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NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, February 18, 2015

LEGISLATIVE CHAMBER

Department of Health and Wellness
Surgical Wait-list and Operating Room Utilization

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Public Accounts Committee

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[Mr. Tim Houston was replaced by Hon. Christopher d'Entremont]

In Attendance:

Mrs. Darlene Henry
Legislative Committee Clerk

Mr. Gordon Hebb
Chief Legislative Counsel

Ms. Evangeline Colman-Sadd
Assistant Auditor General

WITNESSES

Department of Health and Wellness

Dr. Peter Vaughan, Deputy Minister
Ms. MJ MacDonald, Executive Director, Health System Quality
Ms. Sandra Christie, Executive Director, Acute and Tertiary Care
Ms. Karen McDuff, Director of Financial Services

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, FEBRUARY 18, 2015

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN (Mr. Iain Rankin): Order, please, I'd like to call the meeting to order, it's 9:00 a.m. Good morning. I would like to first ask to have all cellphones placed on silent, vibrate or off. We'll start with the introduction of members.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Today on the agenda is the Surgical Wait-list and Operating Room Utilization, which refers to Chapter 4 of the December 2014 Report of the Auditor General. We have the introduction of everyone so we'd like to start with the introductory comments from the witnesses. You can go ahead, Dr. Vaughan.

DR. PETER VAUGHAN: Good morning, everyone. Thank you to the chairman and the committee members for inviting the Department of Health and Wellness to appear before you today. I am pleased to be here, along with MJ MacDonald, Executive Director of Health System Quality; Sandra Christie, Executive Director of Acute and Tertiary Care; and Karen McDuff, Director of Financial Services.

I'd also like to thank the Office of the Auditor General for their December report and their recommendations. Their work helped bring focus and validation to the work already underway at the department to tackle the surgical wait-list in Nova Scotia, and to ensure effective and efficient use of operating room capacity across the province.

The department has accepted all nine of the Auditor General's recommendations, and while it has only been two months since the report was released, I want to assure the panel that my department and the district health authorities have been working hard at implementing each and every one of them, because at the end of the day it is about ensuring that Nova Scotians have better access to quality health services. We recognize that the health system approach to date has been inconsistent from DHA to DHA, and this has contributed to people having to wait for certain procedures for far too long.

There are many who believe that pumping more money into the health system will cure the wait-list concerns. However, we know that we can provide shorter wait times with current resources but this requires changing existing processes and practices first. Once that is complete, we can identify what additional investment may be required and where it could be best put to use. We have been and will continue to work with system stakeholders to make better use of our important and sometimes scarce surgical resources in the system as a whole. This is an important point to remember.

If we take orthopaedics, for example, it is a component of a health care system which is integrated into a larger system, one that is impacted by many factors. With a system view, we can see how things can get slowed down when patients can't flow smoothly between emergency departments, acute care units, alternate levels of care beds, or back to the community with home care or long-term care services if required. This is why province-wide planning and utilization and a health services plan for the province will help us to ensure the right care for patients right across the province.

This important work comes at an excellent time when the health care system is transitioning to a unified Nova Scotia health authority, plus the IWK. The transition to the new health authority is a necessary step for system-wide change, system-wide planning, to ensure consistency and operational policies governing operating rooms and more efficient and effective use of existing surgical capacity across the province. The DHA restructuring will be, in fact, a key initiative in helping to address the inconsistencies the Auditor General identified. This is another reason why we need to consolidate the health care system.

The new Health Authorities Act greatly strengthens system accountability and requires that the Nova Scotia Health Authority and the IWK prepare and submit quality improvement plans. This will improve the department's ability to provide oversight and will help us create an integrated system approach, which is directly in line with many of the Auditor General's recommendations.

We were very pleased that the Auditor General recognized the department's work to date to address wait times through its wait time registry. The report recommended and commended the data accuracy of the registry and noted the efforts the department made to improve elective surgery wait-lists in recent years.

The Auditor General also commented on the department's ability and the website, which is user-friendly and cited additional funding that was allocated over the last two years to perform additional hip and knee replacement surgery for long-waiting patients.

Even with these assets under our belt, we know that surgical wait times can be a challenge in the province, much like other provinces across Canada. While 96 per cent of surgeries in Nova Scotia last year were completed less than a year after the need was identified, we know that we still lag in areas like orthopaedics. Our end goal is patient-centred quality care with timely access to necessary surgery.

I am confident that we will achieve this through collaboration with our partners in the Nova Scotia Health Authority and the IWK, and through a unified one-Nova Scotia health system. I welcome your questions.

MR. CHAIRMAN: Thank you. We will start with the Progressive Conservative Party for 20 minutes. Monsieur d'Entremont.

HON. CHRISTOPHER D'ENTREMONT: Thank you to the Department of Health and Wellness for being here. Dr. Vaughan, it's a pleasure to have you here today to talk about surgical wait times. It seems like one of those issues that never seems to go away. I haven't been in the department for close to seven years and many of these things sound pretty familiar. I would think, as the optimist I try to be, that some of these things would have gotten better over time, but unfortunately it seems to be the opposite. It kind of stayed the same.

Recently there was a letter that was passed around by a number of orthopaedic surgeons from the Pictou area. It was copied to a whole bunch of people - to yourself, to the number of MLAs in that area - and I was going to table that because it also backs up a number of the findings from the Auditor General's Report as well. I thought it was sort of an interesting perspective that it comes from a number of surgeons in that area and what they see as barriers to doing those surgeries or to try to manage their wait lists in that area, so I will table that for the group.

Do you remember the letter? I think it was signed off by Dr. Todd Boudreau, Dr. Tahmir El-Tahan, Dr. Andrew Hayward and Dr. Prem Sequeira from Pictou County. I'm going to go through that a little bit. Quoting from it: "The beds on the surgical ward of the hospital are routinely occupied by an alarming number of non-surgical patients."

So that goes to your comment of people sitting there from alternate levels of care and other issues - they've been there for a long time and the doctors aren't discharging them, and those kinds of things.

Is that a consistent problem across the province? The obvious solution to this is working to add more beds, and we understand the challenges of that, but is that the only solution? Is this a management issue as well? I know it's a big question on that one - that

there are a lot of bed blockers and a lot of reasons for it. Is it more long-term care beds? Is it more beds in our system to try to access that care?

DR. VAUGHAN: Thank you for the question. I think it's an important question, it's one that I think cuts to the heart of what we have been really talking about in our preamble. The opportunity the consolidation brings means breaking down some of the historical barriers that have arisen over time with different approaches to doing things in a number of health authorities. You'll have some health authorities that have been very good and very efficient with managing what we call access and flow, or patient flow, through hospitals from emergency rooms right through to the home care continuum; whereas others have for various reasons not prioritized or been able to introduce some of the efficiencies. It's not one thing that really sort of gives us the solutions to the problem, but certainly working together as we have been with our stakeholders, including physicians - which are a very important part - and surgeons working very closely together with us. In some districts that has happened better than others.

The opportunity with the go-forward in what we are doing with many other programs, including our bed utilization program, allows us to better improve the flow through the hospital system, but it's a joint effort on the part of a lot of players that hasn't necessarily taken place in all health authorities to the same degree. We are a small province and we have a one-Nova Scotia approach; we need to build on that foundation to introduce various opportunities, to introduce efficiencies into the system, and that includes how we manage our ORs and how we utilize those resources.

MR. D'ENTREMONT: We hear as MLAs quite often, the hospitals are running at 100 per cent, not 105 per cent or 110 per cent, where we do have a lot of patients sitting in closets - I guess that's probably an exaggeration of where we're placing patients a lot of times - but they are doubling up far more than they need to. Do you have any stats on which district has experienced it the most, and what kind of blockages are they? Are they long-term care patients, or is it just discharge planning that has gone wrong or things that doctors are holding on to? Do we have any stats that sort of support that side of the discussion?

If I remember a number of years ago when continuing care was trying to do their assessments, of course, the districts wanted to have hold of that because they wanted to have a better feeling of where the flow of those patients was going; now seven or eight years later, nothing has really changed there. So what kind of stats are we working on when it comes to the placement of long-term care that's blocking our system a bit?

DR. VAUGHAN: We can certainly get you the specifics district by district. The challenge today is that each district gathers that information individually and in some cases may do it slightly differently. We have been introducing, the past number of years, the bed utilization management program which has given us very good, robust data across the system, but it also includes the opportunities, with that information, to now be able to better manage the individual needs of those patients. Prior to that we didn't have that robust information, but we can certainly get you the statistics on the individual DHAs.

MR. D'ENTREMONT: Another quote within the letter says, "We also fear that trauma patients are at risk for significant increases in morbidity and mortality due to transfer delays." The AG's Report states, ". . . Nova Scotia does not have adequate processes to manage waitlists for surgery or to optimize operating room use focused on surgical priorities." The essential goal of our health care system is to keep people alive and healthy. These are doctors that are clearly stating that the mismanagement of the hospital's resources is going to result in someone losing their life, which I think we hear a lot of when we talk to hospitals and doctors. Why have we gotten to the point where in parts of this province people are at risk of dying due to mismanagement? Why do we continue to always hit that wall where doctors are really worried about their patients' outcomes?

DR. VAUGHAN: The health care system has evolved over many decades and has evolved not just in Nova Scotia, but historically has evolved from the kinds of individual sort of practices, ways of doing things to the point where now we understand the ability of bringing that useful information that I talked about, through the bed utilization management information, which gives us system-wide information so that we're able to better look at Nova Scotia as one system and where to best allocate resources, based on the best information we have. We didn't have that before, so it's a bit like the dashboard of your car - it's important to know how fast you are going, especially in the conditions that we are experiencing out there these days and to adjust, based on the conditions. That kind of real-time information allows us to better manage and better allocate resources, based on real-time patient needs.

That's the power of looking at the One Nova Scotia approach, to be able to better allocate and understand. We didn't have that in the past and so we were very much dependent on ad hocery to sort of understand what was going on from place to place. Sometimes the physicians or surgeons or nursing staff or even the management staff would see areas that need to be addressed almost after the fact. What we're trying to do now by using and harnessing the power of information is to analyze that information and get ahead of that, like you would in your car - knowing how fast you are going on a slippery patch, to adjust your speed, to adjust resources based on the best available information. That's the power of understanding information.

MR. D'ENTREMONT: Going to the issue of One Nova Scotia, or at least the regional approach to things, the letter goes on and says that this is not just a regional issue, doctors know that when the Aberdeen Regional Hospital is unable to accept those trauma patients they must go to other regions, which puts pressures on those hospitals as well because we sort have an integrated system, just by the virtue of how our paramedic system works, how the EMC transfers patients around the province.

There are two problems with this. First is that the patient faces greater harm the longer it takes to transport them to another hospital, the second is the increased cost associated with driving someone further away. So how do we try to manage those kinds of things? You are a trauma patient and you should be seen at your nearest ER, but that

hospital is running at 110 per cent and the ER is closed because they just can't accept any more. How do we try to manage those immediate problems beyond a wait-list issue? This is not a wait-list issue, this is a trauma life problem.

DR. VAUGHAN: I think the EHS example is an excellent example of the power of consolidation. Twenty years ago government moved to consolidate the ambulance services, we now have one of the premiere ambulance services in North America. We have our challenges, as with any service, but it is internationally rated as one of the top 10 in North America. The power and the ability to do things through integration of the ambulance services is a prime example of the power of being able to address surge capacity. When you have that real-time air traffic control system that we do have in the Emergency Health Services system, that is the foundation for the consolidation in many ways. When you layer the consolidation on top of that, you start to see the potential for being able to manage the kinds of surge capacities required to manage a modern health care system.

Many of the physicians you are referring to are working with us as part of the orthopaedic working group. As I said, physicians and surgeons are critical, as other colleagues are in the health system, to have their input in how to improve the system. No one group can do it by themselves, we all need to work together to improve the challenges and address the challenges we will face and continue to face in any system that is siloized. But the more that we can integrate the system, the more we can adjust in an air traffic control kind of way across artificial boundaries, we will deliver better services to Nova Scotians in the future.

MR. D'ENTREMONT: I've got a few more quotes from the letter before I move on to some other questions from the Auditor General's Report: ". . . the operating room start time is delayed due to a lack of inpatient beds. This inefficiency leads to inadequate time by the end of the day to complete the allotted cases, as well as nursing overtime costs to stay late and finish."

The more you bump that - if you're going to try to keep your list of surgeries for that day, well of course you're going to go along. I'm not a surgeon but I know things can sometimes be a little more than what you expect them to be and surgeries can take a little longer as you roll around.

While there are costs associated with new beds, there are also costs associated with nurse overtime, due to delays in surgeries being bumped. Are you aware of what those costs are, due to those inefficiencies? What kind of experience has the department now had or what kind of data do they have to support nursing overtime and other professional overtime due to surgery going late?

DR. VAUGHAN: One of the challenges of that air traffic control system is understanding what the enablers are to efficiently operate within the operating room environment you're referring to. We have seen that some health authorities across the

province have done a very good job of working with physicians, surgeons, nurses and others to improve the throughput and the efficiency.

One of the key enablers, as you can appreciate, with any system like that is if you start late, you end up late. So it's critically important that everyone work together to make sure they're running as efficiently as possible. There are some ORs that have excess capacity across the province, some ORs stop at two o'clock in the afternoon, while others are running into overtime, into the evening.

So again, the information that we have and the information systems that we are building will allow us to better manage that air traffic control and the flow to avoid the cost overruns in some places, while other places were paying for costs that aren't being utilized well. We have a great deal of information around that and we're happy to share that with you.

MR. D'ENTREMONT: The final quote from the letter before I move on, "Our elective surgery wait time continues to grow, our emergency patients continue to suffer, and operating room time continues to be wasted." So the first question on that one is - it is apparent that this is reaching a critical level, and of course we wouldn't be here talking about it if we didn't think it was important - what is the short-term fix to immediately alleviate some of these issues as the government works for the long-term solution?

DR. VAUGHAN: The issues around de-siloization - and that's a prime example of opportunities that aren't or have not necessarily been spread throughout the system. Places in the Valley, and I know in the South Shore where I was, a lot of improvement has been achieved through working with physicians and surgeons and other staff to look at how to more efficiently use the OR times.

I think as you noted very early on in your first question, this is not a single part of a solution. The health care system is a complex, dynamic system across many, many different components and so the issues with emergency rooms, the flow within the emergency rooms, the issues within the flow of the patients in the hospital beds and the surgical wait times are all connected.

So it's not one simple answer to this question, but as I said in my outline in the beginning, it's really a systems approach. The power of a systems approach right across our small province incorporated with good information allows us to manage and air traffic control the system as a whole. Historically that has not always happened in some of the smaller health authorities in particular. It can be more challenging when they're confined by their geography, but we can certainly do a lot better with a unified and one-Nova Scotia system.

MR. D'ENTREMONT: The doctors go on to say as well that they believe there is a need for beds that are dedicated to surgical patients. I understand the challenge of that because you've got people who are there waiting for a placement in long-term care or

they're waiting a little too long. So what do you do with them if you're now dedicating just surgical beds?

I know in some cases, especially when I look at the patients from southwest, a lot of them go to Kentville for surgery or they come to Halifax for surgery, they're there for a day, and then they get shipped back to Yarmouth or whichever hospital that they can go and convalesce and get better before they're discharged. What are the challenges around dedicating beds for surgical patients?

DR. VAUGHAN: The challenges with dedicated beds for surgical patients is simply the reality that the vast majority of patients who are admitted to hospital today, for example, are going to be people who are falling, people with acute emergencies, unfortunately. Those patients will be admitted to hospital beds.

If you go back in time to a period where you have silos within silos, then you'll have those beds that aren't necessarily being filled when individuals go on holidays or whatever, or off on sick leave or whatever, those beds are critically needed today by patients who have a variety of conditions, as we mentioned. So the whole system approach to management of our bed situation across the province, based on good information, allows us to better manage those. To go back in time to isolation and partitioning of beds is probably not the way that a modern, efficient health care system can possibly manage anymore.

MR. D'ENTREMONT: Your minister made an announcement yesterday that talked about the long-term care wait-list and trying to make adjustments to that. All these things are kind of related, really, because of who those patients are. What are the stats at this point - maybe a regional breakdown of which area would need more long-term care beds. I mean this was a big piece of work back in 2006 with the continuing care strategy in trying to identify in the senior population what kinds of sicknesses they're going to have, what kinds of services they might require, and it sort of flows down to what kind of home care, and in the end, who needs to go to a long-term care facility. What kind of regional breakdowns do you have at this point?

We've added a few beds through the last number of years but I always look at the challenge that I just see far too many people waiting in hospital for a bed in long-term placement, and I don't know how we're going to send them home with home care when they really need to go to a bed and how you balance all those things off. So maybe just a bit of a plug for what yesterday's work was but that just solves a political problem, it just basically solves what that real number is. It doesn't necessarily help us with the bigger issue that we see here today, which is bed blocking.

MR. CHAIRMAN: Dr. Vaughan, just one minute to respond there.

DR. VAUGHAN: Thank you, it's a great question, it's one that has been well studied internationally. Building more warehouses is probably not the trend that is either the right solution, and we've seen that historically, or what Nova Scotians really want or

need. Most people want to stay at home as long as possible; we will always need some resource for people who are not able to stay at home. The solution is not building that and they will come, the solution is to enhance the home support, enhance the home care. That is the future and there are many reasons for that.

We have many examples internationally where other jurisdictions have been much more successful with the same kind of demographic profile, I would add, as we do in Nova Scotia, so it is by no means inevitable that we go down a road where we have to build more institutions to warehouse ourselves as we get older.

The international solutions, those that have systems that have been successful, which we need to learn from, have put resources in place and that's what we're trying to do by managing the wait-lists, first of all, but also focusing resources where we need to, which is moving patients out of the hospital who no longer need to be there and having them be able to be treated with the appropriate resources and technology to be able to support them in the home.

MR. CHAIRMAN: Order, we're going to the NDP caucus for 20 minutes. Mr. Wilson.

HON. DAVID WILSON: Thank you, Mr. Chairman. Welcome to Public Accounts Committee, it's great to see you all here to talk about something that I think is important to Nova Scotians. I've said this often: in Nova Scotia, when you're in need of health care and emergency health care, we're very good at providing that. I think where we fall down is those elective surgeries - knee and hip - specifically around surgeries; that seems to be the challenge, to meet national standards has always been the question.

I think as political Parties, you commit to things and you try to achieve them. Along that line, I'll first ask the deputy, would you agree that the Department of Health and Wellness' role is to achieve the government's mandate, achieve the goals of the current government, no matter what political Party is in place, to achieve their goals and the commitments that they've made to Nova Scotians.

DR. VAUGHAN: I think that's certainly true. The role of the department is to implement the vision of the elected government of the province and that's what we do to the best of our abilities.

MR. DAVID WILSON: In the Liberal platform that was a promise in their document that I think most people are aware of. If they're not - I don't know if it's still on the Liberal website, but if they need it I'm sure I could provide it to them. On their platform they promised to reduce wait times for knee and hip replacement surgeries to meet or be below the national average of six months within the first year of their mandate. Has that work started and have they been able to achieve that benchmark and that commitment?

DR. VAUGHAN: One of the challenges I think we faced - first let me say that over 96 per cent of surgeries in 2014 were completed within a year so we don't have a huge problem with most surgeries. We do have a challenge with certain surgical groups as I mentioned in my opening remarks; orthopaedic surgery being one of those. The real challenge there is a backlog and once you have a backlog of anything you have to work away to manage that.

Government had committed in 2013-14, over $2 million to address that backlog, another $4 million last year to begin to work and focus the targeted resources required to meet the needs of that backlog - which has taken some years to get to - on hips, knees and paediatric spinal surgeries in particular. Those resources have been committed and are being committed. We've seen an increased number of surgeries over the past number of years, but again, a backlog is the challenge. Whenever you get a backlog it takes time to whittle that down.

MR. DAVID WILSON: I know your role is try to provide as accurate information as possible and I think the 96 per cent of surgeries within a year doesn't achieve the commitment that the current government made of the six-month benchmark for knee and hip surgery. From my interpretation of your answer, it's no, they did not live up to the commitment and we haven't seen that benchmark achieved yet.

You did answer kind of my next question, around that backlog. I understand fully that that has an impact on the wait-list. The backlog has been around for a number of years, it's not something that happened overnight so it has been well known for many years. Probably back to when my colleague was Minister of Health, there has been a backlog. I think government has tried to at times - and you indicated that - infuse what we would call an ortho-blitz, for example, to try to address that.

Is that what you're saying is the reason for the delay on achieving the six-month benchmark - the backlog? Is that really what's behind why the government can't achieve that six-month benchmark for orthopaedic hip and knee surgeries?

DR. VAUGHAN: For the past two years, an additional close to 700 hips, knees and paediatric spines have been completed as I mentioned roughly to around $4 million. In this fiscal year, $2 million was added to an additional 350 procedures. So significant resources have been added to try to address that historic backlog as you rightly indicate.

It's fair to characterize that a significant investment has been made to address the wait-lists. Have we been successful in eliminating it? No, we haven't and on days like today when people are unfortunately falling and breaking limbs, those emergency procedures tend to come to the fore and rightly so. Those who are on our wait-lists do continue to wait and we continue to try and invest appropriate resources. Again, it's important to understand that the consolidation of the health authority allows us to be able to manage our resources more efficiently and effectively. Just throwing money alone at the problem would have solved the problem if we had done that - and we did that, collectively

as a country, and the province included, more than doubled investment in health care over the 10-year period from 2000 to 2010, and we still have a problem. We have a problem with efficiency. That's a process problem. We are working on that through consolidation of the health authority, and subsequent to that, a health service plan, an information backbone. This is the creation of a future efficient and effective health care system - one that is sustainable and one we can afford.

MR. DAVID WILSON: So are you saying that the issue of wait times for orthopaedic surgery and the ability to achieve a national benchmark will be solved once the amalgamation of the district health authorities happens? That's what I'm hearing from you - that that will solve this issue and that issue will go away and we'll be able to meet those national benchmarks that have been set out across the country.

DR. VAUGHAN: First and foremost, we have a backlog, and as I mentioned, we are addressing the backlog. We have a situation where we have excess operating room capacity in some hospitals - particularly in some of the regional hospitals across the province. When we consolidate the health authorities, we can begin to manage as a system - like your EHS example - the efficiencies that are required to not only address the backlog, but also to address the go-forward.

We are working extensively, and have been, with the orthopaedic working group, which is made up of the orthopaedic surgeons who are working with us to find solutions to not only the backlog, but the go-forward prioritization of who gets on what list and when. We know currently that there are many Nova Scotians who get their surgery before the clinical indicators might say it's appropriate.

So there seem to be opportunities within the system to improve efficiency by looking at where surgeries can be done, improving the operating room capacities, and again, working with our stakeholders and partners in the system to be able to better manage the care that Nova Scotians need when they need it.

We have a lot of work to do. Is it going to be flick a switch on April 1st and everything is solved? Absolutely not, but we have a plan - we are working on a plan - and that will get us where we need to be to achieve a sustainable health care system and that's what we believe Nova Scotians want.

MR. DAVID WILSON: What concerns me is that in your comments you had mentioned "begin to manage", which concerns me because we're going to be two years into the government's mandate before we see potentially the ability to address - especially the commitments that government has made to Nova Scotians.

I would think - and you may not comment on this but I'll ask it anyway - would you consider it unrealistic to have made a commitment that you could meet the six-month benchmark within the first year of a mandate? I know you've been in the system for a number of years, so is that unrealistic to have made that commitment? Should government

acknowledge that was unrealistic and that wasn't achievable in any way in the first year of any mandate?

DR. VAUGHAN: As you know, any system that's looking to improve what it is doing sets targets - specific, measurable, realistic - "smart targets" as the Auditor General has referred to them, and we are doing that. I think that is the goal we seek to achieve. We will make significant progress on that journey and we will be held accountable for achieving it or not.

It's important to note that a part in one of the recommendations of the Auditor General that was noted was the hiring of an orthopaedic coordinator, which we have already begun and they are already working with the stakeholders to begin to look at some of those issues that we talked about. So we're not waiting, we're not sitting back waiting for something to happen magically on April 1st. We have already begun the thinking and the processes and the integration - working with our stakeholders and hiring an orthopaedic coordinator to look at what can be done, and to begin to develop a process for Nova Scotians to be able to choose through a referral system that will allow them to begin to look at first available surgeries and what surgeons are available sooner than others.

As you know, we've been doing this for many years in cardiac surgery very successfully. This is an area that we're now working to improve within the orthopaedic wait-list because we had a very similar problem, as you may recall, with cardiac surgery a decade or so ago so you would be very familiar with that - that same sort of process, we're putting in place now. We are working and we'll be held accountable to targets but we are making significant progress.

We do appreciate smart goals, they help focus us in terms of what we're doing and we are working to achieve that.

MR. DAVID WILSON: Thank you for that and I would agree that we were, and the government and the department have been, very successful in meeting those benchmarks for cardiac surgery. It's interesting enough that happened without amalgamating the district health authorities. It's interesting that we could do it for something as important as cardiac surgery but knee and hip, we can't do it unless we amalgamate the district health authorities.

I'll move on from that. In your comments you mentioned in your opening statement that you believe - and thank you for a copy of it - that there are many who believe that pumping more money into the health care system will cure the wait-list concerns. With that comment, I reflect back to the Auditor General's Report and on Page 56, in bullet 4.37, the Auditor General's Office indicated: "The Department's recent estimates note approximately $35 million is needed to start completing 90% of hip and knee replacements within the six-month benchmark reported by the Canadian Institute for Health Information. Once this benchmark is achieved, an estimated $7.7 million is needed annually . . ."

In your opening comments, were you referring to the Auditor General, who used department information and figures and how much money is needed to meet those requirements? I'm a bit confused - what did you mean by, some believe that pumping more money into the system would help with the wait-lists?

DR. VAUGHAN: Thank you for the question - "some" is a general term. There are many out there who believe that adding more money to the health care system will solve the problems. As I alluded to and would commend to you, an excellent article in the February 5th *New England Journal of Medicine* by a prominent Canadian researcher, Steven Lewis, who noted that the health care system in Canada - in real dollars - pumped in double the investment in health care.

In Nova Scotia, as an example, we have the worst outcomes of any province. We spend 46 per cent of our resources in the province on health care. We have the most physicians of any jurisdiction, so whatever we are doing and have been doing, it isn't working. Steven Lewis in his article in the *New England Journal of Medicine* noted that it's not about money, it's about better use of the resources we have. Those are both practices, culture and procedure. That's what we're doing in the consolidation of the health authorities.

Some may see it as not that important; we see it as foundational. When you build a house you need to lay a firm foundation to put the walls and the roof up. If you want the roof to stay on, you have to have a firm roof. We firmly believe that this enables us to develop the health care system of the future, based on good information that will allow us to manage in real time the important investment that Nova Scotians make in their health care system. That is the evidence so more money is not the answer.

It is important, however, to recognize that sometimes we need to target resources to deal with specific challenges we face and that historic backlog does require investment and we have been investing and we are making some progress in that area.

Is it just a flick of a switch? Absolutely not. I wish it could be, but health care is much more complex, as we've alluded to, with a number of pieces that are together that need to be managed as one system. Historically that has not occurred so that's why it's important that we take a one, unified, Nova Scotia approach to the management of health care going forward.

MR. DAVID WILSON: Thank you and I would agree with you. In the past, changes to how health care is delivered don't always have to require huge investments. I look at the Collaborative Emergency Centre model; for the overall budget for the province, very little investment to have a huge impact to access to primary care, to keeping emergency rooms open in rural communities. So I would agree with you that it's not just all about throwing money on it, but certain areas do need that targeted investment.

The figure that the Auditor General received - I think you would agree - was from the department's figure of $35 million that is needed to start completing that process. Do you expect anywhere near that investment in the upcoming budget? I know you probably won't answer it, but I think it's worthwhile answering. In the Auditor General's Report, information is given to them that $35 million is needed to start completing meeting the benchmark. Are you anticipating an increase in the budget so that you can target that investment to address the knee and hip surgery wait-lists in Nova Scotia?

DR. VAUGHAN: Thank you for the question and I will answer the question. I think it's an important question. When the Auditor General quoted that figure from the department's information, it was based on analysis of the status quo. The status quo is not working, which is why we're consolidating health authorities.

So to accurately know where targeted investment needs to be targeted, we won't be able to know that until we have the processes in place and we know really how much money we need to invest, and not an estimate based on a previous dysfunctional, in some cases - not entirely, but in some areas where there are efficiencies that can be gained, where those process improvements need to occur. Once we know what those processes and where they need to occur, targeted investment may be required, but at this point in time, we do not have confidence that the numbers and figures quoted in the past indicate what we will need in the future.

MR. DAVID WILSON: I hope there is some investment in it because you indicated that there was a $4 million investment recently and I know that does have an impact on the surgical wait-lists.

In the Auditor General's Report, there have been a number of things they have identified that could lead to why we're seeing some inefficiencies in use of ORs, for example. I know we used the PAR-NS, or the Patient Access Registry system, for wait times here in Nova Scotia and the Auditor General reported that, ". . . surgeons do not consistently use the system's surgery priority system." Why is that? Are there barriers in place for those surgeons and for those who support the surgeons that would make them not use the system we have in place, to try to be as efficient as possible?

MR. CHAIRMAN: Dr. Vaughan, just one minute to respond.

DR. VAUGHAN: Over 60 per cent of surgeons currently submit their information on time. Again, that is an aggregate number. When you start to break it down by DHAs, you'll have some DHAs with much higher numbers and some DHAs with much lower numbers, speaking to the point that we have an opportunity to - and we are working with the orthopaedic working group and all the stakeholders across the system currently to be able to better understand what the barriers are for some of those surgeons. So it's not the majority - it's some.

I know that some of my colleagues don't like doing paperwork so that has always been a challenge for some, but trying to really understand how important that information is to be able to help manage the wait-lists and be able to improve access to patients who need surgery, I think that's the key opportunity as we go forward.

MR. CHAIRMAN: We'll move to the Liberal caucus for 20 minutes, starting with Mr. Maguire.

MR. BRENDAN MAGUIRE: How are you guys doing today? We thank you for coming out today. I have to say, you know how to draw an important crowd. We have two former Health Ministers here today so whatever you're doing, it's pretty impressive. Sorry if I pause for a little bit here, I've got a lot of chicken scratch - I've been taking notes while everyone has been talking.

One of the things we heard the member for Argyle-Barrington say is, seven or eight years later nothing has changed and we're talking about the same thing. What I want to know, first of all, is why does it take an AG's Report to get the ball moving, or has it taken the AG's Report to get the ball moving?

DR. VAUGHAN: We value the thoroughness with which the AG delved into many matters. We are firmly committed to quality improvement, so any information that is evidence-based that allows us to improve what we're doing, we take to heart and we action that information.

The go-forward approach would be that we have already started and are addressing every single one of the recommendations, because we agree with the Auditor General and it's very helpful for us; we understand what the problems are. We have been addressing them, we have brought into play the orthopaedic coordinator to bring in the orthopaedic working group so we're not waiting for some day in the future, these are already occurring now. The consolidation is an important foundation, though, that will allow us to improve that future system.

MR. MAGUIRE: So just for my own, and I had it written down here, what is the health care budget? What's the amount of money we spend?

DR. VAUGHAN: Provincially, approximately $4.2 billion.

MR. MAGUIRE: You said that 46 per cent of the province's resources are going into this, some of the things you said were quite shocking to me, that we have the most doctors and our outcomes are either flat-lining or going down, that to me seems unacceptable. How do we change the direction or what are we doing to change the direction of the ship because we can't continue down the same road?

DR. VAUGHAN: Thanks for the question. The information I quoted was from the Canadian Institute for Health Information - CIHI. They report that we have the highest number per capita of physicians in the country. We spend the most and we have the worst

outcomes. That's a powerful argument for why we need to change what we are doing. That is what we are doing, we are making significant change in Nova Scotia through the consolidation of the health authorities, investing that money on front-line care where evidence shows it needs to be targeted. That's the power of information and that's the world that we currently live in, but we can't get there if we don't take the first steps, and the first steps are the consolidations.

It's not the answer to everything, we need health services planning to build on top of that. We need a contiguous and integrated information system and we are investing in these systems as we go forward. There are many things we can do. Foundationally it's a one-Nova Scotia, consolidated, unified health authority that allows us to manage care across artificial boundaries.

MR. MAGUIRE: One of the other things you touched on was with the ORs. We have a crisis in some areas, people are waiting to get into the OR. You said that some ORs are closing at 2:00 p.m., so to me that just seems like a horrible waste of resources. If we have an OR in let's say Cape Breton that could do a few more surgeries a day, a week, a month, and we have places where there are wait-lists, why have we not shared this in the past? Why have we not said hey, Joe, let's send you to Cape Breton and you'll do surgery there? Are we doing this now or are we going to be doing this? This seems like it's a terrible waste of resources; as a taxpayer, I think people should be upset about that.

DR. VAUGHAN: That's a compelling reason for a change. All the data I quoted are compelling reasons that the status quo is not sustainable. We have over a number of years been working across DHAs to where it made sense in specific areas to look at how we could take on more surgeries in other places, whether it be Bridgewater or Amherst or Cape Breton or wherever.

Some of that has already been occurring in certain isolated pockets. We've seen the successes from that so now it's time to roll it out across the health care system and not really be dependent on vagaries of will in certain areas or an interest in certain areas. We have compelling reasons for change and we must make those changes and we are making those changes. In some of it, those pockets have occurred, there's no question about that, with a great deal of success, but we need to spread that out across the province.

MR. MAGUIRE: It just seems to me that we have a smaller province and it's not taking us days to drive from one end of the province to the other, and putting all political affiliations aside, it just seems that this is something that should have been done a long time ago. I just can't wrap my head around ORs that are going empty or shutting down early, not being used for somebody's brother, sister, father or mother to get a surgery that they need to make their life better.

I'm going to ask one more question because as usual, I could talk all day, but I'm going to pass this on to my colleagues. In the AG's Report it said, "For example, only 58% of hip replacements and 43% of knee replacements met the benchmark between April and

September 2013." Is this number going up? Has it gone up since 2013? Is this becoming more of a success? I'm asking this because it doesn't say it here, you have the answers. Is it flat-lining going down or going up, where are we on the numbers for this?

DR. VAUGHAN: As everyone knows, we have an aging population and these are some of the areas that we do see the consequences, but more than that, we have a population that's well described and has been talked about in this Chamber and others, that isn't necessarily as fit or as healthy overall. We're seeing younger people requiring these kinds of procedures, in large part due to lifestyle and conditions that put them in a situation where they need to have these surgeries which should be a last resort and sometimes more than one procedure over their lifetime because of the general, I'm going to say, deconditioned population.

There is an opportunity to focus on the health part of our portfolio and the wellness part of our portfolio, to improve the overall health status, is not just about fixing it down the road - although we do - but it's about prevention and health promotion. That will have greater payoff down the road or we will continue to have a challenge to meet the consequences of those conditions. Sometimes people on wait-lists are on long wait-lists because they have to make changes to be able to have the surgery to have it successful, so it's required that they have what we call a pre-hab - a pre-rehab - to be able to lose the weight, to be able to become better conditioned or the surgery isn't the magical solution that people want, it's more complex.

MR. MAGUIRE: So yes or no, the consolidation of the boards, is this going to allow the people of Nova Scotia access to more physicians, more specialists, more resources? Will this impact positively the wait-lists and wait times in Nova Scotia?

DR. VAUGHAN: It's important to understand, and the research internationally will tell us that more isn't necessarily better, it's about the right care. That means that as we consolidate the unified approach that we have, the air traffic control to be able to know where there are capacities and patients can choose whether they want to go someplace because they're able to get in sooner, like with cardiac surgery, and we will with the orthopaedic surgery, they will be able to have access based on their choice.

So that is the system we are building in Nova Scotia. Will it improve care? Absolutely, but it does not mean adding more and more resources, however, it means using the resources we currently have appropriately and targeting investment where the evidence makes sense.

MR. CHAIRMAN: Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: Thank you for being here and it's good to see that you've fallen well into your role as Deputy Health and Wellness Minister, and sorry that we lost you at South Shore Health. I want to get into demographics and you did hit on some of my curiosities, and that is I often hear young people - I'm saying young as in my

age - who are off work or not able to work to capacity because they're waiting for knee surgery, yet they're told they are too young to have the surgery. I'm curious, isn't it better to get people better and back into the workforce and contributing to the workforce and paying income tax? It's sad when you see someone young debilitated and not able to work.

DR. VAUGHAN: A great question. It's clear that it's better for everybody, and most importantly the individual, to be back at work, to contribute. It's part of a healthy life, to contribute, to help their families, to help themselves and be productive whenever possible. I can't speak to individual cases but the surgeons will make individual decisions based on the clinical requirements of that individual.

Sometimes the solution, as I indicated, surgery may be down the road but it may not be the right solution for that individual at that moment. They may be better off looking at some of those lifestyle opportunities and challenges that they face, to become better conditioned, and if they need the surgery down the road, then they would get that surgery. That's a surgical decision that the surgeon would make with that individual patient. I think the surgeon would probably also be telling them that they need to make sure that they're living a healthy lifestyle and they're contributing to their own health.

Surgery is not the first solution, usually. It's the solution that is only after all other options have been tried, in the elective. In an emergency situation it may be the only solution. In the elective situation it may be better for people to try to lose weight, to improve their exercise and to do the things we all know but don't necessarily do, to contribute to a healthy lifestyle.

Surgery has complications, every surgery has certain risks no matter what surgery you're talking about. Going under general anaesthetic has a certain degree of risk. Surgeons know that and surgeons don't want to subject people to those unnecessary risks unless the benefit of the surgery is going to outweigh the risk. So they may be telling individuals that you need to look at losing weight, becoming fitter and then down the road, if you still need that surgery, that surgery would be appropriate.

There's another risk of multiple surgeries too. There are certain risks that each time you have that surgery that you have another associated risk with not only the operating room risks or the anaesthesia and surgery, but then you also have the increasing risk of not being as physically fit because of the consequences.

I know that many of the programs today focus on post-surgical rehabilitation, but those are all risks that go hand in hand with any kind of surgical intervention. Sometimes not everybody ends up with the result they want or perhaps desire so surgeons are very careful about putting people on waiting lists based on their clinical need. Sometimes people end up waiting for a variety of reasons.

MS. LOHNES-CROFT: What are the clinical indicators that a surgeon would use?

DR. VAUGHAN: They have a checklist that they go through based on evidence of research of prioritization, and each individual is clinically assessed according to the criteria.

MS. LOHNES-CROFT: Which are pain, age?

DR. VAUGHAN: Pain - age is not so much an indicator but certainly a degree of pain, mobility - those kinds of indicators.

MS. LOHNES-CROFT: Getting back to work?

DR. VAUGHAN: That's an important indicator for everybody. Being back to work means being productive in whatever activity you might be. You may be retired but still active in some kind of interest, so work can have a broad meaning.

MS. LOHNES-CROFT: So would work-related, like with workers' compensation, would that be a non-elective surgery?

DR. VAUGHAN: Workers' compensation is a different category, as you know, outside of the Medicare system. Workers' compensation relates to people who have been injured on the job so they are obviously in need of getting back to work as soon as they possibly can.

MS. LOHNES-CROFT: Okay, thank you.

MR. CHAIRMAN: Ms. Miller.

MS. MARGARET MILLER: I have been sitting here silently and wanting to applaud a lot of your answers. I find it very gratifying to hear your responses to some of these questions - and difficult questions.

When you talk about changes to the unified health care system, you seem very enthusiastic about that and my colleague has alluded to the point that you're acting on behalf of the government, no matter what the government's directive is, but I think it goes beyond that, if I'm not wrong. You really believe in this concept and you really think you're going to see - or expect to see - some really great results.

DR. VAUGHAN: I do believe that Nova Scotia can lead the way. We are a small province. All the challenges that we've talked about are known so we need to work together and we do a very good job in this province when we do come together and focus on solutions. I've already alluded to - and others have too - the success of the Emergency Health Services consolidation 20 years ago. It's foundational.

I do believe that adding the consolidation and breaking down the artificial barriers of silos will allow us to work together to make the health care system sustainable for the

future of Nova Scotia. We have all of those challenges that we've talked about. To just ignore them and think that by throwing more money at the problems we're going to solve our problems, I think we've failed to learn from our history and the history of our colleagues across the country - the failure to not do things differently.

So I am passionate about the opportunity to improve quality of care. Quality and cost are two sides of the same coin, so more money does not equal better care. It's about the right care and effective care for Nova Scotians. We have compelling reasons to do this now and we are doing this now. We are laying that foundation. We will be talking about health services planning. We've got great opportunities in regional centres and adding capacity to those regional centres and to really start to think and act as one Nova Scotia. I'm very passionate about health care in Nova Scotia.

MS. MILLER: That's wonderful to hear. You mentioned about 20 years ago amalgamating the EHS services and also about how with cardiac surgery - that was done quite a few years ago too to oversee that on a province-wide basis. Has this not been a thought of previous governments in the years of amalgamating health services or broadening this to orthopaedics or other areas? Was it so difficult that it was just sort of put on the back burner? Do you have any thoughts on that?

DR. VAUGHAN: It's an interesting question. It's difficult for me to answer. I wasn't involved at that time when they made the changes. Cardiac surgery was done about nine or 10 years ago, I believe, so it's not that long ago in the scheme of things.

The other factor with cardiac surgery, it was pretty much all being done in Halifax and so you had a consolidated sort of base already. With orthopaedic surgery, we've already got four regional resources already in play with some of those artificial barriers impeding that.

I think the cardiac surgery is a great example of what can be done, especially when it looks at people being able to choose - I can wait or I can choose to see someone sooner somewhere. That model, I think, is really one that we want to look at in a variety of areas, but orthopaedics makes sense now because of the challenges we're facing and because of the need that we really face with doing things differently to address that backlog, which has gone on for a long time.

MR. CHAIRMAN: Order. We'll move back to the PC caucus for 14 minutes. Mr. d'Entremont.

MR. D'ENTREMONT: I find it interesting as we go around, the different avenues or angles that we all use. I want to go back to where we left off. You were talking about the warehousing of seniors - not a word that I enjoy using or one that I would ever think of using, I find it interesting the way you used it though. By no means have I ever thought that we should be warehousing seniors. What I do feel though is that there has to be the correct number of services available to them. From the anecdotal information that I have

by the phone calls that I get by the people who I visit, by my family members, there still seems to be an awful of requirement for long-term care, whether rightly or wrongly.

It's very rare that I would receive a phone call in my constituency office looking for more home care. Once in a while it happens: I've got three hours and I'd like to have five, they're here and I'd like to have another visit on Tuesday, those kinds of things. But person after person that we get in contact with, the people who come to see us, are people looking for long-term care. Maybe just before we kick off on more of the Auditor General's stuff, to maybe treat this one a little more softly, what are we going to do with those folks?

I had an aunt who sat in the hospital in Yarmouth for a whole year, an MS patient, who can't go home because she continues to fall down, her husband can no longer take care of her, sits there for a year. Anecdotally, my list seems a little longer than what the department's list is. I just want to be able to balance off those two, the data versus what we continue to hear.

DR. VAUGHAN: Thank you for the question. We have the greatest number of long-term beds per capita of anywhere in Canada. It flies in the face of modern evidence to think that just continuing to do what we're doing is going to solve our problems. As you well know, no one conceived when EHS was born and with the consolidation of ambulance services that we would have advanced care paramedics delivering clot busting drugs in the back of the ambulance. Technology changed that scenario, the ability to deliver those services changed how health care is delivered.

Health care is a rapidly evolving technological area. Many things that we used to do a very short period of time ago, in my lifetime even, were done only in the hospital; gall bladder surgery, for example, that took a week to 10 days now is done in and out the same day. Many scopings, many things are done outside the hospital, and we can evolve our processes and procedures to have them be not only cost effective but also better care for individual patients. The opportunities that we can achieve by delivering services in the home is not only better for patients - and I don't have to tell you the risks of being in hospital, not the least of which is infection, but also other concomitant conditions that occur in an institutionalized setting also tend to occur in the institutional settings for long-term care. It's about thinking differently about how we address our problems.

As I said, we have many cases where individuals, because of individual need, have no other choice but to consider the long-term care environment, but it isn't necessarily the right choice for everybody. As we look at the right choice for the right individual, the home may be in the future - as it is in many jurisdictions not only across the country, but internationally with a similar demographic profile - the better choice for the individual and I believe technology will help us just as it does in EHS and other areas in health care, to improve the service we deliver in the home safer, better, and cheaper.

MR. D'ENTREMONT: I agree with everything you said there, bang on, I probably said it at one point too in some speech that was provided to me by the department. But at

the same time we always have that anecdotal information that we get as MLAs that if the department thinks I can go home, but my husband can't take care of me, they do the interviews, they do the assessments, the patient says one thing, and when they go talk to the family there's something completely different happening there. So it's just sort of treated with that balance - I mean there has got to be a balanced approach on the services that they are required to move them on, to move them out of that acute care setting so the surgeries can move on. It's just more of trying to find the balance there.

I've used up far too much time about this but that's where I think my heart has been on this one for a long period of time. We can't just say we need to send everybody to a long-term care facility but there has to be a balance between those two things and I hope that technology is one of those things that is going to change that because I don't know how many more of those phone calls I can listen to and just beat my head against the wall and not do anything about. It needs to change, I think society needs to change in the way we treat long-term care in that way.

I'll talk about continuing care as a whole medium there and like I said, long-term care is just one part of that whole piece.

Let's move on to the other Auditor General's Report for just a few minutes because I'm almost out of time. In the Auditor General's Report, it says about PAR-NS: "We found the registry's data was reasonably accurate for reporting wait times; however surgeons do not consistently use the system's surgery priority system. This means the resulting waitlist is not correctly prioritized."

I think it said 60 per cent of doctors are pretty good at filling it in so that means that 40 per cent aren't and it changes from place to place. If they are not using the priority system, how were they determining who can be operated on? Who is making that decision? Why are they making those decisions in this way?

DR. VAUGHAN: It's an important question that strikes to the heart of the prioritization tool. Working with the orthopaedic working group, it's about bringing everyone along to see how important those tools are. Surgeons, like physicians, generally are very busy people and sometimes they are not necessarily the best - some of them - at doing that paperwork, they don't necessarily understand how that might have an impact in terms of the prioritization. Some districts are better than others in helping them achieve that goal.

It really is speaking again to the evolution of evidence and how evidence can help us prioritize the acuity within the wait-list. Many of the orthopaedic colleagues are the best ones to try and help not only educate but encourage their colleagues to see the benefit. It's those stories that the other surgeons will tell them how things have improved in their area, how they have better access to OR time, how they are able to treat more patients more efficiently and effectively. That's what the orthopaedic working group and that's what the orthopaedic coordinator are helping to disseminate, the benefits of the prioritization tool.

Prioritization tools internationally and nationally are long in evolution and as we improve those prioritization tools, we will get better at understanding the individual requirements which are so important and being cognizant of the importance of the individual needs of our patients.

MR. D'ENTREMONT: So the registry cost $12 million and the Auditor General maintained that the data is reasonably accurate, so the effectiveness of that system is undermined by the fact that many offices do not even use the system to establish those priorities, so how are we going to get that extra 40 per cent to participate? And I know that anecdotally we can sort of convince them with stories and all that, but is there maybe a bigger hammer the department can use to get them to use the system because I think the outcome of it is far too important. We need to get people through our surgeries here who can't be sitting and waiting in pain all this time, waiting for a knee or hip or whatever it is. It's got to be more than stories here. Do we wield a bigger hammer?

DR. VAUGHAN: It's a great question. It's always the carrot and the stick, isn't it, at the end of the day. One of the good things about the health authority consolidation legislation that we have before us is that we have an accountability framework requirement of that health authority, and wait times are one of those requirements going forward.

Like many things, as we said earlier, the data and the target focuses the mind. So the focusing of the zonal physician co-leadership which is new in Nova Scotia and again leading the country in the new health authority going forward, we'll be partners, to be able to see their colleagues improve in those areas. Those consequences will be determined collectively with the new health authority and physicians because many of the surgeons and physicians want to see this improved too. It's about bringing their colleagues along and they'll be the ones to decide the consequences about allocation of resources at the end of the day, in partnership with the health authority.

MR. D'ENTREMONT: In the breakdown of the data of the wait-lists - and we have four or five sites that do orthopaedics now - out of that 60 per cent, what's the breakdown of that? Is Kentville worse than Pictou or is Pictou worse than Kentville? How is Halifax compared to it? How do they rate amongst each other?

DR. VAUGHAN: We can certainly get you the specific breakdown information. I don't have that before me today, but places like Kentville do a good job - a much higher response rate than, say, Pictou, for example, but we can get you the information.

MR. D'ENTREMONT: So if we put them all in one district health authority, or one health authority - not a district anymore, it's a big district - how is that going to break down the silo because the medical community, from what I've seen about it, is very - "cliquey" is the wrong word, but they're very together and they try to keep their teams and they're very tight with their teams. So how is the management style of a district going to change the siloing of these five sites?

DR. VAUGHAN: Again, working back from that accountability framework, which is publicly reported, that's going to focus the entire senior leadership of that new entity to ensure that the zonal operations are working together and across the zones. The management teams will be working effectively to bring the physician colleagues along.

We have very successful pockets, as we've talked about, and some of it is - when you're living in your own world and you only see your own world, then you don't know anything else outside that world, so the opportunity to spread some of those good activities and benefits is key. Again, the co-leadership model with physicians will enable consequences to behaviour that are not a benefit to the functioning of the system to allow for patients to flow through in a more efficient and effective way.

So it's about management of our resources, and effective management of our resources begins with understanding what the issues are and also what the opportunities are based on the evidence to be able to implement change, and I think we will see that.

MR. D'ENTREMONT: Finally, the Department of Health and Wellness has as one of the recommendations, ". . . should develop a clinical services planning framework for surgery that determines which services will be offered in each location." We know the challenge for rural areas - if you're from Yarmouth and you're trying to get orthopaedics, you've got to travel to Kentville for your meetings and your assessments and all this stuff. So is there going to be a better balance in taking into consideration the travel times that patients are going to have when they develop this new clinical services plan?

DR. VAUGHAN: It's important that patients understand, and all Nova Scotians, that the future health care system is going to be a system that's based on evidence of need and evidence of patient requirement. We want to achieve the best outcome so - there are a lot of examples of where we can cluster activity in various regional centres and improve the efficiency, improve the throughput, improve the service to Nova Scotians.

Some of that is to improve the quality of that service. It's not just about any service. Patients want and expect to have a good outcome at the end of the day. To do that, we need to cluster the expertise and the services to achieve that. There's a lot that can be done in different places across the province in clustering.

A health services plan is one that really sort of begins to look at what the needs and what the opportunities are in a small province like Nova Scotia, to be able to look where we want to look as a province, at what services can be clustered in appropriate areas, but we live in a world where health care is increasingly a high-tech, high-touch industry and so to be able to really provide that quality service . . .

MR. CHAIRMAN: Order. Time has lapsed for questioning from the PC caucus. We'll move to the NDP caucus for 14 minutes. Mr. Wilson.

MR. DAVID WILSON: I'd like to go back to the information that the department provided the Auditor General - it was around the $35 million estimate that the department gave the Auditor General in order for the province to meet the benchmark of six months. I know, deputy, you indicated that is not the case or you believe that won't be the case, that $35 million won't be needed because of efficiencies that may be found after the amalgamation of the district health authorities. Could you maybe provide the committee an update on what the department's estimate is now? I think we would all agree that there has to be some investment in this to address wait times, so what would be the estimate from the department now that's required to achieve the goal of meeting the benchmarks for knee and hip surgery?

DR. VAUGHAN: As I indicated earlier, in 2013-14 we added $2 million, we added another $4 million, and we're adding in this fiscal year $2 million to do an additional 350 procedures, so that's significant resource. We are working with some of our physician and surgeon colleagues, in particular, to address some of the most challenging wait-lists around foot and ankle surgery, for example, which is a fairly specialized area, working with other components of the health care system to look at, again, the conditioning, the wait, some of the enablers that lead to some to those consequences, the general fitness and conditioning - these are important elements to remember that go into the pre-surgical workup.

So, yes, the resource that we're committing to address that backlog now, while important, is not the only thing we're doing to try to organize better access to the services through working with our physician and surgeon colleagues to be able to have them locate to places where the surgeries are required, so it's a multifactorial answer to your question.

MR. DAVID WILSON: I appreciate that, but I kind of was specifically talking about hip and knee replacement, I understand other demands and pressures. The Auditor General does an audit, they request information from the department, and the department gives them that information. What I'm specifically talking about is that the department gave the Auditor General an estimate of $35 million, so I know you indicated roughly about $8 million so far of investment. Now I would believe that that's not all going to address knee and hip surgeries, I believe that that's spread out across orthopaedic surgery. Specifically, when did the estimate change and if you could be more direct - and I apologize if I might cut you off, we only have a few minutes - can you give what the new estimate is to address the knee and hip surgery benchmark or can you give that figure now?

DR. VAUGHAN: The simple answer is I cannot give that figure now because that figure was based on the status quo, and we've talked about the status quo being unacceptable and all the compelling reasons we need change. We will not know until we understand the demand and efficiencies that we're able to achieve, and I think it's important to reiterate the opportunity for efficiencies may allow us to increase the throughput by reallocating to various areas what we are currently doing in one, two or three isolated silos. I'm sorry if I can't give you a hard number today, but we are looking to achieve that number.

MR. DAVID WILSON: That's okay, I appreciate that. My concern is that the information that was provided to the Auditor General's Office was provided, I would assume - and I may ask the Assistant Auditor General - would have been given in the last six months or less. I know that the commitment from the current government to amalgamate the district has been there from day one. I'm a bit concerned that that figure was given but yet it's not what you anticipate will be the figure. So I'm going to move on from there to another area that I think will affect wait times also, especially for orthopaedics but wait times across the board, and that's the nursing shortage that we're hearing about and learning about.

We know from the Premier's comments that he became aware of the nursing shortage on November 14th. I wonder if you could advise the committee of when you and potentially the Minister of Health and Wellness became aware of this nursing shortage that we have here in the province?

DR. VAUGHAN: I wouldn't characterize it as a nursing shortage in the province, I would characterize that we have certain challenges in certain key subspecialty areas, if I can put it in that term - critical care, mental health nursing. We have those two cohorts, and just for example - and I'll put this delicately - an aging cohort, we're all getting older, but those areas in particular have high areas of nursing personnel who are eligible for retirement. Whether they do or not is a personal choice obviously. Those two areas have that aging population, they're eligible to retire sooner than some of the others. They have some challenges as well with long-term disability and sick time and challenges in some areas around maternity leave.

I wouldn't characterize that we're aware of a nursing shortage per se, although we have some challenges in certain key, important areas.

MR. DAVID WILSON: So what steps is the department taking to address that? What we're hearing - I'll use nursing shortage, you may not, but there is a shortage of highly-trained nurses in ICU and those areas that no matter how many new graduates you hire, won't be able to replace those. What are you doing to try to address and target those highly-trained areas that we're seeing a lack of nurses to provide the care?

DR. VAUGHAN: Thank you for the question. We have been successful in keeping nurses in Nova Scotia and we have more nurses in Nova Scotia now than before. We're now seeing nurses come back to Nova Scotia. However, we have a challenge with some of the skill sets that I mentioned. These are subspecialty areas in some cases - perioperative OR nursing, emergency nursing, and critical care nursing in particular. Those are nursing areas that require experience and skill.

We - and I mean we and our partners in the district health authorities - have been working - and successfully in many cases, although there are still some pockets where there are challenges - in helping to train those nurses who are new out of the system, many of them without that experience, who have a desire to go into some of those specialty areas

but do need the experience to be able to function independently in those areas, so we are making those changes.

MR. DAVID WILSON: With your comment about bringing nurses back, I would assume that's not referring to the recent information of having nurses come in from other provinces for a temporary time, to cover those positions. I see you nod "no" so I'm glad to hear that.

You mentioned retirement. We all know and it has been well-documented that in the nursing profession there's a high number of nurses who can retire at any time. That can have a severe impact on health care and health care delivery. Have you seen an influx in retirements this year over last year? Can you provide information on the number of retirements in the last six months compared to a year ago? Are you able to provide that information? Do you keep track of that information?

DR. VAUGHAN: I don't have that information today. We can certainly provide that information to you. We would have to contact the nine district health authorities to get that information. In the future we will be able to have that from one place but we'd be happy to get that for you.

MR. DAVID WILSON: Thank you very much. I think it would be quite easy to get it from the nine. Probably you all have an HR person overseeing that who can send you an email or some information, so I'd appreciate that. I think I'll move on from that one too.

One of the things, of course, is ensuring that people gain access to these services. Throughout this you mentioned on a number of occasions, and I have to applaud you, you're sticking to the message of a one-Nova Scotian approach, which I think we could debate at length here on that. As you mentioned, hopefully you're going to see efficiencies for the OR so that the $35 million is not going to be $35 million, we've heard that before, we've heard it from the minister and the government before that the efficiencies in the first year of amalgamation will be $13 million. We all know that that's not going to be the case. Today, since I have you in front of me, how much has been spent on the amalgamation of the district health authorities to achieve the one-Nova Scotia approach to health care delivery?

DR. VAUGHAN: So sticking to the message, we don't yet know the exact figure today because we won't finish that work until March 31st, and there's a component of that that relates to personnel and we will not have that entire figure until the end. What we do know is that we will have at least $5 million in savings the first year, that efficiencies we will bring into the system for all the reasons we've talked about, and many others, will allow us to operate more efficiently and effectively as we plan and implement a one-Nova Scotia approach.

We don't hope for efficiencies, hope is not a strategy, we intend to have efficiencies. We are building an accountability framework and that accountability

framework is in legislation, that holds the feet to the fire. We will be reporting publicly on each and every one of those metrics we will be achieving and what we don't achieve, there will be consequences and incentives, in some cases, to improve productivity. But we will achieve our desired goals.

MR. DAVID WILSON: Has there been any money spent on severances? I know you indicated earlier about looking across the country, on ensuring that we don't make mistakes as other provinces have. One of the indicators early on around amalgamation was the fact that there is a cost to reducing a number of CEOs and VPs. Alberta, for example, spent tens of millions of dollars on that, and that was one of the alarm bells that was provided to Nova Scotia at the time. Has there been any money spent on severances so far because I know a number of individuals have left, many of them were under contract, so has there been any money spent on severances so far?

DR. VAUGHAN: The simple answer is no. Nova Scotia is being looked at as a model of how you do this kind of transition. We have spent a year with people from the system working together, people who know the system, know the challenges of the current system, who are in the best position to plan what the future health care system management structure looks like. They have been working together very effectively, it's one of our success stories. I think at the end of the day the story to be told is about how Nova Scotians who are in the system, impacted by the system, came together in the interest of Nova Scotians to structure the system for improvement, so they're continuing to work within the system. The CEOs and the VPs are currently working within the system because they're professionals who have focused their careers on improving what they can do to work within the structure they have, but they can only do so much with the structure they have. So the answer to your question is no.

MR. DAVID WILSON: Thank you.

MR. CHAIRMAN: Order. Time has elapsed. We'll move back to the Liberal caucus for 14 minutes. Mr. Stroink.

MR. JOACHIM STROINK: I'd like to bring us back to topic that we're actually here to discuss. The report mentions (Interruption) Or going way off on a tangent. The report mentions there are inconsistencies from district to district with respect to OR processes and policies. How does this have an impact on wait times and OR utilization? Will the new health authority kind of help with that process?

DR. VAUGHAN: The answer is yes. Each different health authority has its own way of doing things and that's part of the issue. Some of them have been very successful, some of them have been very productive in introducing changes and others have not, so there's wide variability across the system. That to us is an opportunity for improvement, taking that variability and then working - we are currently, we're not waiting for April 1st - with stakeholders, the players, the surgeons and others. We've invested in the orthopaedic coordinator to look at the processes. The people who are doing the work, in my experience,

generally know the solutions to the problems so it's very important to bring the people who are in the system together - as we have been doing with the consolidation - to address the issues in the operating room efficiencies. They know what the problems are, they know what the solutions are.

MR. STROINK: Thank you. I also kind of want to touch on something you spoke about earlier in our discussion, creating the foundation of health care. I think with that I see that as more preventive health care. You spoke about youth dealing with surgeries that are only happening in adulthood because of the obesity that is occurring in Nova Scotia. I guess for me, as someone who spends time investing in myself by going to the gym and running and stuff like that, I'm trying to get myself out of the system at a future date.

What are we doing to try to create that process in a larger scale for Nova Scotia? I see that that is how we are going to reduce times, that is how we are going to get people faster through OR, by not putting people in the OR situation.

DR. VAUGHAN: Thank you for the question. As one who is as committed as yourself to both diet and exercise and a healthy lifestyle, I know the importance and have learned the importance over my long career in health care of the value of prevention.

Nova Scotia is one of the national leaders in the Thrive! program. We're working in the schools, we're working across departments to look at healthy activity and transportation and all those important pieces that cross outside of the health care system that are in many cases fundamentally important to enable Nova Scotians to make the healthy choices. So there's a role for all of us in that and we're doing our part in Thrive! to communicate the healthy benefits of that healthy lifestyle, working with our partners in education and other departments in particular.

MR. STROINK: I guess with the Thrive! program, that has been a huge success and it is highly recognized across Canada. I guess that this being the year of sport, what are we going to do to try to encourage more people in Nova Scotia to get active, so they don't end up in the OR? As my colleague said, there doesn't need to be big money to be put into health care to find solutions. I'd like to understand a little bit more but beyond the Thrive! what we're going to do.

DR. VAUGHAN: The activities that we have, we have many great recreational facilities across the province. This weather is not necessarily conducive to many of us who like to get outside and run but we have treadmills, we have activities.

I think the most important thing for all of us in any position across Nova Scotia is to show leadership and to demonstrate what that healthy lifestyle looks like. It's very important that we, in the younger populations, in the schools in particular, be able to encourage activity, what we call "break away from the screens", getting younger people in particular out and about, whether it's in regular sports activities, whether it's going for walks with parents or tobogganing or any other activity that is away from the screen.

There's an important role that we all play across the system. We can do so much in health care in advocating and promoting, but there are many others across the system that can also be an important part of that. We in the health care system have introduced in a pilot project which we're hoping to expand - the personal health record. It's so important that people have the information in their own possession about their own health, being able to understand the impact of small changes in both diet and exercise and some of those negative lifestyle habits that have a huge impact down the road on the costs to the health care system and the concomitant cost and burden to society as well but most important, to the individual.

We're looking to the future to be able to incorporate many of those tools that exist that help individuals understand both the motivation and the impact on healthy lifestyle activity.

MR. STROINK: Thank you very much.

MR. CHAIRMAN: Mr. Maguire.

MR. MAGUIRE: The member for Halifax Chebucto always makes us feel bad with his healthy lifestyle, especially when I'm sitting around eating a donair, so thanks for that.

I actually want to get back off topic. (Laughter) I just want to talk about the nurse retirements. We hear about that a lot. Is this anything new as we see baby boomers getting older? They're retiring. Is this new to this profession? Is this something that's unique to this profession? I'm going to throw a bunch of things at you and then just let you finish out.

I know in my previous employment there was a whole host of experienced workers that were on their way out the door. They recognized that there's a whole wealth of knowledge that once that's gone, it's gone. So what they did was they partnered some of our younger employees up with the more experienced employees and had them train - because you can learn all you want in school, but sometimes the tricks of the trade are learned on the ground and when you're working.

I also want to know - because like I said, it's in the media, we hear about it a lot, some of the members like to talk about it and for good reason - is this unique? Is this the first time the health care system has ever seen retirement? That's what I feel like. I feel like this is the first time we're seeing experienced, professional health care workers retire. Has this happened in the past, and what happened in the past to get us where we are today?

DR. VAUGHAN: It's a great question. The answer is that people have always retired. We're living longer now and we're working longer now, and that's just the reality of the demographic across every profession, which obviously has its pros and cons for people coming in behind and the younger age group finding opportunities sometimes. In health care we have a lot of opportunities with the retirements that we see.

We are seeing what has been described as the baby boom bubble, which is really throughout society. Health care is heavily influenced and dependent on people to deliver services so we are very heavily dependent, unlike some industries which have been able to make changes with advanced technology - in the automobile industry, for example, and robotics. We haven't really seen that yet in health care so we're seeing this large pool of baby boomers, and health care is not unique in that regard because we experience the same problems, or challenges I should say, whether it's in construction or plumbing - it's hard to get some highly skilled resources in many sectors of the economy, but I can only talk about health care because that's the bubble that we're dealing with as the baby boomers move through that demographic pyramid that we're all familiar with.

MR. MAGUIRE: So this isn't unique to the health care system, like I said. It's something that in my previous jobs we've seen. I think it's kind of a double-edged sword, too, for health care because as the baby boomers retire, some of them are having health care issues so they come from working in the system to actually depending on the system.

So in your professional opinion this isn't the first time we've seen retirements in the health care system and it has been handled in the past?

DR. VAUGHAN: What we're seeing now is related to that bubble. It's the large number, and it's true, as you have indicated, beyond health care, but it is certainly a phenomenon that we are dealing with in health care because of the large number of that baby boomer bubble. We've always had people retiring. It's the number of people who are retiring and, again, people are working longer. They're staying in their chosen professions and working longer, so when they do retire in greater numbers, because they are cohorts of age groups, when they start to retire, that's where we see challenges to be able to fill those numbers to the degree that we used to see in previous times - small numbers. Now we've got a larger number of people who are retiring and that's true outside of health care, but it's acute for us in health care, as you've articulated.

MR. MAGUIRE: So what I'm hearing from you - and correct me if I'm wrong - is that this is less about any kind of policy or legislation and more about the age - the baby boomer demographics that we're dealing with.

DR. VAUGHAN: It's a phenomenon that we're seeing throughout society and it would be true in airline pilots as it would be in other sectors. In my sector, in the health sector, we have a very human resource-intense environment and so we're seeing the larger groups being able to retire. We've known this was coming so we've increased the number of people in training programs. Someone has said that people need skills and training when they come out, you don't come out with all the skills you need so there's a certain highly specialized experience. Those are the areas that we experience what we would call areas of need.

MR. MAGUIRE: I don't want to put words in your mouth, but I'll take that as a yes. I'm going to pass that on.

MR. CHAIRMAN: We have two minutes left. Ms. Lohnes-Croft.

MS. LOHNES-CROFT: Dr. Vaughan, in your opening remarks you had said that the department has accepted all the recommendations and are implementing each and every one of them. I'm glad you started this before the consolidation of the authorities. Tell me where you are in this work?

DR. VAUGHAN: We have the orthopaedic working group that's working diligently and these are busy orthopaedic surgeons working with health systems people. We've implemented one of the areas that the Auditor General noted, which was the orthopaedic coordinator position, which is key to be able to develop with the working group the commonalities of the processes that can be spread throughout the system to achieve efficiencies. Remember, this is about efficiency and effectiveness, this is why we're doing this.

We're making improvements to the website. Last week there were the focus groups and by the end of March we'll have a plan to revamp the website to make it more user friendly, you'll be able to access it on your mobile device so you'll be able to have a better understanding of what the wait times are and where. We're implementing that referral pool for patients to be able to go and understand where maybe it's shorter to wait rather than waiting with an individual they may only have seen once, that they'll be able to choose, as we've talked about. We've already begun and initiated a number of activities to improve.

MS. LOHNES-CROFT: Thank you.

MR. CHAIRMAN: If that's all for questioning, I'd like to give you an opportunity to make a few closing comments if you wish.

DR. VAUGHAN: I'd like to thank each and every one of the committee members for their important questions this morning. I hope we were able to provide you with the information you were looking for. If there are any outstanding questions, as I have said, or information the committee needs, I will assure our staff provides it in a timely manner.

We are committed to addressing efficient use of operating room time and tackling surgical wait-lists in this province. The DHA restructuring is a key enabler in helping to address the inconsistencies the Auditor General identified. It will give us an opportunity for a system-wide change and system-wide planning to ensure consistency and operational policies governing operating rooms and more efficient use of existing surgical capacity across the entire province.

Our goal is to provide patient-centred, timely access to necessary surgery. I am confident that we will achieve this through collaboration with our partners in the districts and throughout the health care system to develop a unified, one-Nova Scotia health system. Thank you very much.

MR. CHAIRMAN: Thanks very much for coming in today and being present at the committee for the members.

The next meeting date will be February 25th and that is the Office of the Auditor General presenting their February Financial Report from 9:00 a.m. to 12:00 noon. It's a three-hour meeting, the first hour being an in camera briefing and then the second being public. Following that will be the subcommittee with the agenda and procedure setting from 12:00 noon to 12:30 p.m.

We now stand adjourned.

[The committee adjourned at 10:54 a.m.]