recognized. Our plans are very much focusing on reducing administrative costs - that's what we're trying to do across the health care system so we can focus on scarce resources for front-line patient care, so all of those conversations take place as a part of the AFP conversation.

MS. MACDONALD: Which bring me to a little side bar, I suppose in a way, but nevertheless, I think, of importance to the public and that is the whole process we're going through now around merging the DHAs and reducing administration. We recently had the CEO from the Capital District, left the Capital District and I'm wondering if you can tell us what the severance arrangements were for that individual - this would be Chris Power.

DR. VAUGHAN: I'm not aware that Chris Power has left Capital.

MS. MACDONALD: Is that right? I thought she had left.

DR. VAUGHAN: As of yesterday when I was in conversation with her she was still there, unless something changed.

MS. MACDONALD: She was still there?

DR. VAUGHAN: She's a consummate professional and continues to perform her duties.

MS. MACDONALD: I thought I had seen a message that she had sent around that she was leaving, so she's still working in the system then is what you're saying?

DR. VAUGHAN: Absolutely and all the CEOs, again, consummate professionals working within the system, focusing on patient care, focusing on their staff, focusing on the difficult and challenging job of managing resources in these interesting times.

MS. MACDONALD: Yes, she certainly has a long history of public service for sure.

DR. VAUGHAN: Absolutely.

MS. MACDONALD: Excellent public service. Have any of the CEOs in the DHAs left or have they all been reassigned?

DR. VAUGHAN: None of them have left per se, I mean some have gone to different places like myself. Janet Knox, as you know, is the CEO designated for the new provincial health authority, and some of them, Pat Lee, as you know, has been doing excellent work as one of the co-transition leads along with the department. People have taken on willing assignments, and I must say, it has been impressive the way we have been able to use people within the system, rather than going out to hire expensive consultants from other places in the country, to reset the course. Kudos to those staff, including CEOs, but also to the vice-presidents who have come together and been seconded, and some of those who have been seconded to the transition team to do that important work, knowing very well that there may or may not be a position for them in the future. These are folks committed to doing the right thing.

MS. MACDONALD: I think I will go back now to our more immediate topic. One of the things that I am concerned about, and I noticed that you did make reference to it in the previous questioning - I'm concerned that we haven't had any announcements in the last year, that I can think of, of any new collaborative practices in the province. As you indicated, when we look at the cost drivers in our health care system, there's a ton of evidence that points to physician salaries and drug prices. These are the two big pressures, and they've been the two big pressures in the health care system for a long time.

One of the ways to control pressures but also get better health care is to have more collaborative practices, where physicians who are highly specialized use their time to do the things that they're highly specialized to do and not be in the scope of some other profession's practice that is not quite as specialized.

My question is, why haven't there been any new collaborative practices announced, particularly if we're concerned about containing cost pressures and the improvement of the quality of health care, the doctor shortages, all those kinds of things? It is an obvious measure that will only strengthen our health care system, make it more sustainable, and contain some of the costs.

DR. VAUGHAN: Thank you for that question. Our focus has been on recruiting physicians for rural areas in particular; Digby has three new physicians, a CAPP physician and two return-of-service physicians, so our focus has really been on filling those gaps to provide the necessary care. It's important to understand that the transition of the health authorities is really a foundational piece. It's a governance piece in many ways.

Once we have that foundation in place, it allows us to develop a standardized approach, if you will, to ensure quality and safety. A foundational piece to quality is standardization, to be able to put in play over the next few years an evolution of the collaborative approach that has been taking place for many years. It's not anything new.

You're quite right, in terms of the evidence around the quality and safety with collaborative practice. So we need to see this as a journey and we need to see it as an evolutionary phase. It's not something we can just pop in in various places. It needs to be well thought through and structurally connected. Our focus has primarily been in placing physicians for the present time.

MS. MACDONALD: The amalgamation process as a foundational piece, how long will it take to get that fully operational?

DR. VAUGHAN: It's a great question. We see the opportunity to take this period of time - which I know that some might find is too long - to stand up the new health authorities. As we said, Janet Knox, who is the CEO designate - we will soon be announcing the structure around the VP levels going from 37 to a number that's much smaller than that, somewhere between seven and nine. We haven't quite landed on that yet, but within the next couple of weeks we'll be making an announcement about that. That structure is critically important. We will be laying the foundation for the future based on that with a lot leaner administrative structure so that we can focus our attentions on building that foundation across the province.

MR. CHAIRMAN: Thank you Ms. MacDonald, your time is about up. We'll move to the Liberal caucus and Mr. Rankin.

MR. IAIN RANKIN: Thanks very much. Obviously the health care sector is of extreme importance, being half the budget. I just have a couple of questions and I do want to say that I do think the NDP Government did do a lot of positive things in terms of the CECs. From my perspective, I think our system is going from an acute care system to more of a chronic care system with our aging population. I think that the design, when it was originally thought up, was to treat a lot of acute care. You have people staying in hospital beds longer than they probably need to be, at a large expense.

I think CECs can be used effectively to mitigate against some of that excessive cost within our large hospitals. With this new Bill No. 1 and opportunities for a less fragmented system to manage this, how are we going to ensure that the hospitals themselves are

utilizing their staff to a maximum scope of practice? Further to that - and this goes a little bit more into future practices - how are we going to shift away the responsibilities from physicians, as an example, where a doctor has to come and sign a paper to release a patient from a hospital instead of a nurse practitioner? How are we going to shift the excessive cost? I know one of the examples - I think it started in the last government - the flu shots at the pharmacists, clinics. I think that was a positive one. How are we going to get more services into the hand of LPNs and is there an appetite or anything to go into physician assistants, which are utilized in some of the other provinces?

DR. VAUGHAN: Thank you for that. First of all the issue around accountability is embedded in Bill No. 1 and the legislation. It is an accountability framework that the health authority must publicly report on. That is an important shift in public accountability, not just in terms of the financial, which is obviously important for everyone, but also in terms of quality, accessibility, and other dimensions of care so communities will have a role, through their community health boards, in terms of how are we doing and terms of accessibility, but they will also be reporting publicly in terms of all of those metrics. That will be something that is negotiated between government and the new health authority and again, very much in line with what I have talked about with the physician accountability.

Accountability is about value for money and demonstrating that we as taxpayers in the province are getting what we're paying for. In terms of nurse-led discharge, if you will, from hospitals and nurse practitioner-led discharge as you referred to, that is something that we are looking at, have been exploring for a period of time, and will soon be able to bring something forward on nurse practitioner discharge from hospital, which is a more efficient way. They have the scope of practice; they can do these things. Nurses in emergency have skill sets to be able to assess minor ailments and release patients from emergency rooms with minor ailments. These things are all part of the evolution of health care where the right practitioner is doing the right job for the right patient.

MR. RANKIN: The former Minister of Health and Wellness mentioned the escalating cost of pharmaceuticals and salaries; I think that is driving high cost. Is there any code of conduct that physicians use when they are prescribing these medical solutions to the people who are coming in with maybe a headache, maybe a sign of flu? Do they have any ability to really address the diet and exercises issues before it comes to the point where they are utilizing drug costs and having an implication on that?

DR. VAUGHAN: That's an important point. I think it's a factor that most physicians are certainly well aware of, that diet and exercise are critical components to a healthy lifestyle. The consequences, the sequelae of these events are well known, I think, in the popular literature. Many chronic diseases are impacted by inactivity, by diet - exercise and diet being a key component.

Physicians are very much aware of that. Physicians are, in many ways - I'd rather have them speak to that through their associations - are very much involved in activities.

Doctors Nova Scotia here in Nova Scotia is very publicly active in the need to have diet and exercise as a part of our lifestyle prescription, and the Canadian Medical Association as well talks about these things.

I think physicians do some of that work. The question is, can we all do a better job in the health system? Obviously I think we can, but it really is a partnership with citizens as well. Your counsellor can counsel you, but we all have to take that and put it into action. The benefit of the collaborative practice model is, as we've talked about, it allows physicians to focus on their area of expertise and bring in specific resources as a part of that team, and it may be a dietitian or another health care provider to deal with those specific problems. That's the benefit of that collaborative practice approach.

In terms of pharmaceuticals, certainly the CMA, the Canadian Medical Association, has a code of ethics which articulates in great detail the obligations of physicians to be advocates for their patients, and this would be a component of that.

MR. RANKIN: So it's basically governed by their separate associations, there's no direct link per se to the Department of Health and Wellness that has any strict guidelines?

DR. VAUGHAN: In terms of prescribing medications?

MR. RANKIN: Yes.

DR. VAUGHAN: Well there are obligations to their professional associations, as I said, through their ethics framework. There are obligations through their licensing body which government generally delegates to licensing bodies such as the College of Physicians and Surgeons, the oversight role, and there's a Prescription Monitoring Program which is a partnership with government.

MR. RANKIN: Okay, I guess what I'm trying to get at is in terms of when you're compensating physicians and different health care providers, the focus on quality versus the quantity part. You have fee-for-service and you have a component - was there any attempt to have a salary as being part of it? I know that these are all deep, entrenched interest groups that have their own perspective on how they should be compensated and it's obviously a challenge to get the right mix.

Particularly with this move to a more consolidated management structure which I think you have an opportunity here for the new CEO, for example, is there any attempt to tie her compensation with health outcomes, and the new vice-president's? Can you tie the outcome of the system to that compensation or is it just a flat, base salary?

DR. VAUGHAN: That's a long conversation in terms of performance management and pay for performance that has had variable success not just nationally, but internationally in knowledge-based industries like health care. It works very well in

widget-based industries but health care, it hasn't worked as well as some might have thought and that's a whole other conversation. So the answer is no, pay for performance is not a part of the structure of the remuneration in the new health authority for a couple of reasons - one is the outcomes of shifting and population improvement take a long time to occur and, in some cases, decades to occur.

But the key accountability frameworks that are embedded in the new structure are where the rubber hits the road in terms of the accountability for the CEO and for that senior staff and for, ultimately, the board.

MR. RANKIN: Thanks, that's all I have for now.

MR. CHAIRMAN: Ms. Miller.

MS. MARGARET MILLER: Thank you very much for coming in today. The topic is really great, a lot of good information coming forward and I really appreciate all this information.

I do have a question about the difference between the fee-for-service component and the APP. Do you find that most physicians - is it pretty balanced? I mean, if you get a physician that is being paid for every one of her clients that comes in, does it pretty much balance out with the alternative payment plan?

DR. VAUGHAN: Balance out in terms of the number of services?

MS. MILLER: The economic benefit - the salary, basically.

DR. VAUGHAN: The economic benefits? The fee for service is an environment that some physicians really like. They like to have control over their activities like many small business people, and they are small business people. They're not employees. Most of them have private corporations to run their businesses, so those activities under that fee-for-service environment, they have a great deal of control in terms of their hours and what they're doing. Some physicians really like that flexibility and freedom.

In the APP environment it is more structured and so we have deliverables, and there are certain office hours that they're expected to maintain and certain other activities they're expected to be engaged in. At the end of the day, are they comparable in terms of service delivery? The goal is to make them as comparable as possible. Under the fee-for-service environment we do not have the control over the service delivery, so if a doctor decides that he or she is going to work only a few hours per week, it's entirely within their purview.

In the APP environment, they have an agreement that they're going to work - they have to lay out a calendar and a schedule so we know with predictability, the public knows that services will be delivered. Sometimes there are evening hours or even weekend hours

as a part of that. So there is much more predictability within the APP environment than in the fee-for-service environment where he or she can choose to work what hours they want.

MS. MILLER: I'll pass it on to my colleagues; I see them making frantic notes so I'll let them go ahead.

MR. CHAIRMAN: Mr. Jessome.

MR. BEN JESSOME: Thank you for being here today. I guess my first question - and I'm going to kind of ask a couple of questions leading into something, but other than the demographic challenges that face Nova Scotia, are there any specific illnesses or diseases that cause more significant problems that are exclusive to our province?

DR. VAUGHAN: Sure, I'm happy to answer that question. As you know, Nova Scotia has amongst the oldest population in the country. Some people like to see that as a negative; I like to see that as a positive thing - that means we're doing good things. We'd all like to live to ripe, old, productive older ages; if we're lucky, that's how we'll get there.

We have challenges with some of our earlier comments around lifestyle issues - diet/exercise being one. Diabetes is a significant burden to individuals and to the system. Chronic lung disease is a problem. We've made significant improvements as a province in lowering smoking rates, but still it's a challenge for some folks. Cardiovascular disease is still a challenge, and again, diet and exercise go hand in hand with that. Those would be sort of the top three. Cancer would then be there, and that's a multifactorial disease also related to diet and exercise in some cases.

MR. JESSOME: Mr. Chairman, through you, I'll follow that up with - do these sorts of focus areas of health care create specific challenges in recruiting the types of physicians that you need to suit those illnesses?

DR. VAUGHAN: I think it comes back to that collaborative team approach. No one person today can know everything in health care or medicine. In the 1900s, knowledge doubled every 50 years; today, knowledge in health care is doubling every 12 to 14 months, so no one can keep up with all the activity. That's why we work in teams today in health care. We have family physicians, we have dieticians, we have social workers, we have highly-skilled nurse practitioners and family practice nurses, so you have a team of people. Those folks who have the expertise - we have physiotherapists keeping people active - so you have a variety of folks. Pharmacists are part of some of those teams so really health care is increasingly a team-based activity.

MR. JESSOME: I appreciate that. I guess I was following it up with a perceived problem but it really sounds like, through this collaborative approach, there are ways of addressing it. My follow up was more related to the topic but I think I'll just move on, given your answer to that question.

Through you, Mr. Chairman, when the member for Pictou East was talking, you had addressed the issue of recruiting physicians with regard to an appeal or a focus on their families. I am wondering, because I am not entirely familiar with this alternative payment structure, is it as cut and dried as financial compensation or is the department exploring alternative ways, in terms of perhaps living arrangements? That is just one example I can think of off the top of my head. Is the department exploring those types of compensation to recruit physicians?

DR. VAUGHAN: The alternative payment is exactly that; it's an alternative to the fee for service payment plan. It gives physicians, particularly new physicians coming out, the stability of income. In rural areas that can be a challenge where there isn't necessarily the volume that there might be in a more urban area, so they have the stability to know that they are going to take home that amount of money.

They pay their overhead and their office costs out of that, like any other arrangement. The department is not considering additional fees or additional activities to pay for housing, for example, or office space. All of that would be included in your APP expectation. We believe that the amount of money we are paying is a good, competitive salary.

It's not a salary, I shouldn't say it's a salary, but we often call it that because it is a defined amount of money you are going to make a year. They can make more than that by billing for other services such as workers' compensation, which is not covered by that; seeing patients from the Armed Forces, for example, or other insurance payments they make.

The APP is not a salary. It is in some ways a base. They can build on that by billing other non-insured services. There is no indication at this point that we would be, in a sense, subsidizing housing costs for physicians.

MR. JESSOME: How much time do I have?

MR. CHAIRMAN: You have until 10:06 a.m.

MR. JESSOME: Excellent. I guess the last question here, what sort of mechanisms do you have in place to engage new physicians, student physicians, younger physicians or aspiring physicians in terms of getting feedback on how these funding structures are complementing their needs?

DR. VAUGHAN: We have heard a lot from medical residents, throughout a number of years now, their interest in alternate payment plans. New physicians coming out, pretty much universally - there are always exceptions to every rule - are looking to the alternate payment plan. They are coming out with their own challenges in terms of paying for their medical education so they are looking for predictability more than anything else.

That gives them a great deal of comfort; it allows communities to attract them to their particular areas.

Again, it's the community; it takes a community to recruit a physician and a family. It's so important that the communities, which do a great job across Nova Scotia to welcome physicians and their families when they come to look at communities, it's so important that the schools are highlighted. We have some wonderful school programs - we have seen physicians come from other parts of Canada specifically for some of our school programs or some of the activities that people are interested in, their hobbies and in their pastimes - surfing being one of them. It is remarkable the number of young physicians who choose to come here for those types of activities, or for the arts or other things besides work.

The lifestyle issues for young people today are incredibly important. While they want to be fulfilled at work, they also want to have a fulfilled, balanced lifestyle. We are very well aware of that and the APPs are critically important in being able to recruit and retain physicians to rural areas because of that.

MR. JESSOME: Through you Mr. Chairman, just to dig a little bit deeper, is there any source of - I hate to use the word division - but I guess, isolation of issues relative to what we just discussed with regard to foreign and domestic students.

DR. VAUGHAN: In terms of APPs?

MR. JESSOME: In terms of their likelihood to stay in practice in Nova Scotia based on these funding models.

DR. VAUGHAN: The APPs are helpful for all new physicians. I think it is particular challenging sometimes for any new physician coming into rural communities so the APPs are fundamental to be able to recruit physicians to those areas. As we often say, I know money will get them but it won't keep. It is to our earlier points, the community and the importance of welcoming communities and that is true whether you are from other parts of Nova Scotia or whether you are from other parts of the world. It's so important that we see the importance of . . .

MR. CHAIRMAN: Order, please. I'm sorry once again we have run out of time. I did let that one extend a little bit because I wanted to hear the answer but we will now have to move back to the PC caucus and Mr. Houston for 14 minutes.

MR. HOUSTON: I want to go back to the discussion around collaborative care centres because I wanted to get a sense from you as to the importance of those. Are those an important part of the equation going forward?

DR. VAUGHAN: Great question. Fundamentally, collaborative care is an important part of the go forward. We are currently awaiting the results of the evaluation of

the Collaborative Emergency Centres, the CECs, so once we have that we will have a better understanding in terms of what the challenges and also what the opportunities are. Everything can be improved and I would hazard to guess that there are opportunities to look at better ways to deliver those services, keeping the fundamentals of the CEC in place.

MR. HOUSTON: I just wonder if it turns out, which I suspect it will, more Collaborative Emergency Centres - and more Collaborative Emergency Centres are good things - as you sign, negotiate, or work out these alternative payment plans with doctors, if you could steer them into that type of environment, is that something that you would see as important?

DR. VAUGHAN: We often like to present opportunities to physicians that we think are areas of particular need. Physicians, as independent business people, will go where they want to go. The benefits of the collaborative centres are, I think, evident to us and certainly fit into what we see with young physicians coming out, the kind of practices they are interested in, so that is a plus and one that we do highlight, but it isn't for everyone. Some physicians have a definite idea about where they want to practise, for a variety reasons, sometimes family, sometimes they like certain activities that I just mentioned in terms of sailing, surfing, or whatever, or golfing. They've got pretty good ideas in mind, sometimes, but we do try, along with the communities who do a great job, to try and demonstrate the benefit of their community, and collaborative practices are a key component.

MR. HOUSTON: You mentioned the word predictability quite a bit, predictability of service, and I was reminded of a part of the AG's Report where it talked about physicians are meant to provide a report to the department on how many days they were absent or how many days they were there, and that was a weakness in the report that was discovered, that maybe people weren't sending those in. I just wondered what action you might have taken on that particular issue to try and improve that predictability for Nova Scotians in health care.

DR. VAUGHAN: In terms of the emergency room?

MR. HOUSTON: No, sorry, in terms of just the physicians working the days that they're meant to work under the contract. They're meant to send a report in that says how many days they were absent. I think that was a weakness that was identified. Many of them were not submitting that report, and often cases, those reports were maybe just getting filed and not reviewed. There was no feedback or accountability as to whether they were doing what they were supposed to be doing. I'm wondering if you've taken a specific look at that, to improve predictability.

DR. VAUGHAN: It's an important component of that accountability loop and as a part of the APP deliverable component, they need to be monitored, really, by the local folks who are on the ground in the health authority who are working with them. There has been much improvement in that. Like with anything, there's not 100 per cent compliance with

these things, so there is a monitoring mechanism to be able to allow folks working with the physicians on the ground. It's particularly useful in the Collaborative Emergency Centres where - we have a number of those now across the province and it's much easier. Obviously, they're working with other people. The challenge is when you have folks working individually and there are few of those - less and less over time - but there are still a few, with the collaborative practice environment, there's a manager there as a part of those clinics, so it's not the involvement of someone just by themselves.

MR. HOUSTON: I don't know whether this would be a huge problem or not, but every day that a physician that's on an alternative payment plan is not at work, Nova Scotians aren't getting the level of care and service that they deserve. So I think it is a pretty serious issue, particularly in the rural areas, when you think about it. Nova Scotians wouldn't necessarily know - if they called to get a doctor's appointment and the next one you can get is such-and-such a time, and they don't really know why. So I wonder if there's any thought of really zeroing in on that and holding the physicians completely accountable, even to the point that, if they're not fulfilling their requirements in terms of days at work, they get penalized for that. Have you thought much about that?

DR. VAUGHAN: It's an important question. It comes to the accountability and value for money again. With our contract with Medavie Blue Cross we have an audit process, and three audits a year are done specifically to look at those areas. If there's any variance in terms of what is required - again, looking at, you know, what other shadow billings going back, and having a conversation to make sure that those weren't just errors in reporting - which often is the case - and to look at training the staff to better report activities. But if there are deficiencies, then there are mechanisms to have hold-backs on future payments.

MR. HOUSTON: There are?

DR. VAUGHAN: Yes.

MR. HOUSTON: Okay. I would think, at the minimum, that everyone can submit their report of whether they were absent or present. I think that's something that I'd definitely like to see tightened up.

I do want to go back to the academic funding, because it is certainly an important piece of the puzzle in your mind, and I can see there'd be a lot of value in that. It's a lot of money. It's a couple of hundred million bucks a year, I think. As those contracts are set out, each contract would be relatively unique in terms of the deliverables on what's expected of each physician. I'm wondering who sits down and sets those targets and deliverables with them, through that negotiation?

DR. VAUGHAN: It's important to understand we've made significant progress in terms of clustering those activities. There are now 15 AFP contracts going forward, so, as

we talked about earlier, 500-ish physicians involved in that pool. So the activities within a surgical program and the number of physicians within that surgical program would be agreed upon, and that's part of that process of negotiation with all those parties - why it takes so long sometimes to get that work done, with those very busy clinicians. Each one of those clusters is negotiated as we go forward with the template that has now been agreed upon by all of those folks, which has been a huge piece of work. It's now part of the negotiations to populate that template so that there's consistency across all the APP contracts.

MR. HOUSTON: Do you have a sense of - I think I'm right, on the number $200 million is kind of roughly the range for academic funding - do you have a sense of how much of that is kind of, let's call it pure research versus how much is teaching? By teaching I'm having an expectation that there's an orthopaedic surgeon mentoring somebody and that - do you have a sense, is most of that research or most of that mentoring, or both?

DR. VAUGHAN: I think it's important to understand for those physicians who are engaged in the AFP model that the clinical care is an important part of their research activity sometimes, the clinical research. It's just one of the benefits of the AFP to attract world-class people. We're not trying to parse out, you know, this is how much time you are only going to be allotted to. It's a seamless integration within their departmental AFPs. So that allows them to seamlessly integrate their research activities. It may vary from individual - I'm talking about oncology so they may be having a specific amount of research time. It translates into patient care; it translates into teaching. They are inextricably connected, from the individual academic physician's perspective it's very hard to . . .

MR. HOUSTON: So that makes it hard to assess deliverables and assess - it really makes it hard to get kind of a performance feedback on them. I'm just wondering if you've thought much about how you can make sure that we're getting maximum value for those investments.

DR. VAUGHAN: There are attempts to quantify how much activity is being allocated. This is particularly important to the clinical care component of things, so that one doesn't just slide back into the lab and then neglect one's colleagues in the clinical environment. That just wouldn't wash for a variety of reasons. So there are attempts to quantify . . .

MR. HOUSTON: Sort of self-policed to an extent, too?

DR. VAUGHAN: Well it's a percentage as part of the AFP agreement, which then has performance expectations associated with those deliverables.

MR. HOUSTON: Okay, that makes sense. I appreciate that. I did want to come back, just as a general thing, about the Dalhousie Medical School and the intake there

because it is something that I do hear kind of in places that I wouldn't expect to hear it, really. I don't know if you have any thoughts on that medical school and how it can be better, how it can be improved or made bigger or better or whatever the case may be - just some thoughts you have on that process.

DR. VAUGHAN: In terms of the number of seats available?

MR. HOUSTON: Yes, the number of seats and just in general, but we'll start with the number of seats.

DR. VAUGHAN: I think Dal is recognized as an excellent medical school right across Canada. It has a good reputation for producing high-quality physicians, and excellent training programs in many specialty areas. The question of whether there should be additional seats in Dalhousie Medical School - there have been additional seats funded over the past number of years to Dal Medical School and there is no plan to increase that at the present time.

If you look across the country, a number of new seats have been increased across the country. Our focus is on recruiting at this point; we think the Dal number is reasonable. There's a significant cost to adding new seats. What we're trying to do is attract students, not only retain them from Dal, but also to recruit them from other parts of the country. We think Nova Scotia has a lot of advantages and is a fabulous place to live and to work, and we need to sell ourselves and not be ashamed of that. We have fabulous resources that physicians find when they get here. We need to spend more time recruiting physicians from elsewhere.

MR. HOUSTON: Just as a final question, I'd be interested in your thoughts on what the biggest thing facing health care is. What's the thing that keeps you awake at night right now, that you say, how are we ever going to solve this?

DR. VAUGHAN: That's a great question. I think every health care system around the world struggles to meet the needs and demands of populations with limited resources. Nova Scotia is not unique in that regard. That is the fundamental challenge that every health care system in the world faces, those that are high-performing health care systems - and our vision is to have a high-performing health care system in Nova Scotia that is constantly seeking to improve, which is why we value the comments from the AG's Report as an external view.

Focusing on quality, which means focusing on cost effectiveness, focusing on safety, focusing on accessibility, focusing on appropriateness - evidence of all of these things and reporting evidence of these things is really the hallmark of quality improvement in high-performing health care systems. So I think our vision is to have that reporting, just like we're talking about today in one aspect, but with the new Health Authorities Act, the

accountability framework will give us that public reporting on a number of dimensions, which will help us try to achieve our goal of being the best.

MR. CHAIRMAN: Order. We've run out of time again. Moving to the NDP now for 14 minutes. Ms. MacDonald.

MS. MACDONALD: Thank you very much. I think this is the probably the third time that the Auditor General has looked at the alternate payment plans and alternate funding plans. I hope they continue to monitor this, simply because it's such a significant amount of revenue in the health care budget. I recognize there has been a lot of work done, a huge amount of work done to improve on these plans and these processes, and I think we just have to keep working at it to make them better all the time.

The first recommendation of the Auditor General from the May report is that all physicians who sign on to the academic funding plan should actually sign on. Has that been done? Do we now have compliance in terms of all of the members of those plans? Have they signed on?

DR. VAUGHAN: We do.

MS. MACDONALD: Excellent. That's a good first step. I noticed today that there's an article in *The Chronicle Herald* that we're about to embark on collective bargaining, I guess, with Doctors Nova Scotia around the master agreement. I'm somewhat puzzled about whether the AFPs and the academic funding plans will be part of that, because my understanding is that it's not usually part of that. Could you clarify that for me?

DR. VAUGHAN: Sure, I'm happy to clarify that. It's an important benchmark going forward that we incorporate all of the negotiations for the APP and AFP and fee-for-service into the master agreement going forward. As we're trying to streamline negotiations across the province, this is a part of that streamlining so that we're not in constant negotiations.

MS. MACDONALD: Interesting. It will be interesting to see how that all unfolds, then, because my understanding - and I think that the master agreement itself and the fee schedule is extraordinarily complicated in and of itself. There has been a review, and I'm wondering if a review of the fee-for-service structure - I'm wondering if you could tell us where that stands. My recall is that we literally have hundreds, if not thousands, of little fee codes, and many of them - well I shouldn't say many of them but certainly some of them - are really outdated in terms of the actual practice. So where is that review?

DR. VAUGHAN: That is a great question. It has been recognized for some time, by a number of people, the need for change and modernization, if I can use that language, in the fee code structure in Nova Scotia. There is a project currently underway and that work is being done. Because of the numbers you have articulated, it's going to take some time,

probably about two to three years even, certainly two years, to complete that work. Each one has to be examined individually so there is a lot of work to do. That work is certainly ongoing but we are looking to have it completed in about two years.

MS. MACDONALD: It strikes me as somewhat out of sync with negotiating a new contract for which the fee service would be very much a part of the extent to which there is an increase or not. In the country right now at least two provinces have frozen the salaries of physicians. I think here in Nova Scotia we were able – the previous administration - to hold what was anticipated to be a 3 per cent annual increase in the master agreement to one per cent.

I know it is unlikely you will give us targets here today for what the government is looking at but I guess the question I would expect a response for is whether or not, in the negotiations, there will be an attempt to buy change in the system. What I mean by that is to incentivise more people going to collaborative practice, for example, to deal with the whole question of utilization and maybe you can help us understand what the government's plans will be with respect to those issues.

DR. VAUGHAN: The issue of the fee schedule, I would like to have it been modernized yesterday. We recognize it as a piece of work that is probably long overdue but is underway. We can't, unfortunately, push a pause button. Physicians have been, I think, understanding in that they are citizens of Nova Scotia, and small business people understand the fiscal environment as well as the rest of Nova Scotians, but they are looking to have a conversation, not just about money, and I'm sure there will be conversations about money, but we are also having early conversations about how can we not just do the things the way we have done them but how can we shift to look at different ways of paying for different things.

It is a bit like changing the way we have been paying in one area to another area such as technology, for example, and that can be email, Skyping, or different kinds of - I mean these tools are very much in play every day. Our fee schedule has not kept up but while we are waiting for that, can we do some other things to shift some of those resources to allow for improvement in access because those tools do improve access to services.

So we are having those conversations, early conversations, but there is certainly receptivity. Many physicians would like to be able to do that but are restricted by the current billing system from being able to be paid for those services. We are having those conversations with Doctors Nova Scotia.

MS. MACDONALD: Two questions I would really like to get in before my time is up and one is that the government made a commitment in their election platform to have a doctor for every Nova Scotian in year one. I don't think that commitment has been met. You have indicated that one of the priorities for the department is physician recruitment, so

my question would be, when you do anticipate that that commitment will be able to be met?

DR. VAUGHAN: It's an ongoing activity, as I'm sure the member knows, in terms of recruiting and retaining physicians. It's one thing to recruit, it's another to retain. Nova Scotia, on a per capita basis, has amongst the highest doctor-to-population ratios in Canada so it's not just about numbers, it's about distribution. As we look to create opportunities in our conversations, in the master agreement conversations, what can we do to incent physicians to locate to areas outside of urban areas in particular, as part of our ongoing activities?

There isn't a magic bullet to that conversation; no jurisdiction has a magic bullet to that conversation so it's an ongoing challenge. There are certainly more medical students coming out across Canada now so they are looking for placements. The environment in 2014-15 and 2015-16 is very different than it was even just a few years ago so we are making improvements.

I think it's important to also recognize that nurse practitioners play an important role as a primary care resource and there are many activities to ensure that Nova Scotians get the primary care that Nova Scotians really need. It's really about a team of primary care providers; doctors are important but nurse practitioners are also an important component to that.

MS. MACDONALD: Thank you. What I'm hearing is that it may be hard to reach a conclusion to that particular commitment.

I know there's a physician resource plan, a 10-year physician resource plan that also was developed under the previous administration, and that plan identified that we had an oversupply of physicians in some parts of the province and an under-supply in others. It also identified areas where we needed additional specialists, like in child psychiatry and orthopaedic surgery. Perhaps we don't have enough time to really get into all of the details of that plan but I would like to know, how is the implementation of that physician resource plan coming along and when will we get an update, I suppose?

DR. VAUGHAN: The physician resource plan has been a very helpful tool in helping to understand what the needs will be. It is used as a planning tool. There are some specialties, particularly subspecialty areas, that are challenging to recruit right across Canada and it wouldn't be any different here than in many other places.

At the same time we are in constant conversation with the medical schools around the types of residencies that are in play to ensure that we are able to get out of the medical school training the kinds of physicians that communities in Nova Scotia need. It's a process of implementation but the physician resource plan is a very important planning tool, and other jurisdictions are looking to Nova Scotia and Nova Scotia's experience.

It's not cookie cutter. There are obviously degrees of freedom to those numbers, and so we use it very much as a planning tool. We use it particularly in some of the subspecialty areas that you mentioned when we're looking at recruiting to certain areas. Again, it all comes down to the availability of those resources. In some of the subspecialty areas in particular, there just aren't a lot trained for a variety of reasons but we're having conversations with the universities around that.

MS. MACDONALD: How much time do I have?

MR. CHAIRMAN: Ms. MacDonald, you have until 10:36 a.m.

MS. MACDONALD: Great, I have two more minutes, thank you.

The last questions I have would be around the potential for savings from the DHA amalgamation. We also know that the government said there would be $13 million in savings in the first year, and we now know that has been revised and we're looking at $5 million, I think that was the last number that I heard from the Minister of Health and Wellness. I'm wondering if you could provide us with a bit more detail about where the savings will come from.

DR. VAUGHAN: First of all, I'd like to note that in terms of that accountability framework, in dimensions of quality, cost effectiveness is one of those dimensions of quality. The savings are really ongoing as a modus operandi in terms of the structure of the organization.

The first-year savings - or what I would characterize as year-zero savings, the figures that you quoted are really year-zero savings, as in the organization hasn't even stood up yet - but at least $5 million will be saved as a part of the pre start-up. Year one, which is really after April 1, 2015, the continued savings will occur as that new staff will then be looking at efficiencies that are going to be there when you amalgamate the 10 health authorities - the next level of savings that can be brought into play. Beyond that, we'd be looking at the shared service savings as well that will be coming into play - the so-called back office savings that have been in the works for some time.

I think you're really going to see significant savings - zero, one, two, three - that's when you're going to see the bulk of your savings. It's a scaled saving plan, if you will, but the ongoing savings are going to be achieved in the bench-marking in an ongoing way through the accountability framework. That is probably the most significant part of the structure change.

MR. CHAIRMAN: Order, please. Everybody is getting a little extra time today, but I do have to impose some limits. We'll move back to the Liberal caucus and Mr. Maguire.

MR. BRENDAN MAGUIRE: Recommendation 6.10 said "The Department of Health and Wellness should establish a process to communicate audit results and discuss Medavie audit findings with physicians in a timely manner." I want to talk about what has been done with this recommendation, but also about communications in general within the department.

One of the things that I kept hearing over and over was a lack of communications between family physicians, front-line workers, and emergency responders. I actually received an email from a constituent who was from B.C., and she said how easy it was out there, that she could type in a name and have access to records from multiple hospitals all over the province. I would just like to hear what you're doing on that side, but also what you're doing around the communicating of the audit results to physicians.

DR. VAUGHAN: The communication of the audit results to physicians - are you talking about the Auditor General's results?

MR. MAGUIRE: Yes.

DR. VAUGHAN: That would be through Doctors Nova Scotia, which is the association that represents physicians.

MR. MAGUIRE: In general, is there going to be any response to the lack of communication with the amalgamation of the boards in regard to the different levels of health care? If I walk into a hospital anywhere in Nova Scotia, will they be able to - you know where I'm going with this, right?

DR. VAUGHAN: I think I do - in terms of electronic health records?

MR. MAGUIRE: Yes. I mean, with today's technology this should not be as big a problem as it seems to be.

DR. VAUGHAN: It's a great question, and one that we are very passionate about. I think we're certainly - again, if I can look at that foundational piece with the consolidation, one of the challenges with the health authorities and living in that world - good people working in that world, but the structure inhibits the ability of information to flow. With the consolidation of the health authorities, we are then building on top of that a unified electronic health information system, which is a fundamental piece to allow the seamless transmission of information between and among people who are caring for patients.

It will be important then to see that in that universe patients will have access at some point - not the first day, but down the road, in a number of years - they'll be able to have access to information. That currently exists in some jurisdictions today. If you have an X-ray or a lab test, you can call that up, with the appropriate security mechanisms in place. This is currently in place in some jurisdictions; it's not fiction. It won't happen

overnight; we have to build the house of the health care system in a logical way and in a way that the province can afford so we are sketching out all these pieces.

Innovation is an important component of the future agenda as well, not just innovation in terms of health research and care, which is important, but also in terms of bringing in new technology that allows us to communicate better. It is one of the challenges of the modern world. We have many, many modes to communicate between and amongst each other, yet sometimes communicating is the biggest challenge.

In health care we need to move to a place where we have that communication that is seamlessly occurring between and among organizations and particularly amongst health care providers.

MR. MAGUIRE: I would just like to get your opinion on this: we have been sending emails all over the world and information all over the world for 30 years now, 40 years now, so what prevented the flow of communication and information within the health care system? I guess it's something that I haven't been able to really get my head around because it just seems to me like it would have been a natural step.

DR. VAUGHAN: We have three operating systems currently in play within the hospital-based system in Nova Scotia. That is a significant challenge in a legacy way, so you've got three different systems that don't speak to each other.

MR. MAGUIRE: Microsoft to Apple kind of thing.

DR. VAUGHAN: Exactly. Even today, of course, those systems do speak to each other through Internet protocol. We have to move from those systems that we currently have in play to an integrated system that allows us to function in that universe that you are referring to.

MR. MAGUIRE: I'll ask just one more question and then I'll pass it on - I have a million notes here. In your opening statement you spoke of streamlining the health care system so that much-needed health resources can be allocated where they are needed most. It's a pretty broad statement.

I guess what I would like to know, is this not happening now? What does that actually mean? If the general public said to you, and you specifically said to the front-line care, I think the average Nova Scotian, myself included - I mean it's about access to resources so being able to get your flu shot and also wait times. It's a pretty broad statement just to say that this is going to do this. Could we get a little more detail?

DR. VAUGHAN: Sure, happy to, let me give you an example. Currently within the health authority structure if you want to bring a physician in to work an emergency room shift or do a locum for an over-worked physician who needs to take a break, they each have

to apply for privileges, do the paperwork - and there is a whole lot of paperwork they have to do. That can be daunting, it can be time-consuming and it can be a turnoff, frankly, for some physicians who frankly don't understand why, if they want to go from Kentville to Bridgewater, or Halifax to Yarmouth to work for a weekend, they have to go through that process. That will be gone. There will be a provincial, streamlined approach to credentialing physicians.

MR. MAGUIRE: I said one more question, I apologize. How did we get to that point and did we not see this as something that would prevent physician recruiting? If they are bogged down in paperwork, and they are bogged down in the red tape of it all, to go from one hospital to another, could that not be seen as something that might be a turnoff for a physician wanting to come to Nova Scotia and wanting to work here?

DR. VAUGHAN: Nova Scotia is a relatively small province and it is the approach that we're implementing going forward. I can't speak to the past. I can only speak to the future and what we are building and the reasons we are building it differently.

MR. MAGUIRE: But this is seen as a positive.

DR. VAUGHAN: It is seen as a positive, I think, by just about everyone, and there are probably a hundred examples I can give you from my days in the front line of care in Nova Scotia that people recognize within the system, the benefits of moving to an integrated, province-wide solution.

MR. MAGUIRE: Thank you very much. I'll pass it now.

MR. CHAIRMAN: Mr. Farrell, you have five minutes.

MR. TERRY FARRELL: Thank you for being here today, Dr. Vaughan. I'm Terry Farrell, the MLA for Cumberland North. I wanted to ask you about an issue that I see stretching across all departments, really, and the perception that we have. Infrastructure and services in the metro area that are working to their capacity and sometimes aren't meeting all the needs that are here, and that other infrastructure in outlying communities maybe aren't up to capacity, and I think with the alternative physician funding arrangements that is one of the things that we are seeing there.

One of the things that I have seen that appears to be designed to deal with that is the measure to shorten the wait times with the orthopaedics around the province. Are there any plans to expand those kinds of programs to have patients from the areas where the wait times are longer and the infrastructure is overworked, to have those services delivered in an alternative way and maybe get more out of the alternatively funded physicians or the other infrastructures?

DR. VAUGHAN: Yes, it's a great question. I think that is one of the advantages of breaking down the silos. You can - I'm going to say an air traffic control analogy in terms of where there are, for example - let's talk about the surgical environment where there may be capacity in Bridgewater, or Truro, or Amherst, or Pictou. That analogy can extend across a number of sectors and components of the health care system - so that, if there's capacity, the patient can choose to drive to Bridgewater to get their service, or to Truro from Halifax, or any of those elements - you know, they go from Amherst to Pictou, or Pictou to Amherst. All of those opportunities would be seamlessly integrated into that, what I call air traffic control.

MR. FARRELL: I guess I was thinking more of people driving from metro to Amherst to have those services performed. I think that we have an excellent facility there that could help anybody that wanted to come and join us.

I want to give you an opportunity to expand on something you said earlier. You talked about having a vision to have a high-performing health care system. I often say, with respect to a lot of our systems, that we have possibly the worst one except for all the other ones. Would you like an opportunity to maybe expand on that a little bit.

DR. VAUGHAN: Sure, happy to. I think there is lots of room for improvement right across Canada. When you look at the OECD rankings, Canada comes second last, just above the United States. We as a system have a lot of room for improvement. Nova Scotia is moving in the right direction by making some difficult structural change. Change is not easy, we all recognize that, but some might say it's long overdue and without that fundamental structural change we can't build the future health care system that we all know we want to see.

It unfortunately cannot happen overnight; it is not a flick of the switch but that is a fundamental piece. The governance is an important part of the design of the health care system. It will enable us to break down those silos, to put the mechanisms in place. The accountability framework is fundamental to any health care system that is high-performing so that we are able to see the targets we are trying to achieve, we're publicly reporting on those, we are being bench-marked against that; it is critically important as a measure of future success.

I think the future is bright. I think we have a lot of work to do, make no mistake about that, but I think the structure is that foundation. I always like to use the analogy, remember what it was like with the number of ambulance services we used to have and how challenging that was. Today no one would go back to that system when we have clot-busting, sophisticated drugs delivered to your door by highly sophisticated, trained paramedics, all because of that structure being put in place. This is, I think, a continuation of that journey. We have to get to the fundamental restructuring pieces so that we can do the heavy lifting that needs to be done.

MR. FARRELL: Thanks for your answers and I would like to thank your colleagues as well for helping out here today. Thank you Mr. Chairman.

MR. CHAIRMAN: Thank you Mr. Farrell. With that we have run out of time for everyone. Dr. Vaughan I'd like to give you the opportunity to provide some closing comments.

DR. VAUGHAN: I'd like to sincerely thank all the members, the committee for the opportunity and for your questions this morning, all very important questions. I hope we were able provide you the kind of information you were looking for here today. If there are any outstanding questions or any items that need further clarification, our staff would be happy to provide that information, in a timely manner.

The goal of transition is to create a single, unified health care system for all Nova Scotians that really puts people first; that promotes health and wellness and provides safe, quality health care; creates accessible, effective, streamlined, sustainable health care services. Fewer health authorities will allow us to better plan and deliver health services that Nova Scotians need.

We can integrate policies and services where it makes sense, standardize service delivery and provide more equitable access to specialized services. Developing province-wide plans will make sure that we are using all of our scarce health care assets in the most efficient way possible. As I said before, change is never easy. Health system change can be especially challenging and necessary, some might say long overdue, as we move to modernize health service delivery to better meet the needs of our current and future population.

The overall goal of this transition is to focus our limited resources to provide province-wide safe and consistent services as we lay the foundation for a future of continuous quality improvement based on evidence of need. The province is on its way to building a stronger, unified health care system that will better meet the needs of Nova Scotians; APPs and AFPs are an important part of that transition. I would like to thank you all for your questions today.

MR. CHAIRMAN: Thank you Dr. Vaughan and thank you as well to those who have come with you this morning. We have two items of business before we adjourn. One is our annual report, summarizing the activity of the Public Accounts Committee. It has been distributed to everyone. We have an opportunity today to approve that and I would ask each of you to see our clerk before you leave if you are comfortable in signing off on that. Are there any objections to what has been distributed? Seeing none, I would encourage you to remain and sign off on that document so that it can be put out for public consumption.

The other item that we have is a list of our upcoming meetings and this was approved in our last meeting. These meetings have now been scheduled for the months of November and December. There is one meeting that extends into January but as I've been told by the clerk this morning, it is the same subject that we are meeting on next week on October 29th. We are having the Department of Labour and Advanced Education, the superintendent of pensions coming in to discuss the Financial Hardship Unlocking Program.

That was a topic put forward by the NDP caucus. The January 14th scheduled meeting was put forward by the Liberal caucus and that was on amendments to pension regulations, which I believe is the same topic. There is the option that we could combine both of those meeting into next week's meeting. I would certainly be up to - I'm seeing agreement from the NDP caucus and the PC caucus and I think the Liberal caucus as well. Okay. If something changes, we can revisit it again but that will make things a little simpler and more efficient and we would look to schedule a different meeting come January in that time slot.

With that we will adjourn, thank you.

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